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Fall Edition 2015

INSIDE THIS ISSUE:

How To Live “Successfully” All The Way To The End Of Life

Lee Richman, MD
Gastroenterologist

While I was still practicing at Lutheran Hospital, I consulted on an elderly patient with end stage liver disease. It was quite clear that she was terminally ill, a concept completely unacceptable to her and her family. I spent several hours over several days explaining the circumstances, our inability to offer any therapy that would improve her health, and our desire and ability to provide palliative care to provide her with the most comfort and the best quality of life for her remaining days. Eventually they agreed that that was the best plan for her. I rounded on her the next morning shortly after a young physician who was covering for one of the services following her had talked with the patient and her family. He had reviewed all the things that he could do to evaluate and improve his piece of her health care, ignoring her overall prognosis, but convincing her and her family to withdraw her DNR and her palliative care. She died a few days later, having undergone a series of invasive and expensive tests.

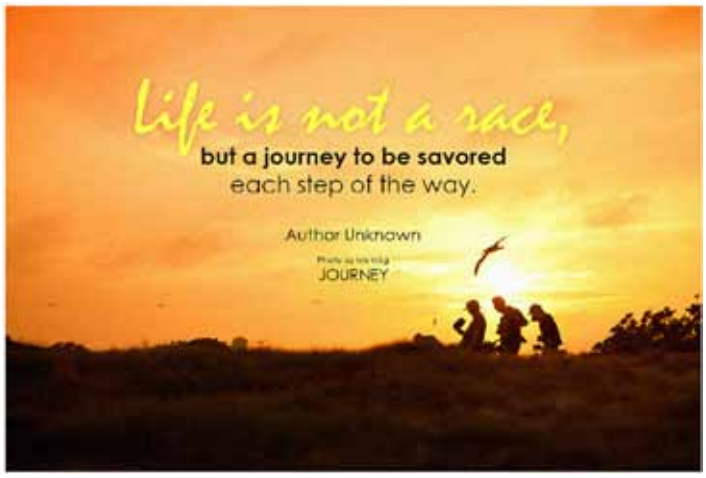
Scientific advances have turned the processes of aging and dying into medical experiences, processes to be managed by health care professionals. But our reluctance to honestly examine and communicate the experience of aging and dying has increased the harm we inflict on people, and often denies them the basic comforts they most need.

Lacking a coherent view of how people might live "successfully" all the way to their very end, we have allowed their fates to be controlled by the imperatives of medicine, technology, and strangers.

Being Mortal is a remarkable book by Atul Gawande, a surgeon at Brigham and Women's in Boston, author of The Checklist Manifesto (which I also recommend highly), and a MacArthur fellow. It addresses the realities of patients and physicians confronting decline and mortality. The book concerns itself with two overarching aspects of our later years, how and where we live as we age and decline, and what care is available and appropriate when we are confronted with impending death, however far off that may be.

Old age has changed. In the past, surviving into old age was uncommon, and those who did served a special purpose as guardians of tradition, knowledge, and history. They tended to maintain their status and authority as heads of the household until death. Surviving parents provided a source of stability, advice, and economic protection for young families. More recently, global economic development has changed opportunities for the young who follow their own path, seek jobs wherever they might be, and escape the perceived shackles of family expectations; working wherever they want, and marrying whomever they want. Both parents and children often view this separation as freedom, maintaining intimacy at a distance. This modernization didn't demote the elderly. It demoted the family, replacing veneration of elders with veneration of the independent self. But this fails to take into account the reality of what happens in life. Sooner or later, independence often becomes impossible. Truth be told, old age is a continuous series of losses; pieces falling off as we drive downhill. We regard this decline as weakness rather than the expected state of affairs, the new normal.

