Colorado Family Physician

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2016 Fall

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IN THIS ISSUE:

COLORADO ACADEMY OF FAMILY PHYSICIANS

From Left to Right: Andrew Nemechek, MD, Eugene Chung, MD, Christopher Oliver, MD, John Campana, MD, Thomas Kenney, MD, Seth Reiner, MD, Andrew Gaines, MD, Todd Capizzi, MD.

The Faces of Hope.

Colorado Head and Neck Specialists, located at Porter Adventist Hospital, treats complex head and neck malignancies, including advanced skin cancer, HPV-related cancers and benign and malignant tumors of the thyroid and parathyroid glands. Trained at the country's premier cancer centers for head and neck tumors, our board certified otolaryngology/head and neck surgeons offer highly-specialized treatment options such as transoral robotic surgery, laser microsurgery, skull-base surgery and microvascular reconstruction of the head and neck.

Our surgeons work closely with an interdisciplinary team of medical oncologists, radiation oncologists, specialty-trained nurses, patient navigators, dietitians, physical therapists, and emotional support teams to ensure compassionate, contemporary and comprehensive care.

To find out more, visit coheadandneck.org or call us at 303-778-5658.

Colorado Head and Neck Specialists

Centura Health.

BEST HOSPITALS U.S.News & World Report NATIONAL EAR, NOSE & THROAT 2016-17

FALL 2016

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EDUCATION & PRACTICE ENHANCEMENTS

HEALTH OF THE PUBLIC

MEMBERS

Edition 49

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Vision Statement:

Thriving Family Physicians creating a healthier Colorado.

Mission Statement:

The CAFP's mission is to serve as the bold champion for Colorado's family physicians, patients, and communities through education and advocacy.

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PRESIDENT'S REPORT

By: Tamaan Osbourne-Roberts, MD

On the Art of Coming Up for Air

Kimi Werner, a world-famous spear fisherwoman from Hawai'i, once said of her sport, one in which she dives to depths unreachable by most people and holds her breath for minutes on end, "When you want to speed up, slow down."

I'm reminded of her words as I sit here on the plane on my way back from Orlando, where it was my privilege to attend the AAFP Congress of Delegates, your national academy's policymaking body. As a free diver and underwater hunter myself, I took the day following the close of the Congress to decompress by diving for scallops on Florida's gulf coast with my friend Jay Lee, immediate past president of the California Academy of Family Physicians (and fellow policy wonk); between bites of sweet shellfish and sips of cold beer, we discussed the events of the past few days. There was so much to do: payment reform, EMR revision, addressing social determinants of health, creating further diversity in our profession. But of all the work left to complete, the most pressing matter, the one looming over so much of the other topics, was physician burnout.

The process of becoming a physician is very much its own kind of dive, an immersion into the depths of our collective calling to become healers. Having made the decision to pursue this difficult path, we start on the surface breathing calmly, staring into the profundity of our profession, and wondering what experiences await us beyond our lines of sight. And then we dive, passing first through the sunny world of premedical education, surrounded by the flash and color of seemingly limitless options; then continuing through medical school, where possibilities begin to fall away, and the sunny dispositions of our premedical days, while they still penetrate, do not illuminate our worlds nearly as well; then down through graduate medical education, where the chill deepens, and we start to feel the crush of immense pressure as the demands of our training mount; and then finally reaching our goal, the early phase of our careers as attending physicians, where we so often find ourselves alone, and in the dark.

This is the first part of our journey, and we have much help from teachers, mentors, and colleagues on our difficult descent. But, in any dive, the way down is only ever half of the trip; in the depths, in the darkness, by ourselves, and in a place without any air, we must learn how to return to the surface, to a place of light and life. Failing to do so doesn't simply limit the health and joy we might bring to those who await us on the surface. If we stay at the bottom too long, our own health starts to suffer…sometimes to the point that we will never return to the surface, ever.

The solution? "When you want to speed up, slow down."

Most of us carry at least a little extra weight on our shoulders from the process of becoming a physician; as family physicians, we sometimes carry our patients' weight, too. Because of that, returning to the surface is even harder than diving down, and some of us begin to give in to the anxiety and panic, start to believe that the way up is too hard, that the surface is too far, that we won't make it.

Don't.

Calm down. Gently, slowly, kick for the light. We can make it. We can get back to a place we can breathe. Look around: there are lifelines all around for you to follow. And whether it's protecting us from unreasonable regulation, fighting for our needs at the state legislature, supporting us in clinical practice, or simply providing venues for reflection and inspiration, I can assure you, as your current president: the Colorado Academy of Family Physicians is working hard to ensure that those lifelines remain in place, and that you have a solid deck to stand on when you get back to the top.

Go ahead. Go on up. Breathe. We're waiting for you.

Until next time.

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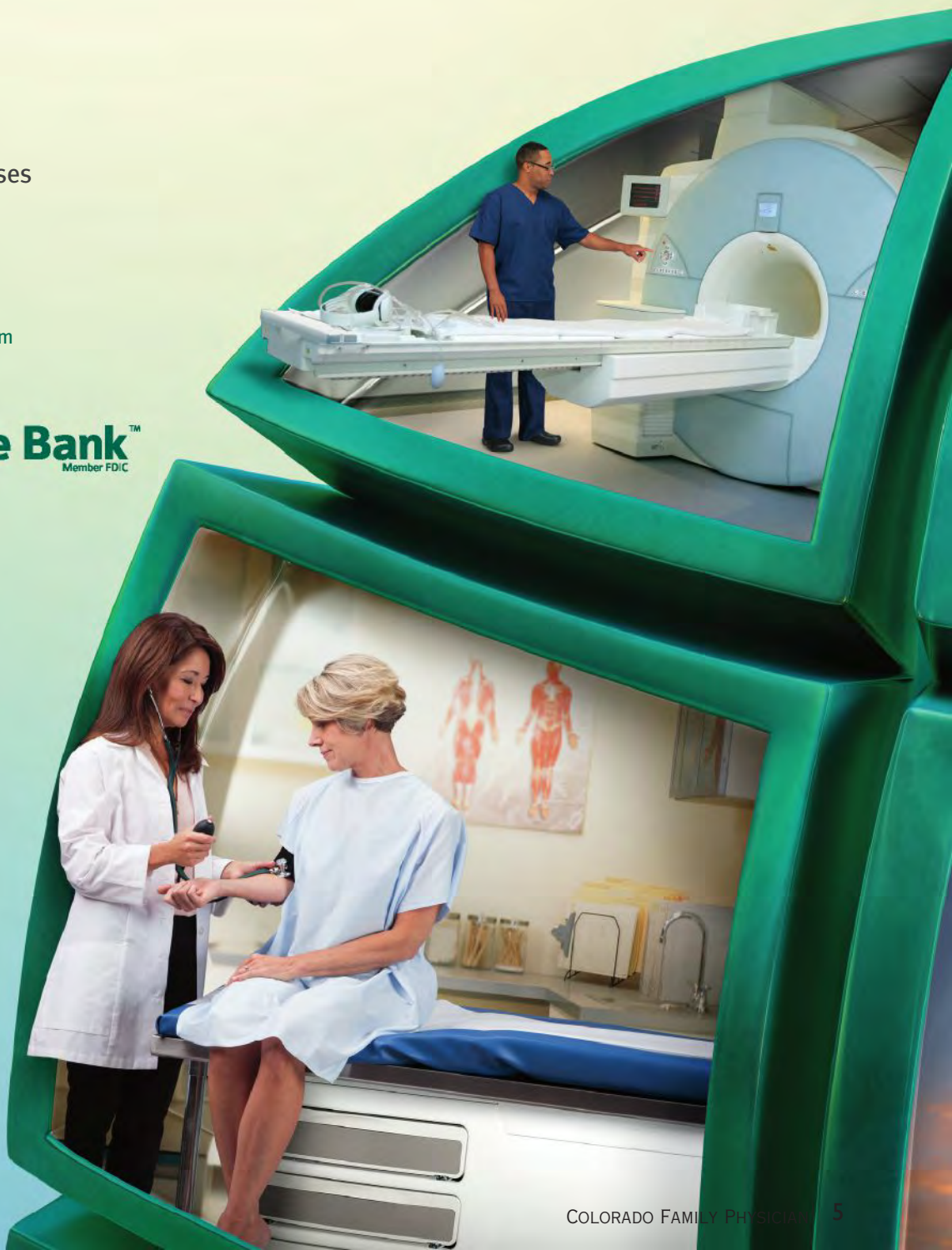


CEO's Report

By: Raquel J. Rosen, MA, CAE

2016 Membership Survey: Results and Forward Steps

This summer, the CAFP conducted our annual membership satisfaction survey. It's a very important part of the work we do, as it gives all of you the opportunity to speak candidly to us. What are we doing right? What are we doing wrong? What can we do and provide that will make your membership with us valuable?

We were happy to see that 92% of the respondents agreed that they are satisfied with membership. We hope this is felt throughout our membership.

That said, we were able to identify a number of specific areas where we can improve. One thing that came through loud and clear is that our membership continues to become increasingly diverse. Many of you work in private practice settings. An increasing number of you are working as employed physicians. And an emerging group of you are exploring new ways to practice, be it in Direct Primary Care or other models.

Because of this diversity of practice, we need to offer a diverse set of resources. Those of you in private practice aren't just physicians, you are business owners. It is up to you to negotiate with payers, watch for the changes that effect payment and practice, and keep your doors open and lights on. You need a health system that makes all of that possible.

Those of you who are employed face a different set of challenges. You need to know how to be a champion for yourself and your patents within a health system. You need to feel empowered to bring forward change within your system, and advocate for what is best for you and for patients.

All members agreed that payment reform continues to be a top concern for you, and you are unsure what work the CAFP has done to make you, or your practice, more financially successful. We understand, and we are frustrated with payment reform too. We know that pilot programs, while valuable, are not enough. Long-lasting payment reform must occur for our health care system to heal, and for family physicians to find more success.

Additionally, an increasing number of you recognize the importance of your own wellbeing. Burnout is a serious problem across practice types, and across all sorts of family physicians. We hope that this can be tackled in two ways: by making the environment you practice in better, reducing some of the stressors that lead to burnout; and by offering you resources at the individual level to help you find more health and happiness.

While the challenges we need to help you address are not small, we make steps toward solving them every day. I hope you will watch our communications over the coming months to learn more about what we are doing to make meaningful change. I hope you continue to share both your struggles and successes with us throughout the winter and spring, and in the next membership survey, so we can continue in the right direction. And I hope you will continue to push forward to make family medicine better, in whatever way gives you the most satisfaction. We are standing with you every step along the way.

While the challenges we need to help you address are not small, we make steps toward solving them every day. I hope you will watch our communications over the coming months to learn more about what we are doing to make meaningful change.

Raquel J. Rosen

Relationships are still the heart of medicine.

The bond you build with a patient makes practicing family medicine special.

The partnerships Children's Hospital Colorado builds with family physicians bring world-class pediatric specialty care to more kids.

In addition to our hospital on the Anschutz Medical Campus in Aurora, we have 16 locations in Colorado with pediatric services including emergency care, urgent care, pediatric specialty clinics, therapy care, diagnostics and observation. Visit **childrenscolorado.org/locations** for a full list.

