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CEO’S REPORT
CAFP LEGISLATIVE UPDATE
CAFP ON THE GO
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THANK YOU TO EVERYONE WHO JOINED US AT THE 2017 ANNUAL SUMMIT!
WHAT TO DO WHEN PATIENTS PRESENT WITH “TUMMY TROUBLES”

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CONGRATULATIONS TO GAVIN CICHELLO, 2017 TAR WARS POSTER CONTEST WINNER!

RURAL CORNER
I am grateful to the CAFP/AAFP for the opportunity to participate in the AAFP’s annual Advocacy Summit in Washington DC.

The Summit kicked off with the participants gathered around tables by state. Loaded with coffee, conference documents, and the desire to make a difference, we listened to speakers on topics critical to family medicine such as Medicaid funding, preexisting conditions, the healthcare exchange, immunizations, and GME funding. We also had experts on Capitol Hill coach us on the most effective strategies for talking with legislators. A physician member of congress spoke with us about the challenges he faces working for change within congress. We wrapped up with a practice session with our state participants where we rehearsed our pitches to the legislators.

I woke up the next morning feeling confident about our mission and ready to engage with the legislative offices. Our mission was a three pronged task: continue to support Medicaid for our most vulnerable patients, continue funding for teaching health centers, and to join the primary care caucus (where our legislators can access more education around the value of primary care). Thanks to Ryan Biehle, the Deputy CEO for Policy and External Affairs at the CAFP, we had meetings set up with all 9 of our Colorado legislators. Interestingly, our first meeting turned out to be with another doctor! That’s right, the first legislative staff we met with was an MD with an MPH, which was another reminder of the varied and important roles we can serve as physicians. As we moved from office to office, I was struck by the sense of genuine concern each office had for the people of Colorado and the strong interest in connecting with family physicians. This was a warmer side of politics not often represented in the news or public square. No matter the political strategy, each office had a clear link to why their proposed stance would benefit our communities. It was incredible how easy the CAFP/AAFP made it for me to come from my home community to the heart of American lawmakers and advocate for our members and patients.

As I strolled through the winding path marked by park benches and leafy green canopies of trees, the white marble pillars of the US Capitol towering overhead, I felt incredibly grateful to be an American family physician. Like many physicians, I have a degree in Biology and spent my summers working two full time jobs and the school year working one to put myself through school. While I am passionate about helping people, I did not always have the time or the focus to advocate in the political arena. As busy family physicians, the CAFP/AAFP gives us the tools, training, and opportunity to engage in politics in our communities and at the national level. The very word politics sometimes evokes some not so positive emotions, but these emotions are the ones that can motivate us as family physicians to lead change in our communities. We know firsthand in a way no one else can the impact of legislation on the health of our communities.

Please consider joining the CAFP in our efforts, whether that be conversations with your patients, volunteering at Doctor of the Day at our Colorado State Capitol, testifying at the Capitol about legislation important to you/your community, joining our CAFP legislative conference calls, or running for a CAFP board position this fall. If you are interested in any of these avenues, please contact me or the CAFP staff. Of course, you could also join us at the AAFP Advocacy Summit next year. As we family physicians move forward together in the time of political uncertainty and change, let us reflect on the words etched on our nation’s capitol dome “e pluribus unum-” out of many one.
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Vision Statement:
Thriving Family Physicians creating a healthier Colorado.

Mission Statement:
The CAFP’s mission is to serve as the bold champion for Colorado’s family physicians, patients, and communities through education and advocacy.
Have Policy Ideas? Turn Them Into Action

Our CAFP membership is diverse, there is no question about that. But there is one thing you all have in common. You can all make a difference and have a voice in the policies that the CAFP and AAFP make.

I’m sure many of you hear that and think there is no way you have the time for such an undertaking. But that’s where the CAFP comes in. Our staff and Board of Directors are here to help you address the concerns that you have, and turn your policy ideas into actions.

For example, during the 2016-2017 legislative session, Direct Primary Care (DPC) physicians came to us with a problem. While they currently represent a small percentage of our membership, they, and the DPC model, are growing quickly. These members needed legislation that would ensure they are not classified as insurance, and are never regulated like insurance. The CAFP stepped up and ran a bill that passed unanimously and with bipartisan support, clarifying that Direct Primary Care is not insurance. These physicians run businesses, see patients, and have busy lives outside of medical practice. The CAFP did the legwork to achieve what these family doctors needed to thrive.

Know that we are here to do that for all physicians in our membership. I encourage you to reach out to me if you see specific policy work that needs to be done. Our CAFP team, including our lobbyists, can be an asset to you.

Likewise, we can help bring your concerns or interests to the AAFP, to make them official AAFP policy.

A couple of years ago, CAFP Board Member and AAFP Delegate Brian Bacak felt concerned over the treatment of minority physicians and patients. He drafted a resolution to take to the AAFP’s Congress of Delegates, that called for the creation of an Office of Diversity within the AAFP. In response, and in working with other stakeholders, the AAFP officially opened the Center for Diversity and Health Equity in 2017.

This is just one example of the thoughts of a member turning into action at the national level. And you absolutely do not have to be a delegate or board member to make this happen! If you have an idea that you think should be brought to the AAFP, let me know. We can assist you with drafting the resolution language, finding support, and bringing it to the Congress of Delegates.

I’ve worked with family physicians for many years, and I know you are a group who believes in taking action, and getting things done. The CAFP shares those values. Together, let’s turn ideas into reality.

By: Raquel J. Rosen, MA, CAE
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Advocacy

CAFP Legislative Update

The 2017 State Legislative Session concluded on May 10th, 2017. Key political conversations included the extent of the federal commitment to key programs like the Medicaid expansion, the state-based insurance exchange, and the Child Health Plan (CHP+). While the federal outlook is still uncertain, Colorado continued its commitment to funding primary care in Medicaid and a bipartisan compromise averted $528 million in cuts to hospitals. CAFP closely monitored 46 bills impacting health care. Read on for an overview of CAFP’s action this session.

CAFP Priority Legislation

Medicaid Reimbursement Rates
“Medicaid Bump”

A key priority for CAFP was, once again, continuing the primary care Medicaid bump. Colorado is one of only a handful of states who continue to pay higher rates. Thanks to extensive CAFP advocacy since the 2016 legislative session, the Governor’s proposed Fiscal Year 2017-18 budget included $54 million to keep enhanced primary care rates in Medicaid. That funding was maintained throughout the state budget process this year and primary care rates (including E&M visit and vaccine administration codes) will remain through July 2018 at 87% of Medicare. This additional funding is expected to continue beyond 2018 through a new, primary care alternative payment methodology. For more on the APM, head to http://bit.ly/2rTq70B

Direct Primary Care Legislation: HB17-1115

HB-1115 was introduced by Representatives Perry Buck (R-Windsor) and Joann Ginal (D-Fort Collins) to define Direct Primary Care (DPC) so that it would not be regulated by the state as insurance. DPC is an emerging payment and delivery model, and Colorado is a leader in the country with more DPC practices than any other state. CAFP worked with numerous DPC physicians across Colorado to draft language that protects practices from the threat of excessive regulation, while ensuring patients have unfettered access to DPC. The bill passed both the House and Senate unanimously thanks to the tremendous efforts of the many physicians who supported the measure, along with CAFP’s skilled lobbyists. It provided an opportunity to highlight for legislators the incredible value of comprehensive, coordinated and accessible primary care.

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

- Sustainability of Rural Colorado (SB17-267 Hospital Provider Fee Enterprise): CAFP has been active in supporting this critical effort to alleviate a looming state budget crisis for over three years. The Hospital Provider Fee (HPF) covers uncompensated care costs for hospitals as well as state costs of the Medicaid expansion. Hospitals pay a fee, which is then matched dollar-for-dollar by federal Medicaid funds, and returned back to the hospitals. The fees collected were counting against the state’s revenue cap created by TABOR, even though they are not taxpayer dollars. Hitting the cap meant lawmakers had to make cuts somewhere. As a result, Colorado’s hospitals were facing a $528 million cut to balance the budget. The move would have jeopardized access to care for Medicaid patients and potentially shuttered a number of rural Colorado hospitals. After months of negotiation, an agreement was reached among House and Senate leaders to turn the hospital provider fee into an Enterprise Fund, which exempts the fees from the TABOR revenue cap and eliminates the need for any budget cuts. The legislation was not without compromise, and several other provisions of the bill included:
  - A reduction in the TABOR revenue cap by $200 million (offsetting some of the room gained for future budgets)
  - Funding state transportation projects by executing lease-purchase agreements of state-owned buildings.
  - Requiring state agencies to submit budget proposals next year with proposed 2% cuts
  - Increasing Medicaid copays for pharmacy (up to $2.54 on average) and hospital outpatient services (up to $4). Pregnant women and children remain exempt from copays.

