CAFP ANNOUNCES 2018 AWARD WINNERS.
PG. 28

PRESCRIBING PAIN MEDICATION SAFELY: WHAT PHYSICIANS NEED TO KNOW.
PG. 18

OUR POWER IS IN NUMBERS: FAMILY PHYSICIANS CAN CREATE CHANGE.
PG. 6
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.

At National Jewish Health, the nation’s leading respiratory hospital, our pediatric specialists incorporate the latest research and treatments to help kids get back to being kids. We breathe science, so you can breathe life.

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Breathing Science is Life.

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.

Our services include: Comprehensive food allergy testing/challenge, exercise physiology and lung function testing, genetic and immune function testing for immunodeficiency, neuropsychological testing, sleep testing.
"Burnout, at its core, is the impaired ability to experience positive emotion.

-Dr. J. Bryan Sexton

It seems in our current environment, there are days when it is difficult to find joy. We as family physicians are left wondering if we are enough, if it has all been worth it, and if this occupation we chose is really the best place for us.

While there are many facets to burnout and many solutions, one simple approach has helped me restore positivity and joy in my life. My co-worker, Dr. Sarah Goldberg, introduced me to a technique presented and researched by Duke University. “The intervention, called ‘Three Good Things,’ revolves around strengthening a person’s ability to perceive and savor positive emotions,” said J. Bryan Sexton, PhD, director of the Duke University Health System Patient Safety Center at Duke Medicine in Durham, North Carolina. The intervention is simple, but with powerful results. “Physicians and other healthcare workers who use a simple tool for 2 weeks show reduced burnout within a few days of starting the intervention and retain most of the benefit a year later,” researchers reported at the American Conference on Physician Health. In a trial by Seligman, after only one week of the intervention, the results were not significantly different than taking prozac, even up to 6 months later. The best results were to use the intervention consistently for 2 weeks, though.

To try the intervention, simply recall 3 good things that happened that day and what was your role in making them happen. Write them down two hours or less before bed, the closer to bedtime the better. They don’t have to be related to work or anything attributable to yourself. You can write down a beautiful sunrise, a savory curry dish, or a smile from a child. Repeat this for two weeks to make the effect last longer. I hope this tiny step enhances your days. You can try it with your children, family members, and friends.

To wrap up my year as president, here are my three good things about the year (in no particular order):

1. The CAFP board and our members. I am so proud to be from a state where our members are so passionate and actively involved! Thank you to all who have dedicated time despite busy schedules to attend opioid meetings, volunteer at Doctor of the Day, meet with our legislators and other key stakeholders regarding our Primary Care Investment Strategy, participated in legislative calls, came to bat for our residents and students, attended and led national meetings, and so many other activities. You inspire me.

2. CAFP staff-Raquél Alexander has been a national leader, voice of wisdom, ingenuity, and grace for CAFP for 30 years. Ryan Biehle has shouldered our charge toward payment reform this year and we couldn’t have a stronger, more thoughtful, and politically aware advocate. Lynlee Espeseth keeps our members up to date every month with e-news, has piloted a new grant finding program, and finds creative ways to advertise and keep our members in the know. Erin Watwood has orchestrated and continually challenges and improves our Colorado-relevant high yield Annual Summit and Wellness Conference. Our lobbyists, Jeff Thormodsgaard and Katie Wolf, continue to navigate difficult waters at the Capitol with class and agility.

3. My ever-patient husband and children who have been flexible, kind and often lent a supportive ear this year.

Thank you for this incredible opportunity! I am grateful for the learning, travels, and inspirational people I have met. I hope work we did together this year continues our legacy for strong medicine in Colorado.

Check out the video: https://www.midmichigan.org/quality-safety/3-good-things/

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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.
CEO’S REPORT

The Power of the Physician

Have you ever looked at the challenges facing our healthcare system and just felt completely overwhelmed? I would guess many of you have. It’s hard not to. There is so much to improve, and much that may need to be changed completely. And with so many competing interests, it’s hard to hear the voices of reason and experience.

I think it has left many people wondering, what power do we have at the end of the day? What can I really do as a physician? What can the CAFP or AAFP accomplish?

So many of the great movements throughout American history came from humble people, individuals banding together, who wanted to see a different future, to have control over the way they got to live their lives or do their work. Indeed, I think that desire was part of the very foundation of our country. That is why I believe that we can make a difference, but it won’t come with any of us working alone.

So this is my ask of you. Stand up with us. The CAFP wants to make healthcare better in Colorado. But without you, the voice of the physician, it can’t be done. We are going to be taking on issues that are tough, and everyone might not agree with us. But we must show our decision makers that what we are doing means something. It means something to you, a physician. It means something to your patients. It means something for our future.

When the time comes, write the letters and make the calls to legislators. Let them know you are paying attention to the choices they make, and you want them to make the right ones. Speak your experiences. No one knows better than you what is working and what isn’t. Write op-eds for your papers, speak to journalists, get engaged at the community level. And show them our power in numbers. You are not alone. The CAFP is the largest single-specialty medical association in Colorado. You are 2,486 present and future family physicians. If we speak together, we cannot be ignored.

I do not promise that change will come as quickly or as easily as we would like. But I do know we have the ability to make people pay attention. Your voices are powerful, and so are the changes that you can make.

Highlights from the January 2018 Board Meeting

Proactive payment reform: Primary Care Investment Strategy (PCIS)-we are introducing legislation in February to measure the percent spent on primary care in Colorado, and to increase this number up to 12-15%.

Leadership development: CAFP has partnered with the Regional Institute for Health & Environmental Leadership (RIHEL) and other partners to offer advocacy leadership training to CAFP members, free of charge. Learn more about the leadership training at http://bit.ly/PCMACProgram. Deadline to apply is March 15th.

Education: Come to our 70th Annual Summit in Colorado Springs registration is open! Visit https://www.coloradoafp.org/cme-and-events/annual-summit/
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CAFP LEGISLATIVE UPDATE

Colorado’s 2018 Legislative Session in Full Swing

Colorado’s 2018 legislative session is in full swing. In addition to CAFP’s top priority of increasing investments in primary care, opioids and prescription drug prices are taking center stage. Freestanding Emergency Departments remain another hot topic, with several failed attempts in prior years to thwart their proliferation or ensure consumers are aware of the costs of care at an ED.

CAFP Primary Care Investment Initiative

CAFP launched our Primary Care Investment Initiative in August, and introduced legislation to increase the share of health care spending going toward primary care from 6% up to 15%. Other states that have taken this path have seen success, with Rhode Island increasing its primary care spending by 37%. At the same time that primary care spending rose, total health spending declined by 14%. The CAFP’s bill would achieve several aims:

1. Establish a Primary Care Payment Reform Collaborative, convened by the state’s Primary Care Office, to produce an annual report on the share of health care spending in Colorado that goes toward primary care. The Collaborative will develop a consensus on the definition of primary care, develop recommendations to increase investments in primary care infrastructure, and track our progress on payment reform.
2. Direct the state’s all-payer claims database to collect non-fee-for-service payments, which are not currently available, to be included in the Collaborative’s annual spending report. These non-FFS payments should be growing over time, and this reporting will enable us to track progress on this front.
3. Establish targets to direct at least 15% of the healthcare dollar to be spent on primary care. Of the three components of the bill, this is of course the more difficult to navigate. CAFP has argued that setting targets is a key strategy to successfully increasing the capacity of and infrastructure in primary care to meet the needs of Coloradans. We know that increased investments in primary care will improve care for patients and drive down total costs. For more on the bill, visit our blog https://www.coloradoafp.org/blog/.

Opioids

SB18-022 most directly affects physicians on the issue of opioids. The bill limits an initial acute prescription of an opioid to a 7-day fill, with the option for prescribing a second 7-day fill. This same bill would also require a prescriber to query the Prescription Drug Monitoring Program on the second fill of a prescription. The bill passed the Senate on a vote of 29-6 and is headed to the House where it is expected to gain approval. A second bill, SB18-040, failed. It would have permitted supervised injection facilities in Colorado. As of this writing, HB18-1007 has yet to be heard in committee. HB-1007 would require health insurers to cover buprenorphine, without a prior authorization, for the first 5-days of treatment. It 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.

Freestanding Emergency Departments

SB18-146 is the first broadly bipartisan attempt to ensure patients are notified of the high costs of receiving care in a freestanding emergency department (FSED). The bill requires notice be posted for patients of the insurance plans accepted by the FSED, and the chargemaster price of the facility fee for the 25 most common services provided in the FSED. It is these facility fees that often set the cost of a service in the ED versus that of an urgent care or primary care clinic. The bill aims to ensure patients are aware of the high cost of freestanding ED’s, and to encourage them to seek care in the setting most appropriate for their condition.