For a list of our outreach clinics, which allow children to remain in their local communities while receiving the same specialty care, visit **childrenscolorado.org/outreach**.

Children's Colorado recognizes the important role family practice providers play in a child's healthcare team. **ONE CALL** is the primary care physician's link to pediatric and adolescent services and information.

Use ONE CALL to help you with:

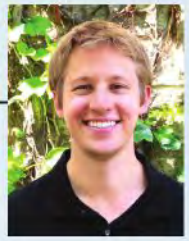
- 24-hour consultations and diagnostic dilemmas
- Arranging patient transport
- Outpatient referrals
- Professional support/ continuing education
- Inpatient admissions
- Identification of pediatric subspecialties
- Any other questions

800-525-4871

Children's Hospital Colorado

CAFP Legislative UPDATE

By Ryan Biehle, Director of Policy and Government Relations



With an unprecedented presidential election upon us, it seems that "the future ain't what it used to be." Indeed, Yogi Berra's wit may pertain as much to the future of family medicine in Colorado as to American politics. Presidential politics tend to dominate the news in these years, but as important as that race may be, at the Academy we're focused on a range of other races and issues at the state level that are sure to impact you. We're working to make sure our future is brighter.

Tobacco Tax Initiative: Amendment 72

We know tobacco is among the worst culprits responsible for premature deaths in the United States. Amendment 72 is our opportunity to pass one of the most effective public health measures to prevent 34,000 Colorado kids from ever starting to use tobacco. CAFP played a key role in developing the measure. I recommend reading Dr. Mike Pramenko's compelling case for it in this edition of the magazine, directly following this report. Once you do, we need your help to get it passed. As a trusted messenger to patients and communities, family physicians can have an immense impact. There are many opportunities to lead:

- Place our Healthy Colorado 2016 Campaign literature in your office waiting room,
- Write an op-ed or letter to the editor – we can even provide you a template,
- Sign up for the Speakers Bureau (the campaign will train you or your staff on the most effective campaign messaging),
- Donate to the campaign at www.healthyco2016.com.

Contact me with your interest or any questions: ryan@coloradoafp.org or 303-696-6655.

Amendment 69: ColoradoCare

ColoradoCare is the single-payer proposal on the 2016 ballot. Taking a considerable departure from our current system, the measure would roll-up healthcare payments into a single entity. When CAFP surveyed our membership, we found members were evenly split in favor of and against the measure. Given we do not have a clear consensus, CAFP has remained neutral while facilitating education on the potential impacts. We hosted a debate on the matter at the CAFP Annual Summit and are happy to answer members' questions as they arise. The Colorado Medical Society convened a physician workgroup, including CAFP members, to review the amendment. For more information, look to this comprehensive resource on the pros and cons of both the current system and ColoradoCare: www.cms.org/coloradocare/analysis

Supporters have made the case that the new system would be far more efficient, eliminating insurer overhead and profits, enabling negotiation to drive down the cost of prescription drugs, and reducing the administrative burden on physicians by streamlining quality reporting, billing, and contracting in a multi-payer system. Deductibles and copays would be prohibited for primary and preventive care. On the other hand, opponents have made the case that physician rates are uncertain under the new system and may be too low. Additionally, access to care may be hindered through burdensome restrictions on the care patients can receive, the doctors they can see, or limited prescription drug formularies, and physicians may lose autonomy to practice in their desired model, negotiate contracts and drive quality measures. There are many questions about how the new system would work. If you have questions that are not answered in the resources provided, please reach out and we will work to find the answer.

CAFP Political Committee Endorses 51 Candidates for State Legislature

Putting primary care front-and-center on the agendas of state leaders is one of CAFP's key strategies to advance family medicine and the health of Colorado patients. This year our Political Committee, led by members of the CAFP Board, endorsed 51 candidates who support family medicine. Our endorsement process is nonpartisan. Candidates from Alamosa, to Fort Collins, to Denver and the Western Slope received endorsements. We contribute to candidates who complete our survey and state their support for CAFP priorities including in particular:

1. Funding the Medicaid primary care "bump,"
2. Maintaining our currently stable malpractice environment,
3. Advancing Patient-Centered Medical Homes and physician-led team-based care, and
4. Increasing the primary care workforce through state support of family medicine residencies, scholarships and loan repayment for rural and underserved primary care physicians

CAFP Board members, lobbyists and staff held our Candidate Reception in late August where 27 of the endorsed candidates attended to learn about these issues and the challenges family physicians face in providing the care they want for their patients. Whichever party controls the state House and Senate chambers come November, family physicians will have a strong voice and allies in advancing the agenda to make Colorado a healthier state.

To see a full list of the endorsed candidates, visit https://www.coloradoafp.org/candidate_reception/

CAFP Receives National Recognition for Legislative Work

The CAFP is excited to announce the AAFP has recognized us with the 2016 Leadership in State Government Advocacy Award. We were recognized for our work in helping to pass House Bill 1142, giving primary care preceptors in rural communities a tax credit. For more information on how to qualify for the tax credit visit: https://www.coloradoafp.org/rural_preceptor_tax_credit/

OPINION: VOTE YES ON AMENDMENT 72

By Michael J. Pramenko M.D.

Knowing is not enough; we must apply.
Willing is not enough; we must do.

-Johann Wolfgang Von Goethe

This fall, Colorado voters will have ample opportunity to consider, discuss, and vote on matters pertaining to health care. With respect to Amendment 69, there are simply too many questions left unanswered for me to comment for or against this proposal to overhaul Colorado's health care system.

On the other hand, plenty of evidence and hard facts support Amendment 72. It would increase Colorado's tobacco tax and use the funds to help reduce health care expenditures for the rest of us well into the future.

According to the National Institute for Health Care Management Foundation, 5% of the population accounts for 50% of overall health care spending. In fact, 1% of the population accounts for 23% of overall spending. Where do you fit in? Indeed, the healthy among us are paying an ever increasing price for the unhealthy.

As patients there are things we need to do to address the massive cost of healthcare in the United States. We can't fix this problem without addressing the major causes of chronic disease: obesity, alcohol, and tobacco.

While we can't live forever, we can certainly live healthier lives while we are here. And, as a country that does tax everyone to help fund healthcare for the masses, we have a responsibility to the medical "safety net." Medicare is the best example. And, commercial insurance operates in a similar fashion. Insurance companies, with or without the Affordable Care Act, need a pool of healthy patients to help fund the medical costs for the sick and chronically ill.

Libertarian, Republican, Democrat, Independent - we all have skin in this game.

Now you have an opportunity, based on factual experience in public health and population health, to affect real change. Together, by increasing the tax on tobacco in Colorado, we can reduce the use of tobacco and improve the health of the population. In addition, the initiative specifically spells out how the tax dollars would be utilized. Here are some highlights that pay large dividends well into the future:

Of the $315 million in projected first year revenue, $92 million would be spent on research at Colorado facilities. This would include research into treatments for cancer prevention, heart and lung disease, Alzheimer's disease, and youth mental health.

$48 million to fund unmet medical and mental health needs for Colorado veterans.

$17 million to provide student debt repayment and training for medical professionals serving rural and underserved areas of Colorado.

$54 million would be spent on Centers for Disease Control prevention recommendations for funding tobacco education, prevention, and cessation programs.

Amendment 72 will appropriately fund population health measures by taxing unhealthy behavior. It will raise the tobacco tax in Colorado such that our tax ranks 11th in the nation vs our current standing at 38th.

We fund our roads, in a large part, with user fees. The more you use the roads – the more you pay to maintain the roads. In order to address rising costs, health care funding requires similar techniques. So here's your chance to get a return on the $700 extra dollars every Colorado household pays to cover the cost of tobacco related disease. Raise the tax on tobacco. Vote yes on Amendment 72.

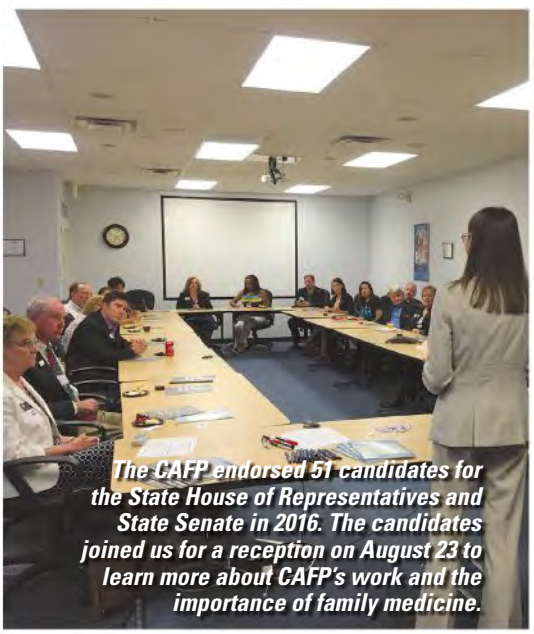
Michael J. Pramenko M.D. is the Executive Director of Primary Care Partners. He is Chairman of the Board of Monument Health and is a Past President of the Colorado Medical Society.

CAFP ON THE GO

Raquel Rosen joined other western states chapter executives for a "Women of the West" gathering in Arizona.

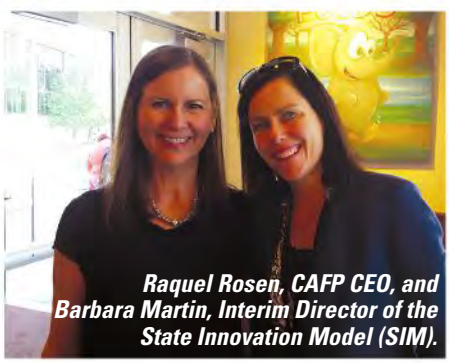
The CAFP hosted a reception in conjunction with the Arizona Academy of Family Physicians for Colorado and Arizona attendees of the AAFP's National Conference of Family Medicine Residents and Medical Students.

CAFP's Director of Policy and Government Relations Ryan Biehle toured the new rural training tracks in Sterling and Fort Morgan to learn how they are training Colorado's future doctors.



The CAFP endorsed 51 candidates for the State House of Representatives and State Senate in 2016. The candidates joined us for a reception on August 23 to learn more about CAFP's work and the importance of family medicine.

CAFP attended the kickoff for the Campaign for a Healthy Colorado, in support of a November ballot measure that would raise taxes on tobacco products and help fund various healthcare initiatives.



Raquel Rosen, CAFP CEO, and Barbara Martin, Interim Director of the State Innovation Model (SIM).

The Colorado Delegation at the AAFP Congress of Delegates in Orlando, FL.

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WE NEVER SAY NEVER.®

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Front Range pediatrics patients can now get appointments within 48 hours. Physicians can refer patients by calling our physician line at 1.800.652.9555 or visiting njhealth.org/professionals.

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Pediatric conditions we treat include: Allergies (such as anaphylaxis, drugs, foods, rhinitis, urticaria, and venom), asthma, atopic dermatitis, autoimmune/autoinflammatory diseases, eosinophilic esophagitis, gastroesophageal/laryngopharyngeal reflux, immunodeficiency, pulmonary diseases, recurrent infections, sleep disorders, sinusitis, vasculitis, vocal cord dysfunction, wheezing in infants.

Our services include: Comprehensive food allergy testing/challenge, exercise physiology and lung function testing, genetic and immune function testing for immunodeficiency, neuropsychological testing, sleep disturbance evaluations.