- Naturopath Registration (SB17-106): Scope of practice is a perennial conversation at the Capitol. Naturopaths (ND’s) are regulated in Colorado, but the statutory requirement to register as an ND was set to expire this year. SB-106 continued naturopath registration. However, in the legislative sausage-making process, ND’s attempted to expand their scope to include prescribing hormones and performing chelation. Though CAFP supported continued regulation of ND’s, we were strongly opposed to expanded scope that would be extremely dangerous to patients. An unfortunate case this year in California illustrates the danger when a patient received a turmeric injection from an ND, and subsequently died. In Colorado, months of negotiation and advocacy...
on SB-106, including dozens of family physicians contacting their legislators, ultimately led to a clean extension of ND regulation without any expansion in scope. We can be sure this and other scope of practice issues will remain on the docket in future legislative sessions.

- **Opioid Crisis (HB17-1350): Failed.** Growing concern over the opioid epidemic is leading policymakers across the country to seek a solution to this complex and difficult problem. Several states have acted through passing measures such as prescribing limits. HB-1350 was a first-in-the-country attempt to allow partial fills of opioid prescriptions, aimed at reducing the number of unused opioids that can find their way into the hands of kids or family members. This problem, commonly known as “diversion,” is a leading contributor to opioid misuse. HB-1350 would have allowed a patient or physician to request a partial prescription fill, enabling a patient to return to the pharmacy to complete the fill only if needed. The bill was introduced late in the session. Without much time for deliberation, the bill failed and legislators established an interim committee to study the issue and other possible state-level solutions. CAFP will be active in this committee, which begins later this summer.

- **Insurance Network Criteria (SB17-088):** SB-88 brings greater transparency to health insurance networks. Now, insurance carriers have to make available the criteria for a provider to be in a particular network, or cost-tier within a network. If the carrier de-selects a physician from a network, the bill also empowers that physician to appeal the decision with the carrier. This provider “de-selection” can be dangerously disruptive to a patient’s treatment if his or her physician is dropped from the network mid-year, and SB-88 offers recourse for folks who are faced with such a situation.

- **Contraceptive Prescription Coverage (HB17-1186):** HB-1186 gives patients the option to get a 12-month supply of contraception, eliminating the need to return to a pharmacy each month or skip a dose. Health plans now must pay for dispensing up to a 12-month supply if prescribed by a physician.

- **Domestic Violence Reporting by Medical Professionals (HB17-1322):** HB-1322 gives physicians immunity when reporting domestic violence, or when not reporting based on the patient’s preference. Under the new law, physicians who do not report to law enforcement must note the victim’s preference in the medical record and make a referral to a victim’s advocate or provide information about services available to victims of abuse. Physicians and patients now have the option to select the best course for their individual situation. The new law ensures patients can access health care without fearing reporting before they are ready. Evidence shows the most dangerous time for a victim of domestic violence is at the time of reporting, hence it is vital to have a safety plan in place.

**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. We were also reserved in putting CAFP resources toward opposing legislation that had a high likelihood of failing without our taking action.

- **Malpractice Liability (HB17-1254):** Failed. HB-1254 aimed to eliminate the noneconomic damages cap for the wrongful death of a child, currently $300,000 in Colorado. While the intent was to eliminate such caps outside of medical liability cases, the overreaching language of the bill would have applied to the practice of medicine. CAFP strongly opposed this move along with COPIC and the Colorado Medical Society. This bill is a reminder of the delicate, and effective, balance that Colorado has struck to maintain a stable liability environment. Whether this bill is a harbinger of future proposals remains to be seen, but it underscores the need to continually educate lawmakers on how a stable tort environment maintains access to high quality care for patients.

- **Immunization Exemptions (SB17-250): Failed.** SB-250 would have eliminated the standard form for medical and non-medical immunization exemptions, jeopardizing the accuracy of state and school immunization records. CAFP testified in opposition to SB-250 for several reasons, including that inaccurate records would cause more kids to receive duplicative vaccines.

- **Efforts to Defund the CIIS Vaccine Registry and Healthy Kids Survey:** There were attempts in the state budget debate to entirely defund the CIIS vaccine registry, a vital clinical tool for physicians providing immunizations. In addition to maintaining this funding, CAFP lobbied heavily and was successful at restoring funding for the Healthy Kids Survey. The survey provides key information on youth health, including suicide ideation and substance abuse. In fact, it is the only source of statewide data on youth marijuana use.

- **Repeal the Colorado Health Exchange (SB17-003): Failed.** SB-003 would have repealed Connect for Health Colorado, the marketplace where over 180,000 Coloradans purchase health insurance and can receive federal tax credits to lower their monthly premium and out-of-pocket costs.

I want to acknowledge CAFP’s outstanding lobby team, Jeff Thorndsgaard and Katie Wolf, for their work to represent Colorado’s family physicians at the state legislature. Their well-earned respect at the Capitol is an asset to advancing the family medicine specialty.
CAFP LEADERS MET NATIONAL POLICY MAKERS IN WASHINGTON DC DURING THE 2017 FAMILY MEDICINE ADVOCACY SUMMIT.

CAFP STAFF AND DELEGATES ATTENDED THE ANNUAL CHAPTER LEADERS FORUM AND THE NATIONAL CONFERENCE OF CONSTITUENCY LEADERS IN KANSAS CITY.

DR. KATIE SEITZ TESTIFYING AGAINST SB-250 THAT WOULD HAVE LOOSENED VACCINE EXEMPTION LAWS.

THE COLORADO PRIMARY CARE COLLABORATIVE HELD ITS 2017 CONVENING ON JUNE 8, BRINGING TOGETHER LEADERS AND THINKERS FROM ACROSS THE HEALTHCARE LANDSCAPE.

DR. CRAIG ANTHONY TESTIFYING ON HB-1186 THAT WOULD ALLOW PATIENTS TO GET A 12-MONTH SUPPLY OF CONTRACEPTION.
GOVERNOR JOHN HICKENLOOPER SIGNS SB-88, REQUIRING TRANSPARENCY IN HEALTH PLAN NETWORK CRITERIA.

GOVERNOR JOHN HICKENLOOPER SIGNS HB-1115, DISTINGUISHING DIRECT PRIMARY CARE AS DIFFERENT FROM INSURANCE.

CAFP STAFF, INCLUDING RAQUEL ROSEN AND RYAN BIEHLE, PRESENTED TO THE RESIDENTS AT SWEDISH FAMILY MEDICINE RESIDENCY.

CAFP PHYSICIANS TESTIFYING ON HB-1115, DISTINGUISHING DIRECT PRIMARY CARE AS DIFFERENT FROM INSURANCE.

CAFP DEPUTY CEO FOR POLICY AND EXTERNAL AFFAIRS RYAN BIEHLE TESTIFYING TO THE COLORADO COST COMMISSION.

CAFP STAFF, INCLUDING RAQUEL ROSEN AND RYAN BIEHLE, PRESENTED TO THE RESIDENTS AT SWEDISH FAMILY MEDICINE RESIDENCY.

THE CAFP WELCOMED THE 2017-2018 BOARD OF DIRECTORS TO THEIR FIRST BOARD MEETING IN MAY.
Hello!

In this quarter’s [Spring 2017] Colorado Family Physician there is a short review of “Shingles Vaccination: Low Uptake in the US”. At $190 a pop (not including the office visit) and at 50% effectiveness, to have vaccinated the 1,000,000 new cases would cost $190,000,000 and prevent 500,000 cases. This would be $380 per case prevented. The vast majority of cases of shingles are nasty irritation with prompt resolution which promptly recedes into memory. Merck’s advertising would have us believe that shingles commonly leads to lifelong blight if you’re lucky enough to live through it. If Merck lowered its price reflecting the usually minor nature of this disease it is possible there would be increased usage.

