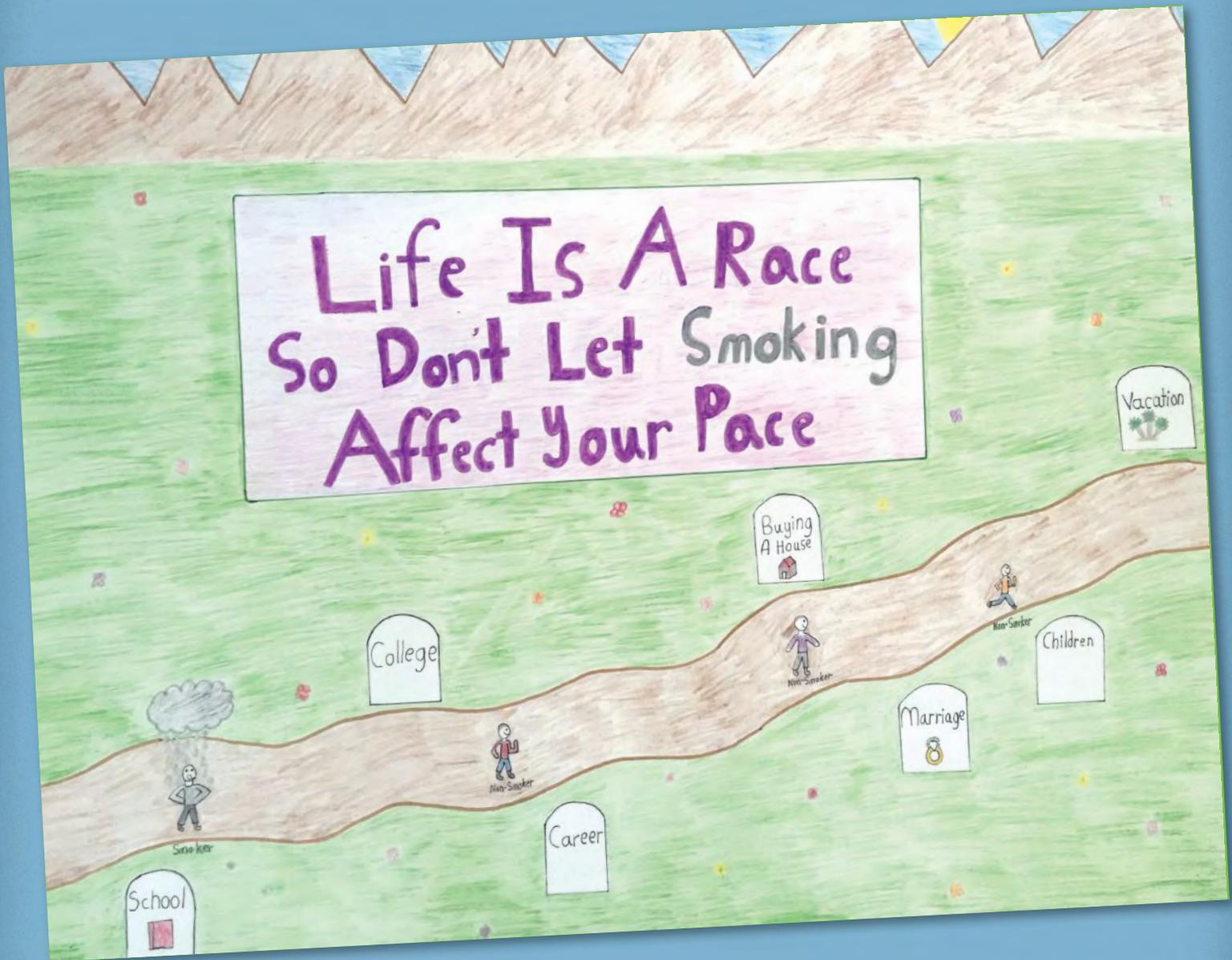


COLORADO FAMILY PHYSICIAN

3rd Quarter
2016 Summer

A Publication from the Colorado Academy of Family Physicians • coloradoafp.org



IN THIS ISSUE:

Legislative Wrap Up: What Was Accomplished During the 2016 Session

Commitment to Service: CAFPP Member Justin Wheeler, MD, Cares for Those Most in Need

Tar Wars Poster Contest: Congratulations to the 2016 Winners!

WHERE KIDS BREATHE EASIER.



WE NEVER SAY NEVER.®

Whether a child has mild or severe eczema, allergies or asthma, referring a patient to National Jewish Health as early as possible can lead to better outcomes. Our Pediatric Specialists use innovative approaches that address each child's individual needs, helping them (and you) breathe easier.

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.



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.

ADVOCACY

President's Report 4
 CEO's Report 5
 CAFP Legislative UPDATE 8
 CAFP on the Go 11

EDUCATION & PRACTICE ENHANCEMENTS

When Your Patient's Asthma Controller Isn't in Control 12

2014 ANNUAL REPORT 17

EDUCATION & PRACTICE ENHANCEMENTS

Femoroacetabular Impingement in the Adolescent and Young Adult Population 32

Thanks for a Great 2016 Annual Summit 34
 SNOCAP RECAP 34

Case Study: Treating Employees and Their Family Members 35

Technology is Transforming the Training and Education of Health Care Professionals 36

HEALTH OF THE PUBLIC

2016 Tar Wars Poster Contest Winners Announced 38

Vaccine News You Can Use 39

Understanding the Diverse Needs Asian Americans and Pacific Islanders in Colorado 41

MEMBERS

A Lifelong Pursuit of Service 42

Rural Corner: New Tax Credits for Rural Preceptors 44

New Scholarship Opportunity for Female Physicians in Colorado 46

Self-Study CME 47

Edition 48



pcipublishing.com

Created by Publishing Concepts, Inc.

David Brown, President • dbrown@pcipublishing.com

For Advertising info contact

Dustin Doddridge • 1-800-561-4686 ext.106
 ddoddridge@pcipublishing.com

Acceptance of ads does not constitute an endorsement by the CAFP of the service or product.

CAFP Board of Directors

Officers 2015-2016

Chair/Past President	Glenn Madrid, MD Grand Junction gmadrid@pcpgj.com	Secretary/ Treasurer	John Cawley, MD Ft. Collins jcawley@afmfc.com
President	Tamaan Osbourne-Roberts, MD Denver tamaan.osbourne.roberts@gmail.com	Member-at-Large	Zach Wachtl, MD Denver zcwachtl@gmail.com
President-elect	Monica Morris, DO Denver mcorriga@zagmail.gonzaga.edu	External Relations/ Awards Committee chair	TBD
Vice President	Brian Hill, MD Castle Pines bhillwv@gmail.com		

Board Members

Term Expiring 2017

Stephanie Gold, MD, Denver
stephanie.gold@ucdenver.edu

Anneliese Heckert, DO, Pueblo
annelieseheckert@centura.org

Anibal Martinez, MD, Castle Rock
anibal.martinez@ucdenver.edu

Mason Shamis, MD, Ft. Collins
mason.shamis@gmail.com

Term Expiring 2018

Craig Anthony, MD, Denver
craig.anthony.vcu@gmail.com

Laurie Patton, MD, Parker
lmpatton@miramont.us

Aaron Shupp, MD, Broomfield
AaronShupp@gmail.com

Zach Wachtl, MD, Denver
zchwachtl@gmail.com

Term Expiring 2019

Gina Alkes, MD, MPH, Buena Vista
galkes@hotmail.com

Krista Ault, MD, Durango
krista.ault@gmail.com

Corey Lyon, DO, Denver
corey.lyon@ucdenver.edu

TJ Staff, MD, MPH, Denver
thomas.staff@daha.org

Delegates

Brian Bacak, MD, FFAFP
Highlands Ranch
brian.bacak@healthonecares.com
term expires 2017

Rick Budensiek, DO
Greeley
rbud5623@aol.com
term expires 2017

Alternate Delegates

Tamaan Osbourne-Roberts, MD,
Denver
tamaan.osbourne.roberts@gmail.com
term expires 2017

Glenn Madrid, MD, Grand Junctions
gmadrid@pcpgj.com
term expires 2017

Resident Representatives

Somayyeh Farazandeh, MD, 2017,
St. Anthony North
somayyehfarazandeh@centura.org

Syed Gillani, DO, 2017, Pueblo
docgillani@gmail.com

Brian Juan, 2017, Pueblo
brianjuan@centura.org

Cleveland Piggott, MD, 2018,
University of Colorado Family Medicine
Residency
capjr14@gmail.com

Matthew Mullane, MD, 2017, St.
Anthony North
matthewmullane@centura.org

Student Representatives

Marshal Ash, RVU, grad 2017
Marshal.Ash@rvu.edu

Bobby Nieland, RVU, grad 2018
Robert.Nieland@rvu.edu

Grace Borton, RVU, grad 2017
Grace.Borton@rvu.edu

Lindsey Herrera, CU, grad 2018
lindsey.herrera@ucdenver.edu

Joshua Told, RVU, grad 2017
Joshua.Told@rvu.edu

Editor

Glenn Madrid, MD
gmadrid@pcpgj.com

Legislative Committee Chair

Monica Morris, DO
mcorriga@zagmail.gonzaga.edu

Brian Hill, MD
bhillwv@gmail.com

Education Committee Chairs

John Cawley, MD
jcawley@afmc.com

Monica Morris, DO
mcorriga@zagmail.gonzaga.edu

Staff

Raquel Rosen, MA, CAE
Chief Executive Officer
raquel@coloradoafp.org

Ryan Biehle
Director of Policy & Government
Relations
ryan@coloradoafp.org

Lynlee Espeseth
Director of Communications, Marketing &
Membership
lynlee@coloradoafp.org

Jeff Thormodsgaard
Lobbyist
jeff@precisionpolicygroup.com

Erin Watwood
Director of Education, Events, &
Meetings
erin@coloradoafp.org

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.

Contact Information for the CAFP

Colorado Academy of Family Physicians
 2224 S. Fraser St., Unit 1
 Aurora, CO 80014
 phone 303-696-6655 or 1-800-468-8615
 fax 303-696-7224 e-mail info@coloradoafp.org

PRESIDENT'S REPORT

By: Tamaan Osbourne-Roberts, MD



To be a family physician is to be a leader.

In theory, such should be obvious. As physicians, we are part of one of the oldest and most venerable of the world's professions; and even amongst physicians, one might argue that, based on the nature of our work (and despite the youth of our official "specialty designation"), for many years, almost all physicians were, by definition, family physicians. Our patients seek our assistance and guidance, asking for our help during some of the darkest moments of their lives. Our communities look up to us, seeking our counsel in many things related to public health and wellness. We understand the complexities of American healthcare better than any other specialty, interfacing with all parts of it, and regularly balancing the needs of people with the hard realities of data and science to pull solutions from the sometimes nigh-impenetrable bowels of the system. Our voices are respected in the exam room and the board room, and are regularly heard ringing throughout the halls of power. By all observable and measurable standards, we are not only a force for good, but a force to be reckoned with, continually seeking justice on behalf of those under our care.

Why, then, are so many of us uncomfortable with this role for ourselves? Why, as a general rule, do we flee the spotlight, and eschew the calling to stand in our truth, up front and unafraid, and direct the great ship of healthcare towards a brighter destiny?

I admit, the preceding may seem to be a bold statement, but I do not make such lightly, nor do I do so without ample research. It has been my express privilege, in my various roles representing our profession, to travel throughout

the state and nation over the past several years, speaking repeatedly with many of our colleagues about their joys, trepidations, worries, and hopes...and I have found that, as family physicians, we often feel uncomfortable with viewing ourselves as leaders. In those same conversations, over time, it has also become clear as to why so many of us feel this way: the reality that most of us went to med school, and then opted to become family physicians, not because we were called to lead, but because we were called to serve. And with the needs of our patients, our communities, and the greater good of our country (and world) foremost in our minds...with our hearts in our work, and our souls rooted firmly in the generations of healers that came before us...thinking of ourselves seems to be, at best, an afterthought. And at worst, selfish and the antithesis of what we are called to be.

Which brings us to an exceptional irony: that it is EXACTLY our principled, dedicated approach that makes us the leaders that are needed, right now, at a time in history when changes in both healthcare and society threaten to fracture our profession and our communities.

American healthcare is currently a wild and stormy sea of transition. The Affordable Care Act has fundamentally changed how a great many Americans pay for medical care, at a time when more and more Americans are less able to afford any of their lives' necessities; at the same time, new payment models such as MACRA, ACOs, and DPCs (to name but a few) are adding further complexity to the system, for both physicians and patients. Increasing physician employment, ushered in

largely by changing demographic and generational expectations, poses new ethical and practical concerns for our profession. Electronic medical records and expanding burdens of paperwork, initially hailed as a gateway to population data and improved health for our patients, must be balanced against the national epidemic of physician burnout...a phenomenon in which research increasingly implicates the rise of physician clerical duties, and in which family physicians are one of the hardest-hit specialties.

Our Hippocratic oath directs us "to apply, for the benefit of the sick, all measures which are required." ALL measures. And at this time, in the current American healthcare ecosystem, "all measures," at least to me, seems to include a clear and present call for our leadership, both individually, and as a profession.

And in this, I hope you will stand with me...with us...at the CAFP and the AAFP, as we seek to surmount these challenges. To lead the way, through rededication to our spirit of service, in ensuring that the citizens of Colorado, and of our great nation, have access to the healthcare they deserve, and that our profession has access to the future it requires. I do not promise that the way will be simple, or easy. Nor do I promise that there won't be disappointments, or many bumps along the way. But I do promise that, if we stand together, seeking justice for our patients, communities, and profession, we will find the bright sun on the horizon, and sail boldly into the coming dawn.

Until next time.

Tamaan K. Osbourne-Roberts, M.D.