COPIC Recognizes Value of PCMH

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The Colorado Academy of Family Physicians greatly appreciates COPIC's generous acknowledgement of the value of the NCQA Patient Centered Medical Home Recognition (PCMH). COPIC has agreed to award one COPIC point for physicians who achieve the initial certification of NCQA PCMH Level 1, one COPIC point for physicians who achieve the initial certification of NCQA PCMH Level 2, and one COPIC point for physicians who achieve the initial certification of NCQA PCMH Level 3.

A COPIC insured Colorado Physician needs to maintain a balance of 3 COPIC points at the end of each calendar year to earn a 10% preferred discount in the subsequent year. Up to 6 COPIC points in excess of the required 3 can be rolled over to the next cycle.

To receive your COPIC points, please fill out the form below and send it along with your NCQA PCMH Certificate to the CAFP office, attention Raquel J. Rosen, 2224 S. Fraser St., Unit 1, Aurora, CO 80014, email it to raquel@coloradoafp.org, or fax it to 303-696-7224.

REQUEST FOR COPIC POINTS

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Practice Name: _____

1. Physician Name: _____ Specialty: _____
2. Physician Name: _____ Specialty: _____
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Address: _____

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Phone: _____ Fax: _____

Email: _____

NCQA PCMH Recognition Level: _____ Date awarded: _____

Please enclose certificate.
Please fax to CAFP at 303-696-7224, mail to CAFP, 2224 S. Fraser St., Unit 1, Aurora, CO 80014, or scan and email to raquel@coloradoafp.org.
Questions? Please call Raquel J. Rosen, 303-696-6655, ext. 10.

All Doors Lead to Practice Transformation

By Barbara Martin, RN, MSN, ACNP-BC, MPH, Interim SIM Office Director

> *"SIM offers providers the resources and support to focus on new ways to improve health outcomes and the patient experience. As we anticipate new ways that providers will be paid in the future, the SIM project helps providers prepare for these changes on the horizon."*
>
> *Sue Williamson, JD, executive director, Colorado Children's Healthcare Access Program*

Colorado practices that are ready to start the process of transitioning from volume- to value-based healthcare delivery models can participate in a number of federal initiatives that support this work in the state. Two of these initiatives are the Colorado State Innovation Model (SIM), which will release its application for the second cohort before the end of November, and the Comprehensive Primary Care Plus (CPC+) initiative.

The goal of both initiatives, which are funded by the Centers for Medicare & Medicaid Services, is to prepare practices for value-based reimbursement, which requires retooling operational practices and policies to provide high-quality, integrated approach to patient-centered care.

Regardless of where you are on the transformation path—just getting started or on the cutting edge—you might be eligible for some of these programs. To help you choose the initiative that's right for you the SIM team developed a decision tree (www.colorado.gov/healthinnovation) with questions to lead you in the right direction.

No Wrong Door

We encourage eligible practices to apply for all available programs that help them meet care delivery transformation goals. For example, SIM and CPC+ (application closed Sept. 15) are complementary initiatives in many ways, which is why we developed a streamlined application to save time for practices that were eligible to apply for both.

Many practices were not eligible for CPC+ for a variety of reasons, including Medicare eligibility restrictions, but might still be eligible to participate in SIM. Such practices include:

- Federally-qualified health centers
- Pediatric practices
- Rural health centers
- Concierge or direct primary care practices that charge retainer fees
- Practices in accountable care organizations (ACO) participating in the ACO Investment Model, Next Generation ACO Model or other shared savings programs

Lessons Learned

The SIM team is about eight months into implementing practice transformation activities with cohort 1 and has received feedback from payers and providers about ways to modify the initiative to ensure long-term success. Cohort 1 practices are receiving the following support to help them integrate behavioral health and primary care:

- A practice facilitator to guide the practice improvement team with ongoing change and quality improvement activities
- A clinical health information technology advisor to help build practice data capacity and create actionable information
- Access to a regional health connector, who connects practices to relevant community and state resources
- Participation payments of up to $5,000 for meeting key practice transformation requirements, access to small grants and payer support
- Access to MGMA DataDive™, an online data benchmarking tool
- Participation in twice-yearly Collaborative Learning Sessions
- Opportunity to earn Maintenance of Certification and Continuing Medical Education credits

While the support package touches every piece of the practice transformation journey, practice coaches say the ability to visit with practice teams on a twice-monthly basis helps SIM practices go farther faster with transformation activities because they can identify necessary changes, map out process changes and keep everyone accountable to goals. The other essential piece is a coach's ability to identify small but meaningful successes, which helps motivate practice professionals, who are inundated with requested and required process changes to continue moving forward.

While coaches acknowledge the hard work required for transformation, which is time-consuming and expensive for practices that live in a fee-for-service world, they say it benefits physicians, staff and patients at every level.

"SIM offers providers the resources and support to focus on new ways to improve health outcomes and the patient experience," says Sue Williamson, JD, executive director, Colorado Children's Healthcare Access Program, Denver, one of the SIM practice transformation organizations. "As we anticipate new ways that providers will be paid in the future, the SIM project helps providers prepare for these changes on the horizon," she adds.

Help your practice prepare for alternative payment models, and join our transformation community and apply for SIM cohort 2 this fall: https://split.practiceinnovationco.org/simapplication.

Additional resources:

- Read about practice transformation success stories: www.colorado.gov/healthinnovation
- Sign up for the SIM newsletter: https://goo.gl/9CZT2q
- Apply for SIM cohort 2: https://split.practiceinnovationco.org/simapplication.

How Medicare's new Chronic Care Management Program Can Improve Primary Care for Patients and physicians

By Syam Palakurthy

Nearly ten years ago, Dr. Vijay Chowdury[1] received a disheartening phone call: one of his patients, Mary,[2] had landed in the Emergency Room for the fifth time in as many months. Mary had multiple co-morbidities including Type 2 Diabetes and mental health issues. A business-as-usual approach to her care clearly was not working. Her situation required a radical change in tactics, so Dr. Chowdury and his staff did what few primary care practices have the luxury of doing: they dedicated an enormous amount of time to working with her. Dr. Chowdury had her come in to see him personally every month. He connected her to a mental health specialist to see monthly, and a foot specialist to see quarterly. His nurse assistant called Mary regularly over the phone to reinforce her medication adherence, and his staff connected her to a dietitian to help her make dietary changes. Thanks to the work of Dr. Chowdury, his staff, his colleagues, and Mary herself, what could have ended as a woefully common tragedy turned into something else entirely: an extraordinary success. In the ten years since that trip to the ER, Mary has never had to return.

Like Mary's situation, many of the current challenges in our health care system stem not from incomplete clinical knowledge, but from system-wide limitations to address the multi-factorial nature of chronic disease. According to a study commissioned by the Robert Wood Johnson Foundation, clinical care governs only a fraction of our overall health outcomes, compared to larger drivers like health behaviors, social and economic factors, and the physical environment in which we live.[3] In the case of diabetes, hypertension, congestive heart failure, and many other extremely common chronic diseases, we know that health behaviors like medication adherence and lifestyle changes can go a long way, but our system has inadequately equipped physicians and patients to adopt a broader approach to disease prevention and management.

This is an issue that hits close to home for me. I was raised by two physician-parents with more than a combined seventy years in practice, and I have spent years listening to the unvarnished truth about the joys and challenges of my parents' profession. With their chronic disease patients, they often feel trapped in a Groundhog Day world of eternal recurrence: the same conversation occurs during each visit about the need to start adhering to medications and making lifestyle changes. Despite the consistency of the message, when the next visit comes around and my parents see their patients' lab results and BMIs, it's as if the conversation never happened at all, and they must take valuable patient time to retread old ground.

With the constant repetition of the same conversations, a sense of hopelessness could easily sink in, a feeling that some patients simply lack the will power to make the needed changes. But behavior change is singularly difficult for every one of us, and more so for patients like Mary with multiple complex co-morbidities, mental health issues, and social factors at play. It requires a break from conventional approaches, but evidence demonstrates that successful interventions exist. A randomized controlled trial conducted by Allina Health, a Minnesota health system, showed that lay health workers with limited but specific training had a significant and positive impact on the lives of patients with diabetes, hypertension, and congestive heart failure. The intervention group patients were 31% more likely to meet their care goals and 21% more likely to quit smoking than the control group patients.[4] Another study at the University of California, San Francisco looked at the use of health coaches to assist patients with hypertension and found that both the patients and their primary care physicians benefited from the intervention.[5] Like Mary's experience, the Minnesota and San Francisco interventions succeeded partially due to highly frequent interactions with at-risk patients.

In the last four months, I have spoken to several dozen physicians and other health care professionals, and have heard similar success stories using a high-touch approach to chronic disease management. But those successes belie a darker reality: in the midst of growing documentation and quality requirements, primary care physicians disproportionately shoulder the financial and time-consuming weight of the comprehensive care that chronic diseases require. Providers all across the country like Dr. Chowdury may already take it upon themselves to shoulder that burden, but that does not make it fair to ask for the additional work and financial risk with no recompense.

Medicare, Medicaid, and private payers have

started to recognize this burden with various programs intended to reward higher value care. Still, many of these programs — Accountable Care Organizations, Patient Centered Medical Homes, Meaningful Use, and PQRS incentives, etc. — require a non-trivial upfront investment. A move away from fee-for-service should eventually benefit primary care providers with more value placed on their work, but it also poses challenges to practices that struggle to make some of the necessary investments before seeing the gains. CMS has started to recognize this with new hybrid approaches to reimbursement that combine aspects of fee-for-service and value-based models.

The Medicare Chronic Care Management program represents the most notable of these hybrid approaches. CMS takes a very progressive approach in two important ways. First, instead of paying for a single encounter, this program reimburses practices that offer chronic care management services to patients on an ongoing and regular basis. Second, it allows for the care management to take place over the phone by a non-physician member of the care team with 'general supervision' by the physician, instead of requiring in-office 'direct supervision.' The program pays a national average of approximately $43 per eligible patient per month. Given that most Medicare patients fit the requirements, this can add up to meaningful revenue for a practice — one Stanford study estimates over $70,000 in additional net revenue per physician.[6] Importantly, practices do not need to make substantial upfront investments — they can start small and scale up the program incrementally. Practices can thereby use the CCM program to help pay for some of the changes needed to take advantage of the coming wave of payment reforms.

A transition away from our current system will not be easy, but the changes stand to benefit primary care providers and patients alike. New reimbursement programs, like Medicare's Annual Wellness Visit, Transitional Care Management code, and Chronic Care Management program, can all help practices finance a broader shift to a value-based model. Our current health system clearly requires major changes; but it will change, for the simple reason that it must — the lives of patients like Mary literally depend on it.

Syam Palakurthy is the founder of SamaCare LLC, an organization that helps physician practices offer health coaching to patients.

Endnotes

1 Physician and patient names were changed to protect the physician's privacy.

2 Physician and patient names were changed to protect the patient's privacy.

3 "Our Approach | Health Factors." County Health Rankings & Roadmaps. Web. 1 May 2016.

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6 Basu, Sanjay, Russell S. Phillips, Asaf Bitton, Zirui Song, and Bruce E. Landon. "Medicare Chronic Care Management Payments and Financial Returns to Primary Care Practices." Annals of Internal Medicine Ann Intern Med 163.8 (2015): 580. Web.