To some extent, medical care can influence whether that hill is steep or gradual. We are good at addressing specific issues such as hypertension and diabetes. But usually, unless we are trained as geriatricians, we are less skilled at addressing the issues that lead to the debility



and depression that encumber old age, such as complex medication regimens, arthritis, lack of balance, keeping toenails trimmed, poor diet, home safety, and isolation. Studies show that dealing with these problems doesn't decrease the likelihood of death, but substantially reduces the likelihood of disability, depression, and the use of home health services.

Another part of the equation of old age (Philip Roth refers to it not as a battle but rather a massacre), is the frequent necessity of people having to give up the life they built for themselves through the years, and moving into "safer" and more manageable independent or assisted living facilities. In the process, they often encounter unwanted, if needed, structure, supervision, and control. These environments, which are a consequence of a society that faces the final phase of life by trying not to think about it, address a number of societal goals, such as freeing up hospital beds, taking burdens off of families, and coping with poverty among the elderly. But they often don't address the goal that matters most to the people that live in them. The elderly often want more from life than safety. They want to make life worth living when they're weak and frail and can't fend for themselves anymore.

According to Abraham Maslow, in The Theory of Human Motivation, we humans have a well-defined hierarchy of priorities, of which safety and survival are foundational. Above those are the need for love and belonging. Above those still are the need for growth and the attainment of personal skills. And even higher is the desire for fulfillment through the attainment of moral ideals and creativity. The fact that old age homes focus on health and safety is recognition of the prioritization of those goals. Reality, however, is more complex. People readily demonstrate willingness to sacrifice safety and survival for the sake of something beyond themselves, such as family, community, and justice, regardless of age. And, interestingly, our driving motivations evolve over time. Early in adulthood we may seek growth, self-fulfillment, achievement, social networks, having, and getting. Later in life we often focus on being rather than doing, the present rather than the future, appreciating simple pleasures, and spending time in our more intimate and fulfilling relationships. This might reflect cognitive changes or adaptation to progressively restricted choices, but it could also reflect wisdom, recognizing the finitude of our time on earth.

While facilities that address aging in place, community, and the concept of "home" are increasingly more common, most "old age homes" and assisted living facilities still are institutions whose primary function is warehousing the elderly rather than actually assisting the living; providing safety for the residents but autonomy primarily for their families. They, and we as medical professionals, usually focus on maintaining and repairing health, rather than the sustenance of the soul. As Gawande states, "making lives meaningful in old age is new. It requires more imagination and invention than does making them merely safe."

Aging and the sight of death on the horizon also raise a question that often vexes us as physicians: when and what should we try and fix and when should we not? In the United States, 25% of Medicare spending is for the 5% of patients who are in their final year of life, most of it in the last couple of months and of little apparent benefit. Often, it is even harmful. In 2008, the National Coping with Cancer project published a study showing that terminally ill cancer patients who were put on mechanical ventilators, resuscitated, or admitted near death to the ICU, had a substantially worse quality of life in their last week than those who received no such interventions. Two thirds of the terminally ill patients reported having had no discussion with their doctors about their goals for end-of-life care, despite being on average four months from death. Interestingly, six months later, their family caregivers were three times more likely to suffer major depression. The remaining one-third who did have such discussions were far less likely to undergo aggressive treatment, suffered less, were physically more capable, and were better able to interact with their loved ones. They were far more likely to die in peace if they had substantive discussions with their doctors about their end-of-life preferences.

People with serious illnesses have priorities besides simply prolonging their lives. Since, for most people, death comes after a long struggle with an ultimately implacable circumstance, their primary concerns include avoiding suffering, strengthening relationships with family and friends, being mentally aware, not being a burden, and achieving a sense that their life is complete. Our system of technological medical care utterly fails to meet these needs. Hospice certainly plays an important role here. Its focus is not on extending life by performing surgery or giving chemotherapy. Hospice, on the contrary, focuses on helping people with a fatal illness to experience the fullest possible lives now, by decreasing pain, maintaining mental awareness, or getting out with the family.

