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Winter 2017

A publication of Arizona Academy of Family Physicians

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Edition 27

Andrew Carroll, MD

Editor's Letter

The Open Access Model

I have been getting more and more heavily involved in the Value Based model, starting to set the parameters that payers are using to determine what is considered "Valuable" to them and to us, the practicing physician. Instead of a non-practicing physician or health plan administrator choosing what would make clinical sense, an actual boots-on-the-ground physician is helping to set that. My hope is that it will make much more sense to the grand majority of us PCP's.

I had the opportunity to ask an executive at one of those very large plans in Arizona how many primary care physicians he believed were engaged in and moving forward with the value based model and its requirements. His answer: 10%.

That really surprised me. I was not sure if it was plain apathy about changing how we do business with health plans, resistance, or failure to recognize the importance of that change. I think we have been told for the past ten years that we must change how we do business, and we have just grown tired (pissed off) about it all.

First there was the Patient-Centered Medical Home. I was never interested in pursuing that certification. But every time we turned around, our professional organization was shoving it in our face. We HAD to become PCMH. It was the future model of care. If we were going to survive in primary care, we had to receive certification. And the AAFP created a division called TransforMED to consult with us to transform our offices. To me, it just looked like a money grab for those creating the standard and supporting it. In truth, perhaps for large practices, it may have made sense to align all their employed physicians. But for us onesies and twosies and threesies (yes, these are terms used quite actively in the healthcare payer field), the amount of money put in would never had come out in the ROI.

But the value based model does make sense. In its future iteration, there will be a per member per month payment. That means for all the crap, ahem, administrative work we do in between visits, we will be compensated. Then when the patient is seen, there will be a fee for service. It's my feeling, though, that that fee for service will be mostly covered in the patient's copay. Finally, there will be a "value" payment or "shared savings" payment; call it what you will. It's a payment for a "job well done." So, if you were a good doctor, kept your patient out of the hospital, controlled their chronic diseases as best you could, and chose specialists that delivered evidence based care that was cost conscious and not simply to help them buy a new Mercedes, then we will be rewarded. It is what primary care does best. It's what makes us valuable.

I will tell you, having been medical director of two Maricopa county clinics early in my career, as well as running a successful medical practice with an integrated medical-behavioral model, that the one change, THE ONE CHANGE, that every practice can easily make that will increase provider satisfaction, massively increase patient satisfaction, reduce no-shows, and reduce emergency room and urgent care visits is to adopt the open access model. If you are going to ignore all the other tenets of the PCMH, you must adopt this one.

The easiest way to do this is to allow your staff to schedule every other appointment for you and nothing more. This means that when you come into the office in the morning, you will only have 50% of your schedule filled up. Once your patients learn and are trained that you have easy availability for same day appointments, they will stop going to the emergency room and urgent care, and call your office. If they don't have to run through a gauntlet to see you, or wait to see if you approve of the same day appointment, they will call your office. Your daily appointment schedule will remain full, you will be happier about your schedule, and your patients will be infinitely satisfied with your office. If you aren't doing this now, then change how you do it.

For the times they are a-changin'.

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NOT on twitter? YOU might be missing out on exciting news and insights from your colleagues! Did you know that MOST young physicians are on Twitter and post daily? Even if you don't want to post, it's worthwhile to "follow" several colleagues, friends and businesses to stay up to date.

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Need help setting up your account? Contact Laura at ldearing@azafp.org and she'll help you!

Let's Talk About The Patients

By Susan Hadley, MD

In the context of all that is going on in our country today let's talk about the patients. As a family physician I have had the privilege to work with patients of every age, gender identity, socio-economic class, race and ethnicity I have worked in inner cities and rural towns, inpatient and outpatient, on the streets and in other countries. I believe that most family physicians went into medicine to take care of people.

The changes in medicine over the years have been challenging for some family docs, and some of us have broadened our involvement beyond patientcare as we work for patient rights and healthcare for all. As an idealistic medical student I worked with the underserved to help improve patient health and the health of their communities. This work is ongoing, with forward movement in some areas and apparent backward movement in others.

This fall I accepted a position with COPE Community Services one of Tucson's Behavioral Health providers which includes medication assisted treatment (MAT- methadone or suboxone) for patients with addiction. Like COPE, most behavioral health entities are working toward integrated care by making primary care accessible at the site where patients receive their behavioral health care. I have two roles at COPE, working as a primary care provider and providing MAT. As a primary care provider I am not able to just provide MAT- I involve myself in all aspects of their care.