Fit Family Challenge Pilot Program Results Published

According to the American Academy of Pediatrics, the primary care practice is the ideal place to identify children who have or are at risk for childhood obesity, and to educate and intervene with families to help children get healthy.

In response to this, the Colorado Academy of Family Physicians, with support and assistance from HeartSmartKids, HealthTeamWorks, the University of Colorado Department of Family Medicine, the Colorado Academy of Family Physicians Foundation, the Anschutz Family Foundation, and the Colorado Health Foundation, launched the Fit Family Challenge pilot program in primary care offices around the state.

The finding from the pilot program were very encouraging, and showed statistically significant changes in a number of tracked areas, particularly related to BMI.

The findings have been published in the July-August issue of the Journal of the American Board of Family Medicine. Access it at www.jabfm.org.

Dan Atkins, MD

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Children's Hospital Colorado
Affiliated with University of Colorado Anschutz Medical Campus

KIDS corner
Keeping Colorado's family physicians up-to-date on health topics

Food Protein-Induced Enterocolitis Syndrome (FPIES):

An Often Overlooked Item on the Food Allergy Menu

Children with immunoglobulin-E (IgE)-mediated food allergy present with symptoms typically associated with allergic reactions that occur reproducibly within minutes to hours after ingestion of the culprit food and have a positive skin test to the offending food. In contrast, children with non-IgE-mediated food allergies often present with symptoms isolated primarily to the gastrointestinal tract such as abdominal pain, nausea, vomiting, diarrhea, food refusal and failure to thrive.

The diagnosis of non-IgE-mediated food allergy early in life is often missed or delayed due to the overlap of symptoms with other GI disorders, a longer delay between food ingestion and symptom onset, a lack of biomarkers (prick skin tests are usually negative) and poor awareness of these conditions by some care providers.

Food protein-induced enterocolitis syndrome (FPIES) is a perfect example of a non-IgE-mediated food allergy that is often misdiagnosed or not diagnosed in a timely fashion. FPIES presents during infancy in both acute and chronic forms. The acute form of FPIES occurs either after initial food introduction or upon reintroduction following removal of a culprit food from the diet. Symptom onset is typically within two to four hours of food ingestion and consists of repetitive, profuse vomiting in addition to pallor and lethargy, often followed hours later by diarrhea. Severe reactions result in acute dehydration, hypotension and/or bloody, mucousy stools filled with eosinophils and leukocytes. Peripheral blood neutrophil counts are increased and often accompanied by thrombocytosis.

Because of the acute onset of symptoms, children with FPIES are often seen urgently in their doctor's office or in the emergency department where they are frequently misdiagnosed with suspected sepsis, acute viral gastroenteritis, or surgical conditions, further delaying the correct diagnosis. In contrast, chronic FPIES occurs when the culprit food is introduced early in life and fed regularly, such as milk or soy formula. Symptom onset is usually within the first three months of life and between one to four weeks of formula introduction. Onset can occur later if formula introduction is delayed, but rarely occurs after a year of age.

Classic symptoms include persistent irritability, abdominal distention, lethargy, failure to thrive, and bloody diarrhea accompanied by laboratory findings of metabolic acidosis, neutrophilia, eosinophilia, anemia and hypoalbuminemia. Methemoglobulinemia and acidosis have been reported in up to a third of infants with severe reactions. Removal of the offending food from the diet results in significant improvement over the following 24 to 48 hours, although symptoms return acutely following subsequent exposures.

Milk and soy formulas are the most common causes of FPIES and in the United States about half of the children who react to one also react to the other. The foods that often trigger solid food FPIES include several that rarely cause IgE-mediated reactions and are commonly the first foods introduced into the infant diet, which is another reason that food allergy is rarely considered the cause. For example, rice is the most common cause of solid food FPIES while other common triggers include oat, barley, avian meats, sweet potato, white potato and corn. A relatively common scenario for FPIES is the infant who is fed rice cereal for the first or second time and develops classical FPIES symptoms two to four hours later. Because

rice is not considered a common food allergen, the diagnosis of a food allergy is not considered or is even discounted if suggested by a parent. About a third of the children with FPIES to milk and/or soy subsequently develop FPIES to solid foods, whereas about 80 percent of infants with solid food FPIES react to more than one food. High-risk food groups in the first year of life include grains, legumes and poultry. Fortunately, most children outgrow milk and soy FPIES by three years of age, although resolution of solid food FPIES may take longer. Interestingly, FPIES to fish and shellfish has been described in older children and adults.

Knowledge of the common food triggers, typical symptoms, timing of symptom onset following food exposure and the different forms of FPIES (acute and chronic) is critical to making the diagnosis. Allergen skin testing is usually negative although recent evidence suggests that those with positive skin tests take longer to outgrow FPIES and may subsequently develop IgE-mediated food allergy. Occasionally, oral food challenge to the suspected food after a period of avoidance is necessary to confirm the diagnosis. Oral food challenges are also considered after 12 to 18 months without a reaction to determine whether the FPIES to the incriminated food has been outgrown.

Because approximately half of positive challenges result in repetitive vomiting and acute dehydration, experienced personnel should perform these challenges in a medical setting with intravenous access and the ability to provide rapid fluid resuscitation. Treatment with a single dose of methylprednisolone is recommended for severe reactions. Routine treatment with antihistamines or epinephrine is not recommended as they do not reduce emesis or lethargy, but a recent report demonstrated a prompt response to treatment with ondansetron in patients with acute FPIES. Accidental ingestions resulting in a reaction often require trips to the emergency room for fluid resuscitation. Providing families with a letter to give to urgent care personnel describing the presentation and management of FPIES helps avoid misdiagnosis and reduces the time to provision of optimal therapy.

Management of the infant with multiple food FPIES often presents a challenge best addressed with assistance from other care providers such as an allergist, a gastroenterologist, a dietician, a feeding therapist and occasionally a psychologist. Input from these specialists aids in insuring optimal nutrition while on the required elimination diet and overcoming feeding difficulties resulting from unpleasant feeding experiences through the provision of strategies that reinforce the feeding and oral skills these infants and children require. Fortunately, the prognosis is excellent as most children outgrow their FPIES within several years. Hopefully, as knowledge about FPIES is gained and disseminated, delays in diagnosis and misdiagnoses will be substantially reduced, resulting in better nutrition and improved quality of life for these patients and their families.

For questions about "Who to consult" visit our website at www.childrenscolorado.org/allergy or call the Allergy team at (720) 777-2575 or toll free via One Call at (800) 525-4871.

This article was written by Dan Atkins, MD, Pediatric Allergy Section Chief at Children's Hospital Colorado. He can be reached by e-mail at dan.atkins@childrenscolorado.org.

Legal Protections When Providing Care Under Emergency and Volunteer Circumstances

By Jean Martin, MD, JD; Senior Legal Counsel
COPIC Legal Department

Physicians and other health providers often provide uncompensated care in emergency circumstances or when acting as volunteers. To encourage these types of activities for the public good, state and federal laws have been enacted to provide qualified immunity from liability for volunteer health care providers.

COLORADO GOOD SAMARITAN LAW

Under Colorado's Good Samaritan law, physicians and others are not liable for any civil damages for their acts or omissions if they, in good faith and without compensation, render emergency care or assistance to a person who is not presently their patient at the place of an emergency or accident, including at a health care institution. The law does not apply to any person who renders such emergency care to a patient he or she is otherwise obligated to cover. The protections under the law do not apply where the person's acts or omissions were grossly negligent or willful and wanton. Gross negligence is willful and wanton conduct, that is, action committed recklessly with conscious disregard for the safety of others.

The Good Samaritan law also protects volunteers from liability for civil damages when they act in good faith to render emergency care or assistance as members of a ski patrol/rescue unit or those who provide counseling to members of the public in crisis situations as a hotline volunteer for a nonprofit organization. It is important to note that this is a Colorado law and Good Samaritan laws vary by state.

RENDERING EMERGENCY ASSISTANCE AS A TEAM HEALTH CARE PROVIDER

Licensed physicians and other health care providers who, in good faith and without compensation, render emergency care or assistance (including sideline or on-field care) as a team health care provider to someone requiring care as a result of having engaged in a competitive sport are not liable for civil damages as a result of their acts or omissions.

Again, this liability protection does not apply if the acts or omissions constitute gross negligence or willful and wanton conduct, or if they are outside the person's scope of practice. Under the law, "competitive sport" means a sport conducted as part of a program sponsored by a public or private school that provides instruction in any grade from kindergarten through twelfth grade or sponsored by a public or private college or university, or by any league, club, or organization that promotes sporting events.

COLORADO VOLUNTEER SERVICE ACT

Health care volunteers also have protection from liability under the Colorado Volunteer Service Act (CVSA), which incorporates the federal Volunteer Protection Act (VPA). Under the CVSA, "volunteer" means a person performing services, other than as a director, officer, or trustee, for a nonprofit organization, a nonprofit corporation, a governmental entity, or a hospital without compensation other than for actual expenses incurred. This includes physicians, PAs, nurses, and other health care providers.

Under the CVSA, a volunteer is immune from liability if the volunteer would have immunity under the federal act. Under the federal VPA, no volunteer of a nonprofit organization or governmental entity is liable for harm caused by the volunteer's acts or omissions on behalf of the organization or entity if:

- The volunteer was acting within the scope of his or her responsibilities;
- Where appropriate or required, the volunteer was properly licensed, certified, or authorized for the activities or practice within the state where the harm occurred;
- The harm was not caused by willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed; and
- The harm was not caused by the volunteer operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires the operator or owner to possess an operator's license or maintain insurance.

The liability protections do not apply where there is misconduct, such as a crime of violence, a hate crime, a sexual offense, a violation of a state or federal civil rights law, or where the defendant was under the influence of intoxicating alcohol or any drug at the time of the misconduct.

AVIATION MEDICAL ASSISTANCE ACT

Physicians also have protections under the federal Aviation Medical Assistance Act of 1988 for providing emergency assistance on flights. Under the Act, a medically qualified individual is not liable for damages brought in a federal or state court arising out of the acts or omissions of the individual in providing or attempting to provide assistance in the case of an in-flight medical emergency unless that person is guilty of gross negligence or willful misconduct. A "medically qualified individual" includes any person who is licensed, certified, or otherwise qualified to provide medical care in a state, including a physician, nurse, PA, paramedic, and emergency medical technician.

Managing the Most Common Sleep Questions from your Patients for Birth Through Adolescence

Susan Crane, PsyD
Stacey L. Simon, PhD

1. What do you think about white noise? Does it help to use sounds during sleep? Would using white noise make a child a lighter sleeper or dependent on it to sleep?
   - Using sounds during the night can often improve sleep. Sounds in the bedroom can keep out other noises that might accidentally wake children up (like noise from the TV in the next room, or noise from a car driving by). It can also be relaxing to have some comforting sounds to associate with sleep.
   - Some examples of helpful sounds include: "white noise" (from a sound machine or app), fans, music, or nature sounds. The sounds should not change too much in volume – be cautious as the radio can get louder during commercials and some classical music has dramatic changes in volume! The sounds should run all night, so they can help children fall back to sleep during natural awakenings throughout the night.
   - The goal is to associate sounds with sleep, so in that way children may become "dependent" on the sounds. These sounds can be used when travelling or sleeping away from home, so it actually helps children sleep in new settings that otherwise may disrupt sleep.