Doctors are not particularly well equipped to navigate these waters. Studies have shown that we usually overestimate how long patients are going to live by a factor of more than five, and that the better we know the patient, the more likely we are to be wrong. Many patients do live longer than expected (median survival is only a statistic), but hope for a long survival can prevent us and our patients from planning for an outcome that is more probable. Since we often cannot predict the length of survival, our impulse is to imagine that they have more time than they do, and to fight; dying with fresh sutures, chemotherapy flowing, and endotracheal tubes in place. After all, there's always something that we can do, and the default is to do it.

But, and here's a big BUT, in 2004 Aetna decided to try and increase hospice options for their policyholders. They allowed those with a life expectancy of less than a year to receive hospice services without having to forego any other treatments, including chemotherapy and radiation. After two years, 70% of patients were using hospice care, up from 26%. Amazingly, although the patients were not forced to give up anything, they did give things up. ER visits dropped in half. Use of hospitals and ICU's decreased by two thirds. Overall costs fell by a quarter. In a companion study in which patients had to give up attempts at curative treatment to receive hospice care, enrollment in hospice also jumped to 70%. In this study, patients received regular phone calls from palliative care nurses who helped them find services for things such as pain control and filling out a living will. Again, hospital usage dropped sharply, ICU usage fell 85%, and satisfaction scores went way up.

In a remarkable 2010 study from Mssachusetts Genral Hospital, patients with stage IV lung cancer were randomized to receive usual oncology care or usual oncology care plus parallel visits from a palliative care specialist, who discussed with them their goals and priorities if and when their situation worsened. The result was that those who saw a palliative care specialist stopped chemotherapy sooner, entered hospice far earlier, experienced less suffering at the end of their lives, and they lived 25% longer! Gawande's conclusion is that our decision-making in medicine has failed so spectacularly that we have reached the point of actively inflicting harm on patients rather than confronting the subject of mortality. Many other studies have seen the same results in patients entering hospice. The lesson appears to be that, at least toward the end of life, you live longer when you stop trying to live longer.

Can mere discussions achieve these effects? The experience in LaCrosse, Wisconsin would confirm that it does. A concerted effort by medical leaders there to get medical providers and patients routinely to discuss end-of-life wishes has resulted in Medicare patients in their last six months of life spending half as many days in the hospital is the national average, despite life expectancy in the community exceeding national norms by a year. The discussion in LaCrosse boiled down to four crucial questions that are easy to formulate but difficult to navigate. At this moment, do you want to be resuscitated if your heart stops? Do you want aggressive treatments such as intubation and mechanical ventilation? Do you want antibiotics? Do you want tube or intravenous feeding if you can't eat on your own?

A large part of the task, according to palliative care specialists, is helping people to negotiate through their overwhelming anxiety about death, suffering, loved ones, and finances. Arriving at an acceptance of one's mortality and a clear understanding of the limits of medicine is a process. It takes time, and it takes skill on our part. The discussion is not about whether or not the patient wants one treatment or another. It's trying to find out what's most important to them under the circumstances, so that we can provide information and advice on what will give them their best chance of achieving it. The discussion should cover what patients understand about what is happening to them and what their prognosis is, what their fears and concerns are about what lies ahead, what kind of trade-offs they are willing to make, how do they want to spend their time if their health worsens, and, of course, who do they want to make decisions if they can't. We and our patients should understand how much they're willing to go through to have a shot at being alive, and what level of being alive is tolerable to them. This speaks to the importance of us, as physicians, not being paternalistic or just informative, but rather being interpretive guides in shared decision-making.

The wise course in navigating in these waters is often unclear. The closing phase of life is an unpredictable, uncontrollable, and relent-

less series of events, from which medicine can offer only brief and temporary rescue. If it's hard to know what will happen, it's hard to know what to do. The challenge is to decide whether one's fears or one's hopes are what should matter most. The autonomy we all seek may not control life's circumstances, but rather may mean getting to control what we do with them.

