ANOTHER LEGISLATIVE SESSION STARTS
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COMMISSION ON FAMILY MEDICINE: REFLECTING ON 40 YEARS 35

INTRODUCING CAFP’S NEW PHYSICIAN BENEFITS PACKAGE,
OVER $1,100 IN SAVINGS 32
Kristian’s asthma was so severe, he would spend days in the ER instead of the classroom. That was before our doctors taught him how to control his asthma. Nowadays, you’ll find Kristian back in school, where he’s discovered a passion for art.

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---

**Kristian**  
Student, Age 11

---

**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.

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The lives of three of my partners were threatened on three separate occasions from January to March of 2017. In the months that followed, a shadow was cast on our practice. I was saddened and worried about the practice of family medicine in a setting where we find ourselves already overwhelmed and sometimes burned out. As I talked with other docs in the community, so many recounted stories of threats to their lives, their families, bullet proof vests, closing continuity practices and even relocating families in response to these very real threats. This made me wonder how prevalent is this problem and what if anything can we do to prevent it?

I did some research and decided to submit a resolution to the AAFP. Did you know that ANY member can submit a resolution to the AAFP? These resolutions then get brought to the Congress of Delegates (COD) for review by committee. During the committee meeting at the COD, attendees can speak in support or opposition of the resolution. The resolution can then be sent to the board for review or voted on by the COD to become AAFP policy/practice/action. This is a means for any of you, our Colorado members, it is possible to present your issues and concerns directly to the AAFP for real change at the national level.

Each year our Colorado academy sends two delegates and two alternate delegates. Along with delegates from all 50 state chapters (as well as resident, student, armed services, Puerto Rico, and the National Congress of Constituency Leaders), the delegates also help select the national board by voting for the President-elect, Board Members, Speaker, and Vice-Speaker. This year, besides the violence in healthcare resolution that I authored, Colorado co-sponsored the “Healthcare is a Human Right” resolution which also passed.

I love being a family doctor, and cherish my time with our patients and the many things they have taught me. Still, day in and day out, it is easy to feel isolated, burned out, and overwhelmed by the EHR, the inbasket, the paperwork, not to mention the opioid epidemic. It was truly refreshing to hear so many of our peers and board members express the same concerns and frustrations as well as plans for improvements at the COD. Our newly elected President-elect John Cullen, a rural doc from Alaska, echoed these concerns and frustrations. I am confident our AAFP leadership will be bold champions for family medicine.

I’d like to thank our Colorado Delegates Drs. Rick Budensiek and Brian Bacak and our Alternate Delegates Drs. Tamaa Osbourne-Roberts and Glenn Madrid for their strong work this year. Thank you to Dr. John Bender, Colorado AFP member and AAFP Board of Directors member for your continued work.

Please see below my resolution “Violence in Healthcare” which was voted on and adopted at the COD this year. I hope it will provide us meaningful data to move forward with advocacy and awareness campaigns. I hope the toolkit will give us some strategies should we face violence today.

I would strongly encourage you to consider submitting a resolution to the AAFP for 2018. Consider attending the 2018 COD with your Colorado team. Let the AAFP understand your issues and work to support your practice.

Violence in Health Care

Introduced by the Colorado and Texas Chapters

Referred to the Reference Committee on Health of the Public and Science

WHEREAS, between 2011 and 2013 the number of workplace assaults averaged approximately 24,000 annually, with nearly 75% occurring in health care settings, and

WHEREAS, data from the Bureau of Labor Statistics show that health care workers are nearly four times as likely to require time away from work as a result of injuries from other forms of violence, and

WHEREAS, like all other workers, health care employees have a right to be safe on the job, and

WHEREAS, workplace violence in outpatient settings is a complex problem about which very little is known in the United States, and

WHEREAS, many international studies have shown high rates of abuse toward family physicians, particularly with mental illness or opioid-seeking behavior, and

WHEREAS, the United States is in the middle of an opioid epidemic, and

WHEREAS, providers are sometimes uncertain what constitutes violence, since they often believe that their assailants are not responsible for their actions in such cases, and

WHEREAS, violence against physicians is largely under reported, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians survey family physicians to characterize and quantify the incidence of violence against family physicians in the workplace and elsewhere related to their practice, and be it further

RESOLVED, That the American Academy of Family Physicians create and promote an educational violence in the workplace toolkit to provide student, residents, practicing physicians, and their staff/nurses with resources, such as active shooter training, metal detector promotion, and de-escalation training.
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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.
Reflecting back on 2017, I’m amazed again by how much happens in one year. 2017 marked another busy and successful year for the CAFP.

We had some great legislative wins, including maintaining increased primary care rates for Medicaid payments and passing our own legislation that defines Direct Primary Care separately from insurance. Plus, with record participation in our Doctor of the Day program, primary care was more visible and important at the State Capitol than ever.

We also freshened up our CME in 2017. We again held our Annual Summit in the spring, but we also added a Fall Wellness Conference in Breckenridge to the mix. Plus, as you may have noticed, you can now earn free CME just by reading this magazine. And be sure to stay tuned for an exciting announcement coming in early 2018, as we prepare to change up the locations of our Annual Summit.

2017 was also a year of planning ahead. And in 2018 much of that planning is going to be coming to fruition.

As we’ve highlighted in the magazine previously, we will be running legislation in 2018 that would double the investment in primary care in Colorado. For so many of you, this would make a difference in the most significant areas you have asked us to work on. From payment reform (more money to primary care) to burnout (the ability to hire additional staff) to better patient care (the ability to offer more and better services right in primary care offices), this legislation covers it all.

Additionally, the CAFP, along with other partnering organizations, has been approved for a grant project from the Colorado Health Foundation designed to give leadership training to primary care providers serving low income, urban communities. Thanks to the grant the training is provided free. You can expect to have a transformative experience, learning how to find the advocate in you. Keep an eye on your emails in early January to learn how to apply for this program.

Finally, for our resident and new physician members, we are introducing a comprehensive benefits package that will help with the transition from residency to the first years of practice. This includes legal services, financial services, CME and more, all completely free. A value of over $1,100. Get all the details on this benefit on page 32.

Thank you for your continued membership with the CAFP, and all that you do for our patients in Colorado.

Wishing you the very best in the New Year,

Raquel

Highlights from the November 2017 Board Meeting

1. Medicaid Reimbursements
   The CAFP Board voted to support Medicaid reimbursements to all specialties that are at least 100% of Medicare.

2. Primary Care Investment Strategy Update
   We continue our work on the Primary Care Investment Strategy (PCIS). We plan to introduce legislation asking that the total spending on primary care be measured and that spending on primary care be brought up to 15% of total healthcare spending, in order to support the PCMH and accelerate payment reform.

3. 2018 Wellness Conference
   We are excited about our Wellness Conference and discussed a variety of topics we would like to see presented. Topics range from personal wellbeing and mindfulness to leadership and physician empowerment training to effectuate change within health systems.

4. New Benefits for New Physicians
   We are excited to introduce the CAFP’s Resident & New Physician Benefits, which include legal counsel for new physicians, free financial planning and student loan advising, free registration to the annual conference for new physicians, and access to compensation data for all interested members.

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Colorado’s 2018 Legislative Session: What Can We Expect?

Colorado’s 2018 legislative session kicks off January 10th and it promises to be a busy one for healthcare policy. All of Colorado’s Constitutional offices (Governor, Attorney General, and so forth) are up for election this year, which will all but guarantee a hot political environment. Beyond CAFP’s own Primary Care Investment Initiative, we can expect several overarching issues will drive the conversation:

1. **Opioids** will be at the top of the list for legislators to address. 6 bills emerged from the interim legislative committee on prescription drug abuse and other substance use disorders.

2. **Less predictable, but certainly a factor, will be the impact of Congress’s actions.** At the time of this writing, Congress is considering the largest tax reform bill in decades. That bill includes a repeal of the Affordable Care Act’s individual mandate. If repealed, this provision is expected to result in loss of coverage for 13 million Americans and to destabilize premiums in the individual insurance market. If the mandate is repealed, Democrats in Colorado’s legislature may seek to stave off such a disruption — but it is unclear what policy lever they might seek to deploy.

3. **Also at risk is the Colorado Child Health Plan Plus (CHP+) program,** which covers some 75,000 kids and pregnant moms. If Congress does not reauthorize funding for this program, which runs out January 31, 2018, we will see a large rise in the uninsured rate for kids and a significant disruption for physicians who provide care to kids on CHP+. If the program ends, Colorado will need to wind down this coverage option and direct families to alternatives like the individual insurance market.

4. **Legislation to address rising prescription drug costs and transparency will likely make an appearance this year as well.**

**CAFP Primary Care Investment Initiative**

CAFP launched our Primary Care Investment Initiative in August, which aims to increase the share of health care spending going toward primary care from 6% up to 15%. It is an exciting legislative push led by family physicians. You can access current information on our blog https://www.coloradoafp.org/blog/.

**Medicaid**

- Separate from this initiative, but related, is the Medicaid primary care bump. 2 years ago, CAFP fought to stave off a 25% cut to Medicaid primary care rates. We were successful in avoiding the deepest cuts, but Medicaid rates continue at only about 87% of Medicare. Due to the passage of the Hospital Provider Fee Enterprise last year, more room has been freed up in the state budget. This may present an opportunity to restore primary care rates to 100% of Medicare, and CAFP will be exploring this possibility alongside our primary care colleagues and the state’s Joint Budget Committee.

**Opioids**

CAFP was highly active in the interim legislative committee on prescription drug abuse and other substance use disorders. Up to 6 bills will likely be considered by the legislature. The first includes a limit on initial opioid prescriptions for acute pain, set at a maximum 7-day supply. The law, if passed, would largely align with Colorado Medicaid’s current opioid prescribing policy. This same bill would also require a prescriber to query the Prescription Drug Monitoring Program on the first refill of a prescription. A second bill would permit supervised injection facilities in Colorado. A third bill would require health insurers to cover buprenorphine, without a prior authorization, for the first 5-days of treatment. This bill would also require that alternative pain treatments like acupuncture, chiropractic and physical therapy be subject to the same copayments and coinsurance as primary care services.

