

COLORADO FAMILY PHYSICIAN

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2015 CAFP Family Medicine
Physician of the Year



Kari Mader, MD
2015 CAFP Family Medicine
Resident of the Year





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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: Candace Murbach, DO



Chaotic Transitions

I had the privilege of attending a meeting last week on the Patient Centered Medical Home and how to accomplish safe transitions of care. It is certainly a “hot topic,” as hospitals and providers are rewarded or penalized for meeting transitions of care guidelines concerning timing of patient follow up and 30 day re-admission rates. One of the new definitions found in Wikipedia is: “coordination and continuity of health care during a movement from one healthcare setting to either another or to home.” Although there are more eloquent definitions, the essential elements are the same. To those of us in primary care, it’s nothing new or enlightening. It used to simply be referred to as discharge planning. When DRG’s arrived on the health care scene, discharge planning became commonplace. It was, of course, linked to dollars. It was a goal and a process, but not so definitively tracked or regulated. Payment for health care is now linked to specific details of care transition with dollars again being the driver, so “transitions in care” is causing new processes to be implemented, positions to be created to carry out and track these functions, and a plethora of players to be joining this “snowball” rolling downhill.

It may sound as if I’m skeptical or that I don’t value the process by the “snowball” comment, but the process is one of the elements in health care about which I feel most passionate. If we do this well, it can allow patients a dramatically improved quality of life. It can help them maintain a higher level of functioning and independence and

It may sound as if I’m skeptical or that I don’t value the process by the “snowball” comment, but the process is one of the elements in health care about which I feel most passionate.

avoid tragic, avoidable problems. It can also prevent medical errors. This is accomplished through a huge multidisciplinary effort. It means everyone involved has to communicate. We have to talk with each other, with the families, with the care providers, with the case managers, with other physicians involved in the care, with the nurses, with home health care workers, physical therapists, occupational therapists, and more. We have to assess the patient’s risks, their background, their home situation, their resources, their family support, their determination, their preferences, and their abilities. Someone, hopefully their Family Physician, has to be accountable. Certainly with fewer Primary Care Physicians following their patients during hospital stays and hospitalists providing so much of the inpatient care, communication reigns paramount to success. When a patient is readmitted in a short period of time or the plan simply falls apart, we need to evaluate what went awry and what could we have altered for a better outcome. It seems all of us involved in the process agree on these issues.

What was astonishing during the

multidisciplinary meeting I attended and what is challenging each day is the chaos that ensues. Some of the difficulties arise when communication breaks down among families or when people are not readily available to participate in developing a plan. All of that is perfectly understandable. People are busy! What is troubling to me is the chaos we create as the health care team. At the meeting, it was shocking to see how different members of the transition team reside in their respective “silos” and defend their position, boast about their plans and accomplishments, and express such confidence in their group’s role in the process. We are all overestimating the effectiveness of our roles in the patient’s life, in their home, and at their bedside. All of us talk to patients, but we don’t all say the same thing. We may talk to each other, but not when the final plan is created. This has to change. Perhaps we will be reimbursed for it; the mechanism is in place. The real payoff is much less tangible and much more important. We can help decrease medical errors, improve lives, resume accountability for our patients, and be proud to be Family Physicians.

CEO's Report

By: Raquel J. Rosen, MA, CAE



WELCOME NEW CAFP STAFF

Lynlee Espeseth started as the new CAFP Director of Communications, Marketing, and Membership on Feb. 2, 2015. She is responsible for our publications including the quarterly CAFP magazine, the monthly electronic newsletter, and email blasts. She is also in charge of advertising, the CAFP website, social media, and membership. If you have any questions for Lynlee please contact her at lynlee@coloradoafp.org, 303-696-6655, ext. 15. We are very pleased to have her join our team.

Our amazing CAFP staff team also includes: Manthan Bhatt, Director of Public Policy; Erin Watwood, Director of Education, Events, & Meetings; and Sarah Roth, Director of Health of the Public. I also include as part of our team our amazing lobbyists, Jeff Thormodsgaard and Katie Wolf. They are all working on your behalf with energetic enthusiasm.

COLORADO PRIMARY CARE COLLABORATIVE (CPCC)

Members of the CPCC Steering Committee met with the Governor's new Senior Policy Director, Kyle Brown, to talk about the Patient Centered Medical Home and payment reform. He was very receptive to our information. He stated that "the triple aim is the Governor's goal." We will continue to work with Kyle to figure out how we can have a centralized health authority in the state.

CPCC is having a convening event on June 5, 2015 to which you are all invited. Come hear about all of the exciting initiatives taking place in Colorado to improve health and health care including the State Innovation Model, the Transforming Clinical Practice Initiative, the Comprehensive Primary Care Initiative, Medicaid's Accountable Care Organizations, and others. For more information please contact erin@coloradoafp.org.

LEGISLATIVE ACTIVITIES

The CAFP lobbyist, Jeff Thormodsgaard, CAFP's Director of Public Policy, Manthan Bhatt, CAFP's legislative committee co-chairs, Glenn Madrid, MD, and Chandra Hartman, MD, along with the CAFP Legislative Committee and CAFP board have all been very engaged during this legislative session advocating for Family Medicine Physicians and your patients. You would be very proud to see them in action. As a matter of fact, you can see them in action by participating in the Doctor of the Day program at the Capitol. If you want to be more engaged with these legislative activities you are also invited to join the CAFP legislative committee which meets by conference call every other week on Thursday evenings during the session. For more information, please contact manthan@coloradoafp.org.

POSSIBLE IMMUNIZATIONS SOLUTION

The CAFP is working with CDPHE to bring a possible solution to Colorado physicians in administering vaccines. SB13-222 was passed in 2013 and it aimed to create a CDPHE plan around centralized purchasing solutions for vaccines. The SB222 committee is in the implementation phase and they have chosen VaxCare as a viable centralized purchasing solution for physicians and local public health agencies. With accounts from other states on VaxCare's success (from WellPoint's CMO to a family practice in Indiana to rural docs in Georgia), we believe VaxCare could allow many small and mid-size practices to vaccinate again, as VaxCare removes the financial burden and risk associated with vaccines by purchasing and billing them. We are working to collaborate with the major health plans to allow VaxCare to come into the state.

Thank you to Manthan Bhatt for doing a great job in representing the CAFP on the SB 222 committee and bringing the voice of Family Medicine Physicians to the table.

PEDIATRIC OBESITY INTERVENTION FOR PRIMARY CARE PRACTICES

The CAFP and the Dept. of Family Medicine developed a program for Family Medicine Physicians and Pediatricians to use for their pediatric obese patients and families. The curriculum is all prepared and ready for you to use. We are offering a training on this on June 1 and 2, 2015 and we have full scholarships available if you sign up soon. For more information please contact sarah@coloradoafp.org.

CAFP'S ANNUAL SCIENTIFIC CONFERENCE

Included in this magazine issue is the full conference schedule and a registration page that you can easily fill out and send in to us. We have the best CME topics and speakers lined up for you including a full day on the latest and greatest research and information in Family Medicine. Bring your families to enjoy the Cheyenne Mountain conference center and the family activities we have planned. Please make your hotel reservations soon to get the best hotel rate in our block.

2015 State Legislative Priorities

by Jeff Thormodsgaard, CAFP Lobbyist

Medicaid Provider Rates & The Primary Care Bump

Medicaid provider rates always remain a high priority for CAFP each legislative session. The Medicaid primary care rate increase, a provision of the Affordable Care Act, requires Medicaid programs to reimburse primary care providers at Medicare levels for two years. This “bump” was funded 100 percent by the federal government in 2013 and 2014, but unfortunately was only temporary with no wind down period. The increase was intended to ensure sufficient provider participation as the Medicaid population expands.

As the temporary provision entered its final months last year, a number of state and federal policymakers considered extending the rate increase into 2015 and beyond, because of the notable role it played in Medicaid provider participation. The Colorado Academy of Family Physicians successfully lobbied the state government to include the primary care bump in their budget; Colorado being one of only 5 states, continued the bump until 2017. Medicaid provider rates are a constant uphill battle for state policymakers and physicians to try and find the balance between available funds and financial viability for participating providers. Maintaining the primary care bump for at least a few more years (with continued lobbying effort to continue), is a significant win for primary care physicians as most states will make an average payment cut of 43 percent to Medicaid primary care physicians next year.

Advanced Nurse Practitioner Education for Prescriptive Authority

Last year, a coalition of nursing organizations and other advocates presented interest in reducing the number of training hours Advanced Nurse Practitioners (APNs) are required to complete before receiving prescriptive authority. After preliminary discussion about legislation in the 2014 session, the stakeholders decided to first send the issue to the Nurse Physician Advisory Task Force on Colorado Health (NPATCH) under the Department of Regulatory Agencies. NPATCH is composed of physicians and nurses, and was formed years ago to help aide in scope of practice issues, to protect the integrity of both professions in the public spotlight.

NPATCH debated the APN issue all summer, receiving input from all interested stakeholders, and considering several different proposals. Ultimately, NPATCH passed a resolution, which the physician community opposed, to change the number of hours an APN is required to obtain independent prescriptive authority from 3600 hours to 1000 hours. Additionally, they also passed a resolution to allow for APRN oversight of these hours. In response, CAFP came up with an alternative proposal, based on the following:

- The CAFP believes that this reduction of hours will hurt patient safety in Colorado and will hurt the team based approach to health care that we strongly support.
- The CAFP in negotiating with the Colorado Nurses Association, found some common ground on 1800 hours. These negotiated points were not included in the introduced bill.