Let me tell you about a few patients: FQ is a 17 year-old patient whose father and uncles have been using heroin since he was a baby; he has seen violence first hand. Recently his father was shot as he was looking on during a drug transaction. JS is a pregnant 23 year-old with her third child. Her previous children were taken by Child Protective Services and although she has been stable on methadone for 2 years with a good job she is unable to get them back. She is terrified she will lose this child even though she is clean from any illicit drugs, and holding a steady job. BH is a 55 year-old male who hurt his back at work and became addicted to pain medication. He lost his good paying job, his family, and his home. LR is a 60 year-old veteran living on the streets for most of his adult life after becoming addicted to drugs when he could not find any treatment for his PTSD.

Our patients all have stories and as family physicians we are there to listen and treat their medical issues (in 7.5 minutes). Let's always remember the individual that is our patient and keep fighting/ working toward healthcare and equality for all, better reimbursement models, more time to care for our patients and for self-care. Let's keep working toward a better healthcare system. Work with the AAFP and any organization that promotes better health for our society. Work with STFM or in any way you can to support and educate our medical students and residents for a bright future in healthcare.

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If you, or someone you know has an interest, please contact CDR Stephen Navarro at 602-364-5222, or email Stephen at Stephen.navarro@ihs.gov. I hope we'll talk soon.

P.S. Your Southwest adventure awaits you.

QIO Collaborative to Help Family Practices Implement Antibiotic Stewardship Programs to Combat Antibiotic Resistance

Antibiotics are life-saving drugs that are critical to modern medicine. They help in the treatment of patients who would otherwise suffer or die from infectious and communicable diseases. However, their increased use has led to antibiotic resistance, which allows bacteria normally susceptible to a particular antibiotic to multiply unopposed, with serious consequences for patients and their communities. Examples include the occurrence of such organisms as carbapenim-resistant Enterobacteriaceae (CRE) and Methicillin-resistant *Staphylococcus aureus* (MRSA). Although antibiotics are generally safe, their use does carry some risk for patients, ranging from minor side effects to the development of life-threatening complications. Additionally, unintended consequences from injudicious antibiotic use can lead to proliferation of pathogens such as *Clostridium difficile (C. diff),* with devastating consequences. The Centers for Disease Control and Prevention (CDC) estimates that each year 2 million Americans are infected with antibiotic-resistant bacteria resulting in 23,000 deaths.[1]

The reality of antibiotic resistance has been recently highlighted with the nationally publicized death of a Nevada woman resulting from a *Klebsiella pneumoniae* infection that was resistant to all 26 antibiotics available in the United States.[2] This case underscores the need to understand and guard against the unindicated prescribing of antibiotics when their use can lead to the development of these so-called "superbugs."

The most important modifiable risk factor for developing antibiotic resistance is the elimination of inappropriate prescribing practices. At least 30 percent of antibiotics prescribed in the outpatient setting are unnecessary, meaning that no antibiotic was needed at all.[3] Moreover, infections with pathogens resistant to first-line antibiotics can require treatment with alternative antibiotics that can be expensive and toxic. Antibiotic stewardship, the practice of monitoring specific, evidence-based indications for antibiotic use, is central to improving appropriate antibiotic prescribing. Through stewardship programs, healthcare facilities monitor, reduce, and prevent misuse and/or overuse of antibiotics using a strategic, multidisciplinary, team approach. Improving antibiotic prescribing through stewardship can help lower healthcare costs and, most importantly, keep patients safe from harm.

A National Effort to Combat Antibiotic Resistance

Recognizing the rising threat of antibiotic resistance, the White House convened a 2015 antibiotic stewardship forum, which brought together more than 100 healthcare leaders involved in stewardship activities.[4] A consensus goal was reached to cut inappropriate prescribing by 50 percent in doctors' offices and 20 percent in hospitals. The CDC agreed to provide data on antibiotic use and prescribing trends to stakeholders, and healthcare system leaders pledged to establish or expand stewardship programs to improve prescribing. In October 2016, the American Academy of Family Physicians (AAFP) joined the CDC and 12 other national health organizations in a focused effort to promote outpatient antibiotic stewardship in order to combat the rise of microbial resistance and protect patients from the effects of antibiotic misuse and abuse.[5]

To help providers with stewardship, the CDC has developed core stewardship principles for implementation in multiple settings, including hospitals, long-term care facilities, physician offices, and other provider settings. In November 2016, the CDC released the *Core Elements of Outpatient Antibiotic Stewardship*[6] (Core Elements), which provide outpatient settings a step-by-step guide to implement or strengthen stewardship programs. In Arizona, this call to action is supported through Health Services Advisory Group (HSAG), the state's Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) contracted with the Centers for Medicare & Medicaid Services (CMS).