**Prescription Drug Pricing and Transparency**

Prescription drug pricing continues to be a hot button issue for patients, particularly as deductibles and coinsurance increase. This year, there may be at least two bills to address this problem. The first would be legislation to require pharmaceutical companies to notify insurers at least 60 days in advance of a price increase on a drug. This would give the insurer time to notify the patient of the impending change, and for the patient to work with their physician on a more affordable alternative. The second bill would eliminate so-called gag clauses in prescription benefit manager (PBM) contracts with pharmacists. Currently, these clauses prohibit a pharmacist from telling a patient when the cash-pay price of a drug is less than their price under the deductible or coinsurance arrangement of the patient’s health plan.

**2018 elections**

The 2018 elections are high stakes for the state, with every major statewide office up for grabs. Republicans also hold a one-seat majority in the State Senate, so both parties will be vying to control the chamber. Depending on the candidates who emerge as their respective parties’ nominees for governor, we may see different health reform proposals get traction. Several Democratic candidates for governor have put out plans for their vision of healthcare, with Cary Kennedy proposing a Medicaid buy-in for Coloradans and Jared Polis supporting Medicare-for-all in his current role as Congressman. Democrat Donna Lynne, also Colorado’s current Lieutenant Governor, is a former executive at Kaiser Health Plan and has primarily focused on healthcare with proposals like offering state subsidies for insurance in the highest cost mountain communities. On the Republican side, no proposals have emerged as yet, but Walker Stapleton has supported ending the state-based insurance exchange and Cynthia Coffman has joined her fellow Attorneys General in requesting information from pharmaceutical manufacturers for an investigation into the causes of the opioid epidemic.
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
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100+
Years Dedicated to Kids

TOP 10
Hospital in the Nation

2000+
Pediatric Specialists

3x
Magnet Recognized
Representatives from the CAFP accepted a Leadership in State Government Advocacy Award at the 2017 AAFP State Legislative Conference.

CAFP President Monica Morris, DO, testifying for her resolution on violence in healthcare at the 2017 AAFP Congress of Delegates.

CAFP Chair Tamaan Osbourne-Roberts, MD, grabbed a selfie with presenter Deepak Chopra at AAFP’s FMX.

CAFP member Dr. Kiyoshi Yamazaki teaching at the December KSA and Bonus CME at the CAFP offices in Aurora.

CAFP President Dr. Monica Morris accepting the Leadership in State Government Advocacy Award.

CAFP Chair Tamaan Osbourne-Roberts, MD, testifying at the 2017 AAFP Congress of Delegates.
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The 2017 Congress of Delegates was held in San Antonio, Texas, from September 11th through the 13th. San Antonio was a wonderful location and great venue for reconnecting with peers and doing the business of the Academy. The Congress meets annually and is comprised of Delegates and Alternate Delegates from AAFP chapters and conferences that represent their constituents and vote on resolutions that help shape AAFP policy and operations. Recommendations from the Congress are then sent through the Board of Directors and the Commissions for further evaluation and action. Of note, during the 2016 COD the Colorado Academy introduced a resolution calling for the establishment of an AAFP Center for Diversity and Health Equity, which was adopted and led to the establishment of the center in the Spring of 2017.

**Town Hall Update:**

The Congress opened with a Town Hall on Sunday night. The ballroom was packed for question and answer sessions with the Board of Directors. Several topics dominated the discussion.

**Maintenance of Certification:**

In a Board report to the COD, AAFP leaders outlined the steps being taken to address the issue, including forming a task force that will consider “additional AAFP policy, as recommended by the (Commission on Continuing Professional Development), regarding ... considerations of alternative options to certification.” The task force is expected to make recommendations to the Board by April.

**Advocacy:**

Health care for all has been AAFP policy since 1989, and Dr. John Meigs said that policy -- set by members through the COD -- was the basis for the Academy’s support of efforts to improve the Patient Protection and Affordable Care Act (ACA) rather than repeal it.

**Administrative Burden:**

Dr. Mike Munger said administrative burden also ranked as one of the top concerns voiced by members in the annual satisfaction survey. He said AAFP leaders meet with the nation’s six largest payers regularly to discuss not only payment but issues such as performance metrics and administrative burden.

**Health Equity:**

Dr. John Meigs said the Academy launched its Center for Diversity and Health Equity this spring, and that initiative is beginning to ramp up its efforts. “We will be a dominant player in this area,” Meigs pledged, “and you will be proud of your Academy.”

**Health System Reform:**

AAFP officers fielded multiple questions about health care reform and single-payer health care systems. Based on actions of the 2016 COD, the Board has prepared a report on that issue, as well.

At the Wednesday plenary session at the AAFP’s FMX, Clif Knight, M.D., the AAFP’s senior vice president for education, introduced his colleagues to a new program developed just for family physicians dubbed Physician Health First. The initiative is built around a web portal that is now open for business and waiting for physicians to explore.

The Congress Sessions on Monday, Tuesday, and Wednesday culminated with elections and announcements for Academy positions for 2018. With regard to Commission Chairs, Brian Bacak, MD, from the Colorado Academy, was appointed 2018 Chair of the Commission on Education.
Election Results for the Board of Directors for 2018:

- Speaker of the Congress -- Alan Schwartzstein, M.D., of Oregon, Wis.

- Vice Speaker -- Russell Kohl, M.D., who lives in Stilwell, Kan.

- Directors -- Sterling Ransome, M.D., of Deltaville, Va.; Windel Stracener, M.D., of Richmond, Ind.; and Erica Swegler, M.D., of Austin, Texas

- New physician Board member -- Benjamin “Frankie” Simmons III, M.D., of Concord, N.C.

- Resident Board member -- Alexa Mieses, M.D., M.P.H., of Durham, N.C.

- Student Board member -- John Heafner, M.P.H., of St. Louis

During the Congress, multiple resolutions were discussed, modified, adopted, referred to the Board, or otherwise acted on to move the business of the Academy and AAFP Policy forward. Resolutions dealing with maintenance of certification, physician wellness, and support for small practices were discussed and acted on. A resolution requesting the AAFP to specifically recognize health as a basic human right for every person was discussed and sent to the board. Notably, the Colorado chapter submitted a resolution dealing with violence in health care settings, and ultimately, a substitute resolution was passed which called on the AAFP to survey members to quantify and characterize instances of violence against family physicians in the workplace, and which asked the Academy to create and promote “toolkits” which can be used by practices for education and preparation for health care provider safety. For a complete summary of 2017 Congress actions, including resolutions, use this link: http://www.aafp.org/about/governance/congress-delegates/2017.mem.html
In 2011, suicide outranked homicides as the second leading cause of death of 15-19 year olds for the first time ever in United States history, and this continues to be the case today (1).

The CDC monitors suicide rates over time and trends indicate a peak in the 1990s particularly among male adolescents (2). Since 2010, there have been increases in both male and female suicide rates. The most dramatic rise occurred in females 15-19 years of age, although males still have overall higher rates of suicide completion (3).

Depression symptoms are pervasive issues in teens and young adults leading to impaired functioning and engagement. The 2009-2012 National Health and Nutrition Examination survey found that 5.7% of individuals 12-17 years old met criteria for moderate or severe depressive symptoms in the two weeks prior to the questionnaire (4). Females in the same survey demonstrated higher rates of depression and suicidal ideation compared to males in every age group (3,4).

What could lead to these increasing rates of depression and suicide? Common factors include family stressors such as finances which affect youth often as much as their parents, increased access to lethal means, and exposure to domestic and community violence. Trauma can be experienced personally (i.e. bullying, child abuse, dating/sexual violence), but it can also be experienced through social media, TV and movies. Increasing awareness of these issues can be lifesaving if family and friends gain knowledge of depression signs. As healthcare providers, we should also acknowledge that exposure to social media of this nature is very often triggering for individuals suffering from depression and suicidal thoughts.

Teen Angst v. Depression
Stress and depression often look a lot alike and telling the difference can be difficult. The National Institute of Mental Health has good reminders for youth and adults about the difference between sadness and depression, as each has unique presentations and features. Regular mood changes including feelings of sadness are short lived, and usually resolve within several days. Depression, however, involves feelings of hopelessness, anger, or frustration that last for much longer and get in the way of normal daily activities.

Adolescence is a transitional phase from childhood to adulthood and by nature can be very complex. This development involves not only biological and physiologic changes, but social and conceptual modifications as well. Neurodevelopment of the amygdala and prefrontal cortex have been implicated in the development of adolescent depression (5). It is normal for youth to seek autonomy and independence. In contrast, withdrawing from fun activities, dropping grades with no apparent cause, isolating self from peers, and making statements of self-harm are not normal (See Table 1).

Suicide is Preventable.
Adolescents and young adults are especially prone to mood lability with developing emotional centers (limbic system), but also have an underdeveloped prefrontal cortex in command of impulse control. Thus, depressed youth are a set-up for suicide attempts. Suicide is the second leading cause of death in adolescents, behind unintentional injuries (CDC). The mixture of an intense emotional trigger with impulsive thoughts of escape or death increases the likelihood of an irrational action. Access to lethal means such as guns, sharp objects or pills/drugs for example are the last part of the equation for suicide completion.