- CAFP members and primary care physicians, as surveyed by the Colorado Medical Society and the CAFP, narrowly believe that APRNs should have prescriptive authority but they oppose lowering the current hours. The house of medicine, under the CAFP leadership, was opposed to the report and sought to amend the bill through our lobbying.
- The physician community was successful in amending SB197 to require that a nurse must obtain a minimum of 3 years of supervised experience before seeking 1000 hours of mentorship to obtain independent prescriptive authority.
- The Colorado Nurses Association made a strong argument that neighboring states were able to attract more APNs because of lower standards.
- In the present political environment, our legislative committee felt it was a strong performance by the CAFP lobbying team that got the 3 years of experience added on to the 1000 hours of mentorship. The goal, which was to insure safety of our patients, was better met than even our negotiated points with the Nurses Association in 2014.
- The CAFP believes that nurses and physicians, working together in teams, can achieve better access to care and the triple aim.

Preceptor Tax Credit Bill

In addition to provider rates, and APN scope of practice, CAFP is also proposing legislation to help incentivize preceptors to teach in rural and underserved areas. In August of 2014, the Colorado Academy of Family Physicians was made aware of the shortage in preceptors in health professional shortage areas by the Area Higher Education Centers. Knowing this, the CAFP decided to tackle the issue and found that a legislative solution was successful in similar states. Specifically, an individual income tax credit for medical preceptors would greatly help recruit and retain primary care medical preceptors. Studies have shown that when a student receives training in rural and underserved areas, they are more likely to go into those communities and practice there. Training the next generation of students in how to treat the most neglected in our society is an important first step to tackling our health professional shortage problem.

HB15-1238, would create an individual tax credit for medical preceptors in health professional shortage areas in Colorado. CAFP has worked in conjunction with a large coalition of stakeholders to make this legislation possible, and has set up the best case scenario to get this bill passed. This bill would allow medical preceptors in health professional shortage areas in Colorado to receive a tax credit of \$1,000 per clinical rotation with one student, up to a maximum of \$5,000. If the medical preceptor sees more than 10% Medicaid, the per clinical rotation per student tax credit would be raised to \$1,500. The bill was introduced in mid-February with two Republican sponsors. We are very excited to announce that the bill, HB15-1238, creating an individual tax credit for medical preceptors in health professional shortage areas in Colorado, passed the House Health, Insurance, and Environment Committee on Thursday, March 12 with overwhelming bipartisan support! The bill will soon be heard in the House Finance committee.



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CAFP ON THE GO



Students and Family Physicians enjoying dinner and conversation at the 2015 Brew and Chew at Dry Dock Brewery



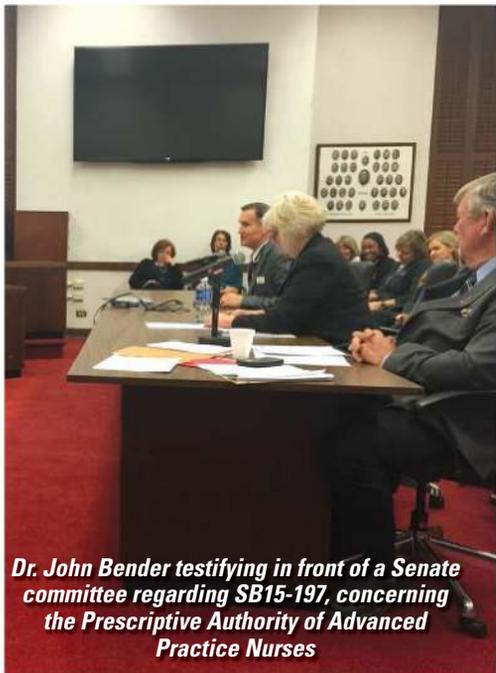
Members of the Colorado Primary Care Collaborative (CPCC) meeting with Kyle Brown, Senior Policy Director for Governor John Hickenlooper



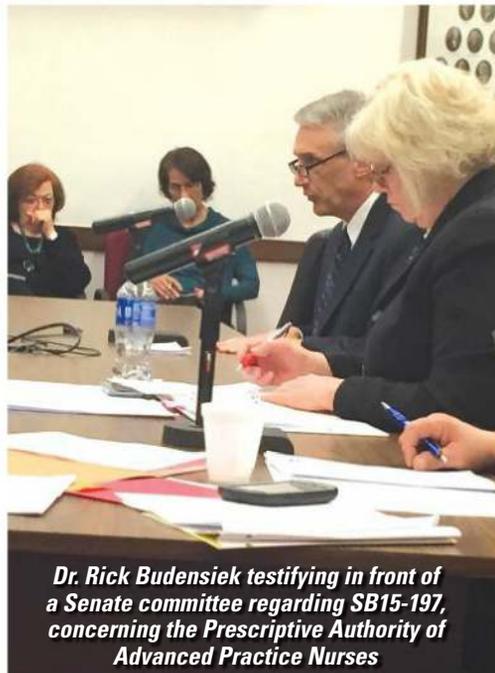
Sarah Roth Exhibiting at Centura Health Physician Group's Winter PCMH Learning Collaborative



Glenn Madrid, MD presenting on CAFP's legislative issues and best practices at the 2015 Multi-State Forum



Dr. John Bender testifying in front of a Senate committee regarding SB15-197, concerning the Prescriptive Authority of Advanced Practice Nurses



Dr. Rick Budensiek testifying in front of a Senate committee regarding SB15-197, concerning the Prescriptive Authority of Advanced Practice Nurses



Governor John Hickenlooper speaking at the Colorado Opportunity Project Stakeholder Summit, attended by Sarah Roth, Director of Health of the Public and Lynlee Espeseth, Director of Communications, Marketing and Membership



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Childhood Nephrotic Syndrome: Diagnosis, Treatment and Long-Term Care

What Is Nephrotic Syndrome?

Nephrotic syndrome is characterized by heavy proteinuria (nephrotic range proteinuria), hypoalbuminemia (Albumin ≤ 2.5), edema and hyperlipidemia. Childhood nephrotic syndrome may be primary or secondary (see Table 1). The most common cause of idiopathic nephrotic syndrome in children is minimal change disease.

How Do Patients Present?

Children with nephrotic syndrome typically present with edema which can be seen on a physical exam as periorbital edema, lower extremity edema, abdominal distention from ascites and anasarca. A common story is a child with a chief complaint of eye swelling perceived by the family to be an allergic reaction that did not get better with an antihistamine. Patients with secondary causes of nephrotic syndrome may also present with systemic symptoms such as the joint pain and malar rash that are seen in systemic lupus erythematosus.

How Do You Work Up Patients For Nephrotic Syndrome?

The first step is to send a urine sample to test for proteinuria. There are multiple ways to test for proteinuria in children (see Table 2). A urine dipstick is adequate for screening, but ultimately a urine spot protein to creatinine ratio should be sent to quantify the amount of protein in the urine. While a 24-hour urine collection is used in adults to quantify protein excretion, this is typically not used in children due to the difficulty in getting an accurate sample. Nephrotic range proteinuria is defined as a spot protein to creatinine ratio of >2 when both the protein and creatinine are expressed in mg/dL (see Table 2).

A formal urinalysis with microscopy should also be sent to look for hematuria which is defined as the presence of >5 RBCs per high powered field. Up to 20% of patients with minimal change disease will have microscopic hematuria but gross hematuria is rare and warrants an investigation for other etiologies. The presence of RBC casts is

consistent with glomerulonephritis and not minimal change disease.

Additional evaluation includes a renal function panel (Chem 7, albumin, and phosphorus) to document electrolytes, kidney function and hypoalbuminemia; lipid panel to evaluate for hyperlipidemia; CBC to evaluate for anemia; complement C3 and C4 (see Table 3); and a renal ultrasound. ANA, dsDNA, ANCA, Hepatitis panel and HIV should be sent in select patients.

A kidney biopsy is not routinely performed when minimal change disease is the presumed etiology of the nephrotic syndrome. Patients who have risk factors to suggest against minimal change disease should be considered for kidney biopsy to aid in the diagnosis and development of a treatment plan. Risk factors include <1 or >12 years of age, presenting with gross hematuria, low complement C3, symptoms of a systemic disease, kidney failure that does not respond to correction of intravascular depletion, and diagnostic testing consistent with secondary nephrotic syndrome.

Table 1. Causes of childhood nephrotic syndrome

Primary nephrotic syndrome	Secondary nephrotic syndrome
Minimal change disease	Drugs: Heroin, Interferon, Lithium, NSAIDs, Pamidronate, Penicillamine
Focal segmental glomerulosclerosis	Infections: HIV, Hepatitis B and C, Malaria, congenital syphilis
Membranous nephropathy	Malignancy: Lymphoma and leukemia
Membranoproliferative glomerulonephritis	Sickle cell disease
	Systemic Disease: Systemic lupus erythematosus, Post infectious glomerulonephritis
	Vasculitis: Henoch Schonlein Purpura, Wegener granulomatosis, Microscopic polyangiitis

When Do You Admit Patients With New Onset Nephrotic Syndrome?

Nephrotic syndrome can often be managed in the outpatient setting. Patients presenting with anasarca, azotemia, hypertension, oliguria/anuria and concern for follow up should be admitted and managed in consultation with a pediatric nephrologist.

How Do You Treat Children With Nephrotic Syndrome Due To Minimal Change Disease?