Being mortal, and Being Mortal, are about the struggle to cope with the constraints of our biology. Medical science has given us remarkable power to push against these limits. But we do real damage in medicine when we fail to recognize that this power is finite. Our job is not merely to ensure health and survival. It is to enable well-being; about the reasons one wishes to be alive all along the way and not just at the end of life. Sometimes we can offer cure, sometimes only a band-aid, sometimes not even that. But whatever we can offer, our interventions, and the sacrifices and risks they entail, are justified only if they serve the larger aims of a person's life. As Gawande writes, "when we forget that, the suffering we inflict can be barbaric. When we remember it, the good we do can be breathtaking."

Read this book.

Avoid Medical Emergencies When You Travel …A Helpful Checklist

Mark Pattridge, MD
Golden View Family Medicine

Recently, on an airplane flight, I was asked to assist with a medical emergency. After sharing my experience with some of my colleagues, I realized that this is not as uncommon as I once thought. I would like to give a few helpful hints on measures that people can take to help prevent medical emergencies while on a typical commercial airline.

The main problem associated with airline travel is decreased oxygenation to the tissues. The two main groups of people that have difficulties with low oxygen levels are people with heart and lung conditions. Without going into great detail, below are some common sense tips that might help you or your loved ones avoid an in-flight emergency.

1. If you are bringing your own oxygen concentrator on a plane, make sure that the battery has enough power to last through the entire flight and even a little longer in case of unforeseen circumstances.
2. It is always a good idea to know what medical conditions you have. You don't have to know the exact names of your conditions, but you should have a general idea, i.e., congestive heart failure, COPD, asthma, coronary artery disease, etc.
3. Always carry of list of your medications with you. Although it may be impractical having the actual bottles of medications with you, a list will save medical personnel time in an emergency situation.
4. If there are medications that you need to take on an 'as needed basis', make sure that you have some of those with you at all times. Examples would be nitroglycerin for chest pain, inhalers for asthma or COPD, etc.

5. If you do require continuous oxygen or have some fairly significant medical conditions, it is probably a good idea for you to reserve an aisle seat on the plan. This will make it easier for personnel to get to you and help you if you are having difficulties on the flight.
6. Make sure that your travelling companion is aware of any urgent health conditions.

In general, these are simple things you can do to reduce the likelihood of having an emergency; however, if you do have an emergency, these tips will make it easier for any medical personnel on board to help you quickly and safely.

So, relax and enjoy your flight!

HIGHLIGHTS

New West Physicians Expands Services With Addition of Neurologist

We're happy to welcome Dr. Scott London to our New West Physicians care team. Dr. London is a Neurologist who will lead our Neurology Services program. He is dedicated to achieving the best possible outcomes for every patient while providing support for every family.

Dr. London grew up in South Burlington, Vermont, hiking in the Green Mountains and swimming in Lake Champlain. He earned his Bachelor's degree from McGill University in Montreal and his Doctor of Medicine degree at the University Of Vermont College Of Medicine in Burlington. He finished his residency in Neurology as well as his Clinical Neuromuscular Fellowship at the University of Colorado Health Sciences Center and has been practicing in the Denver Metro area since 1990. In his free time, Dr. London enjoys running, hiking, skiing, snowshoeing, music, Mediterranean or Italian cooking, and spending time with family and friends.

Dr. London, board certified in Neurology and Electrodiagnostic Medicine, brings his expertise to patients through treatment of diseases of the central and peripheral nervous system. He devotes time to each patient in order to fully understand their unique issues and concerns before

proposing a treatment plan. He supports Habitat for Humanity, Doctors Without Borders, and is the former President of the Colorado Society of Clinical Neurologists.

Philosophy

"Each patient brings me a unique set of Neurologic problems to address that impacts their well-being so it is important to listen intently and thoughtfully. In partnership with the patient's primary care physician, I want to navigate these challenges and strive for the best possible outcome for the individual and their loved ones. Providing this service in a competent and compassionate fashion is paramount for effective health care delivery."