The most important thing we can do for youth in our lives, personally or professionally, is be aware of signs and symptoms of depression and be armed with the appropriate resources to support them. Screening for depression is recommended at least annually by the American Academy of Pediatrics. One helpful tool is the PHQ-9 which screens for symptoms and severity of depression beginning at age 11 (6,7). This assessment in the clinic is used to initiate deeper conversations with youth about their experiences and assess their support and coping skills. Prior to ending a visit, we recommend educating both youth and families on decreasing a young person’s access to lethal means (i.e. safe-storage devices for weapons and locking up or monitoring prescription and non-prescription drug access). Bringing up the topic of mood is often innately therapeutic. If sensitive issues are brought to the surface or a teen meets criteria for major depression it is our duty to provide appropriate treatment services and support for depressed youth at the time of diagnosis.

Taking Action: The What and the How
Three key components of depression treatment include psychotherapy, medication, and appropriate follow-up. Psychotherapy (‘talk therapy’) is evidence-based and the number one recommended treatment for depression. In these sessions, the goals of cognitive behavioral therapy and interpersonal psychotherapy are to provide alternative healthy coping skills. Medications are also evidence-based to improve moderate to severe depression. The most commonly prescribed medications in this age group are selective serotonin reuptake inhibitors (SSRIs), and are appropriate once acute psychosis and risk for bipolar disorder have been ruled out.
Prescribing and monitoring these medications can be provided by primary care physicians if they feel comfortable with the medications; consultation with board-certified specialists in Adolescent Medicine as well as Adolescent & Child Psychiatry are also available via Children’s Hospital Colorado and can be reached through One Call at 720-777-3999. 

Depression is a real (and sometimes scary) health problem so it is important to remember that mental health conditions are treatable. Patients and families also need to be reminded that a mental health issue is not anyone’s fault. Identification of untreated depression and active intervention to treat mood and prevent adolescent suicide are the most vital aspects of ensuring youth safety and success.

As providers, education in mental health is essential for best care of our adolescent patients in the same way that we provide care for physical illnesses and injuries. Striving to bring depression into regular healthcare visits improves the health of our teens—now and for their lifetimes.

References:

Table 1: Signs of Depression

<table>
<thead>
<tr>
<th>Signs of Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged anger, frustration or tearfulness</td>
</tr>
<tr>
<td>Withdrawal from activities of previous enjoyment (sports, clubs, etc)</td>
</tr>
<tr>
<td>Loss of relationships or lack of interest in them (peer friendships, romantic relationships)</td>
</tr>
<tr>
<td>Trouble sleeping or sleeping excessively</td>
</tr>
<tr>
<td>Change in appetite: not eating or eating too much, which may even effect weight</td>
</tr>
<tr>
<td>Moving or speaking slowly (or too quickly if expressing signs of mania)</td>
</tr>
<tr>
<td>Difficulty concentrating or remembering information, which can include a drop in academic performance</td>
</tr>
<tr>
<td>Increased thoughts or references to death or suicide including self-harm behaviors</td>
</tr>
</tbody>
</table>

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Jennifer Woods, MD, is an Associate Professor of Pediatrics and Medical Director in the Section of Adolescent Medicine at Children’s Hospital Colorado. She is board certified in both Pediatrics and Adolescent Medicine and strives to provide the best care to her patients for general health issues, mental health, gynecologic concerns, and eating disorders. Her current research interests include medical education for trainees, male reproductive health issues, and diagnosis and treatment of hypertension in adolescents.

Megan Jacobs, MD, is a board certified pediatrician and is currently finishing her specialty fellowship in Adolescent Medicine at Children’s Hospital Colorado. She is also a Masters of Clinical Science degree student at the University of Colorado. Her clinical and research interests lie in reproductive health including contraception counseling and risk prevention.
CAFP Partners,

We’ve had a busy fall season at SNOCAP. We held our bi-annual Convocation in September, convening our affiliated practices and partners from across the state. Over two days we spent 12 hours sharing project status and success, engaged in a lively poster session, attended our Keynote address by Virginia Commonwealth University’s Dr. Alex Krist, presented awards to practices and partners, and planned ahead for future SNOCAP projects. Slides from our Convocation can be found by joining our LinkedIn Group: www.linkedin.com/groups/4388787

This year we facilitated a World Café exercise to gain insight into future project ideas. The following seven health topics were discussed: chronic pain, adult behavioral health access, adolescent behavioral health access, health equity, built environment/physical activity, dementia, and staff burnout. Participants at tables answered the following questions about each health topic: what is problem in our communities, who is affected, what is currently being done, what gaps are there, who should be at the table, and what could SNOCAP add. Within each topic our attendees identified challenges and gaps, but also found many points of success, suggestions for the future, and often hope. One over-arching theme among all seven topics was policy. Specifically, how we can include policy measures and decision makers. Since September, SNOCAP has been looking for ways to engage policy makers in Colorado, including working with the Eugene S. Farley, Jr. Health Policy Center at Anschutz Medical Campus.

As always, SNOCAP is busy with new projects and grant applications. Recently funded projects include: a PCORI funded project to study how to best conduct group visits with diabetic patients and a project in conjunction with folks from Oregon, Duke, Iowa, Wisconsin, and Canada that will study how to best have Advanced Care Planning conversations with patients. Additionally, SNOCAP is working to begin a project called CASCADE which will study how to prevent atopic dermatitis in infants and children. This project is in conjunction with Duke, Wisconsin, and Oregon. If you might like to participate in one of these, let us know!

As we write this update, our team is packing our suitcases to head to Montreal, Canada for the 45th annual North American Primary Care Research Group (NAPCRG) meeting where we will be presenting on a number of SNOCAP-related projects.

If you are not yet a SNOCAP member please follow this link to sign up for our bi-monthly newsletter: eepurl.com/bfteGf.

As always, thanks for your support,

The SNOCAP Team-
Don Nease (donald.nease@ucdenver.edu), Mary Fisher (mary.fisher@ucdenver.edu), Matt Simpson, Victoria Francies, and Shraddha Gandhi (SNOCAP Student Assistant)

FORGING NEW PATHS: SIM PROVIDER TALKS ABOUT CARING FOR THE ‘WHOLE’ PATIENT

Recognizing that change is inevitable, Glenn Madrid, MD, Western Colorado Physician’s Group in Grand Junction, encourages his colleagues in practices across the state to test new ways to deliver care, optimize their electronic health record (EHR) software and to integrate care to improve patient outcomes. Madrid delivers these and other messages in a video about his practice’s experience with the Colorado State Innovation Model (SIM), which helps providers integrate behavioral and physical health in primary care settings and test alternative payment models. The third and final application for SIM cohort 3 closes Jan. 10: http://bit.ly/sim3application.

While Madrid acknowledges the fact that change can be difficult, and that providers face significant changes to the traditional way of delivering healthcare, he shares examples of how retooling processes to ensure patient-centered care has invigorated his care team. “We have a culture in our group that responds to looking outside of the box,” he says. “We’ve not been afraid to look at innovative things.”

Redefining ‘good’ care
Recognizing the value of integrating behavioral and physical health to improve patient outcomes led Western Colorado Physician’s
Group, a division of Primary Care Partners, to apply for SIM, a governor’s office initiative that is funded by the Centers for Medicare & Medicaid Services.

“In primary care, we know that mental health is a significant component of a person’s general health,” says Madrid. “The chance to have integrated behavioral health is just amazing and I think it really closes an important gap,” he adds. “For me personally it’s been rejuvenating. It feels better to take care of the whole patient.”

The 17-minute video with Madrid includes information about some of the challenges and successes his practice experienced on its journey to integrate behavioral and physical health, including the use of electronic health records (EHRs) and the experience with value-based payment models.

He talks candidly about common fears among physicians about value-based payment models that require new skill sets to succeed in contracts that reward value versus volume of care delivered, and the perceived threat from EHRs.

While frustrations with EHRs are common, Madrid talks about the value of using software to identify high utilizers in your practice, keep patients healthier, avoid costly emergency room visits and build registries. “You can use the EHR to help you do a better job,” he explains.

Instead of seeing it as a threat, Madrid encourages his colleagues to see EHRs as a data-mining tool. “You can use that data to prove to payers that you are saving the system,” which is helpful when negotiating value-based payment contracts.

**Warm handoffs**

Integrated care is not new to many healthcare practices, including Western Colorado Physician’s Group, where providers have talked with patients about mental health, substance use and healthy behaviors in the past. The key difference that Madrid talks about with true integration is a warm handoff with a behavioral health provider in the practice on a regular basis or on certain days to improve the odds that a patient will make the next appointment to get the help he or she needs.

In the past, he says, providers made referrals “hoping that a patient would make an appointment and knowing a good percentage of the time that didn’t happen.”

In integrated practices, odds increase that patients will take that next step and can get in to see a provider in a timely manner.

The initiative, which will ultimately help 400 primary care practice sites and four community mental health centers integrate care during its four-year time frame, helps providers progress along a continuum of integrated care (http://bit.ly/2iijUWai). During this journey, care teams receive coaching from practice facilitators and clinical health information technology advisors, who help assess processes to ensure patient-centered care that improves health outcomes and lowers healthcare costs.

Trusting and using care teams effectively is a key component to improving access to care and to ensuring that patients get the care they need when they need it and from the appropriate care team members, Madrid says.

While he admits that historically he believed that he thought he had to do a job himself if he wanted it to be done ‘right,’ Madrid says SIM “has allowed me to recognize that with good training and building a good team around you, the job can be done better than if you had done it yourself.”

Sharing the care of patients and assessment rather than his or her pain assessment.

“For so long we have asked people, ‘how much pain are you in?’” he says and adds, when we really need to be assessing function. “If we can redirect our patterns of prescribing more toward helping that person’s function rather than pain we’ll do a better job and that’s one of the advancements that SIM has helped us with.”

And while projects for SIM cohort-1 practices differ, the focus on integrated care resonates with providers, like Madrid, who recognize the long-term benefits of integrating behavioral and physical health in primary care settings.

“Hopefully we’re just doing a better job taking care of that patient especially from a behavioral health standpoint. That’s really what SIM has helped us focus on.”