2. Is there anything a parent can do to help their child be a better sleeper?
   - Some tips for better sleep include:
     i. Keep the same bedtimes and wake up times every day, even on weekends.
     ii. Stop electronics (TV, iPad, video games, cell phones) at least 1 hour before bed.
     iii. Follow a bedtime routine. Some ideas to include in a bedtime routine for younger children: bath, looking at picture books, reading aloud, singing songs. For older kids: reading, listening to music, journaling, relaxation exercises. Whatever you choose, it is helpful to do the same things in the same order every night.
     iv. Avoid caffeine at least 8 hours before bed.
     v. Get at least 30 minutes of vigorous physical activity each day.

3. Should I lay down with my child to help them fall asleep?
   - Generally, no. Some families prefer to sleep all together in a family bed. However, many families would like their child to be able to fall asleep on their own and sleep in their own bed all night.
   - If children are not able to fall asleep on their own at bedtime, they will have difficulties returning to sleep during natural wakings in the middle of the night. That is when they cry or show up at your bed in the middle of the night! Children who learn the skills to fall asleep by themselves at the start of the night can then use these same skills to fall back to sleep on their own in the middle of the night.
   - If falling asleep independently is a challenge for your child, working with a sleep psychologist to make a plan to gradually teach this skill can be very helpful.

4. What is the recommended amount of sleep for children of different ages? Is it true that some people just need fewer hours of sleep to function?
   - The ideal amount of sleep for children varies by age. The recommended ranges for number of hours of sleep per night are:
     i. infants (<1 year): 11-18 hours, including naps
     ii. 1-3 years: 12-14 hours, including naps
     iii. 3-5 years: 11-13 hours, including naps
     iv. 6-12 years: 10-11 hours per night
     v. 13-18 years: 8.5-9.5 hours per night
   - It is very rare that some people just need fewer hours of sleep. Most children will have optimal development if they regularly get at least the minimum amount of recommended sleep. Chronically getting insufficient sleep is associated with many health and behavior problems, including obesity, difficulties with attention and concentration, and mood problems.

5. As a parent, when should I be concerned about my child's sleep?
   - If your childs daytime functioning is concerning they appear sleepy or too hyper during the day, have difficulties paying attention in school, or have problems regulating their moods.
   - If your child is regularly getting less than the recommended amount of sleep for their age
   - It is important to evaluate any medical problems that may be contributing to poor sleep (such as regular snoring or obstructive sleep apnea) and address any challenges that are preventing your child from getting a good nights sleep.

Susan Crane, PsyD & Stacey L. Simon, PhD are sleep psychologists in the Sleep Center at Children's Hospital Colorado. They specialize in working with families and children of all ages to improve sleep. The sleep clinic is held at the Anschutz Campus in Aurora and the South Campus in Highlands Ranch.

The sleep team experts at Children's Hospital Colorado can help with any sleep concerns. To schedule an appointment, please call: 720-777-6181.

SNOCAP News

As these summer months turn to fall, and fall starts bringing us into winter, SNOCAP keeps marching on! We are pleased to have Dr. Matthew Simpson, MD, MPH joining our SNOCAP team as co-director of CaReNet. Dr. Simpson had been working closely with SNOCAP previously as a Research Fellow in the Department of Family Medicine since August 2015, and has played an important role in several of our projects already. We are thrilled to have his expertise with us here at SNOCAP and look forward to what he will contribute to our CaReNet team!

Medication Assisted Treatment

At our SNOCAP Convocation in 2013 we heard from our practices that patients on opioid medications were close to, if not at, the top of the list of your concerns. We're happy to report that we now have funding to work with you on this issue!

Jack Westfall and Linda Zittleman from the High Plains Research Network headed up an AHRQ grant submission for Medication Assisted Treatment in Opioid Use Disorder. We were all pleased to find out that it received an excellent score! Congratulations are in order, as they have been awarded the grant to implement Medication Assisted Treatment for Opioid Use Disorder in the High Plains Research Network; eastern Colorado and the San Luis Valley. The grant will begin end of September 2016!

An official statement from the AHRQ website reads:

> The University of Colorado, Denver. Under the leadership of Dr. Jack Westfall, a family physician who recently was certified to provide MAT, this project will expand access to MAT across 24 counties in eastern and southern Colorado. Using a multi-pronged approach, the team will begin by partnering with community members to co-create messages and materials that are locally relevant and that deepen community awareness of opioid use disorder and knowledge of MAT. The team will provide primary care practices with comprehensive training and support for delivery of MAT in their rural primary care practices using face-to-face practice coaching and an ECHO tele-training model. This project will also include a comprehensive evaluation and the development of resources to allow other States and primary care practices to expand access to MAT.
>
> By the time this reaches your mailbox, we will be in the field recruiting practices to participate, so please let us know if you are interested in being a part of this important project!

What's next?

As we write this in late August, snow is starting to dust the peaks, reminding us that Fall and Winter are around the corner. We wish you a great holiday season, and as always are eager to receive your feedback and input on our work. Even better, let us know when we can come visit your practice!!

Don, Mary, & Victoria
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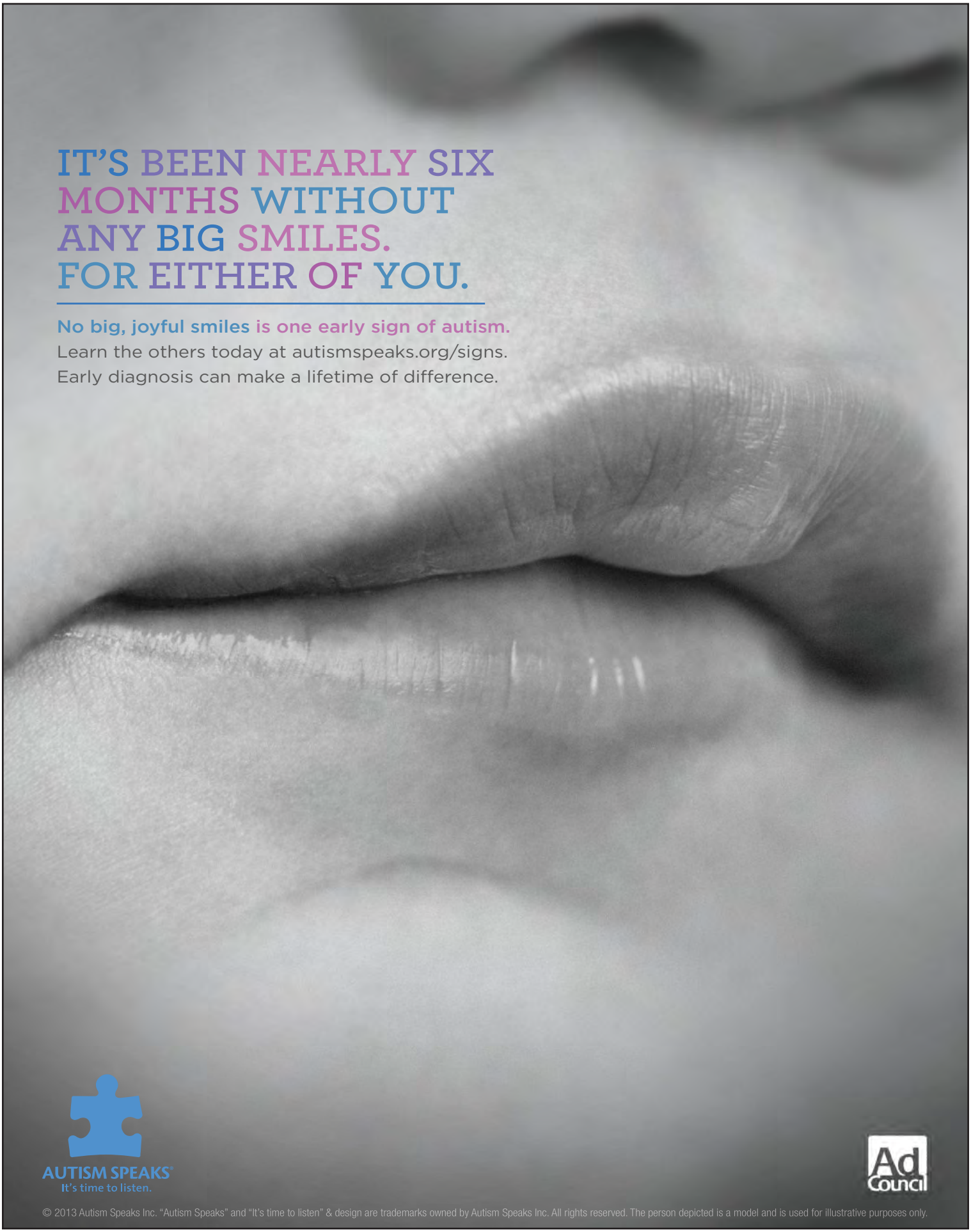
Your SNOCAP team


IT'S BEEN NEARLY SIX MONTHS WITHOUT ANY BIG SMILES. FOR EITHER OF YOU.
No big, joyful smiles is one early sign of autism.
Learn the others today at autismspeaks.org/signs.
Early diagnosis can make a lifetime of difference.
AUTISM SPEAKS
It's time to listen.
Ad Council
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VACCINE NEWS YOU CAN USE

By Walt Larimore, MD, DABFP, FAAFP and Reginald Finger, MD, MPH

2015-16 Colorado Immunization Database Full of Surprises

The Colorado Springs Gazette reported that an immunization database from *Chalkbeat* revealed some interesting items: 1) Boulder is the state's capital for the anti-vaccine movement, 2) children in school districts with increased racial and income diversity are more likely to be immunized, and 3) nearly fifty percent of schools are improving at following students' vaccinations.

This should only improve as new regulations make it more difficult for parents to opt their children out of vaccines and provide the foundation for a comprehensive state-run database expected to start next spring. The new database, which will be available to professionals and the public, will include immunization and exemption rates for not just Colorado schools but also licensed child-care providers.