Welcome To Our New Providers

Stephanie Christie, MD
Arvada Family

Francie Palmer, MD
Lakewood Internal Medicine

Kristine Thorne, PA-C
Lakeview Family Practice

Julie Hsu, PA-C
Hospitalist

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PATIENT NEWS

Online Bill Pay Now Available!

New West Physicians is excited to bring online bill pay to our patients! We have selected Authorize.Net to provide an easy, safe, and secure way to pay your bills online with a credit card.

- Authorize.Net accepts MasterCard, VISA, Discover, and American Express credit cards.
- Payments post to your account within two business days.

Visit our website today at www.nwphysicians.com and click on the "Online Bill Pay" icon located on the Home Page near the 'Search' feature.

Patient Satisfaction Survey Highlights

We would like to thank all of you who participated in our recent patient satisfaction survey. Your comments, thoughts, and opinions are very much appreciated and the information that we gained from your input is invaluable to helping us continue our journey of providing "Excellent Service, Every Patient, Every Time".

For the past several years, we have conducted the survey with the assistance of SullivanLuallin, Inc., one of the premier healthcare customer service consulting firms in the nation.

- Of the 8,100 surveys distributed, we received an astonishing 6,594 response – an 81% return rate as compared to the national average of 45-50%. The survey compared our results against a national database of 325,000 respondents in like practices of similar size.
- New West Physicians scored higher than the National Benchmark in all categories including Satisfaction with your Provider, Staff, Appointments, Billing, and Quality of Care Received.
- We were pleased to see that over 97% of respondents felt comfortable referring their provider. Thank you for trusting us with your friends and family.

We are well aware that patient satisfaction does not end after the survey is completed. We are making strides in improving your experience as they relate to ease of access, phone wait times, and all aspects of customer service. We will continue to strive to exceed your expectations as we care for you, your loved ones, and the communities that we serve.

Learn more about your Privacy Rights, Online Bill Pay, Shared Decision Making, and more by visiting our Website.

Packets and Forms

Whether you need to complete a new patient packet, transfer your medical records from another office to New West Physicians, or prepare for a procedure, the easy-to-access forms are located on our Website under Patients, then Packets and Forms.

MyHealthConnection – Patient Portal Updates

MyHealthConnection is a state-of-the art, secure health management tool you can use anywhere you have access to the Internet. All messages are encrypted to ensure security and your health record is password protected. You will be able to correspond with your providers on non–urgent health issues, request appointments, and much more!

Get started today by downloading the MyHealthConnection Brochure, completing the Request an Invitation to Join section, and taking it with you to your next visit so they can verify your information in person to protect your privacy.

The Patient Portal should not be used for emergencies or urgent health needs. For medical emergencies, always call 9-1-1 immediately.

Diabetes & Nutrition Center

When you eat foods that contain carbs your blood glucose levels increase. By eating the right amount of the right kind of carbs, you can keep your glucose levels in your desired range. Watch a short video about Counting Carbs from Betsy Raube, Diabetes Educator for the Diabetes & Nutrition Center.

The Diabetes & Nutrition Center offers classes and individual appointments for diabetes, prediabetes, weight loss, and medical nutrition therapy.

Watch the video at youtu.be/AkRuC8lwkoQ

MEDICARE CORNER

Open Enrollment Coming Soon!

Medicare's open enrollment period is October 15th through December 7th. Plan benefits for 2016 will be announced in October of this year.

Sharron Metz, our dedicated Senior Patient Advocate, is available to answer questions and help navigate the ever-changing Medicare maze. Call for guidance today so that you receive the coverage you deserve at (303) 716-8044.

Visit our website to learn more about the Insurance Plans we accept.

HIGHLIGHTS

Four Seasons and our Happy Hearts

Tatiana Tsvetkova, MD
Cardiologist

What can the heart look forward to as Fall approaches and how do we keep our heart happy? Fall is about the harvest season, fruits and vegetables, transitioning our exercises indoors, holidays, and the season of giving.