Learn more about SIM and apply for cohort-3 before Jan. 10 to get the support, guidance and practice coaching you need to integrate care and succeed with alternative payment models: https://www.colorado.gov/healthinnovation/apply-cohort-3-last-chance-participate-sim.
PrEPPING FOR HIV PREVENTION

BY KATHERINE FRASCA, MD, AND RONALD H. GOLDSCHMIDT, MD

This activity is jointly provided by Postgraduate Institute for Medicine, the Colorado Academy of Family Physicians, and Terranova Medica, LLC, in collaboration with the Colorado Health Network. This activity is supported by an independent educational grant from Gilead Sciences, Inc.

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Valid through: 12/31/2018

Estimated Time to Complete Activity: 1 hour
There is no fee for this educational activity. Media: Internet and Printed Article

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Target Audience

Primary care providers and other healthcare professionals who interact with patients at risk for HIV in the state of Colorado.

Educational Objectives

After completing this activity, the participant should be better able to:
• Conduct an effective sexual health assessment
• Identify risk groups at sufficiently high risk for HIV to warrant consideration of PrEP
• Evaluate the indications and appropriate prescribing/monitoring practices for the PrEP regimen
• Provide PrEP or refer patients at sufficient risk for PrEP regimen
• Connect patients at risk for HIV within regional patient support resources

Disclosure of Conflicts of Interest

The Postgraduate Institute for Medicine requires instructors, planners, managers, and other individuals who are in a position to control the content of this activity to disclose any real or apparent conflict of interest (COI) they may have as related to the content of this activity. All identified COI are thoroughly vetted and resolved according to PIM policy. PIM is committed to providing its learners with high quality CME/CE activities and related materials that promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest.

Faculty

Katherine Frasca, MD, and Ronald H. Goldschmidt, MD, have nothing to disclose. Dr. Goldschmidt reports that the

Clinician Consultation Center is supported by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau – AETCs and the Centers for Disease Control and Prevention (CDC).

Dr. Goldschmidt received no compensation for his work on this initiative.

Disclosure of Unlabeled Use

This educational activity may contain discussion of published and/or investigational uses of agents that are not indicated by the FDA. The planners of this activity do not recommend the use of any agent outside of the labeled indications. The opinions expressed in the educational activity are those of the faculty and do not necessarily represent the views of the planners. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.

Computer System Requirements

To participate, you will need access to a computer (either MAC or PC), tablet, or smart phone, with a Chrome (version 22.0.1229.94 or greater) web browser, Firefox (version 3.6 or greater) web browser, Safari (version 6 or greater) web browser, or an Internet Explorer (version 8.0 or greater) web browser, JavaScript enabled, connected to the Internet (high speed connection preferred), and cookies MUST be enabled on your browser.

This educational activity may contain discussion of published and/or investigational uses of agents that are not indicated by the FDA. The planners of this activity do not recommend the use of any agent outside of the labeled indications. The opinions expressed in the educational activity are those of the faculty and do not necessarily represent the views of the planners. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.
Disclaimer

Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested in this activity should not be used by clinicians without evaluation of their patient's conditions and possible contraindications and/or dangers in use, review of any applicable manufacturer's product information, and comparison with recommendations of other authorities.

INTRODUCTION

HIV treatment has improved dramatically over the last 3 decades, but prevention remains the optimal strategy. Over 40,000 new HIV infections were diagnosed in the United States in 2015; about two thirds of these occurred in men who have sex with men (MSM). Pre-exposure prophylaxis, or PrEP, provides an important new form of prevention for high-risk individuals. In 2012, the FDA approved the first regimen for PrEP, an oral combination pill consisting of tenofovir/emtricitabine that is taken once daily. PrEP represents one piece of the prevention tool kit: it is NOT a replacement for condoms or other safe sex practices.

HIV Screening and Prevention

Since 2006, the Centers for Disease Control and Prevention (CDC) has recommended that HIV screening be performed routinely for all patients aged 13 to 64 years. Additional specific risk factors are not required. Previous CDC screening recommendations were based on perceived risk, but risk-based testing missed up to a quarter of infections. Repeat screening is recommended at least annually for individuals at high risk for HIV. The preferred laboratory test is a 4th generation assay that detects both HIV antibodies and the p24 antigen.

Despite these recommendations, HIV screening rates in general practice are disappointingly low. A study of Medicaid patients who had been diagnosed with an STI found that only 43% had been screened for HIV. Suboptimal HIV screening represents missed opportunities to improve HIV prevention. Admittedly, it can be difficult to broach the discussion of sexual health in the busy primary care setting, but if questions are rolled into the series of routine questions asked, they are less intimidating to the patient:

- “How many current sexual partners do you have?”
- “Do you have sex with men, women, or both?”
- “Do you have oral, anal, or receptive sex?”
- “How often do you use condoms with the above types of sex?”
- “How often do you use substances (alcohol, drugs) prior to sex?”

Likewise, questions related to substance abuse should be asked as part of the routine assessment and phrased in a way that removes stigma or judgment:

- “How often do you use drugs that are not prescribed by a physician?”
- “What kinds of drugs do you use?”
- “How often do you inject drugs?”
- “Have you ever been in a methadone maintenance or rehab program?”

Individuals who engage in high-risk sexual behavior and have a negative HIV test should be introduced to the prevention toolbox, which includes circumcision, safe sex practices, and PrEP. They should also be encouraged to take advantage of available counseling services, including support for mental health and substance abuse disorders.

Table 1. Risk Factors Indicating that PrEP Should be Considered

<table>
<thead>
<tr>
<th>Men Who Have Sex With Men</th>
<th>Heterosexual Women and Men</th>
<th>Injection Drug Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-positive sexual partner</td>
<td>HIV-positive sexual partner</td>
<td>HIV-positive injecting partner</td>
</tr>
<tr>
<td>Recent bacterial STI</td>
<td>Recent bacterial STI</td>
<td>Sharing injection equipment</td>
</tr>
<tr>
<td>High number of sex partners</td>
<td>High number of sex partners</td>
<td>Recent drug treatment (but currently injecting)</td>
</tr>
<tr>
<td>History of inconsistent or no condom use</td>
<td>History of inconsistent or no condom use</td>
<td></td>
</tr>
<tr>
<td>Commercial sex work</td>
<td>Commercial sex work</td>
<td></td>
</tr>
<tr>
<td>In high-prevalence area or network</td>
<td>In high-prevalence area or network</td>
<td></td>
</tr>
</tbody>
</table>

Which Patients Should Receive PrEP?

Guidelines published in 2014 by the US Public Health Service and the CDC list a number of high-risk categories that should prompt consideration of PrEP in HIV-negative individuals (Table 1).

PrEP is highly effective in adherent patients. A recent study estimated that oral PrEP coverage of 40% of at-risk, HIV-negative MSM over 10 years would prevent approximately 25% of new HIV infections. Increasing PrEP coverage rates to 80% would prevent an estimated 40% of new infections.

PrEP: Contraindications and Precautions

There are a number of contraindications to use of PrEP (Table 2). A creatinine clearance of ≤60 mL/min is an important contraindication for PrEP initiation. Decreases in renal function have been observed in HIV-infected patients on tenofovir-containing regimens, and—in some cases—acute renal failure has occurred. Other important contraindications are the lack of a documented HIV-negative test within the past 7 days or the presence of signs/symptoms of HIV infection, as initiating PrEP in an HIV-infected individual may lead to the emergence of treatment-resistant viruses. There are also several precautions to be considered before initiating PrEP. While PrEP may still be appropriate in the presence of these precautions, patients should be counseled concerning possible risks and monitored carefully.

CONTINUED ON PAGE 20 >>
Adherence Is the Key to Success

Adherence to daily PrEP therapy is critical for preventing HIV infection. In subjects with a detectable drug level in their blood, effectiveness is about 90% across a range of studies. Studies with very low rates of adherence, including 2 studies of women in Africa, have shown poor outcomes. Rates of protection also may be lower in women vs men because of the pharmacologic challenge of reaching levels in vaginal tissues vs anal mucosa.

There are several tools that can help improve PrEP adherence. Patients should be counseled up front about what to expect from PrEP, including possible side effects and the importance of adherence. This discussion should include a review of methods that can be used as reminders, such as cell phone alarms or discreet pill bottles on a key chain so that the pills are always available. It is also important to address adherence barriers, particularly substance use, mental health issues, and domestic violence.

### PrEP Follow-up and Counseling

A number of tests should be performed at baseline and periodically throughout PrEP, including testing for HIV and STIs, as shown in Table 3.

Counseling is a vital component of PrEP. Some of the key points that should be covered include:
- How it works and that is a part of a comprehensive prevention plan (eg, barrier protection, risk reduction, needle exchange)
- Limitations: adherence-dependent, not protective of STIs, doesn’t eliminate risk
- Medication counseling: proper way to take, side effects, reason for limited refills
- Time until protection occurs: need at least 7 days of daily dosing for rectal protection, 20 days for vaginal
- Follow-up and laboratory testing
- Symptoms of seroconversion/acute retroviral syndrome, such as fever and aches

### PrimaryCareHIVPrevention.org

To aid you in your efforts to connect patients to HIV prevention resources in the different regions of Colorado, we have developed the website, PrimaryCareHIVPrevention.org (Figure 1). The website also provides a printable form for you to provide to your patients with information on connecting with their regional prevention manager and other ancillary services provided by the Colorado Health Network (CHN) (Figure 2). On that form is a link to a survey the patient can take to ascertain the quality of their experience with the prevention services from your office and the CHN.
**Conclusion**

Primary care providers are in a key position to help prevent HIV transmission. It is important to make sexual history a priority during health-care encounters and to screen for at-risk patients. PrEP is highly effective, but adherence is critical. Resources are available in your community to support PrEP and help prevent HIV transmission in your high-risk patients.