Prescription Drug Pricing and Transparency

Prescription drug pricing remains at the top of patients’ concerns. In fact, 83% of Coloradans in a recent poll believed the cost of prescription drugs was too high. Several bills attempting to address the price of prescription drugs have failed in the Senate. SB18-152 would have prohibited price gouging on essential generic prescription drugs. SB18-080 also failed, and would have required the state to develop a program to import Canadian drugs at a lower cost than can be obtained in the U.S. One bill in the running as of March 1st, which CAFP supports, is HB18-1260. This bill requires 90 days advance notice before a drug’s price increases, enabling health insurers and consumers to plan for such an increase. It also requires drug companies to provide the reasoning for a price increase above 10%, and directs health insurers to report on the 25 most costly, and 25 most prescribed, drugs to allow Colorado to analyze the impact of prescription drugs on insurance premiums.

Federal Policy: CHP+, Community Health Center and National Health Service Corps Funding

In a frenzy of activity at the beginning of February, Congress reauthorized funding for several critical programs. Congress extended funding for the CHP+ program for 10 years, putting it on solid footing and providing certainty for the 95,000 Coloradans who have coverage through the program. Congress also averted the so-called “fiscal cliff” for federally qualified health centers. Congress continued federal funding for FQHC’s for two years, in addition to funding the National Health Service Corps loan repayment program for another two years. I want to give a note of thanks to members for your persistent advocacy to Congress on these issues, and to those who took part in the AAFP Speak Outs to support these programs that are vital to patients and family physicians.
Healthy patients and a healthy business.

At Commerce Bank, we have the experience to manage the unique financial challenges of the healthcare industry. From simple loan plans that help patients to optimizing your most complex payment processes, we have options that allow you to focus on providing a higher level of healthcare.
CAFP on the Go

CAFP Secretary/Treasurer John Cawley, MD, presenting to students at Rocky Vista University about choosing family medicine.

CAFP Chair Tamaan Osbourne-Roberts, MD, discussing how to expand advocacy efforts at the state and national levels at the Multi-State Forum in Dallas, Texas.

CAFP Member Kenyon Weidle, MD, testifying in support of HB18-1260 to increase prescription drug price transparency.

CAFP Board Member Stephanie Gold, MD, testifying in support of SB-22 to address the opioid epidemic.

CAFP President-Elect Zach Wachtl, MD, presenting on Colorado legislative activities at the Multi-State Forum in Dallas, Texas.

CAFP President Monica Morris, DO, presenting some best practices of the Colorado AFP at the Multi-State Forum in Dallas, Texas.

The CAFP Foundation Board of Directors met in March for a strategic planning session.
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.

To find out more, visit coheadandneck.org or call us at 303-778-5658.

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Updated Colorado Board of Health Blood Lead Level Reporting Regulations for Providers

Background

Recently, the Colorado Board of Health adopted revisions to Rule 6 CCR 1009-7 (https://goo.gl/PcJTX) concerning the Detection, Monitoring, and Investigation of Environmental and Chronic Diseases. To ensure consistency with the current Centers for Disease Control and Prevention’s reference levels for elevated blood lead, the reporting requirements for blood lead tests are updated as follows:

<table>
<thead>
<tr>
<th>Type of Lead Level</th>
<th>Timeframe for Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood lead level ≥ 5 µg/dL AND age ≤ 18 years</td>
<td>7 days</td>
</tr>
<tr>
<td>Blood lead level ≥ 5 µg/dL if age &gt;18 years</td>
<td>30 days</td>
</tr>
<tr>
<td>Blood lead level &lt;5 µg/dL AND age ≤ 18 years</td>
<td>30 days</td>
</tr>
</tbody>
</table>

Reporter: Laboratory or by the physician, healthcare provider, or clinic when blood lead specimens are analyzed in an office or outpatient setting.

Frequently asked questions

When is the updated rule in effect?

The revision was approved by the state Board of Health on November 15, 2017 and went into effect on January 14, 2018.

What does the revision change?

- For individuals up to 18 years of age:
  - Changes the timeframe for reporting blood lead levels ≥5 µg/dL to 7 days and reporting blood lead levels <5 µg/dL to 30 days.
  - Previously for individuals up to 18 years of age, the timeframe for reporting blood lead levels ≥10 µg/dL was 7 days, and reporting blood lead levels <10 µg/dL was 30 days.
• For adults older than 18 year of age:
  o Changes the reportable blood lead level to ≥ 5 µg/dL.
  o Previously the reportable blood lead level was ≥ 10 µg/dL.

Who is responsible for reporting?

Laboratories (whether or not associated with a hospital; by out-of-state laboratories that maintain an office or collection facility in Colorado; and by in-state laboratories which that send specimens to an out-of-state laboratory referral laboratory) or physicians, healthcare providers, or clinics when blood lead specimens are analyzed in an office or outpatient setting (i.e., using LeadCare® II instrument) are responsible for reporting to the Colorado Department of Public Health and Environment (CDPHE).

How do I report?

If you send your blood lead tests to a laboratory for analysis, it is the responsibility of the laboratory to report to CDPHE. However providers using point-of-care testing machines have several options for reporting:

2. Submit the results based using the format described in the Colorado Reporting Software User’s Guide to CDPHE via the following method:
   a. Go to Colorado’s Secure Email Portal located at https://web1.zixmail.net/s/welcome.jsp?b=stateofcolorado
   b. Create an account and email the lead test results through the Secure Email Portal to cdphe_leadreports@state.co.us
3. If you are unable to use the LeadCareII Colorado Specific Reporting Software, but are still interested in submitting results electronically, please contact Matthew Newman at: matthew.newman@state.co.us or call 303-692-2708.
4. If you are unable to use one of the methods described above, you may fax your lead test results to 303-782-0904.

An easy to use reference for reporting blood lead results to CDPHE can be found online at the following link: https://drive.google.com/file/d/0B0tmPQ67k3NVVEN4b01TTXY0UVE/view

What does CDPHE do with the data?

CDPHE sends weekly reports of elevated test results to local public health agencies for appropriate follow-up, and provides follow-up on adult occupational exposures. CDPHE also uses data for identifying and assessing trends, screening rates, spatial relationships, and other analyses. An example is the Targeted Lead Outreach Tool to assist health professionals, which can be found at the following website: https://www.colorado.gov/pacific/cdphe/lead-outreach-tool. CDPHE also summarizes and reports the data on the Colorado Public Health Tracking Portal (www.colorado.gov/coepht), as well as submits data to national CDC,
Greetings from your SNOCAP Practice-Based Research Team.

SNOCAP has been busy in 2018. We’re getting manuscripts out the door, finishing projects, launching new projects, and always submitting proposals for new project funding. Our active research projects cover topics such as medication assisted treatment for opioid use disorders, loneliness, infant eczema treatment, and many others.

Two SNOCAP studies of interest:
- **Diabetes, Obesity and Mental Health Services Access Card Study (DOGMA)** is a paired clinician/patient card study that examines whether clinicians and patients both identify the same diagnoses and treatment for behavioral or mental health issues in patients with diabetes and/or obesity and indicators such as BMI or HbA1c. Also examined will be association between getting behavioral health care and BMI, HbA1c and answers to healthy days questions. The cards take less than 3-5 minutes to complete. We are looking for diverse practices statewide to see if trends differ across the state and expect to recruit one to three providers and 25-40 patients in each practice. Contact Andrea Nederveld at Andrea.Nederveld@ucdenver.edu for more information.

- **Implementing Technology and Medication Assisted Treatment and Team Training in Rural Colorado (IT MATTTRs)** is a response to the repeated calls from rural primary care in Colorado to address patient care for opioid use disorder (OUD). Two groups of local community members are working to change the conversation about opioids in rural Colorado. These groups, in eastern Colorado and the San Luis Valley, partnered with academic researchers in the “Boot Camp Translation” process to create locally-relevant, actionable messages and materials about opioids and treatment options for opioid use disorder. These messages and materials will be distributed in each region in the form of drink coasters (restaurants, coffee shops, and bars), posters (schools, businesses, primary care practices), and program inserts (church bulletins, sports events programs, community events, pharmacy bags). The community-academic partnerships are fine-tuning their distribution plans and anticipate materials will be disseminated throughout much of 2018, starting in mid-March in some areas.

SAVE THE DATE!

**Engaging Communities in Education and Research (ECER) Conference**

The Engaging Communities in Education and Research (ECER) Conference will be held on September 21-23 in Breckenridge, CO. We are excited to be a part of this multidisciplinary event, which brings together preceptors from rural communities in Colorado, Practice Based Researchers and practitioners, and patient and community stakeholders. This year, an additional broad invitation will be sent out to practices that were involved in EvidenceNOW Southwest. If that pertains to you and your clinic, be watching for more information!

