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

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

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

Front Range pediatrics patients can now get appointments within 48 hours. Physicians can refer patients by calling our physician line at 1.800.652.9555 or visiting njhealth.org/professionals.
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Here’s a few things that matter to me:

**Advocacy for issues that affect you.**

- A dedicated Colorado lobbyist who works to be sure that bills which would negatively affect our doctors and patients do not pass (such as Medicaid reimbursement cuts) and supports legislation that would favorably affect us and our patients (the DPC bill and Medicaid bump, tax credits for preceptors).
- CAFP’s legislative committee calls are a forum where physicians from the community can help determine CAFP’s stance on various pieces of legislation.

**Health of the Public/Physician Wellness Committee**

- Committees/workgroups regarding those things closest to our hearts. We are currently working on payment reform, opioid prescribing/safety advisory task forces, the physician wellness conference, as well as a marijuana education program for children.

**Education**

- The CAFP offers opportunities for CME throughout the year at our Annual Summit, Wellness Conference, KSA courses, and webinars.

**Representation at the National Level**

- Our Colorado leaders represent us at the AAFP Congress of Delegates each year, where we have the opportunity to put forth resolutions to become AAFP policy and practice. We also have a current CAFP member, Dr. John Bender, on the AAFP board. We send our leaders to national meetings to discuss state and national issues and bring back ideas to Colorado.

**A Voice in the Colorado Medical Community**

- Our members and leaders regularly are invited and attend meetings and events that give a voice to Family Medicine. Recent examples would be meetings with our PAs and NPs to discuss scope of practice and the medical team, meetings with the health department to discuss newborn screening, and collaboration with CMS regarding opioid safety and prescribing.

**Committee Leaders who Care about Family Medicine in Colorado**

- Our leaders and members testify at our state Capitol and travel to our Nation’s Capital to meet with our legislators and discuss issues important to you.

During our recent member survey, 42% of our members indicated that you were unsure that the CAFP leadership understands your needs and acts accordingly. Some of our most pressing issues that we are working on now include Medicaid claims reimbursement, opioid safety and prescribing, benefits to new physicians, and Family Medicine reimbursement/primary care investment. If you have needs that you feel are unmet or not understood please contact the CAFP or me directly at mcorriga@zagmail.gonzaga.edu, as it is our goal to support our physicians, and part of that is understanding your needs.

---

**Highlights from the August 2017 Board Meeting**

1. **Action Toward Payment Reform**
   The board approved a motion to move forward with the Primary Care Investment Plan which works by collecting data regarding primary care payments in Colorado (national average 8% of spending) and then working legislatively to increase that amount to 12% of total healthcare spending. A new task force was created to work on the plan.

2. **Medicaid Non-payment**
   Many board members expressed grave concerns that some practices are closing their doors, unable to see their Medicaid patients, or allocating excessive staff time in response to Medicaid not paying claims.

   Actions:
   - If your practice is struggling, take our survey here to help us understand the scope of the problem among members: https://www.surveymonkey.com/r/YQCFHLZ
   - CAFP Deputy CEO for Policy and External Affairs Ryan Biehle has already helped some practices obtain their money, and is willing to do so for other practices. Contact ryan@coloradoafp.org or 303-696-6655 x 17

3. **The board approved a pilot for New Physician Benefits**
   A new task force was created to determine the specific benefits and report back to the board.

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**What do you appreciate about your CAFP membership?**

Advocacy

1. **Advocacy for issues that affect you.**

2. **Advocacy for you.**

3. **Advocacy for issues that affect you.**

---

**BY: MONICA MORRIS, DO**
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CEO’S REPORT

Results from the 2017 CAFP Membership Survey

The CAFP conducted our annual membership survey this summer and, like always, the results were extremely helpful to us. Thank you to everyone who participated!

I want to take this time to highlight some of the most important findings, and how the CAFP will be responding.

Many of you aren’t sure what our Board of Directors is up to.

Over 40% of you stated you are unsure if the board understands your needs and acts accordingly. We want to make sure you know what is happening, and can offer ongoing feedback about what is most important to you.

Going forward, watch for updates in the enews and magazine following board meetings. We will have a recap of the most important items that were discussed and decided upon at each meeting.

We are also exploring ways to get more physicians in more parts of the state facetime with board members. Watch for updates on this in the coming months. In the meantime, if your practice or local group of physicians is particularly interested in having a board member visit you, let me know and we will do our best to facilitate.

Additionally, remember that board meetings are always open for our membership to attend. You can see the full list of upcoming meetings and details on our events calendar at https://www.coloradoafp.org/cme-and-events/events-calendar/.

And, as always, please feel free to send feedback, questions and concerns to myself, or to our Board President Monica Morris, DO.

Value of membership is important, and we need to deliver.

Many of you pay for CAFP membership out of your own pocket. More still use CME dollars allocated to you for membership, or ask your employer to pay your membership dues. No matter how you pay, you want to see more value in membership.

To increase the value of your membership, we will be rolling out new member services over the next year.

First, the CAFP is excited to launch the Primary Care Investment Strategy which will benefit all CAFP members. This legislation will require a set percentage of the total health care dollars to be spent on primary care in Colorado. That means more funds back to your practice, and back to you. See the legislative report in this issue for the full details of this exciting step.

Second, for our newest members, we are in the final stages of launching a comprehensive benefits package that will assist physicians as they transition from residency to the first years of practice. This program will include contracting and legal assistance, salary data, deeply discounted CME and more. Watch for the final news about this program before the end of the year.

Wellness is a big issue, and a complicated one.

Over 47% of you asked us to make physician wellbeing and burnout prevention a priority. It was the number two choice behind payment reform (and as many of you know, the two issues are closely linked). However, many of you feel differently about how we should tackle this issue.

For some of you, wellness is only about systemic change in healthcare: Reduce administrative burdens, increase pay, help independent physicians to thrive, and support employed physicians from unreasonable expectations.

For others, wellness is also about learning to find happiness even when the system doesn’t always work. You are looking to feel empowered and find joy.

We think that our approach to tackling wellness needs to, and will continue to, encompass both ideas.

System change is not surprisingly, but frustratingly, slow to come. However, we feel that we have several positive initiatives underway that can begin to make a difference. The above mentioned Primary Care Investment Strategy is one. We are also gathering feedback from members regarding administrative burdens, like prior authorizations, so we can decide appropriate next steps to take. Making systems friendly to family physicians and patients remains a top priority for us.