**References**


**Instructions for Obtaining Credit**

To receive AAFP Prescribed credit visit www.coloradoafp.org/cmequiz. Instructions for completing the post test and reporting your credits are available on the website.

For those requiring AMA PRA Category 1 Credit(s)™, please follow the instructions below. We support green CME by offering your request for CME/CE credit online.

1. Go to www.cmeuniversity.com
2. Register or Login (will take less than 1 minute)
3. Type in “12135” at the top of the page in the field located under “Find Post-Test/Evaluation by Course,” click enter
4. Click on activity title when it appears
5. Choose the type of credit you would like
6. Complete online Posttest and Evaluation
7. Receive an immediate CME Certificate to download and/or print for your files

If you have any questions regarding the CME certification for this activity, please contact Postgraduate Institute for Medicine at: inquiries@pimed.com or (303) 799-1930.

**Figure 1.** PrimaryCareHIVPrevention.org. Companion website with updated statewide and regional resources on HIV prevention.

**Figure 2.** Downloadable patient handout with information on PrEP that directs patient to services at the regional Colorado Health Network office. Available for download at http://primarycarehivprevention.org/wp-content/uploads/2017/11/referral-document_v2a.pdf
Every few months it seems like there are more revelations of large scale data breaches that expose the personal or financial information of millions of Americans. In 2017 there were breaches of Arby’s, Verifone, Dun & Bradstreet, Saks Fifth Avenue, Intercontinental Hotels Group, Chipotle, Kmart and Verizon that have resulted in credit card numbers or personal information being obtained by malicious characters.

The following graphs, compiled by the Identity Theft Resource Center (a non-profit advocacy group), states that the healthcare industry is one of the largest targets for data breaches. By far the largest threats to data security are hacking, skimming and phishing.

**Hacking** normally involves obtaining credentials to install malware that can monitor and extract sensitive information. **Skimming** is the process of attaching a physical device in the card processing environment to duplicate and steal the data. **Phishing** is the practice of sending fraudulent emails or phone calls purportedly from a reputable company to get individuals to reveal information such as passwords, personal information or credit card numbers.

To address these issues, the credit card industry has responded with a set of guidelines called **Payment Card Industry (PCI) Compliance** to ensure that any business that accepts credit cards has implemented secure procedures to protect transmission of card information. PCI Compliance is a requirement for any business that accepts credit cards, but the actual requirements that your business must meet is determined by the equipment and the method of communication used in processing.

As part of PCI Compliance, every business must complete an annual **Self-Assessment Questionnaire (SAQ)** unique to the processing environment. For example, a stand-alone credit card terminal that attaches over an analog phone line has a very simple SAQ that focuses on in-office procedures to protect credit card data. This is because the terminal encrypts all information at the point of entry and then sends the information over an analog phone line which are much more difficult than IP connections for hackers to actively monitor. If your office uses a credit card processing terminal that connects over the internet or through your computers, not only will you have a more demanding SAQ that will ask about your network security, you will also be required to perform quarterly external PCI network scans to ensure that your network is secure from tampering.

PCI Compliance will usually be handled by your credit card processor even if they use an industry-approved PCI subcontractor. However, it is the merchant’s responsibility to make sure that their business has completed all the required steps to achieve compliance. While some credit card processors are very proactive in helping medical offices attain compliance, many don’t view it
as their responsibility. When Best Card reviews statements from medical offices to prepare cost comparisons, approximately 60% of offices are being charged monthly or quarterly PCI Non-Compliance fees. Best Card averages 90% PCI compliance for our dental offices and charges approximately 25% of the annual cost other processors do for PCI compliance.

Having worked with thousands of medical offices for their PCI compliance, below are some helpful tips for any office to avoid PCI issues, maintain security, and identify calls from scammers trying to get information.

- If your office stores physical credit card numbers, be sure to keep all card information locked up when not in use and to shred any card numbers once no longer required for business or legal reasons.

- If you have your office phones connect over IP (instead of analog phone lines), your router must separate phone activity from the rest of your office internet activity. While this should be common practice, many internet service providers such as Comcast, AT&T, etc. have not updated the firmware on the routers that they offer to businesses to be compliant with this practice. Currently you can receive a waiver for this vulnerability to achieve PCI compliance, but beginning January 1, 2018 these routers will no longer be compliant without an update.

- Change passwords to systems if you have an employee leave. Former employees might login remotely and run fraudulent refunds to their own credit cards.

- Never store card numbers on a computer unless they are being stored in an encrypted format (where you cannot see full credit card number) by a PCI approved software/gateway/processor.

- Be very careful when giving access to your passwords or allowing others to remotely login to your office computers. We have had offices that have called us after “Microsoft” called and said that they immediately needed to login to their computers. This is a common scam used to compromise your network and install malicious programs.

- We have had offices call us because “PCI” called and demanded to see a copy of their PCI Scan report. Any PCI compliance steps would be handled in conjunction with your processor, there are no “PCI police” that would call you by phone. Giving away this information would essentially give a roadmap to hack your office network.

- There are many unscrupulous credit card processing companies that will call and say that your equipment or your network is not PCI compliant. They may even say that they need to do an “update” to your terminal and give you something to sign. Unless this call is coming from your credit card processor and they can provide your merchant number, this is an underhanded solicitation. The caller will have no information on the integrity of your systems unless you give it to them. These companies will try to scare you into signing a new agreement that usually has expensive costs and punitive contract terms.

- MasterCard has begun issuing credit cards that begin with a 2 (previously all MC began with a 5) and some terminals need an update to accept these new cards. At Best Card, most of our terminals/online software systems auto-updated but we did have to re-download our VX520 terminals. MasterCard wanted updates completed by 6/30/17 and can assess non-compliance fees of $2,500 per occurrence in the first 30 days, escalating to $10,000 in the next 60 days and up to $20,000 per occurrence for subsequent violations, but Mastercard will send a warning before assessing fines. If you get sales calls saying you are non-compliant and may get fined, there might be some truth to this and you should check with your present processor.

Data security and PCI compliance are an ever-changing part of the business environment, but with reasonable preparations and updates it should be very manageable! If you have any questions about PCI compliance or the credit card processing industry in general, feel free to reach out to Best Card at (877) 739-3952. They save the average medical office $1,860 (27% average savings) per year on their processing costs and offer excellent customer service. If you have a recent statement from your credit card processor and would like a detailed, no-obligation cost comparison, you can send the statement via email to CompareRates@BestCardTeam.com or fax to 866-717-7247. Best Card is the endorsed credit card processor of the CDA as well as associations nationwide.

Primary care has been experiencing both change and difficulty over the last decade. Numerous published studies about burnout indicate anywhere from 40-80% of physicians being unwell at any given moment. Researchers have been trying to figure out what factors are contributing to such numbers. New splits and categories of care in the last 20 years with the advent of urgent care centers, hospitalists, and ambulists have changed the former work environment. In internal medicine programs with specific primary care tracts, they have noted an almost 50% decrease in interest in primary care from the start of residency to the finish.1 The difficulties during ambulatory hours are the main reason cited for the “change in heart.”

This is a tragedy. We need good primary care doctors, and more of them. Time-motion studies can give us a clue as to what primary care physicians are doing with their time during their day, and lead to insights into our busy epidemic. One landmark study published in Annals of Internal Medicine “Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties”2 focused on ambulatory care. This study concluded that for every 1 hour physicians provided face to face care with patients, they spent 2 additional hours doing other tasks, and an additional 2 hours of their personal time at home.

Another article from Annals “Allocation of Internal Medicine Resident Time in a Swiss Hospital: A Time Motion Study of Day and Evening Shifts”3 concludes that a similarly small amount of time (9-22% of the day) is spent face to face with patients. 8 Time-motion studies all conclude that 12-28% of a physician’s day is spent face to face with patients and that 40-51% of the day was spent on the computer. The numbers between these 8 studies are consistent giving us good data about how a primary care physician’s day is run.

This time motion data can be applied to what physicians are experiencing. If you take the conclusion of the Annals Dec 6, 2016 study4 that for every 1 hour that physicians provide direct clinical face to face time nearly 2 hours are spent on “other work” then you can conclude that an ambulist that sees an average of 18 patients a day is doing the equivalent work of an 18 hour day. I think many ambulists would agree that this is what work in the clinic feels like, being rushed and behind most of the time. If we wanted physicians to work a 40 hour work week, which is considered full time for most American’s, this means we would need to cut back to 8 patients a day.

There are numerous tasks that primary care physicians face daily that are not paid for under our current system. These include calling patients, renewing medications outside an office visit, reviewing past records, thinking, discussing patient care with the office team, family conferences, talking with the patient’s specialist, deciding not to undergo certain treatments or procedures, going with a patient to a specialist visit, or attending multidisciplinary rounds in the hospital.

There would be two different ways to work on payment models that could address this time issue and change the way a primary care physician uses their time. One would be to change our existing relative value unit (RVU) system, and the other would be to look at alternative payment models. Currently, under the RVU system, an ambulist makes an average of .97-1.5 RVUs per office visit, or an average of 22 RVUs per an 18 patient day. A new type of “comprehensive primary care visit” which could include an hour of the physician’s time doing all of the above listed tasks and paid from 5-7 RVUs could not only revolutionize primary care, but would also bring their RVU production into a more similar league with their specialists colleagues.

The other method is looking at alternative payment models that pay monthly fee based care instead of RVU based care. These have the potential to allow for physician's time to be utilized in different manners, however, with a majority of ambulists being employed at this time, care must be taken to still not be driven by the same patient numbers per day. If alternative payment models are widely accepted and adopted, then additional measures to ensure that employed physicians are given enough time with their patients would need to be enacted.