QIN-QIO Outpatient Stewardship Collaborative

HSAG is presently forming a collaborative, funded by CMS, to assist outpatient facilities in augmenting their infection-control programs to incorporate the CDC's Core Elements. This effort will build on stewardship programs conducted in acute care settings and align with the CDC's "Get Smart" campaign, promoting appropriate prescribing and working to decrease patient demand for antibiotics. CMS has directed HSAG to focus on antibiotic stewardship in outpatient settings and provide no-cost education, outreach, and technical assistance to spread these principles and build expertise.

The collaborative will focus on helping outpatient providers, such as family practices, implement the four Core Elements of antibiotic

stewardship, which include: (1) commitment, (2) action for policy and practice, (3) tracking and reporting, and (4) education and expertise.[7] Through HSAG-sponsored learning and action networks, family practices will gain access to national and local thought leaders (including the CDC), technical assistance, webinars, subject matter experts, and a change package that includes best practices for antibiotic stewardship, all at no cost. HSAG will also use the Core Elements as the foundation to promote collaboration and synergy among federal, state, and regional stakeholders also working to improve stewardship.

In the December 2016 issue of the *Journal of Family Practice*, an article entitled "Antibiotic Stewardship: the FP's Role" emphasized that "family physicians are key to determining the outcome of the war against antibiotic resistance."[8] The authors recommend that family physicians monitor prescribing practices, develop patient communication, support public health surveillance efforts, and use the best available evidence—all of which mirror the CDC's Core Elements of stewardship and are incorporated in HSAG's collaborative. If you are interested in joining the antibiotic stewardship collaborative or have questions, please contact Keith Chartier, MPH, Associate Director, HSAG, at 602.801.6906 or kchartier@hsag.com. You can also submit the Commitment Agreement by visiting http://www.hsag.com/join-as.

Howard Pitluk, MD, MPH, FACS, *is Vice President, Medical Affairs & Chief Medical Officer;* **Mary Ellen Dalton, PhD, MBA, RN,** *is Chief Executive Officer; and* **Keith Chartier, MPH,** *is Associate Director at HSAG.*

This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. QN-11SOW-C.3.10-01262017-01.

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Family physicians and patients working together to fight flu

The cornerstone of family medicine is an ongoing and personal relationship between physicians and their patients that focuses on integrated care. Educating patients on strategies for health promotion and disease prevention is at the heart of this relationship and encourages them to take active roles in their own health.

A new free web app helps do just that by promoting the avoidance and management of influenza. The app is being trialed here in Arizona before going national.

The Communidy app (the "id" is for "infectious disease") at Communidy.com educates patients about influenza, its seriousness and risks groups, and interprets rapid flu test results that are transmitted automatically from doctors' offices, hospitals, clinics and labs.

Communidy translates the numbers into consumer-friendly, actionable flu information, delivered in the form of incidence maps. Updated daily, the app shows county-by-county flu rates as minimal, low, medium or high and reports what percentage of positive flu cases involve specific age groups – from children under six to seniors 65 and over. Communidy also provides flu facts and useful flu advice.

The app encourages the public to be proactive by recognizing flu symptoms early, contacting health professionals and avoiding infecting family members, friends, co-workers and others.

This free resource can be an effective tool for family physicians and clinical teams in the mission to improve the health of patients, families and communities.

Family medicine is in your hands.

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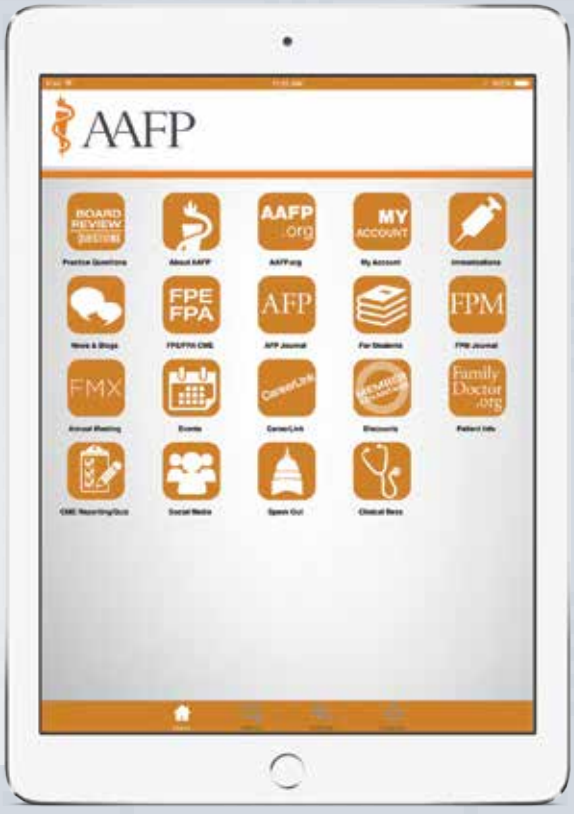