We also want to address the immediate changes we can make for physicians. Our wellness conference this year was well reviewed, because it recognized that yoga or meditation can’t take away all of your stressors. You need more actionable tools to reclaim your time and happiness. We want to build off of this by continuing smaller wellness events for those who find it helpful, as well as offer information in spaces like this magazine.

It’s time to shake up the Annual Summit.

You expressed clearly that it’s time for some fresh Annual Summit venues. We are working with the top venues and locations you suggested to secure conference dates for the coming years. We have taken particular care to pay attention to the preferences of our rural members. Expect a five-year list of dates and venues to be released soon!

As always, let us know what you face in your practice, and how we can work with you to make change. Though our membership is diverse, rarely are we alone in our experiences.
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On our recent member survey, we heard loud and clear that the two issues you want CAFP to prioritize are payment reform and physician health and well-being. That’s why we’re launching a new initiative to increase the investments being made in primary care to at least 12% of total health spending. That may not sound like much, but it is twice what we spend today. Investing in primary and preventive care upfront will in fact drive down overall costs in our healthcare system. Through this initiative, we aim to accelerate the move away from fee-for-service because we cannot wait longer to start paying for value – and primary care is high value. We aim for these added investments to expand the capacity of primary care and support the infrastructure of team-based models like the Patient Centered Medical Home (PCMH).

We don’t have to convince you of the value of primary care. Yet every day we seem to have to prove our worth – to payers, to health systems, to researchers, and to policymakers. We track and report our quality measures, we undergo continuous quality improvement, we change work flows and transform, and transform, and transform our practices to build a better healthcare delivery system. Every day we do this work, and we should. It is vital that primary care lead the charge to improve our healthcare system, so that we can improve the health of our patients. But the trouble comes when primary care shoulders the work without giving us the resources to do that work.

Hundreds of practices across Colorado have transformed to become a PCMH, because it’s the right thing to do and because the PCMH works. Many have done so through the Medical Home Pilot program established a decade ago, but the enhanced payment subsided just several years later. Many are transforming our practices to integrate behavioral health through the State Innovation Model, but the program, and the payment, is soon scheduled to subside. Many are transforming and providing advanced care through the Comprehensive Primary Care Plus initiative. Yet for all the great transformation work being done by our colleagues, a key measure that we’re missing is whether all the improvements in care are being backed by the resources to sustain that effort.

The truth is, we value what we measure. Until now, we have not measured how much we invest in primary care, or for that matter how much of our payments are value-based rather than fee-for-service. The time has come for the payment to match the results.

Recent research by the RAND Corporation and the Milbank Memorial Fund demonstrates in the best-case scenarios, only 8.6 cents of every dollar goes to primary care. Other research indicates typically only 4 to 7 cents of each dollar goes to primary care. Simply stated, the U.S. healthcare system dramatically undervalues primary care. In fact, this under-investment in primary and preventive care leads to overall higher costs to the system. Under-resourcing primary care means longer wait times for appointments, and ever-shorter appointments, so patients turn to the ER. It means greater fragmentation in what should be a well-coordinated medical neighborhood. And it means practices will not have the resources to do the evidence-based transformation we know improves health, like integrating behavioral health, hiring care coordinators and social workers, and supporting the evolving focus on population health.

That’s why the CAFP Board recently voted to move forward with a new Primary Care Investment Initiative. Following on success in Rhode Island and Oregon, CAFP will advocate to set a statewide target for primary care investment. Medicaid, commercial insurers, state employee plans – all should be investing at least 12% of their dollars in primary care. We know if we can invest these resources up front, we’ll see savings in downstream costs and we’ll see better health outcomes. These investments will add needed capacity to primary care by expanding the team. That’s a win for patients. And it’s a win for physicians facing burnout from the 30-visit days and endless 60 hour weeks.
Here, this is a SUBMARINE

Or a spaceship. Or a movie theater. Before the MRI that will help Dr. Michael Handler and his team plan Jacob’s seizure surgery, Jacob transformed the room into an ocean. It reduced his anxiety and eliminated the need for sedation, making this procedure safer. The end result: a calm environment for Jacob and more accurate results for the neurosurgery team at one of the top 10 children’s hospitals in the country.

Children’s Hospital Colorado
Here, it’s different.

100+ Years Dedicated to Kids
TOP 10 Hospital in the Nation
2000+ Pediatric Specialists
3x Magnet Recognized
CAFP Vice President Gina Carr, MD’s 2012 Rural Track graduating class from CU was featured as part of a story in 5280 Magazine about healthcare in Colorado.

Healthcare leaders, including CAFP Chair Tamaan Osbourne-Roberts, MD, met in Pueblo this summer to discuss ways to improve our healthcare system.

CAFP and CIVHC leaders met to discuss the primary care investment strategy.

Students and residents attending AAFP’s National Conference in Kansas City attended a reception held by CAFP.

The CAFP exhibited at the AAFP’s Women’s Health Live Course in Denver.
CAFP joined the Colorado Commission on Family Medicine to celebrate their 40th anniversary.

CAFP CEO Raquel Alexander joined other executives from Western States for the Women of the West Gathering in Idaho.

Students from Rocky Vista University gathered for a networking event co-sponsored by the CAFP at Elk Mountain Brewery.

Steads from Rocky Vista University gathered for a networking event co-sponsored by the CAFP at Elk Mountain Brewery.

Dr. Mark Tomasulo speaks to residents at Peak Vista Residency in Colorado Springs about direct primary care.

CAFP member Dr. Shannon Jantz spoke at a Colorado Senate town hall on opioids in August.
Navigating situations with patients who display signs of domestic violence can be challenging based upon how patients respond, what information they are willing to provide, and their concerns about related consequences. In addition, Colorado recently passed House Bill 17-1322 which allows a discretionary exception for a licensee to report domestic violence.

FIRST OF ALL, IT IS USEFUL TO UNDERSTAND HOW DOMESTIC VIOLENCE IS DEFINED (CRS § 12-36-135):

- **“Domestic violence”** means an act of violence upon a person with whom the actor is or has been involved in an intimate relationship. Domestic violence also includes any other crime against a person or any municipal ordinance violation against a person when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

- **“Intimate relationship”** means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time.

WHAT ARE THE SITUATIONS WHERE A PHYSICIAN IS ALWAYS REQUIRED TO REPORT DOMESTIC VIOLENCE (CRS § 12-36-135)?