The Ever-changing World of Payment Reform in Colorado

I am sure you feel as I do that sometimes life seems to be moving extremely fast. The days at the CAFP office are so busy with many projects and work focused on supporting our family medicine physician members. Fortunately, we have the professional staff, board leaders, and volunteers with expertise to do all that is needed.

And I am sure that in your world things are moving fast, particularly with new medical home and payment reform initiatives created by the Affordable Care Act, namely the Comprehensive Primary Care Initiative (CPC Initiative), Transforming Clinical Practice Initiative (TCPI), and the State Innovation Model (SIM). Hopefully, the newer CPC+ will come to Colorado as well to be a more robust extension of the work being done by the CPC Initiative. And MACRA is coming! What does all this mean for you and your practice? Basically, you need to be ready for the new world of payment reform.

MACRA is the Medicare Access and CHIP Reauthorization Act. It was created after the repeal of the Sustainable Growth Rate, and will be a new way of paying for your Medicare services. The actual payments will begin in 2019 but they will be based on your 2017 practice. We have resources on our CAFP web site at <https://www.coloradoafp.org/resources/macra/>.

The CAFP is collaborating with Aledade to bring you a series of webinars on MACRA and advanced payment models. The webinars will be held over the lunch hour and/or in the evenings. We will be sending out notices to you soon.

This fall we are partnering with HealthTeamWorks and the Department of Family Medicine to bring you an educational conference on MACRA that will get into the nuts and bolts of how you need to prepare your practice for the new model of payment. Please

stay tuned for the details and be sure to attend.

The following is information that the AAFP released in June on MACRA:

- *The AAFP continues to support the core reforms set forth in MACRA.*
- *We believe this law, at its core, is designed to strengthen primary care and make primary care a strong foundation for payment and delivery reform for physician services under Medicare. We support numerous provisions included in the regulation.*
- *Overall, we applaud CMS for identifying and adhering to the fundamental provisions of the law. In general, CMS accurately identified the key elements of the law:*
 - *Create a streamlined quality and performance program inside the fee-for-service system. Create opportunities for physicians to participate in alternative payment models.*
- *We also believe that CMS has made some effort to simplify the program and to eliminate the pass/fail evaluation processes although, again, we think much work remains. While our support for MACRA remains strong, we see a strong and definite need and opportunity for CMS to reconsider the approach to this proposed rule which we view as overly complex and burdensome to our members and indeed for all physicians.*
- *We also call on CMS to issue an interim final rule with comment period so the AAFP can continue to work with CMS to ensure that this law is successful.*

- *We remain concerned that a January 1, 2017, start date does not provide adequate time for education and practice adjustments that will be required to ensure the successful implementation of the quality payment programs in a majority of family physician practices. We call on CMS to prolong the start of the performance period until at least July 1, 2017.*

And speaking of new methods of payment, I recently received a call from a CAFP member asking how the ballot initiative Amendment 69 ColoradoCare would affect family medicine physicians. Mark Matthews, MD, a primary care physician who is working on ColoradoCare had this to say:

The calculations that determined the premium tax are based on provider compensation of 133% of Medicare. However, a predetermined compensation rate is purposely left out of Amendment 69 to allow for adjustments as time goes on. Since all residents will be covered there will no longer be a need for charity care with the compensation for Medicaid patients being the same as for everyone else.

ColoradoCare has a mandate to provide universal continuous health care and will make sure that compensation rates are attractive in order to keep our current health care workforce and add to it.

More information can be found in the following ColoradoCare document: <http://www.coloradocare.org/wp-content/uploads/2016/05/ColoradoCare-and-Providers-5.22.16-complete.pdf>.

continued on next page >>

<< continued from previous page



Colorado Primary Care Collaborative

The CAFP is working with the steering committee and supporters of the Colorado Primary Care Collaborative (CPCC) on more payment reform initiatives. Two chairs have been chosen to lead the CPCC, Scott Hammond, MD, and Archie Villavert, MD, and a new strategic plan has been developed.

The new mission statement of the CPCC is as follows: The Colorado Primary Care Collaborative (CPCC) is dedicated to advancing primary care via the patient-centered medical home (PCMH) and other value-based primary care models by focusing on delivery reform, payment reform, patient engagement, workforce

training, and benefit redesign.

The new CPCC Strategic Plan is as follows:

GOAL 1: Educate employers: Support PCMH & provide PMPM

A. Educate employers on the value of primary care and viable options for payment reform to achieve the Quadruple Aim. Create a fact sheet for employers to take to health plans with the following requests:

1. Ask for a wrap-around insurance product for Direct Primary Care (DPC), such as a catastrophic insurance plan.
2. Ask payers to pay PMPM to encourage Primary Care to become PCMHs/Advanced Primary Care.

Dan Burke, MD, and Scott Hammond, MD, have agreed to co-chair this workgroup.

GOAL 2: Advocate for Payment Reform

A. Develop a policy campaign to go to government with the following requests:

1. Create regulations to make Colorado friendlier towards DPC. The aim of legislation passed in the 17 other states is to define DPC outside the scope of insurance. Thus, DPC is not regulated as insurance.

Clint Flanagan, MD, and Lisa Davidson, MD, have agreed to help with this policy work.

2. Increase the Primary Care dollar – reinvest in Primary Care. The CPCC steering committee is following other national organizations in asking that 15% of the health care dollar go to Primary Care. We have submitted a request to CIVHC to produce a report on current primary care spending in Colorado.

Bert Miuccio, CEO of HealthTeamWorks, will serve as the liaison for this committee regarding the research report.

GOAL 3: Advocate for all Coloradans to access health care through PCMH or other value-based models

A. Request that the Governor follow Ohio’s lead and mandate that all state employees get health care in advanced primary care practices.

These are exciting goals and we hope that you will participate on one of these subcommittees. Please contact me at raquel@coloradoafp.org if you are interested in one of these strategic areas. We need your help.

InnovAge congratulates **DR. MARY FAIRBANKS**

2016 CAFP Family Physician of the Year

Dr. Fairbanks is one of the healthcare experts with InnovAge PACE—Program of All-inclusive Care for the Elderly—who provides interdisciplinary and coordinated medical care. InnovAge PACE can be an excellent option for individuals with limited financial resources or declining ability to perform activities of daily living.

Learn more at MyInnovAge.org or 888.992.4464



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



The 2016 Legislative Session concluded on May 11th, 2016 after a total of 686 bills were introduced. Major topics included enterprising the Hospital Provider Fee which would have freed up room in the state budget, construction defects laws, a \$3.5 billion transportation bond proposal, liquor sales in grocery stores, and workforce development. CAFP was active on a number of healthcare-related bills and our two priority bills passed successfully this year.

- office visits
- preventive visits
- immunizations
- counseling and health risk assessments
- neonatal critical care.

CAFP maintains that rates should be on par with Medicare and that we need to make the bump permanent beyond June 2017. We have already begun meeting with the Governor's Office, State Budget Director and Medicaid Department to discuss a path forward. Sustainable funding is essential to ensuring patients have access to vital primary care services and that family physicians and practices are compensated fairly into the future.

Rural Preceptor Tax Credit: HB16-1142

After two years of pushing for legislation to secure a tax credit for family physicians who precept medical students, we were successful this year. CAFP led the charge in concert with the Colorado Rural Health Center, CU School of Medicine and others to get a \$1,000 tax credit for rural preceptors in primary care. See the Rural Corner section of the magazine for more on the credit and how to qualify.

Bills CAFP Supported

The following bills were supported by CAFP. Unless otherwise noted, these bills passed and were signed into law by the Governor. A complete list of legislation tracked by CAFP is available by logging in on the CAFP website at: www.coloradoafp.org/advocacy/legislation

- **HB16-1047 Interstate Medical License Compact:** authorizes the Governor to enter into a compact with other states to enable physicians licensed in a compact member state to obtain an expedited license, enabling them to practice medicine in Colorado or another member state.
- **HB16-1142 Rural and Frontier Healthcare Preceptor Tax Credit:** Creates a \$1,000 personal income tax credit per year on or after Jan. 1, 2017 for health care professionals who serve as a preceptor during the applicable income tax year. The tax credit is available to a taxpayer practicing primary care in a rural or frontier area during the portion of the tax year the credit is being claimed. The number of tax credits is capped at 200 for any one income tax year.



CAFP Priority Legislation

Medicaid Reimbursement Rates “Medicaid Bump”

Our top priority, as you have seen before, was maintaining enhanced rates for primary care providers under Medicaid. While primary care rates have been on par with Medicare since 2013, the state proposed to slash them to 75% of Medicare. CAFP led the newly formed Primary Care Alliance to urge the legislature to avoid these cuts. Hundreds of CAFP members took action through our member survey, contacting their legislators, and lobbying during CAFP Day at the Capitol to fight against these cuts. We secured one-time state funds of \$20 million (\$56 million including federal matching dollars), avoiding the deepest cuts but effectively setting primary rates at 87.3% of Medicare.

The funds will be targeted to certain primary care codes and will be in effect from July 1, 2016 – June 30, 2017:

- **HB16-1390 Immunity When Overdoses Reported:** Under current law, a person who reports an emergency drug or alcohol overdose event is immune from criminal prosecution if certain conditions are met. This bill extends that immunity to the victim of overdose. Additionally, the bill sought to extend this immunity to an underage person in need of such medical assistance from a marijuana overdose.
- **HB16-1407 Extend Medicaid Payment Reform & Innovation Pilot:** HB-1407 permits the Medicaid Payment Reform and Innovation Pilot Program to continue on an ongoing basis. This pilot program established Medicaid PRIME through Rocky Mountain Health Plans on the Western Slope. Additionally, the bill authorizes additional innovative pilots and CAFP worked to ensure it would permit a potential Medicaid Direct Primary Care pilot.
- **HB16-1408 Cash Fund Allocations for Health-Related Programs:** In addition to funding health programs facing declining revenues from the Tobacco Master Settlement Agreement (Colorado Health Service Corps, HIV prevention), HB-1408 addresses the Primary Care Provider Medicaid Rate Bump. It allocates \$20M from the CHP+ Trust Fund and federal matching funds of \$36M (\$56M total) to significantly reduce the cut that would otherwise occur for certain primary care reimbursement codes. Funds are targeted to primary care office visits, preventive visits, immunization administration, health screening services, and newborn care.
- **SB16-027 Medicaid Option for Prescribed Drugs by Mail:**

Previously, most Medicaid patients were unable to fill prescription drug orders by mail. This bill gives patients the option to fill prescriptions for chronic conditions by mail, without higher copayments.

- **SB16-135 Collaborative Pharmacy Practice Agreements:** Changes the way collaborative pharmacy practice agreements are created between a licensed pharmacist and a physician or advanced practice nurse. Allows a pharmacist to provide evidence-based health care services to one or more patients pursuant to a specific treatment protocol delegated to a pharmacist by a physician or advanced practice nurse. Additionally, it creates an avenue for the Board of Pharmacy to establish state wide protocols for pharmacists to use, once approved by the Board of Medicine, the Nursing Board and the Board of Public Health. CAFP amended the bill to ensure any rules must be approved by the Board of Medicine and to ensure any treatments and services provided by a pharmacist are communicated back to the primary care physician in the patient's medical home.
- **SB16-158 Physician Duties Delegated to Physician Assistant:** Clarifies and expands how physicians and physician assistants (PA) work together within the Colorado Medical Practice Act. The bill clarifies what duties a physician may delegate to PA within his or her scope of practice, improving access to care in underserved communities within the structure of the act, and retaining physician supervision and delegation of PA activities.
- **SB16-169 Emergency 72-hour Mental Health Procedures:** *Vetoed by Governor.* Colorado

statute currently specifies that a person who is placed on an emergency hold may be taken to a facility designated by the executive director of the Department of Human Services for a 72-hour mental health hold for treatment and evaluation; however, designated facilities are often not available and patients are often held in jails without appropriate healthcare services. The bill attempted to prioritize the facilities where a patient should be taken and define the terms under which these individuals may be taken to such facilities. The bill was vetoed by the Governor due to concerns from the Office of Behavioral Health, however the veto statement directs the Department to establish an interim taskforce to find a resolution.

- **HB16-1164 Transfer Immunization Exemption Duties to CDPHE:** *Failed on House Floor.* This bill aimed to centralize immunization exemption reporting at the Colorado Department of Public Health and Environment, rather than continuing administration by schools and local public health agencies. CAFP supported the bill to enhance immunization exemption data collection, as Colorado has some of the lowest immunization rates in the country.
- **HB16-1294 Contraception Coverage Public & Private Insurance:** *Failed in Senate State Affairs Committee.* This bill would have required health plans to cover each method of birth control available without cost sharing for the patient. While CAFP held that coverage for such services would ensure that

continued on page 10 >>

<< continued from page 9

physicians and patients were the ones making healthcare decisions, opponents of the bill were not supportive of the proposed benefit mandates.

- **HB16-1322 Health Coverage Prescription Contraceptive Supply:** *Failed in Senate State Affairs Committee.* This bill would have required health plans to reimburse providers for dispensing contraceptives up to a 12-month supply, rather than the current 3-month maximum.
- **HB16-1420 CO Healthcare Affordability & Sustainability Enterprise “CHASE Hospital Provider Fee Enterprise”:** *Failed in Senate Finance Committee.* Hospitals pay the provider fee into a cash program overseen by the Department of Health Care Policy and Financing (HCPF), enabling Colorado to draw down federal matching funds. These additional dollars are used to support Medicaid coverage for over 400,000 vulnerable Coloradans. This bill sought to change the program into an enterprise under TABOR, thus removing the revenue from the state’s revenue cap. The bill would have restored a \$73 million cut to hospitals to cover uncompensated care – particularly critical access hospitals. It would have also prevented cuts in future years to roads, K-12, and higher education. Continuing the fee in its current structure will also squeeze the state General Fund and potentially impact future Medicaid funding. This bill was the Governor’s and state Democrats’ top priority, and was sponsored by Republican Senator Larry

Crowder (Alamosa). However, Republican Senate leadership was opposed to the proposal due to concerns that it skirted TABOR.

