SUMMER 2018

FP COLORADO

FAMILY PHYSICIAN

JOHN BENDER, MD, FOR AAFP PRESIDENT-ELECT.

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CAFP ANNUAL REPORT 2017. A YEAR IN REVIEW. PG. 19

FIGHTING ADDICTION IN RURAL COLORADO. PG. 44

COLORADO ACADEMY OF FAMILY PHYSICIANS
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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.

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COLORADO FP FAMILY PHYSICIAN

SUMMER 2018

Edition 56

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PRESIDENT'S REPORT

BY: ZACH WACHTL, MD

Can't We Just Do an I&D On Payment Reform?

Much of what I do in my clinical practice doesn't provide immediate gratification, and I have come to accept that as just part of the job. Does counseling on smoking lead to an immediately noticeable decrease in lung cancer death rates? Does lowering an A1c save someone's life tomorrow? Does the end of a 15-minute preconception counseling visit end with the delivery of a healthy term baby? Clearly those answers are NO, but as family physicians we believe, and evidence shows us, that our efforts DO indeed make a difference long term.

Working with the CAFPs legislative committee over the last 7 years has often mirrored my experience in clinical practice. We advocate for the best interests of our patients, and yet healthier communities do not appear at the end of a conference. Testifying in front of a committee on changes necessary to protect the interests of family physicians doesn't immediately remove prior authorizations, paperwork or other burdensome administrivia. Although HB18-1365, our Primary Care Investment Initiative, was well received, our efforts did not succeed in increasing the share of the health care dollar that goes towards our primary care practices. But we will continue all of these fights, knowing they are central to our viability as health care providers, and believing we are moving the needle.

Sometimes though, it is rewarding to see the immediate results of your labors. There's nothing like the satisfaction of a good I&D of an abscess, or IUD insertion, or repair of a laceration to break up the office visits with treatment plans predicated on long-term future rewards. With that in mind, I am taking a brief detour from my legislative focus to work on an issue that I believe we can make concrete measurable changes as an academy: our role as community leaders on environmental sustainability and the health effects of climate change on our patients.

I would like to (re)introduce you to the Medical Society Consortium on Climate and Health, of which the AAFP is a signatory. I'd encourage you to look at their information available at https://medsocietiesforclimatehealth.org/, as they have invaluable data showing how climate affects our patients and communities. I have had the opportunity to attend several talks by this organization during my tenure as a CAFP executive board member, and have been energized (pun intended) by their presentation. Because of this, I have asked that the CAFP create a taskforce to investigate how we can be active in two different arenas: 1) How can the CAFP office and activities be more conscious of environmental sustainability and renewable energy and 2) How can we best promote these actions to our members to spread to their practices and communities.

You may be thinking, how can making change in energy use provide an immediate reward (since this is the thesis of my message)? We are not going to be able to see a sudden increase in snowpack, or decrease in high ozone days. We will not see less vector borne illnesses tomorrow or less asthma exacerbations. But we WILL be able to see how an energy efficiency audit can lower our energy bill. We will be able to touch a programmable thermostat. We will be able to see how a switch to renewable energy source will decrease our consumption of traditional energy. This is something tangible that we can accomplish, which just like an I&D is immediately rewarding, but will also allow us to know we are making changes to improve the health and wellbeing of our patients and communities, which is clearly in our purview as family physicians.

By our next magazine, I hope to report to you the tangible and economically sound changes our chapter has made to become more environmentally sustainable, or even that our chapter is a leader amongst other state chapters in this area. I would encourage you to share your ideas with our taskforce as well, as we are looking for ways to spread best practices. Have you created a community garden at your clinic? Have you put in solar panels? Have you run an energy audit at your office? Are you an active advocate in your community for environmental sustainability? Feel free to share with me at ZachWachtlCAFP@gmail.com.

And please don't worry…this does not detract from the hard and necessary work I will do advocating for you and your practices with the legislature and stakeholders. Our Primary Care Investment Initiative steering committee is meeting shortly to help chart our next best course of action, which I believe could be both incremental and aspirational. We will continue this battle to promote adequately compensated primary care practices as the lynchpin required for better outcomes in a lower cost health care system for all. And I hope that before I am done writing these messages, I will also have tangible benefits that I will be able to report to you on this front as well.

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Vision Statement:

Thriving Family Physicians creating a healthier Colorado.

Mission Statement:

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

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CEO'S REPORT

By: Raquel J. Alexander, MA, CAE

Addressing the Family Medicine Pipeline

You don't have to look far to find stories about how important it is to grow the family physician workforce. In Colorado alone we need 1,733 more family physicians by the year 2030, according to data from the AAFP.

But solving this problem isn't easy, and as you may know, there are lots of different groups looking at lots of different ways to do it. Some are engaging students as young as elementary school in medical career exploration. Some are promoting diverse mentors to help inspire and create a diverse new workforce. More still are focusing on the entire system, seeking to make it a place where family physicians can thrive and do the work they want to do.

When the CAFP Foundation reviewed its strategic plan this spring, the issue of the family medicine pipeline came up again and again as a priority. But what should the CAFP's role be?

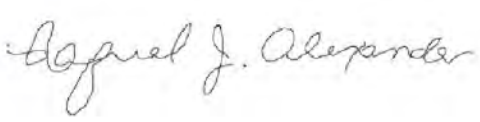
Our greatest strength is you, our membership in Colorado. We believe that engaging both medical students and family medicine residents with our membership can be a vital step in continuing a strong family medicine workforce in Colorado. Yes, there is much that needs to change in the larger world of healthcare to encourage more students to choose family medicine. But we still feel we have a specific, local role to play.

So what does your support of our Foundation do? 100% of funds donated from members go directly to students and residents, to support them in attending family medicine-centered events in Colorado.

The experiences students and residents have at these events can be transformational. A medical student who has been discouraged from going into family medicine realizes they don't have to listen. A resident who never imagined practicing in rural Colorado discovers it's the path for them.

If you've considered supporting the foundation, in any way, I would encourage you to do so. We all need quality family physicians to continue to practice here in Colorado. This is a great way for your money to go directly to the place where it can make a difference. Donations are tax deductible, and can be made easily on-line at https://www.coloradoafp.org/about/foundation/. If you prefer to mail a check, please make it out to Colorado Academy of Family Physicians Foundation and send to: Colorado Acadamy of Family Physicians, 2224 S. Fraser St., Unit 1, Aurora, CO 80014.

Thank you for your support, and for inspiring the next generation of family physicians.



Highlights from the May 2018 Board Meeting

CAFP member and AAFP Board Member Dr. John Bender is running for AAFP President-elect. CAFP leaders and staff will be joining Dr. Bender at the 2018 Congress of Delegates in New Orleans to support his campaign. See more about Dr. Bender in this magazine issue.

CAFP's New Physician Benefits Program is off the ground and running. New physicians can take advantage of many free services including an employment contract review, financial and loans review, CME and more. Learn more at www.coloradoafp.org/benefits.

The CAFP and key stakeholders are planning next steps for the Primary Care Investment legislation. A report is expected this summer that will show how much Colorado spends on primary care. For more information on the legislation and next steps see this issue's Legislative Update.

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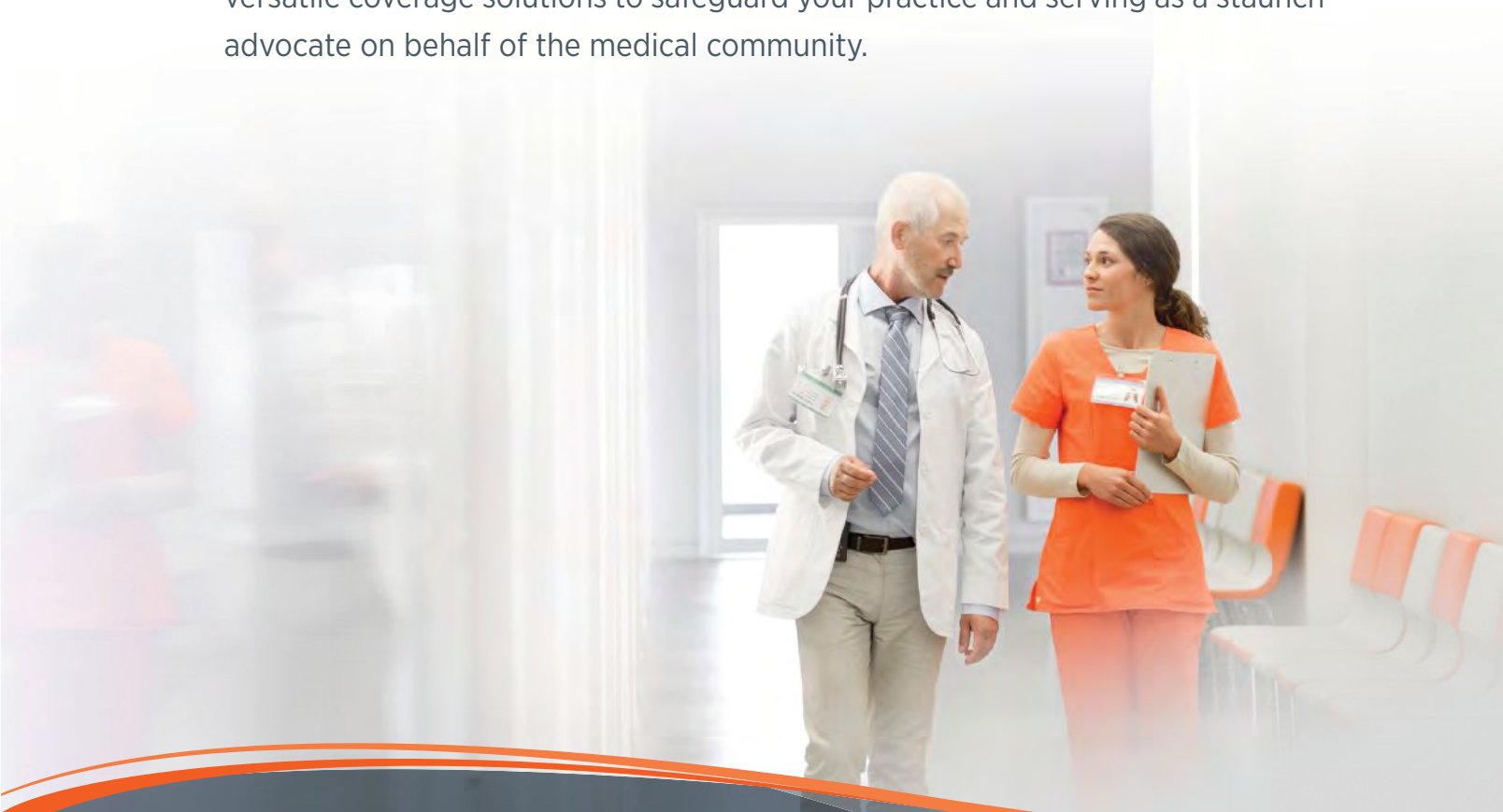