- A bullet wound, a gunshot wound, a powder burn, or any other injury arising from the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument that the licensee believes to have been intentionally inflicted upon a person;

- An injury arising from a dog bite that the licensee believes was inflicted upon a person by a dangerous dog (as defined in C.R.S. 18-9-204.5(2)(b)); or

- Any other injury that the licensee has reason to believe involves a criminal act.

- Additionally, a physician is required to report **“serious bodily injuries”** which are defined as: bodily injury which, either at the time of the actual injury or at a later time, involves a substantial risk of death, a substantial risk of serious permanent disfigurement, a substantial risk of protracted loss or impairment of the function of any part or organ of the body, or breaks, fractures, or burns of the second or third degree (CRS § 18-1-901)

So, any injury related to domestic violence that meets the criteria above or meets the definition of “serious bodily injuries” must always be reported. A physician may not “opt out” of reporting any injury that meets one or more of these three criteria. In fact, there are serious legal implications for those who fail to report an injury that meets one or more of the above three criteria.

WHO SHOULD REPORT (CRS § 12-36-135)?

Current law requires any licensed physician, physician assistant, or anesthesiologist assistant (licensee) who attends or treats any of certain injuries, including injuries resulting from domestic violence, to report the injury at once to the police of the city, town, or city and county or the sheriff of the county in which the licensee is located.

WHAT ARE THE NEW UPDATES FROM THAT CHANGE DOMESTIC VIOLENCE REPORTING REQUIREMENTS (HB 17-1322)?

In 2017, state statutes were updated to outline the circumstances in which a physician is not required to report a case of probable domestic violence. In addition, the statute notes documentation, patient notification, and referral rules:

A licensee may, but is not required to, report an injury that he or she has reason to believe occurred as a result of domestic violence if:

- The victim of the injury is at least eighteen years of age and indicates his or her preference that the injury not be reported; and

- The injury is not an injury that the licensee is required to report as noted in the previous “ALWAYS report” section.

In addition, other related actions include:

- If a licensee does not report an injury pursuant to a victim’s request, the licensee shall document the victim’s request in the victim’s medical record.

- Before a licensee reports an injury that he or she has reason to believe resulted from domestic violence, the licensee shall make a good-faith effort, confidentially, to advise the victim of the licensee’s intent to do so.

- If a licensee has reason to believe that an injury resulted from domestic violence, then, regardless of whether the licensee reports the injury to law enforcement, the licensee shall either refer the victim to a victim’s advocate, or provide the victim with information concerning services available to victims of abuse.

Importantly, if a physician chooses not to report domestic violence in accordance with a patient’s request that meets the above criteria, there is language in the statute granting the physician civil and criminal immunity. Lastly, the language of the statutes still allows a physician to exercise his or her judgment: Even if the patient requests that a more minor domestic violence injury not be reported the physician still may report it to law enforcement.
As I write this in mid-August, your SNOCAP team is still fairly fresh from our annual North American Primary Care Research Group Practice-Based Research Network (PBRN) conference in Bethesda, MD. That conference featured a lot of participation from Colorado and the Agency for Healthcare Research and Quality (AHRQ). I’d like to reflect on that in this recap.

As context, however, it’s always important for me to reflect on why we do practice-based research. Practice-based research’s primary mission should be to improve the care delivered by you to the patients and communities you serve. If we are not doing that, we should find other work.

One take away for me from the PBRN conference was that our work in Colorado matters to the rest of the country. Our Colorado based team presented 2 posters, 2 oral presentations, and 2 workshops at the meeting. Our peers around the country watch and respect our work, and it has influence on what they do in their own backyards. Many of us who attended and presented received requests at the conference for more information and requests to come learn from how we do things. I want you, my fellow CAFP members, to know that because we could not do this work without your ongoing support. You answer our requests for participation, provide feedback on our work, and continue to partner with us in this effort to improve the level of primary care in this great State. Keep it up!

In just over a month, we’ll have a chance to meet up in person and celebrate that work at our September SNOCAP Convocation in Aurora. If you can’t make it, we’ll try to recap that in our next Recap. And if you’re not a part of one of our networks yet, but reading this makes you think you’d like to try it out, drop us a line or sign up for our bi-monthly SNOCAP newsletter by following this link: eepurl.com/bfteGf. We’d love to have you on board!

Thanks for reading, and thanks for your support,

Don
Healthy coping and self-soothing strategies are often effective tools for helping us to manage the effects of stress and intense emotions in our patients. These strategies have also been shown to help moderate the relationship between stress and the development of more severe health problems (e.g., depressive symptoms and physical health concerns). Instruction in healthy coping may, therefore, be considered an important preventive exercise for children and teens. Primary care providers can instruct children, adolescents, parents, and caregivers about the use of healthy coping strategies.

Stress is normal
- Children, adolescents, parents, and caregivers face a multitude of acute and chronic life stressors, which may include: pressures related to academics, peer relationships, social media, life transitions, political climate, separation or loss of caregivers, poverty, familial conflict, exposure to violence, and physical illness.
- Exposure to adverse or stressful experiences during childhood occurs at high rates and without appropriate intervention, has been linked to problems in adulthood.

What is coping?
- Coping commonly refers to an individual’s effort to regulate emotions, cognitions, physiology, behavior, and situations, in reaction to stressful events or challenging circumstances. In other words, coping can be described as anything that one does in an attempt to manage stress.
- During stressful situations, coping skills can help to diffuse or “turn down the volume” of intense emotion, allowing for increased control over how an individual chooses to respond to the situation.
- Coping skills generally serve one or more of the following purposes:
  - self-soothing: engages the body’s natural calming system
  - distraction: redirect to more pleasurable activities to decrease intensity of emotion
  - opposite action: engagement in an activity that generates an emotion or experience that is counter to the distressing one
  - emotional awareness: activities that promote emotional exploration and increase clarity
  - mindfulness: focus on being grounded in the present

Not all coping is helpful
- Often, individuals develop unhealthy methods to deal with stress and difficult emotional experiences.
- Self-harm behavior, substance abuse, unhealthy eating, social withdrawal, aggression, and other maladaptive behaviors can emerge as misguided attempts to manage stress. While these behaviors can be effective in the moment, they do not promote long-term health.