Bills CAFP Opposed

CAFP took a thoughtful approach to the legislation we opposed. CAFP’s lobbying team was able to amend several bills that we initially opposed, thus moving us into a neutral or support position (SB16-135, for example). We were also reserved in putting CAFP resources toward opposing legislation that had a high likelihood of failing.

- **HB16-1113 Protect Human Life at Conception:** *Failed.* CAFP opposed this bill because it would have criminalized the actions of a physician providing women’s health services, including for providing contraceptives such as IUDs, and exposed physicians to prosecution for a class 1 felony.
- **HB16-1218 A Woman’s Right to Accurate Health Care Info:** *Failed.* This bill would have established a new series of criteria required to be met by patients and by physicians providing women’s health services and abortions. CAFP opposed this bill because it would have criminalized the actions of a physician, creating a cause of action and exposing physicians to three times the amount of actual damages.
- **SB16-152 Changes and Notices For Health Care Services:** *Failed.* This bill would have created new requirements for carriers and providers to provide consumers with certain information for out-of-network services. CAFP opposed the bill primarily because it expanded the value of a lawsuit by creating

a private cause of action for plaintiffs against physicians for deceptive trade practices, thus exposing physicians to three times the amount of actual damages (treble damages).

Bills Actively Monitored

- **HB16-1360 Continuing Regulation of Direct-Entry Midwives:** Implements the recommendations of the Department of Regulatory Agencies: the regulation and registration of DEMs by DORA will continue for seven years, and DEMs may not perform operative or surgical procedures. The executive director of DORA is required to convene a working group, consisting of individuals with expertise in risk management and knowledge in the practice of midwifery, to investigate the means to manage risks in the practice of midwifery. The American Congress of Obstetricians and Gynecologists took the lead on negotiating this bill. CAFP had two outstanding concerns with the final bill version and attempted to amend it along with the Colorado Medical Society. CAFP’s amendments would have precluded midwives from performing vaginal births after cesarean (VBACs) and second degree sutures. However, these amendments failed in committee and the bill was signed into law without these proposed restrictions.

I want to acknowledge CAFP’s lobby team, Jeff Thormodsgaard and Katie Wolf, for their tremendous work to represent and promote family medicine at the state legislature. They elevate our priorities with legislators and leaders across state government.

CAFP ON THE GO



Governor John Hickenlooper signs House Bill 1142, which creates a tax credit for primary care preceptors in rural communities.



Dr. Robert "Buz" Bricca of Durango testifying in support of House Bill 1142.



CAFP CEO Raquel Rosen receives the pen used to sign House Bill 1142.



Governor John Hickenlooper signs House Bill 1408, the funding vehicle for enhanced Medicaid primary care rates.



CAFP staff members joined Dr. Caroline LeClair to discuss ways to bring more family medicine preceptors to rural communities in Colorado.



Colorado family physicians Dr. Glenn Madrid and Dr. Jeff Cain, and Ryan Biehle of the CAFP, met with Senator Michael Bennet during the Family Medicine Congressional Conference.



Colorado attendees met with Senator Cory Gardner during the Family Medicine Congressional Conference.



Colorado family medicine leaders attended the 2016 National Conference of Constituency Leaders in Kansas City.



Colorado attendees met with Representative Mike Coffman during the Family Medicine Congressional Conference.



CAFP staff met with student family medicine leaders at Rocky Vista University College of Osteopathic Medicine.



Welcome to the new CAFP board members who were installed at the Annual Summit in April!!



CAFP President Jamaan Osbourne-Roberts testifies on Senate Bill 158, clarifying duties delegated by physicians to physician assistants.

WE'RE CHANGING THE GAME in heart care

UCHealth is the only system in the state to offer the WATCHMAN™ Device

Reduce the risk of stroke without anticoagulants

Now your non-valvular atrial fibrillation patients have an alternative to long-term warfarin therapy for stroke risk reduction with the WATCHMAN Device, only offered at UCHealth.

Call to refer

Medical Center of the Rockies
Loveland

970.460.2255

University of Colorado Hospital
Aurora

720.709.2996



uchealth.org/watchman-implant



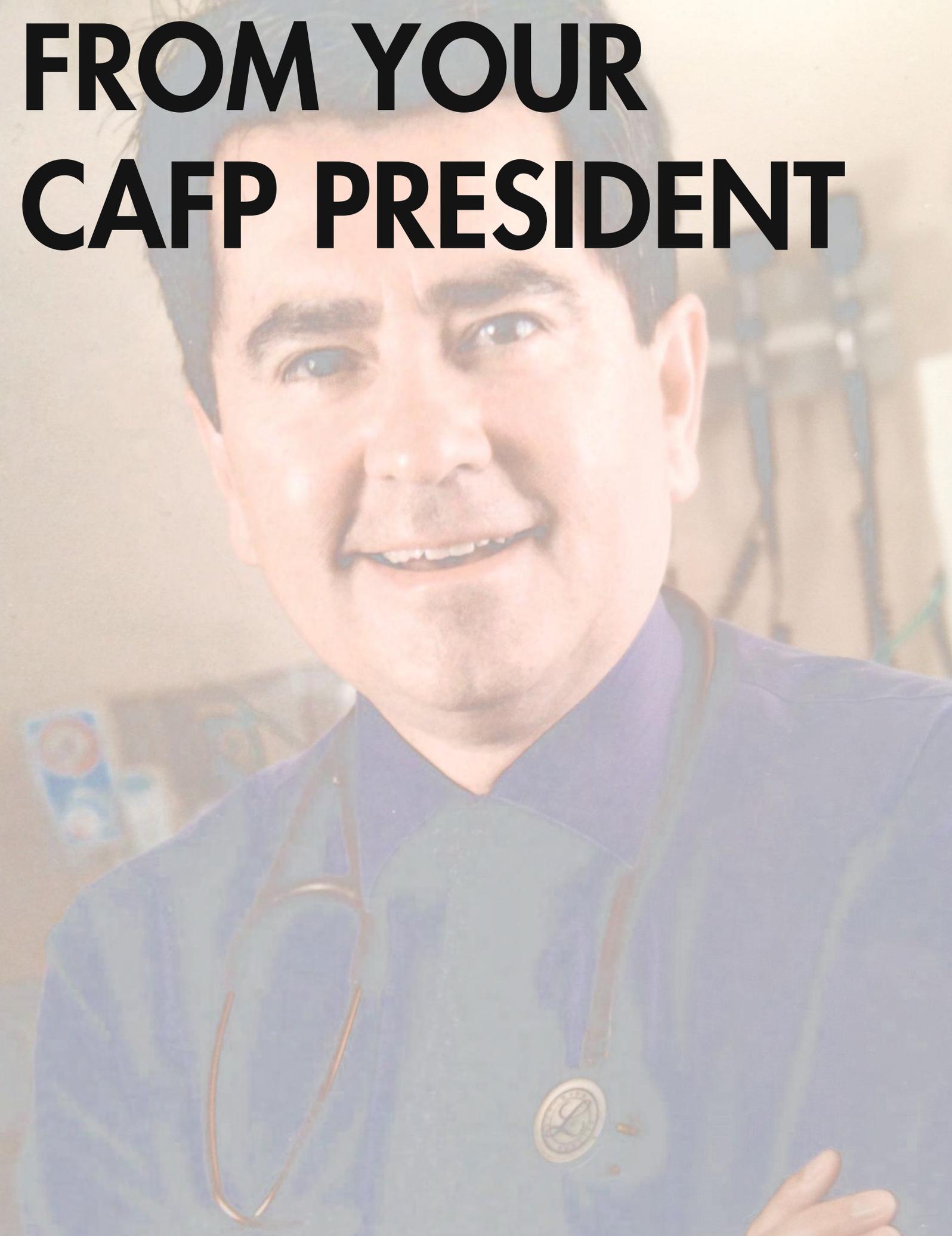
COLORADO ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR COLORADO

2015 ANNUAL REPORT



FROM YOUR CAFP PRESIDENT



The Colorado Academy of Family Physicians continues to remain a strong organization representing the family physician in education and practice development, advocacy as well as health of the public. I am pleased to present the Academy's 2015 annual report.

In 2015, the AAFP held the annual Congress of Delegates and the FMX (Family Medicine Experience) in Denver. This was a terrific week of CME and networking with fellow family physicians in our back yard. And true to Colorado, we were proud to have John Bender, MD, FAAFP elected to the AAFP Board of Directors. He will undoubtedly represent us well on a national level. We of course held our Annual Scientific Conference in Colorado Springs at the beautiful Cheyenne Mountain Conference Center in April. It continues to be a wonderful experience in its own right and is well attended. Your academy continues to be very active and a leader nationally in efforts to promote family medicine. Efforts include issues related to practice transformation and payment reform. Leaders are sent regularly to Washington DC to discuss important legislative topics with your US Senators and Representatives. In addition, leaders convened in Kansas City at the Annual Chapter Leader Forum as well as the National Conference of Constituency Leaders. We were able to advance professional and leadership development as well as continue policy development on a national level. We continue to be active with the Doctor of the Day at the state capitol. This very important opportunity allows all family physicians to interact directly with your legislators.

The CAFPP continues to be active in the Colorado Primary Care Collaborative (CPCC), a collection of stakeholders including providers, payers and hospital systems, to advance continued efforts for payment reform and practice transformation. I was honored to be selected by Governor Hickenlooper to sit on the SIM (State Innovation Model) advisory board. SIM as you may know is a \$65 million grant to Colorado to integrate primary care and behavior health. Your Director of Policy Ryan Biehle also sits on a working group for SIM which will be instrumental in transforming how we practice along with our behavior health specialists.

Your Academy continues to be financially sound. Please be assured that your annual dues are being used with great intention, care and responsibility. Membership continues to grow with over 2300 total members in the state, which represent over 80% of family physicians in the state. This qualifies Colorado as a "large" chapter (small, medium, large, extra large). We boast 100% family medicine resident membership and have an ever growing medical student membership. We have several social gatherings for students at both University of Colorado and Rocky Vista medical schools as well as for all residents.

I would personally like to thank every member of the CAFPP as well as the CAFPP board. Your continued support of the Academy's efforts is a tremendous investment in the future of family medicine and frankly in the future of our nation's health care system success. Please consider joining any and all efforts of the CAFPP.

Sincerely,
Glenn Madrid, MD



2015 MEMBERSHIP STATISTICS

2,302 Members

1,562 Active Members

206 Resident Members

366 Student Members

143 Life Members

22 Inactive Members

3 Supporting Members

COLORADO ON THE NATIONAL STAGE



COLORADO REMAINS ONE OF THE MOST INNOVATIVE STATES IN THE NATION FOR FAMILY MEDICINE. THE PHYSICIANS AND PRACTICES MAKING WAVES HERE ARE RECEIVING NATIONAL ATTENTION, AND FOR GOOD REASON. FROM THE PRIMARY CARE TEAMS ON THE WESTERN SLOPE REDUCING COSTS WHILE IMPROVING CARE, TO TRAILBLAZING PHYSICIANS ALONG THE FRONT RANGE EXPERIMENTING WITH NEW MODELS OF PAYMENT LIKE DIRECT PRIMARY CARE, THE #FMREVOLUTION IS ALIVE AND WELL IN OUR STATE.

SHARING EXPERIENCES

The national Health is Primary campaign stopped in Denver in conjunction with the October FMX conference. Physicians and other primary care leaders from across the state gathered to share their stories of success, and discuss what it will take to move primary care forward in our state, and in our country. The panel discussions, moderated by Colorado's T.R. Reid, featured local leaders including Clint Flanagan, MD, Cissy Kraft, MD and Luke Casias, MD (pictured).

Reid, featured local leaders including Clint Flanagan, MD, Cissy Kraft, MD and Luke Casias, MD (pictured).

Photo copyright 2016 Chris Crawford /AAFP News



ELECTED

Dr. John Bender of Ft. Collins was elected to the American Academy of Family Physicians Board of Directors during the Congress of Delegates in September. Having a voice from Colorado on the national Academy's board means that the concerns and challenges of Colorado family physicians and patients are understood and tackled by national leaders. Congratulations to Dr. Bender!



NATIONALLY RECOGNIZED

Dr. Glenn Madrid of Grand Junction (pictured in purple tie) was invited to the White House to meet with President Obama in recognition of the significant work his practice has done to reduce costs while improving the quality of care patients receive. Because of Colorado's success with programs like the Transforming Clinical Practice Initiative (TCPI) and the Accountable Care Collaborative, additional programs, like the State Innovation Model (SIM), continue to be made available.

Photo copyright 2015 The White House



THE FUTURE OF FAMILY MEDICINE



SUPPORTING THE NEXT GENERATION OF FAMILY PHYSICIANS IS A TOP PRIORITY FOR THE COLORADO ACADEMY OF FAMILY PHYSICIANS. BY ENGAGING WITH STUDENTS FROM THE UNIVERSITY OF COLORADO SCHOOL OF MEDICINE AND ROCKY VISTA UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE, AND RESIDENTS IN THE NINE FAMILY MEDICINE RESIDENCY PROGRAMS ACROSS THE STATE, WE HELP FOSTER NOT JUST THE NEXT GENERATION OF FAMILY PHYSICIANS, BUT THE NEXT GENERATION OF FAMILY MEDICINE LEADERS. AS COLORADO CONTINUES TO ATTRACT THE BEST AND BRIGHTEST, WE REMAIN #FAMMEDSTRONG.

LEARNING WITH LEADERS

Choosing family medicine isn't always the easiest path in medical school. That's why CAFP works to connect students interested in primary care with practicing family physicians. This year, over 50 medical students joined CAFP leaders at Dry Dock Brewery for a Brew & Chew to discuss why family medicine matters, what the future of family medicine is, and why students should have a passion for it.