Steroids remain the first line therapy for childhood nephrotic syndrome due to minimal change disease. Patients will complete 12 weeks of oral steroids consisting of six weeks of daily steroids (prednisone 2 mg/kg/day with a maximum dose of 60 mg) and then six weeks of alternate day steroids (prednisone 1.5 mg/kg/day given every other day with a maximum dose of 40 mg). The traditional regimen will stop all steroids at the end of the 12 weeks. Some nephrologists will do an additional one to three month steroid taper after the 12 weeks are completed but there is no evidence that a prolonged taper decreases the risk of relapse or prolongs the time to first relapse. Patients are considered steroid responsive if they enter remission, as defined by an absence of protein in the urine, in <4 weeks (see Table

Table 3. Kidney diseases associated with low complement C3

Post infectious glomerulonephritis Lupus nephritis Membranoproliferative glomerulonephritis C3 glomerulonephritis Atypical hemolytic uremic syndrome Endocarditis associated glomerulonephritis Ventriculoatrial (VA) shunt nephritis

4). Children will typically respond to steroids in 7-14 days and 95% of children with minimal change disease will respond to steroids in less than four weeks. Children who continue to have proteinuria after four weeks of steroid therapy are considered steroid resistant, are unlikely to have minimal change disease, and should undergo kidney biopsy to direct further therapy. Relapses are treated with high dose steroids (prednisone 2 mg/kg/day with

a maximum dose of 60 mg) until the patient is in remission for three days and then decreased to alternate day steroid dosing (prednisone 1.5 mg/kg/day given every other day with a maximum dose of 40 mg) for an additional four weeks. Alternatively, rather than four weeks of alternate day steroids, some nephrologists will do a steroid taper after remission has been achieved. Patients who are steroid dependent or who have frequent relapses may require additional therapy such as Tacrolimus, Cyclosporine, Cyclophosphamide, Mycophenolate mofetil and Rituximab in order to sustain remission.

What Are Possible Complications Of Minimal Change Disease?

Edema develops in patients with nephrotic syndrome due to sodium retention and decreased oncotic pressure secondary to

Table 2. Proteinuria testing in children

	Normal Value	Notes
Urine dipstick	Negative or trace	Concentrated and alkaline urine can lead to false positive results. Dilute urine can lead to false negative results. Any patient with $\geq 1+$ protein should have a repeat first morning urine sent for spot protein to creatinine ratio to look for persistent proteinuria.
Spot protein to creatinine ratio	6 months to 2 years of age: < 0.5 mg/mg creatinine >2 years of age: < 0.2 mg/mg creatinine	In children, it is just as adequate for diagnosing proteinuria as a 24-hour urine collection. Need a first morning urine sample to differentiate between transient/orthostatic proteinuria and persistent proteinuria. Nephrotic range proteinuria is a ratio >2 mg/mg creatinine.
Spot microalbumin to creatinine ratio	<30 mg/g creatinine	Used to detect early kidney disease in patients with diabetes mellitus.
24-hour urine collection	<100 mg/m ² /day	Patient must be fully toilet trained because missing one urine void makes the collection invalid. An adequate sample should have 15-20 mg/kg/day of creatinine in females and 20-25 mg/kg/day of creatinine in males. Nephrotic range proteinuria is 40 mg/m ² /hour or >50 mg/kg/day.

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<< continued from page 11

hypoalbuminemia. Edema can become severe and lead to immobility and weeping skin, as well as respiratory distress from pulmonary edema and pleural effusions. Edema may be managed with fluid and sodium restriction, diuretics (loop and thiazide) and 25% albumin infusions.

Thromboembolism risk is increased in patients with nephrotic syndrome due to losses of coagulation factors leading to low AT III, low free protein S and low plasminogen. Additional risk factors include thrombocytosis, increased platelet activation, high fibrinogen, immobility, intravascular volume depletion and hemoconcentration. The most common sites for thromboembolism include pulmonary embolism, renal vein thrombosis and deep vein thrombosis. Routine prophylactic anticoagulation is not recommended but aspirin may be considered in patients at high risk.

Infection risk is increased in patients with nephrotic syndrome due to low serum IgG levels and loss of factors important in the alternative complement pathway. Patients are treated with steroids and other immunosuppressive medications further increasing their risk. They may present with urinary tract infections, cellulitis, pneumonia, spontaneous bacterial peritonitis and bacteremia/sepsis. Prophylactic antibiotics are not currently recommended in patients with nephrotic syndrome. Patients

who are actively nephrotic and/or on immunosuppressive therapy should be seen and evaluated for any fever to rule out a serious bacterial infection. Children may be adrenal insufficient after prolonged steroid exposure and stress dose steroids may be needed during times of illness.

What Immunizations Do You Recommend For Children With Minimal Change Disease?

Both the polysaccharide (PCV 23) and conjugate (PCV 13) pneumococcal vaccines should be given. Patients should receive PCV 13 per routine CDC guidelines and one dose of PCV 13 should be given to patients who completed a PCV 7 series. The PCV 23 should be administered to all children ≥ 2 years of age and repeated in five years for a total of two lifetime doses. The PCV 23 can be given eight weeks after a dose of PCV 13. Annual inactivated influenza vaccination should be administered to patients and household contacts; however, the intranasal influenza live virus vaccine should be avoided. Standard childhood inactivated immunizations should be given per CDC recommendations but live immunizations, such as MMR and Varicella, should be avoided while receiving steroids and other immunosuppressing medications. Live immunizations can be administered one to three months after discontinuing therapy depending on the immunosuppression being used.

What Are The Long-Term Outcomes For Children With Minimal Change Disease?

Patients who respond to steroids typically have a good prognosis. 10-20% of patients will complete the initial course of steroids and have no further relapses. Of the approximately 80% of children who relapse again, half will have infrequent relapses and half will have frequently relapses. Some of these patients will be steroid dependent and approximately 10% of patients will develop late steroid resistance. Most steroid responsive children will have a significant decrease in the number of relapses and achieve long-term remission by adolescence, but they can continue to relapse into adulthood. Steroid resistance is associated with an increased risk of developing end stage kidney disease.

Want To Learn More About Kidney Related Issues?

The Children's Colorado Kidney Fun Fact of the Month is a monthly e-mail about a kidney related topic. Each message includes helpful information for everyday practice including suggested initial work up and links to articles, websites or other useful resources on the topic. If you are interested in receiving the Kidney Fun Fact of the Month please e-mail Dr. Missy Hanna at melisha.hanna@childrenscolorado.org. You may opt out of receiving it at any time. If you have a kidney related question or consult, you may reach a member of the nephrology department any time by calling (720) 777-3932 or toll free through One Call at 1-800-525-4871.

Kids Corner is a regular feature of the CAFPP News brought to you by the Children's Hospital Colorado Department of Family Medicine. For questions about this article or suggestions for future topics please contact Dr. Laura Pickler, the Chief of Family Medicine at Children's Colorado, through One Call at (720) 777-3999 or (800) 525-4871.

Table 4. Important definitions in nephrotic syndrome

Remission
First morning urine protein to creatinine ratio < 0.2
Dipstick reading negative or trace for three days
Relapse
First morning urine protein to creatinine ratio >2
Dipstick reading 2+ or more for three days
Frequently relapsing
two or more relapses in six months
four or more relapses in one year
Steroid dependent
Relapse during steroid taper
Relapse within two weeks of discontinuing steroid therapy
Steroid resistant
Inability to achieve remission after four weeks of steroid therapy



Working together to provide the **best care for kids.**

Sleep problems can occur at any age, but when they occur in infants, children or young adults, they can have a big impact on the entire family. Twenty percent of all children suffer from some type of sleeping problem, and the causes range from poor sleep habits and behavioral problems to primary sleep disorders such as obstructive sleep apnea and insomnia. Whatever the cause, the impact can be disruptive to children and their families.

Children's Hospital Colorado Sleep Center provides a comprehensive service for evaluating, diagnosing and treating any sleep disorder. Our physicians, nurse practitioners, sleep psychologists and surgeons work to improve sleeping problems so that the entire family can return to an optimal night of sleep. Our team maintains close contact with the referring primary care provider to develop an individualized plan that best serves the patient and gives support to the family to continue that plan at home.

For more information about our multidisciplinary sleep program, please visit childrenscolorado.org/sleep.

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Neurology
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Sleep Laboratory
Otolaryngology
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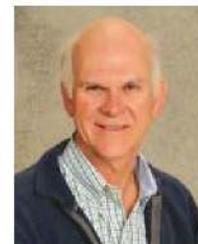


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Sleep Disorders Presenting in the Family Physician's Office

Ricky T. Mohon, MD, FAAP, FACP
Medical Director of Sleep Medicine, Breathing Institute, Children's Hospital Colorado
Program Director, Pediatric Pulmonary Fellowship, University of Colorado School of Medicine
Professor of Clinical Pediatrics
Board Certified in Pediatric Pulmonology and Sleep Medicine



Quality sleep can be difficult to obtain. Too much, too little, disrupted and abnormal timing of sleep can all have negative impacts on a child's concentration, alertness and behavior. It can be challenging for the primary care provider to find some relief for patients and their families. The most recent edition of the International Classification of Sleep Disorders, 3rd Edition (ICSD-3) identifies six major divisions of abnormal sleep including insomnia, hypersomnolence, movement disorders, circadian rhythm sleep wake disorders, parasomnias and sleep related breathing disorders. Recognizing that a patient may have symptoms of a sleep disorder can lead to proper evaluation and therapy.

Most family medicine physicians are quite familiar with patient complaints of snoring, large tonsils and daytime fatigue being associated with obstructive sleep apnea (OSA). This diagnosis is fairly easy to recognize in the prototypical four- to seven-year old and is routinely confirmed with an overnight sleep study, polysomnography, and then managed with a tonsillectomy and adenoidectomy. Cure rates for this common scenario are high at 90-95%.

