

COLORADO FAMILY PHYSICIAN

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COLORADO ACADEMY OF
FAMILY PHYSICIANS

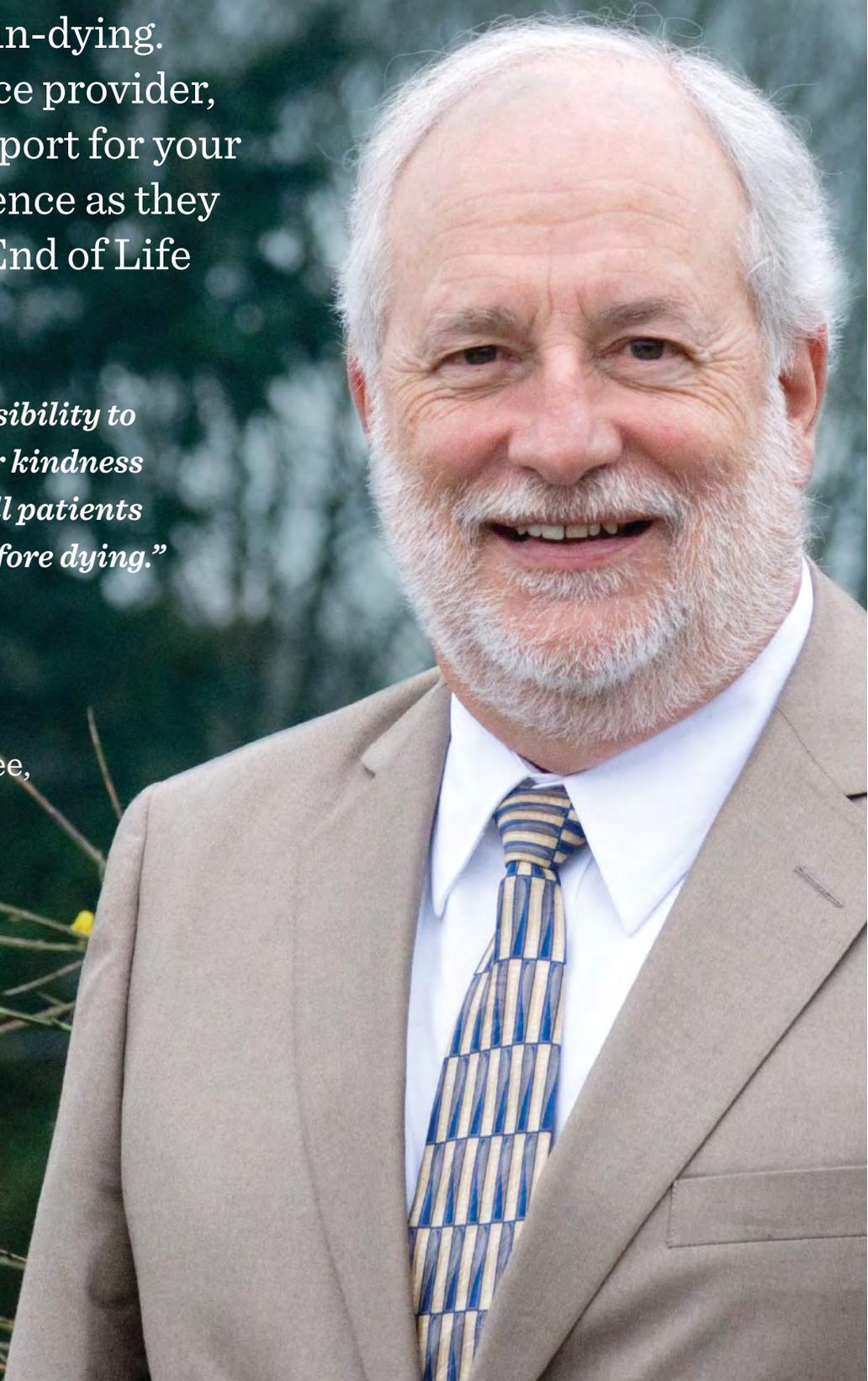
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—Dr. David Grube, M.D

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Vision Statement:

Thriving Family Physicians creating a
healthier Colorado.

Mission Statement:

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

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PRESIDENT'S REPORT

By: Tamaan Osbourne-Roberts, MD FAAFP



*“ ‘Hope’ is the thing with feathers -
That perches in the soul -
And sings the tune without the words -
And never stops - at all -...”*

—Emily Dickinson

It was during my third year of college, in the season of my MCAT, that I opted to seek the Roman Catholic sacrament of Confirmation. While my religious zeal (and indeed, my faith itself) had never taken a straight line, instead zigzagging in the peaks and valleys that characterize so many of our lives, the commitment to helping others represented by my medical studies had inspired me to seek out tangible symbols of my dedication, and as a dyed-in-the-wool Catholic, Confirmation seemed appropriate...a culturally relevant, full-throated and public declaration of a life of service.

Amongst the many rituals and rites of the process was the need to seek a confirmation name; that is, the name of a saint whose story embodied the ideals that I hoped to move forward with as a confirmed Catholic, a role model who spoke to the specific life I wanted to lead. As a future healer, and as a child of immigrants who hoped (and still hopes) to bring his skills and talents to the aid of those across the world, I pored over various resources, seeking a name that would resonate with these goals, and I eventually settled on St. Raphael, patron saint of both healers and travelers.

On the day of my confirmation, so that he might seal me with the correct confirmation name, the archbishop leaned over and asked me for the appellation I had chosen. “Raphael,” I responded.

To my surprise, the bishop did a double-take. He then glanced mischievously at my parish priest, looked back at me, smiled warmly, and said, “Well, that’s a lot to live up to.”

Only then did I realize just how ambitiously I’d chosen. Raphael is no ordinary saint...he is an archangel, and indeed, only one of three angels (archangel, or otherwise) mentioned by

name anywhere in the Catholic Bible. Of all the saints I might have picked, I’d inadvertently picked from the handful that clearly transcended human ability.

I smiled sheepishly, knowing that he was right...and still, with the typical confidence of a future physician, I leaned forward and allowed him to seal my forehead with perfumed oil, whispered blessings, and my promise to emulate the life associated with the name I’d chosen. I knew such would be difficult, likely impossible, but I was willing to try.

And on many difficult days as a physician since, I must admit...I wonder if this is the universe’s way of telling me perhaps I tried to bite off more than I could reasonably chew.

The profession of family medicine is one in which we are all called to serve. Some of us are called by spiritual or religious devotion. Some of us are called by our families: parents, siblings, or others who chose to tread the path of the physician before us. Some of us are called by something vague and hard to quantify, but which pushes us out into the world, seeking to do good. But in almost all cases, it is some bright thing with wings—hope, love, devotion, maybe even an archangel—that has moved us forward in the work that we have chosen to make the focus of our lives, that bears us through the days of our successes and the nights of our difficulties.

So, then...what do we do when the skies we fly through threaten to crush those wings?

The last eight years have been a whirlwind of change for medicine in general, and family medicine in particular. Following the results of the recent election, the next four years promise little other than the same, even if now in a different direction. The politics and the politicians change, but the storm continues to rage. Left wing...right wing...it hardly matters which way the wind blows, if the maelstrom threatens to crush both wings and throw us from the sky.

In such a storm, a safe haven is needed. And it is exactly such a safe haven that the

Colorado Academy of Family Physicians seeks to provide. The winds may be unsteady and unpredictable...but we are not. Our goal is simple: to stand as a rock, resolute in defense of patients and physicians, a perch upon which all may alight to steady themselves before taking again to flight.

A few years ago, I found myself in reflection at a Catholic monastery in Orange County, off the southern California coast. One of my best friends, a brilliant man who is very deeply involved in his faith, had asked me to join him there; he had recently been diagnosed with an exceedingly slow-growing, but metastatic, cancer, and he knew that much in my personal and professional life had left me sick of heart, and shaken of spirit. With that in mind, he thought we might spend some time together, reconnect to each other and to existence, and consider our paths forward together...him, in the decades of health he hoped to have left, and me, in whatever time I would be granted to make a difference in the world. While my faith was decidedly not what it once was, something encouraged me to make the flight out to accompany him.

While there, I walked into the gift shop, and perused the various pieces of jewelry...and chanced upon a sterling silver medal of St. Raphael. On a whim, I bought it, and asked the monastery’s abbot to bless it for me. I took it out the other day to look at...it hadn’t tarnished at all, and the archangel’s wings stood out in bold relief above the traveler he was accompanying, shielding him from harm. I considered wearing it...and then realized that I am not yet again at a place in my spiritual journey where I would feel right doing so. However, just holding it gave me hope, and filled me with calm.

Sometimes, all one needs is a good pair of wings, and a place to perch for a little while...and the rest will work itself out.

Until next time.

Tamaan K. Osbourne-Roberts, M.D.

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Reflections on 2016, and a Look Forward to 2017

Happy New Year CAFP members! I hope you enjoyed your holiday season.

During this time of year, I always find myself reflecting on the past months, and looking forward to what is ahead. 2016 was a successful year for the CAFP, though not a year without challenges. Our academy now represents over 2,300 members, and last year we again saw great growth. I want to welcome all of you who joined us in 2016, either as a first time member or as a transferred member from another state. We are so thankful for each and every one of you.

2016 started with the kick-off of the legislative session. It proved to be a challenging year at the Capitol, with many budgetary constraints and competing priorities. Our main focus was the proposed cuts to Medicaid, that would have reduced payments to 73% of Medicare rates. This was unacceptable, and would have hurt many of your practices, particularly those of you in rural and private practice. The CAFP led the fight against these cuts, and ultimately succeeded in raising the rates to 87.3% of Medicare. We know that any percentage less than 100 is still felt among members, and we continue to press for ways to bring Medicaid and Medicare rates into permanent parity.

I am encouraged by the Governor's proposed 2017 budget, which includes the rates we worked for last year. I believe this is a positive sign that the importance of primary care is being recognized by our leaders.

We were also happy to be a part of House Bill 1142, which allows rural primary care preceptors to take a \$1,000 tax credit on their personal income taxes. Our hope is that more students will experience what being a

rural family physician is all about, and that our members find this financial incentive helpful!

Outside of the Capitol, the CAFP won awards from the AAFP for membership and legislation, our Fit Family Challenge research was published in the ABFM Journal, we produced videos on Tar Wars and Marijuana, we awarded family physicians for their excellence, watched you take care of patients while serving as Doctor of the Day, got to know you better at our Annual Summit, and

visited with you throughout the year when concerns came up. I continue to be amazed by the level of dedication and care you show your patients.