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CAFP LEGISLATIVE UPDATE

July 2018 Legislative Wrap-Up

RYAN BIEHLE, MPA, MPH
DEPUTY CEO FOR POLICY
AND EXTERNAL AFFAIRS

This year, in addition to engaging in the top policy debates and defending the interests of family physicians' and patients, CAFP led our own initiative. We proposed our signature legislation to advance our members' top priority: payment reform that reinforces primary care as the foundation of a high functioning health care system. We fostered alliances to advance health care cost containment efforts, explore options to expand coverage, and stood beside the other medical specialties to address the opioid epidemic while striking a balance to avoid legislating medical judgment in a complex and evolving field. Here's a look at what happened this session, and the new laws impacting family medicine.

CAFP FOLLOWED 58 BILLS	
Supported: 27 Success Rate 15 of 27 signed into law (56%)	Opposed: 7 Success Rate 6 of 7 failed to pass (86%)
*Pass rate for all legislation introduced in 2018 General Assembly was 60%	

CAFP's Legislative Committee, open to all CAFP members, took a thoughtful approach to the legislation on which we engaged. CAFP's lobbying team was able to amend several bills that we initially opposed, thus moving us into a neutral or support position. We were also reserved in putting CAFP resources toward opposing legislation that had a high likelihood of failing without our taking action.

CAFP Priority Legislation

Investing in Primary Care: HB-1365

After winning strong bipartisan support in the House Health Committee on a vote of 11-2, CAFP's **House Bill 1365 Primary Care Investment** was sent to a second committee where it was unfortunately caught in a broad effort to stall numerous pieces of legislation. The bill would have begun annual statewide reporting on the share of payers' spending on primary care and developed recommendations to increase that spending to 15% of the healthcare dollar.

Despite the setback, we'll be making progress to increase spending on primary care from 5% up to 15% of the healthcare dollar. We built a strong coalition working on this effort that now includes the American Academy of Pediatrics – Colorado Chapter, Colorado Community Health Network representing Federally Qualified Health Centers, and the American College of Physicians – Colorado Chapter. Running the legislation helped break a logjam to accessing primary care spending data, enabling the group to secure a $13,000 grant to extract and analyze data from Colorado's All-Payer Claims Database. We expect to have this initial analysis in-hand this summer, and will leverage the information to progress toward a doubling of the resources currently invested in our primary care system.

Hot Topics of the 2018 Session

Opioids

CAFP was heavily engaged in advancing a number of bills to address the opioid epidemic. **SB-22 Clinical Practice for Opioid Prescribing** was signed into law and limits an opioid prescription for acute pain to an initial 7-day supply, with some exceptions including chronic pain, cancer-related pain or palliative care. A physician may prescribe a second 7-day fill, but must query the prescription drug monitoring program when prescribing the second fill. Look for forthcoming guidance from CAFP and COPIC on the new law.

Another bill, **HB-1007 Substance Use Disorder Payment and Coverage** requires insurers to provide coverage without prior authorization for a 5-day supply of at least one FDA-approved drug to treat opioid dependence. All future prior authorizations for medication assisted treatment for substance use disorders must also be handled by insurers as "urgent prior authorization" requests.

Also of note, **HB-1136 Substance Use Disorder Treatment** adds SUD inpatient and residential treatment to the state's Medicaid benefit, pending federal approval. CAFP amended **HB-1279 Electronic Prescribing of Controlled Substances** to ease the burden and give physicians more time to implement the law. After securing the amendments that moved us to a neutral position, the bill was ultimately voted down. It would have required opioid prescriptions to be electronically prescribed.

Transparency

Transparency was a central theme this year at the legislature. One long-fought success was on transparency concerning freestanding emergency departments. CAFP supported **HB-1282 Facility Unique Identifier Per Site of Service**, which requires facilities with freestanding ED's to have a unique ID for the site, so that claims and costs can be compared at freestanding versus hospital-based sites. The cloak on freestanding ED's impact on rising health costs will be lifted going forward. **SB-146 Freestanding ED's Consumer Notice** will also require ED's to notify patients that they are seeking care at an ED with higher pricing than urgent care, and to notify patients after screening or stabilization of the chargemaster price of the 25 most commonly provided services.

Although CAFP supported the effort, **HB-1260 Prescription Drug Price Transparency** stalled. The bill would have required pharmaceutical companies to notify patients and

CONTINUED ON PAGE 10 >>

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<< CONTINUED FROM PAGE 8

insurers 90 days in advance of a price hike greater than 10%, and it would have asked insurers to provide information on how prescription drug prices affect premiums.

Keep an eye out for a possible 2018 ballot initiative that would kick the door in on price transparency across the health care system. **HB-1365 Health Care Charges Disclosures** failed, but signatures are currently being gathered for a ballot initiative with the same language. CAFP did oppose this bill on the grounds that it could force physicians to choose between breaking either the state disclosure law, or federal antitrust laws.

Health Care Costs

Numerous proposals were put forth to address health care costs, with many from both sides of the aisle. Few saw success in the end, but one did pass that addresses prescription drug costs. **HB-1284 Disclosure of Prescription Costs at Pharmacies**, supported by CAFP, allows patients to access their prescriptions at lower cost if available. At times, a prescription is cheaper to purchase with cash than with a copay or deductible under a health plan's negotiated rates. But prescription benefit manager contracts with pharmacies often contain "gag clauses" that prohibit pharmacists from telling patients about the lower cost option. HB-1284 prohibits these gag clauses in contracts and allows pharmacists to tell patients about their options.

Several bills addressing costs aimed to do so through the levers of health coverage. CAFP supported **HB-1384 Study Health Care Coverage Options**. While unsuccessful, the bill would have directed the state to study the costs and feasibility of a Medicaid buy-in "public option," as well as market-based options for expanding affordable coverage including a public-private partnership and a regional cooperative affiliated with a private insurer. CAFP opposed **SB-214 Medicaid Self-Sufficiency Waiver**, which was defeated on a bipartisan vote in the Senate. Its aim was controlling state Medicaid costs, but would have reduced the number of Coloradans with health coverage. It required all able-bodied patients to work and put a 5-year lifetime cap on Medicaid eligibility for any able-bodied adult.

Budget

CAFP secured $54 million in 2016 and 2017 to fund the Medicaid "bump," ensuring primary care physicians would be paid a higher percentage of Medicare. That funding was again included in the 2018 budget and will be used to fund Medicaid's enhanced alternative payments, such as PMPM and performance payments, through the Accountable Care Collaborative 2.0. Additionally, the legislature boosted funding for provider loan repayment by $250,000, while family medicine residencies got an additional $600,000 to support family physician training.

From Left to Right: Andrew Nemechek, MD, Eugene Chung, MD, Christopher Oliver, MD, John Campana, MD, Thomas Kenney, MD, Seth Reiner, MD, Andrew Gaines, MD, Todd Capizzi, MD.

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.

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CONTRIBUTE TODAY TO ELECT CANDIDATES WHO SUPPORT FAMILY MEDICINE

The CAFP is the bold champion for Colorado's family physicians and patients, and thus must play a vital role in influencing state policy. We have strong relationships with lawmakers. We connect lawmakers directly to CAFP members. And we make a difference.