Healthy coping and self-soothing strategies are often effective tools for helping us to manage the effects of stress and intense emotions in our patients.
Parents and caregivers manage stress
- Caregivers may benefit from examining their own typical coping strategies and how they are modeling healthy coping for their children
- Families with younger children may consider developing a “family coping plan,” to practice healthy coping strategies together
- Using movie or book characters for examples on healthy and unhealthy coping can also be helpful in teaching younger children about coping in an age appropriate way

Talking to teens about coping (Tip: you don’t have to call it “coping”)
- Inquire broadly about anything the teen currently does to manage emotions, make him or herself feel calm, or “turn it around” when struggling
- Encourage teens to consider what strategies have helped them in the past, even if these strategies were not conceptualized as “coping” (e.g., “I usually feel better after soccer practice” suggests that exercise may be a coping skill even if soccer practice is not attended in order to manage stress or cope)
- Use of the teen’s own language is encouraged to help increase the likelihood of engagement (e.g., instead of a “coping plan,” teens may respond better to the idea of a “stress management plan,” a “list of calming activities,” or some other label of their choosing)

Resources / References
Children’s Hospital Colorado’s Pediatric Mental Health Institute professionals are trained to help youth and their families collaboratively identify and create healthy coping habits. To refer a patient for consult call 720-777-6200.


Sample coping strategies:

<table>
<thead>
<tr>
<th>Self-Soothing</th>
<th>Distraction</th>
<th>Opposite Action</th>
<th>Emotional Awareness</th>
<th>Mindfulness</th>
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<tr>
<td>Deep breathing</td>
<td>Calming activities (listening to</td>
<td>Enjoyable activities</td>
<td>Cognitive strategies: coping thoughts</td>
<td>Grounding exercises (counting your breaths,</td>
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<td>Tensing and relaxing major muscle</td>
<td>music, painting/drawing)</td>
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<td>counting or subtracting by sevens, counting</td>
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<td>but it’s only temporary; “I can ride this</td>
<td>the colors you see)</td>
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<td>Five senses grounding activities (5 things you</td>
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<tr>
<td>Meditation or guided imagery</td>
<td>Talk to someone</td>
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<td>Self- affirmations</td>
<td>see, 4 things you hear, 3 things you feel, 2</td>
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<td></td>
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<td></td>
<td>Journaling</td>
<td>things you smell, 1 thing you taste)</td>
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Sample coping strategies:

- Self-Soothing:
  - Deep breathing
  - Tensing and relaxing major muscle groups (Progressive Muscle Relaxation)
  - Meditation or guided imagery

- Distraction:
  - Calming activities (listening to music, painting/drawing)
  - Activities (puzzles, baking, playing a game)
  - Talk to someone

- Opposite Action:
  - Enjoyable activities
  - Exercise

- Emotional Awareness:
  - Cognitive strategies: coping thoughts (e.g., “this situation is really rough, but it’s only temporary; “I can ride this out”)
  - Self- affirmations
  - Journaling

- Mindfulness:
  - Grounding exercises (counting your breaths, counting or subtracting by sevens, counting the colors you see)
  - Five senses grounding activities (5 things you see, 4 things you hear, 3 things you feel, 2 things you smell, 1 thing you taste)
Early Seizure Diagnosis and Management for the Primary Care Clinician

Dr. Joshi and her pediatric neurology colleagues can be reached through One Call for consult at 720-777-3999 or Toll Free at 800-525-4871.

To the lay public, seizures typically evoke a visual picture of a person shaking uncontrollably sometimes with a change in color and frothing at the mouth: overall a near death experience. Add to that the possibility of this happening to a young and developing child and it is sure to cause significant parental concern as well as physician concern about the following main questions: Is this likely to happen again? What is the chance of brain damage because of either repeated overt seizures or possible missed seizures? What can I do to prevent another episode? What investigations can I perform before the patient is seen by the neurologist?

After a single seizure, what is the chance that it will happen again?

It is first important to establish that the event of concern is indeed a seizure. This can only happen after a very detailed clinical history which establishes that the event happens suddenly, disrupts normal behavior, has an onset, evolution and offset. Most the seizures last 1–2 minutes in duration. Remember that everything that shakes or stares is not a seizure.

In one of the first seizure clinics (Hamiwka et al) it was found that 30 percent of patients had episodes that were not seizures [this would include paroxysmal events like behavioral spells of inattention, syncope, stereotypies etc.], another 30 percent had episodes where previous seizures predated the first recognized seizure and lastly in 30 percent this was truly the first ever event.

If the patient had a true unprovoked seizure [meaning that there was no provocation factor like fever, abnormal electrolytes, brain infection etc.] the chance that the patient can have another event is anywhere from 14–60 percent according to the American Academy of Neurology practice parameter on treatment of a child with a first unprovoked seizure. Patients that have an abnormal EEG are more likely to have a subsequent event compared to patients that have a normal EEG. Additional risk factors that increase risk for future seizures include a remote insult to the brain, seizures occurring in sleep, or postictal Todds paresis. Typically, seizures do not change characteristics from event to event. This means that it is unlikely that the patient might have significant jerking of all four extremities one day followed by episodes of staring or laughing out of context the next day, followed by episodes of rage attacks some other time. It is more likely that the patient might initially appear to stare or twitch one part of their body and then progress into shaking of one extremity or the other. It is important to document behavior of the patient after the event of concern. A seizure is the clinical manifestation of an abnormal, abrupt, purposeless electrical discharge in the brain and therefore one expects that after such a discharge the behavior of the patient should not come back to normal immediately. It is always helpful to review home videos that parents/caretakers may have of suspicious events on their smart phones/ other devices.

Seizures do not respect night or day time and therefore episodes of concern that happen circumstantially only during narrow times or around certain activities alone are less likely to be seizures.

If the patient has a second unprovoked event then the chance that the seizures will continue happening is 80–90 percent and providers should take steps to prevent future episodes by starting the patient on preventive/prophylactic anti-seizure medications.

Can seizures cause brain damage?

Given the significant redundancy of the brain and the developmental potential of a growing child, a single seizure that is not prolonged [meaning not greater than 30 minutes] would be unlikely to cause any clinically discernible developmental
problems. In many cohort studies that looked prospectively at seizures [Camfield et al, Shinnar et al] it was found that even after 8–10 events there was no evidence of long-term or established brain damage. However, given the pernicious nature of a generalized tonic-clonic seizure, it is important to establish that the parents know what to do during a seizure and discuss seizure first aid and seizure safety. The Epilepsy Foundation of Colorado has robust resources for parents and families.

Since most seizures last 1–2 minutes, it is generally recommended that any seizure that lasts up to five minutes should be considered an episode of impending status epilepticus and therefore we advise parents to administer rescue medications or contact 911 after this duration if they do not have any rescue medications. We encourage primary care providers to discuss seizure safety and first aid with the family and to provide a seizure rescue medication; commonly used seizure rescue medicines include rectal diazepam or intranasal midazolam.