With this in mind, we move forward into 2017, prepared to do work on your behalf. The year is still shaping up, but I wanted to let you know about a new coalition we are taking part in that will address Quality Payment Programs or QPP, that promise to reward the delivery of high-quality patient care. The goal of the coalition is to equip you and your staff with what you need to succeed as the focus continues to shift towards value-based care, and take back your experiences to share with others. For

more information on the coalition visit www.coloradoafp.org/QPP. The CAFP is also working with the Colorado Primary Care Collaborative to plan a convening event for June 8, 2017. The event speakers will bring updates on all that is happening in Colorado regarding payment reform.

I recently read an article by Joel Cooper, MD, on physician burnout which he refers to as physician abuse. This has been a frequent topic among our members. Because of that, the CAFP is planning a 2017

Now more than ever I hope our family-medicine strong voices can work together for better patient outcomes, and better physician satisfaction.

fall conference on physician resilience to bring you education, tools, and advice on how to have a balanced, fulfilled life. We know this will happen in two ways: by making individual changes that help you live better, and by working to improve the greater practice environment that you are in.

Now more than ever I hope our family-medicine strong voices can work together for better patient outcomes, and better physician satisfaction.

Wishing you all the best in the new year,

Raquel J. Rosen

Relationships are still the heart of medicine.



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

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

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Children's Hospital Colorado

CAFP Legislative UPDATE

By Ryan Biehle, Director of Policy and Government Relations



Medicaid Payment Reform on the Horizon

CAFP's biggest priority over the past year has been to maintain enhanced funding for primary care in Medicaid. As announced in a November email to members, with your support, op-eds and letters to policymakers, we were successful in our advocacy efforts. The funding was included in the Governor's proposed budget for Fiscal Year 17-18. CAFP's lobby team will continue to work throughout the state budget process to ensure the funding is maintained in the final budget later this Spring.

Shortly after that budget announcement, the state Medicaid department released a draft Request for Proposal to rebid the Accountable Care Collaborative (ACC). ACC 2.0 is Medicaid's vehicle to advance payment reform with primary care as the foundation. CAFP is reviewing the 170 page RFP and will be advocating to ensure family practices are reimbursed fairly to support the Patient Centered Medical Home – team-based care, coordination, expanded hours, and more. We know the PCMH can improve health, but the old fee-for-service system does not adequately support this model. Here are a few of the proposed changes for ACC 2.0:

- New Regional Accountable Entities (RAE's) responsible for payment and coordination of both physical and behavioral health.
- Medicaid will pay the RAE's a PMPM payment between \$14.50 - \$15.50. RAE's will then be responsible for passing on at least 30% of those payments to primary care practices, though will have flexibility to make additional payments. These arrangements may vary across the 7 RAE regions and will be done through the regular contracting process with physicians.
- In addition to the PMPM payments, Medicaid proposes a two-track path for primary care payment under a modified fee-for-service (FFS) system. It aligns in some respects with the federal Comprehensive Primary Care Plus (CPC+) program. The first track enables higher FFS payments for primary care service codes. Track two allows for prospective payment of a significant portion of the FFS amounts, with the remainder paid under FFS. Practices will have to meet criteria to qualify. We expect those criteria to mirror PCMH activities but will be working to ensure any criteria do not place additional burdens on physicians.

2017 Legislative Session

Medicaid funding will again be a priority for CAFP, and we will work to maintain the nearly \$57 million for the primary care bump. The session begins January 11th and the dynamics are largely similar as last session, as Democrats retained control of the House while Republicans retained Senate control. Two sunset bills we will be tracking, which are regularly scheduled

reviews of current law, concern naturopathic doctors' practice abilities and reauthorizing the Division of Insurance. Current task force recommendations on these sunsets do not appear to raise issues for family physicians, such as significant scope expansions, but we will want to ensure that remains the case throughout the legislative process.

What's Next for Health Reform and the ACA

The short answer – we do not yet know what the future holds for health reform on a national scale. As President-Elect Trump's administration is assembled and the new Congress enters session, we will be working with the American Academy of Family Physicians to ensure family medicine is central to any proposed reforms. At the same time, we have been strong proponents of expanded health coverage for all Coloradans, eliminating financial barriers to primary and preventive care, continuing the Children's Health Insurance Program and accelerating payment reforms. We will continue to push these priorities.

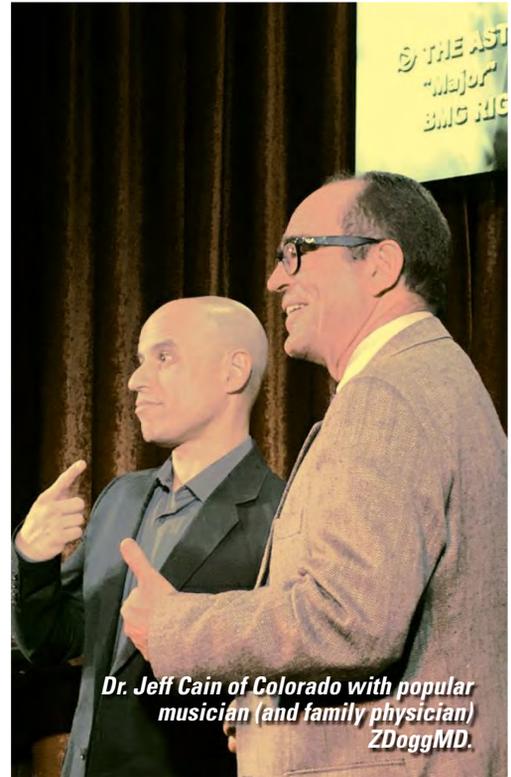
The President-Elect's reform proposals, as envisioned on the campaign trail, include block-granting Medicaid, permitting the sale of insurance across state lines, and expanding the use of Health Savings Accounts to more consumers and enabling them to save, tax-free, for medical expenses. While the specifics of any proposals are yet to come, Congressman Tom Price (R-GA) was recently announced as the cabinet pick for U.S. Department of Health and Human Services (HHS), and he will presumably have a hand in any reform efforts. Rep. Price introduced the *Empowering Patients First Act* in Congress, which is one "repeal and replace" proposal and may give an indication of potential reforms. The proposal includes allowing Medicaid patients to purchase private insurance instead with subsidies, providing tax credits to those up to 300% of the federal poverty level (lower than the 400% threshold in the ACA, and limiting the credit amount available to approximately \$5,000 for a family), and permitting HSA funds to be used to pay for direct primary care memberships.

As an orthopedic surgeon, Rep. Price is well acquainted with the medical profession. It remains to be seen what his agenda at HHS will be. We do know he voted for the Medicare Access and CHIP Reauthorization Act (MACRA), which extended CHIP funding through September 2017 and altered the path for Medicare to begin paying for value, particularly in primary care. Though a supporter of MACRA, he has criticized its rollout and urged simplification of reporting requirements for the new value-based payment system. At the same time, he has criticized Medicare's innovation initiatives under the ACA, any action on which could impact programs such as the Comprehensive Primary Care + initiative or the State Innovation Model, both high priorities in Colorado. The AAFP and CAFP have been strong supporters of these initiatives, and we would seek to maintain their progress.

CAFP ON THE GO



Medical students and family medicine residents joined the CAFP for a fall student-resident mixer at Dry Dock Brewery in September.



Dr. Jeff Cain of Colorado with popular musician (and family physician) ZDoggMD.



CAFP staff met with residents at the new Sky Ridge Family Medicine Residency in Lone Tree.



Dr. Stephanie Sandhu, a resident at Saint Joseph Family Medicine Residency Program, presented information on Amendment 72 to students at the University of Colorado School of Medicine.



The CAFP received the Leadership in State Government Advocacy Award at the AAFP State Legislative Conference for our legislation that created a tax credit for rural preceptors.



The CAFP hosted a PCMH training session in conjunction with Red Rocks Community College, part of a grant designed to help both practices and PA students deliver quality care.

OPINION: WHEN WILL IT EVER BE THE RIGHT TIME?

By Daniel J. Wandsneider, DO, PGY-2

It comes as no surprise that America spends more than any other country on healthcare. In fact, in many cases, we spend twice as much of our national GDP on healthcare than most developed countries. Currently about 18% of our nation's GDP is swallowed up by our health care system. This is compared to the highest European spenders: France, WHO's number one ranked health care system, spends about 11%, or Germany who spends 10% of their GDP. Even though we spend almost twice as much as the world's highest ranked health care systems, we still have millions of Americans in the U.S. who do not have access to healthcare. We rank 11 out of 11 top countries in the world for health care performance according to the Commonwealth Fund in 2014. France, Germany, Japan, Italy, Finland, Sweden, and several others all spend much less but *provide care for all and have better outcomes*. America has implemented the Triple Aim – enhancing patient experience, improving

fails to provide affordable care to millions of our people. Other nations do not seem to have a problem with it. Other democratic nations are doing just fine with a single payer system. When casually discussing this topic, American physicians always use the word “socialism” as a tactic for their argument against universal healthcare. What is Medicare? Medicaid? The VA? These are fragmented systems that are funded by taxpayers to provide medical care for a subset of people. Why not create a unified, improved system to provide care for all constituents that has consistent quality metrics, removes payment to greedy and crafty insurance companies, and cuts down on overhead costs? There are ways to have private insurance companies, private hospitals, private physicians in the setting of a universal payer system. It has been done by several developed, democratic nations for years, such as Germany, who boasts a consistent form of low cost, quality yielding universal health care system since 1884.

This article is not to convince you that a universal health care system is necessary for the US. But it is obvious that we need very radical change. We can no longer afford to argue against health care reform when we spend more than any other nation but rank 37 out of 191 countries (according to the WHO), leaving millions of Americans either uninsured or with suboptimal coverage. If America wishes to be a world leader in the future, health care reform will need to be at the forefront of our minds. There will never be an easy or comfortable time for radical health care reform. As there continues to be millions of preventable deaths secondary to lack of health care access, we can no longer look away. The time is now.

Opinion pieces are submitted by individual CAFP members. They are not necessarily a reflection on CAFP policy positions or views, and do not represent the views of all CAFP members.

This article is not to convince you that a universal health care system is necessary for the US. But it is obvious that we need very radical change.

population health, and reducing costs. But can we truly achieve this without a single payer system or at the very least a dramatic overhaul?

It is difficult to understand that a nation as great as ours spends so much money on this “system” but

The Colorado Chapter Delegates, Rick Budensiek, DO and Brian Bacak, MD, attended the Congress of Delegates in Orlando from September 19th to the 21st along with our Alternate Delegates, Glenn Madrid, MD and Tamaan Osbourne-Roberts, MD, and our Chapter Executives and Staff. We had a ringside seat to the workings of the Academy and the 2016 election, culminating in the election of Mike Munger, MD, to the Position of President-Elect for the Academy.