Value-based care has been the term to describe these alternative payment plans. I would like to introduce a new name for this concept; the “Slow Medicine Movement”. Many have found value in slowing down, such as sourcing locally and paying for quality made food in the Slow Food Movement. I believe that the same concept could be applied to medicine, and is supported by these time-motion studies. If we slow down our care and see less patients a day, but spend more time with each patient, I believe we would see overall lower costs of care, much higher quality of care, and a dramatic change in both patient and physician satisfaction. Time matters. If we want to increase our quality, we need more time.

References

The Faces of Hope.

Colorado Head and Neck Specialists, located at Porter Adventist Hospital, treats complex head and neck malignancies, including advanced skin cancer, HPV-related cancers and benign and malignant tumors of the thyroid and parathyroid glands. Trained at the country’s premier cancer centers for head and neck tumors, our board certified otolaryngology/head and neck surgeons offer highly-specialized treatment options such as transoral robotic surgery, laser microsurgery, skull-base surgery and microvascular reconstruction of the head and neck.

Our surgeons work closely with an interdisciplinary team of medical oncologists, radiation oncologists, specialty-trained nurses, patient navigators, dietitians, physical therapists, and emotional support teams to ensure compassionate, contemporary and comprehensive care.

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Colorado Head and Neck Specialists

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Family physicians are well aware that herpes zoster is one of the more painful and debilitating conditions afflicting otherwise healthy middle-age to older adults. The condition results from a reactivation of herpes zoster (chickenpox) virus, which has remained dormant – “hidden out” – in an individual’s dorsal nerve root ganglia since the time of primary chickenpox infection, usually in childhood. A more complete clinical description of herpes zoster can be found on the Centers for Disease Control and Prevention website (tinyurl.com/y7qkyajk) as well as in many medical texts. A description more appropriate for lay readers is offered by the Mayo Clinic (tinyurl.com/ya2ftnuq). Roughly twelve percent of those suffering an episode of zoster go on to develop a much more painful and longer lasting complication – post-herpetic neuralgia (PHN). (tinyurl.com/yblddxyc)

The annual risk of herpes zoster in immunocompetent adults was estimated at about 1 percent per year in 2011, despite the availability of a live vaccine since 2006. The vaccine would have had little impact on incidence because the estimated coverage in that year for persons over 60 was 16 percent, and the vaccine efficacy about 51 percent (tinyurl.com/y7a3pavh). The CDC estimates that an individual’s lifetime risk of zoster is almost one in three (tinyurl.com/y6w7pwq7).

The approach to immunization for herpes zoster is quite different from that for most viral diseases in that the vaccine must aim to protect against an infection originating within the individual, rather than introduced by an external exposure. When making immunization policy, we are accustomed to thinking not only about immunologic factors but also about community circulation of the virus, risk of exposure, and herd immunity. In this case, essentially everyone already has the virus. Primary chickenpox infection in childhood was almost universal in this country until the 1990s, when a childhood vaccine was introduced (tinyurl.com/yaq6pw4w). Thus, all those in their 60s and older – the ages at which zoster attacks are of most concern – must be considered at risk for at least four more decades.

A live herpes zoster vaccine (marketed as Zostavax® by Merck) was licensed in the U.S. in 2006 and recommended by the CDC’s Advisory Committee on Immunization Practices in 2008 for all adults sixty years and older (tinyurl.com/y7hj43ab). This vaccine is formulated just like live chickenpox vaccine for children, but with a much higher dose of virus. Researchers found that the immune system would respond sufficiently to this challenge to provide reasonably adequate protection to most people against the threat of reactivation of dormant virus from the nerve roots. The uptake of this vaccine in U.S. seniors has been less than impressive. As we noted in March of this year, CDC surveillance found a vaccine coverage rate of 31.8% in 2014 in persons age 60 and over (tinyurl.com/zqf6dwd). Meanwhile, the efficacy of the live vaccine, as presented in the October 2017 ACIP meeting is estimated at 70 percent at ages 50-59, 64% at ages 60-69, 41% at ages 70-79, and just 18% for those over age 80. Models show the effectiveness of the vaccine waning by half at five years and to essentially zero at nine to eleven years post-administration.

In June of this year, based on the severity of zoster attacks and especially PHN, we affirmed that physicians should routinely recommend the live zoster vaccine for all patients over 60 without a medical contraindication – that is, until a better alternative became available. That time has come.

For some time, investigators have worked to develop a vaccine based on an immunogenic subunit of the virus, coupled with an adjuvant. This approach would substantially improve on the efficacy offered by a live vaccine. In September, 2016, the New England Journal of Medicine published a trial of this product, named Shingrix® by Glaxo Smith Kline (tinyurl.com/mu2zbcw). This vaccine is made of zoster glycoprotein E with an adjuvant composed of MPL (made from a Salmonella strain) and Saponin QS-21 (tinyurl.com/y7uffd3k). Efficacies over a 3.7 year follow-up were found to be 97.2 percent in this trial with almost no variation by age group (96 to 97 percent). Data presented to the ACIP in October 2017 were only slightly more modest (97 percent efficacy at age 50-70 and 91 percent at age over 70).
Caveats exist. Because this vaccine is new, duration of immunity is unknown. Projections based on the available four years of follow-up suggest that duration might be double that of the live vaccine, but until those years have elapsed, no one can say for sure. Though no serious adverse events have been traced to this vaccine so far, local reactions are significant. In data presented at the October 2017 ACIP, about 17% of vaccine recipients experienced a grade 3 local reaction (100 mm redness or swelling, or symptom preventing normal activity). This kind of reaction is to be expected from a vaccine containing an effective adjuvant. The other drawback is that this vaccine is delivered in two doses, two months apart, compared to one dose for the live vaccine.

FDA licensed Shingrix® on October 20 for those aged fifty and over. On October 25, the ACIP proceeded to a complex, fascinating three-hour series of presentations, debate, and vote on recommendations for this vaccine. Issues included those detailed above as well as a series of cost-effectiveness analyses. The exact cost of the vaccine is not yet known, but estimates presented at CDC for the analyses ranged around $320 including administration fees for the two-dose series.

After much consideration, the ACIP voted:

1. To recommend the subunit vaccine for persons fifty years of age and over (14 in favor, 1 opposed)

2. To recommend the subunit vaccine for those who previously received the live vaccine (12 in favor, 3 opposed)

3. To recommend the vaccine preferentially over the live vaccine in persons sixty years of age and over (8 in favor, 7 opposed)

In my opinion (RF, as a former ACIP member), the tradeoff is between about a 10 percent risk of a zoster episode and the pain that goes along (in a conservative, 10-year time horizon) versus about a 17 percent risk of feeling sick for a day and having a pretty bad sore arm for two or three days – twice in two months. If I am in the 83 percent who will not feel sick, I would likely only have a moderately sore arm. I have decided that I will take the sore arm (with aspirin on board!) and get the vaccine.

Not everyone may agree. But, for us, we now know that we have an option that is far more likely to prevent zoster and PHN than just a few weeks ago. We recommend that you discuss it carefully with your patients. Hopefully this information will help.

Other Vaccine News You Can Use

1. The CDC now advises that it is no longer necessary to observe an egg-allergic patient for 30 minutes following receipt of a flu vaccine. Further, the vaccine can be given by any physician with experience in evaluating allergic reactions (tinyurl.com/ycskmvwm).

2. Unvaccinated people may be the cause of increase in measles outbreaks in the US, a study suggests. People who have not received measles vaccine “are the most likely reason for the steady increase in the rate of measles and major outbreaks in the United States,” according to a study conducted by the Centers for Disease Control and Prevention that was published in Journal of the American Medical Association (tinyurl.com/y7lekxxva). Nakia Clemmons, a CDC epidemiologist, stated that the research suggests that some communities in the US with large numbers of unvaccinated people may be at increased risk for outbreaks. She added (tinyurl.com/y7ouz6a8), “Being unvaccinated rather than failure of vaccine is the main driver of measles spread.” [Dr. Finger’s comment: Many people point out the high percentage of cases in vaccinated persons in measles outbreaks. However, what happens when a measles outbreak occurs is that the virus, usually introduced and spreading among unvaccinated persons, finds its way to those few percent of vaccinated people who did not develop adequate immunity. The measles virus is more efficient at ferreting people out than any public health program can hope to be.]

3. Would you have thought that having an older brother or sister would put an infant at higher risk of being hospitalized with influenza? It does. Read more at tinyurl.com/yaf9efjl.

4. The third trimester of pregnancy is the best time to vaccinate our pregnant patients for pertussis as it will significantly protect the newborn baby until their first shots. Read more from the CDC at tinyurl.com/yaphdrbw.
NEW REPORT: COLORADO NOT MEETING NATIONAL IMMUNIZATION TARGETS

CCIC RELEASES COMPREHENSIVE STATE OF THE STATE’S IMMUNIZATIONS REPORT

The Colorado Children’s Immunization Coalition (CCIC) recently released a comprehensive report on the state of immunizations in Colorado. Using newly- and never-before available school and child-care data from the Colorado Department of Public Health and Environment (on close to 1 million children) in conjunction with national, county-, and hospital-level data, the State of the State’s Immunizations report reveals that current vaccination rates in Colorado fall short of the targets set by the U.S. Department of Health and Human Services’ Healthy People 2020 goals for health promotion and disease prevention. Additionally, the report finds that more than 57,000 K-12 students and over 8,000 children enrolled in licensed child care facilities across the state are not up to date on required immunizations.

Other key highlights from the State of the State’s Immunizations report include:

- The health and economic costs of vaccine-preventable diseases in Colorado are significant. In 2015, hospital and emergency department charges to treat children in Colorado for vaccine-preventable diseases totaled $35 million. Additionally, the report finds that vaccine financing in Colorado is complex; 34 percent of physicians have, in the last year, considered discontinuing providing all childhood vaccines to privately insured patients because of cost.