What can I do to prevent another episode?

After a single seizure, many times we will hold off on starting preventive medication. However, after two or more seizures preventive medication is recommended. In rare cases after a single seizure if the chance of this patient having repeated seizures is very high either due to a brain abnormality or metabolic disturbance, a neurologist might consider starting medications right away.

What investigations are warranted after a single seizure?

After a first seizure, the International League Against Epilepsy guideline does recommend obtaining baseline lab testing to include a Chem-7, to look for abnormalities especially in glucose, sodium, magnesium, calcium looking for reversible causes of a seizure. It is important to stress that a routine EEG that is normal does not exclude a diagnosis of a seizure disorder since it is merely a sample in time and the yield of this test is not very high. Therefore, although an EEG could help in localizing seizure onset as well as in prognostication of future seizures, it is rarely diagnostic in and of itself other than in cases of childhood absence epilepsy or in cases of infantile spasms where one expects to see hypsarrhythmia, a type of EEG pattern commonly associated with infantile spasms, in the majority of infants. If an EEG is abnormal the chance that the seizures might repeat are likely high.

What should I do if the patient has already had a few seizures by the time they report to my clinic?

When a patient has already had a few seizures by the time they report to the PCPs office, it is important to be able to prevent further seizures. Discussion with a neurologist about next steps and possible treatment initiation is important; the neurologist can help make a quick assessment of whether an immediate treatment plan is required or whether the patient can wait for further evaluation.
Adult Vaccination is Low, with Minimal Improvement in Recent Years

Only minimal improvements have been made in vaccination coverage among U.S. adults in recent years according to the CDC. In its analysis of data from the 2015 National Health Interview Survey (tinyurl.com/ybkwbm7), the researchers looked at adult vaccine coverage for influenza, pneumococcal, tetanus, hepatitis A, hepatitis B, herpes zoster, and human papillomavirus. Although vaccine coverage rose in several of the seven vaccines studied from 2014 to 2015, these were small increases, the CDC noted.

Another analysis of these data (tinyurl.com/ya6ttxnc) found two thirds of older Americans have never had a shingles vaccine, and close to half haven’t had a tetanus shot in the past 10 years, while only 69 percent had received the influenza vaccine in the previous year. A recent study of nursing homes (tinyurl.com/yarsx9y) revealed about 76 percent of residents received the influenza vaccination and about 68 percent had had the pneumococcal vaccination. Coverage was well below the Healthy People 2020 target of 90 percent for both vaccines. With simple standing orders, these should be closer to 100 percent. The bottom line is that we physicians can and should do better.

The awareness of the need for vaccines by adults is low among the general population. Health care professional recommendations for vaccinations are strongly associated with a patient’s receiving vaccines. Integrating assessment of adult patients’ vaccination needs, recommendations, and offers of vaccination as a part of routine adult clinical care could greatly improve the adult vaccination rate, according to the CDC.

Oops, I gave the wrong varicella vaccine, what do I do now?

According to Michael D. Holzer, MD, MPH, (tinyurl.com/yccy2rot) while both varicella vaccine (Varivax) and varicella zoster vaccine (Zostavax) target the same virus, they differ in the amount of the virus present in the vaccine. Zoster vaccine has 14 times the amount of varicella virus as the varicella vaccine. Besides filling out an incident report, the family physician should consider:

1) If varicella vaccine is administered when zoster vaccine was indicated:
   • The dose would NOT count.
   • Zoster vaccine should be administered the same day or ≥28 days later.

2) If zoster vaccine is administered when varicella vaccine was indicated:
   • The dose administered would count as a dose of varicella vaccine.
   • If this was the first dose, the second varicella vaccine should be given ≥28 days later.
   • If patient is <50 years old, the manufacture should be notified OR VAERS reporting done due to the vaccine only being licensed for ≥50 year olds.

Do I need to start a vaccine series over if the patient returns 5 years after the second vaccine was due?

According to the CDC (tinyurl.com/kod9r9n), the answer is, “No.” While we should try to adhere to vaccine schedules as close as possible, vaccine series should not be started over regardless of the interval between doses. In other words, if a patient has documentation of only one dose of hepatitis B, hepatitis A, varicella, and/or MMR vaccine from 5-10+ years ago, the second dose can be given today; the vaccine series should not be started over. The third hepatitis B vaccine should be administered at least 8 weeks after the second (and at least 4 months after the first). The only exception to this rule listed by the CDC is with oral typhoid vaccine, which may need to be restarted depending on the number of doses taken and interval between doses.

ACIP Approves New Influenza Vaccine Recommendations

New draft recommendations on influenza vaccines for children and pregnant women were unanimously passed by the CDC’s Advisory Committee on Immunization Practices (ACIP) after a lengthy debate over specifics regarding recommendations for pregnant women. According to Family Practice News (tinyurl.com/ybbm7h4n) the proposed recommendation that sparked the debate would change the wording of the previous recommendation for pregnant women to receive a seasonal inactivated vaccine (IIV) to “any licensed, recommended, and age-appropriate, trivalent or quadrivalent IIV or RIV [recombinant influenza vaccine] may be used.”

Some members of the committee were hesitant to introduce this new wording, concerned that the language was too strong for the uncertainty some of the committee felt about the safety of including a recombinant influenza vaccine (RIV), Flublok, among those recommended. However, the majority of committee members pointed out that the responsibility of determining safety lies with the FDA, which has already licensed the Flublok trivalent vaccine with expectations that the quadrivalent vaccine soon will follow.

The ACIP also voted unanimously to change the safe age limit noted in
influenza guidelines for use of Afluria (IIV3) from 9 years and older to 5 years and older. A footnote saying that the ACIP recommends Afluria for children 9 years and older will be removed. This change, which mirrors the licensing Afluria has with the FDA, was based on research conducted by Seqirus that showed fever levels were the same for Afluria trivalent and quadrivalent vaccines in children 5 to 9 years old, both of which were less than historical vaccine rates.

Also, just as it did for the 2016-2017 influenza season, the ACIP has again decided to recommend against use of live attenuated influenza vaccine (LAIV; FluMist) for the 2017-2018 flu season because of the vaccine’s reduced efficacy. The approved recommendations will be sent to the director of the CDC and the HHS and once reviewed and approved will be published in the CDC’s Morbidity and Mortality Weekly Report.