A key element of our strategy is to support and elect lawmakers who will stand up for our priorities. We can't do this work, however, without contributions from our members. CAFP's Political Committee ensures family physicians' voices are heard loud and clear, even when the trial attorneys and insurers contribute tens of thousands of dollars. You can contribute to support family medicine today www.coloradoafp.org/advocacy/contribute/.*

Through CAFP's Political Committee we support candidates who – regardless of party – will stand up for our issues. We support candidates who:

- Will protect Colorado's balanced tort environment without raising malpractice caps
- Support an expanded primary care physician workforce and the future of our specialty
- Support payment reform that will reinforce a stronger primary care system, investing resources where we know they will drive down cost and improve health

Since the last election in 2016, CAFP fought for family medicine and counted a number of wins that were bolstered by the CAFP Political Committee:

- $112 million to increase primary care reimbursement rates in Medicaid
- A $1,000 tax credit for family physicians who precept medical students in rural Colorado
- Protected vaccine access by funding the CIIS immunization registry and preventing growth of non-medical immunization exemptions.

Make a contribution to the Political Committee today so that we can elect candidates who will stand up for you and your patients. Go online to www.coloradoafp.org/advocacy/contribute/.* Or Call 303-696-6655.

Zach Wachtl, MD, FAAFP
President

*Please Note: Contributions are not tax deductible.

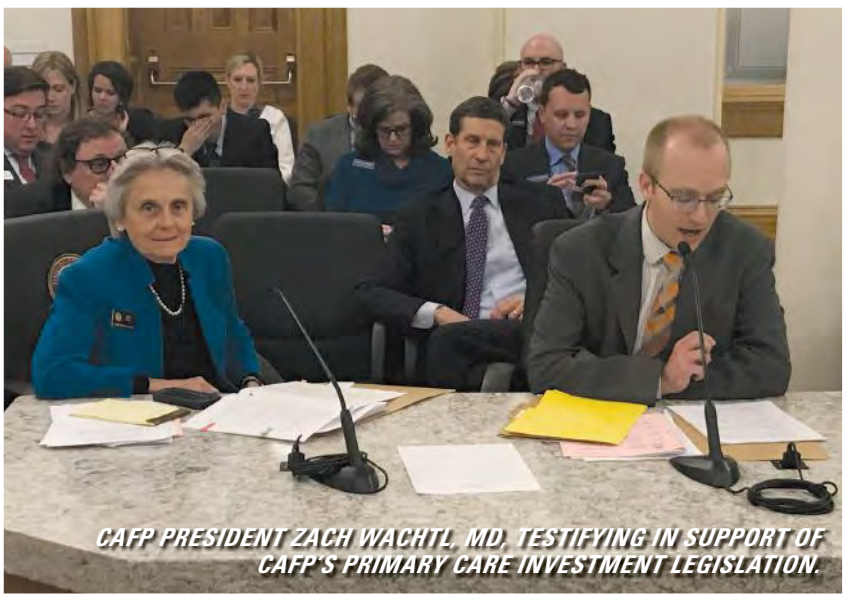
CAFP ON THE GO

THE CAFP DELEGATION TO AAFP'S ANNUAL CHAPTER LEADER FORUM (ACLF) AND NATIONAL CONFERENCE OF CONSTITUENCY LEADERS (NCCL) IN KANSAS CITY.

CAFP PRESIDENT ZACH WACHTL, MD, MEETS WITH SENATOR CORY GARDNER AT THE 2018 AAFP FAMILY MEDICINE ADVOCACY SUMMIT IN WASHINGTON, D.C.

THE COLORADO DELEGATION AT THE 2018 AAFP FAMILY MEDICINE ADVOCACY SUMMIT IN WASHINGTON, D.C.

CAFP VICE PRESIDENT GINA CARR, MD, TESTIFYING IN SUPPORT OF SENATE BILL 22, LIMITING INITIAL OPIOID PRESCRIPTIONS TO SEVEN DAYS.



CAFP PRESIDENT ZACH WACHTL, MD, TESTIFYING IN SUPPORT OF CAFP'S PRIMARY CARE INVESTMENT LEGISLATION.

AF WILLIAMS FAMILY MEDICINE INTERNS SIT IN SENATE COMMITTEE CHAIRS AS DR. JEFF CAIN OF COLORADO SPEAKS ABOUT FAMILY MEDICINE ADVOCACY AND USING THEIR STORIES TO MAKE CHANGE.

THE CAFP HOSTED A SPRING HAPPY HOUR FOR FAMILY MEDICINE RESIDENTS AND MEDICAL STUDENTS AT DRY DOCK BREWERY IN AURORA.

STAKEHOLDERS MEET TO DISCUSS NEXT STEPS AND STRATEGIES FOR CAFP'S PRIMARY CARE INVESTMENT WORK.

CAFP MEMBER KENYON WEIDLE TESTIFYING IN OPPOSITION OF SENATE BILL 214, MEDICAID WORK REQUIREMENTS.

MISTAKES PHYSICIANS MAKE THAT HURT THEIR DEFENSE

BY COPIC'S PATIENT SAFETY AND RISK MANAGEMENT DEPARTMENT

Physicians' previous actions and the way they carry themselves can have significant impact on the outcome of a medical liability lawsuit. A 2017 *Medscape* article[1] explored this issue by asking several defense attorneys for advice they would give physicians facing a lawsuit and what they should consider now in order to provide defensible care.

Don't come across as arrogant in a deposition or trial setting. "Juries expect attorneys to be accusatory and sometimes nasty. They give them some leeway. But they expect different behavior from physicians in a case involving a patient whom they may have injured," said Mark Fogg, COPIC's General Counsel, in the article.

Physicians who show no concern for an injured patient can appear unempathetic and insensitive. "Trials are a form of theater," said Rick Boothman, chief risk officer at the University of Michigan Health System and a malpractice defense attorney, in the article. "What happens in a courtroom often turns on whether the jury likes the defendant doctor. Jurors know that expert witness testimony can be bought, and dueling experts can cancel each other out. But jurors want to like the doctor. That's sad, because we're litigating intensively complex medical matters and a doctor's likability is a pretty iffy threshold."

Poor documentation can cause jurors to question the physician's actions. This can include failure to document key instructions, noncompliance, significant signs/symptoms as well as altering past records, noted the article. "A mistake isn't malpractice," said Fogg. "You don't have to be perfect. In most cases I defend, there was some mistake. But if the documentation evinces a reasonable thought process, we can defend the doctor. The records should show their rationale for treatment, what options they considered, and what they ruled out."

EHRs can unintentionally create liability issues. "Electronic records don't always allow doctors to provide a narrative that describes their thought process," said Fogg. He added that templates can be a problem when physicians are forced to pick the closest thing to what they are looking for or they mistakenly check a wrong box. In addition, overuse of copying and pasting that leads to inaccuracies can undermine credibility. Fogg noted that "Most electronic records have a box where the physician can write a narrative. If you looked at the record 2 or 3 years later, could you reconstruct your thought process? That should be the goal."

If you work with allied health professionals, be aware of the liability risks. "Doctors are liable for supervising their physician assistants (PAs). In most practices, they'll set parameters on what the PA should do. For example, every patient complaining of chest pain must be seen by the physician as well. There's often miscommunication. Perhaps the PA didn't follow the parameters, and that led to a heart attack that wasn't diagnosed. Physicians need to be clear about what they expect, and they must supervise appropriately," said Fogg.

[1] *Mark Crane. Ways to Avoid Sabotaging Your Malpractice Defense - Medscape - Jul 05, 2017*

SNOCAP
State Networks of Colorado Ambulatory Practices & Partners

BIGHORN CaReNet COCO Net Colorado Children's Outcomes Network HIGHPLAINS RESEARCH NETWORK PEACHnet

CAFP Partners,

Over here at SNOCAP, we feel we are sprinting through spring and quickly into summer.

Earlier this year we reached out to all of our SNOCAP members and partners to offer one person attendance to the NAPCRG Practice-Based Research Network's annual conference in Bethedsa, Maryland this June. It gives us great excitement to have a member from La Junta traveling with us this year. SNOCAP always "shows up" by involving patients in the work we do, which regularly includes inviting folks to join us at conferences; however this year was special in that we spread word around more broadly for anyone interested. We are looking forward to sharing how practice-based work is done in Colorado.

In May, SNOCAP attended the Rocky Mountain Research Forum with the Colorado Association of Family Medicine Residencies (CAFMR). For the second year in a row, SNOCAP was delighted to review the top proposals to score and give awards. We will be sending one resident from the top team to the upcoming 2018 NAPCRG Annual conference this November in Chicago, Illinois. The second and third place teams were awarded gift cards to use to spend time as a group outside of work. Thank you to all the groups who submitted proposals, and to CAFMR for inviting us to the event.

SAVE THE DATE!

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 focuses will be on empowering patients and on how a broad community can uncover and discover ways toward careful and kind care for all.

Registration for the conference will open soon and will come out via SNOCAP's 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.