But what about the more complicated, less common presentations? What does a primary care provider do to help those patients, and who can he or she consult for help?

Children with OSA often present with symptoms of loud snoring, restless sleep, daytime fatigue and enlarged tonsils. Referral directly to an otolaryngologist for surgical assessment is the routine practice of many primary care providers. An ENT physician may elect to bypass the need for a formal sleep study and suggest a pathway directly to surgical intervention with tonsillectomy and/or adenoidectomy. But if the history and physical are not conclusive for the more common presentation of OSA, an ENT physician may elect to do a confirmatory sleep study or flexible laryngoscopy to evaluate the severity of airway obstruction. This latter scenario occurs often with children less than two years old, those with neurologic or neuromuscular disorders, and in patients with craniofacial abnormalities, such as Crouzon, Pierre Robin, or Down syndrome. All of these patients are at higher risk of post-operative

complications and should be categorized in severity of OSA using the sleep study both prior to surgical interventions and post-operatively as recommended by the American Academy of Sleep Medicine (AASM) practice parameters.

For those patients who cannot be cured of obstructive sleep apnea with surgical intervention, the use of noninvasive ventilation (NIV) using continuous positive airway pressure (CPAP) is an option. A sleep physician or nurse practitioner can evaluate, diagnose and treat for OSA by using CPAP at almost any age. Patients with neuromuscular disease, scoliosis and primary neurologic disorders frequently have secondary sleep apnea, obstructive and/or central, and these patients too can benefit from specialized NIV using Bi-level positive airway pressure (BIPAP), which provides true noninvasive ventilatory assistance. For patients having difficulty adjusting to CPAP therapy, sleep psychologists can help with a desensitization program that provides specific instructions to family members that help to teach young patients how to effectively use the CPAP device.

In an infant or child that will not go to sleep or will not return to sleep after awakening, the diagnosis of behavioral insomnia of childhood may be appropriately made by a family physician. Histories of the parent or caretaker noting that they have to rock the child to sleep, that the child won't sleep in their own bed, or that the child demands multiple bedtime stories, multiple bathroom requests or another drink of water are all clues to the diagnosis. Multiple family dynamics may be preventing the infant or child from achieving the ability to "self soothe" to sleep, a critical behavior that involves learning how to initiate sleep and return to sleep after a nighttime awakening.

Proper parental guidance by a primary care provider can correct many of these insomnia complaints, but patients who are refractory to these interventions can be treated effectively by a behavioral sleep psychologist. These dedicated providers work with patients (and often stressed family members) to sort out difficulties in falling asleep, staying asleep and/or getting an adequate amount of sleep. The sleep psychologist can provide invaluable instructions to help parents teach infants and toddlers how to "self soothe" (see Table 1).

Table 1. Tips for Treating Behavioral Insomnia of Childhood**Table: Tips for Treating Behavioral Insomnia of Childhood**

1. Use consistent bedtime scheduling
 - a. Same bedtime seven nights per week
 - b. Same morning wake up time seven days per week
2. Develop a regular bedtime routine
 - a. Have standard routine to initiate going to bed
 - b. Limited pre-bedtime routine to 20-30 minutes
 - c. Provide positive reinforcements for following the routine
3. Teach child to “self soothe” and return to sleep independently
 - a. Full extinction
 - b. Graduated extinction
 - c. Slow fading of parental presence

these behaviors can be difficult and time consuming for a family physician and may warrant referral to a behavioral sleep psychologist. More extensive evaluation with detailed sleep logs and actigraphy chronicle the 24-hour wake/sleep activities of patients and are analyzed and reviewed in detail with the patient and family. This information is used to develop a plan for successful sleep and subsequent improvement in daytime alertness and concentration.

Disorders of hypersomnolence are characterized by patients that have difficulty staying awake in the day. Despite appropriate sleep opportunities at night these patients have excessive daytime sleepiness which is the hallmark of narcolepsy and idiopathic hypersomnia. Differential diagnoses must be considered, and includes insufficient sleep syndrome, environmental sleep disorder, obstructive sleep apnea, inadequate sleep hygiene and other primary medical conditions and drug effects. For more complex case presentations, a referral to a sleep medicine physician may be warranted. A detailed sleep history and diagnostic testing with polysomnography and a multiple sleep latency test can tease out this broad differential diagnosis for hypersomnias. With correct diagnosis and therapy using wake promoting agents,

In summary, it is important to have patients with sleep disorders evaluated and appropriately treated. Quality of life and improvement in overall health for those patients can be achieved by the various interventions including surgical, medical and behavioral.

Insomnia and daytime sleepiness is a common complaint of the adolescent teenager and young adult. Behaviors like staying awake well after midnight and having to awaken for school in the early morning frequently result in chronic sleep deprivation, daytime fatigue and decreased alertness. Worrying about the next day’s activities, using electronics in bed and drinking caffeinated beverages in the evening can all lead to poor sleep secondary to inadequate sleep hygiene, as described in the ICSD-3. Inability to go to sleep prior to early morning hours may be a sign of a circadian rhythm sleep disorder called delayed sleep phase syndrome. All of these young patients are at increased risk of accidents and poor school performance. Correction of

patients can be hopeful for a significant improvement in quality of life.

In summary, it is important to have patients with sleep disorders evaluated and appropriately treated. Quality of life and improvement in overall health for those patients can be achieved by the various interventions including surgical, medical and behavioral. Quality of life for other family members caring for these patients may be a secondary goal.

For questions about who to consult visit our website at www.childrenscolorado.org/breathing or call the Sleep Team coordinator at (720) 777-6181 or toll free via One Call at (800) 525-4871.

The Colorado Department of Public Health and Environment and a group of physicians have created a guideline on marijuana use and breastfeeding.

Please visit coloradoafp.org/physicianresources to download the guidelines.

Top Ten Tips To Improve Handoffs

By COPIC's Patient Safety and Risk Management Department

Handoffs or handovers abound in medicine. The path of care from the first visit to completion is rarely seamless. In most medical encounters there is a coordination of care that must occur, and it involves communication between providers. According to The Joint Commission, 66 percent of sentinel events involve communication failures.

Here are some tips for handoffs:

- 1. The basis of good handoffs is identifying in what situations and to whom handoffs occur.** Changes in shift in the ED, an on-call weekend situation or a discharge to a different facility are obvious examples of handoffs. Less obvious examples include the injection order to your RN, and the end of an office visit when you give the patient complex instructions or a referral to another clinician.
 - 2. Be aware of the barriers to doing handoffs.** The EHR is an obvious hurdle, and finding the time and the right setting can be a problem. Also, calling a physician's office is always a challenge and cell phones aren't always answered.
 - 3. Come up with a format or form as to how handoffs will occur.** I-PASS (great in the ED setting) and SBAR (Situation-Background-Assessment-Recommendation) are two common mnemonics that outline your handoff. The Agency for Healthcare Research and Quality's website offers several resources such as "Strategies to Improve Handoffs."¹ However, remember that the effectiveness depends on how well providers comply. Setting expectations, getting agreement, standardizing the handoff technique and making it part of the organizational culture are keys to ongoing success.
 - 4. Handoffs are a transfer of information and responsibility.** What information does the next provider need to care for the patient? What test results are you waiting for and what will be done with them? The delegation of responsibility and the decision tree must be clear. Always use an
- "if/then" style to your handoff such as "If the D Dimer is positive, we will do a spiral CT; if it is negative, we will discharge."
- 5. Consider the difference between asynchronous and synchronous communication.** In the expanding digital world, one now can communicate by fax, email, text or a messaging service built into the EHR. Each person's preferences are different, and texting or emailing critical information to someone who doesn't check such messages regularly is problematic. Asynchronous communication requires confirmation.
 - 6. There needs to be a read back or a closed loop communication.** Whenever there is a verbal communication by phone or in person, there needs to be a clear ending comment that states what duties will be done and that responsibility has transferred.
 - 7. Involve the patient if you can.** The same principles of a clear ending comment apply. For example, "You will see the surgeon about this mass. Do you understand and will you do that?" Then, carefully document the discussion. If it is an urgent situation, advocate for the patient and help streamline the referral.
 - 8. Planned handoffs should be held at a fixed time and there needs to be adequate time to do them correctly.**
 - 9. Limit interruptions.** As best as you can, you need to have undivided attention when doing a handoff.
 - 10. Determine the role of technology.** Is there an IT solution with support and access to labs, X-rays and so on? Is a checklist an option? Do you want a digital handoff for your service and a verbal handoff for the sicker patients?

Endnotes

- ¹ <https://innovations.ahrq.gov/qualitytools/strategies-improve-handoffs>



67th Annual Scientific Conference

April 23-26, 2015

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Adult Moderate Procedural Sedation – Thursday, April 23, 2015 – 8:00 AM – 9:00 AM – Lecture, 9:00 AM -12:00 PM – Verification Session			
PALS – Thursday, April 23, 2015 - 1:00 PM - 2:00 PM			
BLS – Thursday, April 23, 2015 - 2:00 PM - 3:00 PM			
ACLS - Thursday, April 23, 2015 - 3:00 PM - 6:30 PM			

Will you be joining us for the 2015 Annual Scientific Welcome Reception Thursday, April 23 from 4:30 PM - 6:30 PM? (included in your registration fee)

Yes No

Will you attend the Early Release/Long Acting (ER/LA) Opioid Risk Assessment & Mitigation Strategy (REMS): Achieving Safe Use While Improving Patient Care Session Thursday, April 23 from 6:30 PM - 8:30 PM?

Yes No

Please circle which program/workshop you plan to attend Saturday, April 25:

Office Procedural Workshops – Injections Marijuana Behavioral Health Genomes Alzheimer's

Will you be utilizing our Child Care Services?