This year we are pleased to welcome Dr. Victor Montori from the Mayo Clinic as our plenary speaker. His key focus areas of work include evidence-based clinical practice, shared decision-making, minimally disruptive medicine, and systematic reviews and meta-analyses.

Registration for the conference will open soon and will come out via our bi-monthly newsletter.

If you are interested in learning more, become a SNOCAP member and sign up for our bi-monthly newsletter: eepurl.com/bfteGf.

Cheers,

The SNOCAP Team -
Don Nease (donald.nease@ucdenver.edu), Mary Fisher (mary.fisher@ucdenver.edu), Matt Simpson, and Victoria Francies
Health care professionals and facilities should be aware of Colorado Senate Bill 65, a new law that became effective January 1, 2018, and requires them to publicly disclose “direct pay” charges for their most commonly performed services. SB 65 was passed in the 2017 legislative session with bipartisan support and created the “Transparency in Health Care Prices Act.”

Under the Act, a “health care provider” is a person licensed, certified, or registered in the state to provide health care services or a medical group, independent practice association (IPA), or professional corporation (PC) providing health care services. “Health care services” means medical, mental, dental or optometric care or hospitalization or other services for the purposes of preventing or treating a physical or mental illness or injury. It includes services rendered through telemedicine.

**Requirements**

Health care providers must make available to the public the health care prices for the 15 most common services they provide. These must be the direct pay prices that a provider charges before negotiating any discounts (often the self-pay amount a patient would pay without insurance or other third party payment). The price which must be disclosed is the standard service charge for a particular diagnosis and does not include any amount charged for complications or exceptional treatment.

The top 15 services must be identified by CPT code, or other coding system accepted as a national standard for billing, with a plain English description. Providers who, in the normal course of practice, regularly provide fewer than 15 services must make available the health care prices for the services most commonly provided.

The price for a specific health care service may be determined from any of the following:

- The price charged most frequently for the health care service during the previous 12 months;
- The highest charge from the lowest half of all charges for the health care service during the previous 12 months; or
- A range that includes the middle 50% of all charges for the health care service during the previous 12 months.

This list must be updated at least annually.

The notice must be made available to the public in a single document either electronically or by posting it conspicuously on the provider’s website if one exists. A practice, IPA, or PC with six or fewer providers with the same license type may comply with the requirement by making the prices available in patient waiting areas. A provider who is a member of a PC that contracts with a single HMO is compliant if the PC or the HMO makes available to the public, either electronically or on its website, the prices for the 15 most common health care services the provider or HMO would charge patients who are not members of the HMO.

The provider must include a disclosure specifying that the price for any given health care service is an estimate and that the actual charges are dependent on the circumstances at the time the service is rendered.

The provider must also include the following statement: If you are covered by health insurance, you are strongly encouraged to consult with your health insurer to determine accurate information about your financial responsibility for a particular health care service provided by a health care provider at this office. If you are not covered by health insurance, you are strongly encouraged to contact our billing office at (insert telephone number) to discuss payment options prior to receiving a health care service from a health care provider at this office since posted health care prices may not reflect the actual amount of your financial responsibility.

A hospital-based health care provider that is not an employee of the hospital where the services are being delivered is not required to provide health care prices for the services the provider renders in the hospital setting.

There are additional requirements for health care facilities under the bill. To view the full bill, go to https://leg.colorado.gov/bills/sb17-065
LIFE THREATENING AIRWAY COMPLICATIONS OF VIRAL UPPER RESPIRATORY INFECTIONS

Case Report

It seems appropriate that I am writing this article on a Saturday afternoon while waiting in the operating room for a child to come up from the emergency room for an urgent bronchoscopy. This 18-month-old male was hospitalized three days recently for typical croup. On the second and third days after discharge he did not seem to be getting much better at home, and presented to the ER this morning febrile with biphasic stridor. He easily desaturated when upset or after coughing, and his voice was increasingly hoarse. Suspecting a complication of his recent URI, we performed a flexible fiberoptic nasal laryngoscopy. That scope showed purulent secretions, percolating back and forth between the vocal cords, with each stridorous respiration. The vocal folds themselves appeared coated with a thick exudate. Our suspicion of bacterial tracheitis seemed confirmed. Rigid bronchoscopic debridement cleared the obstruction, cultures were obtained, and he was transferred to the pediatric intensive care unit for observation and medical management.

With the CDC reporting that this year’s influenza season at “near-epidemic” levels, it should not be surprising that more influenza and other viral upper respiratory infection related complications are high. H3N2 Influenza A seems to have arrived a bit early this year, and is the case with these strains, it causes disease that is more severe and difficult to contain. Holiday travel, a more virulent strain of virus, and poor coverage by the annual influenza vaccine seems to be to blame.

Although myriad complications of viral infections occur, two life-threatening upper airway complications
are seen most frequently. These complications are subglottic/tracheal stenosis and acute bacterial tracheitis.

Early in the respiratory season, croup, or laryngotracheobronchitis, is more common. Croup is classically caused by parainfluenza virus, but any number of viruses, including influenza, can cause this inflammation and swelling immediately below the larynx. The “seal-bark” cough is produced when these inflamed subglottic tissues forcefully contact each other during the paroxysms of coughing. Stridor occurs with the increased airway resistance and labored respirations accompany the narrowed airways. Stridor may be inspiratory at first, but progression to biphasic stridor occurs as swelling progresses. Intubation and mechanical ventilation are not commonly necessary, but when necessary here is where the trouble starts. Intubation in an urgent/emergent setting is never easy or relaxed. The intubation equipment may be incomplete or seldom used for younger patients. Traumatic intubation combined with an endotracheal tube that is slightly too big for the swollen airway is a recipe for disaster.

This inflamed subglottis, surrounded by the cricoid cartilage, is the natural narrowest portion of a child’s airway. The oversized endotracheal tube can easily reduce blood flow to the subglottic mucosal lining and cricoid cartilage, setting up a location for infection and eventual mucosal necrosis. After the acute infection is resolving and extubation things may seem ok for a few hours to days, but fibrosis and scarring begin to occur. Because the cricoid is a complete ring, there is no place for that fibrosis and scarring to proceed but internally. Granulation tissue builds up leading to a more firm, and often permanent, subglottic or tracheal stenosis.

Acute bacterial tracheitis usually occurs sooner after the initial viral insult. It is thought to occur when the viral insult results in loss of mucosal surface cilia. The resulting poor mucociliary clearance allows a secondary bacterial process to take hold, most commonly Staphylococcus aureus and Streptococci. This secondary bacterial superinfection causes tremendous inflammation, mucosal sloughing, and a resulting exudative process. These thick exudates are cleared well, dry out, and progress to increasingly block the trachea. This crusting may lead to a emergent airway that even endotracheal intubation may not solve. These crusts and thick exudate must be debrided or suctioned via rigid bronchoscopy to clear the airway and restore ventilation to the distal lung parenchyma. If caught early, the bacterial process may be limited to the glottis and immediate subglottis. Again, if caught early, surgical debridement may not be necessary, but immediate surgical intervention must be available should more conservative measures fail to rapidly improve airway stability. These conservative measures should include continuous intensive care unit monitoring, humidification, hydration, intravenous broad-spectrum antibiotics to cover Staph and Strep, and intravenous steroids. Although not common, sepsis can and does occur in the child with acute bacterial tracheitis.

Complications of viral upper respiratory infections cannot always be avoided, but early recognition of the signs and symptoms of those complications can mitigate long term consequences.

What to do?
• A high index of suspicion for complications must be maintained. Diligence on the part of providers is of utmost importance.
• Pediatric Intensive Care Unit and Pediatric Otolaryngology consultation should be obtained for any atypical signs, symptoms, or progression of infections.

What is atypical?
• Anything that does not almost immediately respond to normal treatments with corticosteroids, usually dexamethasone, and/or racemic epinephrine followed by close observation in the emergency department or inpatient hospitalization.
• Recurrence of worsening symptoms following a normal, or typical response, to regular management.

Complications of viral upper respiratory infections cannot always be avoided, but early recognition of the signs and symptoms of those complications can mitigate long term consequences. Attention to details in the history, physical examination, and progression of the illness with appropriate treatment are hallmarks of good pediatric care. Early and appropriate consultation with specialists and escalation of monitoring and care are critical to insure complete recovery and the best outcomes for children.