Wishing you our best-

Don Nease (Donald.nease@ucdenver.edu), Mary Fisher (mary.fisher@ucdenver.edu), and Matt Simpson

Children's Corner

BY JOEL STODDARD, MD
CHILD AND ADOLESCENT PSYCHIATRIST, CHILDREN'S HOSPITAL COLORADO
ASSISTANT PROFESSOR OF CHILD PSYCHIATRY AT THE UNIVERSITY OF COLORADO SCHOOL OF MEDICINE

ANXIETY MANAGEMENT IN CHILDREN AND ADOLESCENTS

Most children and teens experience anxiety to some degree, usually about some dreaded event like a test or performance or peer evaluation. Anxiety becomes disordered when such apprehension is persistent, distressing, and impairing. When the anxiety becomes severe enough, it can negatively impact academic and social functioning.

In a large, influential epidemiologic study, the NCS-A, one third of adolescents met criteria for an anxiety disorder, with about a tenth being severely affected. Physicians confront anxiety in children on a daily basis. Despite being so widespread and impairing, anxiety disorders are often difficult to detect.

Parents and children may not mention concerns because they may be embarrassing and or the child's anxious behavior is not disruptive. Even if not disruptive, anxiety may be very distressing. It might result in functional impairment to which the family has become acclimated and no longer recognize as problematic. Children and teens may only complain of anxiety-related physical symptoms, often stomach aches or headaches. A careful history revealing clear triggers helps in sussing the anxious origin to such complaints. Think of stomach aches that reliably occur in the morning before school as one example.

Another issue is that anxious youth may only express irritability or disruptive behavior. Well-crafted screening practices can help, along with a reliable referral network for further evaluation. For example, the Pediatric Symptom Checklist is a well-validated tool that covers quite a bit of ground and is freely available in a number of languages. It can be found here https://www.massgeneral.org/psychiatry/services/psc_home.aspx. It is important to consider using a broad screening tool like the PSC, because anxiety symptoms may not stand alone, co-occuring with other mental health issues that should not be missed. Other omnibus measures that any physician might use are the Behavioral Assessment System for Children (https://www.pearsonclinical.com/education/landing/basc-3.html) or the Achenbach System of Empirically Based Assessment, which is commonly known by one of its questionnaires, the CBCL (http://www.aseba.org/).

It's important to use more broad measures at initial assessment to avoid missing confounding psychopathology. For follow up or evaluating someone with an established anxiety disorder, a more focused instrument like the Screen for Chilld and Related Anxiety Disorders (SCARED; http://pediatricbipolar.pitt.edu/resources/instruments). Despite its name, the SCARED focuses only on anxiety disorders and has been often used as a way to monitor symptom change, as opposed to just screening for anxiety. It is free to use and one of the most widely used instruments for monitoring anxiety symptoms.

Prior to starting an anxiety treatment, it's crucial to rule out other mental disorders, environmental exposures, and physical conditions that present with anxiety-disorder-like symptoms. For example anemia may first present as anxiety. School refusal may reflect a non-disordered adverse situation, like bullying. Cases in which somatic symptoms are the only complaint often require a reasonable evaluation of underlying pathology. Here, a careful history and experience and sound judgment on the part of a clinician plays a critical role in evaluation. Next, specifying the type of anxiety disorder will direct treatment. For example, a specific phobia may be best treated by exposure therapy while generalized anxiety or social anxiety may be best treated by cognitive behavioral therapy and/or SSRIs. Broadly speaking, most anxiety disorders are treated by a combination of family education, psychotherapy and medications.

Family education has two major components. The first component is educating the family on the prevalence of anxiety and its prognosis. Generalized anxiety, social anxiety, and separation anxiety all likely arise from a common root. A toddler with anxious temperament is at high risk for developing one of these in the future. A common progression may be separation anxiety disorder followed by generalized anxiety disorder or social anxiety disorder. Anxiety disorders tend to be persistent with a waxing and waning progression through childhood and adolescence. They predict anxiety, depression, and substance use disorders in adulthood proportional to the degree of anxiety in childhood. The second component of family education. It is important to discuss the role of the family in perpetuating anxiety, especially for young and school aged children. While many families tend to accommodate anxious youth, some adopting a highly protective stance, shielding their youth from further aversive situations. General advice to families that it is reasonable to resist their anxious child's tendency towards avoidance of normal activities, even if it causes some distress. This is often tricky to do in a brief encounter and may be left to the therapist.

Psychotherapy is considered first line treatment for anxiety disorders by most practice standards. It seeks to dissipate these concerns with two basic "active ingredients": cognitive

Children's Corner

restructuring and exposure. These techniques address a common theme for all anxiety disorders in that they arise from a perceived threat — harm, peer rejection, separation, panic, imperfection, or some amalgam of diffuse concerns. Cognitive restructuring helps a youth 'reappraise' whatever they dread. For example, a therapist might help a young athlete interpret pre-game jitters as excitement rather than anxiety. Exposure is just what it sounds like: confronting the fear. However, this is best done in a therapeutic environment to prevent worsening the anxiety.

Several medication options can help youth with moderate to severe anxiety. Evidence supports the use of selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine reuptake inhibitors (SNRIs) in adolescents, particularly SSRIs based on their efficacy and relative safety. However, they are not risk-free and not robustly effective. The number needed to treat for anxiety disorders of about three to six for anxiety. Indeed, they can cause anxiety-like symptoms themselves, commonly related to gastrointestinal syptoms or behavioral activation. The most concerning side effect is an increase in "suicidality" an FDA-term for suicide related thoughts or behaviors. Overall, evidence supports some increase in suicidality, which is uncommon and continues to be studies. Thus SSRIs and SNRIs have black box warnings on suicidality in youth.

Partial Hospitalization Program at Children's Colorado

The Partial Hospitalization Program at Children's Hospital Colorado provides intensive treatment for children and teens with psychiatric difficulties, like anxiety, that prevent them from functioning in their home, school or community.

We treat children and teens who require more intensive services than can be offered in a traditional outpatient setting, who are at risk of psychiatric hospitalization, as well as those who have stepped down from an inpatient hospital stay.

Our program runs Monday through Friday from 8:30 a.m. to 2:30 p.m. and is offered year-round. Summer months and holiday breaks are ideal times for families who are concerned about their children missing school, but who also recognize that their child may need additional services to help treat their anxiety and depression. This program also provides excellent preparation for children who experience anxiety or have difficulty transitioning back to school in the fall. Families and referring providers can contact us directly at 720-777-7794.

SUMMIT WRAP-UP

Thank you to everyone who joined us for the 2018 Annual Summit in Colorado Springs. We enjoyed another fun year!

The 2019 Summit includes a new venue and more great CME at the Hilton Fort Collins, May 2-5, 2019. Early registration is open now, save $100 off your registration costs with coupon code EARLYBIRD. Register now at www.coloradoafp.org/summit.