STUDENT & RESIDENT CONNECTIONS

Family medicine residents are some of the most helpful resources for medical students. As they begin their careers in family medicine, with memories of Match Day still fresh, they are a great influence for those feeling inspired by primary care. In October, the CAFP hosted a Nosh & Gather in Denver's RiNo neighborhood where students and residents were able to network and discuss what makes family medicine great.



EXPANDING EDUCATION

CAFP worked with the family medicine student groups at CU and RVU to bring family medicine experts into the classroom for discussions on topics not covered in typical curriculum, but that are important to the next generation of doctors all the same. With presentations ranging from marijuana to LGBT medicine to financial management, students got an extra dose of learning over their lunch hours.



ADVOCATES FOR CHANGE



PROTECTING THE FUTURE OF FAMILY MEDICINE DEMANDS LEGISLATIVE ACTION. FROM PAYMENT REFORM TO PRESERVING THE SCOPE OF FAMILY MEDICINE, THE CAFP IS ON THE FRONTLINES, DETERMINING WHERE POLICY IN OUR STATE NEEDS TO GO, AND FIGHTING FOR WHAT IS RIGHT FOR FAMILY PHYSICIANS. BE IT THE PUBLIC OR PRIVATE SECTOR, INDIVIDUAL LEGISLATORS OR LARGE ORGANIZATIONS, THE CAFP ENSURES FAMILY MEDICINE HAS A SEAT AT THE TABLE AND DECISION MAKERS KNOW THAT IN COLORADO, #HEALTHISPRIMARY.

SHAPING THE FUTURE

In June, the Colorado Primary Care Collaborative (CPCC) brought together leaders from all corners of healthcare, including physicians, legislators, public and private payers, researchers, educators and more. The conversation was all about primary care in our state—where are we, and where do we need to go? The discussion helped to formulate what actions the CPCC, CAFP, and other supporters will need to take to make primary care in our state the strongest in the country.



MAKING OUR VOICES HEARD

When legislators are making healthcare policy decisions, they need to hear the voice of the family physician. CAFP members frequently testify during the legislative session on a broad range of issues, from tobacco cessation to payment reform, and many issues in between. Because of CAFP’s strong presence at the Capitol, our physicians are heard and respected at the legislature.



A CENTRAL FOCUS

In February, leaders from the CAFP and other Colorado primary care organizations met with Kyle Brown, PhD, a senior health policy advisor in the office of Governor John Hickenlooper. As statewide healthcare decisions are made, and opportunities like the State Innovation Model become available, primary care must be at the center of these discussions, so policymakers understand that family physicians are indeed the center of our greater healthcare system.



A LOCAL FAMILY MEDICINE MOVEMENT



WELCOME TO
COLORFUL
COLORADO

CHAMPIONING OUR MEMBERS AND THE HEALTH OF ALL COLORADANS ARE TWO OF THE CORNERSTONES OF THE CAFP. STUDENTS WELCOME FAMILY PHYSICIANS INTO THEIR CLASSROOMS TO LEARN MORE ABOUT THE DANGERS OF TOBACCO, AND AFTERWORD CREATE POSTERS WITH MESSAGES OF HEALTHY LIVING. THE CAFP AWARDS ARE AN OPPORTUNITY TO CELEBRATE THE PHYSICIANS AND PRACTICES CHANGING PATIENTS' LIVES FOR THE BETTER. AND THE ANNUAL SCIENTIFIC CONFERENCE IS A WAY FOR US ALL TO GATHER AND LEARN WITH EACH OTHER. OUR MEMBERS ARE PROOF THAT IN COLORADO, WE #MAKEHEALTHPRIMARY.

TAR WARS WINNERS

Colorado students continue to enjoy Tar Wars presentations in their classrooms, and the annual poster content that goes along with it. The 2015 winner was Joshua Jeffers from Saints Peter and Paul School, with his global themed poster pictured below. In second place was Molly Merrill from Aspen Creek Pre K-8, and in third place was Marley Cristillo from Chipeta Elementary School. Honorable mentions went to Sophie Christopher from Aspen Creek PreK-8, Keira Peterson from Aspen Creek PreK-8, and Porscha Jacobs from Idalia Elementary School.



2015 CAFP AWARD WINNERS

The CAFP recognized exceptional physicians and practices in 2015. The 2015 CAFP Award Winners included Elias Hernandez, MD, Family Physician of the Year (pictured below), Leah Cooper, MD, Teacher of the Year, Kari Mader, MD, Resident of the Year, and University Family Medicine of Westminster and Boulder, Patient-Centered Medical Home Best Practice of the Year.



CAFP ANNUAL SCIENTIFIC CONFERENCE

In April, family physicians, medical students, family medicine residents and other primary care professionals from across the state gathered in Colorado Springs for the CAFP Annual Scientific Conference.

The extended weekend of education and networking included presentations on some of the hottest topics in Colorado, including opioids, immunizations, and marijuana.

Attendees also took part in family-friendly activities, like a super hero themed exhibit hall, square dancing lessons, and a family dinner.



CAFP BOARD OF DIRECTORS

Officers

Chair/Past President

Candace Murbach, DO, Pueblo

President

Glenn Madrid, MD, Grand Junction

President-elect

Tamaan Osbourne-Roberts, MD, Denver

Vice President

Monica Morris, DO, Denver

Secretary/Treasurer

Anna Wegleitner, MD, Denver

Member-at-Large

Brian Hill, MD, Castle Pines

External Relations/Awards Committee Chair Rick Budensiek, DO, Greeley

Term Expiring 2016

Michael Archer, MD, Westminster

John Cawley, MD, Ft. Collins

Virginia Richey, MD, Denver

Wendy Richmond, MD, Pueblo

Term Expiring 2017

Carolynn Francavilla Brown, MD, Denver

Anneliese Heckert, DO, Pueblo

Brian Hill, MD, Castle Pines

Emma Stout, MD, Pueblo

Term Expiring 2018

Craig Anthony, MD, Denver

Monica Morris, DO, Denver

Laurie Patton, MD, Parker

Zach Wachtl, MD, Denver

Delegates

John Bender, MD, Ft. Collins

Kent Voorhees, MD, Littleton

Alternate Delegates

Brian Bacak, MD, Highlands Ranch

Rick Budensiek, DO, Greeley

Resident Representatives

Aaron Shupp, MD, 2016, Pueblo

Kaitlyn Christopher, MD, 2016, St. Anthony North

Christine Horstmeyer, MD, 2016, St. Anthony North

Brian Juan, MD, 2017, Pueblo

Syed Gillani, DO, 2017, Pueblo

Student Representatives

Netana Hotimsky, RVU, grad 2016

Maggie Reinsvold, CU, grad 2016

Lindsey Herrera, CU, grad 2018

Grace Borton, RVU, grad 2017

Joshua Told, RVU, grad 2017

CAFP STAFF



Raquel Rosen
CEO
raquel@coloradoafp.
org



Lynlee Espeseth
*Director of
Communications,
Marketing &
Membership*
lynlee@coloradoafp.org



Erin Watwood
*Director of Education,
Events & Meetings*
erin@coloradoafp.org



Ryan Biehle
*Director of Policy &
Government Relations*
ryan@coloradoafp.
org

CONNECT WITH US



twitter.com/COAFP



facebook.com/coloradoafp



coloradoafp.org/blog

Colorado Academy of Family Physicians
2224 S. Fraser St. #1, Aurora, CO 80014
303-696-6655
www.coloradoafp.org





BACK IN MOTION.

Everyday mobility and function is critical to quality of life. At University of Colorado Hospital's Orthopedics Department, your patients can expect timely appointments and access to our fellowship-trained physicians whose highly specialized knowledge allows more accurate diagnosis and treatment. From head to toe, we help hundreds of patients each year by reducing pain and regaining function while delivering award-winning care.

For a consult, transfer or direct admit, please call DocLine toll-free at **1.844.285.4555**. To refer a patient to one of our clinics, please contact the preferred clinic directly.



**University of
Colorado Hospital**
UNIVERSITY OF COLORADO HEALTH



Orthopedics
UNIVERSITY OF COLORADO

Aurora/Anschutz Medical Campus • Boulder • Denver/Cherry Creek
Denver/Lowry • Lone Tree



Brought to you by the Orthopedics Department
at University of Colorado Hospital—

RANKED #1 IN COLORADO.

Proud to be ranked among 5280's Top Docs.



William C. Anderson III, MD

Allergist and Co-Director of the Multidisciplinary Asthma Clinic, Children's Hospital Colorado

Assistant Professor of Pediatrics, University of Colorado School of Medicine



When Your Patient's Asthma Controller Isn't in Control: Troubleshooting Pediatric Asthma in School-Aged Children

First, do I have the correct diagnosis?

With asthma being the most common chronic illness of childhood, a familiar approach for a patient initially presenting with episodic wheezing or cough is an empiric trial of albuterol or inhaled corticosteroids. However, when a patient is not responding to standard or escalating controller or quick relief therapy, other etiologies must be considered (Table I).

History can guide the diagnosis of asthma, and objective measures can confirm it. Spirometry can provide an assessment of lung obstruction and bronchodilator reversibility. Within an allergist or pulmonologist's office, a fractional exhaled nitric oxide level (FeNO) can provide evidence of lower airway eosinophilic inflammation, and a bronchoprovocation test can assess airway hyperresponsiveness.

Is my patient's asthma well controlled?

National Heart, Lung, and Blood Institute Expert Panel 3 guidelines (<http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines>) provide a roadmap to pediatric asthma management. Asthma severity and subsequent treatment "step" choice is based both on the impairment domain (daily symptoms, nocturnal symptoms, albuterol use, activity limitation) and on the risk domain (number of exacerbations per year requiring steroids). Children with well controlled asthma need albuterol during the day less than twice per week, wake at night with symptoms less than twice per month, and receive steroids less than twice per year.

Did I pick the best controller for my patient?

When initiating a controller at step 2 in school-aged children, low-dose inhaled corticosteroids have been shown to improve asthma control, albuterol use, and pulmonary lung function responses more than leukotriene receptor antagonists. Those children most likely to respond to inhaled corticosteroids have markers of allergic inflammation including elevated total eosinophil counts, serum IgE, and FeNO.

When escalating therapy at step 3, most school-age children have a preferential response to the addition of a long-acting beta agonist to a low dose inhaled corticosteroid compared to an increasing dose of inhaled corticosteroid or the addition of a leukotriene receptor antagonist. Race and the presence of eczema can further predict which treatment option is best for patients (Table II).

Is my patient actually taking their controller?

Adherence to controller therapies in pediatric patients is low. A study showed only 20-30% adherence to inhaled corticosteroids, with only 4-5 prescription refills per year. Self-reporting of adherence is no better with a 30% discrepancy between reported and objective controller use in one study of school-aged asthmatics. Pharmacy refill rates are one way to assess adherence but has its own limitations, as filling the prescription does not equate with use. Electronic monitoring devices (EMDs) are a new approach to monitoring adherence through objective, real time data on medication use. EMDs can also provide patient reminders and feedback on medication use. If poor adherence is confirmed, the provider must address the underlying reasons for poor adherence in order to rectify it (Table III).

If my patient is taking their controller, are they using it correctly?

Controller and quick relief medication use can be confusing with several delivery devices available, emphasizing the need to educate patients on appropriate technique for each device. Spacers are recommended for use with all metered dose inhalers (MDIs), regardless of age (Figure 1). A recent study indicated that while over 90% of patients had a healthcare provider explain the use of a spacer, less than 4% of patients and families could perform the essential steps to ensure proper spacer use with an MDI. The use of spacers with an MDI can reduce oropharyngeal drug deposition below 6% compared to 30-70% without a spacer.

What co-morbidities could be impacting my patient's asthma?

Poor asthma control may stem from associated co-morbidities (Table IV). Up to 85% of children with asthma are atopic, and 40% of pediatric patients have allergic rhinitis. Tree, grass, and weed pollen sensitivity can contribute to variability in asthma control, especially during peak pollen and respiratory viral seasons (Figure 2). Animal dander is a common perennial allergen that can lead to poor asthma control due to persistent airway inflammation. Contrary to popular belief, there is no such thing as a hypoallergenic dog. Families can employ avoidance strategies to minimize allergen exposures (Table V).

Compared to asthmatic children without secondhand smoke exposure, children with asthma and secondhand smoke exposure are more likely to be hospitalized, present to the emergency department, wheeze, and demonstrate lower lung function. Smoking cessation should be offered to every smoking caregiver.

Am I addressing psychosocial factors that may be impacting my patient?

Recent studies show that psychosocial factors explain poor asthma control in over 50% of children seen in a subspecialty asthma clinic for poor control. Financial constraints can limit access to medications or prohibit environmental control interventions. Chaotic and stressful home environments often disrupt routine medication administration and may make attending appointments difficult. Working with social workers or providing community resources to your patient's family in these situations may improve their asthma management more than any escalation of therapy.

When should I refer my patient to an asthma specialist?

Asthma specialists can be allergists or pulmonologists. Family medicine physicians can consider referring any child who has poorly controlled disease despite medium dose inhaled corticosteroids or above, as those patients are at increased risk for medication side effects and severe exacerbations (Table VI). Allergists should be involved when a patient's asthma is poorly controlled due to allergic triggers or when they have other atopic conditions. Pulmonologists should be involved when the diagnosis is unclear, especially under the age of 2 years, as the differential for recurrent wheeze and cough is broad.

continued on page 30 >>



University of Colorado
Anschutz Medical Campus
School of Medicine – Department of Family Medicine
University of Colorado Family Medicine Clinics
Senior Instructor/Assistant Professor – Physician

Family Physicians wanted in beautiful Colorado!