Ed McAuliffe, MD

The authors reply:

We thank Dr. Ed McAuliffe for raising the issue of cost-effectiveness of Zostavax®, the currently available herpes zoster vaccine. Rather than costing $380 per case prevented, the figure is roughly $7,800 per case prevented according to a published, comprehensive cost-effectiveness analysis of the vaccine (tinyurl.com/khqznrs). This net figure is calculated by subtracting costs of vaccinating an age-specific population minus costs saved by cases prevented, divided by number of cases prevented. Thus, it accounts for the fact that not every elderly person would experience an episode of herpes zoster even if unvaccinated.

We concede that if cost savings were the motivation, routine use of this vaccine would be highly questionable. We believe that prevention of pain and suffering is the overarching purpose. For example, Up to Date says, “Both acute zoster and PHN (post herpetic neuralgia) can be severe conditions associated with profound psychosocial dysfunction including impaired sleep, decreased appetite, and diminished libido.”

Furthermore, those who still come down with zoster after the vaccine tend to get milder cases. More importantly, the risk of PHN, ophthalmic herpes zoster, and hospitalization is reduced by about 70% among vaccine recipients. The number “needed to treat” to prevent one case over three years is 58 for herpes zoster and 364 for PHN.

In our opinion, avoiding or reducing these risks makes the vaccine look inexpensive. Just ask any patient who has had PHN or ophthalmic zoster how much they would now give to have prevented it.

A further consideration is imposed by the fact that we may soon have a much more effective zoster vaccine. According to a recently published study in the New England Journal of Medicine (tinyurl.com/mu2zbcw), a recombinant glycoprotein subunit vaccine demonstrated an efficacy of 97.2 percent in adults 50 years of age and older and 89.8 percent in those 70 and older. This compares to approximately 50 percent for the current vaccine. This vaccine is currently under review by the FDA with a decision expected later in 2017.

We maintain that family physicians are well advised to recommend herpes zoster vaccine for most of our patients 60 years of age and older.

Reginald Finger, MD, MPH
Walt Larimore, MD, FAAFP
Or a spaceship. Or a movie theater. Before the MRI that will help Dr. Michael Handler and his team plan Jacob's seizure surgery, Jacob transformed the room into an ocean. It reduced his anxiety and eliminated the need for sedation, making this procedure safer. The end result: a calm environment for Jacob and more accurate results for the neurosurgery team at one of the top 10 children's hospitals in the country.
THANK YOU TO EVERYONE WHO JOINED US AT THE 2017 ANNUAL SUMMIT!

Be sure to save the date for the 2018 Annual Summit, April 12-15 at the Cheyenne Mountain Resort in Colorado Springs.
It used to be that a child who suffered from inexplicable stomach distress might have to learn to live with issues such as chronic stomach pain or nausea. After a plethora of inconclusive tests, doctors reached the end of the road, and there wasn’t much else they could offer beyond ways to manage their symptoms.

Chronic and recurrent abdominal pain is common in children, and the term functional pain disorder refers to pain for which a specific cause (by history, physical examination, or laboratory tests) has not been found. It occurs in 9 to 15 percent of all children. In boys, pain is most common between ages five and six years. Girls have pain most commonly between five and six years and 9 and 10 years. The economic cost related to this condition in children is not known but is likely to be substantial, considering that expenses associated with irritable bowel syndrome (IBS) in adults have been estimated to be $8 billion to $30 billion per year.

New research has led to improved understanding that may help children with chronic unresolved GI symptoms. The answers lie in the emerging field of the “second brain,” or the billions of neurons that live in the gastrointestinal (GI) tract. When functioning properly, these nerves gather vital information and send it to the brain. Information about hunger, satiety, fluid balance and vitamin and mineral needs are transmitted between the GI tract and brain. They can malfunction for any number of reasons: a past illness such as a GI virus, a chronic condition like celiac disease or an imbalance of the bacteria in the GI tract. If the signal transmission between the brain and GI tract is malfunctioning, there could be a perception of pain or other nonspecific GI symptom without a detectable reason for it.

Clinical presentations that might signal a second brain issue include:

- Dysphagia related to ineffective esophageal motility
- Gastroesophageal reflux
- Gastroparesis
- Cyclic vomiting syndrome
- Hirschsprung’s disease
- Intestinal Pseudo-obstruction
- Slow transit constipation
- Pelvic outlet disorders related to constipation

Everyone will experience injury to their GI neurons at some point, and most will recover without the emergence of chronic discomfort. New evidence suggests that stem cells in the gut can grow new neurons to replace the damaged ones, much the same way it happens in the brain. But some people seem to have challenges replacing damaged neurons, though physicians are not sure why.

Jaime Belkind-Gerson, MD, pediatric gastroenterologist, Director of the Neurogastroenterology and Motility Program, and “second brain” expert at Children’s Hospital Colorado, is trying to find more precise answers.

Belkind-Gerson said he and his team are looking more closely at patient biopsy samples and analyzing patterns of expression of several genes of interest as well as often doing genetic analysis searching for specific gene abnormalities associated with chronic pain. In addition, they are studying the potential mechanisms that cause chronic pain, in the laboratory using several transgenic mouse strains. These have been used to study the response to injury of specific neurons and glial cell subtypes throughout the body.

“The diagnosis that something’s wrong with the ‘second brain’ can be challenging,” he says. “We have to make sure there’s nothing that would otherwise explain the symptoms, such as a bug, or colitis or food allergy. Everyone is a little bit frustrated because the GI doctors usually say, ‘We can’t find any structural abnormality, even within endoscopic biopsies.’”

Dr. Belkind-Gerson’s intervention hinges on obtaining a good history of the illness. Signs that may point to a “second brain” problem are primarily a diagnosis of exclusion.

“In general, we need to make sure there are no alarm symptoms or signs,” said Belkind-Gerson. “These include
but are not limited to weight loss, deceleration of linear growth velocity, significant vomiting, chronic severe diarrhea, evidence of gastrointestinal blood loss, persistent right upper or right lower quadrant pain, unexplained fever, family history of inflammatory bowel disease, or abnormal or unexplained physical findings. The predictive value of blood tests, with or without alarm signals, has not been studied adequately; similarly with endoscopy.”

“We’ll start with lifestyle changes first,” Dr. Belkind-Gerson says. “We’ll have them work on better sleep, lowering anxiety, getting exercise — things which will often be reflected in gut symptoms.”

If symptoms don’t improve, he then considers medications, such as selective serotonin reuptake inhibitors, SSRIs.

Ninety-five percent of serotonin production takes place in the gut. The physiology of serotonin in the gut is complex and there is evidence that there are at least 14 serotonin receptors, each mediating an array of different functions. Amongst these, serotonin is believed to mediate sensory and motility components, immune response, nausea and proprioception and recent evidence suggests that it may be a trophic factor for the reestablishment of injured neurons in our GI tract.

For the time being, for general GI health, Dr. Belkind-Gerson recommends keeping kids active — which helps with motility and sensory function — as well as eating a balanced diet and minimizing stress. Though lifestyle changes are difficult to implement, “They’re well worth it to keep our ‘second brain’ happy,” he says.

And for the long term?

“I think we’re going to find out a lot in the coming years. We — and others — are working hard in our labs to figure this out,” Dr. Belkind-Gerson says.