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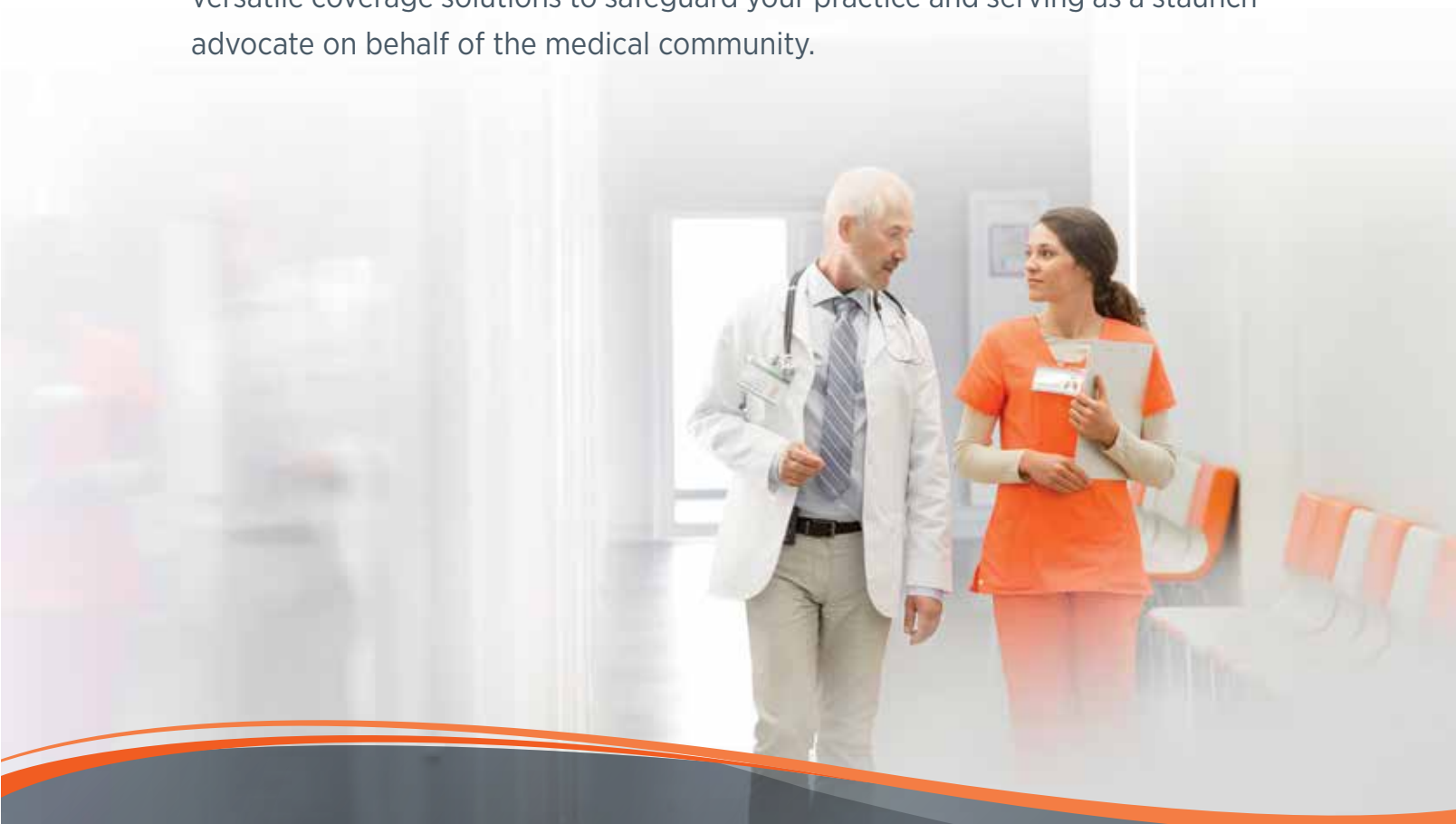

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Advanced registration closes on March 31, 2017