Adults know about most vaccines, but skip them. So, YOU can make a difference!

Most adults know what vaccinations they need and about the diseases they prevent, but they still remain non-compliant. While cost and access were previously believed to be barriers to adult vaccine compliance, a new study suggests that improving adult vaccination rates can be as simple as a nudge from a physician. The study, published in Vaccine (tinyurl.com/y7pls8fn), researchers found that a wide range of respondents reported awareness of vaccine-preventable diseases ranged from 63 to 94 percent, but that ranged by disease type. According to the report, participants were most aware of influenza and pneumonia, followed by herpes zoster, hepatitis B, pertussis and tetanus. Respondents were least aware of HPV. According to Medical Economics (tinyurl.com/y9ladad), “The researchers hypothesized that lower compliance with adult vaccination may be a consequence of physicians not recommending immunization to adult patients.” Peng-Jun Lu, MD, PhD, of the CDC, who led the study, said, “A healthcare provider recommendation is the strongest predictor of whether adults get vaccinated. Whether or not they stock vaccines, all healthcare professionals should routinely assess patient vaccine needs and recommend the appropriate vaccines to ensure their patients are protected against serious, sometimes deadly, diseases.”

CONTINUED ON PAGE 20 >>
**Less Than Half of Pregnant Women Getting Vaccinated Against Pertussis**

CDC researchers found that “less than half of women” in the U.S. are undergoing vaccination against pertussis (Tdap). However, the good news is that this is way up from just 27 percent in 2014.” The findings were published online by the CDC in AdultVaxView (tinyurl.com/ycujszl).

**College Students Less Likely Than Average Population to Seek Out Flu Vaccine**

The National Foundation of Infectious Diseases (NFID) issued a report (tinyurl.com/mmobzdy) finding that vaccination rates for the flu on college campuses ranged only from eight percent to 39 percent in 2016, below the recommended levels to prevent outbreaks. The article focuses on a recent outbreak of the flu at The College at Brockport which sickened 375 students, few of whom received the annual flu shot despite it being offered for free.

**Influenza Vaccination Reduces Disease Severity among Adults Hospitalized with Influenza**

Obviously, infection prevention is the primary goal of influenza vaccination, but symptom reduction for those infected and mortality risk reduction for those hospitalized is also a benefit. The effect can be significant. For example, a recent study in Clinical Infectious Disease (tinyurl.com/y6nrtxu) reported that adult influenza vaccination in the 2013-14 season was associated with a 52%-79% reduction in influenza-related hospital death and a 37% reduction in ICU admission, compared with no vaccination. Also, ICU stay was shorter for the vaccinated in the 50-64 y group.

**Flu vaccine does not significantly reduce overall “influenza-like illness”**

Influenza vaccination reduced flu virus infections in older adults but not the number of “influenza-like illnesses,” a study in the *Journal of Infectious Diseases* found (tinyurl.com/ycujszl). Researchers said people tend to see the flu and “influenza-like illnesses” as the same thing, which creates a perception the flu vaccine does not work and reduces usage. In reality, actual influenza infection constitutes a small enough fraction of “influenza-like illnesses” that even when the vaccine prevents a substantial amount of influenza infection, its impact on the greater total is diluted enough to prevent the vaccine from showing a statistically significant protective effect. Family doctors can and should educate their patients about this.

**Vaccination and Influenza Risk: What is the Influence of Obesity? Aging?**

A NIH funded prospective observational study of the trivalent inactivated influenza vaccine (IIV3) in adults during the 2013-15 flu seasons was published in the *International Journal of Obesity* (tinyurl.com/y6qgyht) and found that obese adult recipients of the vaccine had double the incidence of influenza and/or influenza-like illness compared with those who are healthy weight and vaccinated. However, a study in 2016 (tinyurl.com/y7wejx7) reported among vaccinated children, rates of confirmed influenza were similar in obese and nonobese children. So, what are we FPs to do with this information? One option suggested by Dr. Neil Schachter, a professor of pulmonary medicine at Mount Sinai School of Medicine in New York City (tinyurl.com/ya976j7), is to consider obese people as candidates for the double flu shot practice, similar to a practice done in elderly patients. Because the older population is at a high risk of getting the flu, some are given a flu shot in the early fall then again in January. Until official CDC recommendations come along, we think this is a reasonable approach for the elderly and the obese.
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A new initiative from the American Academy of Family Physicians (AAFP) seeks to educate providers, staff and patients about the vital need to vaccinate teenagers. In many states, including Colorado, vaccination rates among teens for HPV, flu, meningitis and others are below the goals set by Healthy People 2020. Parents of teenagers may not realize that adolescent vaccines can be just as life-saving as the vaccinations their children received as babies.

Family physicians play an important role in getting patients of all ages vaccinated. The CAFP hosted a panel during the 2017 Wellness Conference to remind physicians of the most updated recommendations, and what is at stake for adolescent patients and their families.

Dr. Zach Wachtl, a family physician with Clinica Family Health, kicked off the evening by facilitating a discussion among attendees, asking them what works and what doesn’t in their practice. Physicians and practitioners from many different settings shared challenges, from hesitant parents to confusing guidelines. They also shared strategies to overcome these challenges, as there are few people a family physician can better learn from than a fellow physician.

After Dr. Wachtl, Lynn Trefren, Immunization Branch Chief from the Colorado Department of Public Health and Environment, shared the most
updated guidelines for adolescent vaccines; what vaccines, when, and why. Michael Ball, a 4th year pharmacy student at CU’s Skaggs School of Pharmacy, added to Lynn’s presentation by giving an in-depth look at the science and recommendations behind the HPV vaccine.

To close the night, CAFP welcomed Robbin Thibodeaux, a parent advocate with the National Meningitis Association, who lost her 19-year-old son Tommy to meningitis. Robbin shared the horrible reality that, even though she carefully vaccinated her children when they were young, she was never advised to vaccinate Tommy for meningitis. She asked providers to remember that even vaccinations that aren’t mandatory can and do save lives.

To help all providers increase vaccination rates in their practices, talk to parents and teens about vaccines, and feel confident with current recommendations, the AAFP has created a new adolescent vaccination toolkit. Providers will find resources including videos, Q&A’s, reminder postcards, posters and more. Physicians interested in accessing the materials available from the AAFP can find them at http://www.aafpfoundation.org/foundation/our-work/grants-awards/all/HighlightonVaccinations4Teens/HOV4TResourceLibrary.html.