Yes No

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CAFP 67th Annual Scientific Conference Agenda

Thursday, April 23	Speaker	Location	CME
6:30 AM – 8:00 AM 8:00 AM – 3:00 PM	Breakfast in Dining Room DOT Medical Examiner Training Course	Mountain View Restaurant Remington's II	7.5
8:00 AM – 9:00 AM	Adult Moderate Procedural Sedation Lecture	Cheyenne 1	1
9:00 AM – 12:00 PM	Adult Moderate Procedural Sedation- Skill Verification Session		
10:15 AM – 10:30 AM 12:00 PM – 5:00 PM	Break Self Assessment Module- Diabetes	Grand Rivers Gallery EPR Amphitheater	12
12:15 AM – 1:15 PM	Lunch in Dining Room	Mountain View Restaurant	
1:00 PM – 2:00 PM	PALS Skill Verification	Cheyenne 1	10
2:00 PM – 3:00 PM	BLS Skill Verification	Cheyenne 1	1
3:00 PM – 3:15 PM	Break	Grand Rivers Gallery	
3:00 PM – 6:30 PM	ACLS Course	Cheyenne 1	0
4:00 PM – 6:30 PM 5:00 PM	Welcome Reception Dinner in Dining Room	Registration Area Mountain View Restaurant	
6:30 PM – 8:30 PM	Extended Release/Long Acting (ER/LA) Opioid Risk Assessment & Mitigation Strategy (REMS): Achieving Safe Use While Improving Patient Care	Amphitheatre	2
Friday, April 24			
6:30 AM – 8:00 AM 8:00 AM – 5:00 PM	Breakfast in Dining Room All Day infoPOEMS	Mountain View Restaurant Grand Rivers Ballroom	6.7
8:00 AM	Door Prize Drawing		
8:00 AM – 8:15 AM	Intro to infoPOEMS		
8:15 AM – 8:45 AM	Cardiovascular Disease (CHF/rhythm)		
8:45 AM – 9:15 AM	Deep Venous Thrombosis and Pulmonary Embolism		
9:15 AM – 9:30 AM	Complementary, Alternative and Integrative Therapies		
9:30 AM – 10:15 AM 10:15 AM – 10:45 AM	Exhibit Hall Break Hospital Medicine Update	Colorado Ballroom	
10:45 AM – 11:15 AM	Pediatric Update 2015: Tubes, Tonsils, & Tympanic membranes		
11:15 AM – 11:45 AM	Diet, Nutrition, Obesity		
11:45 AM – 12:00 PM	Cerebrovascular Disease		
12:00 PM – 1:00 PM	Lunch in Dining Room	Mountain View Restaurant	
1:00 PM – 1:30 PM	Guidelines We Can Trust		
1:30 PM – 2:00 PM	Tobacco & Substance Abuse		
2:00 PM – 2:30 PM	Type 2 Diabetes Mellitus		
2:30 PM – 2:45 PM	Intelligent imaging: What Should I Order		
2:45 PM – 3:30 PM	Exhibit Hall Break	Colorado Ballroom	
3:30 PM – 4:00 PM	Obstructive Sleep Apnea		
4:00 PM – 4:30 PM	Neurology & Headache		
4:30 PM – 5:00 PM	Editor's Choice		
5:00 PM	Door Prize Drawing & Adjourn		
5:15 PM – 6:30 PM	Exhibit Hall Reception – Super Hero Theme, Children Welcome!		

CAFP 67th Annual Scientific Conference Agenda Continued

Saturday, April 25		Speaker	Location	CME
7:00 AM – 7:45 AM	Breakfast with the CAFP Leaders		Mountain View Restaurant	0.5
8:00 AM	Door Prize Drawing			
8:00 AM – 9:00 AM	Wound Care Made Easy	Kristine Miller, MD	Grand Rivers Ballroom	1
9:00 AM – 10:00 AM	ICD – 10	John Beard Gary McGriss Susan Thurston	Grand Rivers Ballroom	1
10:00 AM – 10:15 AM	Break		Grand Rivers Gallery	
10:15 AM – 11:15 AM	Adolescent Immunizations & the Barriers That Exist*	Pamela G Rockwell, DO	Grand Rivers Ballroom	1
11:15 AM – 12:15 PM	Urgent Care Pediatrics	Margaret Clarke, MD FAAP	Grand Rivers Ballroom	1
12:30 PM – 2:00 PM	Awards/Installation and Lunch		Remington's Arkansas and Platte	
2:00 PM – 5:00 PM	Office Procedural Workshops – Injections	Morteza Khodaei, MD, MPH, FACSM, FAAP		3
2:00 PM – 3:00 PM	Marijuana Update	Kenneth Finn, MD	Rio Grande	1
2:00 PM – 3:00 PM	Tackling the Challenges of Behavioral Health Integration	Jeff Bullard, MD Jan Bishop	Gunnison	1
3:00 PM – 4:00 PM	Pharmacologic & Non-pharmacologic Management of Dementia	David Nowels, MD	Rio Grande	1
4:00 PM – 5:00 PM	Genomes	Matthew Taylor, MD	Rio Grande	1
5:00 PM	Door Prize Drawing & Adjourn			
6:00 PM – 9:00 PM	Family Friendly Dinner – Super Hero Theme		Centennial Ballroom	
Sunday, April 26				
6:30 AM – 8:00 AM	Breakfast in Dining Room		Mountain View Restaurant	
9:00 AM	Door Prize Drawing			
9:00 AM – 10:00 AM	AAFP Leader Presentation	Wanda Filer, MD	Grand Rivers Ballroom	1
10:00 AM – 11:00 AM	Legislative Update	Jeff Thormodsgaard Judy Zerzan, MD, MPH	Grand Rivers Ballroom	1
11:00 AM – 11:15 AM	Break		Grand Rivers Gallery	
11:15 AM – 12:15 PM	It's Catching...Updates in Communicable Diseases	Lisa Miller, MD, MSPH	Grand Rivers Ballroom	1
12:15 PM	Grand Travel Prize Drawing & Adjourn			

*This CME activity is supported by an educational grant to the AAFP from Merck

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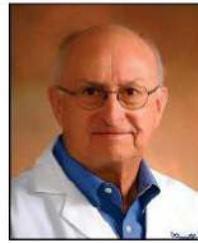
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New Recommendations for Meningococcal Vaccination

Meningococcal meningitis has never been among the more common infectious diseases in the United States or globally. Nonetheless, it can be quite a devastating experience for both patient and family when it occurs. The age groups at highest risk are infants and children less than four years of age and teens and young adults aged 15 through 22.¹ A case in a high school or college student is especially frightening, as a young person can be perfectly healthy one moment and in a few hours be gravely ill with an extremely high fever, may lose consciousness quickly, and may not survive despite the best of care. Even today, the case-fatality ratio for reported cases is about 15 percent.

In the 1990's, one of us (RF) had known a gentleman personally whose twelve-year-old son had succumbed to a meningococcal infection so rapidly that he never reached the hospital. The other (WL) served in the ER in residency alongside another resident, where both were exposed to a patient who coded in the ER and later died of meningococcal meningitis and sepsis. Both went home after the shift, unaware of the exposure, and one never woke up. She was found dead at home from meningococcal sepsis.

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

antigen on which to base a vaccine, primarily because it is the same across all strains within each serogroup. If a vaccine based on the capsule can be made to work, it should protect uniformly well against any infection by an organism in that serogroup.

For serogroups A, C, Y, and W-135, the polysaccharide vaccine worked relatively well overall in older children, teens and adults, but offered no protection for serogroup B. As with *H. flu* and the pneumococcus, the polysaccharide needed to be linked (“conjugated”) to a protein in order to provoke a response from the less mature immune systems of infants and toddlers. This was accomplished in the mid-2000s. It was this quadrivalent (A,C,Y, W-135) conjugate vaccine that my committee recommended for young adults in 2005. A second (booster) dose was added to the recommendation in 2010; other detailed instructions concerning those at increased medical risk of meningococcal infection have been added along the way.⁴

Thirteen serogroups of Neisseria meningitidis, the causative organism of meningococcal meningitis, have been identified. Of these, just five (A, B, C, Y, and W-135) cause almost all cases of disease.³ Group A is responsible for outbreaks in Africa’s “meningitis belt” but is rarely seen in the United States.

From 2003 to 2006, I (RF) served as a member of CDC’s Advisory Committee on Immunization Practices. Each member had the responsibility of chairing one work group. Because of my previous experience, I asked if I could lead the meningococcal group. We worked with CDC epidemiologists to formulate the recommendation for teens and young adults to receive the meningococcal vaccine that was available at that time.²

Thirteen serogroups of *Neisseria meningitidis*, the causative organism of meningococcal meningitis, have been identified. Of these, just five (A, B, C, Y, and W-135) cause almost all cases of disease.³ Group A is responsible for outbreaks in Africa’s “meningitis belt” but is rarely seen in the United States. The five groups differ from each other based on the capsular polysaccharide of the organism. As with *Hemophilus influenzae* (*H. flu*) and *Streptococcus pneumoniae*, the capsule is the easiest

The reason that serogroup B meningococcus was not included in the previous vaccines is that this bacterium posed a much more difficult problem for an interesting reason. The mature human immune system readily forms protective antibodies against the other meningococcal serogroups. However, the group B polysaccharide capsule happens to resemble human neural glycoproteins so closely that our immune systems do not recognize this polysaccharide as something foreign, and thus decline to produce antibodies against it.⁵ Until recently, the immunization strategy against meningococcal disease has had to bypass group B and focus on dealing with the others.