The Department of Family Medicine at the University of Colorado Denver Anschutz Medical Campus is seeking Board Certified/Board Eligible full-time family physicians for our clinical practices located in the Boulder, Westminster, Lone Tree (South Metro) and Stapleton areas.

Recognized nationally as a leader in family medicine, the Department of Family Medicine is dedicated to achieving the Triple Aim and helping our patients become healthier through education, patient care, research, and community partnership.

Our clinics are certified as Patient Centered Medical Homes and are undergoing practice re-design focusing on exemplary patient-centeredness and a superior patient experience.

KEY POSITION ESSENTIALS:

- Full time providers provide 32 hours/week of clinical care
- We have a fully integrated Electronic Medical Record through EPIC
- The University offers a generous benefits package, including insurance, time off, and retirement benefits.
- Clinical site renovations are ongoing or completed at each location
- Pharmacy and care management support
- Teaching opportunities with students and residents

Two years of practice experience in ambulatory and Patient Centered Medical Home/Integrated Practice settings is preferred. Individuals with other clinical or practice experience will be considered.

Job descriptions and openings can be found at www.cu.edu/cu-careers (search "family medicine")

Find out more about future opportunities within the Department of Family Medicine by providing a letter of interest and a Curriculum Vitae to:

Brian Bacak, MD, FAAFP
Associate Vice-Chair for Clinical Affairs
Mail Stop F496
12631 East 17th Avenue Aurora, CO 80045
brian.bacak@ucdenver.edu

"The University of Colorado Denver and Health Sciences Center requires background investigations for employment."
"The University of Colorado is committed to diversity and equality in education and employment."

<< continued from page 29

What is the Multidisciplinary Asthma Clinic (MAC) at Children’s Hospital Colorado?

The MAC provides a comprehensive, team-based approach to the care of difficult-to-treat and severe asthmatics. Patients will have a dedicated team of providers including Allergy, Pulmonary, and Social Work, with access to Speech Therapy, Nutrition, and Psychology as needed. This team will be able to evaluate for co-morbid conditions complicating their asthma, identify triggers for asthma, optimize care for their allergies, and explore psychosocial barriers to their care. A dedicated patient navigator helps families coordinate a potentially complicated medical system. Asthma education is strongly emphasized with families including symptom recognition and medication use. Referrals can be made by calling 720-777-6181.

Table I: Differential Diagnosis for Pediatric Asthma

Allergic rhinitis	Laryngeal webs
Aspiration	Malacia (broncho, tracheo, laryngo)
Bronchopulmonary dysplasia	Primary ciliary dyskinesia
Chronic sinusitis	Recurrent infection/immunodeficiency (bronchiolitis, bronchitis, pneumonia)
Congenital heart disease	Tumor or mass
Cystic fibrosis	Vascular rings
Foreign body aspiration	Vocal cord dysfunction
Gastroesophageal reflux disease	
Interstitial lung disease	

Table II: Choosing the Best Step 3 Controller Medication in School-Aged Children Inadequately Controlled on Low-Dose Inhaled Corticosteroids

• No eczema → Add a long-acting beta agonist to inhaled corticosteroids
• Eczema + Black race → Increase dose of inhaled corticosteroids
• Eczema + Hispanic race → Add a leukotriene receptor antagonist to inhaled corticosteroids
• Eczema + White race → Add a long-acting beta agonist or leukotriene receptor antagonist to inhaled corticosteroids

Table III: Reasons for Poor Medication Adherence

• Cultural factors surrounding medication use and choice
• Familial socioeconomic constraints (medication cost, lack of insurance)
• Lack of improvement from medication use
• Lack of parental supervision
• Medication-related side effects
• Ownership of disease management (child versus parent)
• Parental and patient health literacy
• Secondary gain from poor disease control
• Treatment regimen complexity

Table IV: Comorbidities Associated with Poor Asthma Control

Allergic rhinitis
Environmental allergen exposure
Gastroesophageal reflux disease
Obesity
Obstructive sleep apnea
Psychiatric disorders
Psychosocial stressors
Secondhand tobacco smoke exposure
Vocal cord dysfunction

Table V: Strategies to Reduce Environmental Aeroallergen Exposure

<u>Pollen</u>	<ul style="list-style-type: none"> Keep windows closed and use air conditioning if possible, especially in the bedroom Stay indoors when pollen levels are high Take a bath and change clothes after coming indoors Avoid mowing lawns or raking leaves
<u>Animals</u>	<ul style="list-style-type: none"> Keep pets outside of the bedroom at all times and off upholstered furniture Take a bath and change clothes after visiting someone who has an animal Have someone without allergies brush and bathe the pet regularly outdoors Vacuum at least twice a week using a vacuum with a HEPA filter
<u>Dust Mites</u>	<ul style="list-style-type: none"> Use dust mite proof covers for mattress and pillows Use a dehumidifier to keep the home dry Vacuum the carpet regularly

Table VI: Reasons to Refer a Patient to Allergy or Pulmonary

<ul style="list-style-type: none"> Diagnosis remains uncertain Need for additional testing (i.e., spirometry, FeNO, methacholine challenge, sweat chloride test) Evaluation of possible allergic triggers Increased asthma education required NHLBI step 3 therapy or higher for asthma control Poor control despite guidelines based therapy Life-threatening asthma exacerbation Hospitalization or recurrent emergency room visits for asthma Management of other atopic comorbidities Consideration for immunotherapy

Femoroacetabular Impingement in the Adolescent and Young Adult Population



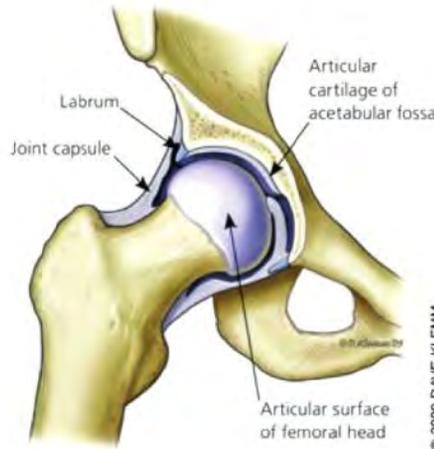
By Stephanie Mayer, MD, Orthopedics Institute, Children's Hospital Colorado Sports Medicine Center, stephanie.mayer@childrenscolorado.org

The hip joint and its surrounding structures make up a very complex anatomic region of the body. It can be thought of in layers from deep to superficial. The hip joint is a ball and socket joint made of the femoral head and the acetabulum. Two types of cartilage are present in the hip. Articular cartilage covers the surface of the femoral head and the acetabulum, and a fibrocartilaginous ring called the labrum sits around the majority of the outer rim of the acetabulum (Figure 1). Within the joint capsule there are three main ligaments for stability. Twenty seven muscles cross the hip joint and also contribute to stability as well as motion. More superficially, there are many vessels and nervous structures crossing the joint.

The femoral head is a spherical structure which articulates congruously with the hemispherical acetabulum. Femoroacetabular impingement or FAI is a mechanical disorder which occurs when there is abnormal abutment of the acetabulum with the femoral head-neck junction due to an abnormal shape of one or both of these bones. As this impingement occurs, the labrum and outer edges of cartilage are entrapped between the bones and can become irritated or torn.

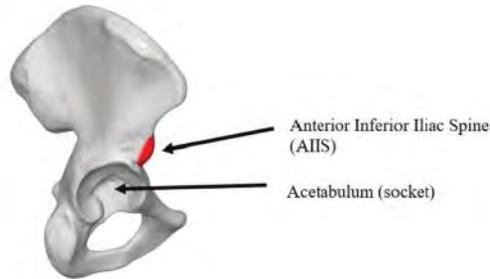
There are three main types of FAI (Figures 2 and 3). Cam type FAI occurs when there is an aspherical femoral head creating a mismatch between the shape of the ball and socket in which the femoral head exerts

Figure 1: Hip joint anatomy. Illustration credit to Kuhlman GS and Domb BG. Hip Impingement: Identifying and Treating a Common Cause of Hip Pain. Am Fam Physician. 2009;80(12):1429-1434.



© 2009 DAVE KLEMM

Figure 3: Anterior inferior iliac spine impingement.

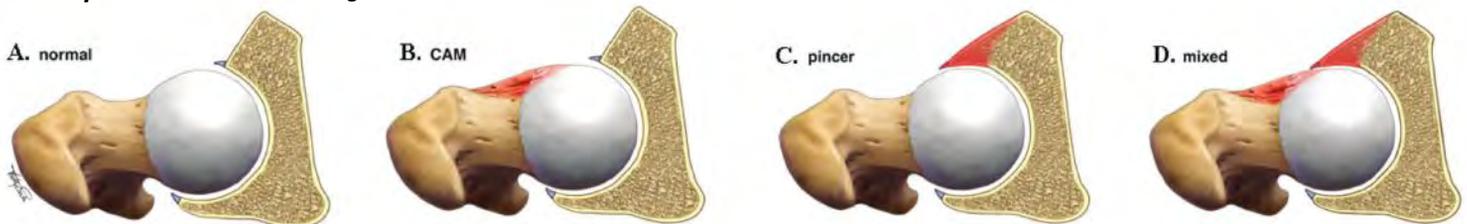


abnormal shearing forces across the labrum and cartilage as it enters the joint. This morphology of the femoral head can be due to previous slipped capital femoral epiphysis or Perthes disease, but can also be idiopathic. In pincer type FAI, there is excessive bone at the rim of the acetabulum causing an overconstrained joint and a crushing force on the labrum as the femoral head impinges upon the edge of the acetabulum. Lastly, subspine impingement involves an enlarged anterior inferior iliac spine, which sits just above the hip joint and is the attachment site for the rectus tendon. This bony prominence can impinge upon the femoral head with hip flexion. This pinches the labrum below the AIIS (sub-spine.) Many patients have a combination of these bony deformities.

The etiology of these bony deformities is unknown, however there may be an association with higher activity levels and participation in sports at a young age. A higher prevalence of FAI morphology has been shown in sports such as hockey, basketball, lacrosse, soccer and football. Traditionally, males have larger cam deformities, while pincer morphology is more common in females. A prominent AIIS is often seen in running and kicking sports, and is thought to be associated

with a reaction of the AIIS due to traction stress from the rectus tendon. Interestingly, FAI morphology is seen in about a third of the asymptomatic population. The prevalence of

Figure 2: Cam and pincer FAI. Illustration credit of Earle V. Hip Impingement: The femoral acetabular impingement story. In Brukner PD and Khan K. Clinical Sports Medicine Online Blog.



continued on 20 >>

asymptomatic FAI morphology is higher in athletes.

The injury to these soft tissue structures causes pain which is typically felt in the groin during activities involving flexion or rotation of the hip. There can also be a sensation of popping or catching. Due to the joint pain, patients often develop abnormal compensatory muscle patterns. This can cause pain in these muscles and tendons as well as exacerbate the joint pain from FAI. Most patients will not have a specific injury which triggered their pain, but instead describe an insidious onset of pain with activities. Pain with sitting (hip flexion) is a common complaint in addition to pain with activities. Classically, true hip joint pain is felt in the groin, however many patients describe a deep pain centered in an area wrapping from the groin to the lateral hip. This is called the “C” sign, as patients often cup a hand around this area in a “C” to describe the location (Figure 4). Pain in the posterior hip, around the greater trochanter, or in the gluteal muscles is generally musculotendinous pain due to compensatory movement patterns.

On exam, groin pain with hip flexion and hip flexion along with internal

Figure 4: The “C” sign.



rotation are the classic findings. Limited hip internal rotation is common because the impingement limits the rotation of the femur into the acetabulum.

If the diagnosis of FAI is suspected, a radiographic work up with plain films is initially performed. This includes an AP pelvis and lateral view of the hips. A Dunn lateral view is preferred for FAI instead of the more commonly obtained Frog lateral because the greater trochanter does not obscure the femoral neck in this position (Figure 5). These radiographs will help to determine if there are bony deformities suggestive of cam, pincer or subspine impingement. An MRI is helpful to evaluate the labrum and cartilage as well as the surrounding muscular structures which may show signs of tendonitis or bursitis. MRI is also useful to rule out less common, but equally significant pathology which can mimic FAI pain such as stress fractures, neoplasms, or avascular necrosis.

If the diagnosis of FAI with a labral and or cartilage injury is confirmed, the initial treatment is activity modification, NSAIDs, and physical therapy. Although PT cannot change the bony anatomy that caused FAI, and cannot heal the labral and cartilage injury, it can retrain the patient to recruit the appropriate muscles for their activity when abnormal compensatory patterns have been acquired, and can improve overall core strength. In some cases this can improve pain such that surgical intervention is not necessary. In some cases, however, the pain is persistent and surgical intervention is warranted. A trial of 6-8 weeks of physical therapy is indicated in most cases of impingement.

FAI can be treated with hip arthroscopy in most cases. Hip arthroscopy is a minimally invasive surgery similar to knee or shoulder arthroscopy that can be performed as an outpatient. The goal of this surgery is to repair the torn labrum and shave down the abnormal femoral and acetabular bone to eliminate the

impingement, thereby relieving the stress on the labrum and cartilage. Post-operatively, patients are on crutches with partial weight bearing for several weeks, but begin physical therapy for range of motion and strength within the first few days after surgery. Return to activities is expected around six months after surgery when muscle strength and function has returned. The time to an unrestricted return to sports is often likened to the recovery following ACL reconstruction.

Figure 5: Dunn lateral of the hip showing cam deformity.



The ultimate goal of the surgery is to relieve the bony deformity which caused the labral and cartilage injury, repair the torn labrum, and prevent further degeneration of the hip joint such that the patient can return to unrestricted activities pain free. Recent outcomes have shown that return to sports at a level at or above the pre-operative level is around 80%.