The week was launched by our current Board Chair, Wanda Filer, MD, who showed the ZDogMD video (Health Is Primary, YouTube) and talked about the foundational nature of primary care, which resonated with all of us. One-fifth of all physician office visits in the US are made with Family Physicians. Our patients are complex, averaging 5-7 diagnoses, and Family Physicians have been the #1 recruited specialty in the US for the past 10 years, with salaries up an average of 17%. We provide more mental health care than psychiatry, and we're the only specialty where ADDING a physician to a community improves the costs of care and the lives of patients. She and the rest of the leadership, however, reminded us that challenges are multiple and broad. To quote our outgoing Chair, Dr. Robert Wergin, "Everybody has a plan until you're punched in the nose". Our leaders reminded us that they are committed to protecting patients, supporting primary care and public health, and that they feel that the need to defend healthcare as a fundamental human right.

After the opening sessions, the Congress sessions got underway. In the Congress of Delegates work sessions and on the floor, changes or additions to AAFP policy are proposed, discussed, and then recommendations are made to the board to implement or study changes as appropriate.

Several interesting or notable resolutions from the Congress were discussed. The Colorado chapter introduced a resolution dealing with diversity and the support of student, resident, and practicing physicians with regard to their educational and work environment and overall wellness. The efforts were built on the testimony of Colorado's delegation at the 2015 COD in support of policy statements on community policing. These efforts were summarized in the official conference proceedings as follows:

"During the Sept. 20 business session, discussing items from the Reference Committee on Health of the Public and Science, delegates adopted a new policy statement on discriminatory policing that is supported by the Department of Justice's 2015 *Final Report of the President's Task Force on 21st Century Policing*.(www.cops.usdoj.gov) The statement says the AAFP agrees with the report's recommendation "that law enforcement agencies should adopt and enforce policies prohibiting profiling and discrimination based on race, ethnicity, national origin, religion, age, gender identity/expression, sexual orientation, immigration status, disability, housing status, occupation or language fluency."

The reference committee recommended Board referral of a substitute resolution asking the AAFP to establish an Office of Diversity that would:

- serve as the official repository for policies and information related to discrimination, diversity and cultural proficiency;
- support members in efforts toward nondiscrimination in education, training and practice;
- communicate messages to members and the general public; and

- support the development and implementation of anti-discrimination and hate crime laws, as well as public policies that protect victims of discrimination.

Delegates adopted the substitute resolution and asked the Board to provide the 2017 Congress of Delegates a report on the issue. Because of the AAFP Board's strategic plan for 2017 on physician well-being, burnout, and diversity, the delegation believes that a referral to the board is an appropriate routing for this very important subject.

In other business, the COD adopted a substitute resolution sponsored by the Oregon chapter that addressed gun violence as a public health issue. The substitute resolution called on the AAFP to send a letter to HHS Secretary Sylvia Burwell requesting a comprehensive report on gun violence, explaining the urgent need for action to limit the number of injuries and deaths. Other resolutions originating in the Reference Committee on Health of the Public and Science adopted during the business session included one asking the AAFP to update its policy on climate change and air pollution, which was written in 1969, so that it specifically addresses "greenhouse emissions from human activities."

Additional COD Reference committees included Advocacy, Practice Enhancement, Education, and Organization and Finance. Issues discussed included items focused on physician wellbeing, and physician burn-out. The AAFP has identified the issue of burnout as a top strategic priority for 2017 and launched a comprehensive initiative to tackle it head-on. One resolution requested that the AAFP continue dialogue with the Federation of State Medical Boards (FSMB) to reduce the stigma of and barriers to seeking mental health care. Another resolution, which was passionately discussed at the COD, called for the elimination of the ABFM's cognitive knowledge exam secondary to the burden it places on physicians in practice and a perceived poor link between completion of the exam and quality in patient care. Ultimately, the resolution was defeated and in turn, a substitute resolution was introduced focusing on communicating to the ABFM that changes are needed to the Maintenance of Certification process to reduce the expense, time, and work burden for physicians.

Additional resolutions of interest included one asking for the AAFP to encourage the development of a specific time-based CPT code to assist physicians with the large administrative burden associated with patient care and another asking the Academy to advocate for a per-member, per-month (PMPM) fee from payers to help compensate physician practices for prior authorization services. Both resolutions were referred to the AAFP Board of Directors for further consideration.

Finally, several resolutions were introduced out of a concern for physicians in independent practice. A resolution from the Washington and Texas chapters asked the AAFP to create a policy statement "explicitly supporting family physicians in private practice." According to the resolution, that support should include updating existing educational materials to assist these physicians and ensuring that new physicians understand their options regarding private practice. The reference committee resolution was adopted as written by the COD

For a full summary of all Congress of Delegates activities, with links to the resolutions, go to: <http://www.aafp.org/about/governance/congress-delegates/2016.html>.



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Headache Management in Primary Care

Headaches are a frequent complaint in family medicine¹ and often present in childhood. Nearly 60% of children and adolescents worldwide experience recurrent headaches, 8-12% have migraine, and 1-2% suffer from chronic daily headache.²

Diagnostic Approach

The clinician's first priority is to distinguish primary from secondary headache. Common causes of secondary headache are listed in Table 1. A thorough physical examination (Table 2) is 98% sensitive for detecting intracranial pathology,³ however certain historical clues are important to elucidate (Table 3). Evidence-based indications for neuro-imaging are listed in Table 4. A lumbar puncture (LP) is indicated when headache is associated with fever and nuchal rigidity. An LP with

Table 2. Components of Thorough Headache Exam

- Vital signs, including blood pressure and temperature
- Palpation of the head and neck to assess for sinus tenderness, thyromegaly, or nuchal rigidity
- Head circumference (even in older children)
- Skin assessment for neurocutaneous syndrome, particularly neurofibromatosis ad tuberous sclerosis
- Detailed neurological examination with particular attention to fundoscopic examination, eye movements, head tilt, finger-nose-finger testing for dysmetria, and tandem (heel-toe) gait for ataxia.

Adapted from: Kedia, S., Jorgensen, J., Perry, S. & Pickard, D. (2013). CHCO Clinical Care Guideline for the Outpatient Management of Primary Headache.

Table 1. Secondary Causes of Acute Headache in Children

- Upper respiratory tract infection
- Medications and analgesic overuse
- Acute pharyngitis
- Substance use
- Sinusitis
- Toxic exposures
- Meningitis
- Hydrocephalus or shunt malfunction
- Hypertension
- Brain tumor
- Hemorrhage (intracranial or subarachnoid)
- Idiopathic intracranial hypertension

Adapted from Lewis, D.W. (2002). Headaches in children and adolescents. *American Family Physician*, 65(4), 625-632

Table 3. Red Flags for Secondary Headache

- Young age (<5 y/o)
- New onset or worsening headache
- Postural headache
- Posteriorly located headache
- Focal neurologic deficit
- AMS
- Fever
- Nighttime awakening
- Headache
- Vomiting
- Early morning headache and or vomiting
- Neurocutaneous stigmata

Adapted from: Kedia, S., Jorgensen, J., Perry, S. & Pickard, D. (2013). CHCO Clinical Care Guideline for the Outpatient Management of Primary Headache.

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I didn't talk for a very long time

Jacob Sanchez
Diagnosed with autism

Lack of speech is a sign of autism. Learn the others at autismspeaks.org/signs.



AUTISM SPEAKS®

Table 4. ACR Indications for Imaging

Neuroimaging is not routinely recommended in children with recurrent headache & normal exam
Neuroimaging is recommended in children with: <ul style="list-style-type: none"> • Abnormal exam • Sudden severe headache • Associated seizures • Chronic progressive (worsens over months) • Persistent confusion or altered consciousness
Neuroimaging should be considered in children with: <ul style="list-style-type: none"> • Substantial change from previously stable pattern • S/S of increased ICP • Awakens child from sleep or causes AM vomiting • Precipitated by Valsalva (cough, sneeze, bending or with exertion) • Post-traumatic (< 3 mo), worsening or neuro s/s • Ophthalmoplegic migraine • Basilar type migraine • Hemiplegic migraine • Compromised immunity • History of malignancy • Vomiting without cause

Adapted from: Hayes, L.L., Coley, B.D., Karmazyn, B., Dempsey-Robertson, M.E., Dillman, J.R., . . . Wootton-Gorges, S.L. (2012). American College of Radiology Appropriateness Criteria: Headache – Child. Retrieved at <https://acsearch.acr.org/docs/69439/Narrative/>

opening pressure should be performed when subarachnoid hemorrhage (thunderclap headache), acute or chronic meningitis, or pseudotumor cerebri is suspected. When there is altered mental status, lateralizing signs or papilledema, obtain neuroimaging to exclude a space-occupying lesion prior to performing LP. Electroencephalogram (EEG) is not indicated for headache evaluation unless there are symptoms suspicious for seizure.³

The primary headaches include migraine, tension-type, the trigeminal autonomic cephalalgias, and new daily persistent headache.⁴ Children with migraine typically report mid-frontal or bilateral headache, pounding or throbbing in character, worsened by activity, and accompanied by sensitivity to light or sound, and nausea or vomiting. Fewer than 25% of children will have a warning (aura) consisting of blurry vision, flashing lights, colored spots, strange tastes, or weird sensations occurring 5-60 minutes before the onset of their headache.⁵

Table 5. ICHD-3 (Beta) Diagnostic Criteria for Migraine and Tension-type Headaches

	Migraine	Tension
Recurrence	> 5 attacks	> 10 attacks
Duration	1-72 hours	30 min to 7 days
Quality	Throbbing/pounding	Pressure tight band
Severity	Moderate to severe	Mild to moderate
Location	Unilateral/bilateral	Bilateral
Physical activity	Worsens	No effect
Associated factors		
Nausea/vomiting	At least one of these	Not present
Photo/phonophobia		None or one (not both)

Patients presenting with brainstem aura or hemiplegic symptoms require an initial evaluation for stroke. Brainstem aura symptoms consist of dysarthria, vertigo, tinnitus, hyperacusis, diplopia, ataxia, or decreased level of consciousness.⁴ Hemiplegic migraine presents with a typical aura that is followed by fully reversible unilateral weakness. While the visual or speech deficits will last less than 60 minutes, the focal weakness can last up to 72 hours. These individuals should have an MRI/MRA of the brain. An MRA of the neck is needed to evaluate for arterial dissection in children with neck trauma. *The use of triptans or ergotamine remains contraindicated in the setting of brainstem or hemiplegic migraine.*⁶

Tension-type headaches are reported as a band-like tightening around the head, mild to moderate in severity, lasting from 30 minutes to several days.⁴ Like migraine, there can be sensitivity to light or sound, but these headaches are not associated with nausea or vomiting and don't worsen with physical activity (Table 5).