“We hope to be able to identify specific genetic, microbiome and/or chemical abnormalities in each specific patient. This will likely include analysis of blood, feces and intestinal biopsies. The treatment would be aimed at correcting the specific problem using microbiome manipulation. Changes are diet and life-style, use of trophic factors that enhance enteric nervous system recovery and medication to restore neurotransmitter and chemical imbalance in the ENS. Several groups including ours (Children’s Hospital Colorado GI) is also experimenting how best to transplant neural stem cells into the gut so that these can make new neurons and repair the underlying damage. We hope to have many important advances in this field in the next few years.”
Micturition is a complex, coordinated timed organization between bladder storage and emptying. The urinary bladder, composed of smooth muscle fibers, acts in two ways. It functions to store urine by the relaxation of the detrusor muscle to allow for filling, or contracts to allow for the expulsion of urine. The urinary sphincter is a continuation of detrusor smooth muscle that converges to form a thickened bladder neck controlled by the autonomic nervous system, and a somatically controlled external component (striated muscle); both must relax to allow for the contracting bladder to expel urine. It is the striated muscle component of the external sphincter that a person has direct control over. Storage of urine is achieved by bladder relaxation and simultaneous contraction of both the bladder neck (internal urinary sphincter) and the external urinary sphincter. Micturition occurs when the bladder neck and the external urinary sphincter relax and the bladder contracts, allowing for the unobstructed expulsion of urine. Potty training and bladder awareness allow for normal micturition to develop. These muscle groups function to support pelvic floor organs as well as assist in urinary and fecal continence.

Dysfunctional voiding occurs when the forced contraction of the sphincter muscle is done in a repetitive fashion and the two muscle systems strain against each other, causing a malfunction to occur. Typical chief complaints a clinician may see in practice include UTIs, enuresis, nocturnal enuresis, voiding postponement, gastrointestinal issues including chronic retentive constipation, and encopresis secondary to the willful contraction of the pelvic floor muscle group as a whole.

The Department of Urology at Children’s Hospital Colorado is focusing its efforts to enhance care of patients within the community. Forty percent of referrals to urology are diagnoses of dysfunctional voiding and/or stooling. The mainstay of treatment involves rehabilitation of bowel and bladder habits to improve overall health, which is often temporarily enhanced with medications as well. If conservative treatment with a bowel and bladder program either alone or in combination with medication management does not support success in a timely manner, or if families prefer non pharmacological options to treatment, we can now offer an additional option for management. It is called Pelvic Floor Rehabilitation (PFR) and it is performed through the collaboration of the Urology Department and the Physical Therapy Department at Children’s Hospital Colorado Anschutz Campus in Aurora.

Pelvic Floor Rehabilitation is a noninvasive treatment technique that uses electronic monitoring of normal automatic bodily functions, in this case the pelvic floor muscles, to train the voluntary control of those muscles using visual feedback. The patient is instructed how to properly sequence his/her pelvic floor muscles using a visually stimulating video game. Unlike Kegel exercises, which primarily focus on strengthening the external urinary sphincter in response to stress urinary incontinence after childbirth, PFR assists patients to learn how to relax this overly tight muscle.

Specifically, with incontinence, it teaches the patient how to identify, isolate and target sensations and muscle groups associated with voiding and stooling. This allows them to better control the striated muscles associated with bladder and bowel control.

During the assessment period, a trained physical therapist will place gel based external electrodes on the patient’s abdomen and around the rectum. These electrodes are connected to a computer that will record muscle activity. The patient sits to perform specific computerized programs (Urostym) for 20-30 minutes. These protocol programs calculate the muscle’s fatigue point, which is essential to assess the pelvic floor’s strength and determine the most effective rehab program for the patient. The patient plays a computer game to work on tightening and relaxing the muscles within the pelvic floor. Simultaneously, the patient works on relaxing the abdominal muscles at all times.

Pelvic Floor Rehabilitation is a contributing factor in dysfunctional voiding. Patients are sent home with pelvic floor exercise homework which will help them reinforce the muscle rehabilitation and skills learned during the session in functional positions. The goal of PFR is for the patient to become aware of the muscles used for holding and releasing urine, promote muscle function and coordination, and to minimize the use of accessory muscles to help them become continent of urine and stool.

All patients suffering from dysfunctional voiding should be placed on a bowel and bladder program to promote overall good bladder and bowel habits. However, if there is no evidence of improvement within a 2-3 month period, then referral to pediatric urology is warranted and our staff would gladly be happy to assist with patient care. For further information or to refer a patient please contact Children’s Hospital Urology, 720-777-3926 or Children’s Hospital Colorado Physical Therapy, 720-777-6655.
2016 was a year of many changes across the country and here at home in Colorado. Like always, health care also continues to change at a very fast pace, in ways that we sometimes expect and sometimes don’t.

What is most important to the CAFP, in these ever-changing times? To always go back to our mission: “To serve as the bold champion for Colorado’s family physicians, patients and communities, through education and advocacy.”

Without question, one of the ways we can be a bold champion for members is to be good stewards of your membership dues. That means being financially responsible with your money. Both in the amount we spend, as well as what we spend it on. In this Annual Report, you will find examples of the sound investments we sought to make in 2016, and how that money comes back to you, the physician, as well as the communities you practice in.

For example our advocacy efforts, which focused on staving off payment cuts and creating incentives for providers who are inspiring the next generation of the primary care workforce. Our educational programming, which focused on delivering affordable CME and engaging students and residents who will add greatly to our health care system. And our public health work, which is dedicated to preventing smoking, one of the costliest health battles we continue to fight. Each and every day, the CAFP works to make sure that every dollar invested in a membership with us is a dollar we spend wisely, and gives a return on investment to you and your patients.

Of course, none of this would be possible without you, our members. That was especially clear in 2016, when the CAFP was recognized by the AAFP for our outstanding membership numbers. This included first place awards for the highest percent increase in active members and the retention of new physician members, and a second place award for the highest retention of active members. We were also recognized for having 100% of Colorado Family Medicine Residents as members. Truly, it is because of our vibrant, supportive and growing membership that we are able to make primary care in Colorado great. The entire CAFP Board of Directors and staff cannot thank you enough for your membership, and for your support of primary care.

It was my pleasure and my honor to serve as your president.

Tamaan K. Osbourne-Roberts, MD
2016 Membership Statistics

2,354 Members

1,567 Active Members
223 Resident Members
388 Student Members

148 Life Members
3 Supporting Members
25 Inactive Members

2016 Financial Data

The CAFP continues to be very strong financially. We seek to be responsible and mindful stewards of your membership dues. This includes making socially responsible investments. None of the CAFP’s investment portfolios include tobacco stocks.

Current Assets: $811,557.12
Fixed Assets: $389,026.34
Total Assets: $1,200,583.46
Total Liabilities: $162.62
Total Income: $592,295.59
Total Expense: $552,881
Net Ordinary Income: $39,413.93
Net Other Expenses: $30,470
Net Income: $8,943.84
Medicaid Primary Care “Bump”

During the 2016 legislative session, the state proposed cutting primary care payment rates for Medicaid. Previously, Medicaid payment rates were on par with Medicare. Facing difficult budget constraints, the state proposed reducing these rates to 75% of Medicare. The CAFP knew that was unacceptable. Primary care physicians need appropriate compensation to be able to continue seeing Medicaid patients. We led the newly formed Primary Care Alliance to fight for better payment. We were able to avoid the deepest cuts, bringing primary care reimbursement up to 87.3% of Medicare. The process also allowed us to shine a light on how important primary care is to Colorado. Hundreds of CAFP members shared feedback on how the cuts could hurt practices and patients, called and wrote to legislators, and lobbied at the Capitol. It was impossible for legislators to ignore how harmful balancing the budget on the backs of primary care physicians would be. We continue to fight for a permanent solution, that would bring Medicaid payments into parity with Medicare.
Rural Preceptor Tax Credit

Primary care physicians bring enormous value to rural communities, both economically, and through the local care they deliver. We know that when students and residents train rural, they tend to practice rural.

Unfortunately, some Colorado counties don’t have a single family physician. The problem is compounded by a shortage of rural preceptors. At the time of the bill 160 rural preceptors were available, but 300 were needed to meet the number of interested students.

House Bill 1142 created a $1,000 tax credit available now to MDs, DOs, PAs, APNs and dentists who live in counties without a city of 50,000+ people and precept at least 1 student for a 4 week rotation. The tax credit is taken on personal income taxes. Our hope is that this incentive helps rural providers who want to precept, and expands our rural care network.

One Rural Family Physician Can Create¹

4 Additional Jobs  $286,952 in Wages, Salaries & Benefits  $396,275 in Revenues

2016 CAFP Annual Summit

The CAFP continues to offer discounted CME to members through our Annual Summit. The 2016 event featured topics like mental health, opioids and Suboxone, marijuana, Hep C, physician health and the social determinants of health.