For questions about “Who to consult” visit our website at www.childrenscolorado.org or call the Sports Medicine team at 720-777-3898 or Hip Preservation team at (720) 777-5665 or toll free via One Call at (800) 525-4871.

THANKS FOR A GREAT 2016 ANNUAL SUMMIT

Thank you to all the physicians, students, residents, presenters and exhibitors who joined us for the 2016 Annual Summit! Be sure to save the date for the 2017 Summit, April 20-23 at Cheyenne Mountain Resort in Colorado Springs.



SNOCAP RECAP Summer 2016

Happy summer from SNOCAP! Since our last issue, we have welcomed a new member to our team! We welcome Victoria Francies, MPH to the SNOCAP (and CCTSI-Community Engagement) staff as our new Project Implementation Manager. Victoria joins us from the Colorado HealthOP where she worked as manager of population health programs. One of Victoria's first assignments will be to reach out to our practices to uncover ways to make our bimonthly e-mail newsletter more relevant!



ECER Conference - Breckenridge in October!

What are you doing in October? The Engaging Communities in Education and Research (ECER) Conference will be held October 14-16, 2016 in Breckenridge. ECER brings together providers and their staff from a variety of disciplines for two days of learning and networking. We are thrilled to announce that Dr. Tom Bodenheimer from the School of Medicine at the University of California-San Francisco will be joining as the keynote speaker. He will be speaking on making the most of teams within and beyond the walls of our practices. Contact us about remaining spots!

YOU ONLY HAVE ONE HEART
YOUR LIFE DEPENDS ON IT

ASK YOUR PROVIDER ABOUT WAYS YOU CAN LOWER YOUR CARDIOVASCULAR RISK.

YOU ONLY HAVE ONE HEART
ASK YOUR PROVIDER ABOUT WAYS YOU CAN LOWER YOUR CARDIOVASCULAR RISK.

ORICE LOOK

DID YOU GET YOUR BROCHURE AND CHECKLIST TODAY?

EvidenceNOW

The patient has been asked about and/or given a copy of the patient education material (PEM) from the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. The Agency's patient education materials are based on the patient and are not subject to the official position of AHRQ or the U.S. Department of Health and Human Services.

Case Study:

Treating Employees and Their Family Members

By COPIC's Patient Safety and Risk Management Department

Late one afternoon, the office manager of a rural medical practice brings her 15-year-old son to see her boss, a family practitioner (FP). The son has upper respiratory infection symptoms with fever, myalgias and a stiff neck. He is seen quickly by the FP and given a zithromax pack from the sample closet. The next day, the son wakes up and is confused. The mother calls the FP, who speaks with her in-between appointments. He attributes the "confusion" to the patient's fever and suggests more vigorous antipyretics and fluids. Twenty-four hours later, the patient becomes lethargic, febrile, and cannot be prompted to take oral fluids or food. The mother takes her son to the local ER, where he is diagnosed with bacterial meningitis and admitted. He has a difficult hospital course and never recovers fully. A rift develops in the office between staff members supportive of the mother and other staff who are supportive of the FP's care. The mother quits, and one year later, she files a medical liability claim against the FP for failure to timely diagnose meningitis.

In this case, there is no medical record for the son at the FP's practice. The whole incident was a "curbside" visit, no vital signs were documented, and the FP was rushed in his evaluation at the end of a long day. If this had been a regular office visit, or one prompted by the phone call after that visit, he might have made the same diagnosis and prescribed the same treatment, but the lack of documentation makes this a difficult case to defend.

Treating employees and their families brings up significant concerns about confidentiality, appropriateness, documentation,

expectations, and errors arising from biases. While an absolute "no employee treated in the office" policy may be unworkable and may also, for geographic, specialty or trust reasons, not be a solution for patient care, there are some things to consider:

1. **Confidentiality**—Office records of employees that can be perused by their co-workers are a risk. Give consideration to having records of this nature in a secure area, whether electronically or in physical form. When you are treating employees, your confidentiality policy needs to stress that the medical records can only be viewed for legitimate purposes such as treatment, coordination of care, scheduling, and payment issues. Audit trails of the access to employee and other privacy risk patients may reveal breaches. Your policy and its enforcement should be clear and consistent, and everyone should understand the risk of inadvertent disclosure.

2. **Documentation**—All employee patients should have the complete formal history and examination pertinent to their needs as other patients expect and receive. This includes elements such as complete vital signs in an acute illness. The visit should take place in your office, and you should document the visit and any tests or referrals given. The natural tendency to "curbside" treat and either not or insufficiently document can result in serious diagnostic oversights, medication errors borne out of informal and quick assessments, and a minimization of serious illness.

3. **Expectations**—A brief visit

with an employee's spouse might be a "no charge" on your part, but did you suggest a referral? Did you document the encounter? Is the evaluation in your area of expertise? There is often a strong tendency to just do a curbside consult in order to minimize the time or difficulty, and the issues of incomplete evaluations and cognitive errors become even more evident. We often care deeply about our employees and this will set us up for conflicts.

4. **Cognitive errors**—Diagnostic reasoning is often faulty when you evaluate those you care about, including employees. This results in errors in either direction of a decision. One might feel lymph nodes and decide to order a biopsy or a scan when watchful waiting is in order. Our normal clinician acumen may not kick in, and we may want to exclude the possibility of all diseases. You might examine the abdomen and suggest waiting, when appendicitis is really the diagnosis. This is described in cognitive literature as an "affection bias" and it refers to when you can't imagine someone close to you having a serious illness.

5. **Medical samples**—Dispensing samples of prescription medicine requires prescriptive authority. Employees should only receive samples on the authority of the physician or an allied health professional who has such authority. Distribution of samples should be documented in the medical record. This should be discussed with staff and there should be a "no tolerance" policy in terms of dispensing sample medications without the proper authority.

Technology is Transforming the Training and Education of Health Care Professionals

By Ági Erickson
Director of Project ECHO®, Weitzman Institute

By Daren Anderson, MD
Director, Weitzman Institute,
Vice President, Chief Quality Officer, Community Health Center Inc.

Addressing the national epidemic of prescription opioid addiction and overdose has challenged and mobilized the public health and public safety arenas. The CDC has reported over 145,000 deaths in the United States related to opioids; and the call for action is being met not only by primary care providers but also by federal agencies, policy makers, public health agencies, specialists, and community organizations. Every neighborhood in the United States is being affected, and innovative, practical tools and solutions are needed to address this crisis.

Primary care providers are key stakeholders in this battle as a large portion of opioid prescriptions come from primary care. Primary care is the foundation of a good health care system and needs to be strengthened through continuous education and training. By equipping our health care professionals with more education and support for implementing evidence-based best practices in pain care and opioid dependency, providers will be able to better meet the challenge of providing safe and effective care to patients with pain.

The Weitzman Institute, a research and innovation center operated by the Community Health Center, Inc., the largest Federally Qualified Health Center in Connecticut, is a national leader in primary care redesign. Weitzman staff has developed a broad range of practical tools and creative solutions to help health center

providers, public health institutions, and payers address the national epidemic of prescription opioid addiction and overdose.

The State of Colorado Department of Health Care Policy and Financing partnered with the Weitzman Institute to launch a Chronic Pain Disease Management Program in March of 2015. This program provides Project ECHO Pain, an innovative educational videoconference that connects primary care providers with a multidisciplinary team of pain specialists twice monthly for one year. Project ECHO Pain improves provider knowledge and confidence in the management of chronic pain through case-based learning and brief didactic presentations. The faculty team from the Integrative Pain Center of Arizona is led by Bennet Davis, MD, one of the nation's leading pain specialists, and includes pain specialists with expertise in anesthesiology, physical medicine and rehabilitation, behavioral health and pain psychology, pharmacy, acupuncture and traditional Chinese Medicine.

Last year, 84 providers from 42 practices across the state of Colorado had the opportunity to participate in Project ECHO Pain through the Chronic Pain Disease Management Program.

Participants were enthusiastic regarding the impact of this program on their practice. Joshua Blum, MD, from Denver Health Family Center stated "As a primary care physician, I see how a lack of access to multimodal and multidisciplinary

treatment often results in a frustrating overreliance on dangerous oral analgesics and other marginally effective approaches to chronic pain treatment. Project ECHO helps fill this need." Dr. Blum participated in Project ECHO Pain for one year and is now joining a new ECHO, also provided by the Weitzman Institute, focused on treatment of opioid addiction—Project ECHO Buprenorphine.

The Chronic Disease Management Program is now entering its second year. To provide additional support to tackle the challenge of opioid abuse, the program will include a new component called the Buprenorphine Telehealth Program. Project ECHO Pain and Project ECHO Buprenorphine are available at no cost to Colorado Medicaid PCPs through the sponsorship of the Colorado Department of Health Care Policy and Financing.

- Project ECHO Pain provides sessions twice monthly for one year. Participants and staff members from participating sites also receive access to PainNET, an online resource where staff can access pain care tools, news, and blogs, and collaborate with experts and peers.
- Project ECHO Buprenorphine links providers with specialists in treatment of opioid addiction, providing them with the support and expert advice that they need to gain confidence in their management of opioid dependence with buprenorphine. The sessions are provided once a month for one year.

For more information about participation in Project ECHO Pain or Project ECHO Buprenorphine, contact Ági Erickson, Director of Project ECHO, at 860-347-6971 x3741 or Agi@chc1.com. Find a brochure at http://weitzmaninstitute.org/sites/default/files/CHC_HCPFChrPainBup20162.pdf



Colorado Physician Health Program

...because

Healthy Doctors Give Better Care

The Colorado Physician Health Program (CPHP) has been serving Colorado physicians and physicians assistants with all health conditions, from medical problems to situational issues, including stress and burn-out, since 1986. If you, or a colleague should need assistance visit our website at www.cphp.org or call us at (303) 860-0122 to get assistance today.



Have a conversation. **CHANGE A LIFE.**

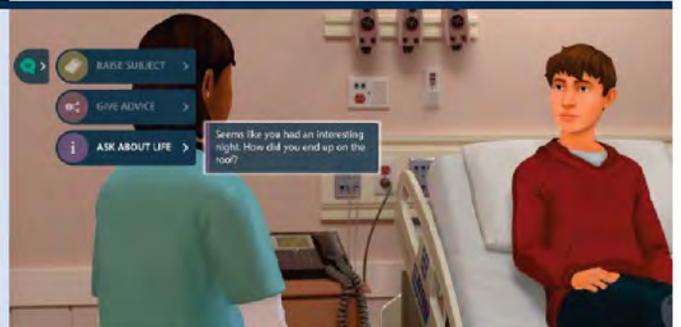
Screening, brief intervention, referral to treatment (SBIRT) is an evidence-based prevention service for adolescents and adults. It helps a patient understand the connection between alcohol and other drugs and health. It should be as routine as taking a blood pressure. A short conversation helps a patient make changes to improve their life.

SBIRT Colorado provides **NO-COST TRAINING** and support. Online and in-person training provides CE credits for nurses and physicians.



Screening, Brief Intervention, Referral to Treatment

Practice screening and brief intervention skills in online, interactive scenarios with virtual patients.



Learn more at www.improvinghealthcolorado.org/training

Tar Wars®

2016 Tar Wars Poster Contest Winners Announced

Congratulations to the 2016 Tar Wars Poster Contest winners, and thank you to the schools, teachers and physicians that participated in Tar Wars during the 2015-2016 school year!

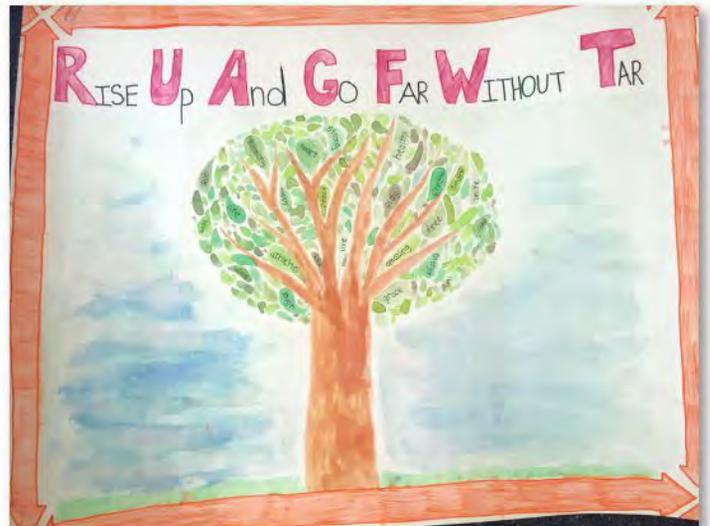
- 1st Place- Lynnea Waddell, Chipeta Elementary, Colorado Springs
- 2nd Place- Emma Kimbrough, Holy Family Catholic School, Grand Junction
- 3rd Place- Olivia Sherry, Aspen Creek K-8, Broomfield
- Honorable Mention- Jin Kim, Stony Creek Elementary, Littleton

Exciting New Opportunity for Tar Wars in the Classroom

Thanks to a grant from COPIC, the CAFP has created video versions of the Tar Wars and Marijuana Supplement presentations. Students will join Dr. Tamaan Osbourne-Roberts to learn more about the dangers of smoking, and Dr. Aaron Shupp to learn more about staying safe around marijuana.

Physicians are encouraged to share these videos with schools they have relationships with. The videos can also be used in your practices to educate children and families about tobacco and marijuana. To access the videos, visit <https://www.coloradoafp.org/health-of-the-public/tar-wars/>

Find the videos at <https://www.coloradoafp.org/health-of-the-public/tar-wars/> under video presentations.



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

Vaccination Aversion Contributing to Recent Disease Outbreaks

A study published in JAMA (tinyurl.com/zytovou) suggested that vaccination aversion is contributing to the recent outbreaks of measles and pertussis in the United States. Researchers found that of the 1,416 measles cases reported “since the disease ceased to circulate in the United States in 2000, 57% were in people who had no history of being vaccinated.”