- Immunization rates vary widely across the state, with variation between counties, and among school districts and schools. While vaccination rates in Colorado have risen over the past 15 years, there remain high rates of underimmunization across the state. In 2015, only 75.4 percent of children aged 19-35 months were up to date on routine vaccinations, meaning that 1 out of 4 children is underimmunized. In 13 Colorado counties, less than half of children are up to date on routine immunizations.

- Colorado still has one of the highest non-medical exemption rates in the country. Colorado is one of only 18 states that allows parents to claim exemptions from vaccines required for school or child care entry based on personal or philosophical reasons. The report finds that virtually all of the state’s exemptions are for non-medical reasons, which comprise over 95% of the exemptions at K-12 schools.

The report concludes with specific recommendations for researchers, public health officials, healthcare providers, lawmakers, parents and the media to help increase vaccination rates in Colorado. To read the full report, visit https://www.childrensimmunization.org/.
FOR SOME OF OUR MOST ELITE SOLDIERS, THE EXAMINATION ROOM IS THE FRONT LINE.

Becoming a family medicine physician and officer on the U.S. Army health care team is an opportunity like no other. You will provide the highest quality health care to Soldiers, family members, retirees and others, as well as conduct medical research of military importance. With this elite team, you will be a leader – not just of Soldiers, but in family health care.

See the benefits of being an Army medical professional at healthcare.goarmy.com/hb76

To learn more about the U.S. Army health care team, call 303-873-0491.
**Note:** This is primarily intended to inform physicians treating patients > age 18 years for whom a recommendation for medical use of marijuana is being considered.

“Cannabis” is used interchangeably with “marijuana.” Cannabinoids refer to chemical components of cannabis (i.e., THC or cannabidiol [CBD], including synthetic versions).

### Effectiveness

- **There is substantial evidence** that cannabis or cannabinoids are effective for:
  - Treatment of chronic pain in adults - primarily neuropathic pain.\(^1,2\)
  - Treatment of chemotherapy-induced nausea and vomiting.\(^1\)
  - Improving patient-reported multiple sclerosis (MS) spasticity symptoms.\(^1,2\)

- **There is moderate evidence** that cannabis or cannabinoids are effective for:
  - Treatment of short-term sleep outcomes (associated with obstructive sleep apnea, fibromyalgia, chronic pain, MS).\(^1\)
  - Treatment of drug resistant seizures with CBD in children and young adults with Dravet syndrome.\(^3\)

- **There is limited evidence** that cannabis or cannabinoids are effective for:\(^1\)
  - Increasing appetite/decreasing weight loss associated with HIV/AIDS.
  - Improving provider-measured MS spasticity symptoms.
  - Improving Tourette syndrome symptoms.
  - Improving anxiety symptoms (in context of assessment of social anxiety symptoms).
  - Improving post-traumatic stress disorder (PTSD) symptoms.

- **There is no or insufficient evidence** that cannabis or cannabinoids are effective for all other diseases and conditions, due to lack of published clinical trials.\(^1\)

### Side effects

- From clinical trials, the following side effects were reported significantly more often among participants receiving cannabinoids than among controls: dizziness, disorientation/confusion, euphoria, dry mouth, drowsiness/somnolence, nausea, fatigue/asthenia.\(^2\)

### Drug interactions

**Note:** The lack of a cited interaction does not preclude the possibility that a drug interaction exists (and no studies have yet reported an interaction with that particular drug).
There is evidence of clinically important drug-drug interactions between cannabis or cannabinoids and the following medications: chlorpromazine, clobazam, clozapine, CNS depressants (e.g., barbiturates, benzodiazepines), disulfiram, hexobarbital, hydrocortisone, ketoconazole, MAO inhibitors, phenytoin, protease inhibitors (indinavir, nelfinavir), theophylline, tricyclic antidepressants and warfarin.\(^4\)

**General risks of marijuana use**

**Note:** These mainly represent evidence from studies of recreational cannabis users focused on adverse health effects. Only content areas where there is “substantial” research evidence are presented. Furthermore, _the studies informing the evidence statements below are “observational” in design, thus, for most of these statements, causality cannot be clearly established_ (e.g., cannabis use and schizophrenia may “travel together” rather than represent a causal relationship). Thus, these findings should be extrapolated with caution, especially in the context of medical marijuana use.

- **There is substantial evidence:**
  - That cannabis use is associated with increased risk of motor vehicle crashes.\(^1,4\)
  - That cannabis users, including adolescent and young adult users, can develop cannabis use disorder.\(^4\)
  - That adolescent and young adult cannabis users are more likely than non-users to use and be addicted to illicit drugs in adulthood.\(^4\)
  - That frequent cannabis users are more likely than non-users to have memory impairment (lasting a week or more after last use).\(^4\)
  - That THC intoxication can cause dose-related acute psychotic symptoms.\(^4\)
  - That cannabis use is associated with development of schizophrenia, with highest risk among most frequent users.\(^1,4\)
  - That frequent cannabis smoking is associated with chronic bronchitis.\(^1,4\)
  - That cannabis smoke contains many of the same cancer-causing chemicals as tobacco smoke; however, there is mixed evidence as to whether cannabis smoking is associated with lung cancer.\(^4\)
  - That THC crosses the placenta and into fetuses of women who use cannabis during pregnancy; and THC is present in breast milk and passes into breastfeeding infants.\(^4\)

**References**


**More information**

www.colorado.gov/cdphe/categories/services-and-information/marijuana
email: marijuana.research@state.co.us
The transition from residency to full time practice can be both exciting and stressful. The CAFP is happy to announce a new, comprehensive benefits package designed for graduating residents and new physicians. This includes a contract review, financial review, free CME, compensation data and more. That adds up to a total savings of over $1,100.

Learn more about all the benefits available below. Have questions? Reach out to Lynlee Espeseth, Director of Communications, Marketing and Membership at lynlee@coloradoafp.org or 303-696-6655 x 16.

- Free CAFP CME Conference Registration (One Time Use)
- Employment Contract Review. The CAFP will cover up to $500 for a contract review. For residents and physicians in the first year of practice this will cover most costs. For those 2-7 years into practice, fees may be higher and all fees over $500 will need to be covered by the physician. Be sure to discuss with your attorney if the fee might exceed $500.
- Compensation Data. Husch Blackwell LLP has access to compensation survey data to guide your decisions around salary, time off, and more.

Colorado Academy of Family Physicians Announces New Physician Benefits Package

What Is This Benefit All About?

Once you have graduated from residency, you will likely be required by various bodies to earn a certain number of Continuing Medical Education (CME) credits per year. Some of these credits will need to be “live.” That is, education that takes place in-person with other physicians or medical professionals.

The CAFP offers live CME opportunities throughout the year, including our largest event, the Annual Summit. The good news? By attending just one Annual Summit you can earn enough live credits to cover all the live CME the AAFP requires you to have for a three-year period.

What are the Savings?

The CAFP will cover your registration costs for one full conference. For the Annual Summit, that’s a $375 value.

Who Can Use This Benefit?

Members of the CAFP who are in their first two years post-residency.

How Do I Take Advantage?

Watch for information to come via snail mail and email, announcing our CME opportunities. When you are ready to take advantage of your free conference, email Erin Watwood, CAFP’s Director of Education, Events and Meetings at erin@coloradoafp.org. Let her know you wish to take advantage of your free conference benefit, and she will get you registered.

Employment Contract Review (One Time Use)

What’s Included?

- An initial consultation to determine your goals, values and priorities.
- Comprehensive contract review.
- Email summary of suggested changes and comments.
- Additional consultation after your review of the email summary.
- Compensation Data. Ms. Udell has access to compensation survey data to guide your decisions around salary, time off, and more.

The attorneys below are partnering with CAFP to provide employment contract reviews for family physicians seeking a job in Colorado. Having an attorney review your contract can give you peace of mind, and helps ensure the contract meets your needs. Common areas of concern include the terms of liability tail coverage, total compensation including paid time off and CME, productivity requirements and bonuses, call coverage, noncompetition clauses, and buy-in potential.

Available Professionals:

Denver Metro Area

Antonio Bates Bernard, Attorneys at Law
Brian Bates
About ABB: http://www.ablaw.com/about_approach.php
(303) 733-3500
bbates@ablaw.com
What’s Included?
- Employment Contract Review. The review includes: an initial consultation to determine your goals, values and priorities.
- Email summary of suggested changes and comments.
- Additional consultation after your review of the email summary.
- Compensation Data. Ms. Udell has access to compensation survey data to guide your decisions around salary, time off, and more.

Fort Collins/Northern Colorado

Wolfe Van Ackern & Cuypers LLP
Ken Wolfe
(970) 493-8787
kwolfe@wvc-law.com
What’s Included?
- Employment Contract Review. The review includes: an initial consultation to determine your goals, values and priorities.

Arizona

Husch Blackwell LLP
Jim Miles, Lawson Parker, and Kyle Montour
About the Husch Blackwell Healthcare Unit: https://www.huschblackwell.com/industries_services/healthcare-life-sciences-and-education (303) 749-7268
jm.miles@huschblackwell.com
What’s Included?
- Employment Contract Review. The review includes:
  - An initial consultation to determine your goals, values and priorities.
  - Comprehensive contract review.
  - Email summary of suggested changes and comments.
  - Additional consultation after your review of the email summary.
  - Compensation Data. Husch Blackwell has access to compensation survey data to guide your decisions around salary, time off, and more.

The Law Office of Appalenia R. Udell
Appalenia Udell
(303) 748-4895
law@appalenia.com
What’s included?
- Employment Contract Review. The review includes:
  - An initial consultation to determine your goals, values and priorities.
  - Compensation Data. Ms. Udell has access to compensation survey data to guide your decisions around salary, time off, and more.

Grand Junction/Western Slope

Childs McCune Attorneys
Julie Warren
(303) 296-7300
jwarren@childsmccune.com
What’s Included?
- Employment Contract Review. The review includes:
  - An initial consultation to determine your goals, values and priorities.