2016 CAFP Award Winners

The Annual Summit also gives us the opportunity to recognize exceptional family physicians and practices, including those who are nominated for and receive our annual awards. Congratulations to the 2017 winners:

Patient Centered Medical Home of the Year
Lone Tree Primary Care

Teacher of the Year
Kurt Dallow, MD

Family Physician of the Year
Mary Fairbanks, MD

Resident of the Year
Michael Matergia, MD
Primary care physicians bring great value to the healthcare system. More family doctors means more access, more prevention, continuity, relationships, and cost savings.

The CAFP continues to engage medical students and family medicine residents. Our goals include helping medical students interested in family medicine find mentors, advice, and success; and helping residents find Colorado connections that will encourage them to stay in our state to practice.

The CAFP held the annual Student and Resident Mixer at Dry Dock Brewery in Aurora to introduce students and residents to the CAFP and our family medicine leaders.

Team-Based Care Grant

The CAFP collaborated with Red Rocks Community College Physician Assistant Program on a grant that encourages team-based care between physicians and PAs. This initial portion of the grant ended with a training session at Red Rocks Community College, where attendees had the opportunity to learn about the value in high-quality, team-based care.
2016 Tar Wars Poster Contest Winner

Congratulations to the students who were recognized for their artwork during the 2016 Tar Wars Poster Contest!

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

New Tar Wars Videos Available

In an effort to bring Tar Wars presentations to more schools, and prevent more children from smoking, the CAFP created video versions of the Tar Wars presentation. These videos can be used by presenters, or by schools unable to bring in a Tar Wars presenter. The videos cover both the main Tar Wars program, as well as a supplemental marijuana video. Thanks to COPIC for providing the grant funding that made this project possible.
CAFP Board of Directors

**Officers**
- **Chair/Past President** – Glenn Madrid, MD, Grand Junction
- **President** – Tamaan Osbourne-Roberts, MD, Denver
- **President-elect** – Monica Morris, DO, Denver
- **Vice President** – Zach Wachtl, MD, Denver
- **Secretary/Treasurer** – John Cawley, MD, Ft. Collins
- **Member-at-Large** – Gina Alkes, MD, MPH, Buena Vista

**External Relations/Awards Committee Chair** – Rick Budensiek, MD, Greeley

**Term Expiring 2017**
- Stephanie Gold, MD, Denver
- Anneliese Heckert, DO, Pueblo
- Anibal Martinez, MD, Castle Rock
- Mason Shamis, MD, Ft. Collins

**Term Expiring 2018**
- Craig Anthony, MD, Denver
- Laurie Patton, MD, Parker
- Aaron Shupp, MD, Broomfield
- Zach Wachtl, MD, Denver

**Term Expiring 2019**
- Gina Alkes, MD, MPH, Buena Vista
- Krista Ault, MD, Durango
- Corey Lyon, DO, Denver
- TJ Staff, MD, MPH, Denver

**Delegates**
- Brian Bacak, MD, Highlands Ranch – term expires 2017
- Rick Budensiek, DO, Greeley – term expires 2017

**Alternate Delegates**
- Glenn Madrid, MD, Grand Junction – term expires 2017
- Tamaan Osbourne-Roberts, MD, Denver – term expires 2017

**Resident Representatives**
- Somayyeh Farazandeh, MD, 2017, St. Anthony North
- Syed Gillani, DO, 2017, Pueblo
- Brian Juan, MD, 2017, Pueblo
- Cleveland Piggott, MD, 2018, University of Colorado
- Matthew Mullane, MD, 2017, St. Anthony North

**Student Representatives**
- Lindsey Herrera, CU, grad 2018
- Grace Borton, RVU, grad 2017
- Joshua Told, RVU, grad 2017
- Marshal Ash, RVU, grad 2018
- Bobby Nieland, RVU, grad 2018
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Say Hello

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
Empathy and Support at the End of Life

This fall, citizens of Colorado voted to legalize medical aid-in-dying. As a physician or hospice provider, your education and support for your patients makes a difference as they navigate the Colorado End of Life Options Act.

“As physicians, it’s our responsibility to listen to our patients, and offer kindness and compassion. Terminally ill patients should not suffer needlessly before dying.”

–Dr. David Grube, M.D

Compassion & Choices’ Doc2Doc hotline offers free, confidential telephone consultation with one of our seasoned medical directors, each with years of experience in end-of-life medical care including medical aid in dying. Call us anytime at 800.247.7421 or visit http://bit.ly/doctor2doctor
Dr. Smith, an internal medicine physician, was informed by his receptionist that one of his patients had “no-showed” her scheduled appointment. This was the fourth time in six weeks that this patient scheduled an appointment, responded affirmatively to a reminder call the day before, but then failed to show up without contacting the office. Dr. Smith asked his staff to send the patient a letter notifying her that she was dismissed from the practice due to repeated violation of the office’s no-show policy.

Eight weeks later, Dr. Smith received an email from the Colorado Medical Board (CMB) stating that a formal complaint had been lodged against him by this patient. In her complaint letter, the patient alleged, among other things, that Dr. Smith had discriminated against overweight people and people with her political views. The patient included numerous anecdotes which she alleged were her experiences demonstrating Dr. Smith’s pattern of discrimination.

Dr. Smith felt that the allegations were absurd and knew they were factually inaccurate, causing him frustration and uncertainty about how he should respond to the CMB. He also worried that this complaint might somehow become public information or affect his credentialing process at a hospital where he was applying for privileges.

Feeling stressed, Dr. Smith spent several hours over the weekend drafting an angry, multi-page response to the CMB written in a manner that spoke more directly to the patient instead of the CMB. After receiving Dr. Smith’s response, the CMB advised Dr. Smith that he would have to rewrite a response addressed to them (not the patient) regarding the original allegations.

This case illustrates how a common type of patient complaint may result in notification from the CMB. It also shows how trying to handle the situation yourself without professional legal advice or personal restraint can be time-consuming, emotionally taxing, non-productive, and may even make your situation worse.

When patients complain to the CMB for allegations such as discrimination, abandonment, inappropriate behavior, physician incompetence, or other scenarios, it may result in you receiving a request for more information from the CMB. It is important for physicians to understand that all CMB inquiries should be taken seriously and should be addressed professionally and in a timely fashion. The basics of a CMB inquiry are as follows:

• The CMB receives notifications regarding allegations of potential unprofessional conduct by a physician. These notifications can come from an unhappy patient and/or his or her family members.
• The CMB contacts the physician by email and requests a response to the allegations. Not responding because there was an outdated email on file (so you didn’t receive it) is not an acceptable reason.
• A physician typically has 30 days from the date of the CMB’s email to respond. The email will state how many days are allotted for the response. Failure to respond within the designated time frame may result in formal discipline against your medical license.
• The CMB wants objective information from you that will enable them to understand, evaluate, and resolve the allegations.

Physicians can make several common mistakes when they attempt to handle the CMB request themselves:

• Failing to deliver a response to the CMB within a 30-day window—This can result in disciplinary action from the CMB including the possibility of medical license suspension.
• Responding to the patient directly in an angry, defensive manner or failing to respond to the CMB in a dispassionate “just-the-facts” manner—This can raise further concerns for the CMB to evaluate a physician’s actions and it can make things much worse for the physician.
• Trying to handle the response process yourself without professional legal help—This can be time consuming, take away from your medical practice, and cause excess stress in your professional and personal life. You should seek professional legal help in drafting a response (physicians insured by COPIC have access to attorney support as part of their coverage).
• Having an outdated email on file with the CMB—The CMB generally reaches out to physicians by email when requesting responses to complaints. If the CMB has an outdated email and a physician claims to have never checked that email, that is considered the same as a non-response.
More business means more challenges. And more ways we can help.