Both migraine and tension-type headaches are considered chronic when they occur at least 15 days a month for more than 3 months. About 2.5% of all migraine sufferers will convert from episodic to chronic headaches each year.⁷ Chronic headaches are often the result of taking acute medications too frequently. These **medication overuse headaches** are best eliminated by stopping acute medicines altogether for 2-3 weeks; this can be done immediately for all medications except opioids or butalbital containing analgesics. After that time, *acute medicines should not be taken more than 2 to 3 times per week.*⁶ Other risk factors for migraine “chronification” include high-frequency headaches, the presence of cutaneous allodynia, history of head or neck trauma, obesity, sleep disorder, mood disorder, poor response to stress, excessive caffeine use, dehydration, and various demographic factors⁷ (Table 6).

Table 6. Risk Factors for Migraine Chronification

Patient Characteristics	Episodic Migraines	Chronic Migraines
Clinical characteristics		
Headache frequency	<15 days/month	>15 days/month
Severe HA pain	78.1%	92.4%*
Duration of HA w/out meds	38.8 (mean hours)	65.1 (mean hours)*
Duration of HA w/meds	12.8 (mean hours)	24.1 (mean hours)*
SES characteristics		
Race (%white)	87.3%	90.7%
Women (%)	80%	78.6%
Low income (< \$22,500)	24.9%	29.9%
Comorbidities		
Depression	17.2%	30.2%*
Anxiety	18.8%	30.2%*
Obesity	21%	25.5%*
Cutaneous allodynia	63.2%	68.3%*

*Indicates statistical significance (p<.05) between EM and CM.

Adapted from: Katsarava, Z., Buse, D. C., Manack, A. N., & Lipton, R. B. (2012). Defining the Differences Between Episodic Migraine and Chronic Migraine. *Current Pain and Headache Reports*, 16(1), 86–92. <http://doi.org/10.1007/s11916-011-0233-z>

New Daily Persistent Headache is a chronic headache that has been unremitting within three days of its onset. These headaches are typically bilateral, non-pulsating, mild to moderate in intensity, and not aggravated by routine physical activity. They may have photophobia or phonophobia (but not both) and only mild nausea without vomiting. MRI with MRV should be considered to exclude venous thrombosis. LP is often performed to exclude high or low-pressure headache. Head trauma or viral infection are other potential causes for this syndrome.

Approach to Treatment

The headache pattern should guide the management plan. Whereas children with episodic headaches are treated primarily with acute abortive therapies, children with chronic headaches should be treated primarily with preventative medications and behavioral interventions. Treatment is aimed at decreasing the frequency, severity and duration of attacks, minimizing any headache-related disability, and preventing progression to chronic headache.⁶ Lifestyle management must be optimized in all children with recurrent headache (Figure 1).

Acute/Abortive Treatment

Effective acute treatment requires rapid administration of an appropriate agent at the correct dose delivered via the most appropriate route. The goal is complete relief of the headache and associated symptoms within two hours. A three-tiered **headache action plan** is recommended (Figure 2) for all patients with recurrent headache. First and second-line treatment includes oral re-hydration and a non-steroidal anti-inflammatory drug (NSAID) (Table 7). An anti-emetic may be needed if nausea or vomiting is present. An age-appropriate triptan medication should be considered if conservative management fails (Table 8). Headaches that are already established on waking, escalate quickly, or are accompanied by early vomiting may require alternative delivery routes (suppositories, nasal sprays or subcutaneous injections). Third line treatment is typically an oral cocktail of an NSAID plus an anti-dopaminergic agent (prochlorperazine or promethazine) given with diphenhydramine to prevent acute dystonic reactions and akathisia.⁶

If home management fails, patients may require intravenous therapy in an emergency department or infusion center (Figure 3). Approximately 6-7% of children will fail ED management and may require admission for dihydroergotamine (DHE) treatment⁶. These admissions typically last 3-5 days and should include an evaluation for psychiatric comorbidities and a consultation with physical therapy to address cervicalgia or physical deconditioning.

Preventative Treatment

Daily medications should be considered when headaches occur more than once a week or cause school absences or other disability.⁶ Pediatric migraine disability can be systematically assessed in children 4-17 using the PedMidas scale (Figure 4). Migraine sufferers are 2 to 5 times more likely to have anxiety or depression than those who don't have migraine⁸. Though chronic headaches can certainly prompt changes in mood, research suggests that many of these children were anxious or depressed prior to the transformation of their headaches. Effective management ultimately requires treatment of these comorbidities, lifestyle modification and the development of better coping strategies.

Take-home points:

- Headaches are common in children and adolescents.
- Intracranial pathology can be reliably detected with a thorough physical examination and identification of historical “red flags”. Imaging is indicated in a child with an abnormal neurological exam.
- Episodic headaches should be treated rapidly with an effective dose of an acute abortive medication.
- Chronic headaches are most effectively treated with preventative medications, lifestyle management, and a multidisciplinary treatment team.

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Table 7. Acute Headache Therapies

Medication	Form	Dosage	Maximum dose	Frequency	Formulations	COST*	Side effects
NSAIDS:							
Ibuprofen (Motrin®/Advil®)	PO	10mg/kg/dose	800 mg	Q 6 to 8 hours	Chew: 100 mg Tab: 200 mg Syrup: 100 mg/5 ml	OTC	GI bleeding, GI Ulcers, decreased platelet function
Naproxen (Aleve®/Naprosyn®)	PO	5 to 7 mg/kg/dose	500 mg	Q 12 hours	Susp: 125 mg/ml Tab: 220, 250, 375, 500 mg.	OTC	
Acetaminophen (oral)	PO	Weight 16.1 to 21.5 kg = 240 mg	Maximum daily dose (oral or rectal): Greater than 12 yrs = 3 g/ 24 hours Less than 12 yrs = 5 doses/ 24 hours or 2.6 grams/ 24 hours	Q 6 hours	MANY OPTIONS	OTC	Hepatic toxicity
		Weight 21.6 to 27 kg = 320 mg					
		Weight 27.1 to 32.5kg = 400 mg					
		Weight 32.6 to 43 kg = 480 mg					
		Weight greater than 43 kg = 500 mg					
Acetaminophen (rectal)	PR	Weight 16.1 to 27 kg = 325 mg	Maximum daily dose (oral or rectal): Greater than 12 yrs = 3 g/ 24 hours Less than 12 yrs = 5 doses/ 24 hours or 2.6 grams/ 24 hours	Q 6 hours	MANY OPTIONS	OTC	Hepatic toxicity
		Weight 27.1 to 43 kg = 487.5 mg					
		Weight greater than 43 kg = 650 mg					
Antiemetics							
Promethazine (Phenergan®)	PO/PR	0.25 to 1 mg/kg/dose	25 mg	Q 4 to 6 hours	Rectal: 12.5, 25, 50 mg Syrup 6.25mg/5 ml, 25 mg/5 ml Tab scored 12.5, 25, 50 mg		Blurred vision, dystonic reaction
Prochlorperazine (Compazine®)	PO/PR	0.1 mg/kg/day	10 mg	Q 6 to 8 hours	Rectal: 2.5, 5, 10 mg Syrup: 5mg/mL Tablet 5, 10, 25 mg		

Adapted from: Kedia, S., Jorgensen, J., Perry, S. & Pickard, D. (2013). CHCO Clinical Care Guideline for the Outpatient Management of Primary Headache.

Table 8. Acute Migraine Treatment

Medication	Form	Dosage	Maximum dose	Frequency	Formulations	Cost*	Side effects
<p>Triptans: Triptans should not be used more than two times per week with a maximum of six times per month. Do not administer dihydroergotamine (nasal DHE or IV DHE) within 24 hours of the last dose of triptan. FDA approved: Treximet ≥ 12 years old, Rizatriptan ≥ 6 year olds, Almotriptan ≥12 year olds, and Zomig ≥ 12 years old. Although other triptans are commonly prescribed in the community and may be effective, they are not FDA approved and safety has not been established in pediatric patients. A consultation with a neurologist is recommended prior to prescribing these medications.</p>							
Rizatriptan (Maxalt®)	PO	< 40 kg: 5 mg > 40 kg: 10 mg	< 40 kg: 10 mg/24 hours > 40 kg: 20 mg/24 hours	Can repeat in 2 hrs	ODT: 5, 10 mg Tab: 5, 10 mg	\$25-39/ tab Generic \$10/tab	Nausea, dizziness, weakness, flushing
Almotriptan (Axert®)	PO	6.25 to 12.5 mg	25 mg/day	Can repeat in 2 hrs	Tab: 6.25, 12.5mg	\$9-27/tab	Nausea, somnolence, dizziness
SUMatriptan (Imitrex®)	PO **	Less than 50 kg: 25 mg	100 mg/24 hours PO	Can repeat in 2 hrs	Tab: 25, 50, 100 mg	25 mg: \$17/9 tab 50 mg: \$50/9 tab 100 mg: \$70/9 tab	Nausea, dizziness, weakness, flushing
		Greater than 50 kg: 50 mg				5mg: \$137-265/6 doses 20mg: \$145-158/ 6 doses	
	Intranasal	Less than 50 kg: 5-10 mg Greater than 50 kg: 20 mg	40 mg/hours intranasal		Intranasal: 5, 20mg	2 syringes: \$130-175	
	SC	0.06 to 1 mg/kg	12 mg/hours SC		SC: 4 mg/0.5 mL , 6 mg/0.5 mL		
ZOLmitriptan (Zomig®)	PO	Greater than 50 kg: 2.5 to 5 mg/dose	10 mg/24 hours	Can repeat in 2 hrs	Tab: 2.5,5mg ODT: 2.5,5mg	\$29-65/3 tab dose pack (generic)	Nausea, dizziness, chest pain and tightness, weakness, paresthesia
	IN	5 mg/dose			Intranasal: 5mg	6 doses: \$350-380	
Eletriptan (Relpax®)	PO	Greater than 50 kg: 20 to 40 mg/dose	80 mg/24 hours	Can repeat in 2 hrs	Tab: 20,40 mg	\$36-48/ tab	Nausea, weakness dizziness, paresthesia
Naratriptan (Amerge®)	PO	1 to 2.5 mg/dose	5 mg/24 hours	Can repeat in 4 hrs		\$35-36/ tab	Nausea, dizziness, pain (CNS)
Frovatriptan (Frova®)	PO	2.5 mg/dose	5 mg/24 hours	Can repeat in 2 to 4 hrs		\$15-54/ tab	Flushing, dizziness, fatigue, xerostoma, paresthesia
Treximet (Sumatriptan and Naproxen)	PO	10 mg sumatriptan/60 mg naproxen	85 mg sumatriptan/500 mg naproxen	1 dose every 24 hours	Tab	\$26-30/ tab w/ coupon	Nausea, dizziness, chest pain and tightness, weakness, paresthesia, xerostoma

Adapted from: Kedia, S., Jorgensen, J., Perry, S. & Pickard, D. (2013). CHCO Clinical Care Guideline for the Outpatient Management of Primary Headache.

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Figure 1. Lifestyle Management

All children need to be counseled on behavior modification as “headache hygiene”—maintaining healthy habits to prevent headaches.