Immediate consultation with providers from all available pediatric specialties is available by calling One Call at Children’s Hospital Colorado, 720-777-3999 or 719-305-3999 (Colorado Springs).
SAFER PRESCRIBING: PRACTICAL STEPS TO HELP KEEP YOU AND YOUR PATIENTS OUT OF DANGER

As most anyone in healthcare can tell you, the prescribing of controlled substances is receiving ever-increasing scrutiny by regulators, the press, and other stakeholders. At CPEP, the Center for Personalized Education for Physicians (www.cpepdoc.org), we see this first hand. We have been providing Clinical Skills Assessments for physicians and other health care professionals for almost 30 years, but, in the past few years the frequency of referrals based on prescribing concerns has escalated. Today, approximately one-third of our Assessment Program referrals are for physicians with identified prescribing problems. Many referred physicians are aware of the current concerns about opioid prescribing and the opioid epidemic, but do not believe that their prescribing habits are any different from that of their colleagues, and are surprised by the Board’s inquiry. Others admit that they may have been uncomfortable with some of their prescribing but felt that they were doing the best they could for their patients with the resources available.

Problematic prescribing patterns can endanger patients and can put physicians’ careers and livelihoods at risk. With all that in mind, are there practical steps prescribers can take to protect themselves and their patients? Here is a partial list of helpful strategies:

**Issue: High-dose prescribing may endanger patients and draw scrutiny**
Published prescribing guidelines do not all agree about what thresholds of dosing should prompt higher levels of screening and caution. There is consensus, however, that higher overall doses of opioids increase the risk of patient mortality.

**Strategy: Exercise caution when dosing and consider referral to specialists**
The Colorado Policy for Prescribing and Dispensing Opioids, released in 2014 and currently under review) states that morphine milligram equivalents per day (MME/d) over 120 are “more likely dangerous” and warrant additional precautions including consideration of referral. The CDC is more conservative, recommending careful reassessment at doses over 50 MME/d and avoidance of doses over 90 MME/d. When appropriate, don’t hesitate to get help from consultants (pain management specialists, addictionologists, or psychiatrists).

**Issue: Opioids and benzodiazepines increase risk and regulators know it**
Licensing boards and other overseeing entities frequently raise concerns about clinicians who have a significant number of patients on both agents.

**Strategy: Avoid concurrent prescribing of benzodiazepines and opioids**
Pay close attention to the FDA’s “black box” warnings and CDC recommendations against co-prescribing of opioids and benzodiazepines. However, be aware that benzodiazepine withdrawal can be dangerous, and tapering can be tricky. Seek assistance from specialists when needed.

**Issue: Patients don’t always act in their own best interests – or yours**
Addiction is insidious – deceptive and crafty. Patients with dependence issues – perhaps even some you have known for years, may be driven to desperate measures you would not expect.

**Strategy: Assess patients for risk of abuse before prescribing and periodically thereafter**
Several risk assessment tools are available, such as the Opioid Risk Tool (ORT), Screener and Opioid Assessment for Patients with Pain (SOAPP®-R), and Current Opioid Misuse Measure (COMM). In addition, obtain a urine drug test before prescribing and at least annually, as recommended in the CDC guidelines.

**Issue: Poor documentation is an invitation to trouble**
There is an old adage that “If you didn’t document it, you didn’t do it.” Licensing boards and others take issue with clinicians who
prescribe controlled substances when the rationale for doing so (and why an alternative approach is not being used) is not evident from the record.

**Strategy: Record as much as you can**

Be aware that gaps in documentation can be viewed with great suspicion by regulators and investigators. Unfortunately, the demands on clinicians’ time seem to increase every day, increasing the temptation to take short cuts in documentation. Resist those temptations and use whatever systems you have available to you to honestly record your patient interactions and the rationale for your clinical decisions.

Want to learn more?

The description of each one of the strategies listed above is really just scratching the surface. One of the best things that you can do to improve your prescribing practices is to become educated about the management of chronic pain. If you’d like to learn more about the management of chronic pain, including non-opioid and non-pharmacologic measures, plan on attending the *Basics of Chronic Pain Management: Essentials for the Non-pain Management Specialist* symposium on April 12th at the 2018 CAFP Annual Summit at the Cheyenne Mountain Conference Center. To register, visit www.coloradoafp.org/summit and select the “Pain Management Pre-Conference Course” option.

---

### Identifying Risky Prescribing Patterns and Safe Prescribing Patterns

(This information originally appeared in Colorado Medicine, Vol. 114, No. 5, Sept/Oct 2017)

<table>
<thead>
<tr>
<th>Risky Prescribing Behaviors</th>
<th>Safe Prescribing Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust that every patient is being totally forthcoming about diagnosis, previous evaluation, and prior treatment.</td>
<td>Trust, but verify. Obtain and review old records.</td>
</tr>
<tr>
<td>Decide that it is not worth assessing risk of addiction until concerns arise.</td>
<td>Routinely assess risk of addiction before initiating – even for short term prescriptions, which could potentially be enough to trigger an addiction in remission.</td>
</tr>
<tr>
<td>Assume that the patient’s prior provider established an appropriate diagnosis and treatment plan.</td>
<td>As for any other condition, assess for legitimate treatment indications before adopting a prior clinician’s treatment plan. This is your patient now and it is your treatment plan.</td>
</tr>
<tr>
<td>Skip checking the Prescription Drug Monitoring Database (PDMP) until concerns arise.</td>
<td>Routinely check the PDMP before prescribing.</td>
</tr>
<tr>
<td>Skip doing drug testing because you don’t want patients to think that you don’t trust them.</td>
<td>Establish office protocols for testing all patients receiving chronic opioids, with frequency based on risk.</td>
</tr>
<tr>
<td>Prescribe controlled substances to self or family.</td>
<td>You and your family have established medical providers to address prescribing needs.</td>
</tr>
<tr>
<td>Prescribe escalating doses of opioids because the patient is not improving.</td>
<td>Reconsider the diagnosis and/or treatment plan. Failure to respond to a reasonable trial of opioids may be reason to lower or discontinue an opioid.</td>
</tr>
<tr>
<td>Fail to be vigilant for signs of diversion.</td>
<td>Do urine drug testing (ideally randomly) to identify inconsistencies and respond appropriately. Consider pill counts, if warranted.</td>
</tr>
<tr>
<td>Sign prescriptions for (or give your computer authentication to) your nurse to do refills while you are on vacation.</td>
<td>Get coverage during your time away.</td>
</tr>
</tbody>
</table>
MEDICATION ASSISTED TREATMENT FOR PATIENTS WITH OPIOID USE DISORDER: GET PAID FOR TRAINING TO HELP YOUR PATIENTS

Like most of us, you probably have patients in your practice right now that have developed an opioid-addiction problem. Medication assisted treatment (MAT) may be an excellent option for them to get the help they need to overcome the problems addiction can cause in their lives and their families. Now, through the IT MATTTRs 2 program, Colorado physicians can get compensated for the time they invest in completing the required DEA training to be able to prescribe buprenorphine in the primary care setting to help their patients with opioid use disorder.

Physicians’ employers can be compensated up to $1000 for completing the 8 hours of required training and applying for their DEA X waiver enabling them to prescribe buprenorphine as a means to help patients with opioid use disorder. Employers of Nurse Practitioners and Physician Assistants can be compensated up to $2040 for their 24 hours of required training.

Interested practices can have their entire office team trained on MAT and opioid use disorder from an expert practice facilitator. The practice facilitation package was originally developed by the High Plains Research Network for practices in Colorado’s Eastern Plains and San Luis Valley. This project allows for clinics in the rest of the state to benefit from the training.

Training the entire clinic—providers and staff—helps members overcome stigma and myths about treating patients with opioid use disorder at the practice and incorporate evidence based processes into their day-to-day workflows. Practices receive $1400 for completing the five one-hour Team Training sessions.

Dr. Barbara Troy, a family physician in Alamosa, CO recently talked about her efforts to provide MAT to patients struggling with opioids. “Our patients need access to this treatment. One or two providers cannot do it alone. We need more physicians and more clinics to provide medication assisted treatments and to start to stem the tide of this epidemic in our local communities.”

Colorado physicians have a special opportunity to increase access to life saving treatments and get paid extra to do it. To sign up for the incentives, practice facilitation or to learn more, visit the IT MATTTRs 2 website at http://www.practiceinnovationco.org/itmatttrs2/providers/

Or contact Dr Knierim at Kyle.Knierim@UCDenver.edu

IT MATTTRs 2 funding for both the provider incentives and practice facilitation comes from the Colorado Office of Behavioral Health as a part of the State’s Targeted Response to the Opioid Crisis project.

IT MATTTRs 2 Information Technology for Medication Assisted Treatment and Team Training in Rural Colorado is convened by the Department of Family Medicine at the University of Colorado School of Medicine.