2017 ACE CONFERENCE – APRIL 6-8
CONFERENCE SCHEDULE

Thur, April 6th — Topic/Event

8:00 am **Breakfast & Registration**
9:00 am The Transformation of Post Acute Care & How FP's Prepare for the Sicker Patient- Jim Dearing, DO
10:00 am Comprehensive Alzheimers Treatment in the Primary Care Setting – Mohammed Ali Khezrian, MD, CMD
11:00 am **Break & Exhibits**
11:15 am Diagnosis and Adequate Treatment of Opioid- Induced Constipation: Improving Outcomes in Patients with Chronic Pain – Richard Stefanacci, DO
12:15 pm **Lunch & Exhibits**
1:30 pm AAFP Chapter Lecture Series: Type 2 Diabetes: Medication Management & Patient-Centered Lifestyle Modification Support - Peter Ziemkowski, MD
2:30 pm State of the State: Infectious Diseases in Arizona – Lisa Villarroel, MD
3:30 pm **Break & Exhbitis**
3:45 pm Maintenance Therapy for the Long-term Care of Patients with COPD – Integrity
4:45 pm Strategies for Improving Long-term Management of Hepatic Encephalopathy: Assessing Therapies for Secondary Prophylaxis – Alpesh Amin, MD
5:45 pm **Adjournment for the day of CME Training**

Friday, April 7

8:00 am Pediatric Potpourri - Steve Brown, MD
8:30 am Musculoskeletal – John Hickner, MD
9:00 am CV Disease (CHF/rhythm) – Gary Ferenchick, MD
9:30 am Pneumonia & Flu – Mark Ebell, MD
10:00 am **Break & Exhibits**
10:30 am Hospital Medicine – Gary Ferenchick, MD
11:00 am Guidelines We Can Trust - Steve Brown, MD
11:30 am Skin Diseases – John Hickner, MD
12:00 pm **Lunch & AZ Legislative Update**
AzAFP Board of Directors Meeting - Mariposa Conference Room
1:00 pm Screening & Prevention – Mark Ebell, MD
1:30 pm Hypertension - Gary Ferenchick, MD
2:00 pm Behavioral Medicine Update - John Hickner, MD
2:30 pm UGI Problems - Mark Ebell, MD
3:00 pm **Break & Visit Exhibits**
3:30 pm Headache/ Neuro – Steven Brown, MD
4:00 pm Diet, Nutrition & Obesity - Gary Ferenchick, MD
4:30 pm Editor's Choice – All Speakers
5:00 pm **Adjournment for Day of CME – Awards Reception Immediately Following at Desert Willow – Sponsored by Blue Cross Blue Shield of Arizona**

Accreditation – Pending Application for 20 CME credit hours

CONFERENCE SCHEDULE (CONTINUED)

Sat, April 8th — Topic/Event

7:30 am **Breakfast**
8:00 am Diabetes/Endo – Gary Ferenchick, MD
8:30 am Cerebrovascular Disease – Mark Ebell, MD
9:00 am Choosing Imaging - Steve Brown, MD
9:30 am DVT, PE & Anticoagulation – Mark Ebell, MD
10:00 am **Break**
10:30 am Editor's Choice – All Speakers
11:00 am Pain Management – John Hickner, MD
11:30 am Peri-Operative Care – Steven Brown, MD
12:00 pm Allergic Conditions - John Hickner, MD
12:30 pm **Lunch & AAFP Update provided by AAFP VIP**
2:30 pm Treating IBS: Listen, Look, and Learn From Your Patients – Spire Learning
3:30 pm **Break**
3:45 pm Mild to Moderate Atopic Dermatitis: Pathogens and Targeted Therapies for Improved Outcomes – Spire Learning
4:45 pm **ADJOURNMENT OF MEETING**

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Presbyphonia: The Aging Voice

by Mindy A. Black MD and Robin Samlan, PhD, CCC-SLP, Department of Otolaryngology, University of Arizona College of Medicine

Presbyphonia, also known as presbylarynx or aging voice, refers to the age-related alterations in the upper aerodigestive tract that result in changes to a person's voice. While presbyphonia itself is not pathologic, it can influence a person's ability to communicate and have social, work-related, and psychological effects. If the changes progress to the point where they impair an individual's ability to communicate effectively, then presbyphonia can significantly affect a person's quality of life.

Voice Production

Three components work together to produce the voice. One is the lung, which - in conjunction with the diaphragm and muscles of the rib, back, and abdomen - presents a stream of air to the larynx.

The second component is the larynx itself. As air passes through the larynx, the vocal cords vibrate, creating a variety of sounds that pass upward through the glottis.

Finally, the sound is resonated through the supraglottic vocal tract, which includes the throat, mouth, and nose. These air chambers shape the sound into words or song.

Age-Related Changes in Voice Production

The function or structure of all three of the above-mentioned components change with age.

Lung The lung's contribution to voice production changes because there is a decreased force (FEV1), and rate of contraction of the respiratory muscles, along with a stiffening of the thorax and loss of elasticity of lung tissue. These changes diminish the upward flow of air from the lungs through the larynx.