1. Fluids: Drink enough fluid (6 to 8 glasses per day) and avoid caffeine.
2. Sleep: 8 to 10 hours of sleep each night and go to bed at the same time each night and awaken at the same time each day keep a regular sleep schedule.
3. Nutrition: Consume balanced meals at regular hours and do not skip meals. Triggers are different for each individual. Possible food triggers include aged cheese, artificial sweeteners, caffeine, chocolate, citrus fruits, cured meats (packaged lunchmeats, sausage, pepperoni), MSG, nuts, onions, and salty foods.
4. Exercise/stretching: At least 45 minutes of aerobic activity and 5 to 10 minutes of stretching every day.
5. Stress: Stress is the number one trigger for children. Consider stress management, counseling, or relaxation techniques.
6. Electronics overuse: Limit use of electronics to less than 2 hours per day and none 1 hour prior to bedtime.

Adapted from Kedia, S., Jorgensen, J., Perry, S. & Pickard, D. (2013). CHCO Clinical Care Guideline for the Outpatient Management of Primary Headache.

Figure 2. Headache Action Plan

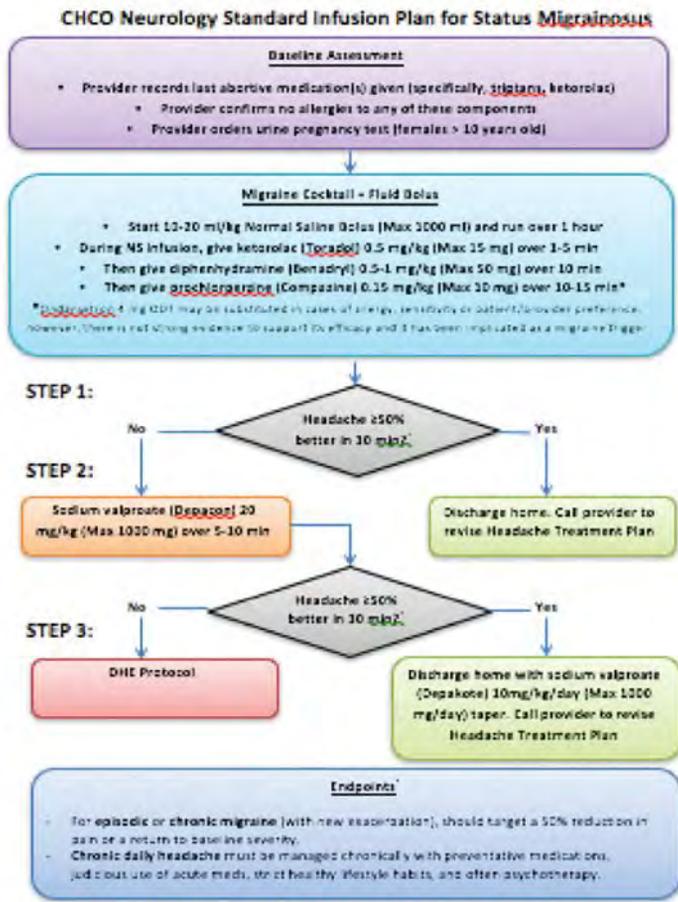
What Healthy Habits do I need to work on:

Fluids (no caffeine)	Drink 6-8 glasses (3-4 16 ounce bottles) of water a day
Meals	Eat 3 meals a day with plenty of fruits and vegetables A little protein in each meal (examples of proteins: nuts, peanut butter, milk, cheese, etc.) If you are skipping meals, try quick meal ideas such as an Instant Breakfast Shake or Smoothie; Trail mix or Peanut butter with fruit; Nutrition bars
Sleep	Get at least 8 hours of sleep per night
Electronic Use	Limit total free time electronic use to 2 hour or less a day No electronics for 1 hour before bedtime
Exercise	5 times per week for 45-60 minutes a day
Yoga/Stretching	You should stretch every day

Acute Headache Treatment: What do I take when I get a headache

First Line = At Onset of Headache or Aura
Drink 24 ounces of a sports drink or other fluid replacement without caffeine {HA Acute Meds:30615}
Second Line = 2 hours later for continued headache
{HA Acute Meds:30615}
Third Line = 2 hours after second line
{HA Acute Meds:30615}
Acute Treatment Failure
If your 1st, 2nd, and 3rd line treatments fail, call the urgent line at (720) 777-6895 to discuss the need to go to Infusion Center or Emergency Department
DO NOT TAKE ANY OF THE ABOVE MEDICATIONS MORE THAN 2-3 TIMES PER WEEK

Figure 3. Infusion Plan for Status Migrainosus



From: Leung, S., Bulloch, B., Young, C., Yonker, M., Hostetter, M. (2013). Effectiveness of Standardized Combination Therapy for Migraine Treatment in the Pediatric Emergency Department. *Headache* 53, 491-497.

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Figure 4. PedMIDAS Scale

PedMIDAS

Headache Disability:

The following questions try to assess how much the headaches are affecting day-to-day activity. Your answers should be based on the last three months. There are no "right" or "wrong" answers so please put down your best guess.

1. How many full school days of school were missed in the last 3 months due to headaches? _____
2. How many partial days of school were missed in the last 3 months due to headaches (do not include full days counted in the first question)? _____
3. How many days in the last 3 months did you function at less than half your ability in school because of a headache (do not include days counted in the first two questions)? _____
4. How many days were you not able to do things at home (i.e., chores, homework, etc.) due to a headache? _____
5. How many days did you not participate in other activities due to headaches (i.e., play, go out, sports, etc.)? _____
6. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in the 5th question)? _____

Total PedMIDAS Score _____

Headache Frequency _____

Headache Severity _____

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From: Hershey, A.D., Powers, S.W., Vockell, A.L., LeCates, S., Kabbouche, M.A., Maynard, M.K. (2001). PedMIDAS: development of a questionnaire to assess disability of migraines in children. *Neurology* 57(11), 2034-9. Retrieved at <https://www.cincinnatichildrens.org/service/h/headache-center/pedmidas>

Help to Succeed in Medicare's Quality Payment Program:

On-site Practice Support and the PRIME Registry from ABFM



By Kyle Knierim, MD

Colorado primary care practices are fortunate to have options to help them navigate and succeed in Medicare's Quality Payment Program (see QPP.cms.gov for more detail). Starting January 1, 2017, your future Medicare payments will be impacted by your clinical quality measures, clinical improvement activities, use of HIT, and eventually cost of care. Whether you are in an Advanced Payment Model, including CPC+ or NexGen ACO, or in the Merit-based Incentive Payment System (MIPS), there are opportunities to help you succeed with Medicare and commercial value based payment models. Two of those opportunities available to Colorado primary care practices are:

1. The **PRIME Registry**, developed and sponsored by the American Board of Family Medicine, is a population health and performance improvement tool for clinicians and practices. It extracts patient data from your EHR and turns it into actionable measures including measures for SIM, CPC+, MIPS and EvidenceNOW SW.
2. On-site practice support that includes 9 months of practice facilitation to help build primary care competencies, the infrastructure for data capture, and quality improvement skills necessary to improve your chances of achieving bonuses.

Both of these opportunities are available at no cost¹ to primary care practices enrolling in EvidenceNOW SW. Following a baseline practice assessment, practices work with a practice facilitator from the Colorado practice transformation organization of your choice to develop a customized practice improvement plan that addresses your specific pain points and areas of interest using Cardiovascular Disease as the condition of focus.

The core measures of EvidenceNOW are identical to MIPS measures: aspirin, blood pressure, cholesterol and smoking cessation. Because these measures align, practices in EvidenceNOW are already focusing on improving the quality of cardiovascular preventive care for their patients, knowing that this work will also improve their ability to succeed under MIPS.

The **PRIME registry** is the result of an investment of millions of dollars and hundreds of hours of expertise from high performing family physicians to develop a tool to support family physicians now and in the future. The PRIME registry extracts patient data from your electronic health record (EHR) and turns it into actionable measures to:

- View and track the quality of patient care
- Automate measure submission for your ABFM Certification/Performance Improvement activities (formerly called "MC-FP/Part IV credit")
- Automate measure submission for federal quality

improvement reporting through: ENSW, Physician Quality Reporting System (PQRS); MIPS and Advanced Alternative Payment Models (APMs) to come

- Support CPC+, including Track Two, measure collection and submission.

The PRIME Registry technology team is currently working with more than 85 EHRs (list is available at primenavigator.org).

How EvidenceNOW SW helps practices with the Medicare Quality Payment Program:²

In 2017, 85 percent of the MIPS composite score will rely on the quality performance measurement and advancing care information. EvidenceNOW is focused on helping primary care practices develop the skills and capacity to excel in these areas. An additional 15 percent of the MIPS composite will target practice improvement, another central focus of EvidenceNOW. Primary care practices that participate in EvidenceNOW will be well prepared to perform well on the MIPS composite score. Additionally, the skills gained through participation in EvidenceNOW will prepare primary care practices to join APMs and qualify for positive payment adjustments.

Most providers who receive Medicare Part B payments will need to participate in the Quality Payment Program. Performing well under the Quality Payment Program will require a strong foundation in clinical quality improvement, outcomes, and measurement. EvidenceNOW focuses on small- and medium-sized practices, and offers expert consultation and coaching to help primary care practices build these capacities and increase their potential for success.

¹ ENSW can offer licenses for up to 5 providers per practice for 18 months at no cost.

² https://escalates.org/wp-content/uploads/2016/11/10625_AHRQ_MACRA-MIPS_FactSheet_508.pdf

FOR MORE INFORMATION:

Regarding

1. EvidenceNOW SW or to register for an informational webinar <http://www.practiceinnovationco.org/ensw/>
2. PRIME Registry: www.primenavigator.org

Contact: Kyle.Knierim@UCDenver.edu or call 303.724.8968

Now More Than Ever:

Preexposure Prophylaxis (PrEP) for HIV prevention is important for primary care providers in Colorado



By Deborah Monaghan, MD
Public Health Academic Detailer
Colorado Department of Public Health and Environment



Preexposure prophylaxis (PrEP) is daily oral antiretroviral therapy used to reduce the risk of acquiring HIV infection in HIV-negative adults. In contrast to HIV treatment regimens that typically consist of three or four agents, PrEP is a once-daily, fixed-dose combination of two antiretrovirals. The only FDA-approved drug is Truvada, a combination of tenofovir disoproxil fumarate (TDF) 300 mg and emtricitabine (FTC) 200 mg. In 2014, the U.S. Public Health Service and the Centers for Disease Control and Prevention issued clinical guidelines for using PrEP to prevent HIV in the United States.¹

In contrast to HIV treatment regimens that typically consist of three or four agents, PrEP is a once-daily, fixed-dose combination of two antiretrovirals.

Why should Colorado primary care physicians care about PrEP?