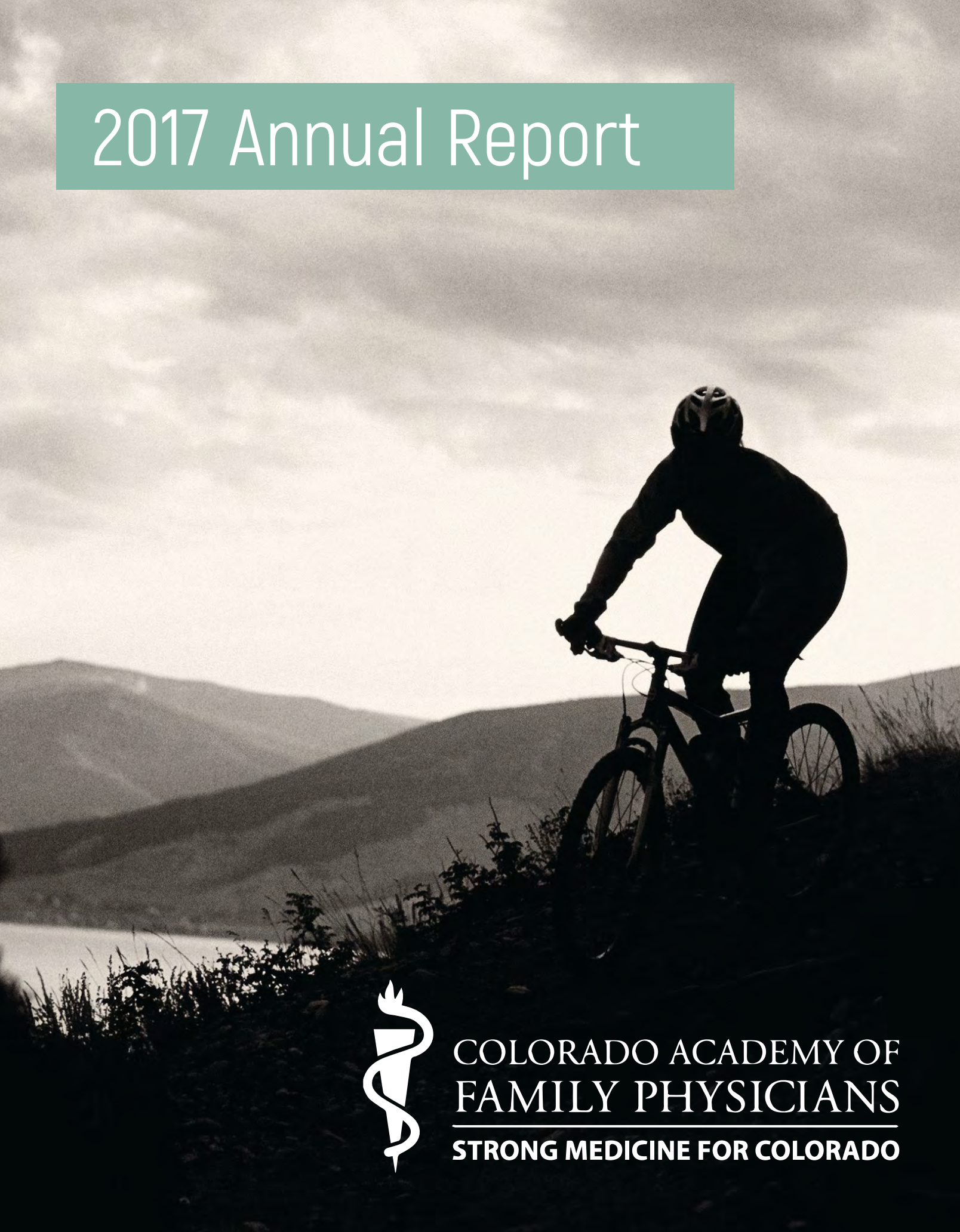








2017 Annual Report



COLORADO ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR COLORADO

2017 was another active year at the CAFP! Your staff and leaders were present at the state and national level advocating for payment reform, decreased administrative burden, working to support our students and residents, and continued funding to GME. 2017 was a year of laying a great deal of groundwork for our coming efforts. We worked on grants, educational programs and more. I was honored to write a resolution that was passed by the AAFP Congress of Delegates aimed at researching violence in the healthcare workplace. This resolution will shape national efforts, and we are taking on this issue on the state level as well, with the plan to create an educational toolkit for members.

We worked with Colorado state legislators, other physician groups, safety net clinics, patient advocate groups, and many more to develop the strategy that ultimately became our Primary Care Investment Legislation. Together with the Colorado Primary Care Collaborative, we put on the June conference "Primary Care Payment & Delivery Reform: What's on the Horizon," which included payment experts from across the state and nation. Our state has one of the largest groups of Direct Primary Care (DPC) physicians in the nation. We worked with Colorado DPC physicians to pass a DPC bill in Spring 2017. Our advocacy efforts were recognized at the national level, and we received the State Advocacy Award from the AAFP for this Direct Primary Care bill.

We felt the scorch of burnout so prevalent in our practices today, and launched the first ever Wellness Conference in Fall 2017. We continue to actively discuss measures for addressing burnout at every level (administrative burden, payment reform, workplace violence, etc.). Also in education, our 2017 Annual Summit once again delivered high yield, relevant educational opportunities for our members.

In hopes of bringing more value to your membership dues, we have expanded the benefits offered to our members, and launched the "New Physician Benefits Package" (please contact Lynlee on our staff if interested, there are some fabulous perks there).

Thank you to all of our members for your continued support! I have been overwhelmed and inspired by the work you do. Together, we will continue to advance the work of our mission statement "to serve as the bold champion for Colorado's Family Physicians, patients, and communities, through education and advocacy."

It was an honor and the experience of a lifetime to serve as your president.

Monica Morris, DO

2017 Membership Statistics

2,454 Members

1,584 Active Members	242 Resident Members	430 Student Members
167 Life Members	4 Supporting Members	27 Inactive Members

2017 Financial Data

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

Current Assets: $845,510.08

Fixed Assets: $390,341.07

Total Assets: $1,235,851.15

Total Liabilities: $162.62

Total Income: $603,266.35

Total Expense: $577,275.95

Net Ordinary Income: $25,990.40

Advocacy at the Capitol

11
CAFP Physician Members Testified

11
Committee Hearings CAFP Testified In

Advocacy from Anywhere

276
Letters Sent to Legislators

134
CAFP Members Took Action

SpeakOut Outcomes

Senate Bill 88: Network Selection/De-Selection Criteria.
CAFP Position Supported
Passed on Bipartisan Vote in Senate 30-5 and House 44-20. Signed by Governor

SB 106 - Naturopath Sunset.
CAFP Position Supported: No expansion of scope
Passed on Bipartisan Vote in Senate 34-0 and House 54-11. Signed by Governor

CIIS Vaccine Registry Funding
CAFP Position Supported: Funding maintained in budget, CIIS will continue
Joint Budget Committee supported 6-0 to include in budget

SB 267 – Hospital Provider Fee Enterprise/Sustainability of Rural Colorado
CAFP Position Supported: $528 million cut to rural hospitals avoided
Passed on Bipartisan Vote in Senate 25-10 and House 49-16. Signed by Governor

CAFP Testified on 9 Different Pieces of Legislation and Had a 100% Success Rate in the Ultimate Outcome of the Bills on Which CAFP Testified.

SB-250 would have loosened vaccine exemption requirements and eliminated a standardized state exemption form.
CAFP Opposed. Bill defeated on Senate floor

SB-106 Naturopath Sunset
CAFP Opposed expansion of naturopath scope. Bill passed without expanded scope

HB-1094 Telehealth
CAFP Supported. Prevents insurers from charging higher copays for telehealth services than for in-person services

SB-250 Coverage of 12-Month Contraception Supply
CAFP Supported. Requires health insurers to pay for a 12-month contraceptive supply if prescribed by a physician

HB-1322 Domestic Violence Reporting by Health Professionals
CAFP Supported. Eliminates mandatory reporting by a physician if the victim of domestic violence, who is a patient, does not wish the case to be reported. Requires a referral to a victim's advocate, and provides immunity to the physician for reporting or not reporting.

HB-1115 Direct Primary Care is not Insurance
CAFP supported. Ensures Direct Primary Care practices are not regulated as insurance companies.

Tamaan Osbourne-Roberts, MD testifying on behalf of Senate Bill 88, regarding insurance network transparency.

Doctor of the Day By the Numbers

2017 saw record participation in the Doctor of the Day program at the state capitol. Family physicians treated legislators, staff and visitors, and offered a first-hand example of how important family doctors are.

37
Patients Treated at the Capitol

48
Doctor of the Day Participants

36
Out of a Possible 78 Days Covered

2017 Colorado Primary Care Collaborative (CPCC) Convening

Leaders from across the Colorado and national primary care landscape gathered together to discuss:

Primary Care Payment & Delivery Reform:
What's on the Horizon

The Impact of a Family Physician

Family Medicine's Contributions to the Economy in Colorado

$4.7 billion in direct and indirect economic output

29,107 jobs, direct and indirect positions

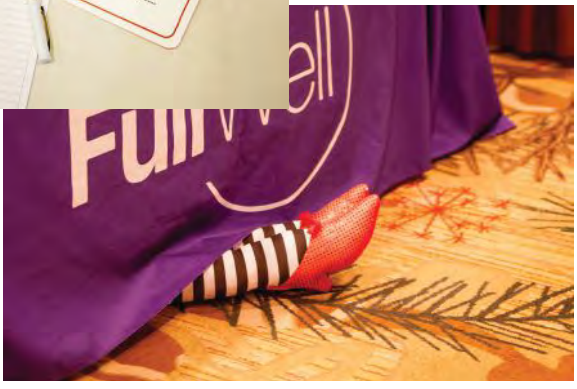
$2.3 billion in direct and indirect wages and benefits

Data via AAFP and AMA. (February 2018). AMA Physicians' Economic Impact Study. Retrieved from https://www.physicianseconomicimpact/org/

Governor John Hickenlooper signs HB-1115, distinguishing Direct Primary Care as different from insurance.

2017 CAFP Annual Summit

Family medicine centered education is what the Annual Summit is all about. Topics at the 2017 Summit included HIV prevention, physician wellness, medical aid in dying, and GME reform. Plus, a Wizard of Oz themed exhibit hall, student and resident events and more.



2017 CAFP Award Winners

Family Medicine Resident of the Year
Brenda Campos-Spitze, MD

Family Medicine Teacher of the Year
Jeff Cook, MD

Family Medicine Physician of the Year
Steve Lavengood, MD

Patient-Centered Innovation Award
Concussion Consultants at Centura
Rocky Khosla, MD

Fall Wellness Conference

In 2017 the CAFP introduced a new wellness-focused conference for family physicians. Real world tools, practical advice, and preparing physicians to work in a frequently imperfect system were discussed.

EDUCATION & PRACTICE ENHANCEMENT

Improving the 5 Dimensions of the Diagnostic Process

New research identifies strategies to reduce diagnostic errors

Receive CME by reading this article! Visit www.coloradoafp.org/cmequiz.

By COPIC's Patient Safety and Risk Management Department

Building upon the landmark 2015 Institute of Medicine's "On Improving Diagnosis in Health Care" study, a recent Annals of Internal Medicine article[1] examines five dimensions of diagnosis, along with strategies to reduce diagnostic errors in hospitalized patients.