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REPORT FROM AAFP’S NATIONAL CONFERENCE OF FAMILY MEDICINE RESIDENTS AND STUDENTS FROM COLORADO’S DELEGATES AND ALTERNATE DELEGATES

Cleveland Piggott, MD, MPH; University of Colorado Family Medicine Residency, PGY3, Resident Delegate

It was my 3rd time to AAFP National Conference for Residents and Students and first time as a resident. This is one of my favorite conferences. To be with around five thousand attendees who are all interested or passionate about family medicine is incredibly energizing and inspiring. Many of these attendees were old colleagues and peers which is always nice to see. I spent a lot of time networking and brainstorming with these colleagues about how we can make our residency programs and academies stronger and better. I look forward to bringing these ideas back to Colorado.

In my position as delegate, I participated in the Congress sessions at National Conference. At these sessions, I listened to hearings on resident resolutions and had opportunities to vote for them. There was a gambit of resolutions on everything from age limits on ATV use, resident wellness, international medical graduate issues, etc. Additionally, I co-wrote a resolution with Dr. Kyle Leggott on advocating for Health Care as a Human Right. This resolution passed congress, and it will now be reviewed by the AAFP board of directors and subcommittees.

Another unique aspect of being a delegate is I vote for the resident candidates for various AAFP positions. I’m incredibly impressed with the resident leaders the AAFP has had this past year and excited for the new group of resident leaders who are incredibly intelligent, passionate, and diverse in every definition of the word. I’m thankful that the AAFP values resident and student voices throughout their organization.

One of my favorite aspects of National Conference is helping to recruit amazing medical students to our state. I love the collaborative approach Colorado takes in recruiting residents, and I lost my voice talking to so many great students. I had a great time talking to our Colorado medical students at a CAFP sponsored event Thursday night. On Friday, the Colorado residencies held an event with a record number of about 95 students! Seems like everyone wants to come to Colorado. I can’t blame them.

I’m thankful for the CAFP for allowing me the opportunity to represent Colorado at National Conference.

Katie Teixeira, Rocky Vista University, Student Delegate

I was so thankful to have been able to represent CAFP at the AAFP National Conference. The conference was well organized and I’d highly recommend any medical student interested in pursuing Family Medicine or primary care to attend. My favorite workshop was “Caring for the Underserved: Role of the Family Physician.” The room was packed, with standing room only and some people extending out into the hallway. This session had a panel of family physicians from various...
Member Recognitions

Congratulations to the University of Colorado Family Medicine Interest Group (FMIG) on earning the 2017 Excellence in Programming: Policy & Innovation Initiative Award from the AAFP.

Congratulations to Michael Bradfield, MD, MPH (North Colorado Family Medicine Residency Program), and Cleveland Piggott, MD, MPH (University of Colorado Family Medicine Residency), for being recognized with the 2017 AAFP Award for Excellence in Graduate Medical Education.

Do you have exciting news about yourself or a colleague that you would like recognized by the CAFP? Contact Lynlee Espeseth at lynlee@coloradoafp.org or 303-696-6655 x 16.

CONGRATULATIONS TO DR. BRIAN BACAK FOR BEING NAMED THE CHAIR OF THE AAFP’S COMMISSION ON EDUCATION FOR 2017-2018.
Kyle Leggott, MD, University of Colorado Family Medicine Residency, PGY2, Resident Alternate Delegate

Attending the AAFP National Conference of Residents and Medical Students in Kansas City, MO is always an invigorating and energizing experience. I had the opportunity to attend as a 4th year medical student, and I appreciated the guidance I received from Residency Programs at the Expo Hall. The sessions designed for medical students helped prepare me for residency applications. This year, I attended as a Resident, and it was like returning home. Being surrounded by other Family Medicine physicians and eager medical students helps revitalize my passion for our specialty. I had the opportunity to attend plenary speeches, co-sponsor a resolution, and sit on a reference committee for the Resident Congress.

The plenary speeches focused on the future of family medicine, where our specialty is going and how we can deliver the best care to our patients. This varied from talks on advocacy and health care reform, to new and innovative models for providing care. The underlying theme between all the speakers was a passion for primary care and a desire to transform the health care landscape.

This was the first year that I participated in the resident congress. I was fortunate enough to co-sponsor a resolution for Health Care as a Human Right, which passed the resident congress. The process of writing and speaking on behalf of the resolution was an instructive and empowering experience. I got to see firsthand how much discussion goes into the resident resolutions, as I sat on a reference committee which reviewed the resolutions and gave recommendations on them. I hope to continue attending the National Conferences in the future, and pass along my own enthusiasm for family medicine.
Violence against healthcare professionals is becoming increasingly common. 75% of workplace assaults occur in healthcare settings, and healthcare workers are nearly four times as likely to require time away from work because of injuries from other forms of violence. Recently, tragic headlines have brought attention to the dangers physicians and others face when they are at the frontlines of patient care.

Unfortunately, the problem is complex, understudied, underreported, and not always easily understood. Many healthcare professionals are unsure what exactly constitutes as violence, since patients and families are sometimes facing very difficult or traumatic circumstances. With the rise in opioid addiction and the sometimes limited resources for patients facing mental illness, it is often those in family medicine who see the worst abuse.

All people, including healthcare professionals, have a right to be safe at work. And, as physician and rapper ZDoggMD says in his new video Say Something (www.zdogmd.com/say-something), it’s time to listen to healthcare professionals, to take violence in healthcare settings seriously, and to do something about it.

It was with that spirit that CAFP President Monica Morris, DO wrote and brought forward a resolution to the 2017 AAFP Congress of Delegates titled Violence in Health Care. After witnessing violence at her own practice, Dr. Morris was inspired to take action. The resolution calls on the AAFP to gather data from members to better understand violence in their workplaces. It asks the AAFP to create a toolkit accessible to family physicians and others, to help them understand what to do in the event of violence at their practice, and how to hopefully prevent it from occurring.

During the committee where the resolution was heard, Dr. Morris testified about her own experiences, and why she wanted to bring forward this resolution. After her, many physicians, from diverse regions and practice settings, stood to testify about their own experiences with workplace violence, and to show support for this important issue. It was clear that violence towards physicians is not a problem for just one area, or just one type of practice. It effects healthcare workers of all backgrounds.

The resolution passed the committee and was adopted by the AAFP. It is the hope of our Delegation and Board of Directors that these resources bring help and a voice to all family physicians and healthcare professionals, who deserve to return home safely from work each and every night.
CALL FOR NOMINATIONS FOR CAFP BOARD OF DIRECTORS AND CAFP AWARDS

CAFP Board of Directors Seeks Nominations for 2018

Do you work with or know an exceptional family physician? Have you been seeking ways to get more involved with family medicine leadership in our state?