Over the past five years, between 325 and 400 new HIV diagnoses have been made each year in Colorado.² In combination with viral load suppression in people living with HIV and other options for risk reduction, PrEP can help limit the spread of HIV. Family medicine providers typically don't treat HIV in patients; the disease usually is managed by infectious disease physicians. However, managing PrEP in HIV-negative patients gives primary-care providers an opportunity to play an active and vital role in preventing HIV. Discussing PrEP can strengthen relationships with patients at high risk for HIV, and it can alleviate the burden of HIV-negative patients who need to seek PrEP care from infectious disease providers.

Your role: HIV still exists in Colorado. Primary care providers can improve access to HIV prevention with PrEP.

How effective is PrEP?

PrEP is safe and highly effective. Multiple trials have shown that when taken correctly, PrEP can decrease HIV risk by as much as 92 percent in adults. These trials, including the iPrEx study³ of men who have sex with men (MSM) and the Partners PrEP study⁴ of serodiscordant heterosexual couples, are detailed in the CDC's clinical guidelines.

The take home: When taken daily, PrEP can reduce the risk of acquiring HIV by 92 percent.

How safe is PrEP?

PrEP is generally well-tolerated. Nausea and fatigue in the first month of treatment were reported in about 10 percent of patients, but more often in the antiretroviral groups than placebo groups.^{3,4} In the US MSM Safety Trial,⁵ the TDF component was associated with a small decrease in bone mineral density (one percent decrease at the femoral neck and 0.8 percent decrease for total hip) but was not associated with reported bone fractures at any anatomical site. When used for HIV-1 treatment, TDF is known to cause small decreases in glomerular filtration, but no evidence of clinically significant elevations in serum creatinine were noted in Partners PrEP⁴ and no grade ≥ 3 creatinine elevations were seen in the US MSM Safety Trial.⁵

Side-effects summary: GI symptoms can be seen in about 10 percent of patients and usually subside after the first month. Bone mineral density can be followed in patients with other risk factors, and creatinine clearance should be followed every six months.

Can my patients afford PrEP?

In Colorado, there are many financial resources for patients who want to receive PrEP. Medicaid and many private health insurers cover PrEP. Patients who are uninsured or underinsured may be able to take advantage of manufacturer copay and drug-cost assistance programs or get help from Colorado's Public Health Intervention Program (PHIP).

The good news: Most patients can get help paying for PrEP.

What about drug resistance and ongoing testing?

To date, there have been two cases of reported PrEP failure due to drug-resistant virus.⁶ Because PrEP is not adequate treatment for HIV, patients should be tested and

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documented as HIV-negative before starting PrEP. Patients on PrEP should be tested at least every three months so that those who become infected do not continue taking an insufficient treatment regimen.

Bottom line: Drug resistance has been rare, but patients should be tested regularly for HIV infection while taking PrEP.

Who would be a candidate for PrEP?

PrEP is recommended as one prevention option for sexually-active adult MSM, transgender individuals, and heterosexually active adult men and women who are at substantial risk of acquiring HIV. PrEP also should also be discussed with men and women whose partners are living with HIV.

In short: Any adult who is at substantial risk of acquiring HIV could be a candidate for PrEP.

Where can my patients and I get help?

The Colorado Department of Public Health and Environment (CDPHE) will launch a campaign in early 2017 to both providers and patients at high risk to update and inform about PrEP as one option to decrease the risk of acquiring HIV.

CDPHE helps patients access financial assistance for PrEP and offers free public health academic detailing to Colorado providers. I am a physician working as a detailer for CDPHE and am available to help you incorporate PrEP into your primary care practice in a way that is cost-efficient, time-effective and of the most benefit to your patients.

I realize you are busy, and new evidence-based data is being generated rapidly. I can provide summarized data, pocket-sized clinical guidelines, printed information for patients and providers, and billing and coding assistance. I can meet with you one-on-one to assess your needs and help you incorporate HIV prevention into your practice.

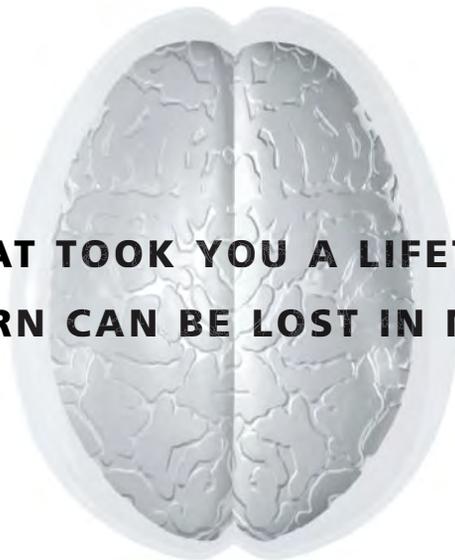
I also am happy to speak at practice meetings or conferences on the basics of PrEP, HIV prevention, working with MSM and transgender individuals, taking a sexual history, and extra-genital STI testing. Please feel free to email me at deborah.monaghan@state.co.us or call me at 303-692-2767.

For more information, visit stdhivco.org. The references below also provide a wealth of information and include the 2014 Clinical Practice Guidelines from the U.S. Public Health Service and the CDC.

It's true: There are a variety of ways for Colorado patients and providers to learn more about and get help with PrEP.

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Requests For Medical Records

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By Dean McConnell, JD, Senior Legal Counsel
COPIC Legal Department

In the era of open access, patients have the ability to request documentation of their visits with medical providers. Worker compensation, divorce and custody controversies, life or disability insurance application reviews, and ongoing legal proceedings all periodically lead to these types of requests. In each situation, sensitive information and potentially adverse comments in the record may result in unfavorable consequences for the patient.

Under HIPAA, patients have the right to review (free of charge) and receive a copy (for a reasonable, cost-based fee) of their medical and billing records and any other records that are used to make decisions about a patient. Failure to comply with HIPAA's access requirements has been one of the top five most common violations of HIPAA.

A partial list of the most common

records that a provider is not required to produce (i.e. patients do not have a right of access) includes:

- Quality assurance or professional review materials;
- Psychotherapy notes (personal notes of the therapist pertaining to counseling sessions; medications, dates of visits, billing information and other parts of the records are still subject to the right of access);
- Information compiled in anticipation of a civil, administrative, or criminal action;
- Clinical Laboratory Improvement Amendments (CLIA) records that are exempt or prohibited from disclosure;
- A medical record which, if released, would likely cause harm to the patient or another person (in the professional judgment of the provider);
- Research study records, but only if the patient agreed during the consent process and only while the clinical trial is in progress (patients must be informed that their right to access will be reinstated following the conclusion of the clinical trial);
- Information obtained from someone other than a health care provider, such as a family member or close friend, under a promise of confidentiality.

A common myth is that you cannot provide copies of another provider's records that are contained in your records. This is not true. A HIPAA FAQ specifically states that a provider can produce such records and, in fact, it may be a violation of the right of access if you do not do so when requested by the patient. A provider may require a patient to submit any request for access to records in writing, but only if the patient has been informed of this requirement, usually in the Notice of Privacy Practices.

GUIDELINES FOR PROVIDING RECORDS TO PATIENTS

In general, physicians are required to provide the records in a "timely" manner (as soon as reasonably possible, but no later than 30 days after the request). In unusual situations beyond the control of the physician, an additional 30-day extension may be obtained if the patient is notified before the expiration of 30 days. These unusual circumstances may exist, for example, if the records are off-site and cannot be retrieved within the 30-day time frame.

Being too busy, short-staffed, or similar reasons will not suffice. The Privacy Rule requires physicians to produce the records in the form and format requested by the patient, if readily producible in that form and format, or if not, in a readable hard copy form. For example, if a patient requests an electronic copy of a paper record, the physician is required to scan the paper information into an electronic format if the office has scanning capabilities.

The physician can charge a reasonable, cost-based fee for providing a copy, but can only charge for the following:

- The cost of labor for actual copying time. Time spent reviewing the request, retrieving the records, etc. cannot be charged;
- The cost of supplies (e.g. paper and toner, or USB drive or DVD, if electronic); and
- Postage if the patient requests the records be mailed.

If the patient requests a summary or explanation of the records, labor for creating the summary may be charged if the patient agrees in advance to the proposed fee.



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Practice Transformation: A Personal Journey for Healthcare Professionals



By Heather Grimshaw, Communication Manager, State Innovation Model

One of the first things BJ Dempsey, a practice facilitator at HealthTeamWorks, does before she talks with healthcare teams about integrating behavioral health and primary care is to learn whether they have lost patients to suicide.

“I’ve found that it turns the tide,” says Dempsey, who has five years of experience as a practice coach. “If the practice has lost someone to suicide it’s very upsetting to the staff and they’re motivated to do something, even if it’s not perfect.”

That something is to start integrating behavioral health and primary care to ensure that patients get the help they need when they need it. HealthTeamWorks is one of 25 practice transformation organizations for the Colorado State Innovation Model (SIM), a federal initiative funded by the Centers for Medicare & Medicaid Services.

Integrating behavioral health and primary care can take different forms as illustrated by the first cohort of SIM practices and community mental health centers that started their work in February.¹ The group represents a sliding scale of integration efforts, which can start with screening patients for depression and other behavioral health issues and culminate, for some, with hiring a behavioral health specialist, who works in the clinic to support providers and ensure patients get the care they need when they need it.

Intervention

SIM, which will work with 400 primary care practices and four community mental health centers to integrate primary care and behavioral health, support the delivery of whole-person care.

Statistics show that 45% of people who commit suicide have seen a primary care physician within a month, and 20% have seen a primary care physician within 24 hours. Recognizing an opportunity to help these patients at these critical junctures is a powerful impetus for integration, say practice coaches.

“There is a real need for this type of intervention,” Dempsey explains. If a practice has a history of a patient committing suicide (and many do) the staff remembers the patient.

“It’s personal,” she adds.

Emilie Buscaj, MPH, PCMH CCE, a program manager at HealthTeamWorks, explains that while many practice professionals recognize a need to intervene, one of the biggest barriers to doing so is apprehension and some fear.

“A lot of providers are nervous,” she says. Nervous to ask questions that might lead in a direction they’re not comfortable with or do not have the training or time to address. “[Most] don’t feel comfortable having conversations about depression, anxiety and substance use. They want more opportunity to follow-up on those issues but they’re not getting paid to do that and don’t have the ancillary staff who have the training and skills [in fee-for-service environments].”

In addition, many clinicians also do not know about community resources that can help address behavioral health issues, yet many appreciate the fact that behavioral health issues can cause, contribute to or exacerbate physical health issues.

This is one of the reasons why SIM helps providers test value-based reimbursement models that reward patient outcomes. It is also why the initiative provides myriad supports that help extend access to behavioral health resources in communities across the state.