Free training for Providers is available online at http://www.practiceinnovationco.org/itmatttrs2/providers/

Or a hybrid of online and four hours in person

Grand Junction: Tuesday, March 27th, 2018

Denver Hosted: Wednesday, March 28th, 2018

Colorado Springs: Thursday, April 19th, 2018

Durango: Friday, April 27th, 2018

Denver: Wednesday, June 13th, 2018

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.
2018 CAFP Annual Summit
Through the Decades
A Celebration of CAFP’s 70th Anniversary

April 12-15, 2018
Cheyenne Mountain Conference Center
Colorado Springs, CO

Thursday, April 12

8:00 AM
Basics of Chronic Pain Management: Essentials For the Non-pain Management Specialist
Steven Wright, MD
Abby Anderson, MD
Haley Burke, MD
Lisa W. Corbin, MD, FACP

12:00 PM
Knowledge Self-Assessment: Heart Failure
Nida Awadallah, MD

2:00 PM
PALS Skill Verification
Kristin Paston

1:15 PM

3:30 PM
BLS Skill Verification
Kristin Paston

2:15 PM

3:45 PM
ACLS Course
Kristin Paston

5:00 PM
### Thursday, April 12 Continued

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>5:30 PM</td>
<td>Conference Welcome- Drinks &amp; Light Appetizers (Included in Registration)</td>
</tr>
</tbody>
</table>
| 6:00 PM | Violence in the Healthcare Workplace: A Roundtable Discussion  
*Monica Morris, DO* |
| 7:30 PM | Dinner in Mountain View Restaurant (Included in Registration)         |
| Close  |                                                                      |

### Friday, April 13

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:20 AM</td>
<td>Conference Welcome &amp; Door Prize Drawing</td>
</tr>
</tbody>
</table>
| 8:30 AM | COPIC Talk- Breast Density Notification Required by Law in Colorado: What Providers Need to Know  
*Mary Freivogel, MS, CGC* |
| 9:30 AM | CDPHE Vaccine Talk: Reportable Zoonoses in Colorado  
*Jennifer House, DVM, MPH, DACVPM* |
| 10:30 AM | Break                                                                 |
| 10:45 AM | Keynote Address  
*T. R. Reid* |
| 11:45 AM | Lunch- Awards & Board Installation, Past President’s Presentation (Included in Registration) |
| 1:30 PM  | infoPOEMS- Acute Respiratory Infections  
*Mark Ebell, MD* |
| 2:00 PM  | infoPOEMS- Atrial Fibrillation / Anticoagulation  
*Gary Ferenchick, MD* |
| 2:30 PM  | infoPOEMS- Musculoskeletal: Back and Knees  
*John Hickner, MD* |
| 3:00 PM  | Exhibit Hall Break                                                    |
### Friday, April 13 Continued

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:45 PM</td>
<td>infoPOEMS- Useful Tools for Point of Care Testing</td>
</tr>
<tr>
<td></td>
<td>Mark Ebell, MD</td>
</tr>
<tr>
<td>4:15 PM</td>
<td>infoPOEMS- Hyperlipidemia</td>
</tr>
<tr>
<td></td>
<td>Gary Ferenchick, MD</td>
</tr>
<tr>
<td>4:45 PM</td>
<td>infoPOEMS- Men’s Health</td>
</tr>
<tr>
<td></td>
<td>John Hickner, MD</td>
</tr>
<tr>
<td>5:15 PM</td>
<td>infoPOEMS- Editor’s Choice</td>
</tr>
<tr>
<td></td>
<td>Mark Ebell, MD, Gary Ferenchick, MD &amp; John Hickner, MD</td>
</tr>
<tr>
<td>5:30 PM</td>
<td>Door Prize Drawing</td>
</tr>
<tr>
<td>5:35 PM</td>
<td>Exhibit Hall Reception: “Through the Decades” - Join the Exhibitors for Drinks &amp; Light Refreshments (Included in Registration)</td>
</tr>
<tr>
<td>7:00 PM</td>
<td>Dinner in Mountain View Restaurant (Included in Registration)</td>
</tr>
<tr>
<td>8:00 PM</td>
<td>Student and Resident Beer &amp; Wine Tasting</td>
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<tr>
<td></td>
<td>End</td>
</tr>
</tbody>
</table>

### Saturday, April 14

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 AM</td>
<td>Breakfast Discussion on Wellness- Working Off Stress: A Path Towards Resiliency</td>
</tr>
<tr>
<td></td>
<td>Joshua Scott, MD, PhD</td>
</tr>
<tr>
<td>8:25 AM</td>
<td>Door Prize Drawing</td>
</tr>
<tr>
<td>8:30 AM</td>
<td>infoPOEMS- Liver &amp; GI Update</td>
</tr>
<tr>
<td></td>
<td>Mark Ebell, MD</td>
</tr>
<tr>
<td>9:00 AM</td>
<td>infoPOEMS- Hypertension</td>
</tr>
<tr>
<td></td>
<td>Gary Ferenchick, MD</td>
</tr>
<tr>
<td>9:30 AM</td>
<td>infoPOEMS- Asthma &amp; COPD Update</td>
</tr>
<tr>
<td></td>
<td>John Hickner, MD</td>
</tr>
<tr>
<td>10:00 AM</td>
<td>Break</td>
</tr>
<tr>
<td>10:15 AM</td>
<td>infoPOEMS- Editors Choice</td>
</tr>
<tr>
<td></td>
<td>Mark Ebell, MD, Gary Ferenchick, MD &amp; John Hickner, MD</td>
</tr>
</tbody>
</table>
Saturday, April 15 Continued

11:00 AM
infoPOEMS- Screening Update
Mark Ebell, MD

11:30 AM
infoPOEMS- Dementia & End of Life Care
Gary Ferenchick, MD

12:00 PM
infoPOEMS- What’s Up with Vitamins?
John Hickner, MD

12:30 PM
All-Member Business Lunch and Legislative & Advocacy Update in Remington’s Room (Included in Registration)

2:00 PM
Building a Healthcare System That Patients Can Trust
David Silverstein

3:00 PM
Ophthalmology for the Non-ophthalmologist
TBD

4:00 PM
Center for Improving Value in Healthcare
Tamaan Osbourne-Roberts, MD

4:00 PM
Procedural Workshop- Splinting & Casting
Cory Lyon, DO, FAAFP
Jack Spittler, MD

5:00 PM
Door Prize Drawing

5:05 PM
All Member Happy Hour and Student & Resident Poster Session in Registration Area- Check Out Research Done by Colorado Students & Residents and Vote for Your Favorite (Included in Registration)

6:00 PM
Dinner in Mountain View Restaurant (Included in Registration)

End

Sunday, April 15

7:55 AM
Door Prize Drawing

8:00 AM
COPIC Talk- Case Studies in Infectious Disease
Eric Zacharias, MD

8:00 AM
Student & Resident Track- Alternative Practice Models
Anibal Martinez, MD & Mark Tomasulo, MD
Sunday, April 15 Continued

9:00 AM
The Importance of Early Detection of Ankylosing Spondylitis
Barbara Goldstein, MD

10:00 AM
Break

10:15 AM
Obesity
Carolynn Francavilla-Brown, MD

11:15 AM
Climate & Environmental Health
Matthew Burke, MD, FAAFP

12:15 PM
Grand Travel Prize Drawing

12:20 PM
Student & Resident Track- Debt Managament & Budgeting
Jay Sorensen Navarre & Joe Matelich

Student/Resident Track- Motivational Interviewing & Difficult Conversations
Deb Seymour, PsyD

Register Today at www.coloradoafp.org/summit. Questions? Contact Erin Watwood at erin@coloradoafp.org or 303-696-6655.

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ACCESS TO SPECIALTY CARE IN AURORA, COLORADO: eCONSULTS AS AN IMPORTANT PIECE OF THE PUZZLE

Background

Colorado, like many other states, struggles in providing underserved patients with access to specialty care. In its recent report, Managing Medicaid in Colorado (1), the Colorado Health Institute outlines the key challenges and opportunities with Medicaid expansion, as more than 1.3 million Coloradans are now covered by Medicaid. In 2014, Medicaid caseload increased by 49.2% in Colorado, and in Denver, 60,000 more people had Medicaid at the end of 2014 than the beginning of the year.(2, 3) While the result of this was a remarkable increase in health insurance coverage in Denver from 83% to 94%, it has also magnified existing challenges in access to specialty care for Medicaid populations.