Nearly “70% of these patients were unvaccinated due to nonmedical exemptions.” And, in eight of twelve whooping cough outbreaks for which detailed vaccination data was available, as many as 93 percent of unvaccinated patients were intentionally not immunized.

Researchers have shown that Mississippi, which only allows medical exemptions for vaccines, has much higher vaccination rates than states with more lenient laws, such as Colorado. In California, where a 2014 measles outbreak led to 111 cases, legislation was passed to eliminate nonmedical exemptions to vaccination.

“When vaccine refusal rates are high, the rates of measles and pertussis are higher,” researcher Dr. Varun Phadke, a fellow in infectious diseases at Emory University in Atlanta, told HealthDay News (tinyurl.com/j49parv). In 2000, the United States was declared measles-free. But infected travelers returning to the country have caused outbreaks, and unvaccinated children are most at risk.

Flu Shots in the Morning Provide Greater Immune Response

The study published in the journal Vaccine (tinyurl.com/huqfn59) reported that flu shots may be more effective when people get them in

the morning than in the afternoon. British researchers assessed 276 people 65 and older who received vaccinations against three different flu strains between 2011 and 2013. The patients received the vaccines either between 9 a.m. and 11 a.m., or 3 p.m. and 5 p.m. People in the morning group had a much larger increase in antibodies against two of the flu strains one month after vaccination, the researchers found.

“We know that there are fluctuations in immune responses throughout the day and wanted to examine whether this would extend to the antibody response to vaccination,” said lead investigator Anna Phillips in an interview with HealthDay News (tinyurl.com/j2yypgt). “Being able to see that morning vaccinations yield a more efficient response will not only help in strategies for flu vaccination, but might provide clues to improve vaccination strategies more generally.”

Another study author, Janet Lord, added, “Our results suggest that by shifting the time of those vaccinations to the morning we can improve their efficiency with no extra cost to the health service.” The researchers said they plan to conduct a larger study on the timing of flu vaccinations to test their hypothesis. And they will also examine if morning vaccinations boost the effectiveness of the pneumococcal vaccine, which protects against pneumonia.

When Pregnant Moms Get the Flu Vaccine, Their Babies Do Better

Meanwhile, a study published in Clinical Infectious Diseases (tinyurl.com/gsun7b) indicated that getting a vaccination against influenza while pregnant “may reduce the risk of stillbirth.” After examining birth and maternal vaccination records for 58,008 pregnancies

in Western Australia during the 2012 and 2013 flu seasons, then adjusting for confounding factors, the study authors “found that the risk of stillbirth was 51 percent lower in vaccinated women than in unvaccinated ones.”

Meanwhile, another study, published in Pediatrics (tinyurl.com/hmm445j), reported that infants aged 6 months and younger were 70% less likely to get the flu if their moms got the flu vaccine during pregnancy, compared with those whose mothers were not vaccinated. The study also found an 80% decrease in flu-related hospitalizations among infants whose mothers were vaccinated during pregnancy.

continued on 40 >>

PAIN?

GO WITH THE BEST in interventional care

COLORADO PAIN MANAGEMENT, P.C.
 Peter Reusswig, M.D.
 Paul Leo, M.D.
 303-286-5067

- Level II Accredited
- Over 35 years of experience
- All diagnostic and therapeutic injections, neurolytic, implantable devices
- Safe, cost-efficient, and goal-oriented
- Dedicated to the pain care of your patient
- Board Certified in Anesthesiology and Pain Medicine

WE GOT YOUR BACK

www.coloradopainmanagement.com

<< *continued from 39*

New Guideline Revises Egg Allergy Language for Influenza Vaccination

AAFP News (tinyurl.com/zsbtoon) has a helpful report about the CDC's Advisory Committee on Immunization Practices unanimous approval of an update of their 2016-2017 influenza vaccine recommendations that includes guidance on the acceptable use of live attenuated influenza vaccine for patients with an egg allergy. In these new recommendations is the acceptable use of live attenuated influenza vaccine (LAIV; FluMist) as an option for individuals with an egg allergy of any severity, including severe anaphylaxis. Also, the ACIP removed the requirement to observe egg-allergic patients for 30 minutes post-vaccination, noting that 15 minutes of observation is recommended for all patients receiving vaccines, particularly adolescents for syncope.

Two-Dose Chickenpox Shot Gets the Job Done

A study published in the journal *Pediatrics* (<http://tinyurl.com/z66md7l>) reported that among school children, two doses of the chickenpox vaccine is better than one. Giving the first dose at age 1 and the second dose at ages 4 to 6 is nearly 100 percent effective in preventing the once common childhood disease, researchers have found.

Before routine chickenpox vaccination began in 1995, virtually all children were infected at some point, sometimes with serious complications. About 11,000 children were hospitalized each year for chickenpox, and 100 died annually from the disease, according to the CDC. One-dose vaccination greatly reduced incidence of chickenpox, but outbreaks continued to be reported in schools where many kids had been vaccinated. That led the CDC in 2006 to recommend a second vaccine dose.

To evaluate effectiveness of the double-dose regimen, the researchers collected data on 125 children with chickenpox in Philadelphia and northern Los Angeles and compared them with 408 kids who had not had the disease. They found that two doses of the vaccine was slightly more than 97 percent effective in protecting kids from chickenpox.

The reduction in chickenpox in the community as a result of two-dose vaccination will also protect children who have weakened immune systems and are not eligible for the chickenpox vaccine, she said.

School vaccine requirements should include two-dose varicella vaccination, the researchers told *HealthDay News* (tinyurl.com/jrot5ab). "In addition, 'catch-up' varicella vaccination is also important," they said. This applies to anyone over 6 who has not had a second vaccine dose, especially if they could be exposed to chickenpox or shingles, a painful condition in older people caused by reactivation of the chickenpox virus, she said.

Some Parents See Flu Vaccine as Less Important than Others

Medical News Today (tinyurl.com/znvxbjn) reported on a national pole of parents which revealed 59% of parents whose children did not receive flu shots this season said they viewed the vaccine as less important than other childhood vaccines. Researchers surveyed 1,367 parents and found those whose children did not get the flu vaccine were three times as likely as those who did to say their doctor recommended the flu vaccine less strongly than other immunizations. Physicians could do a better job of emphasizing the importance and safety of this vaccine. Especially since, according to the CDC, around 20,000 children under 5 have to be admitted to hospital in the U.S. every year because of flu complications and some cases result in death.

A related study from the

CDC (tinyurl.com/hw7bg28) reported that less than 50% of U.S. children younger than two are fully vaccinated against influenza. The study found that while rates improved across all demographics over the study period, the most dramatic shortfall was among the 6 to 23 months age range.

Study Looks at Vaccination Rates in US Youths After VFC Program Implementation

According to a Reuters report (tinyurl.com/jp2tupr), vaccination for polio increased from about 89% in 1995 to 1997, just after the US government implemented the Vaccines For Children program, to almost 93% in 2011 to 2013. Rates for measles, mumps, and rubella vaccine rose from 90% to 92%, and use of the DTaP vaccine increased from 80% to 83%. The findings in *Health Affairs*, based on data on vaccination rates for children ages 19 months to 35 months from 1995 to 2013, showed a decline in racial and ethnic disparities, but those who were white and from high-income households were still more likely to get the vaccines than their nonwhite and low-income peers.

Cancer Centers Call for All Kids to Complete HPV Vaccine Regimen

The U.S.' National Cancer Institute-designated cancer centers released a statement (tinyurl.com/gwm2x7e) calling for all children to complete the three-shot HPV vaccine regimen. The centers called the potential spread of HPV a "public health threat" and urged doctors to be advocates on the issue. According to the CDC just "forty percent of girls and 21 percent of boys in the United States are receiving the recommended three doses of the HPV vaccine." Those rates are far below "the desired goal of 80 percent by the end of the decade, set by the U.S. Department of Health and Human Service's Healthy People 2020 mission."

Understanding the Diverse Needs of Asian Americans and Pacific Islanders in Colorado

By Aditi Ramaswami, Colorado Coalition for the Medically Underserved and Harry Budisidharta, Asian Pacific Development Center

On October 11, 2015, The New York Times published a column titled, “The Asian Advantage.” The author of the column, Nicholas Kristof, wrote that “it’s no secret that Asian-Americans are disproportionately stars in American schools, and even in American society as a whole. Census data show that Americans of Asian heritage earn more than other groups, including whites. Asian-Americans also have higher educational attainment than any other group.”

The column sparked a heated discussion and many readers sent letters to the editor in response to the column. They noted that Mr. Kristof failed to distinguish between different Asian American and Pacific Islander (AAPI) ethnic groups and that he has perpetuated a harmful “model minority” myth that all AAPIs are successful because of hard work, strong families, and emphasis on education. This is a dangerous stereotype, though, and one that disregards the diversity of the Asian population. It’s also becoming more and more outdated, especially with the burgeoning population of Asians who come to America escaping politically unstable countries, only to find that their new reality conflicts with the one perpetuated by a lingering myth. The problem is the data: it’s very deceiving.

Colorado is home to approximately 185,000 descendants of and immigrants from 30 Asian and 25 Pacific Island nations, making the Asian American and Pacific Islander (AAPI) population the most diverse in the state. Viewing the AAPI population as a whole, it appears that they are better off than any other racial or ethnic group: the high school graduation rate for AAPI Coloradans is 85% compared to 77% for all Coloradans, the median household income of AAPI Coloradans is nearly \$14,000 more than the state median, and 11% of AAPI Coloradans live in poverty compared to 13% of all Coloradans. Moreover, AAPIs appear

to enjoy optimal health, outperforming other populations on everything from maternal child health to risky behaviors to life expectancy.

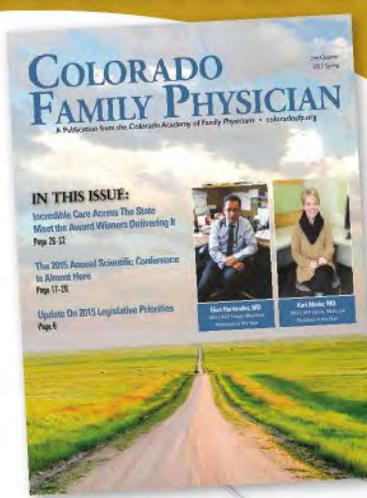
Again, though, the problem is the data. The experiences of the Japanese generally differ from those of Hmong individuals, which are different than those of Indians—yet, they are all lumped together to make up the Asian dataset. For example, in the US, 6% of all Asians report frequent mental distress, compared to 11% of all Americans; however, 21% of Bhutanese refugees in America suffer from depression, and their suicide rate is nearly twice the national rate. While overall, the percentage of uninsured Asian Americans was slightly below the national average of 16% in 2012, 20% of Vietnamese Americans and 25% of Korean Americans were uninsured. Another example: a California survey revealed that while 19% of the state’s residents visited the ER in the past year, 13% of their Asians and 34% of their Pacific Islanders did. Disaggregating the data is the only way to reveal these differences between various Asian populations.

To understand the true mosaic of what it means to be Asian, we need more granular, Colorado-specific data. Without it, we won’t recognize areas of great need within a diverse population. Collecting sufficiently disaggregated data is quite the undertaking however, which means in the meantime, we can capitalize on ways to better the health care experiences of Asians and Pacific Islanders whom we know to be more medically vulnerable. To this end, physicians can apply existing data and information (and look to important trends that are starting to be documented, like those by the Centers of Disease Control and Prevention) about these groups to the way they practice medicine, so that they can avoid automatically thinking that their Asian patients need not require treatment comparable to their

counterparts of other racial minorities.

More importantly however, this data speaks to the fact that all Coloradans carry their own stories and cultures, based on a variety of complex factors, and a disservice to patients is done when health care providers assume an understanding of one’s culture and lived experience. It behooves our health care workforce—physicians and non-physician providers—in Colorado to adopt practices of organizations that embody cultural responsiveness, like those of the Asian Pacific Development Center, which is working to ensure that patients receive integrated health care that is appropriate to the cultures of all Asians and Pacific Islander ethnicities, including those most vulnerable to poor health and well-being. That being said, there is much more work to be done.

Reach Family Physicians in COLORADO



Advertise with us

contact Dustin Doddridge at
800.561.4686 ext. 106
or at
ddoddridge@pcipublishing.com

A Lifelong Pursuit of Service

by Lynlee Espeseth



Family physicians, especially family physicians who choose to work with the most underserved patients, tend to have similar qualities. A view of medicine not just as science, but as a service; an upbringing that introduced them to primary care; and a true desire to make a difference for the patients they see.

CAFP member Dr. Justin Wheeler is a prime example of this. From his upbringing to his time in the National Health Service Corps to his current work at Clinica Family Health, his desire to bring care to communities in need is evident.

Dr. Wheeler grew up in rural Montana and always had an interest in science and research, but learned quickly he didn't want to spend his time in a lab. Growing up in a rural community, he had visited his family physician plenty of times with typical "farm kid" injuries, and after going to a liberal arts college in Minnesota, began to see the connection between medicine and service, and how medical sciences and social sciences could combine. As

he grew to love what a career as a physician could be, it became apparent to Dr. Wheeler that being a family physician was the right choice.

"I love family medicine because you get to take care of people for their whole lives, it is a longitudinal relationship," says Dr. Wheeler. "You can see three or four members of the same family. Because we take care of not just individuals but families, there is a natural extension into the community. Family medicine is born out of the social determinants of health."

Dr. Wheeler's interest in community health and the social determinants of health naturally gave him an interest in underserved areas. However, there are very practical challenges to practicing in such communities. The cost of a health education can be an incredible burden, and often discourages students from practicing in the locations that need them most.

For Dr. Wheeler, the National Health Service Corps was a way to make the kind of care he wanted to deliver a reality.