Support

Coaches, who visit SIM practices twice a month on average, help care teams analyze and improve processes, use data to identify areas for efficiency and prepare for value-based reimbursement. They initiate and facilitate discussions about how to provide integrated, patient-centered care.

“One of the things SIM accomplished is putting a spotlight on the behavioral health part of things,” says Jen Miller, a practice improvement consultant at HealthTeamWorks, who says some practices need basic help with team huddles while others are ready to create risk-stratifications for patient panels.

In addition to practice coaches who help care teams identify more efficient ways to operate, SIM provides practices with the following supports:

- Clinical health information technology advisors, who focus on the optimization of technology
- Regional Health Connectors,² who identify community resources that practices can use
- Continuing education
- Small grants to support infrastructure changes
- A partnership with local public health agencies that widens the scope of integration efforts
- A partnership with the Colorado Multi-payer Collaborative to align SIM metrics and assessments with value-based payment models that will ensure sustainability

First Steps

Infrastructure changes required to provide integrated care can be expensive and time-consuming for practices, Buscaj says. Yet these changes lead to better outcomes and more satisfied providers and staff. A few examples of changes made to integrate care in SIM practices:

- Designate a care manager to identify high-risk patients and connect them with appropriate care team members for follow-up
- Redesign team huddles to review high-risk patients and structure bidirectional communication with leadership to

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“help staff align efforts and reduce the feel of chaos in a practice,” Dempsey explains

- Develop a team-based culture to streamline processes and improve access for a larger patient base with Health First Colorado (Medicaid) insurance, explains Shelli James, a practice facilitator at HealthTeamWorks, who says patients “were falling through the cracks” prior to the change

Learn more about SIM transformation efforts in a SIM video series,³ get a list of practices and community mental health centers⁴ participating in SIM cohort 1 and learn more about the application for SIM cohort 2,⁵ which will be released this winter.

Resources

1. <https://www.colorado.gov/healthinnovation/sim-practice-transformation>

2. <http://www.coloradohealthinstitute.org/key-issues/detail/new-models-of-health-care/colorado-regional-health-connectors>
3. https://www.youtube.com/watch?v=_2ZcOr3Gg9I&feature=youtu.be
4. <https://www.colorado.gov/healthinnovation/sim-practice-transformation>
5. <https://www.colorado.gov/healthinnovation/cohort2>

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SNOCAP RECAP

EDUCATION & PRACTICE ENHANCEMENT



As we write this, the finish line for 2016 is close and we are doubled over trying to catch our collective breaths. This summer and fall have been busy attending and presenting at conferences. It's been exhausting, but we're excited for the months ahead!

In October, SNOCAP ventured to Breckenridge to co-host the Engaging Communities in Education and Research (ECER) Conference. This year, SNOCAP had dedicated breakout sessions to discuss specific work. We also honored several of our practices and partners for their dedication over the past year. Congratulations to the CaReNet Patient Advisory Council, Staci Bishop and Kim Tate from HPRN, Michele Wallendal and the team at Pediatrics 5280 from COCONet, and (not pictured) the Westminster Medical Clinic from BIGHORN! SNOCAP held a session to prioritize health topics for the coming year. The outcome: mental health and specifically the link it has with both diabetes and obesity. We are interested in a network-wide card study to gain prospective from providers and patients. Thank you for your participation in this session.

In other news! Over the past year, discussions have occurred regarding a new PBRN specific to the Western Slope. Interest developed as practices became involved in PBRN projects and recognized that few others were involved on the Western Slope. Issues specific to the geographic region have surfaced that likely require asking



different questions and research strategies to answer. A small steering committee has formed and outreach to practices and organizations has begun. Our model includes health care related organizations as well as practices and practitioners. We have been in touch with several different organizations ranging from academic institutions to Health Information Technology companies. We are calling our network PEACHnet: *Partners Engaged in Achieving Change in Healthcare Network*. If interested in joining, or for more information, contact Anne Nederveld at: andrea.nederveld@ucdenver.edu

Wishing you well,
The SNOCAP team
Don Nease, Mary Fisher (Wold),
and Victoria Francies

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Update on Recommendations for Group B Meningococcal Vaccination

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

In April, 2015, in this publication, we described the background, rationale, and then-current status of vaccine recommendations for meningococcal disease in the United States.¹ We noted that vaccination for serogroups A, C, Y, and W-135 has been recommended for adolescents and young adults in the U.S. since 2005. Though meningococcal meningitis is uncommon, it is a horrifying, often-fatal disease that leaves physicians, parents, and loved ones alike wondering what they could have done to prevent it. CDC's Advisory Committee for Immunization Practices (ACIP), during my (RF) tenure, recommended this vaccination despite an unfavorable cost-effectiveness equation.² Recommendations have undergone minor revision several times since.³

We further noted that *Neisseria meningitidis* serogroup B poses a unique problem immunologically because its capsule antigen is similar to normal human tissue. Earlier vaccines could not include Group B because they were based on the capsule antigen. However, by the early 2010s, vaccines based on other antigens in the bacterium had been developed. Candidate Group B vaccines have been used with some success for control of outbreaks on college campuses.^{4,5}

After the publication of our article, in June, 2015 the ACIP approved a "Category B" recommendation for the use of Group B meningococcal vaccines (MenB-4C – Bexsero® by Glaxo Smith Kline, or MenB-FHbp – Trumenba® by Pfizer).⁶

The Category B option is available to the ACIP when it believes that the evidence is not strong enough to warrant a universal "Category A" recommendation for the entire population of a given age group, but is sufficient to warrant that vaccination is safe and effective and can be used at the discretion of the individual clinician.⁷

The Committee on Infectious Diseases of the American Academy of Pediatrics (AAP) has concurred with this approach and with this specific recommendation.⁸ Both ACIP and AAP make a Category A recommendation for persons ten years of age or older who have specific medical risk factors (including those with persistent complement component deficiencies, anatomic or functional asplenia, or microbiologists working with serogroup B meningitis), or as part of an outbreak control strategy.⁹

In October, 2016, the ACIP once again deliberated on Group B meningococcal vaccination, and reaffirmed its stance for a Category B recommendation. One technical change was implemented,¹⁰ one which requires an explanation of a difference between the two vaccine products.

Bexsero® is given in two doses, at 0 and 1 months. No distinction in dosing schedule is made between use in high risk persons and routine use.

Trumenba® can be given in either two (0 and 6 months)

or three (0, 2, and 6 months) doses. The three-dose schedule is the most effective and continues to be recommended for high risk persons and in outbreaks.

The two-dose schedule has now been judged appropriate (reasoning from a balance of effectiveness and cost considerations) to be administered at clinician discretion under the Category B recommendation for short-term protection against the disease for persons aged 16-23 (with a preference for administration between ages 16 and 18) not at high risk. This modification was approved by the ACIP in October.

The products cannot be interchanged. One must finish the series with the same product with which one starts.

Even the Category B recommendation for persons aged 16-23 not at high risk is enough to drive vaccine expenditures to some degree, in both the public and private sectors. In particular, ACIP in a separate vote authorized Group B meningococcal vaccine for persons aged 16-18 inclusive who are eligible for the federal Vaccines for Children program.

During the ACIP meeting, two related studies were presented in which anaphylaxis was seen in some vaccine recipients, with one episode per 11,000 in one study and one per 59,000 in another. While not sufficient to trigger a reversal of the recommendation, these findings are of concern in a vaccine targeted against such a rare disease.

Family physician and ACIP voting member Douglas Campos-Outcalt, M.D., M.P.A., of Phoenix, expressed to AAFP News that universal vaccination of those ages 16-23 would cost an estimated \$2-4 billion. This is well into the millions of dollars per case prevented. The entire CDC budget is \$6-7 billion, he pointed out.

Many are not pleased when ACIP makes Category B recommendations on any vaccine – seeing the option as an "unwillingness to commit". However, most recognize that in some situations, a case for pressing public health priority cannot be made. Here the decision of an individual clinician with his/her patient should prevail, and the regulatory and financing structures should be flexible enough to support the decision. We agree.

But because the latest recommendation is not Category A, patients may have questions. That is why the 2015-2016 AAFP Vaccine Science Fellows have created a frequently asked questions (FAQ) document about the vaccines for family physicians as part of their fellowship. You can find the FAQ at tinyurl.com/hq2kdb2.

Endnotes

- 1 Finger R, Larimore W. New Recommendations for Meningococcal Vaccination. CAFP Bulletin April, 2015.
- 2 CDC. Prevention and Control of Meningococcal

- Disease. MMWR May 27, 2005 Vol 54 #RR07;1-21
- 3 CDC. Prevention and Control of Meningococcal Disease. MMWR March 22, 2013, Vol 62, #RR02
 - 4 National Foundation for Infectious Diseases: Addressing the Challenges of Serogroup B Meningococcal Disease Outbreaks on Campuses. <http://www.nfid.org/meningococcal-b>
 - 5 <https://public.health.oregon.gov/DiseasesConditions/DiseasesAZ/MeningococcalDisease/Pages/Meningococcal-Update.aspx>
 - 6 CDC. Use of Serogroup B Meningococcal Vaccines in Adolescents and Young Adults: Recommendations of the Advisory Committee on Immunization Practices, 2015. MMWR October 23, 2015, Vol 64(41);1171-6
 - 7 (Do not confuse “Group B” with “Category B”!)
 - 8 AAP Committee on Infectious Diseases: Recommendations for Serogroup B Meningococcal Vaccine for Persons 10 Years and Older Pediatrics September 2016, Vol138, number 3: e20161890
 - 9 CDC. Use of Serogroup B Meningococcal Vaccines in Persons Aged ≥10 Years at Increased Risk for Serogroup B Meningococcal Disease: Recommendations of the Advisory Committee on Immunization Practices, 2015 MMWR June 12, 2015 / 64(22);608-612
 - 10 See www.cdc.gov/acip on the panel at right. Presentation slides from the October 2016 ACIP meeting, and meeting minutes, will be available shortly.

VACCINE NEWS YOU CAN USE

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

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WHO declares Americas free of measles, but CO FPs need to keep an eye out

The New York Times (tinyurl.com/haadd9j) reports global health experts announced at the Pan American Health Organization in Washington DC that measles has been eliminated from the Americas. The article points out that the last case of *endemic* measles in the Americas was in 2002, although there have been outbreaks since then because of imported strains. Reuters (tinyurl.com/hdrzmk6) points out that the Americas is the first region in the world to eliminate measles after a 22-year vaccination campaign.

U.S. News & World Report (tinyurl.com/hy8k8ne) reports the CDC is reminding us that measles can still be imported from other regions, so vaccination must continue. A perfect example was the measles outbreak that occurred in an Amish community in Ohio in 2014; the largest the US had seen in over 20 years. It was almost entirely limited to an Amish community, and most who became ill had never been vaccinated against measles. That outbreak was traced to two young Amish men who traveled to the Philippines to do typhoon-relief work. When the workers returned home, they unknowingly brought measles with them. Over several months, the infection spread to 383 children and adults—99 percent of who were Amish. However, “the fact that this outbreak was confined almost exclusively to the Amish indicates that high vaccine coverage in the general Ohio population probably prevented further spread of measles.”