Larynx The larynx also changes. The cartilage in the larynx calcifies. The arytenoid joints within the larynx develop irregularities. And, the muscles of the larynx undergo atrophy with a corresponding increase in fatty infiltration and connective tissue. All of these changes reduce tension on the vocal cords, making the voice weaker and breathier.

These age-related laryngeal changes influence the pitch of the voice. Typically, the voice becomes weaker, breathier, and more high pitched. It can be difficult to hear the aging voice in noisy environments, such as restaurants or social gatherings. In addition, many individuals report significant vocal fatigue.

On visual examination of the larynx in older adults, one typically sees bowing or atrophy of the vocal cords with an elliptical glottic gap between them. These changes can be contrasted to the appearance of the larynx in a younger individual by comparing Figures 1 and 2 on the other side of this page.

Supraglottic Vocal Tract With age, the facial muscles atrophy and lose elasticity, as does the oral mucosa. Dental structure also changes (e.g., tooth loss). In addition, there are degenerative changes in the palatal and pharyngeal muscles. Finally, diminished salivary function leads to oral dryness, discomfort, and dysphagia. Some older adults have occasional episodes of aspiration.

All of these factors - changes in the lungs, larynx, and supraglottic vocal tract - lead to the classic senescent voice changes. These are listed in Table 1.

Diagnosis

To make the diagnosis of presbyphonia, other conditions that can present with similar voice complaints must first be excluded. Examples include vocal cord nodules or cysts, vocal cord paralysis from a variety of conditions, including cancer, and Parkinsonism. Patients with depression, or frailty syndrome, may also demonstrate a softer/weaker voice. This may be helped by treatment.

The key diagnostic tests are (a) laryngoscopy during respiration, phonation,

TIPS ABOUT DEALING WITH PRESBYPHONIA

- When older adults have voice changes, they should undergo an examination with laryngoscopy and videostroboscopy to exclude pathological conditions, and, if none are present, confirm that the findings are consistent with presbyphonia.
- Refer patients with presbyphonia for voice therapy with a speech and language pathologist.
- For patients whose quality of life is significantly impaired by presbyphonia, and who have not had satisfactory improvement with voice therapy, consider referral for procedures like injection laryngoplasty (medialization) or bilateral thyroplasty.

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and at rest, and (b) videostroboscopy (examining the vibratory pattern of the vocal folds during phonation with a strobe light). Abnormalities of this vibration suggest conditions such as polyps or cysts.

Individuals with presbyphonia will have normal mobility of the vocal cords and normal vibration. But, they will have bilateral vocal cord atrophy that interferes with the ability to tightly appose the cords. This vocal cord insufficiency contributes to the weak, breathy senescent voice (Figure 2).

Treatment

A variety of treatments are available, the choice of which is usually based on how a person's voice changes affect quality of life. Most patients are encouraged to try voice therapy before moving on to invasive procedures.

Voice Therapy Voice therapy is administered by a speech and language pathologist and involves two components. The first component is education about voice production and vocal health. The second is voice exercises, in which patients are taught voice production techniques to strengthen the voice. Voice therapy is the first-line treatment and most patients participate in 4-8 therapy sessions.

Invasive Procedures For patients requiring additional treatment after voice therapy, there are both endoscopic and open procedures. Fewer than one in five patients with presbyphonia undergo these procedures.

Injection laryngoplasty (medialization injection) involves injection of material (calcium hydroxylapatite, hyaluronic acid, collagen, or others) adjacent to the vocal folds to close the glottic gap between vocal cords. It can be performed under general anesthesia or as a convenient office-based procedure.

Another more definitive approach, bilateral medialization thyroplasty, is an open surgical procedure performed under local anesthesia with mild sedation. The larynx is accessed via the neck and a small window is created in the laryngeal cartilage overlying the vocal cords. Material is implanted deep to the laryngeal cartilage to medialize the vocal cords.

If voice therapy has not provided adequate results, most laryngologists will recommend a trial of injection laryngoplasty first. If results are satisfactory, patients can repeat injections or proceed with definitive correction by undergoing bilateral medialization thyroplasty.

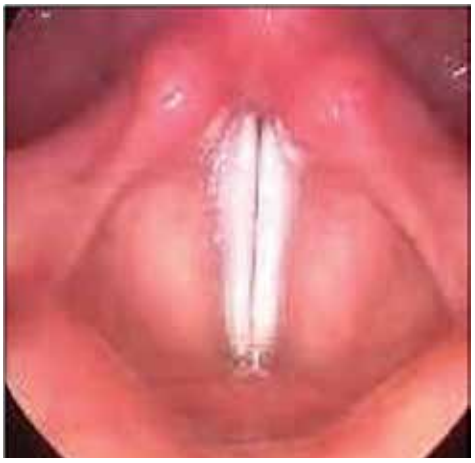

Figure 1, left, shows the larynx of a young adult. Note the closely apposed vocal cords.