Harvest season will bring an abundance of fruits and vegetables so consider trying a new recipe - perhaps a new Mediterranean vegetable dish! As we see the leaves and the weather change, soon many of us will face the challenge of keeping up with exercise and physical activity which is very important to keep our hearts happy.

It is great time to check with your local recreation center to inquire about their Silver Sneakers exercise program, or classes that are available to keep you active. Consider walking with a friend, or walking in the mall to brighten your mood as the days get shorter.

The heart is the ultimate concept of giving. The more it does – exercise, heartbeats, and gives to others, the healthier it is. With the holiday season of gratitude and giving approaching, the heart will have many opportunities for generosity.

I was hiking Herman Gulch on Sunday August 30th, watching leaves beginning to change, climbing quite high to the Herman Lake at the Continental Divide, when I encountered a 10 or 11 year old boy who was walking toward me. He stopped, smiled at me, and said "you are almost there." This was exactly what I needed to continue to move forward.

I caught up with the family of the boy on my way down to learn about his dream to get to MIT to work on robotics. When I asked why he wanted to pursue this career, he responded, "to make people's lives easier and the world better."

Even with the season change or any change we have to face, the world remains a special place, with kindness and smiles today, and dreams of a great future.

Breast Cancer Screening

Tom Jeffers, MD
Arvada Family Practice

In the United States, breast cancer is the 2nd leading cause of cancer related deaths in women, behind lung cancer. However, more women die from cardiovascular disease than cancer.

Screening recommendations for early breast cancer detection include: self-breast examination, clinical breast examination (by your healthcare provider), and mammography. These recommendations are always being fine-tuned by various agencies. With respect to breast cancer screening, the United States Preventative Services Task Force (USPSTF), the American Cancer Society (ACS), and the American College of Obstetrics/Gynecology (ACOG), all weigh in and not all with the same recommendations.

Please see the following recommendations:

Organization	Self breast exam	Clinical breast exam	Mammogram
ACS	Suggested monthly	Suggested annually	age 40-50, annually age 50-74, every 2 years
USPSTF	Against teaching	No evidence to support	age 40-49 individual discretion 50-74 every 2 years
ACOG	Suggested monthly	Suggested annually	annual at age 40 and beyond up to age 75

As you can see, there is not consistency in recommendations from respected organizations with regards to breast cancer screening.

Here is my approach:

- First, screening is for asymptomatic individuals. If you can feel a breast mass, or if you have a bloody nipple discharge, then you have a medical problem that needs to be assessed. This does not come under the category of screening.
- Second, any screening procedure suggested by your doctor is advice that you should seriously take into consideration. That, coupled with your specific concerns for your health, should be discussed with your healthcare provider so that a mutually agreed upon plan is carried out.

Self-Breast Exam (SBE)

New terminology for self-breast exam is Self-Breast Awareness. I instruct women to begin SBE's in their 20's. First, observe your breasts – look in the mirror – is there symmetry? Also raise your arms above your shoulders and observe. As previously mentioned, bloody nipple discharge is a concern.

Palpate (feel) your breasts. There are two standard techniques:

1. I favor lying down and with the opposite hand, examining the inner half of your breast. Then, with your arm raised over your head, examine the outer half and the axilla (arm pit). What is concerning is a rock hard mass stuck to the tissues around it. Repeat the procedure on the opposite breast.
2. The second technique for SBE is checking yourself in the shower starting at the nipple and areola in increasing concentric circles.

Comparing findings from one breast to the other is helpful. With cyclic hormonal changes, many women find mid-cycle or premenstrual lumps or tenderness. Some women have fibrocystic breast disease; however, I prefer the term dense, lumpy breasts. I think it's important for women to know the look and feel of their breasts over time – so that when an abnormality becomes evident, she will know to bring it to the attention of her doctor.

Clinical Breast Exam

I think a clinical breast exam performed by your health care provider annually is advisable. This is usually performed at an annual physical examination. I use this examination to instruct patients on the technique for self-breast examination.