The Colorado Academy of Family Physicians is seeking nominations for our Board of Directors. Physicians may nominate themselves or a colleague (please be sure the person you are nominating is interested in serving on the board). The nominations process is simple:

1. For those nominating themselves: please send a paragraph explaining why you are interested in board service to Raquel Alexander, CEO, at raquel@coloradoafp.org by December 1, 2017.

2. For those nominating someone else: please send a paragraph explaining why the individual you are nominating would make a valuable addition to the board to Raquel Alexander, CEO, at raquel@coloradoafp.org by December 1, 2017.

Nominees will be compiled and sent to full membership for a vote.

Those elected to serve on the board will be installed at the 2018 CAFP Annual Summit, and will serve a three-year term. For more information about the Board, please visit www.coloradoafp.org/about/board.

CAFP Seeks Nominations for the 2018 CAFP Awards

Nominations for the 2018 CAFP Awards are now open. The CAFP Awards are designed to recognize exceptional family physician leaders in our state. The awards include:

**Family Physician of the Year**

The Family Physician of the Year Award recognizes an outstanding family physician who provides outstanding care, enhances their community, is a role model professionally and personally, and is an exemplary representative of the AAFP, CAFP, and family medicine profession.

**Teacher of the Year**

The Teacher of the Year Award recognizes an exceptional family medicine educator, teaching part-time, full-time or volunteer. Nominees should demonstrate dedication to preparing the next generation of family physicians to provide excellent, patient-centered care.

**Family Medicine Resident of the Year**

The F. William Barrows Award for Outstanding Family Medicine Resident Award recognizes a first, second or third year resident who demonstrates clinical, academic or teaching excellence and a dedication to patients, colleagues and the community.

**CAFP Patient-Centered Innovation Awards**

The CAFP Patient Centered Innovation Awards recognizes family medicine practices, health systems, health centers or residencies that have developed and implemented an innovative approach to improving patient-centered care.

All nomination forms and more information about the awards can be accessed at www.coloradoafp.org/about/awards. All nomination are due by December 1, 2017. Winners will be recognized at a luncheon during the 2018 CAFP Annual Summit.

If you have any questions about the awards please contact Lynlee Espeseth at lynlee@coloradoafp.org or 303-696-6655 x 16.
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The Colorado Health Institute released the 2017 Colorado Health Access Survey in September. This comprehensive look at insurance coverage, access, satisfaction, affordability, and general health had much to say about our rural communities.

**The Mountains and the Individual Marketplace**

Connect for Health Colorado, Colorado’s state-based ACA marketplace, provides insurance coverage for only about 8% of Colorado’s population. However, some parts of Colorado have much higher usage rates than that, particularly among our mountain communities and in the northwest corner of the state. Counties like Moffat, Rio Blanco, Routt, Jackson and Grand had the highest exchange usage rates of any counties in the state. Along the I-70 mountain corridor, over 15% of residents are insured through the individual marketplace.

There is both good and bad news related to the use of the individual marketplace. The use of the marketplace may indicate positive gains in insurance coverage (adding to Colorado’s continued high rates of insured individuals, 93.5% in 2017). Additionally, many of those utilizing the exchange qualify for tax benefits to help offset the costs. 93.6% of Connect for Health Colorado customers reported that they were in excellent, very good or good physician health, compared to 86.6% of overall Coloradans.

Unfortunately, 53.8% of Connect for Health customers lost or switched plans over the last year, compared to 18.5% of those with employer-sponsored insurance and 17.1% covered by Medicaid or CHP+. That churn can result in disruption in healthcare services, limited access, and less consistency in providers. Additionally, the northwest part of the state had lower satisfaction levels with their insurance. This may be due to higher rates of dissatisfaction with premiums and deductibles among those who purchased insurance on the exchange.

**Rural Communities Still Struggle with Coverage Rates**

While Colorado has held onto a strong overall rate of coverage, that rate does not always extend to our rural communities. The four corners of our state faced some of the highest uninsured rates, with 13.1% of individuals uninsured in the northwest, 11.6% in the southeast, 10.7% in the northeast and 10.6% in the southwest.

Why do some still lack insurance? The major reason given was cost, with 78.4% of respondents reporting that
is why they did not have coverage. Following cost was eligibility. Those without insurance may have lost a job that previously offered it, lost eligibility for Medicaid, or lost a family member that had previously provided coverage. The complexity of the system also kept people away from attempting to purchase or qualify for insurance. 9.3% of rural Coloradoans are uninsured compared to 6% of those in urban areas.

If there is a silver lining to that news, it is that even in the region with the highest uninsured rate (the northwest, at 13.1%), that rate has dropped by nearly half since 2013.

Access and Affordability is a Struggle for Rural Communities

Access and affordability can also be worse in some Colorado communities. The central west and southeast portions of the state had some of the highest percentages of individuals who skipped care due to cost (including visits to primary care and specialty care, and purchasing prescription drugs). Likewise, 16.4% of rural Coloradans report struggling to pay their medical bills, compared to 13.6% of urban Coloradans.

Wait times to see a physician in rural Colorado showed mixed results. The good news? Across the entire eastern part of the state, most of the southern part, and in the northwest, wait times were some of the lowest in the state (1 to 1.8 days) to receive primary care. Unfortunately, wait times in the south central and southwest parts of the state were still high. Likewise, when shifting to look at specialty care, many of these rural communities reported high wait times. It is worthwhile to note, however, that access to specialty care was a challenge in many places, including more urban counties like Adams and Boulder. Some rural counties, including along the I-70 corridor and in the south central part of the state, reported fairly short wait times for specialty care.

Overall, the Colorado Health Access Survey showed that diversity can exist both between rural and urban communities, as well as between our different rural communities. While gains have been made, there is still more to do to ensure rural Coloradans have access to affordable, good quality care. The CAFP will continue to support the issues that will make real changes to these problems, including advocating for changes to our insurance system that could continue to increase rural coverage rates, and championing programs that encourage physicians to practice in the communities that need them. Until there is parity in care and coverage across our entire state, our work is not done.

To access the full report, visit https://www.coloradohealthinstitute.org/research/colorado-health-access-survey.
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As part of the CAFP Discount Program, the following companies are offering special pricing and opportunities to CAFP members.

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

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

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