The strategies highlight the importance of first understanding how these errors occur, and then developing practical ways to improve results.

"Defining whether a diagnostic error has occurred can be difficult. Diagnosis evolves over time, often across multiple providers and settings. Standards for diagnostic accuracy and timeliness for most conditions are ill-defined, and physicians must constantly achieve diagnostic rigor with judicious use of tests or procedures," note the researchers in the article.

"In view of these conceptual challenges, the term 'error' should be used only when unequivocal evidence suggests that a key finding was missed or not investigated when it should have been. Errors should also be framed as learning and improvement opportunities, not moments for assigning blame."

Analysis of diagnostic errors by the researchers showed that they generally arise from a mix of individual cognitive factors and system-related factors. Often times, there is a breakdown during the patient-physician encounter and identified problems include poor data gathering, misinterpretation, overconfidence in diagnostic judgment, or knowledge deficiency.

System-related factors often emerge from breakdowns in communication, coordination and teamwork, or from a lack of robust policies and procedures.

In conclusion, the researchers mention that "Diagnosis determines most therapies and procedures that hospitalized patients receive. With so much at stake, efforts to understand and prevent diagnostic errors represent a new horizon of opportunities for hospital medicine."

[1]*Ann Intern Med. 2016;165:HO2-HO4.*

DIMENSION OF DIAGNOSTIC PROCESS	STRATEGIES FOR IMPROVEMENT
The patient-physician encounter	Allocate time and nurture skills to communicate effectively with patients; improve clinical reasoning by critically reflecting on decisions; utilize Web-based decision-support resources and other colleagues
Performance and interpretation of diagnostic tests	Collaborate with lab professionals and radiologists to develop an appropriate strategy and to interpret test results; seek face-to-face communication in difficult-to-diagnose cases
Follow-up and tracking of diagnostic information over time	Clarify responsibilities and processes for following up on abnormal findings and results; use health information technology tools, such as electronic triggers and notifications, to ensure follow-up of pending test results; do not overlook diagnostic data obtained before the current hospitalization, visit or encounter
Subspecialty consultation-related communication and coordination	Use direct communication for critical decisions; reevaluate the diagnosis as a team when multiple consultants are involved
Patient-focused strategies	Encourage patient/family participation; improve engagement through clear discharge instructions and a follow-up plan; encourage patients to be proactive in ensuring that the post-discharge evaluation is done in a timely manner

In 2017 CAFP introduced CME accredited articles in our publication, Colorado Family Physician. These free CME opportunities are another way for physicians to quickly earn the credits they need. Learn more at www.coloradoafp.org/cmequiz

Tar Wars Poster Contest Winner

Congratulations to Gavin Cichello, 2017 Tar Wars Poster Contest Winner! Gavin is a 5th grade student at Chipeta Elementary in Colorado Springs.

Congratulations also to Gavin's teacher Jaimer Kronmiller and Gavin's Tar Wars presenter Rhonda Heschel.

Colorado continues to struggle with key adolescent vaccination rates, including HPV, meningitis, influenza, and others.

Thanks to a grant from the AAFP, the CAFP hosted "Highlight on Vaccinations 4 Teens," a showcase of local and national vaccine advocates and experts who have personal experience with the importance of adolescent vaccinations.

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COLORADO ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR COLORADO

WALT LARIMORE, MD, DABFP, FAAFP
REGINALD FINGER, MD, MPH

NAVIGATING THE COMPLEX AND CHANGING WORLD OF ANNUAL FLU VACCINATION

As we move through the summer, you need to consider once again this year how you will explain the current situation about influenza vaccination to those who ask us – your families, your colleagues, and your patients. Sometimes it seems that the news, the facts, and the recommendations are as changeable as the influenza virus itself. In this article, I have attempted to respond to five of the most common questions you are likely to hear.

1) ***What has been going on in the southern hemisphere with flu? Do the reports of very poor flu vaccine effectiveness from Australia have any meaning for us in the U.S.?***

Because influenza travels around the globe each year with remarkable speed, what happens in any part of the world with flu activity and vaccine effectiveness is important to all of us. Early in each calendar year, recommendations must be made for the formulation of the current year's flu vaccine, which will be released for use in the early fall. At the time of the decision, the northern hemisphere is in the middle of its current flu season. Thus, information about which viruses are circulating and how last fall's vaccine is performing, are incomplete. The southern hemisphere, on the other hand, is between flu seasons, so information from there generally comes with six months' additional "lead time" to supplement what we see here.

In 2017, the effectiveness of the flu vaccine in Australia against the most commonly circulating subtype (H3N2) was poor (10 percent, tinyurl.com/yan4lp4c). This figure, while certainly bad news that needs to be taken seriously, must be evaluated with other information in mind as well. We elaborate further in response to the next question.

2) ***If flu vaccine is so much less effective than other vaccines, as evidenced both from the Australia data and from interim data in the U.S., then why do we continue to recommend it?***

Indeed, the interim estimates of efficacy for the U.S. influenza vaccine released in February of this year were 36 percent overall, and 25 percent for the H3N2 subtype (tinyurl.com/ycpls9kg). This is considerably lower than in most years (tinyurl.com/yd39fqzf). Researchers continue to work on the particular problems with the H3N2 component of the vaccine, which may include reduced efficacy because of its passage in eggs. Most influenza vaccines are still produced using eggs, though cell-based and recombinant vaccines are available (tinyurl.com/heqypjh).

However, vaccine efficacy against laboratory-confirmed flu seen in doctors' offices (the main measure of efficacy used) does not tell the whole story. Clearly, efficacy against confirmed flu is going to be higher than efficacy

against "influenza-like illness" generally, because the percentage is diluted by lack of efficacy (obviously) against illnesses not caused by influenza virus. The other side of the coin is that efficacy against severe disease (that causing hospitalization, ICU admission, and death) is significantly higher than against influenza disease generally. Stated another way, even if you do get the flu, the vaccine is likely to dramatically limit the severity of the disease. See this study for evidence of vaccine effectiveness against ICU admission and death, *even among those who were hospitalized for confirmed flu infection* (tinyurl.com/yczh3lry). This factor alone convinces me to get the flu shot – though admittedly, I am a little older than many of your patients and possibly more at risk for complications.

3) ***What is going on with the nasal flu vaccine? Off again, on again, what is the deal?***

Yes, LAIV4 (quadrivalent live-attenuated influenza vaccine – the nasal "spray") was removed from the annual recommendation in 2016, because researchers found efficacy in the prior two seasons that was too low to live with (tinyurl.com/ya4qq54o). In response, the manufacturer (AstraZeneca) made some modifications, enough to convince the current Advisory Committee for Immunization Practices (ACIP) in February of this year to reinstate the recommendation. A more complete review of this situation by authors at the University of Minnesota's Center for Infectious Disease Research and Policy (CIDRAP) is found here: tinyurl.com/yck7dy4a.

4) ***What are we doing about influenza pandemic preparation?***

In a word, the best preparation for a pandemic is to keep up and strengthen our systems for annual influenza vaccination. We had a pandemic in 2009. The H1N1 pandemic strain of virus spread rapidly around the globe, though fortunately, in stark contrast to the tragedy in 1918-19, this strain essentially behaved no worse clinically than most flu strains that circulate each year (see tinyurl.com/yacmwkr8). Once a pandemic strain is recognized, the system "gears up" to produce enough vaccine, as quickly as possible, to vaccinate everyone who will agree to take it. In the meantime, the other things that have to be done – enhanced clinical and laboratory surveillance, accurate and timely public communication, and rapid availability of flu antiviral medication – are done all the better if we are in practice at doing these things all the time.

5) ***What is with the push to get college students vaccinated?***

College students, like the rest of us, are recommended to receive the flu vaccine every year. It is not hard to figure out that residential college students may be at higher risk of infection because they live in close quarters. Further, a flu epidemic is very disruptive to academics at any level, because classes and studies proceed on a relatively inflexible timeline for most students. I had the opportunity to participate in quite an interesting webinar recently, offered by the National Foundation for Infectious Disease (NFID, see tinyurl.com/y74c2hur). Bottom line … many college students told surveyors that they did not feel that they were at risk for the flu. Some were not sure the vaccine worked, and some were concerned about side effects of the vaccine, and some believed – erroneously – that one could get the flu from taking the vaccine. Interestingly, the students believed that competitive "get your shot" challenges with free incentives, especially free food (!) could work quite well to encourage vaccination.

Vaccine News You Can Use

WALT LARIMORE, MD, DABFP, FAAFP
REGINALD FINGER, MD, MPH

The ACIP recommended Heplisav-B, a new adult adjuvanted recombinant vaccine for hepatitis B, which is the first new hepatitis B vaccine in 25 years. It is made by Dynavax Technologies Corp. and uses an additive (immunostimulatory phosphorothioate oligodeoxyribonucleotide [HBV-ISS], for those interested in such things) that boosts the body's immune response. The main advantage is that it is given in two shots over a single month. Experts hope that will improve vaccination rates, because other hepatitis B vaccines are given in a harder-to-complete regimen of three doses over six months. The most common adverse reactions reported within seven days of vaccination were injection site pain (23-39%), fatigue (11-17%), and headache (8-17%). However, there are still concerns about a potential increase in acute myocardial infarction and immune mediated disorders, and a phase 4 study to address these concerns is being conducted. Thus, the optimal use of this vaccine is still to be determined. The Wholesale Acquisition Cost for Heplisav-B is estimated to be $115 per dose or $230 per regimen.