This brief report will discuss an innovative demonstration project, and example of a public-private partnership between Aurora Health Access and RubiconMD, to test the feasibility of an electronic consultation solution to address these challenges. Electronic consultations, or eConsults, have been gaining increasing uptake in the United States as a streamlined clinician-to-clinician interaction that leads to improved access to specialty care, efficiency, better care coordination, lower costs and high PCP satisfaction.(4-9)

Partners

Aurora Health Access and Doctors Care

Aurora Health Access (AHA) is a community-based health alliance, whose mission is to improve access to care and create a healthier Aurora, with a focus on the most vulnerable and underserved. Working in and for Aurora, Colorado since 2009, the membership includes over 1,700 individuals working in and around Aurora’s health care sector. In 2015, in response to member concerns, AHA formed the Access to Specialty Care (ASC) Task Force. The charge to the Task Force was to assemble stakeholders, learn about Aurora’s specialty care access barriers, and identify potential solutions. The focus for the Task Force was on the impact to vulnerable populations: those insured by Medicaid, undocumented individuals, those without insurance, and those with high deductible plans.

One valued partner throughout this phase, was Doctors Care, a private, nonprofit organization dedicated to improving access to healthcare for low-income, medically underserved individuals in the South Metro area. Through leveraging their internal membership and working with external partners, the ASC Task Force sought to test the impact of eConsults in the region using RubiconMD.

RubiconMD

RubiconMD’s mission is to democratize medical expertise and provides a robust network of highly skilled specialists and subspecialists across the country through an intuitive, user-friendly electronic platform of electronic consultations between Primary Care Providers (PCPs) and specialists. These eConsults are a HIPAA-compliant modality of connecting PCPs to specialty care clinicians for consultative questions using a web-based platform, E.H.R. integration, or mobile application. PCPs using RubiconMD have access to over 150 specialties and subspecialties, including adult, pediatric and behavioral health specialties.

The Demonstration Project

In 2017, AHA, Doctors Care, and RubiconMD launched an eConsult demonstration project in the Aurora/Denver Metro region. The partnership set out to offer 120 eConsults through RubiconMD over a 4-month period to PCPs in the Aurora/Denver metro area. PCPs participation was completely voluntary.

Methods

All eConsults submitted on the RubiconMD platform by Colorado PCPs during the demonstration project period, June 1, 2017 - October 31, 2017 were eligible for analysis. Data from the RubiconMD platform was analyzed using simple statistical methodologies in SQL and Python. This data analysis was deemed exempt by the University of California, San Francisco’s Institutional Review Board (IRB #17-23022).
Results

Participants: 20 PCPs across the metro Denver region participated in the demonstration project. PCPs represented a diverse range of primary care settings and clinicians (Table 1).

<table>
<thead>
<tr>
<th>Practice Setting (n = no. sites)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Primary Care</td>
<td>15</td>
<td>75%</td>
</tr>
<tr>
<td>FQHC/Community Health Center/Safety Net Clinic</td>
<td>4</td>
<td>20%</td>
</tr>
<tr>
<td>Employer Onsite Clinic</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PCP Type (n = no. of PCPs)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>12</td>
<td>60%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>4</td>
<td>20%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Nurse Practitioner/Physician Assistant</td>
<td>4</td>
<td>20%</td>
</tr>
</tbody>
</table>

Table 1. Participant and Practice Characteristics

eConsult Traffic and Utilization

During the 5-month demonstration project, PCPs submitted 236 eConsults on the RubiconMD platform, on average 11.1 eConsults per PCP (Figure 1).

Figure 1. eConsult Users and Traffic by month.

eConsults by Specialty

Of the 236 eConsults submitted to RubiconMD during the 5 months, the five most commonly used specialties were Dermatology, Endocrinology, Neurology, Cardiology and Hematology (Figure 2).

Figure 2. eConsult Use by Specialty

Turnaround time

RubiconMD promises eConsult turnaround time (TAT) within 12 business hours. TAT is the time from submission of the eConsult by a PCP to the time that the specialist submits a response. For the eConsults submitted in this demonstration project, the median turnaround time for eConsults was under 4 hours – 3:56:00 (3 hours and 56 minutes).

PCP and Specialist Submission Time

PCP submission time is the amount of time spent by a PCP in submitting an eConsult. Specialist submission time is the amount of time spent by a specialist responding to an eConsult.

In this demonstration project, the median PCP submission time was 9 minutes, 37 seconds. For specialists, the median submission time for responses was 5 minutes, 8 seconds (Figure 3).

PCP Case Creation Time

Specialist Response Creation Time

Figure 3. Average Submission Times for PCP and Specialist

CONTINUED ON 24 >>
PCP Reported Satisfaction

At the completion of every eConsult, PCPs are given the option to rate the quality of their experience and the specialist response using a familiar and simple 1 to 5 star rating scale. For the eConsults in this demonstration project, the average rating was a 4.92 out of 5.00.

PCP Reported Impact

When a PCP closes an eConsult case, they are additionally asked to report an “outcome” of the eConsult, or the impact of the eConsult. This is provided in a drop-down menu and providers may choose more than one of the five listed outcomes (Figure 5).

PCPs in this demonstration project reported that the eConsult Improved their care plan (81%) was educational for them (61%), avoided a diagnostic study that may not have been needed (40%), avoided a referral (18%) or had no effect (1%). Figure 4 depicts these findings.

Figure 4. PCP-reported eConsult Impact

Qualitative Feedback

We conducted informal user interviews with 20 PCPs in the demonstration project to better understand their experience using the platform and the value of eConsults on their work and patient care. Through these informal interviews with PCPs in the Greater Denver region, three themes emerged - educational value, patient experience & satisfaction and empowerment and referral utilization.

Conclusions

In this small demonstration project, spearheaded by the Aurora Health Access’ ASC Task Force, we found that leveraging a high quality electronic consultation platform led to improved and timely access to specialist expertise, particularly in specialties of greatest need in the region; achieved high levels of PCP satisfaction, improved PCP care plans and had high educational value; strengthened the patient experience, and reduced referral utilization.

While this project was limited to a specific region in Colorado, the implications are important for metro Denver and the rest of the state, as it contends with both the challenge and the opportunity of an expanded Medicaid population that will most certainly require better access to specialty care.

References:


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.
U.S. adults do not receive MMR vaccine before traveling abroad

A majority of U.S. adults “who should get vaccinated against measles before traveling abroad don’t do it,” according to a study published in the Annals of Internal Medicine (tinyurl.com/ybr9kzwa). The article reports that the Centers for Disease Control and Prevention (CDC) “recommends two doses of the MMR (measles, mumps, and rubella) vaccine for adults traveling outside the U.S. who were born before 1957 and lack either a documented measles infection, records of adequate vaccination, or a positive blood test for immunity to measles.” The study found that “slightly more than half of international travelers in the United States who were eligible to receive the MMR vaccine before traveling did not get vaccinated between 2009 and 2014.” In particular, the CDC is advising that due to “outbreaks of the disease in some popular vacation destinations” that “Americans traveling to Europe … take steps to protect themselves against measles.” (tinyurl.com/yd4q58t) European countries reporting cases of measles over the last year include “Austria, Belgium, Bulgaria, the Czech Republic, Denmark, France, Germany, Hungary, Iceland, Italy, Portugal, Slovakia, Spain, Sweden, and the United Kingdom, according to the European Center for Disease Prevention and Control.”

A decline in measles vaccination rates could triple number of infections

Routine childhood vaccination is declining in some regions of the U.S. due to vaccine hesitancy, which risks the resurgence of many infectious diseases with public health and economic consequences. How does vaccine hesitancy affect annual measles cases and economic costs in the United States? The surprising answer from a recent study in JAMA Pediatrics estimating that just a five percent decline in measles vaccination rates could triple the number of young children who get infected with the virus in the U.S. Currently, about 93 percent of youngsters “aged 2 to 11 years old get the measles vaccine,” but “if this vaccination rate dropped to 88 percent, it could result in at least 150 additional measles cases a year and cost government health programs $2.1 million, not counting hospital bills,” the study estimated. (tinyurl.com/y8j3ckzf)

ACIP OKs 3rd MMR vaccine dose for at-risk individuals

College students who received a third dose of the measles, mumps and rubella vaccine during a mumps outbreak at the University of Iowa in 2015 were 78% less likely to develop mumps, compared with their peers who had only received two MMR vaccine doses, CDC researchers reported in The New England Journal of Medicine. The findings also showed a 9.1 times increased risk of mumps among those who received their second MMR vaccine dose at least 13 years before the outbreak, compared with those who had their second vaccine dose two years before the outbreak. (tinyurl.com/y946uokz) As a result, the CDC’s Advisory Committee on Immunization Practices (ACIP) recommended an additional dose of MMR vaccine for people who have been vaccinated twice but face increased odds of developing mumps because of an outbreak. However, the guidance in the agency’s Morbidity and Mortality Weekly Report (MMWR), which supplements 2013 guidelines, continues to advise only two doses of MMR vaccine for the general population. (tinyurl.com/ybq6eeoo)

Guidance spurs increase in vaccinations among pregnant women

A CDC report showed the rate of tetanus, diphtheria and pertussis vaccinations among pregnant women in the U.S. increased from less than 1% before 2009 to 54% in 2015. “These increases reflect the implementation of evolving recommendations, which currently recommend that all pregnant women be vaccinated during each pregnancy, ideally in the third trimester,” researchers wrote in the CDC’s MMWR (tinyurl.com/ybpu4t48). Despite the large vaccination rate increases, the researchers warned that the prevalence of Tdap vaccination remains far below the ACIP recommendation that every woman be vaccinated during each pregnancy. “Increasing vaccination coverage during pregnancy could help reduce the impact of pertussis on infant morbidity and mortality,” the CDC wrote.