Fortunately, there exist antigens in the meningococcal organism other than the capsule. After considerable research, several of them have been found that are consistent enough from strain to strain to make vaccine

development feasible, and that also have been shown to induce formation of antibodies that investigators believe will be protective. Two candidate vaccines have been developed. The immunologic details of the products are beyond the scope of this article, but were reviewed for the ACIP in a slide presentation that is available to readers.⁶ The first vaccine, Bexsero® by Novartis, was used in 2013-14 to help control two college campus outbreaks of group B meningococcal disease under an FDA Investigational New Drug protocol.^{7,8} It received FDA approval for use in 10-25 year olds on January 23, 2015.⁹ The second vaccine, Trumenba® by Pfizer, gained FDA licensure for use, also in 10-25 year olds, on October 29, 2014.¹⁰ It has recently been used in two college campus outbreaks.

In October 2014 and February 2015, the ACIP discussed possible recommendations for the group B meningococcal vaccines. Because the vaccine is expensive and because, fortunately, the incidence of group B meningococcal infection has fallen to less than 1 case per million per year even without a vaccine, the cost-effectiveness figures for group B meningococcal vaccine do not support an immediate recommendation for universal use in any age group. I remember that even for the quadrivalent vaccine in 2005, making the universal recommendation that we did was probably the biggest cost stretch that the ACIP was willing to consider during my tenure. In February, The ACIP recommended vaccine use in group B meningococcal outbreaks and for those at increased medical or occupational risk, namely those with persistent complement component deficiencies, those with functional or anatomic asplenia, and microbiologists.¹¹

Family physicians should understand that a recommendation for universal use of any vaccine in any age group drives a very large expenditure of funds, both in the public and private sectors. However, once a vaccine gains FDA licensure, the physician is free to use that vaccine for a patient if he or she judges that the benefit for that individual justifies the cost. For any of several reasons, the decision may be different for an individual patient than



for a large population. College students and parents may consider an extra \$200 worth the assurance that though no vaccine is perfect, they have done what they can, with the tools available, to avoid a sudden tragedy.

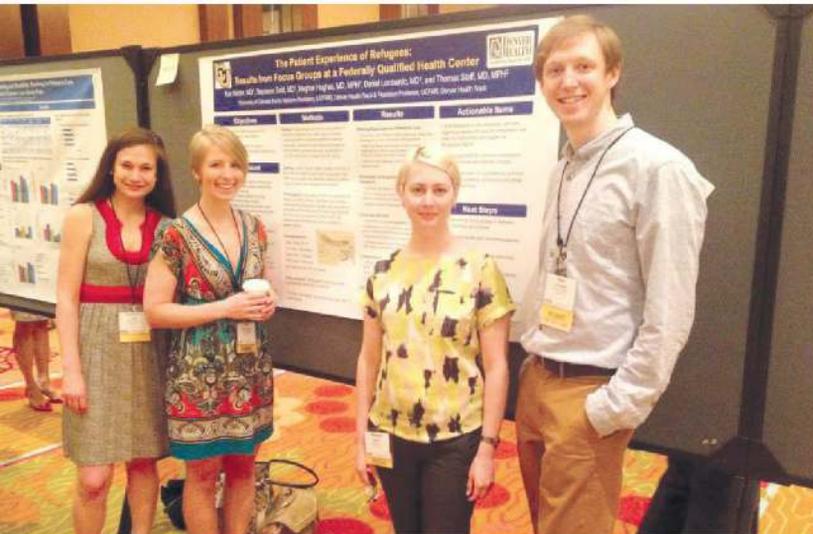
Endnotes

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Evaluating and Enhancing the Patient Experience in Non-English, Non-Spanish Speaking Populations

The Lowry Family Health Center (LFHC), part of Denver Health, is the primary practice site for four residents per year in the underserved medicine track at the University of Colorado. LFHC serves a diverse patient population, greater than 50% of whom speak neither English nor Spanish and are largely refugees. Over the last 2 years, the Denver Health system began utilizing the CAHPS questionnaire to assess the patient experience to drive improvement initiatives. Unfortunately, the survey is only in English and Spanish, thus it was missing a large portion of our patient population.

Given that a better patient experience has been correlated with better adherence to treatment and often better health outcomes, my co-residents and I identified this as an area to explore in our clinic.¹ A literature search revealed few studies that have addressed the patient experience of refugees. In light of this, we decided to undertake a research project where we would utilize focus groups to better characterize the experience of the various refugee groups at the LFHC to both guide future QI initiatives at our clinic and contribute to the general fund of knowledge for others serving these populations.



With the help of a grant from the Denver Health Foundation, we conducted focus groups in our top five non-English, non-Spanish languages from June to August 2014. We utilized a standard set of questions derived from the CAHPS questionnaire with language adapted from the input of key informants. Qualitative analysis of transcription data identified key themes of the factors that patients felt affected their health. Beyond several positive themes, they identified that barriers to their health fell into the following categories: access (22%), cultural customs (18%), medication (16%), environment (13%), and communication (12%). More specifically within those categories, the top 6 identified barriers included: wait time for appointments (22%), access to healthy food (17%), differences in medical care

Kari Mader, MD
University of Colorado FMR, Denver Health Track

in the US versus home country (15%), transportation to clinic (12%), varying food practices (10%), and difficulty reading pill bottles (9%).

Thanks to the support of the CAFP, we were able to present some of our preliminary data at the STFM Annual Conference in 2014. Now, after the conclusion of our groups, we have learned a great deal about our patients and the process of this type of inquiry, and we now have a basis at the LFHC to guide further steps to serve our patients. Our residency class is currently exploring potential QI projects in two action areas: access to appointments and how medication instructions are communicated (addressing access and difficulty with reading pill bottles). Our clinic is lucky to have a pharmacy, a WIC office, and a dental clinic, and is one of the Denver sites for the refugee screening program. We believe this offers a unique and special environment to move forward with improvement initiatives that can occur in concert with our entire medical home and result in greater impact. In addition to our resident-led initiatives, others in our medical home have already been pioneering initiatives to add languages to the Denver Health appointment phone line and develop education classes on topics identified by our focus groups, such as healthy eating in the US and basics of the US healthcare system.

My co-residents and I hope to present the final results of this study at the North American Refugee Health Conference in June. An unanticipated bonus of this project has been that we have been able to utilize core community engagement principles and learn public health concepts via “learning by doing.” We believe this extracurricular activity has augmented our residency training, and we will be reflecting on this experience in a works-in-progress presentation this year at the STFM Annual Conference.

Moving forward, we hope for two main outcomes of this pilot. First, that our work will spur multiple QI initiatives from current staff and future residents at the LFHC. Second, that our work will result in the creation of a patient advisory board of bilingual patients representing each language and cultural group at the LFHC, providing an ongoing means to gauge the experience of our entire patient population and continually use that to improve patient health.

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Caring for Colorado's Vulnerable Kids

There are three criteria used to define high quality health care by the National Survey of Children's Health: having adequate insurance, receiving preventive health care, and getting ongoing, comprehensive, coordinated care in a medical home. Unfortunately, Colorado isn't meeting all three for most of our kids. While the percent of uninsured children in Colorado has decreased from 13% in 2007 to 7% in 2013, a significant percentage of Colorado children still don't have consistent coverage. Around one in six kids is not getting an annual medical check-up, and barely more than half have a medical home, leaving hundreds of thousands of kids vulnerable to poor health. A full 60% of Colorado children are not meeting this national standard of high quality health care.

To draw attention to the needs of these vulnerable kids, All Kids Covered, a collaborative effort between over 40 organizations across the state, recently released a new report on the quality of health care for Colorado kids. The data shows disparities in access to care for certain demographic groups, indicating that some children are significantly more vulnerable than others:

- **Racial and ethnic minorities:** 67% of Hispanic children in Colorado did not receive high quality care in 2011 and 2012, along with 65% of black children and 63% of children of other races in Colorado, compared to 56% of white children. For many Hispanic kids, the issue is compounded; in primarily Spanish-speaking households, they are 1.4 times more likely than in English-speaking households to not have health insurance, a medical home, and access to preventive care.
- **6-17 year olds:** Kids between zero and five years old are 1.2 times as likely to receive high quality care as 6-11 year olds, and 1.4 times as likely as 12-17 year olds.
- **Boys:** 64% of boys, compared to 56% of girls, did not receive high quality care in 2011 and 2012.
- **Children in low-income households:** Kids living in poverty are half as likely to receive high

Aditi Ramaswami
Public Policy Coordinator, Colorado
Coalition for the Medically Underserved



quality health care as those whose families earn over 400% of the Federal Poverty Level, or \$97,000 per year for a four-person family income.

- **Children with parents who have less formal education:** Colorado kids with parents or guardians who have had more than a high school education are nearly twice as likely to receive high quality care as those with parents who did not graduate from high school.

It is important to recognize how far we have come in ensuring optimal health for all kids in our state. At the same time, there is still much work to be done to provide a better safety net for the kids who continually fall through the cracks of Colorado's health care system. As we continue making progress toward getting all kids covered, we also must commit to providing access to preventive care and other services in a medical home for every child. Continuity of care is important, and providers that partner with families and aim to deepen their understanding of the patient's unique needs and cultural values are invaluable to a child's health. Armed with good data, which we've summarized in our *Ensuring Quality Health Care for Colorado's Children* report, we can better understand the gaps that remain and see where we should focus our attention and resources. If we truly care about a bright future for Colorado, then we need to invest in a health system that meets the needs of all children.