According to the Gazette, "Public health advocates say giving parents access to immunization data helps them gauge the risk of communicable disease outbreaks and make informed choices about where to send their children for school or child care." The importance of this tool is that Colorado has one of the lowest immunization rates in the country, partly because it has been so simple for parents to opt their children out of shots. (details at tinyurl.com/h74z8tx)

A New Web-Based Resource to Help You Build a Successful Immunization Program

You can find tools to help improve your immunization practices at tinyurl.com/h8gy9p7, including:

- Resources to support health professionals with vaccine administration
- An overview of private sector services and vendors that support inventory management
- Job Aids and video training to support providers in the proper storage and handling of vaccines
- Resources for health professionals seeking reimbursement for services offered to patients
- Tools and resources to improve vaccination rates
- Information regarding the Vaccines for Children (VFC) program which uses federal funding to provide low- or no-cost vaccine to children who might not otherwise be vaccinated because of inability to pay
- An on-line form to submit questions to the state immunization clinical staff

(details at at tinyurl.com/h8gy9p7)

Dramatic Effect of Immunizations on Mortality for Children and Young Adults

Univadis reported that in the 20th century childhood mortality decreased rapidly and vaccination programs are most commonly cited as the principal reason. However, the exact quantification of this contribution has not been demonstrated until a recently published study of historical data from the Netherlands. In the prevaccine era, the contribution to the mortality burden was 1-4 percent for diphtheria, 3-8 percent for pertussis, and 0-1 percent for tetanus. When the use of vaccines became widespread, these contributions to the mortality burden decreased rapidly to almost zero. (details at tinyurl.com/jxpy5p8)

Morning Vaccinations Boost Immune Response

Medical Economics reports, "It may sound simple, but the key to improved vaccination efficacy may be the time of day that a vaccine is administered." A study published in *Vaccine*, revealed that the immune system "may be more receptive to vaccines earlier in the day." According to the report, "It is possible that diurnal variations in immune cell responses and/or levels of hormones with immune modifying properties, such as cortisol or inflammatory cytokines, provide an advantageous period for vaccination responses to occur. Therefore, adjusting the timing of vaccination may be a simple, cost neutral, and effective public health intervention to improve vaccination responses, particularly in older adults." (details at tinyurl.com/j3xbgq8)

CDC Reports Very Low Febrile Seizure Risk after Childhood Vaccines

NPR reports that CDC researchers reported that children given influenza or DTaP vaccubes had no greater risk of fever-related seizures than normal, while those given the pneumococcal shot only had a slightly higher likelihood of seizure. The findings, published in *Pediatrics*, were based on 2006 to 2011 data involving 333 cases of febrile seizures in children ages 6 months to 23 months. The study also revealed that only up to 3 per 10,000 children given all three vaccines at once were likely to have febrile seizures. (details at tinyurl.com/zjunvk6)

More Data Shows Tdap Vaccine is Safe in Pregnant Women and Helps Babies

HealthDay News reported on a study in *Human Vaccines & Immunotherapeutics* finding, once again, that Tdap vaccine is safe for pregnant women and can help protect their newborns from whooping cough in the short term. The findings, based on data involving nearly 1,800 births to women who received and did not receive the shot, showed the only difference in health outcomes was in cesarean-section rates, which researchers said was not likely tied to the vaccine. (details at tinyurl.com/glhompm)

Maternal Tdap Protects Premature Infants

Family Practice News reported on a study published in *Pediatrics*, which showed that maternal immunization in the early third trimester (from 28 weeks) protected premature infants from pertussis. Two months after their premature birth, infants born to vaccinated mothers had significantly higher concentrations of all five measured

antigens, compared with those born to unvaccinated mothers. (details at tinyurl.com/zjwz4z6)

Maternal Flu Immunization Protects Infants

Family Practice News also reported on another study published in *Pediatrics* reaffirming that infants born to mothers who received flu immunization during pregnancy were 70% less likely to contract lab-confirmed influenza and 81% less likely to be hospitalized for flu before age 6 months, compared with infants of unimmunized mothers. Yet just one in ten pregnant women received the vaccine, a proportion that has steadily risen since the 2009-2010 H1N1 flu season. "The results of this large retrospective study support the conclusions of prospective studies regarding the protective benefit of maternal influenza immunization during pregnancy," reported the researchers. "Interventions that target both healthy pregnant women and those with chronic conditions are needed to increase vaccine uptake," they wrote. (details at tinyurl.com/jm9c5a6)

However, Maternal Flu Vaccine Efficacy Drops in Newborns at 8 Weeks Old

The Centers for Disease Control and Prevention (CDC) states that, among children of all ages, those under 6 months of age are at the greatest risk of being hospitalized from flu. And, *Medical News Today* reminds us that "infants under the age of 6 months cannot receive flu vaccination, so protection against the virus is established through immunization their mothers receive during pregnancy. But exactly how long does maternal flu vaccination protect infants after birth?" According to new research published in *JAMA Pediatrics*, infants may only receive adequate protection against the virus in the first 8 weeks of life. The study discovered that efficacy of maternal flu vaccines in infants dropped from 85.6% during the first 8 weeks of life to about 25% to 30% at ages 8 to 16 weeks and 16 to 24 weeks. The research team says the results highlight the need to identify alternative strategies that protect infants against flu from 8 weeks of age. However, it should be remembered that other data show that 97 percent of flu-infected infants are born to non-vaccinated mothers. (details at tinyurl.com/gnbccy8)

Long-Lasting Immunity After Vaccination for Tetanus and Diphtheria

NEJM Journal Watch reports that "immunization against tetanus and diphtheria is so effective that concern about vaccine-related adverse events associated with booster vaccinations has assumed greater importance." This phenomenon—that concern about side effects waxes when vaccines are so successful that awareness of the disease wanes, and vice versa—has been seen repeatedly through the decades. Currently, repeat immunization in the U.S. is recommended every 10 years for those aged >6 years, but longitudinal studies have suggested that antibody titers last far longer than this interval. According to Journal Watch "In a cross-sectional study, researchers analyzed tetanus and diphtheria toxin-specific antibody levels among adults and estimated that, without further booster vaccination, 95% of the population would remain protected against tetanus for up to 72 years and against diphtheria for up to 42 years," adding, "These results indicate that protective antibody responses against both tetanus and diphtheria are very long-lived and persist well beyond the currently recommended 10-year interval for booster vaccination. As the authors note, the lower antibody titers in older individuals could be due to incomplete initial vaccination or to immune senescence." The researchers suggest a booster vaccination at age 30 that also includes acellular pertussis (i.e., Tdap) followed by another booster at age 60. (details at tinyurl.com/ha6eohr)

Federal Panel Says Nasal Spray Flu Vaccine Should Not Be Used

STAT NEWS reported that research presented at a medical meeting in Atlanta showed the nasal spray FluMist vaccine "was somewhat effective, but still not did not work as well as flu shots," according to the maker of the vaccine, AstraZeneca. However, Centers for Disease Control and Prevention flu expert Joseph Bresee, MD, said, "We could find no evidence (the spray) was effective." As a result scientists from the CDC told the federal Advisory Committee on Immunization Practices that the FluMist vaccine "has not worked in the past three years." The panel said the "nasal mist influenza vaccine used by millions should not be used this coming flu season." Dr. Bresee said, "The problems with FluMist have perplexed CDC scientists and the company, and both are working to try to learn more." (details at tinyurl.com/zmtkpf2)

Quadrivalent Flu Vaccine Shows Advantages Over Trivalent Formulation

Univadis reported a retrospective modeling study based on data from 5 EU countries (France, Germany, Italy, Spain, and United Kingdom) during 10 influenza seasons from 2002 to 2013 which showed the quadrivalent influenza vaccine (QIV) is linked to a substantial reduction in public health burden and influenza costs compared with the trivalent influenza vaccine (TIV). Furthermore, QIV use would have saved €15 million on general practitioners, €77 million on hospitalizations, and €150 million on workdays lost. Why this matters—influenza causes 3 to 5 million cases of severe illness and about 250,000 to 500,000 deaths each year worldwide. (details at tinyurl.com/zhqq3ts)

Influenza Vaccine: How Long Does Protection Last After the Shot?

Univadis also reported a study from *Vaccine* reaffirms that influenza vaccine effectiveness (VE) lasts up to six month after vaccination. Why does this matter? Univadis says, "Optimal timing of the vaccination is hard to predict because the influenza season starts at different times each year. As a consequence, early influenza vaccination may offer the best protection." (details at tinyurl.com/gvxyvx4)

AAFP National Conference:
Resident Delegate Report

Dear CAFP,

This year's AAFP National Conference was a great success! There were more registrants than ever before, and the Colorado section at the Residency Expo was enormously popular. I had the pleasure of serving as the Colorado Resident Delegate to the National Conference this year. In my role, I attended Resident Congress meetings and participated in debate about several current topics in medicine. Some of these topics included supporting physician wellness endeavors, increasing OCP availability and counseling services to teens, supporting the LGBTQ community, reducing implicit bias as practitioners, and increasing cross-cultural & linguistic education/awareness training during residency.

There were a record 66 resolutions presented to the Resident Congress this year. I authored a resolution that advocated for the language "Allow Natural Death" in place of "Do Not Resuscitate" during code status and end-of life discussions, which was passed with overwhelming support. I also participated as a co-author on three additional resolutions, on topics ranging from Nexplanon training to anal cancer screening guidelines, that were all passed.

I believe that the future of family medicine, and medicine as a whole in the United States, is very bright. There are so many motivated, intelligent, and passionate young men and women who are ready to champion family medicine far into the future. I saw many of them at this conference…their energy was palpable. It is truly an exciting time for our specialty.

It was an honor to represent Colorado in this year's AAFP National Conference Resident Congress. Thank you!

Sincerely,

Matt Mullane, MD, MPH
PGY-3
St. Anthony North Family Medicine Residency

Report from the Gay Lesbian Bisexual Transgender (GLBT) Constituency Delegate on the National Conference of Constituency Leaders (NCCL) of 2016, Kansas City

By Ingrid Justin MD
Fort Collins, Colorado

More than 250 family physicians attended. My first impression was how cheerful and happy to see each other the participants seemed (except for us bewildered and cautious first timers), unusual at meetings of any kind. The wide variety in people made the meeting a welcoming and encouraging place to learn.

A bit of explanation is in order:

The National Conference of Constituency Leaders is a subgroup of the American Academy of Family Practice Congress of Delegates which was created in 1990 to give a voice to various underrepresented members of the American Academy of Family Physicians. Currently, the constituencies represented include: Women, Minorities, New Physicians, International Medical Graduates and GLBT Physicians. Each constituency group generates resolutions and joins with other interested groups or individuals in developing them. These are then submitted to one of several Reference Committees for evaluation and passage recommendations. Ultimately, most resolutions come before the voting NCCL delegate group at the Joint Business Session for discussion and passage. The resolutions that pass are forwarded to the Academy's Congress of Delegates for consideration and vote.

As a new attendee, there was much for me to learn during the three day conference. This ranged from how to be an effective delegate, the NCCL process as a whole, the rules of order used to run formal meetings as well as the art of crafting usable resolutions. The meeting provided a very sophisticated app for use by each attendee which included daily schedules, handouts, networking opportunities and listserve discussion groups.

The structure of the meeting itself encouraged getting to know other participants in one's own constituency as well as one's state chapter. Many attendees return year after year in an effort to cement relationships and rise in the management/political level of the NCCL as a whole. They learn, over the years, the art of being leaders which they can carry back to their state chapters, onward to the AAFP Congress of Delegates or allow to inform other causes and enthusiasms.

The energy level of the conference as a whole was very high. People were friendly, open and reached out to one another. There were many inspirational and educational talks that any participant could attend. Likewise, from breakfast on, we ate meals in shifting groups. This variety provided many networking opportunities. I attended a wonderful evening with the Colorado delegation. There was one grand party. The days were long and productive and overwhelming.

There were probably forty to fifty physicians taking part in the GLBT discussion group. Many attendees had come with proposals in mind. Most of the resolutions ultimately ended up with the Health of the Public and Science Reference Committee. Another several resolutions flowed to the Education Reference Committee. Examples of GLBT interest group generated resolutions include "To Improve Access to Pre-Exposure Prophylaxis for HIV (PrEP) Training" and "Oppose Transphobic Legislation Regarding the Use of Public Facilities." Many physicians from the GLBT Constituency lent their support and experience to other issues. Several examples include "Unconscious Bias Training in Residency and for AAFP Members" as well as the ever popular "Necessary Changes to the ABFM MC-FP Process."