New acellular pertussis vaccine may solve waning immunogenicity problem

Researchers at the annual meeting of the European Society for Paediatric Infectious Diseases reported on a novel, monovalent, acellular pertussis vaccine containing a recombinant, genetically inactivated pertussis toxin displayed markedly greater sustained immunogenicity than the widely used Sanofi Pasteur Tdap, known as Adacel (tinyurl.com/yd8ovnue). The impetus for developing new acellular pertussis vaccines is the documented resurgence of pertussis in the face of the fast-waning immunogenicity of the currently available vaccines. We’ll be watching the ongoing research into this new vaccine development.

FDA approves first 2-dose hepatitis B vaccine

The FDA approved the first 2-dose hepatitis B vaccine (Heplisav-B, tinyurl.com/y7bxyoygc). The vaccine is indicated as prophylaxis against all
known HBV subtypes in adults aged 18 years of age or older. The two 0.5 mL doses are administered 4 weeks apart. Of significance, the vaccine failed to gain approval in February 2013 and again in November 2016. The largest of three studies reported a higher rate of myocardial infarction (0.3% vs 0.1%) versus the comparator 3-dose vaccine (Engerix-B, GlaxoSmithKline). The FDA announced a postmarketing safety study will be implemented. On the positive side the approval was based on immunogenicity data from randomized, blinded, multicenter phase 3 clinical trials, showing a greater seroprotection versus Engerix-B in: adults aged 18-55: 95% vs 81.3, adults aged 40-70: 90.1% vs 70.5%, and adults aged 18-70: 95.4% vs 81.3%. Adverse events were not insignificant and included injection site pain (23-39%), fatigue (11-17%), and headache (8-17%). The manufacturer in the U.S., Dynavax, expects to commercially launch Heplisav-B in the United States in the first quarter of 2018.

Should you vaccinate psoriasis patients for Herpes Zoster?

Patients with psoriasis are already at risk for Herpes Zoster (HZ); however, patients with psoriasis who use the biologic, tofacitinib (Xeljanz), are at even increased risk for HZ. Of these patients, those of Asian descent, on higher doses, elderly patients, and those who have used biologics in the past are at even greater risk. Seven percent of those with HZ had to be hospitalized, while eight percent had multidermatomal HZ. The bottom line? Family physicians should consider vaccinating these high-risk patients. The study was published in The Journal of the American Academy of Dermatology (tinyurl.com/y9rggx6l).

Pre-vaccination water intake doesn’t prevent presyncope in adolescents

Teens who received intramuscular vaccines within 10 minutes to 60 minutes after drinking 500 mL of water had similar presyncope occurrence in the primary or restrictive outcomes, compared with those who received usual care, researchers reported in Pediatrics (tinyurl.com/yaczbpap). The findings, based on data involving 1,807 youths ages 11 to 21, also showed that presyncope was tied to younger age, pre-vaccination anxiety, receiving two or more injected vaccines, history of passing out or nearly passing out after an injection or blood draw, and increased post-vaccination pain.

CDC Recommends Cholera Vaccine for Certain Travelers

The CDC is now recommending that adults traveling to areas of active cholera transmission receive a recently-approved, single-dose oral vaccine. The vaccine was approved by the FDA in 2016 after a fast-track and priority review designation. The CDC’s ACIP finalized its recommendation last May, making it the only U.S.-approved vaccine against cholera. Three other vaccines are recommended by the World Health Organization (WHO) but are not available in the United States. (tinyurl.com/yawa3qug)

Pediatric flu vaccinations tied to reduced flu hospitalization risk

Children ages 6 months to 23 months and those ages 2 years to 4 years who were fully vaccinated against influenza were 48% and 67% less likely to be hospitalized due to flu, respectively, compared with those who weren’t vaccinated, Canadian researchers reported in PLOS ONE (tinyurl.com/y92z5bhg). The findings also showed a 39% lower odds of flu-related hospitalization among those who were partially vaccinated.
Cleveland Piggott, MD, a resident at the University of Colorado Family Medicine Residency, has always been drawn to a life of service and promoting social justice.

His parents, Cleveland Sr. and Sandra, immigrated to the United States from Panama.

“I saw the sacrifices they made to help me,” says Dr. Piggott. “It made me want to help those who haven’t always had it easy.”

Fulfilling the desire to help others through family medicine wasn’t always on the top of Dr. Piggott’s list of interests, however. He considered political work, going into ministry, and even becoming a ballroom dancer. But an influential 9th grade biology teacher and a desire to create big change while still helping people one on one eventually guided Dr. Piggott to medicine. As an undergraduate Dr. Piggott attended a family medicine focused conference, and by the end of his first year of medical school, he knew family medicine would be his path. Another thing that solidified his decision? Never being told he shouldn’t do family medicine.

Dr. Piggott recognized how many students are discouraged from choosing family medicine, despite how closely the values that brought them to medical school, like changing the world and doing good, align with family medicine. Seeing a lack of family medicine mentorship across the medical education community, Dr. Piggott has set out to change the conversation at the University of Colorado. He started a mentorship program at CU, linking medical students with family medicine residents or faculty who have similar family medicine interests. He has also started an advocacy group that promotes family medicine on the CU campus. The group tackles projects like increasing preceptors, working on curriculum design and engaging in projects that encourage family medicine interest. One project in particular is a video series called “Today in Clinic,” where residents and faculty members can share more about what they do and why they love family medicine.

What is it that keeps Dr. Piggott energized and engaged with medical students?

“I think it’s related to my interest in social justice,” Dr. Piggott says. “If I can improve systems, help others succeed, help a small community succeed, that is rewarding for me.”

And Dr. Piggott’s contributions to the medical school and residency have not gone unnoticed.

“During residency, Dr. Piggott has become known as a strong leader at the local, regional, and national levels. We are fortunate that Cleveland has brought his considerable talents to the University of Colorado Family Medicine Residency Program and has already made significant contributions during his first two and a half years of training,” says Linda Montgomery, MD, FAAFP, Program Director at the University of Colorado Family Medicine Residency. “It came as no surprise that he was elected as a chief resident and has stepped into that role with enthusiasm and fresh thinking.”

Despite Dr. Piggott’s busy life outside of patient care, he has far from neglected that vital part of family medicine.

Dr. Piggott witnessed the struggles his family faced when his Grandfather was diagnosed with Alzheimer’s. It gave him insight into caregiver burnout, and the importance of helping people in their most difficult times.

Even and especially with patients that may be considered challenging, Dr. Piggott always tries to empathize with the experiences of others.

“I feel privileged to be where I am and have what I have. When patients are difficult or challenging, I try to see it from their lens. How hard it must be to have that illness or have that background,” says Dr. Piggott.

Faculty members at the residency have noticed the impact that Cleveland has on patients.

“Cleveland has been successful early in his young clinical career in the outpatient and inpatient setting. He has demonstrated kind, compassionate, thorough, evidence based care to his patients in these settings. He manages a patient panel that he is passionate about and that are very committed to him,” says Corey Lyon, DO, FAAFP, Associate Professor and Associate Program Director of the University of Colorado Family Medicine Residency. “All of his patients have benefited by the complete and compassionate care he provides.”

After graduating from residency this spring, Cleveland will be continuing at the University of Colorado Family Medicine Residency, doing fifty percent clinical work and fifty percent medical student and residency education. Clearly, the next generation of family medicine physicians in Colorado are in good hands.
Leaders come in all forms. For over 25 years, Dr. John Lee Miller has been a quiet but inspirational leader to the faculty and residents at the St. Anthony North Family Medicine Residency Program.

In the numerous letters of recommendation received for Dr. Miller’s nomination, colleagues and residents reflected on Dr. Miller’s humble, selfless, and incredibly hard-working nature. His dedication to patients and fellow physicians manifested in a willingness to be the last car in the parking lot at night, or to always volunteer to work on Christmas, or to take the late-night phone calls of residents who had questions or concerns.