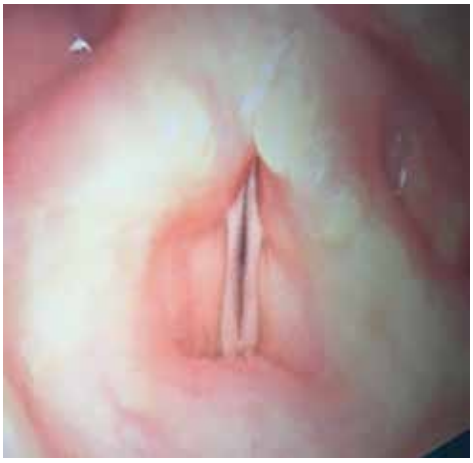

Figure 2, right, shows the larynx of an older adult. Note that the vocal cords are not tightly apposed, leaving a glottic gap.

Which Treatment is Best?

There is limited research that focuses specifically on age-related presbyphonia. Several small studies have shown improvement in voice-related quality of life with specialized voice therapy and surgery. Others have shown poor outcomes with both voice therapy and surgery. Suffice it to say that rigorous prospective trials are needed to evaluate outcomes. Furthermore, it has become clear that glottis incompetence is only one component of age-related dysphonia. Future studies need to focus on the complex process of phonation and the specific changes with age.

Table 1. Classic Senescent Voice Changes

Weak	Rough
Breathy	Voice Fatigue
Pitch changes	Aspiration while speaking

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Federal Healthcare Policy

Susan Cannata, JD, AzAFP Lobbyist

Potential changes to federal health care programs have been on the national news lately, but policymakers at the Arizona Capitol are keeping a close eye on the broad impacts those changes could have on longstanding programs at the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Economic Security.

Federal funding has played a key role in Arizona health care for many years, and is integral to existing programs and funding structures. Because of the many ties between Arizona's programs and federal revenue streams, it is impossible to predict state impacts without details on how Congress will act.

The legislative budget office reports that federal changes to health care could impact as many as 549,000 Arizonans who are currently enrolled in state programs. Depending on the details of federal changes, it could cost Arizona between $96.9 million and $1.4 billion to maintain existing health care programs without the federal funding our state currently receives.

There are several key ways federal action could influence state funding and programs:

- Block grants could replace existing funding partnerships. Establishing block grants, or a fixed amount of undesignated funding, for each state would be a major change to the health care funding system. Most budget analysts say it is too soon to predict how this could impact existing programs. AHCCCS Director Tom Betlach has described the block grant proposal as "the single largest transfer of risk in the history of the United States from the federal government to the states." Many details would be negotiated and established if this system advanced.

- Federal match rates could be cut. Arizona uses those dollars to fund services to adults and children who qualify for programs like KidsCare.

- State matching funds could be reduced. Federal action could also impact the state revenues currently available to draw down federal matching funds, since the state's Hospital Assessment is authorized only if federal funds make up at least 80% of the funding for programs. If federal resources drop below that level, the Hospital Assessment is eliminated and the current matching funds for acute care costs of programs for adult coverage in some programs at AHCCCS are eliminated.

- State revenues could be reduced. Medicaid funding has an impact on the funds that are available for any state budget priority because of a 2% insurance premium tax that insurers are assessed on the payments they receive from AHCCCS. If Medicaid spending is reduced, so are the payments to insurers and so are those insurers' taxes to the state.

Governor Ducey and his staff are actively working with Congress to attempt to minimize the uncertainties for Arizona as federal action is negotiated. The Governor has said it is important to have a new plan in place before a total repeal of the Affordable Care Act, in order to avoid action that will "pull the rug out from under" Arizonans who rely on federal health care programs.

It appears this discussion will continue, as President Trump and Congressional leaders concede that a health care overhaul is a big task. While federal discussions continue, Arizona budget leaders and health care advocates are keeping a careful eye on what the changes will mean for Arizona's finances and services.

For more analysis from the legislative budget office, visit www.azleg.gov/jlbc/ACA122016.pdf.

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How The AAFP National Conference of Constituency Leaders Shaped Me as a Physician Leader

Ravi Grivois-Shah, MD, MPH, MBA, FAAFP

I don't think I've ever been more warmly welcomed yet overwhelmed at the same time!

It was the Spring of 2009, and I was a newbie to what was then called NCSC (National Conference of Special Constituencies), now the NCCL (National Conference of Constituency Leaders) for the AAFP.