Nevertheless, a recent study in the New England Journal of Medicine (tinyurl.com/gtlqf88) evaluated the Amish outbreak and concluded that it “could have been better controlled if clinicians had recognized the index cases sooner.” Only after a febrile illness with rash developed in 2 additional returning relief workers, then in 12 additional contacts within the Amish community, was measles recognized and reported to the health department—a full 30 days after the two index patients presented. The researchers remind us, “Health care providers

should maintain a high awareness of measles when returning unvaccinated travelers present with a fever and rash.”

This would be an especially important warning for FPs in Colorado, for as the Denver Post warned us (tinyurl.com/zdn4bf7), “Colorado kindergartners have the lowest vaccination rate for measles in the country, a distinction that health experts say makes the state especially vulnerable to a major outbreak.” A newly updated immunization database (tinyurl.com/hgnkane) created by Chalkbeat reveals that Boulder remains the hotspot for the anti-vaccination movement in Colorado—but it’s not alone.

According to the Centers for Disease Control and Prevention (CDC), just 82 percent of children in Colorado have gotten the two-dose vaccine that protects against measles. That’s far below the national average of 95 percent, as well as below the threshold needed to achieve herd immunity, which hovers around 94 percent. And certain parts of the state are even worse. Some school districts in Western Colorado have undervaccination rates five times higher than the state average. (tinyurl.com/zpbsgg9)

Dr. Edwin J. Asturias, with the Colorado School of Public Health, University of Colorado School of Medicine, and Children’s Hospital Colorado, told the Post, “We are going to have a large outbreak of measles.” It’s not if, but when. (tinyurl.com/zdn4bf7)

AAP Policy Statement: Immunization exemptions for child care and school attendance

What’s the bottom line? The American Academy of Pediatrics (AAP) says, “Nonmedical exemptions are not appropriate and are harmful to the community.” (tinyurl.com/zrdefaq)

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As CAFP members know, childhood immunizations prevent thousands of deaths, millions of serious illnesses, and billions of dollars in direct and societal costs each year. Despite the obvious success of vaccines, some parents decline some or all vaccinations for their children, requesting nonmedical (personal belief) exemptions to comply with school requirements. In fact, a recent survey (tinyurl.com/zwa684d) published by the AAP found that “from 2006 to 2013 there was an increase in parental vaccine refusal, with more parents seeing vaccines as unnecessary and less being concerned about safety, adverse effects.”

Unfortunately, Colorado (along with 46 other states) allows for such nonmedical exemptions. There are true contraindications to some vaccinations, and such children require medical exemptions for school attendance, relying on the “herd” to protect them from vaccine preventable diseases. Of interest, the survey reports that parents are increasingly refusing because parents think that vaccines are unnecessary and less because of safety and adverse events.

But, the AAP, after reviewing the public health consequence of immunization exemptions as well as the legal and ethical considerations around nonmedical exemptions issued a policy statement concluding that “refusal to vaccinate not only places the individual child at risk but also possibly the entire community, as a vaccinated herd is essential to prevent most vaccine-preventable diseases.”

The AAP adds:

- Immunization requirements are an effective way to protect both the individual child and the community.
- AAP supports laws that enforce certification of immunization for all children.
- AAP supports valid medical exemptions to specific immunizations when appropriate.
- AAP urges all states to enact laws to eliminate

nonmedical exemptions from immunization requirements.

Personal belief exemptions that allow unvaccinated children to attend school place communities at risk for outbreaks of communicable diseases and hinder the health of our children. This policy lays out a clear and convincing argument to eliminate such exemptions and supports all health professionals who care for children in their efforts to make sure all their patients are vaccinated.

Prenatal versus postpartum Tdap vaccination

Preventing pertussis in infants less than eight weeks of age was 85 percent more effective when Tdap vaccination was administered during 27 to 36 weeks gestation than postpartum vaccination, a recent study found. (tinyurl.com/j2817hh) Furthermore, prenatal Tdap vaccination prevented both the occurrence of and reduced the severity of pertussis in infants.

Rate of HPV vaccination among teen boys at nearly 50 percent, but FPs could do better

In “To Your Health,” the Washington Post (tinyurl.com/zbjrbh4) reports that “the rate of HPV vaccination among teen boys in the United States surged” last year, “suggesting that more parents and physicians are embracing the message that it’s as important for boys to be vaccinated against the human papillomavirus as it is for girls.” The CDC “reported ... that 49.8 percent of boys ages 13 to 17 had gotten at least one of the recommended three doses as of 2015, up 8 percentage points from 2014.” Meanwhile, “the rate for teen girls rose more slowly: Almost 63 percent had gotten at least one dose, compared to 60 percent in 2014.”

In addition, a recent study (tinyurl.com/ja2nkyg)



Member Recognitions

Congratulations to Dr. Jonathan Zonca, who received his FAAFP at the AAFP’s Family Medicine Experience (FMX) in Orlando this fall.

showed HPV vaccine is even more effective than thought. “After eight years of vaccination, the reduction in the incidence of cervical neoplasia, including pre-cancers, have been reduced approximately 50 percent. This is greater than what was expected—that’s pretty exciting,” said lead researcher Cosette Wheeler. The study also showed that the protection appears to occur even when only one

or two of the recommended doses of the vaccine are given. “Right now, the recommendation is three doses for girls and boys before the 13th birthday, so that you are protected before you become exposed,” Wheeler explained.

Added to this is a just-published simple way FPs could do even better. According to the research (tinyurl.com/jc4kknk), to convince parents to

get their kids vaccinated against HPV, tell them “I strongly believe in the importance of this cancer-preventing vaccine for [their child’s name].” Sixty-five percent of parents agreed it was a persuasive argument. Surprisingly, even “parents disinclined to vaccinate were most receptive to messages about HPV infection being common, cancers caused by HPV, and HPV vaccine effectiveness.” (tinyurl.com/jc4kknk)

Remembering Howard Netz, MD

Howard Netz, MD, past-president of the CAFP (1978-79) passed away on November 7, 2016, at the age of 86. Dr. Netz was born in Topeka, Kansas and moved to Denver as a teenager. He graduated college with a degree in pharmacy and managed three drugstores across Denver. After serving in the US Army at Fort Sam Houston in San Antonio, he attended CU Medical School on the GI Bill. He was one of four founders of New West Physicians, was one of the first physicians in Colorado to become board certified, and served multiple generations of families in his over 35 years of practice.

“He was a good man and a good physician. His patients loved him very much,” said Dr. Glenn Cosh, a friend and fellow past-president of the CAFP (1986-87). “He was a quiet and unpretentious doctor, but intellectually he had no peers. He was greatly loved in the Lakewood community.”

Dr. Netz is survived by his wife Joanne, his daughter Jill, his son David, daughter-in-law Nancy, four grandchildren and seven great-grandchildren.

To honor Dr. Netz’s memory, and his dedication not only to his patients but to the University of Colorado School of Medicine, donations can be made in memory of Dr. Netz at www.giving.cu.edu/HowardNetz.

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New Grant Aimed at Tackling Rural Opioid Crisis in Colorado

By Lynlee Espeseth

Opioid addiction is quickly becoming one of the largest public health crises in the United States. In rural communities, the effects have been particularly hard felt. Rural Colorado may be struggling even more than other parts of the country, as some reports suggest that Colorado could rank as high as second in the nation for nonmedical use of prescription pain killers. In 2014, “opioid overdoses killed 41 Coloradans per month.”¹

What is being done to counteract this? One method gaining in popularity is Medication Assisted Treatment, or MAT. The method combines buprenorphine and behavioral therapy to help people combat their addiction.

Unfortunately, MAT is not readily available in many of the rural communities that need it most. In these communities there is often an overall lack of physicians, particularly physicians equipped to treat addiction or who are licensed to prescribe buprenorphine.

The federal Agency for Healthcare Research and Quality is seeking to change this, providing \$9 million to three initiatives, including one led by Dr. Jack Westfall, designed to help bring MAT to rural communities in Colorado.

The program, called "IT MATTERS Colorado," will run in 24 rural counties encompassing eastern Colorado, as well as south central Colorado. The goal is to educate primary care providers, patients and communities about Opioid Use Disorder (OUD) and Medication Assisted Treatment, and to equip primary care practices with the tools they need to address OUD and MAT. This will include a number of specific steps, including getting more providers certified to prescribe buprenorphine, increasing access to behavioral healthcare, reducing disconnects between local providers and initial opiate prescribers, helping practices meet all requirements, and

making sure rural primary care facilities have access to the appropriate training. The High Plains Research Network and the Colorado Research Network will be the primary organizations conducting this work. Education and support to primary care practices will be delivered both in person, through Shared Onsite Knowledge Dissemination (SOuND), and remotely, using Project ECHO Colorado.

The grant also seeks to change things outside of provider's offices, as it is understood that opioid abuse, and a

The stigmas attached to addiction and behavioral health issues often prevent people from seeking treatment. This is especially true in very small, rural communities, where some patients don't want to be seen parking at or going into a behavioral health office, for fear that someone will see and recognize them.

lack of treatment, is not only about a lack of providers. The stigmas attached to addiction and behavioral health issues often prevent people from seeking treatment. This is especially true in very small, rural communities, where some patients don't want to be seen parking at or going into a behavioral health office, for fear that someone will see and recognize them. The initiative will account for this by providing Boot Camp Translation (BCT) that takes technical

and medical information, and translates it into something that is relevant and actionable for local populations. The goal is to reduce the stigmas around addiction across entire communities, and encourage patients and families to seek treatment.

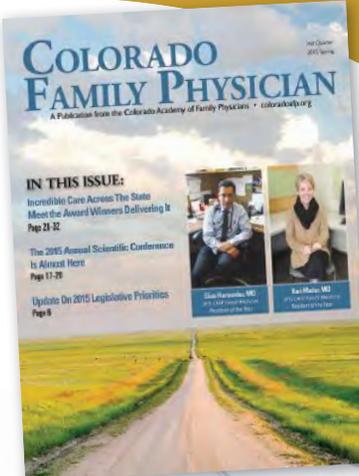
The initiative officially begins in January, 2017, and will be rolled out over the course of three years.

If you have questions about the program contact Jack Westfall or Linda Zittleman at Jack.westfall@ucdenver.edu or Linda.zittleman@ucdenver.edu

1. <http://www.coloradohealthinstitute.org/key-issues/detail/community-health/colorado-county-drug-overdosedead-rate>



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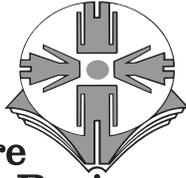
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