Colleagues also spoke of Dr. Miller’s incredible wealth of knowledge. Throughout his career Dr. Miller has had many different experiences that contributed to his diverse expertise.

Before coming to St. Anthony North, Dr. Miller worked in New Mexico with the Indian Health Service, serving as a physician, chief of the department, and as an educator, training American Indian physician assistant students. After leaving New Mexico Dr. Miller and his wife, Katherine Miller, MD (also a family physician) opened a private family medicine practice in Canon City Colorado, where they performed full spectrum rural family medicine, including obstetrics.

Dr. Miller is also a passionate researcher. In his time at St. Anthony North Dr. Miller created the Rocky Mountain Research Forum, and has continued to mentor residents in their own research projects throughout the years.

Ultimately, however, it is Dr. Miller’s demeanor that has had an impact on so many that he has worked with. In teaching the next generation of family physicians, he exemplified what a great family physician truly is.

“Dr. Miller helps me to remember why I want to be a doctor,” says Matthew Mullane, a 2016 St. Anthony North Graduate. “His example reminds me that a good doctor strives to create an environment of humility, compassion, friendship and service wherever she or he goes.”

For Dr. Miller, working with residents was simply another way to enjoy the practice of family medicine.

“The residents were energetic and very bright. They keep you current and take you into the future. It’s fun watching them develop and graduate, and see where they go after residency,” says Dr. Miller. “I believe I got more out of it than the residents did.”

While the experience might have been important for Dr. Miller, it is impossible to ignore the impact he has had on those around him.

Dr. Miller retired in 2017, though he continues to precept. Who he is, his work, and his legacy remains with those he worked alongside.

“Dr. Miller should have a statue of himself erected outside St. Anthony’s.”

“Dr. Miller has been an incredible example of what a family medicine physician should be: humble, inquisitive, selfless. Many of us who know Dr. Miller know him as a very soft-spoken person. I have never once heard him complain; I have never heard him raise his voice much more than a whisper. That is a pretty unique characteristic for someone of his intelligence and wisdom,” says Matt Ludemann, MD, a former resident and current faculty member at St. Anthony North. “While he would never say this himself, he has had a profoundly impactful career. Dr. Miller should have a statue of himself erected outside St. Anthony’s.”
WELCOME NEW MEMBERS

The CAFP would like to welcome the following new members who joined our organization in December, January and February.

NEW ACTIVE MEMBERS
BIANCA BRYANT-GREENWOOD, MD
SAMUEL CLOUD, MD
RYAN EVANS, MD
KATHRYN GOEKE, MD
ANNE GOYETTE, MD
MORGAN LAUER IRION, MD
JOY MAGRUDER, MD
JEFFREY MANUEL, MD
SAMANTHA MATNEY, MD
TIMOTHY MOSER, MD
MEGAN TRAXINGER, DO
JESSICA WALKER, MD
ROSEMARY ANDRIANAKOS, DO
JOHN DYGERT, DO
AARON FRASER, DO
JACQUELYNN GOULD, MD
NANCY MOYA, MD, FAAFP
CLANDRA ROBINSON, MD
JENNIFER SAPP, DO
RAYMATTIE SINGH, MD
SUSAN TAYLOR, MD
PEGGY WRICH, DO
KALINDI BATRA, MD
JENNIFER CARAGOL, MD
TIMOTHY COLEMAN, MD
HEATHER HOLMSTROM, MD
LIAM LUNSTRUM, DO
ALEXIS MICHOPOULOS, DO
JOHN RIBADENEYRA, MD
MELISSA SCHMALZ, DO
PAMELA ALENZA, MD
STEPHEN WILLS, MD
TONYA WREN, MD

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TYLER ARGYLE
NEAL FERRIN
ROBIN HARLAND
DEVYN HOLMSTEAD
KABIR HUSAIN
RYAN MASTERSON
HEIDI YEN
ERIKA ANDERSON
JACKSON BELL
KIAN BIDANJIRI
GAVIN CARDWELL
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MYKENZIE MATTHEIS
MARK MCCORMICK
MAI NGUYEN
AARTI PRASAD
TAYLOR REISER
HAYDEN SCHUETTE
JORDAN VERLARE

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Roaring Fork Family Practice in Carbondale is delivering innovative, whole-person care through an integration of behavioral and physical health. Gary Knaus, MD, one of the founders of the practice, has been providing exceptional care to patients in Carbondale and beyond for over 35 years.

This year they are both being honored. Dr. Knaus with the 2018 CAFP Family Physician of the Year Award, and Roaring Fork Family Practice with the CAFP Foundation’s 2018 Patient-Centered Innovation Award.

For Dr. Knaus, care is about what is right for the patient. He is known for being one of the rare physicians who still makes house calls. While it may seem like an exceptional thing to do, Dr. Knaus just sees it as part of good patient care.

“So much of healthcare is about building relationships...
over time,” he says. “It’s [making house calls] an extension of that key pillar of what we do as primary care doctors.”

House calls are also a way for patients to be at ease, and it takes another challenge out of their day, particularly for older patients.

“It’s a time to get to know people in a different way. It’s relaxed, it’s in their living room,” says Dr. Knaus. “My philosophy is, if it’s easier for me to drive four blocks than for the patient to spend hours getting ready and finding transportation, then I should do it.”

And that exceptional care, both in the clinic and out, is not lost on patients.

“He has patients from Rifle who dutifully drive past numerous other primary care office on the fifty-minute drive to our clinic to see Gary,” says Lauren Sontag, MD, a fellow family physician at Roaring Fork Family Practice. “It is clear that he exemplifies what it is to be a family physician: a kind heart, an eager mind, and a listening ear, all with a deep commitment to community.”

Being part of a community is important to Dr. Knaus. Practicing in a mountain area like Carbondale has meant that patients are friends and neighbors. As a family physician, Dr. Knaus can have an even better understanding of those he treats. He knows what a family might be going through, or the circumstances a patient comes from.

Dr. Knaus is also an active member of the broader medical community. He sits on the Board of Rocky Mountain Health Plans, and helped Roaring Fork Family Practice to be an early adoptor of Electronic Health Records, and a participant in CPCI and other practice transformation activities. Why has Dr. Knaus found such activities so important?

“I guess I’m a big picture guy. I can see the broader view of how things work. It’s an advantage we have as primary care doctors, because we know how the whole system fits together,” he says. “CPCI and practice transformation has really transformed how we work. It has reenergized the practitioners, doctors who have been in practice twenty, thirty, forty years. It makes you current and keeps you vital.”

The importance of innovation and transformation in practice is also what led Roaring Fork Family Practice to create a program integrating behavioral and physical health for patients. When they started practice transformation efforts, the practice was determined to help patients who had behavioral healthcare concerns, but found themselves always making referrals to outside resources. That left the responsibility with the patient to take the next steps. The practice felt that if they were truly to provide whole-person, patient-centered care, they had to stop being just a coordinator of care and instead become a provider of care.

In mid-2015 the practice hired their first full time integrated behavioral health specialist. Combining funds from practice transformation programs and refining their billing process has allowed the Licensed Clinical Social Worker to remain on staff.

The practice has started many different programs and projects since integrating behavioral health. They provide group visits for chronic pain patients to empower them with self-management strategies using cognitive behavioral therapy. Roaring Fork Family Practice has also been able to do more community outreach on the topic of behavioral health, connecting with local schools, nursing homes, and other relevant community groups.

Integration of behavioral health has changed the practice and the lives of patients in many ways. When the practice brought on a Licensed Clinical Social Worker, only 9.64% of patients were being screened for clinical depression, and assisted with follow up. Today that number is up to 62%. But it is the impact on patient lives that has made the practice most proud. They have been able to help patients find funds for life-changing dental work, access stable housing, navigate the challenges of caring for a loved one, and much more.

Behavioral health in the practice has even stretched beyond patients, to the doctors and others providing care.

Dr. Knaus attended the AAFP’s 2017 Family Medicine Experience conference, and heard a great deal about the growing problem of provider burnout. Recognizing what a problem this could be in his own practice, Dr. Knaus brought the information back to Colorado. Now, the practice’s Licensed Clinical Social Worker has developed a joy of practicing initiative to help providers and employees work through the challenges they are facing.

Dr. Knaus is proud of the work Roaring Fork Family Practice is doing, and indeed what all of family medicine is doing.

“Those outside of medicine, if they could see what primary care does behind the scenes to help it would be eye opening for them,” he says. “So much of the medical is caught up in the political. But we are reinventing how we work and it is for the good.”
As part of the CAFP Discount Program, the following companies are offering special pricing and opportunities to CAFP members.

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