Multiple early childhood vaccinations do not increase infection risk

Children's total vaccine antigen exposure before age two is not associated with increased odds of gastrointestinal, lower and upper respiratory, and other bacterial and viral infections that were not targeted by the vaccines during the next two years, researchers reported in the *Journal of the American Medical Association* (tinyurl.com/ydgdauzv). According to the researchers, the study, based on data involving 944 children, should reassure physicians and parents "the theory of overloading an infant's immune system is highly unlikely" (tinyurl.com/yavs72un).

HPV Vaccine: Good news and a caution

A study published in the *Journal of Infectious Diseases* (tinyurl.com/ybdwv7gl) reported "the proportion of boys and young men in the U.S. receiving the human papillomavirus (HPV) vaccine has more than tripled since 2011." Among 9- to 26-year-old males, 27 percent had received at least one dose of the vaccine in 2016, compared to 8 percent in 2011. Vaccination rates rose from 38 to 46 percent in girls and women over the same time period. However, research was presented at the Society of Gynecologic Oncology's annual meeting indicated clinicians "may be failing to routinely offer the HPV vaccine to boys, potentially putting them at risk of cancer later in life" (tinyurl.com/yakpty2c). The researchers found that "one in five parents of teen boys said they did not intend to have their son vaccinated against HPV mainly because their doctor did not recommend it." However, "that was true for just one in 10 parents of teen girls." So, this is reminder for us to be sure and let parents of both boys and girls know the importance of this vaccine as, "the study found the most commonly cited reason for not vaccinating children was a mistaken belief that the HPV vaccination is not necessary."

Maternal flu, Tdap shots in pregnancy safe for babies, study finds

CDC researchers reported in *Pediatrics* (tinyurl.com/yc4klbuy) that infants whose mothers received influenza and Tdap immunizations during pregnancy did not have a higher hospitalization or mortality risk for any of the infections covered by the vaccines in the first six months of life, compared with those whose mothers did not receive either vaccine. In fact, maternal vaccination provided a significant protective effect against infant respiratory hospitalizations. The findings were based on 2004 to 2014 data involving 413,034 live births. The study's findings are consistent with other studies showing vaccination during pregnancy is not linked to childhood hospitalization, development issues, or chronic conditions. "Our study helps strengthen the growing evidence of long-term safety of vaccination in pregnancy for infants," the authors wrote (tinyurl.com/y7ghgxhq).

BY LYNLEE ESPESETH

STOP AND THINK

PREVENTING MARIJUANA USE IN COLORADO YOUTH

NEW YOUTH MARIJUANA PREVENTION PROGRAM DEVELOPED BY CAFP PREPARES TO LAUNCH

Colorado voters legalized the use of recreational marijuana on November 6, 2012. In the almost six years since, policy makers and citizens alike have been carefully watching to see what consequences might arise. Most seem to agree the "great experiment" has been a mix of successes and failures.

One issue of high priority to family physicians and many others is the effect on young people. Unfortunately, that news hasn't all been good. *The Denver Post* has reported that retail marijuana shops have clustered in predominantly low-income and minority neighborhoods[1]. Community members in these neighborhoods expressed concern over how this might be affecting local young people.

Additional research conducted four years into legalization made other unfortunate findings[2]. In Colorado, marijuana use among students aged 12 to 17 was higher than the national average and was increasing at a rate greater than the national average. Colorado was first in the nation for last-year and last-month marijuana use among that same group. Hospitalizations due to marijuana have increased 70 percent since legalization, and marijuana is increasingly found in adolescent suicide victims.

All of this is more likely to impact communities of color and low-income communities in Denver and surrounding areas. Since legalization the number of black and Hispanic youth arrested for marijuana related crimes increased 58 and 29 percent, respectively. Marijuana related offences are up in both elementary and high schools, and juveniles on probation were testing positive for marijuana at increasing rates.

What can be done? Of course, a broad effort must be undertaken to address the multifactorial elements driving these statistics. But the Colorado Academy of Family Physicians (CAFP) felt that there must be a place for family physicians to engage and help communities.

It turns out the answer was resting in a long-established place. Physician volunteers doing *Tar Wars* presentations in local schools reported that kids had far fewer questions about tobacco, and far more questions about marijuana. Teachers were asking for a marijuana specific curriculum, as it was an increasing point of concern in their classrooms.

The Tar Wars program was started in Colorado by Dr. Jeff Cain and colleagues, and became a national effort housed within the AAFP. It was designed to teach kids about the dangerous effects of tobacco, and help them think about how tobacco advertising might be trying to manipulate them into using an unhealthy and addictive substance. *Tar Wars* presentations are delivered by family physicians or other healthcare volunteers in fourth and fifth grade classrooms, reaching kids at the age they start to consider drug use.

Using the knowledge learned over many years of the *Tar Wars* program, the CAFP has developed a new program "Stop and Think: Preventing Marijuana Use in Colorado Youth." The curriculum is modeled after *Tar Wars*, but addresses the new and evolving issue of legalized recreational marijuana.

Funding for curriculum development was provided by a grant from the Family Medicine Philanthropic Consortium, part of the AAFP and AAFP Foundation. Curriculum development was completed by CAFP staff, under the advisement of a team of family medicine residents from the University of Colorado: Stephanie Eldred, MD, Logan Mims, MD, John Weeks, MD, and Allyson Westling, MD.

The CAFP is now pursuing a second round of funding that will support a pilot program of the curriculum to be delivered in key schools identified in Denver neighborhoods that have the highest concentration of retail marijuana shops. This pilot program will gather feedback from parents and educators, and allows for refinement of the curriculum before it is expanded statewide.

In addition to this school-based work, the CAFP will be developing accompanying resources that can be utilized by family physicians. In a recent survey of the CAFP membership, 50% of members felt well-versed in educating children and parents about marijuana use, while 42% did not feel well-versed, with many members indicating they felt they could be doing more. The majority of respondents (62%) did not have substance abuse counselors directly in practice and 91% did not have standard discussion or educational materials to use in practice. Because so much work is being done in the space, the CAFP's role will be to streamline and make easily available existing physician resources, and to supplement anything that is missing.

For more information about the Stop and Think program, please contact Lynlee Espeseth at lynlee@coloradoafp.org or 303-696-6655 x 116.

1 http://www.denverpost.com/2016/01/02/denvers-pot-businesses-mostly-in-low-income-minority-neighborhoods/

2 https://learnaboutsam.org/wp-content/uploads/2016/11/SAM-report-on-CO-and-WA-issued-31-Oct-2016.pdf

BY HEATHER GRIMSHAW

ANSWERING THE CALL FOR HELP: IMPROVING MENTAL HEALTH IN COLORADO BOYS AND MEN

Most health care professionals recognize the need to improve awareness of mental health issues as well as access to mental health services, and a new report published by the Colorado State Innovation Model (SIM) provides a roadmap for achieving those goals.

Strategies in "Raising the bar on behavioral health awareness, prevention and treatment for boys and men: A call to action" (http://bit.ly/mental-health-call-to-action) suggests partnerships that extend beyond traditional health care settings, activities and a timeline for action. While the focus is on boys and men, the call-to-action — which was released in May during Mental Health Awareness month — will benefit all Coloradans.

Statistics cited in the report that highlight the need for a more collaborative approach:

- In Colorado, one in five people need mental health services.
- Colorado consistently ranks in the top 10 states for suicide death rates.
- There is an upward trend in indicators for methamphetamine, heroin and prescription opiate abuse in Colorado as well as fatal overdoses related to each.

The 42-page report represents about 12 months of work initiated and led by the SIM population health workgroup, one of seven workgroups that guide SIM, a federally funded, governor's office initiative that will help 25% of the state's primary care practices and four community mental health centers integrate behavioral and physical health during its four-year time frame.

"The multi-disciplinary approach to addressing the mental health of boys and men will help us change the health care dynamic in our state," said Gov. John Hickenlooper. "When health care experts work alongside other partners, we ensure Coloradans receive the care they need when they need it most."

SIM workgroup members selected boys and men because strategies to address behavioral health issues of this population are disproportionate to the burden of suicide and substance use, according to data published in the report.

"This actionable report will lead to meaningful change," says Barbara Martin, RN, MSN, ACNP-BC, MPH, SIM director. "It contains the type of data as well as context that will encourage more effective partnerships among communities, schools, employers and faith-based organizations that will lead to better health for boys and men as well as all Coloradans."

Examples of targeted outcomes published in the report:

- By 2028 Colorado will see a decrease in the percentage of men who report poor mental health.
- By 2028 Colorado will see a decrease in suicide rates for boys, working-age and older men.
- By 2028 Colorado will see a decrease in prescription drug overdose deaths for boys, working-age and older men.