At Commerce Bank, we know that as your company expands, new financial challenges arise. That’s why we work with you to secure new equipment, streamline cash flow and finance real estate. That means you can get back to focusing on running a successful business.
As more children adopt demanding schedules with increased academic work loads and an abundance of extracurricular activities, some react by showing signs of increased stress and anxiety.\(^1\) Our academic system has accelerated so children are now expected to complete school work previously given to children in higher grade levels. Early education has become less play focused and children receive a more academically rigorous curriculum. This change is evident by the amount of time children spend preparing for 3rd grade exams that measure performance in math and reading. On average, 77% of kindergarteners received 90 minutes of daily reading instruction in 2010 whereas only 32% received daily reading instruction in 1998.\(^2\) With increased academic demands and busy schedules, children may need to take an intentional break in the day to relax and recharge. The practice of mindfulness is quickly gaining recognition as an activity to help children manage feelings of stress and anxiety.

Mindfulness can be practiced during breaks at school, between homework assignments, before bedtime, and when children may be experiencing heightened feelings of stress or anxiety. Families can initiate a mindfulness session by sitting in a relaxing environment and concentrating on their sensory perceptions such as how they feel when taking deep breaths.\(^3\) This form of relaxation allows children to temporarily let go of distractions in their lives and focus only on a sensation of their choosing without overreacting or feeling overwhelmed. With practice, children can benefit from mindfulness both behaviorally and developmentally by learning how to process and understand their thoughts, emotions, and surrounding environment. The activity is a form of reflection, which can improve their well-being.\(^4,5\)

Since mindfulness is an emerging topic, much of the research published evaluates adult populations. However, studies on children have revealed similar results that connect the practice of mindfulness to positive states of mind. Teaching children to be mindful can improve their:

- Ability to manage anxiety \(^6\)
- Executive function skills \(^4\)
- Attention capabilities \(^7\)
One of the important executive functions children build through mindfulness is emotional control. Mindful children are more equipped to process their feelings instead of resorting to a habit or impulse response. A 2014 study conducted in Richmond, CA observed the implementation of the Mindful Schools program where teachers worked with children to practice mindfulness over the course of 7 weeks. Students in 17 different classrooms participated in 15 minute mindfulness sessions, and teachers used a rubric to report their behavior. Results indicated that practicing mindfulness improved students’ ability to pay attention in class, maintain self-control, respect others, and participate in classroom activities.

The benefits of children practicing mindfulness can also be observed in very young children, possibly as young as preschool aged. Data from a 2015 study measuring preschoolers’ inhibition responses revealed that mindful yoga improved their ability to manage impulses. The study used a series of assessments including asking the children to not watch while an adult wrapped a gift, asking children to not touch the present after it was wrapped, and asking children to play ‘Head, Shoulders, Knees, and Toes’ by performing the opposite motion as the interviewer. The children who studied mindful yoga performed better on the assessments by showing a greater ability to delay gratification and control both behavior impulses and attentional impulsivity.

Ultimately, the goal of introducing children to mindfulness is to improve their self-reflection outside of designated times when they’re focused on breathing—to gain a greater awareness about their experiences, thoughts, and feelings. Caregivers who are interested in helping their children practice mindfulness at home can follow these three tips:

- **Use mindfulness to focus on different types of sensations:** Although basic mindfulness helps children concentrate on their breathing, they can also focus on how their legs or arms feel or on scents such as the smell of an orange peel. Focusing on sounds is another good mindfulness exercise. Children can concentrate on the sound of a fan rotating, birds chirping outside, or another sound that is part of the environment where they are practicing.

- **Practice mindfulness during activities that require movement:** This helps children incorporate mindfulness into everyday activities. Walking can be a good way to start because children focus on the physical sensation of how their legs or feet feel while moving.

- **Make time for mindfulness as a family:** Families can dedicate an area of the house to practice mindfulness together and they can also set aside a time of day such as before bedtime. Both caregivers and children should talk about how they felt throughout the day or what they focused on to help become more mindful.

### About Pathways.org

Pathways.org is a national not-for-profit dedicated to maximizing children’s development by providing free tools and resources for medical professionals and families. Medical professionals can contact Pathways.org to receive free supplemental materials to give away at well child visits and parent classes. Our free brochures can be viewed at Pathways.org. For a free package of brochure to give away to families, please email friends@pathways.org.


2017 CAHP Wellness Conference

Resilience in Action: Practical Advice for Wellness In & Out of Practice

August 11-13, 2017
Beaver Run Resort & Conference Center
Breckenridge, CO

Learn more and register at www.coloradoafp.org/wellness

Friday, August 11

12:00 PM
Knowledge Self Assessment

5:00 PM

6:00 PM
Adolescent Vaccination Panel (Dinner Provided)

* This activity is supported by a grant from the AAFP
Saturday, August 12

7:00 AM
Breakfast

8:00 AM
Morning Wellness Break (Self-Guided)

9:00 AM
Introduction & Overview
- Background, definitions, prevalence of burnout
- Literature review of burnout, resilience, and evidence-based interventions
Abbie Beacham, PhD

9:45 AM
Break

10:00 AM
Concurrent Workshops: Mindfulness
- Introduction, science of mindfulness
- Practices, tools
Jennifer Reese, MD & Abbie Beacham, PhD

Concurrent Workshops: Connecting with Joy & Gratitude in Practice
- Overview of positive psychological interventions
- Practices, tools
Jennifer Reese, MD & Abbie Beacham, PhD

11:00 AM
Concurrent Workshops: Connecting with Joy & Gratitude in Practice
- Introduction, science of mindfulness
- Practices, tools
Jennifer Reese, MD & Abbie Beacham, PhD

Concurrent Workshops: Mindfulness
- Introduction, science of mindfulness
- Practices, tools
Jennifer Reese, MD & Abbie Beacham, PhD

12:00 PM
Lunch Followed by Wellness Break (Self-Guided)

2:00 PM
Concurrent Workshops: Finding Your Values Compass
- Introduction to values
- Exercise to identify values in different life domains, discussion
Jennifer Reese, MD & Abbie Beacham, PhD

Concurrent Workshops: Peer to Peer Support
- Review second victim and evidence of benefits of peer support
- Education and practice with interactive discussion on how to be a good peer
Jennifer Reese, MD & Abbie Beacham, PhD

3:00 PM
Concurrent Workshops: Peer to Peer Support
- Review second victim and evidence of benefits of peer support
- Education and practice with interactive discussion on how to be a good peer
Jennifer Reese, MD & Abbie Beacham, PhD

Concurrent Workshops: Finding Your Values Compass
- Introduction to values
- Exercise to identify values in different life domains, discussion
Jennifer Reese, MD & Abbie Beacham, PhD

4:00 PM
Adjourn for Dinner on Your Own and Self-Guided Activities
## Sunday, August 13

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:00 AM</td>
<td>Breakfast</td>
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<td>8:00 AM</td>
<td>My Personal &amp; Professional Network</td>
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<td>- An in-depth and interactive workshop to help participants identify</td>
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<td>and reflect on and access personal and professional support</td>
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<td>networks, building personal resilience and professional joy.</td>
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<td>Exercise 1: My support timeline</td>
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<td>Exercise 2: My network</td>
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<td>Exercise 3: Gratitude exercise from timeline and network</td>
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<td>Martina Schulte, MD</td>
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<tr>
<td>9:45 AM</td>
<td>Break</td>
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<td>10:00 AM</td>
<td>Creating Structures to Live with Intentionality</td>
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<td>- Identifying new ideas, practices and intentions from the workshops</td>
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<td></td>
<td>and figuring out how to incorporate them into real life is the</td>
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<td>purpose of this session. It will focus on ways to create structures</td>
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<td>to begin to put practices into action. Current networks around</td>
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<td>scheduling will be reviewed and the group will have the chance to</td>
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<td>learn one scheduling tool. In-depth practice.</td>
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<td>Exercise: Scheduling template adapted from Stephen Covey and The 7</td>
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<td>Habits of Highly Effective People</td>
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<td></td>
<td>Martina Schulte, MD</td>
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<tr>
<td>12:00 PM</td>
<td>Conference Adjourn</td>
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**SAVE A LIFE. DON'T DRIVE HOME BUZZED. BUZZED DRIVING IS DRUNK DRIVING.**

**U.S. Department of Transportation**

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**EXPLORE THE EXTRAORDINARY | 2017**

**Love, Light and Healing Energy**

**FEATURED SPEAKERS**

**EBEN ALEXANDER, MD**  
Neurosurgeon & Near-Death Experiencer  
Author | PROOF OF HEAVEN

**JEAN WATSON, RN, PhD**  
Caring Science Founder  
Author | CARING SCIENCE AS SACRED SCIENCE

**MARK ANTHONY, JD**  
Psychic Lawyer & Near-Death Experiencer  
Author | EVIDENCE OF ETERNITY

**MARJORIE HINES WOOLLACOTT, PhD**  
Neuroscientist & Meditation Author | INFINITE AWARENESS

**WITH SPECIAL PRESENTATIONS BY:**  
**LARRY DOSSEY, MD**  
**AND P.M.H. ATWATER, LHD**

**WESTMINSTER, COLORADO | AUG 3 – 6**

**neardeathconference.com**
SNOCAP has been busy planning for the upcoming conference season! Our director, Dr. Don Nease, has been traveling to all corners of the planet sharing information and learning from others, while Mary and Victoria have stayed behind to help submit conference abstracts and get plans in order for the upcoming SNOCAP Convocation. An additional huge thanks to our practices who have helped with updating their practice information via our online practice contact survey. This information is crucial when writing grant proposals and sharing our work.