The National Conference of Constituency Leaders provides excellent opportunities to learn and practice the sometimes mysterious skills of leadership in a safe and encouraging environment. State chapters and the AAFP as a whole benefit. While I have always been pleased and impressed with the American Academy of Family Practice, observing our academy's commitment to listen to and train ALL it's members as potential leaders and in how to take part in the process is truly heart warming.

Hanging in the Balance

On August 11-14th, the 26th Annual Balance Conference for Women Physicians was held in Breckenridge, Colorado. CAFP recently established the Balance Conference for Women Physicians Scholarship to honor Dr. Martha Illige, an iconic Colorado family physician and educator, and one of the conference's founders. Here's a report from inaugural scholarship recipients, Amy Tubay and Maria Otazo, a faculty-resident dyad from the Rose Family Medicine Residency Program in Denver.

A Resident's Perspective: Maria's Story

Maria Otazo, MD

We all know that burnout is an unfortunately common phenomenon for residents. Although my program is probably ahead of the curve in that it has a physician wellness program built-in for residents, it did not save me from my own feelings of burnout. As my second year of residency began, I thought that I had healed. That is, until I attended the Balance Conference. I had the privilege of meeting other female physicians in various stages of their careers. We laughed together, cried together and healed together. The lectures were informative and engaging, and the resilience training has definitively made an impact on the way I approach medicine, my patients, my training and my life. I feel the deepest gratitude for the support I received from everyone who attended and for the new friends and mentors I have gained. Truly, I am lucky to have had the privilege to attend this conference.

What it Means for Faculty: Amy's Story

Amy Tubay, MD

From the moment I met her two years ago, Dr. Martha Illige encouraged me to get involved with the Balance Conference. After attending this year as a presenter and CAFP scholarship winner, I finally understand why. While the conference offers high-quality and relevant educational sessions in a beautiful setting, its true purpose is to nurture conversations, self-awareness, and relationships that will sustain female physicians throughout their lifetime. Much like Martha herself (who attended every single conference since its inception), the Balance Conference inspires each attendee to find joy in medicine, to engage in community, and to be exactly who they are. Many of us need a gentle (or not so gentle) nudge to create time for renewal and reflection in our lives. Martha Illige nudged many lives in the right direction over her long and distinguished career. Thanks to the CAFP, her legacy will continue to shift the balance for generations of family physicians to come.

More information about the Balance Conference and CAFP's Scholarship can be found here:

http://balanceconference.org/conference.html?tabmenuid=conference

https://www.coloradoafp.org/balance-conference-scholarship/

Practicing Family Medicine

A Lifetime of Joy

> *"Happiness lies in a vocation that satisfies the soul."*
>
> *– William Osler*

In 1938 Mevrouw (Miss) Van Beverwÿk taught biology in Holland to a room full of refugees from Nazi Germany. I was one of her students, then twelve years old, fascinated by what Mevrouw Van Beverwÿk showed us: silkworm cocoons which we were allowed to unravel: fledgling birds fallen from their nest in the high oak trees surrounding the classroom. When polio struck the school and several students lost the ability to walk, to breathe, to even move, Mevrouw Van Beverwÿk entreated us to search for a cure for this dreaded scourge when we grew up. Right then, I decided to become a doctor.

My family, as Jews, continued their flight from Nazi Germany and arrived penniless in the United States in 1939. I received scholarships, and in my third year of college entered an essay contest sponsored by *Mademoiselle Magazine*. I was invited, as the representative of my college in New England, to attend a conference in New York at which my idol, columnist James Reston of the *New York Times,* was the speaker. My travel expenses, by plane, were paid, but I took the Greyhound bus and had enough money left over to extend my trip to Philadelphia and interview for medical school.

It was not until the following summer that I received a letter from the medical school. I remember the day, remember the postman handing me the letter, my hesitancy in opening it and the squeal of joy that escaped me when I read that I was accepted. I ran upstairs to find my mother. Waving my letter I alarmed her, because tears of happiness were rolling down my cheeks. This was truly a moment of excitement, of jumping up and down with joy, of hugs; and, what I did not realize at that time, the beginning of a career filled with joy and satisfaction. The apprehension, the worry of the previous few months, was suddenly erased. My teachers' advice to have alternate plans -- because female, penniless Jews did not get into medical school in 1947 in the United States -- could be forgotten. I did get in!

Application for financial help was successful and I rented a small, cold attic room within walking distance of school. Medical school was difficult, challenging and often discouraging. There were too many bones on the skeleton with bumps and creases, all with difficult names, I had to remember; too many formulas I had to recite in biochemistry. However, once I started seeing patients, in the third year, all that changed. I knew then, that my decision at age twelve had been correct.

Every day I learned from patients

about human beings, knowledge the textbooks did not teach. I remember the old gentleman in the Philadelphia General Hospital who had been treated for an aneurysm of the aorta by the insertion of a gold, coiled wire into the aneurysm. The end of the wire still barely protruded from his chest wall. He used to snip a bit of the gold wire to help him out when financial difficulties overcame him. What ingenuity!

I remember the wards full of small children with whooping cough and tuberculous meningitis; the room with a thick fog where children with croup were confined. I learned about the parents' distress because they could not even see their sick babies through the glass windows of this steamy room. As an intern I worked in a large ward where many iron lungs, like bellows, were used to keep our polio victims breathing. Those of us who worked in the contagious disease hospital feared a fate similar to that of my colleague, a young radiologist, would befall us. He was confined to an iron lung, a long metal tube which contained his entire body and from which only his head protruded. We tried to rig up a recording system for him so he could read x-rays projected on the ceiling. He was unable to breathe and was never able to leave his iron lung. We visited him, after our endless shifts, to tell him the jokes we had saved for him. He thanked us with his smile. His dire circumstances moved us to acknowledge his humanity and need for friendship.

Then, in 1953, came the relief, the joy we shared with the world: the polio vaccine was discovered. From dawn to dusk, as residents, we stood on the street giving injections of the vaccine to endless lines of citizens, all of us celebrating that Jonas Salk's vaccine had become available. I, myself, celebrated that Mevrouw Van Beverwÿk's plea had been answered, that we could now protect our patients from this dread disease.

As a family physician in training, I learned how to deliver babies, a favorite part of my duties. To share the awe and delight of parents at the birth of a healthy child is a great privilege. Laughter, hugs

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and tears of joy all occur in the delivery room and spread to grandparents and siblings in the waiting room. Joy is contagious, and, as the assistant to the birth, I always found myself caught up in the exuberance.

My first employer, after I finished my training, was a lumber company located on an isolated Native American reservation. I was to live in the small company town, which was surrounded by beautiful, tall ponderosa pine trees, but which was completely segregated by race and social class. Soon after I arrived the excellent physician, who had for a long time been in charge of the primitive industrial hospital and clinic, became ill. Suddenly I found myself practicing medicine outside of an academic setting, hours away from any consultants, without a laboratory, forced to rely on my own resources.

Alone and apprehensive I survived the first memorable week. On Monday, a lumberjack, after a sawmill accident, came in with his arm amputated above the elbow. I had to refer to my anatomy textbook to make sure that I tied off all the vessels in the stump. To my relief the wound healed in due time. I had barely put away my book and cleaned up when a young man came in from the sawmill with a four to five-inch- long splinter in his buttocks. I removed this splinter and many more during my time as the lumber company's employee. The next afternoon a worker, screaming in pain, was brought to the clinic. A huge log had rolled off a truck and pinned him to the ground. Not only did he yell in pain, he also yelled for the 'damn doctor' to come. He would not believe that I was that very person. To top off the week a teenager showed up, after a hunting accident, which had shattered his humerus. I sawed off a broomstick and used it to stabilize his arm. I was ecstatic when, eventually, the bone healed, enabling my patient to go hunting once more. Needless to say, I was exhausted after such an initiation, but also satisfied that my training had prepared me for this challenge.

After I opened my own office in the Midwest, I helped to establish a clinic for women who needed advice about family planning but could not afford private care. This clinic was run entirely by volunteers in the basement of a church. The women expressed their gratitude for a package of birth control pills and our service. I felt thankful that I was allowed to participate in this work. The same feelings accompanied my work with street children in South and Central America as well as in the United States. In these instances, I knew what I did -- sew up a laceration, treat an earache -- gave only momentary relief. But I did not forget the smiles, the occasional 'gracias', I received in return for my work.

During part of my career, when women physicians were still a rarity, I taught in medical school. Often I had to remind the medical students that they now were in medical school and no longer had to compete so ferociously against one another. Also I had to remind my faculty colleagues that, although I was a woman, I had been duly appointed and deserved their respect. In discussions of medical ethics, the future physicians and I talked about problems they had never thought about, but which they might face in the future: we reviewed how they saw the doctor-patient relationship; truth telling; and assisted suicide. The future physicians and I had many thought-provoking, interesting conversations while also studying the names of bones and immunization schedules.

My duties as a teacher did not prevent me from seeing patients and keeping office hours. The opportunity to daily learn about human beings never lost its adventure for me. Once, a little girl with leukemia, three or four years old, was a patient of mine. She was very ill and had to endure painful treatments over a period of many months. Her mother, father and I seriously questioned whether we were justified in continuing her chemotherapy, which made the child miserable, when we were so uncertain of success. She finally recovered, but many worrisome questions about her future remained. The family moved and I lost touch with them.

Decades later, I was in a restaurant and as I was leaving, a man at the next table stood up and said, "You saved my daughter's life." He told me that my little patient was about to receive her PhD and get married; he showed me the picture of a lovely young woman, my youngster, grown up. I was so joyful that I hugged this gentleman right there, in the restaurant, and thanked him for sharing his good news with me. I still feel happy when I think of that chance encounter.

It is a sacred time to hear a patient tell you, as the physician, "I have never told this to anyone." When trust is established, both patient

"When work is a pleasure life is a joy."

– Maxim Gorky

and physician can promote healing together. I have been told by patients of illegal abortions, fathers abusing their daughters, married men contracting sexually transmitted diseases outside the sphere of their marriages. These revelations come at unexpected moments, after the patient is standing at the door saying, "Good bye," after you have finished treating a sunburn. A young man came to see me for a sore throat. As he was leaving the exam room, doorknob in hand, he turned, closed the door and said, "I want to tell you something I have never shared with anyone. If I tell you, maybe my chronic anxiety and fear will decrease. When I was six years old my alcoholic father pursued me into a cornfield wielding a heavy, iron chain. I hid and did not dare to breathe so the corn stalks would not move and reveal my presence. I stayed in the field, fighting to control my trembling, until it became dark. Then I sneaked into the barn for warmth and spent the night there." When he finished, we sat together in silence for some time, until he was ready to leave. We agreed to see each other again soon.

These moments are rare, but never forgotten, and received with deep gratefulness and humility.

In the day-to-day practice of medicine there are frustrations, disappointments, failures and mistakes. Nonetheless there is the human connection of one individual to another, the recognition that the intent is to help, even if that goal is not always obtainable. The joy, the satisfaction comes from the reaching out of one person of good will to another and the knowledge, both parties have, that healing is not and cannot always be the end result, but that abandonment is never an option.