Mammogram

The one agreement between all three advisory committees is that mammography is a cornerstone test for the early detection of breast cancer.

Early breast cancer detection usually results in less invasive surgery and a greater likelihood of survival.

Without getting too complicated, I need to explain the concept of false negative and false positive results. A false negative is when the test is normal, but a cancer is subsequently discovered. A false positive is when an abnormality is found, but subsequent testing found nothing wrong.

With respect to mammography, there is a greater risk of both false negative and false positive results for women in their 40s. This is because the breast tissue is denser earlier in life. The best yield (less false positive and negative results) for mammography is between 50-74 years of age.

I recommend earlier mammography for patients with a family history with a first degree relative with breast cancer (mother or sister). I usually advise annual mammograms 10 years younger than a first degree relative's diagnosis.

The decision of when to begin screening mammography and the frequency of screening should be one made by the patient and health care provider at the annual physical examination. For more information, visit our Website and click on Your Health Guide.

Caring Spirit

Giving back to our community is one of New West Physicians' core values. It is in this spirit that New West provided donations to numerous organizations on Colorado Gives Day so that funds could be leveraged to raise even more money for the recipient organizations. This year, donations will benefit individuals who are homeless, uninsured/under-insured, mentally ill, hungry, or in hospice care. Our 17 medical offices also sponsor numerous community events throughout the Denver Metro area. New West Physicians had a team again this year in the MS150, a two-day fundraising bike ride organized by the National MS Society. Our employees even get in on the action with one employee embarking on a quest to gather socks for those in need, calling her venture "Heat for Feet".

DELICIOUS RECIPE

Turkey Meatballs with Spaghetti Squash

Ingredients:

- ❑ 1/3 cup soft whole wheat bread crumbs (1 slice bread)
- ❑ 1/4 cup grated onion
- ❑ 1 teaspoon garlic powder
- ❑ 2 ½ tablespoons minced flat leaf parsley
- ❑ ½ teaspoon red pepper flakes
- ❑ 1 teaspoon dried thyme
- ❑ ½ teaspoon whole fennel seeds
- ❑ 1 pound 93% lean ground turkey
- ❑ 2 egg whites
- ❑ 1 (12 to 16 ounce) spaghetti squash
- ❑ 1 can (about 14 ounces) no-salt-added crushed tomatoes
- ❑ ¼ cup fat-free reduced sodium chicken broth
- ❑ 1 teaspoon dried oregano
- ❑ 1 tablespoon minced fresh basil
- ❑ 1/3 cup minced green onions

Instructions:

1. Mix bread crumbs, onion, garlic powder, parsley, red pepper, thyme and fennel seeds in a bowl. Mix ground turkey with egg whites in a separate large bowl. Add seasoned crumbs and knead mixture well. Cover and chill meat for 10 minutes. Preheat broiler.
2. Split squash in half. Remove seeds. Place in glass baking dish, cut side down. Add 3 to 4 tablespoons of water. Microwave on HIGH for 10 to 12 minutes, or until fork-tender. Set aside to cool.
3. Form 20 meatballs with chilled turkey. Put meatballs on baking sheet; broil 4 to 5 minutes. Turn meatballs and cook 4 minutes more. Mix tomatoes and broth in 12-inch skillet; simmer over low heat. Add meatballs, oregano, basil, and green onions. Stir and cook until hot, about 10 minutes.
4. Scrape squash into strands onto serving plate. Top with sauce and meatballs.

Makes 4 Servings

Nutrition per serving

- Calories 224
- Total Fat 3 g
- Saturated Fat 1 g
- Protein 31 g
- Carbohydrates 20 g
- Cholesterol 47 mg
- Dietary Fiber 4 g
- Sodium 450 mg

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HEART/STROKE NCQA RECOGNITION

DIABETES NCQA RECOGNITION

Top Docs 5280

ABIM American Board of Internal Medicine

American Board of Family Medicine