The National Health Service Corps provides loan repayment and scholarships to primary care medical, dental, and mental and behavioral health professionals who choose to practice or train in areas with limited access to care. Professionals commit to serving at least two years at the National Health Service Corps site they are assigned to, but many stay longer, and continue in their service to the underserved. The National Health Service Corps model helps to solidify the idea that health professionals are much more likely to work in underserved communities and with underserved populations if they have exposure to that type of care. It also eases the fears many physicians have as they prepare to finish their education and begin their lives as full time physicians.

"It [the National Health Service Corps] helps to bridge the time in your life when you need to feel really secure about your future; when you're just starting a career, relocating, and starting a family. It lets you do what

you want to do, serve the underserved, without fear that you won't have the opportunities to do the things in life you want to do," says Dr. Wheeler.

For students considering the National Health Service Corps, Dr. Wheeler says that there are many avenues to take within the program for students who know this type of service is right for them.

"Know where your clinical interests are," says Dr. Wheeler. "The Corps is designed to serve communities, if you are interested in that, it's a natural fit."

His time in the Corps was a period where Dr. Wheeler wanted to explore and be adventurous, but couldn't do it without escaping the reality that all physicians face- that there are lots of aspects of their lives that must be fulfilled. His husband needed job opportunities, and while they were looking for something rural, they also needed access to activities. Serving at a site in the San Luis Valley fulfilled their needs, but there are many types of programs, from urban to rural, that can fit the needs of many types of students.

Serving in the National Health Service Corps balances practical needs with truly unique learning opportunities.

"Serving in the San Luis Valley was an opportunity to explore a new part of the country, learn more about a new part of the state with a rich history and lots of connections to social justice movements, and in some ways get to be a part of that. It was exhilarating," says Dr. Wheeler. "I got to practice unencumbered, full spectrum family medicine. The community was accepting and supporting, patients came from all over. On Fridays, farmworker buses would come with dozens of patients who had needs. I got to learn about the migrant farmworker population from Guatemala. I would have never had an opportunity to learn about that, learn about ancient languages, to explore the area, without serving in the corps."

If a student has a feeling that this type of service is right for them, it can lead to a long career of feeling fulfilled by care they deliver.

Indeed, Dr. Wheeler continues to

work with underserved populations as the Vice President of Clinical Services at Clinica Family Health. Clinica serves a patient population that is largely on Medicaid or uninsured. 93% are at or below 200% of the federal poverty level. Across Clinica's six medical clinics and two dental clinics, over 47,000 patients in Broomfield, south Boulder and west Adams county are served. Their innovation, and models of team based, integrated care receive national and international attention for success.

For Dr. Wheeler, service to others through medicine has been a passion built and expanded upon throughout his life. His experiences growing up, during his education, through the National Health Service Corps and now at Clinica prove to him that for those called to serve the most in need, it is a lifelong pursuit.

"If in your gut you feel like this kind of work is for you, that won't go away. It is fundamental."

For more information on the National Health Service Corps visit nhsc.hrsa.gov.

Make sure your family has a plan in case of an emergency.

Fill out these cards, and give one to each member of your family to make sure they know who to call and where to meet in case of an emergency. For more information on how to make a family emergency plan, or for additional cards, go to ready.gov

Ready



Family Emergency Plan



EMERGENCY CONTACT NAME: _____
TELEPHONE: _____

OUT-OF-TOWN CONTACT NAME: _____
TELEPHONE: _____

NEIGHBORHOOD MEETING PLACE: _____
TELEPHONE: _____

OTHER IMPORTANT INFORMATION: _____

DIAL 911 FOR EMERGENCIES

Ready

Family Emergency Plan



EMERGENCY CONTACT NAME: _____
TELEPHONE: _____

OUT-OF-TOWN CONTACT NAME: _____
TELEPHONE: _____

NEIGHBORHOOD MEETING PLACE: _____
TELEPHONE: _____

OTHER IMPORTANT INFORMATION: _____

DIAL 911 FOR EMERGENCIES

Ready



RURAL CORNER

New Tax Credits for Rural Preceptors

By Ryan Biehle

At 104,000 square miles, we've got a lot of ground to cover in Colorado. It may be no surprise that patients, in many cases, have to travel 30 miles or more just to see their primary care doctor. In fact, several counties in Colorado don't have a single primary care physician. This challenge of getting care to the places and people most in need is not a new one, but innovative strategies are needed to ensure we can meet the needs of Coloradans everywhere. That's why this year, a new tax credit will be available to primary care physicians who precept medical students in rural communities. By taking at least one student for a 4-week rotation, you can qualify for a \$1,000 personal income tax credit.

You can qualify for the tax credit starting in the 2017 tax year. The Colorado School of Medicine or your regional Area Health Education Center (AHEC) will be able to provide you with a certification to acknowledge your eligibility for the credit.

To qualify, you'll just need to meet a few requirements:

1. Be an MD, DO, PA, APN, or dentist
2. Practice in primary care
3. Be an unpaid volunteer preceptor for a student on a 4-week rotation
4. Be practicing in a rural or frontier area. You can verify eligibility through one of the certifying agencies, but generally

those living in a county without a city of 50,000+ people will qualify.

Become a Preceptor

There are currently 160 rural primary care preceptors across the various professions. However, we need 300 to meet the interest of students who want to rotate in a rural area. If you or

a colleague you know is interested in being a preceptor, now is a great time to get involved to help train the next generation of primary care physicians. In addition to the teaching experience and the tax credit, several other benefits of precepting include:

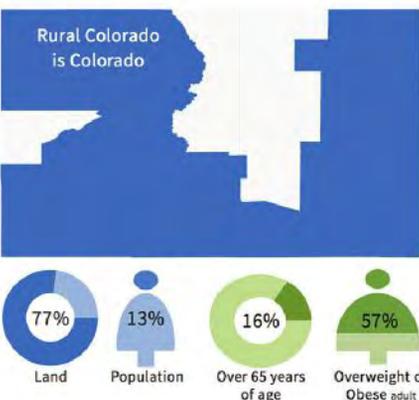
- A leadership role in training students and shaping the future of family medicine
- A faculty appointment
- Library and Up To Date access

To Find out More about precepting for the MD or DO programs:

CU School of Medicine Office of Community Based Medical Education: (303) 724-0044

Rocky Vista University Office of Clinical Affairs: Email oca@rvu.edu or call (720) 875-2838

The bill establishing the tax credit, House Bill 16-1142, passed with overwhelming bipartisan support. We are grateful to the bill's sponsors for shepherding it through the General Assembly. We thank them for their leadership: Rep. Perry Buck (R-Windsor), Rep. Joann Ginal (D-Fort Collins), Sen. Larry Crowder (R-Alamosa) and Sen. John Cooke (R-Greeley). The bill was championed by the Colorado Academy of Family Physicians in partnership with the Colorado Rural Health Center and Colorado AHEC. We'd also like to thank Governor John Hickenlooper for his support in signing the bill into law on June 6, 2016.



300 preceptors are needed, only 160 currently



THE STRENGTH TO HEAL

and stand by those who stand up for me.

Learn the latest treatments and play an important role in the care of Soldiers and their families. As a physician on the U.S. Army Reserve health care team, you'll continue to practice in your community and serve when needed. You'll work with the most advanced technology and distinguish yourself while working with dedicated professionals. You'll make a difference.

To learn more about the U.S. Army health care team, call 303-873-0491 or visit healthcare.goarmy.com/eb19.



New Scholarship Opportunity for Women Physicians in Colorado

To honor and recognize Dr. Martha Illige's many contributions to family medicine in Colorado, the Colorado Academy of Family Physicians Foundation is introducing a new scholarship opportunity for women family medicine residents and faculty members in Colorado.

The Martha Illige Scholarship to Attend the Annual Balance Conference will award one resident-faculty dyad consisting of a woman family medicine residency faculty member and a woman PGY-2 or PGY-3 resident from the same program \$1200.00 per person to help defray the costs of attending the Annual

Balance Conference together.

The Annual Balance Conference is designed for women physicians and offers both education and relationship building. To learn more about the conference visit <http://www.balanceconference.org/>.

To learn more about applying for this scholarship, and all scholarship opportunities offered by the CAFPF Foundation, please visit <https://www.coloradoafp.org/students-residents/colorado-family-medicine-scholarships/>.

Congratulations to the Following CAFPF Members On Their Accomplishments!

- Stacie Lynn Johns, MD, FFAFP, received her Degree of Fellow from the AAFP

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

CAFP DISCOUNT PROGRAM

As part of the CAFPF Discount Program, the following companies are offering special pricing and opportunities to CAFPF members.

Strengthen Your Immunization Efforts
with the Leading Vaccine Buying Group



More than 15,000 clinicians count on Atlantic Health Partners for discounted vaccine prices, purchasing support, and program management assistance.

JOIN TODAY FOR:

- Most favorable pricing for Sanofi, Merck, MedImmune, Pfizer, and Seqirus vaccines
- Discounts for medical and office supplies and services
- Reimbursement support and advocacy
- Medicare Part D vaccine program
- Patient recall discount program

800-741-2044 • info@atlantichelpartners.com
www.atlantichelpartners.com

BEST CARD: Discounted Credit Card Processing – Thousands of medical offices are saving an average \$1,860 annually (27%) since switching to Best Card. Members receive great rates and unparalleled customer service. You get people not prompts!

Have you updated to new EMV "chip reading" technology? As of the October 2015 liability shift, your practice is at risk if not. Best Card offers members a one-time \$100* discount on new EMV terminals, with some available for as little as \$259-100-\$159 with 2-year warranty. *Discount prorated if processing <\$8,000/month.

Email or fax your recent credit card statement to CompareRates@BestCardTeam.com or 866-717-7247 or to receive a detailed no-obligation cost comparison and a \$5 Amazon gift card.

For more information, call 877-739-3952.



Industry Leading Health Technology Consulting & Care Management Firm

As a CAFPF Discount Program Vendor, we provide experience in Practice Transformation, Meaningful Use, ICD-10, PQRS, Privacy/ Security, Optimization, Care Management Services, we have experience working on over 150 EHR Systems. We help healthcare providers develop a seamless Chronic Care Management/ Transitional Care Management program(s) to improve patient outcomes and drive recurring revenue without the need to increase staff.

CareVitality, Inc. a subsidiary of EHR & Practice Management Consultants, Inc. has a close working relationship with ambulatory practice and are well aware of their challenges and pain points, and have structured their service offerings around those challenges. These services can help your practice optimize the use of your EHR to meet workflow needs, meaningful use stage 2 and participate in value-based care initiatives. We have a special focus on the doctor, patient and family engagement-related services and include everything from implementing a patient portal and online scheduling to consulting services to help you improve your workflow, recurring revenue and patient outcomes.

We assist providers in creating a better work-life balance, alleviating much of the burden chronically ill patients place on your staff by utilizing our patient-centered clinical care team. Our Healthcare Technology and Care Management Services help improve the health of your patients and the wealth of your practice.

To learn more about CareVitality's service offerings, please visit www.carevitality.com or call 1-800-376-0212.

Health E-careers Network: FPJobsOnline is the official online job bank of the Colorado Academy of Family Physicians and provides the most targeted source for Family Physician placement and recruitment. Accessible 24 hours a day, seven days a week, FPJobsOnline taps into one of the fastest growing professions in the U.S. Please visit www.FPjobsonline.com or call 1-888-884-8242! Mention you are a CAFPF member to receive discount.

Self-Study CME

Improve patient care and bridge your knowledge gaps with AAFP self-study CME—when and where it's convenient for you.

Clinical Packages

Use AAFP self-study packages to enhance your expertise and expand your knowledge on common family medicine topics. Featuring recorded audio and video presentations from current AAFP live clinical courses, these interactive self-study packages take approximately 20-45 hours to complete and include:

- 18-43 lectures between 30 and 60 minutes in length
- Opportunities to report CME and evaluate after each lecture
- Interactive interface with QuestionPause™ to briefly halt the presentations
- Post-test (online)

Choose the package format that's



right for you:

USB Flash Drive with Online Access

BEST VALUE: A one-year online subscription and USB Flash Drive. Smartphone/tablet compatible. Includes a print and PDF color syllabus.

Online Access

Study when and where you want with a one-year online subscription. Smartphone/tablet compatible. Includes a PDF color syllabus.

USB Flash Drive

Convenient, portable access to all of your self-study materials. Includes a USB Flash Drive, audio CDs with select packages, and a print and PDF color syllabus.

Online access valid one year from purchase date of online-inclusive package.

How to Benefit Your Chapter through the AAFP Revenue Share Program

At checkout, add 4MYCHAPTER in the source code box and a portion of your purchase revenue will be shared back with your chapter.

*The Colorado Department of Public Health and Environment
Retail Marijuana Education Program introduces:*

Marijuana Pediatric

Exposure Prevention and

Pregnancy and Breastfeeding

Clinical Guidance

Evidence-based guidance for Colorado health care providers to talk with patients about marijuana exposure.

Visit Colorado.gov/CDPHE/marijuana-clinical-guidelines for

- Marijuana Pregnancy and Breastfeeding and Pediatric Exposure Prevention Clinical Guidance
- Marijuana Factsheets for Patients
- Marijuana Clinical Guidelines Educational Webcast
- Additional resources for health care professionals



**Colorado Academy of
Family Physicians, Inc.**

2224 S. Fraser St., Unit 1
Aurora, Colorado 80014

Presorted Standard
U.S. Postage Paid
Little Rock, AR
Permit No. 2437

WE'VE GOT MORE THAN JUST YOUR BACK.

2,000+

providers reviewed
on-site every year.

These assessments of medical practices reinforce better patient outcomes, reduce liability risks and support improvements in quality performance measures. We keep you covered from front to back.



Better Medicine • Better Lives
callcopic.com | 800.421.1834

COPIC is endorsed by