I did not practice without help. My first office was in a one-time beauty parlor with only one nurse. After several years I moved from there to a good sized office with five women, nurses, social workers, nurse practitioners and receptionists working together. We almost always had students, medical residents and student nurses spending time with us. My staff was great; we worked hard, but also had fun together, celebrating birthdays and all sorts of holidays. We were a group of women dedicated to helping our patients feel better, and we enjoyed doing that.

Practicing medicine has always been a satisfying undertaking for me. Even when I had to attend a dying patient, if we could establish a path of communication, I did not experience only sadness, but warmth, support, affection and even love that wove me, as the doctor, to the patient, so that, together, we faced death.

The office received a call one day from a young woman explaining that her grandmother, a Christian Scientist, requested a house call. I drove to the home after office hours and found a lady, in her seventies, with a far-advanced cancer of the face. She had never seen a physician, but her pain had prompted the granddaughter's call. I sat down next to the bed and introduced myself, talked about pain medicine, took the patient's hand and reassured her that I would teach her beautiful granddaughter how to administer the medication. Even before we gave her any drug I could feel her relax. She mumbled a "Thanks," while her eyes pleaded and thanked at the same time. I felt empathy for this brave woman, who, because of her belief, had never had any help in containing her illness. I knew asking for medication now was difficult for her and I told her that I understood this and respected her decision. We communicated even at death's door. I left that home with admiration for the loving, caring granddaughter as well as esteem for the grandmother.

Towards the end of my career my daughter and I practiced together. She had spent a rotation during her family practice residency in my office and we learned during that time that we enjoyed working together. The years I shared the practice with my daughter, now a mature physician, were the best. Her more recent education complemented my knowledge and my experience helped her; I helped her identify pertussis, she helped me get certified in advanced cardio-pulmonary resuscitation. Our patients liked the 'family' family practice and often, unable to remember our first names, would ask for the 'old' one or the 'young' one, an effective way to keep us apart.

Occasions for joy in medicine continue after retirement. The bus driver, the waitress and medical student greet me, "Hi, you used to be my doctor/teacher." This is great fun, especially if the person looks happy and healthy. An unexpected extension of the practice of medicine that I appreciate, is that former patients contact me on the internet to up-date me on their health and their families' well being. They know that I am interested.

Innumerable times, over many years, I have thanked Mevrouw Van Beverwÿk for steering me in the right direction. She inspired me to pursue medicine; even though as a twelve year old I had no way of anticipating the joy I would experience practicing family medicine during my lifetime.

In Remembrance

In 2016, the CAFP and family medicine community in Colorado lost exceptional leaders, teachers and friends. We are grateful for the legacies and memories they leave behind.

Kenneth Atkinson, MD

Kenneth Atkinson, MD, was a caring citizen, devoted family man, and a hero. His family, the patients he served, and the citizens of the state of Colorado suffered a great loss upon his death on April 4, 2016. Dr. Atkinson was a graduate of the University of Colorado School of Medicine in 1977, and a graduate of the Mercy Family Medicine Residency of Provenant Mercy Medical Center in 1980. He was a loving husband, the proud father of three daughters, one son and grandfather of five grandchildren. After the tragic loss of his daughter and son, Dr. Atkinson turned their loss into a way to help others through the development of the Kendall and Taylor Atkinson Foundation (KATA), named after his daughter and son in support of fighting Fanconi anemia. Dr. Atkinson lived his life as a devoted Christian, it was said that Dr. Atkinson, on his worst day, was better than most of us on our best day. Dr. Atkinson was deeply loved by his patients, and would often see patients for free if they could not pay. He was a true hero, who tragically lost his life trying to help a neighbor who had been shot. The CAFP and AAFP are extremely grateful to Dr. Atkinson for providing a model of how to live life as a caring and involved citizen, family physician, Christian man, and a heroic neighbor.

Congratulations to Skip Carstensen, MD, past CAFP board member, on his retirement this year!

Do you have exciting news about yourself or a colleague that should be recognized? Email Lynlee Espeseth at lynlee@coloradoafp.org

Martha Illige, MD

Martha Illige, MD, was a fabulous physician, loved by both her patients and colleagues. Dr. Illige was a graduate of the University of California Health Sciences Center in 1977, and a graduate of the University of Colorado Health Sciences Center Family Medicine Residency in 1980. She began practice in the metro Denver area in 1980 in private practice, providing full spectrum family medicine care including obstetrics and pediatrics. Dr. Illige became a leader at the Center for Personalized Education for Physicians, serving from 1994 through the time of her death as Associate Medical Director, Medical Director, and Consultant. Dr. Illige joined the faculty of the Rose Family Medicine Residency in Denver 1997, serving as a teacher of holistic, full spectrum family medicine including inpatient work and obstetrics. Dr. Illige was recognized for her exemplary teaching through the Colorado Academy of Family Physicians Teacher of the Year Award in 2005, and the AAFP Part Time Teacher of the Year Award in 2006. Dr. Illige volunteered innumerable hours to the Colorado Academy of Family Physicians through advocacy and teaching, serving both Denver and the United States through her leadership at the breast milk bank, scholarly presentations on breast feeding, and passion for breast feeding for all new moms, inspiring a generation of residents who adopted her same passions. Dr. Illige enriched the national and international community of physician education and evaluation professionals through invited lectures worldwide, and enriched the lives of female physicians nationally through her 23 years of service to the Balance Conference for Women Physicians, and was absolutely loved by her patients, colleagues, and family. Dr. Illige was a champion of inclusivity, individuality, and the ethos that ALL patients matter: their wishes, feelings, hopes, dreams, and lives deserve the upmost care, concern, and respect by their family physician. Dr. Illage passed away on June 26, 2016. A memorial scholarship fund in her name has been created by the Colorado Academy of Family Physicians Foundation.

Virgilio Licona, MD

Virgilio Licona, MD, was not simply a remarkable and compassionate physician, but also a figurative giant of health policy, a passionately involved citizen, a devoted family man, a fiercely proud American, and a tireless champion of the underserved. Dr. Licona, born in Corpus Christi Texas as the son of farmworkers, continually sought to provide justice and culturally competent health care for society's most forgotten and disadvantaged. He graduated from Colorado State University and founded La Clinica del Valle shortly thereafter. When he struggled to find a physician assistant willing to work in the clinic, he completed physician assistant training and joined Pueblo Community Health Center. When he encountered difficulty in securing a physician to work in the health center, he trained as a physician at the Autonomous University of Hidalgo and completed residency in family medicine before returning to work at Pueblo Community Health Center. Dr. Licona long recognized that the fight for justice for the underserved and communities of color often extended from the exam room into the board room, and thus repeatedly served as a health care leader in Colorado and throughout the country, as the first person of color to serve as President of the Colorado Academy of Family Physicians, a board member of The Colorado Health Foundation, Colorado Community Health Network, and the Community Health Association of Mountain/Plains States, a member of the National Advisory Council of the National Health Service Corps and the National Rural Health Advisory Committee, and a member of the Commission on Governmental Advocacy of the American Academy of Family Physicians. In recognition of his exemplary service, Dr. Licona's colleagues elected him to serve as a member of the Board of Directors of the American Academy of Family Physicians, a position in which he served with passion and utter distinction. Dr. Licona took the rare step of opting not to run for president of the American Academy of Family Physicians following his term of board service, instead choosing to return to work with Salud Family Health Centers in Colorado, an organization which he helped to found in 1970, and helped to grow from a clinical practice running out of a converted onion shed into the state's second largest FQHC network and a national model for community health. Dr. Licona tirelessly mentored innumerable medical students and physicians, many of whom have gone on to become leaders of the profession themselves. Governor John Hickenlooper declared "March 29 to be forever after Virgilio Licona Day" in the state of Colorado. The American Academy of Family Physicians and the Colorado Academy of Family Physicians publicly express their extreme gratitude to Dr. Virgilio Licona for service to his community to the nation, to the profession, and to the multitude of physicians who he mentored and cared for.

RURAL CORNER

Dr. Andrea Wismann, a Rural Track graduate, now practices in Springfield, CO. She served as a summer preceptor for Leah Foster, a 2nd year medical student in the Rural Track.

Update on the Rural Track in the University of Colorado School of Medicine

By Mark Deutchman MD
Professor, Dept. of Family Medicine
Director, Rural Track, School of Medicine
Associate Dean for Rural Health
Director, Colorado AHEC

The University of Colorado is one of only about 30 U.S. medical schools that has a program specifically designed to attract, admit and nurture students who aspire to become rural physicians. We emphasize primary care, particularly Family Medicine. CU's Rural Track (RT) has now been in existence for 11 years and has become a recognized national leader. We attract and admit the right students, provide curriculum that gives students rural knowledge and experience, enlist the mentorship of rural physicians committed to educating their successors and evaluate our progress. We are also now working on securing financial and relational support to insure the long-term continuation of the program.

About 10% of each medical school class joins the RT and our students meet the same admission requirements as all other students. The RT adds these specific rural-related experiences and mentorship to the regular medical school curriculum:

- Seminars on rural medical health topics and workshops teaching medical skills during the first two years of school.
- A 4-week summer rural preceptorship during which students experience the life and work of a rural physician.
- A summer interdisciplinary rural immersion experience that is shared with students from the nursing, pharmacy and physician assistant programs.
- A third year 12-week rural clinical rotation. Many of our students spend additional rotations in rural areas.

- Mentorship and information on scholarship and loan repayment programs.

- Help with residency options and practice placement

Rural Family Physicians serve as preceptors for the majority of the summer rural clinical preceptorships and third year 12-week rural clinical rotations. These experiences are key components of the curriculum. Through these experiences, RT students see first-hand the variety, quality, rewards and trials of rural practices – mostly Family Medicine. They continually express how this real-world experience away from the academic medical center reinforces their resolve to "go rural" and builds their confidence.

After 11 years of operation through the long educational pipeline through med school and residency, we have seven classes of RT graduates who have entered residency including four that have completed residency and entered clinical practice. We are proud of our results:

Residency choice: 42% of the 132 RT graduates have chosen Family Medicine. This is in contrast to the overall Family Medicine match rate of only about 10%. Thus, RT students are more than four times more likely to choose Family Medicine than the general run of CU School of Medicine graduates. For the last several years, RT graduates comprise 50% of CU's Family Medicine residency match even though we constitute only about 10% of the class size.

Family Medicine practice: 50% of the 66 RT graduates who have completed residency are in Family Medicine.

Rural practice: 46% of the 66 RT graduates who have completed residency have entered rural practice. RT graduates now practice these Colorado towns: Del Norte, Walsenburg, Springfield, Sterling, Eagle, Buena Vista, Canon City, Craig, Montrose, Glenwood Springs, Rifle and Gunnison.

The cost of the RT is supported approximately 25% by the School of Medicine but requires additional financial support from external stakeholders to continue past 2017. We are building a funding collaborative to secure the future of the RT through endowment and ongoing funding commitments.

Watch a video about the RT here: https://www.youtube.com/watch?v=SVdvJ8j9O7s

For more information about the Rural Track, or to help by becoming a clinical preceptor or offering financial support, contact:

Mark Deutchman, M,. Director, Rural Track, School of Medicine, Associate Dean for Rural Health
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