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Taking Steps Towards Behavioral Health Integration

Jeffrey M. Bullard, MD
Vault, MaxHealth Family Medicine,
Acuity Brain Center, Dallas, Texas

The recent suicide of Robin Williams, along with tragedies like Sandy Hook Elementary and the Aurora, Colorado theater shooting, have been followed by a wake of attention questioning the state of mental health care in the US. It is a valid question that unfortunately is not answered simply or quickly. How does someone like Williams, who had access to the best doctors and facilities, escape treatment? The understanding of depression, like most mental illness, is marred with uncertainty. Brain pathways, neurotransmitters, environmental effects and genetics are all at play in a disease that some feel is not a disease at all, but a weakness, and a disorder which scientists struggle to clearly define.

Some things, however, are certain. Patients who suffer from conditions like depression, bipolar and anxiety, and yet go untreated, have an increased likelihood of becoming victims of suicide. Often overlooked is that patients who have chronic conditions like Parkinson's disease, which Williams was also battling, have a higher risk of becoming depressed.

Of course, to be successfully treated for depression and mental illness, one must first be diagnosed.

Organizations like the NCQA have included more robust mental health integration requirements for clinics working to achieve PCMH recognition.

One out of ten adults in the US is diagnosed with depression, and a whopping one out of five suffers from mental illness. Despite mental illness affecting so many, our health care system is not currently equipped to handle its treatment. In most areas, Primary Care Physicians (PCP) care for the bulk of our country's depressed. CMS's 2013 *Accountable Care Organizations Program Analysis* reported that up to 50% of depressed patients go undiagnosed by their doctor because of limited time and lack of brief, easy to administer screening and assessment tools. Even after diagnosis, each PCP has a comfort level in assessing and treating mentally ill patients and will refer patients to mental health providers once that comfort threshold has been reached. In many areas, mental health providers are overstretched or not present at all. Because of this shortage, it is not unusual for it to take weeks or months to get in to see a psychiatrist or other mental health provider after being referred.

In the last several decades, the medical and mental

health worlds have been almost completely disconnected. A patient's mental health benefits have been kept separate from their medical benefits, resulting in two essentially separate healthcare silos with almost no exchange of information. Recently though, we have begun to understand that medical conditions and mental illness are intricately linked. The connection between depression and heart disease, cancer, allergies or chronic pain was once thought to be causal with depression resulting from high symptom burden. We now understand that depression is an independent risk factor. Care coordination and integration between medical and mental health care is now recognized as essential in improving outcomes and decreasing the cost of care.

Things are also starting to change for care delivery and patient symptom monitoring and self-reporting. Organizations like the NCQA have included more robust mental health integration requirements for clinics working to achieve PCMH recognition. Value-base reimbursements and Medicare Shared Savings Programs include quality measures that focus on improved behavioral health integration and care coordination. Several states like Colorado and Illinois are bringing together thought leaders from the medical, mental health, community health, public health and insurance sectors to plan and implement statewide initiatives for integrating medical and mental health care.

Patient engagement is also changing in the age of smartphones and internet connectivity. Brief, easy to administer screening and assessment tools are being created, enabling providers to assess, monitor and engage patients for mental health conditions. For example, Vault (vaultintohealth.com) is a cloud-based app that allows providers to schedule tests and screenings for patients to take before, during or after appointments, using any web-enabled device. Vault also allows a patient to share that information among their providers, all from their smartphone, tablet or computer.

While many of the changes are driven by the need to decrease health care spending, these changes also strive to improve the care quality and outcomes. No matter the incentive, change is required to keep our at-risk population from slipping through the cracks. A great deal of reform is still ahead, but with innovative tools, an eye on care integration and a reset of the acceptable standards, many physicians will soon begin to realize integration in their offices.

Teaching With Passion and Compassion

CAFP Teacher of the Year Leah Cooper, MD, Leads By Example as an Advocate for Exceptional Primary Care

By Lynlee Espeseth

Without educators to guide them, Family Medicine residents wouldn't have as rich an educational experience. And for Leah Cooper, MD, without Family Medicine residents her teaching experience wouldn't have been as special.

"You can't be a teacher without students," she says. "I feel thankful for the experience to work with so many bright, dedicated and fun residents. I learned something from them every day."

Dr. Cooper was a faculty member at Swedish Family Medicine Residency in Littleton, Colorado for 14 years. Previous to that, she served as a Family Medicine Physician in rural La Junta, Colorado, practicing a full spectrum of family medicine and developing a passion for truly exceptional care.

For Dr. Cooper's residents, that passion was clear.

"Dr. Cooper personified family medicine and how it should be taught to family medicine residents. She provided a very humanitarian approach and helped remind us daily to treat the patient and not the disease," says Erica Liesmaki, MD, a former resident at Swedish Family Medicine.

Dr. Cooper agrees that leading by example, and reminding students to treat the whole patient, is a vital part of being an educator.

"It's my mission in life to transmit that message," Dr. Cooper says. "There are a lot of people out there who need someone to be kind to them. And when we have good collaboration, patients feel like we're on their side. I can meet people where they are in life."

Dr. Cooper is also passionate about advocating for the importance of primary care, and the effect its existence can have on patients.

"It's been well proven that people's health is better when they have a Primary Care Physician," she says. "I feel very strongly that primary care is important and we need more of us."

For students and residents, Dr. Cooper connects primary care back to the core of what makes it both vital and fulfilling.

"I try to express to students and residents that it's fun, it's exciting, and the personal relationships are fabulous. Especially being in primary care and being a Family Physician, seeing multiple generations, it's hard to beat that fulfillment," she says. "That personal relationship of really knowing someone well is very important. The medical system is at its best when there is really strong primary care."



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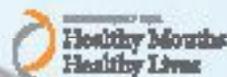
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Care In A Rural Community

CAFP Family Physician of the Year Elias Hernandez, MD, is dedicated to changing his community inside and outside of the clinic.

By Lynlee Espeseth

Driving east along Interstate 76, away from the ski resorts and fourteeners, you enter a part of Colorado that doesn't always receive the most attention, but that is no less important to our state.

Here, among the grasslands and farming communities, being a Family Physician is both challenging and rewarding, and can be just as surprising as it can be anywhere else.

This is particularly true in Fort Morgan, where Elias Hernandez, MD, serves his community and the patients of the Fort Morgan Salud Family Health Center.

Fort Morgan is a diverse community, where the farming industry, meat packing industry and sugar factory bring in workers from all over the world. Nearly 45 percent of patients at the Fort Morgan clinic are Hispanic, 10 percent are Somali, many don't speak English, and many more don't have sufficient insurance. In a rural community like this, a trip to the doctor only happens when you are in great need.

While caring for a rural and diverse population has its challenges, those challenges are part of what brings Dr. Hernandez great joy.

"We can find common ground with patients across cultures for treatment, and can provide treatment in a loving and caring way," he says. "That's the wonderful part of practicing and that's what really attracts me; being in that diversity, being in a rural community."

With each new patient Dr. Hernandez sees, he reminds himself of a simple philosophy: "Patients are humans like we are. They hurt as we hurt."

Born and raised in Cuernavaca, Mexico, Dr. Hernandez attended medical school at the Universidad de Montemorelos Escuela de Medicina in Montemorelos. As a medical student, Dr. Hernandez was able to interact very directly and personally with patients, and that education greatly affected the way he practices now. Patients can expect Dr. Hernandez to make house calls, check in with them long after business hours, and get to know who they are as people, not just as patients.

And while hundreds of miles separate Cuernavaca and Fort Morgan, he and his wife and children have come to feel that this community is their community, and they want to do everything they can to make it better. Dr. Hernandez helped to facilitate the Fort Morgan clinic's move to a larger, state-of-the-art facility; and along with his wife and other community members opened



a new private school in Fort Morgan. These efforts not only benefit Fort Morgan's current residents, but serve as a way to attract new residents, including new doctors.

And while offering great benefits in a community is one way to attract new physicians, Dr. Hernandez knows that almost nothing is more important than giving students and residents the opportunity to learn firsthand in a rural setting.

Dr. Hernandez actively works with the students and residents who come to the Fort Morgan clinic's training site. While these students and residents often begin their time unsure of what to expect, they leave having had a full rural physician's experience. They live with Dr. Hernandez and his family, see the diversity of the population, and experience the many aspects of patient care they are responsible for. They are encouraged to be open and sympathetic to their patients, and to let those experiences guide the rest of their education and career. Dr. Hernandez hopes it is these lessons and experiences that will encourage young physicians to return to Fort Morgan, or to settle in one of the many rural communities across the state.

As to what makes primary care an incredible career, he asks young physicians to consider the role of the Primary Care Physician.

"Think about being the foundation of what we do. Think about being one of the major influences in a community. It's very satisfying in many ways. The joy and the care that patients show to you more than you can show to them, that's what makes it satisfying."

Champion For A Cause

CAFP Resident of the Year Kari Mader, MD sees opportunity where others find challenges.

By Lynlee Espeseth



For some, caring for people is a calling. For Kari Mader, MD, it undoubtedly was, and that is what led her to a career in family medicine.

In medical school Dr. Mader knew she wanted to use the skills she had been given to serve the needs of society in general. And while she was drawn to many different specialties, it was family medicine that gave her the best ability to do so.

“I felt the greatest need in society was strong primary care doctors who can see any patient that walks through their door,” she says. “I didn’t want to ever have to say ‘I can’t comment on that because you are a child or you are pregnant.’ The average person on the street just needs a primary care doctor.”

Dr. Mader is a passionate advocate for the change that is happening and will continue to happen in primary care. She has experienced firsthand how forward thinking those in primary care are, and how much of an impact primary care will have on the future of all medicine.