I was a delegate for the GLBT constituency -- physicians who identify as gay, lesbian, bisexual, transgender, or their allies. It is one of five constituency groups including women physicians, minority physicians, IMG (international medical graduates), and New Physicians represented at NCCL.

I was welcomed by all five constituencies that first year as I approached the new attendee orientation session, met those also representing the GLBT constituency from chapters all over the nation, and collaborated with fellow family doctors on resolutions that addressed a myriad of issues affecting our members, our profession, our patients, and our communities.

I was overwhelmed by all the ways available to make an impact during those 3 fast days in Kansas City. Write resolutions. Meet talented and dedicated family docs from coast to coast. Join a reference committee. Serve as a teller. Run for a leadership role. Oh my! Thanks to some great mentoring and role modeling, I stepped up during my NCCL to become a member of a reference committee to review testimony and resolutions, and ran successfully as a both Co-Convener for the GLBT constituency for the following year and as a delegate to the AAFP Congress of Delegates.

I've attended every NCCL since, and I'm thrilled to attend from April 26-29 for my 9th NCCL, this time as its Convener, leading the conference from start to finish.

NCCL is at its core a conference focused on advocacy, and is unique in organized medicine. To my knowledge, no other medical society brings together its most underrepresented physician groups that come from some of the most marginalized communities and gives them such a powerful voice affecting policy and leadership in their organization.

Resolutions passed at NCCL go straight to the AAFP Board of Directors to review. Many go to AAFP Commissions to address further. Some go all the way to the

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Congress of Delegates to potentially become official AAFP policy. NCCL attendees are proud to have had a hand in shaping AAFP policy on issues such as violence in minority communities, reproductive health access, and marriage equality.

Multiple leaders are also selected from NCCL each spring. Each of the 5 constituencies has two Co-Conveners who help organize and plan for NCCL through the NCCL Advisory Group, work with chapters to recruit delegates from around the nation, lead the constituency meetings, and chair the reference committees. NCCL also selects 8 voting delegate positions at the AAFP Congress of Delegates, 6 representing the Special Constituencies and 2 representing New Physicians. In addition, NCCL delegates also select a New Physician member of the AAFP Board of Directors, an AMA-YPS delegate, and a Convener who will lead the conference for the following year.

I've had the honor of serving in many of these roles. A few months after my first NCCL in 2009, I was an Alternative Delegate from the Special Constituencies to the AAFP COD in Boston, and Delegate the following year in Denver. I served as a Co-Covener for the GBLT constituency during the 2010 NCCL. During the 2012 NCCL, I was elected as the New Physician member of the AAFP Board of Directors. And it was last year, at the 2016 NCCL, that I was elected as Convener for the upcoming NCCL.

NCCL has truly shaped me as a physician leader. Thanks to the experiences I've garnered and all the amazing family docs who I met and learned so much from, I've been a more effective leader and advocate for my patients and communities, for my state Chapter as a leader in Illinois and now in Arizona, and for my profession as a whole.

I'm not alone in this. Every year I see more and more leaders at the state level (members of chapter boards and chapter delegates to the COD) and in our AAFP Commissions who, like me, came up through NCCL. I see more and more leaders in our profession, from FQHC Medical Directors and hospital leaders, for example, who, like me, learned what it means to be a leader in health care through NCCL.

As I prepare to guide NCCL 2017 as its Convener this April, I look back at how NCCL has shaped me as a physician leader. I'm encouraged and proud of AzAFP for regularly funding and recruiting all 5 constituency delegates year after year, which will not only help AzAFP recruit strong leaders for its board in the years ahead, but will help create a stronger Academy locally and nationally that will benefit all of us, our profession, and our patients and communities.

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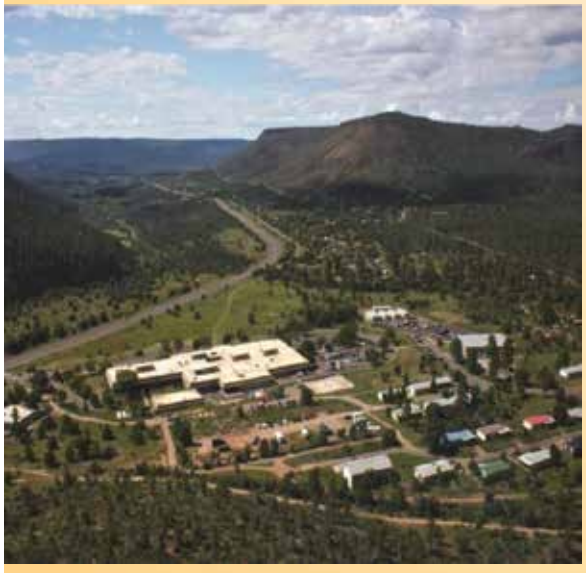

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