Brian Bates
Antonio Bates Bernard, Attorneys at Law
Denver Metro Area

Ken Wolfe
Wolfe Van Ackern & Cuypers LLP
Fort Collins/Northern Colorado

Jim Miles, Lawson Parker, and Kyle Montour
Husch Blackwell LLP
Arizona

Julie Warren
Childs McCune Attorneys
Grand Junction/Western Slope
What’s Included?
- Employment Contract Review
- Contract review for jobs in Utah
*Note: the CAFP stipend is not available for employment contracts in Utah
- Review typically includes 1-2 hours for the review, and a face-to-face or teleconference with the physician to discuss the contract

What Is This Benefit All About?
As you prepare to finish residency and enter practice, you probably have lots of questions about your student loans. Should you refinance? Are there different payment options based on the job you take? How can you set yourself up for financial success?

The CAFP is here to help. We’ve joined together with financial planners who specialize not just in student loans, but in working with medical professionals who have student loans.

What are the Savings?
The CAFP will cover all costs associated with this benefit. A $300 value.

Who Can Use This Benefit?
All graduating residents and new physicians up to 7 years into practice who are planning to practice, or are currently practicing, in Colorado.

How Do I Take Advantage?
All financial professionals will work with you virtually. Explore the list below to choose a financial professional who is right for you. When you reach out, let them know you are a part of the Colorado Academy of Family Physician so we will be billed for the services.

Available Professionals:
Joy Sorensen Navarre
Navigate, LLC
http://www.navigatestudentloans.com/
What’s included?
- Comprehensive review of your current student loans
- Custom solutions based on your career and family plans
- Review of repayment scenarios: income-driven repayment, Public Service Loan Forgiveness, National Health Service Corps loan forgiveness or private loan refinance
- Identification of your best repayment options
- Step-by-step instructions to maximize your savings and avoid common mistakes or omissions
- Unlimited follow up at no extra charge. As career or family plans change we’ll reevaluate with you. Plus, if your loan servicing company makes an error, we’ll help you straighten it out.

Paul S. Garrard
PGPresnets, LLC
http://www.pgpresents.com/
What’s included?
- Detailed review of the borrower’s entire student loan portfolio
- Online review of all federal repayment options, including IBR, PAYE, and REPAYE, and their forgiveness provisions, plus online help with repayment calculators.

- Review of Public Service Loan Forgiveness, including how to start the eligibility process and track borrower payments towards PSLF, plus updates on proposed changes.
- Review of federal consolidation and determination of whether borrowers are candidates for federal consolidation.
- Objective discussion about refinancing and how to know if borrowers are candidates for refinancing with a private lender, including our extensive detailed questionnaire on how to select a private lender for refinancing.
- Written summary and plan within 48 hours of phone consultation.
- Proactive follow up through our extremely popular “Courtesy Check” emails to ensure the borrower’s repayment strategy is going as planned.
- Unlimited ongoing support from PGPresents at absolutely no additional cost to the member of CAFP.

Travis Hornsby
Student Loan Planner, LLC
https://www.studentloanplanner.com/
What’s included?
- Comprehensive review of PSLF, income driven repayment, refinancing, and more as it relates to your short and long-term goals
- Analysis how loan forgiveness impacts the financial aspects of private and public sector offers

CONTINUED ON 30 >>
- Reviewing impact of the doctor’s loan strategy on spousal income and loans
- Discussion of how saving for retirement and paying back student loans are deeply connected
- Any questions you have about student loans. Period.

Daniel Wrenne
Wrenne Financial Planning
https://wrennefinancial.com/cafp

What's included?
- Present complete inventory of your student loans
- Understand goals and objectives for debt repayment
- Present visual illustrations of various payoff strategies
- Determine best strategy, given your current circumstances and future expectations
- Formalize game plan with a standalone document which includes:
  - Summary of your plan and our discussions
  - Detailed breakdown for how to execute on the strategy
  - Future considerations, and things you will need to keep in mind should your circumstances change

Free Compensation Data

What Is This Benefit All About?
When you're considering job offers, it can be hard to know what you should be getting paid. The location, practice size, and scope of what you will be doing can all affect appropriate compensation.

The CAFP is here to help. We offer custom compensation data to our members, to help you get paid what you deserve.

What are the Savings?
The CAFP has a subscription to Medical Group Management Association’s pay dashboard. A benefit of over $5,000.

Who Can Use This Benefit?
All CAFP members.

How Do I Take Advantage?
If you are ready to consider specific jobs, and would like a compensation report customized to your unique situation, email Lynlee Espeseth, CAFP's Director of Communications, Marketing and Membership, at lynlee@coloradoafp.org. She will work with you to gather the necessary information to complete a customized report.

Practice Exploration

What Is This Benefit All About?
Have you ever wished you could get better insight into a unique type of practice, one you didn't necessarily experience in medical school or residency? What would it be like to have a thriving solo practice in a rural mountain town, run a state-of-the-art Direct Primary Care practice in metro Denver, or be a part-owner in a large private practice?

Members of the CAFP practice in these diverse settings and more. To help you explore what career is right for you, the CAFP has identified a list of physicians, all in unique settings, who are open to answering questions from residents, and showing them what their practice is all about.

Who Can Use This Benefit?
All CAFP resident members.

How Do I Take Advantage?
Review the list of family physicians below. If one of the practice types catches your eye, reach out and let them know you are a resident member of the CAFP, and are curious to learn more about their style of practice.

Please be aware that many of these physicians are not only doctors, but business owners too. Please allow them some time to respond to you, and recognize that they may not all be available to visit with you at all times throughout the year.

Available Professionals

Ivan Alkes, MD
Solo Practice Physician in Grand Junction, CO
dralkes@acsol.net

Gina Carr, MD
Mountain Rural Solo Practice Physician
http://swanmountainfamilyclinic.com

John Cawley, MD
Independent Practice Physician
https://afmnoco.com/

Lisa Davidson, MD
Solo Direct Primary Care Physician
http://www.insightprimary.com/

Robin Dickinson, MD
Solo Direct Primary Care Physician
https://communitysupportedfamilymedicine.com/

Clint Flanagan, MD
Direct Primary Care & Independent Practice Physician
http://northvistamedical.com/
https://nexterahealthcare.com/

Glenn Madrid, MD
Independent Practice Physician
http://www.pcpgi.com/

Member Recognitions

Congratulations to Kimberly Bentrott, MD, for being named Physician of the Year by the Center for Health Progress.

Congratulations to Tamaan Osbourne-Roberts, MD on being appointed to the AAFP’s Commission on Quality and Practice.

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.
The Colorado Commission on Family Medicine (COFM) is celebrating its 40th anniversary. COFM was established in 1977 by the state legislature to support the training of family physicians and increase the placement of graduates in rural areas. It is a success story of how a public and private partnership can benefit the citizens of the state.

Forty years ago, Dr. Harvey Phelps, a Republican state representative from Pueblo, and Tillman (“Tillie”) Bishop, a Democratic state senator from Grand Junction, sponsored a bill to establish the Commission. At that time, they realized the need for family physicians in rural and underserved areas and saw the family medicine residency programs as a vital asset for producing primary care physicians. According to state statute, the Commission was established to advise the legislature regarding the placement of family physicians in rural areas and to ensure high quality training within the residency programs. The statute also defines COFM membership: a citizen representative from each of the seven congressional districts, the residency program directors, deans of the medical schools in the state, and a representative from the Colorado Academy of Family Physicians. Today, the COFM board is composed of 19 members and meets quarterly.

Family medicine training in Colorado has seen significant growth in the recent years. The number of family medicine residencies in the state has increased from 9 to 11. Three new rural training tracks have been added. Five residencies have added more training slots. The state legislature has tripled its annual allocation to the residencies. Consequently, the annual number of graduates will increase from 68 to 96 by 2020. Historically, less than 20% of the physician residents come from Colorado’s medical schools, yet about 65% of graduates stay in Colorado to practice. Of the graduates who stay in the state, last year 50% of them now practice in rural and urban underserved settings.

COFM is unique to Colorado. It is the foundation for unmatched collaboration among the family medicine residencies. The programs collaborate to recruit medical students, train new faculty physicians, immerse resident physicians in rural practices, share research at an annual forum, and learn about practice transformation at an annual conference.

In addition to training family physicians, the residencies are an important segment of Colorado’s safety net of patient care. In 2016, over 71,000 Coloradans received health care in the family medicine residency clinics. Seventy percent of the patients were beneficiaries of Medicaid (49%) or Medicare (15%), or were uninsured (5.5%).

Forty years of collaboration has produced vibrant family medicine training in Colorado. It’s a success story worth telling.

Locations of Colorado Family Medicine Residency Programs
- Fort Collins (Fort Collins)
- North Colorado (Greeley)
- Peak Vista (Colorado Springs)
- Rose (Denver)
- Sky Ridge (Long Tree)
- Southern Colorado (Pueblo)
- St. Anthony’s North (Westminster)
- St. Joseph’s (Denver)
- St. Mary’s (Grand Junction)
- Swedish (Littleton)
- University of Colorado (Denver)
The University of Northern Colorado Nursing Programs:

- Nursing BS Degree: RN-BS
- Nursing MSN Degree: Adult-Gerontology Acute Care Nurse Practitioner (AGACNP)* or Family Nurse Practitioner (FNP)** Emphasis
- Nursing DNP Degree: Post-Bachelor’s with AGACNP* or FNP** Emphasis
- Post-Master’s Certificate in AGACNP* or FNP**
- Nursing DNP Degree: Post-Master’s*
- Nursing Education PhD Degree*

The *AGACNP and Post-Master’s doctoral programs are online with summer intensives in Greeley, CO; and the **FNP Programs are delivered on-campus one day a week + online.

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**Industry Leading Health Technology Consulting & Care Management Firm**

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

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

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

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