Unfortunately, many medical students aren’t aware of this, and don’t learn soon enough what primary care is all about.

“There can be a stigma against primary care in medical school, and that may be the message students get, but once they get into it and see the innovation and changes they are surprised by that. The problem is that many students don’t get to that point,” says Dr. Mader.

To combat this, a group of University of Colorado

students, including Dr. Mader, have started a Primary Care Progress (PCP) chapter in Colorado. PCP is working to revitalize the world of primary care and address the provider shortage happening across the United States. This is done through state chapters that bring together health profession students who advocate for training, team work, innovation, and changing the conversation happening around primary care.

In 2013 a group of students started envisioning what the Colorado chapter of PCP could be. They were interested in more curriculum involving primary care, more resources to learn about primary care, and changing the way primary care is viewed and talked about. They also wanted a place where they could grow their primary care skills, and from that came the new, free student run clinic DAWN (Dedicated to Aurora’s Wellness and Needs) for the uninsured. The clinic will give students the opportunity to see what primary care is all about, see how a Patient Centered Medical Home operates, and give back to the community they are a part of.

Giving back to the community has also been a major part of Dr. Mader’s residency. She sees patients at the Lowry Clinic, a federally qualified health center that is part of the Denver Health system. Many of the patients who visit the Lowry Clinic are refugees, and speak neither English nor Spanish. Resources for these patients can be limited, so being a Patient Centered Medical Home, equipped with a pharmacy, dental clinic, WIC clinic, and more, has helped the Lowry Clinic better serve them.

“It’s a once in a lifetime training experience,” says Dr. Mader of her residency. “Language barriers are just the tip of it. You face challenges like how patients conceptualize healthcare and disease, and cultural customs in terms of food, medication, and perceptions of medical providers. You have to try to navigate it individually each time, and that can take a lot more time and a lot more continuity with patients. That challenge is overwhelming sometimes, but at the same time it is incredibly rewarding. You get to make a difference for a very marginalized population.”

Dr. Mader has never shied away from these challenges. Along with her fellow residents she has initiated a number of programs including refugee experience talks and group pain visits for Nepali women from Bhutan. The goal of these programs is not just awareness, but real programming that can positively affect the care patients get at the Lowry Clinic and beyond.

Dr. Mader recognizes how easy it can be to feel burned out in medicine, but encourages students to follow their passions and explore how fulfilling primary care can be, and how rewarding it is to serve a need.

“You can truly follow someone from birth to death, and it’s a really beautiful thing when you can do that.”

Innovation In Patient Care

CAFP Patient-Centered Medical Home Best Practice of the Year, University Family Medicine of Westminster and Boulder, Is Putting Patients at the Center of Care

By Lynlee Espeseth



Innovation is happening all the time in primary care. University Family Medicine's Westminster and Boulder clinics are embracing that innovation, and have become NCQA recognized Patient Centered Medical Homes. While the process isn't always easy, it has helped to change patient lives for the better.

"The whole concept is taking what used to be a very traditional clinic environment, and transforming that, so the patient is at the center of our medical care," says Anne Donovan, Practice Manager. "Envision a pie being sliced, with the patient in the center. The physician is in one of those slices, but you may also have an anticoagulation nurse or a social worker or a behavioral health scientist in one of the slices. You want an interdisciplinary team around the patient."

What happens when the patient, not the provider, is placed in the center? Not only do they have an entire team focused on their care, but they are put in control, and are asked to be engaged in their own health.

"When you have to take ownership for your health it's not always comfortable, familiar or easy. But patients see the value in it," says Anju Visweswaraiyah, MD, an Attending Physician at the Westminster clinic. "Patients know their expectations, they know their responsibilities. There is a lot to be said for patient ownership. At the end of the day, when you put the patient in the center, that also puts them in the center of taking care of their own

health. With how healthcare is going, we need patients to understand their role in managing their health."

The vision to transform the University of Colorado's primary care clinics into Patient Centered Medical Homes came from Colleen Conry, MD, Professor, Medical Director of Ambulatory Services at the University of Colorado Department of Family Medicine. There were many steps, committees, task forces and approval processes along the way, but eventually A. F. Williams Medical Center in Stapleton became the first. The Westminster and Boulder clinics received their recognition in 2014.

Staff at the clinics agree that one of the most important parts of becoming a Patient Centered Medical Home is having a provider champion. In Westminster, that was Dr. Visweswaraiyah. In Boulder, it was Dr. Corydon Sperry.

Not only have Dr. Visweswaraiyah and Dr. Sperry championed the mission, they have been devoted to engaging their entire staff as well.

"Really have a partnership between provider and staff so everyone feels like they have ownership and are part of the mission. It only works when everyone is common minded about how it works and how it will benefit the patient," says Dr. Visweswaraiyah.

Both the Westminster and Boulder clinics have implemented programs that bring all staff members into patient care. One is these is the Healthier Living Colorado program, a six week course attended by patients and caregivers over the age of 18, who are facing health issues and could benefit

from setting and achieving health goals to alleviate those issues. Healthier Living Colorado receives systems management, implementation support and training for preventative evidenced based programs through COWA (Consortium for Older Adult Wellness), an organization dedicated to patient self-management.

What is unique about Healthier Living Colorado at the Westminster and Boulder clinics is that their own staff members have completed the training to work as coaches in the program.

Approaching the program in this way has worked well for patients, who feel comfortable engaging with staff members they already know. It has also been beneficial for the coaches, who get to play a bigger role in the health of patients than they otherwise would have been able to.

"When we're doing our everyday things, we don't always have the connection with patients like providers do," says Natasha Johnson, a Medical Assistant and Healthier Living Colorado Coach. "This is a way for me personally to go above and beyond and actually help patients and see that patients are changing and doing better because of what you are teaching them."

Donovan, Dr. Visweswaraiyah and Johnson all agree that stopping to recognize those moments of success is what can make all the difference when facing the work that comes with changing the way you provide patient care.

"It takes a lot of energy and commitment," says Donovan. "Emphasize celebration, recognize champions, and stay motivated."

Leadership & Advocacy In Memory of Dr. Bob Brockmann

In 2013, Colorado Academy of Family Physicians President Bob Brockmann, MD, passed away unexpectedly from cardiac arrest. Dr. Brockmann was a champion and advocate for Family Medicine, and to honor his legacy CAFP created the Bob Brockmann, MD, Memorial Fund Scholarship for Medical Students & Residents. The

purpose of this scholarship was to continue the support Dr. Brockmann showed for medical students, Family Medicine residents, advocacy and leadership.

One of the 2014 scholarship recipients, Dr. Warren Pettine, shared his memories of Dr. Brockmann and his experiences presenting work on integrated behavioral and physical health in Washington, DC in the fall of 2014.



Dr. Warren Pettine

Dr. Brockmann was a man of conviction. He was a role model who, during our time together with the Colorado Medical Society's (CMS) Council on Legislation (COL), taught me how to put one's ideals and talent to action, action that made the world better. After Dr. Brockmann's passing, his scholarship has guided my career along a path that I hope he would approve of.

Dr. Brockmann's motivation was always clear: he cared about patients. His handling of a bill concerned with the distribution of naloxone was particularly instructive. Naloxone is used to counteract overdoses on opioids. It has no abuse potential on its own, and is safe for self-administration. During the 2012-2013 session, legislation was introduced permitting its distribution to heroin addicts, allowing them to have it on hand for when it is most needed.

But there were problems with the bill. Dr. Brockmann led the majority in concerns regarding patient safety. He was worried about proper training in administration of the medicine, and contacting emergency technicians to provide the necessary, comprehensive follow up care. Dr. Brockmann researched what was happening in other states, looked at the political landscape in Colorado, passionately educated the rest of us in the room, and in the end worked directly with the bill's authors to fix what was needed. This was all done on his own time and of his own prompting. Politically, the bill was easy for us to support, and costly

to oppose. Rather than take the easy way, Dr. Brockmann assumed the risk and time necessary to make sure it was done right. I will never forget that example.

After Dr. Brockmann's passing, the memory of his leadership stayed with me. The scholarship in his name has made possible my own health policy project regarding the integration of physical and behavioral health. When practices look to integrate these forms of health care, it is difficult to estimate the effects on revenues and expenditures. How much will a psychologist or social worker bring in? How much will they cost in salary, office space or other logistical areas? Dr. Ben Miller of the University of Colorado Department of Family Medicine is a national expert on behavioral health. He and his team have been working on a web-based tool practices can use to answer these questions. The Brockmann scholarship supported my work with them to assemble the tool, and then present it at a national conference in Washington D.C. this past fall. At the conference, I was able to meet leaders in the field of health policy. Through presentations and conversations, I learned the course of bringing an intervention from initial studies to law. My own project with Dr. Miller was very well received. In a way, Dr. Brockmann's scholarship helped me make change on a national scale, however small. I like to think he would have smiled at that.

The scholarship is already playing a large role in my professional development. As a result of this experience, I have decided to make health policy a major part of my career. Through advocacy, one can make it easier for physicians to provide patients with quality care. We can also build systems that enable people to be healthy from the start.

Dr. Brockmann showed me how one can engage in policymaking and cause widespread change. His scholarship has also helped shape my path forward. Dr. Brockmann's memory will always stay with me. Thank you all for creating the scholarship, and making these experiences possible.

Other 2014 scholarship recipients included Kari Mader, Matthew Simpson, Meghan Hughes, Jesper Brickley and Stephanie Gold.

If you would like to contribute to the Bob Brockmann, MD Memorial Fund Scholarship for Medical Students & Residents please contact Raquel Rosen at raquel@coloradoafp.org or 303-696-6655 x 10.

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