**SAVE THE DATE** for the 2017 SNOCAP Convocation and CCTSI-Community Engagement Research Exchange and Poster Session. Join us on Friday and Saturday, September 22-23, 2017 at the Hyatt Regency Hotel in Aurora. SNOCAP partners/affiliates will receive more information soon. If you are not currently a SNOCAP partner and would like additional information, please email our Coordinator, Mary Fisher at mary.fisher@ucdenver.edu, or follow this link [http://eepurl.com/bfteGf](http://eepurl.com/bfteGf) to sign up for our bi-monthly newsletter.

In May, SNOCAP awarded three poster teams of residents that submitted to the Colorado Family Medicine Residencies’ Rocky Mountain Research Forum (RMRF). Congratulations to the top three teams; from University Family Medicine Residency – Denver Health Track, Saint Joseph Family Medicine Residency, and University Family Medicine Residency. Each will send one representative to the 2017 North American Primary Care Research Group (NAPCRG) conference in Montreal, Canada! Check out this link [http://www.cofmr.org/rocky-mountain-research-forum](http://www.cofmr.org/rocky-mountain-research-forum).

Thanks for continuing to read our SNOCAP updates to stay informed.

Wishing you well,

Your SNOCAP Team
Don Nease, Mary Fisher, Victoria Francies, and Shraddha Gandhi

---

**SCL Physicians**

**WORK HARD AND PLAY HARD!**

Blend location & organizational fit into your professional and personal life. SCL Physicians meets all those needs, while supporting why you went into medicine!

At SCL Physicians, we are committed to providing exceptional patient care, as well as supporting a high standard of living for our physicians. The Denver/Boulder area is an outdoor enthusiast’s paradise, offering hiking, fishing, cycling, skiing and National Parks, to help you enjoy a balanced Colorado lifestyle.

- Join a growing multi-specialty group of medical professionals
- We offer a large patient base and busy clinic with the potential to grow
- Enjoy a climate with all four seasons, and the extensive outdoor recreational activities Colorado offers
- Family friendly communities rich in culture & history
- Competitive salary with productivity incentives
- Excellent benefits package including malpractice & tail
- Commencement bonus, relocation and CME reimbursement

Now recruiting an experienced Family Medicine MD/DO to join a growing and existing clinic with our premier medical group, SCL Physicians. Several locations within the Denver/Boulder area available. Seeking for our Oasis location and our Aurora, CO location.

Contact Lee Meyer, Physician Recruiter, for details:
Lee.Meyer@sclhs.net
303-813-5048
Learn more about us: [SCLPhysicians.org](http://SCLPhysicians.org)
A study published online in *Pediatrics* ([tinyurl.com/jvgzpzx](http://tinyurl.com/jvgzpzx)) reported that babies appear to be less likely to contract pertussis “if their mothers are vaccinated against the potentially fatal respiratory infection during pregnancy.” The researchers examined “data on almost 149,000 infants born in California from 2010 to 2015” and found that infants “whose mothers got the Tdap booster vaccine for tetanus, diphtheria, and pertussis were 91 percent less likely to get whooping cough during the first two months of life, a critical period before US infants typically get their first dose of the pertussis vaccine.”

In related research, CDC researchers examined infants ages 4 months and younger between 2002 and 2005, before the implementation of Tdap recommendations in the US, and found that those whose mothers had coughs lasting for at least five days had a more than 43 times higher risk of developing pertussis, compared with those whose mothers did not have prolonged new cough. The findings in *The Pediatric Infectious Disease Journal* ([tinyurl.com/lry39r7](http://tinyurl.com/lry39r7)) also showed a more than 20 times increased risk of pertussis among those exposed to at least one nonmother contact with prolonged cough in primary and secondary households.

This immunization is critical, as another recent report from the CDC ([tinyurl.com/l8gr2ky](http://tinyurl.com/l8gr2ky)) emphasizes that “infants younger than 2 months accounted for 38.7% of all pertussis cases from 2000 to 2015, the largest burden among the four age groups studied.” CDC data showed a 47.6% decrease in total pertussis cases in that time period. The CDC adds, “Although pertussis cases have been increasing in the United States, there is a way to help protect infants (those who are at the highest risk of death and complications from this disease)—vaccinating pregnant women and children is the best way to prevent this disease in infants.”

The bottom line: Be sure that all of your pregnant patients and all others living in their households are immunized against pertussis and influenza. Don’t forget to include care providers and extended family (i.e., grandparents).

Parental flu vaccine concerns may influence uptake in children

According to research in *Vaccine* ([tinyurl.com/kuzu9a9c](http://tinyurl.com/kuzu9a9c)), parents who chose to vaccinate their children against influenza during the 2015-2016 flu season (1) had previously received the influenza vaccination themselves, (2) believed that the vaccine is safe and effective, and/or (3) thought that their children were more susceptible to influenza. The findings, based on a cross-sectional survey involving 1,001 parents of youths ages 2 to 7, also showed lower odds of flu vaccination during the 2016-2017 flu season among those who (1) thought there were negative associations between the vaccine and safety and/or (2) believed that the vaccine would create short-term side effects or long-term health problems.

A related study in *Pediatrics* ([tinyurl.com/msw5jot](http://tinyurl.com/msw5jot)) analyzed vaccination coverage in Oregon and reported that youths whose parents received the flu shot were almost three times more likely to have a flu shot themselves, and they were also more likely to receive other vaccines, compared with youths whose parents did not have the flu shot. Similarly, children whose parents were not vaccinated against the flu were less likely to be vaccinated against diseases such as human papillomavirus.

The following three reports offer ways we FPs can overcome some of this vaccine hesitancy:

1) Educate parents that most kids who die of flu are not vaccinated

In findings published in *Pediatrics* ([tinyurl.com/n5y287y](http://tinyurl.com/n5y287y)), CDC researchers “found that at least three-quarters of kids who died from influenza between 2010 and 2014 had not been vaccinated in the months before they got sick.” The CDC team estimated that “on average, 65 percent of flu-related deaths could be prevented if all US” children received a “yearly flu shot.” Meanwhile, “among children with high-risk medical conditions, the vaccine could cut the risk of death in half.”

2) Provide access to online videos to help vaccine-hesitant patients

The AAFP has three new online videos on influenza, zoster, and pneumococcal vaccines that can help family physicians educate patients on the importance of vaccinations. The videos can be viewed at tinyurl.com/mzzb96b.

3) Provide patient prompts to increase flu shot rates
The flu vaccine has been shown to prevent, or at least lessen symptoms, of influenza, yet less than half of American adults receive the vaccine annually, according to the CDC (tinyurl.com/l9pjrxa). Another key to improved vaccination rates is as simple as a programming change that reminds physicians to have the conversation about the flu vaccine with their patients. Many excellent reminder systems are detailed in The Community Guide at tinyurl.com/lo6jn9p.

**Stronger vaccine exemption laws may reduce measles outbreak risk**

States with easy nonmedical vaccine exemption policies were 140% and 190% more likely to experience a measles outbreak than states with medium and difficult exemption policies, respectively, researchers reported in Academic Pediatrics (tinyurl.com/lu1bc5t). The findings also showed that strengthening immunization policies reduced outbreak size by 50% and bolstered public health, health care system, and individual cost savings.

**Too few adults getting vaccinated, experts find**

Only 20% of adults are getting the recommended tetanus-diphtheria-pertussis and pneumonia vaccines, according to a surveillance summary published by the CDC (tinyurl.com/m5mres9). Current vaccine recommendations can be found on the CDC web site at tinyurl.com/gu59oy2.

**HPV Vaccine May Not Be Dangerous When Inadvertently Given Early In Pregnancy, Study Suggests**

Research published in the New England Journal of Medicine (tinyurl.com/lidyeq7d) suggests human papillomavirus vaccine “is not dangerous ... when it is inadvertently given during early pregnancy.” Investigators found that “among 1,665 women exposed to the ... vaccine while pregnant, there was no increased risk of having a child with a major birth defect compared to 6,660 women not exposed during pregnancy.” The investigators also did not see an “elevated risk for spontaneous abortion, preterm birth, low birth weight, stillbirth, or having a child who is small for gestational age.”

**Health officials consider 3rd MMR vaccine dose as mumps outbreaks increase**

Increasing mumps outbreaks in the US since 2006, as well as waning mumps immunity, are prompting federal health officials to investigate the efficacy of an additional dose of measles, mumps, and rubella vaccine. CDC viral diseases expert Mona Marin told the CDC’s Advisory Committee on Immunization Practices (ACIP) that state and local health officials have expressed interest in implementing a third MMR dose to prevent mumps outbreaks (tinyurl.com/leg68p5). Public health officials are worried that the sudden spike of mumps cases in the US, which have been reported in 37 states so far this year. The most recent information from CDC about mumps cases and outbreaks can be found at tinyurl.com/jnxlcby.

**Somali community falls victim to measles outbreak after anti-vaccination campaign**

The Washington Post, on its front page (tinyurl.com/kwwsgyu), said a “full-blown outbreak” of measles in Minnesota is “one of the starkest consequences of an intensifying anti-vaccine movement in the United States and around the world that has gained traction in part by targeting specific communities.” The Post blamed the spread of the disease on “Andrew Wakefield, the founder of the modern anti-vaccine movement,” who traveled to Minneapolis “at least three times in 2010 and 2011 to meet privately with Somali parents of autistic children, according to local anti-vaccine advocates.” The New York Times (tinyurl.com/kreles3) reported that Minnesota health officials are “grappling with the largest outbreak of measles” since 1990, and the disease “is mainly sickening young children of Somalian immigrants who fell under the sway of anti-vaccination activists.” The Times said Minnesota “has reported 41 confirmed cases of measles since April, and the outbreak is the largest this year in the United States, which had essentially eradicated the disease in 2000 before discredited research stoked fears of a link between vaccines and autism.”

**CDC panel updates guidance on HBV revaccinations for some infants**

A single additional dose of hepatitis B vaccine should be given to babies born to mothers with hepatitis B and who did not respond to the primary three-dose vaccine series, instead of a second three-dose revaccination, according to updated recommendations (tinyurl.com/mk2w2b6) from the CDC’s ACIP. However, the guidance said that those whose hepatitis B antibody levels remained below 10 mIU/mL after the revaccination should receive the two other doses and undergo post-vaccination serologic testing one to two months after the final dosage.

**US Health Officials Scramble To Cover Yellow Fever Vaccine Shortage**

The AP (tinyurl.com/kukndab) reports US health officials are warning that a manufacturing problem has created a shortage of YF-VAX, the only version of the yellow fever vaccine licensed in the US, and the CDC says it could run out. Stockpiles of the vaccine “have been strained globally, and shortages were a major problem during recent outbreaks in Africa.” The Washington Post (tinyurl.com/mq2aexl) reported that the CDC’s Marty Cetron said the agency is working with the FDA “address the shortage by expanding access to a different type of yellow fever vaccine that will be imported from France.” According to the Post, the alternative, Stamaril, is “considered investigational and is unlicensed in the United States but is registered in more than 70 other countries and is believed to have a comparable safety and efficacy profile to the one currently in use in the US.”
WHERE FOR CARE

Health organizations across Colorado have joined together in a new statewide health education effort to help people understand how to access the right care, at the right time, at the right level. The “Where for Care” campaign aims to create consumer awareness around the concept that there are choices for where consumers should seek care – and it’s no longer just the decision of what hospital to choose.

The collaboration, led by the Colorado Hospital Association (CHA), was created to curb consumer confusion surrounding the various levels for treatment – such as primary care, urgent care and emergency department – and their associated costs. With more and more care options becoming available – through retail clinics, telehealth, insurer-provider nurse lines, freestanding emergency departments and urgent care centers – consumers need to better understand what each care site offers, what the cost implications may be and when they should seek care at each of those places.

“Consumers look at all the available care sites – like emergency departments and urgent care centers – but don’t know how they differ from care received at the hospital,” said Steven Summer, CHA president and CEO. “They may not understand the intricacies of their insurance coverage. Through the Where for Care campaign, we want to change that and empower people so that they know exactly what to expect in terms of cost and care before they enter a medical facility. All care sites exist for a reason, and our goal is to begin to help consumers understand when they should seek care at each level of care, which will lead to more efficient use of the health care system and will benefit all involved.”

CHA funded the development of the campaign, with support from its member hospitals and health systems and several partner organizations. Other partners involved include the Center for Improving Value in Health Care (CIVHC) and the Colorado Chapter of the American College of Emergency Physicians (ACEP).

CHA applied to the Denver Ad Club Good Works program and was accepted as a partner. The Good Works program matches non-profit organizations with an advertising agency that agrees to create a campaign and assist with the media buy. Burns Marketing partnered with CHA to develop effective creative concepts and to write the initial material needed to create collateral and the website, www.whereforcare.org.

The Where for Care campaign is a valuable resource for consumers, and this partnership among hospitals and community partners better informs people before they become patients.

For more information, visit www.whereforcare.org.

CONGRATULATIONS TO GAVIN CICHELLO, 2017 TAR WARS POSTER CONTEST WINNER!

Gavin is a 5th grade student at Chipeta Elementary in Colorado Springs.

Congratulations also to Gavin’s teacher Jaime Kronmiller and Gavin’s Tar Wars presenter Rhonda Heschel.

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Twelve. That’s how many of Colorado’s 42 hospitals in rural areas were threatened with shutting down this year, while more faced dramatically scaled back services. That is, until a seemingly rare bird in today’s political climate took flight – bipartisanship.

75% of Colorado’s 64 counties are rural, and the people who live in these areas often have to drive great distances to get access to healthcare. Regular access to primary care is a challenge, and the distance can mean the difference between life and death in an emergency. That’s why the Sustainability of Rural Colorado Act – Senate Bill 267 – was so important to pass this year. The bill averted a $528 million cut to Colorado’s rural hospitals by turning the hospital provider fee into a government-run enterprise. The move removes the revenues from state budget caps imposed by TABOR, a state law that restricts the growth of state spending.

SB-267 is a celebration of bipartisanship and the art of compromise, and it represents a commitment to the vitality of Colorado’s rural communities. Family physicians are among the remaining few who continue to practice where they are most in need. Family physicians outnumber emergency physicians in rural areas by a ratio of 7 to 1. Nearly 23% of family physicians practice in rural areas, compared to 10% of physicians in other specialties.
Beyond maintaining the health of rural residents, physicians and hospitals contribute substantially to the economic health of our communities. They are the keystone of a community. Had the cuts to hospitals gone through, many rural communities’ economies could have gone into a spiral. Rural hospitals employ hundreds in high paying jobs. Physicians alone contribute millions to a local economy, generating over $1 million in direct economic activity and contributing to the creation of 22 jobs on average.

Though it took three years of negotiation and the threat of devastating cuts on our doorstep, SB-267 is indicative of the way we do things in Colorado. In a test of leadership, parties can reach across the aisle, and we can bridge the perceived urban-rural divide to the benefit of our communities.
As part of the CAFP Discount Program, the following companies are offering special pricing and opportunities to CAFP members.

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**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 CAFP member to receive discount.
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