> *"AFTER A BABY IS BORN, THERE IS A STRONG FOCUS ON THE MOTHER AND WE HAVE NOTICED THE FATHER IS OFTEN IGNORED," SAYS MEGAN SWENSON, MA, LPC, LAC, MANAGER OF INTEGRATED CARE AND CARE COORDINATION FOR JEFFERSON CENTER. "IT'S OPENED A LOT OF CONVERSATIONS AND GIVEN US THE OPPORTUNITY TO DELVE INTO THE HEALTH OF THE FAMILY, THE HEALTH OF THE CHILD AND THE HEALTH OF THE FATHER. WE TALK TO FATHERS ABOUT WHY THEY ARE IMPORTANT TO THE HEALTH OF THEIR FAMILIES."*

"This call to action will be used to shape behavioral health in Colorado to ensure better health outcomes," says Tista Ghosh, MD, MPH, director of public health programs and deputy chief medical officer, Colorado Dept. of Public Health and Environment, co-chair of SIM population health workgroup.

With a timeline that stretches through 2028, the report is intended to redefine how we talk about mental health, screen for conditions, enable

appropriate interventions and expand access to the right care at the right time in the right places.

Publication of the report is a culmination of time, energy and passion for SIM workgroup members, who will play active roles in disseminating findings and engaging partners in activities.

Implementation strategies

"I can already see ways this will be used in local public health agencies across the state," says John Douglas, Jr, MD, executive director for the Tri-County Health Department, co-chair for the SIM population health workgroup.

The report's focus on boys and men is appreciated by SIM partners at the Jefferson Center for Mental Health, one of four bidirectional health homes that is integrating physical and behavioral health with SIM funding. The team started paternal and primary child caregiver depression and anxiety screenings in January and have received positive feedback from new fathers about what they see as a welcome interest in their health. Additionally, Jefferson Center has started screening all parents and primary child caregivers for Adverse Childhood Experiences (ACEs). Studies have shown that high ACEs can affect a person's physical and mental health and possibly affect their parenting skills and the family's health.

"After a baby is born, there is a strong focus on the mother and we have noticed the father is often ignored," says Megan Swenson, MA, LPC, LAC, manager of integrated care and care coordination for Jefferson Center. "It's opened a lot of conversations and given us the opportunity to delve into the health of the family, the health of the child and the health of the father. We talk to fathers about why they are important to the health of their families."

Shannon Tyson-Poletti, MD, assistant medical director, Jefferson Center, concurs. "We focus a lot on moms and parenting with moms but we haven't focused on parenting and mental health of the dads, which is equally important for the development of the family and child."

The team screens all primary child caregivers for depression and anxiety, and offers healthy relationship counseling for adolescent young men and women.

"Our hope with that is to prevent trauma, domestic violence, future child abuse, substance abuse and mental illness in these young people," explains Tyson-Poletti. "Men and boys are equally important in this equation and cannot be ignored. Early intervention, rather than later intervention, leads to improved physical and mental health outcomes. We think this is a real opportunity."

Read the report for more information and context: http://bit.ly/mental-health-call-to-action.

COLORADO ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR COLORADO

Member Recognitions

Congratulations to family medicine resident Poorvi Pfenning, MD, on receiving a 2018 AAFP Foundation Family Medicine Leads (FML) Emerging Leader Institute Scholarship.

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.

BY LYNLEE ESPESETH

Perseverance And Passion: Dr. John Bender is On a Mission to Make Healthcare Work For Patients and Doctors

Dr. John Bender of Fort Collins, Colorado currently sits on the AAFP Board of Directors. He is running for AAFP President-elect at the 2018 AAFP Congress of Delegates in New Orleans this fall. Below, Dr. Bender talks about what drives him forward, how his family has shaped his life as a doctor, and his goals for the AAFP.

"I love America. I love the way our founding fathers set up our country, and I believe we can advocate to make it better." To hear Dr. John Bender speak, about his practice, his family, family medicine, or his work to make healthcare better for all, is to hear someone who has unending passion and energy for everything he does.

For the last three years Dr. Bender has been serving on the Board of Directors of the American Academy of Family Physicians, along with running his medical practice, Miramont Family Medicine. In those three years he has continued to watch the healthcare industry go through rapid and often difficult change.

"Healthcare remains an industry going through incredible change," says Dr. Bender. "We have had to shepherd members from SGR to MACRA, family physicians need relief from box checking, we need better EHR systems, and we need jobs that are more than data entry to keep the pipeline of family physicians strong. New politicians and elections always present new challenges, and we have had to make sure the good parts of healthcare reform are not lost."

With such a list of challenges one might expect Dr. Bender to feel defeated. But that just isn't a position he is willing to take. His passion for advocacy and his belief in the power of the family physician drives him forward to continue to make change.

"I have found that persistent resolve works. Going back to representatives year after year works," says Dr. Bender. And indeed he lives that philosophy. Dr. Bender has written three pieces of legislation, all that have passed with bipartisan support in the Colorado Legislature. He has also been a strong supporter on initiatives from other groups that would benefit family physicians.

"I have stood behind both Colorado Governors Bill Ritter and John Hickenlooper six or seven times for bill signings. There is so much pride in seeing that work come to fruition," says Dr. Bender.

Working at the state level has shown Dr. Bender what an exceptional place Colorado can be, both in terms of health innovation, and in the relationships the healthcare community has with the Governor, policy makers and other bodies.

"They listen to us," says Dr. Bender. "That same credibility should be happening at the federal level with messaging and strategies that work."

During his time on the AAFP Board Dr. Bender has been working hard to bring a Colorado mentality to the national level. He was in Washington, D.C. advocating for change four times last year. Those visits led to some strong victories, such as teaching health center funding increases from $60 million to $125 million, long range extension of CHIP funding, and prevention of multiple attempts at a full repeal of the Affordable Care Act.

Dr. Bender pushes all family physicians to get involved in the legislative process. Both to have a say in what will affect them, and because physicians are such a respected group at all levels of government.

"Some groups are not always trusted by politicians, but physicians and other healthcare providers are. Physicians have credibility. You are seen as genuine, hardworking, and caring. You can leverage that for the greater good," says Dr. Bender.

Beyond his passion for advocacy, it is Dr. Bender's family that keeps him driving forward to make healthcare better, and gives him a special passion for what he does.

"Patients will ask me, 'What would you do if this was your own mother?'" says Dr. Bender. "I want to answer that question earnestly and honestly."

Throughout his career Dr. Bender has had the opportunity to reflect on just how important and life changing a family member's illness can be. Dr. Bender diagnosed his wife Theresa with kidney cancer, and is thankful every day that she is now cancer free.

His family has also made him a strong advocate for change in mental health policy. His eldest son, a military veteran, completed three overseas tours to the Middle East. After returning from his third tour, he and his family became concerned that his son was experiencing Post

Photo

Traumatic Stress Disorder. As his concern grew, Dr. Bender eventually had his son visit one of the mental health practitioners in his own practice, where he was diagnosed with schizophrenia.

That diagnosis started a lengthy process of work to get the care and coverage his son needed. Even as a military veteran, one who had sacrificed so much for his country, the process was not easy. The help that Dr. Bender and his family encountered along the way made all the difference.

"I am thankful and grateful there were resources out there that we were able to call on for help, and I want that for all patients," says Dr. Bender. "Family medicine should continue to lead the way for behavioral health integration and to reduce the stigma of having a mental health diagnosis. We still see too much institutionalized discrimination towards mental health disorders. Our voice is their voice."

Given all of his experiences with advocacy and the deep knowledge gained from caring for his own family, what does Dr. Bender hope to achieve if elected President-elect of the AAFP?

"I want to press to gain as much as we can in the area of payment reform. Unless there is payment reform there are often not fixes in other areas," he says.

He is encouraged by the Advanced Primary Care Alternative Payment Model that the AAFP has proposed, and that has been brought to Health and Human Services Secretary Alex M. Azar.

"The Centers for Medicare and Medicaid Innovation have given the go-ahead to explore this," says Dr. Bender. "The model would increase access to primary care and it would increase the investment in primary care. When the focus is on primary care, expensive and sometimes wasteful services can be lessened. We need to get that message to media, to regulators, to policy makers, and to our members to get the changes we want."

Dr. Bender is also passionate about developing clinical expertise in family physicians in the areas of social determinants of health and population health. It's an area so often overlooked, but so vital to answer questions like: Do these medications actually work? Are people out of the emergency room? Are people actually healthy?

"No specialist can begin to touch this except family physicians," says Dr. Bender. "You have the expertise to do this."

Dr. Bender is eager to continue support of HealthLandscapes and other tools available to family physicians that allow them to impact the social determinants of health in big ways.

During his time on the Board Dr. Bender also served as the liaison to the AAFP Commissions on Membership, Governmental Advocacy, and Professional Development. He has served on the Board of the AAFP Foundation and as a curator for the Center for the History of Family Medicine.

Those positions gave him diverse opportunities to effect change for AAFP members, from awarding scholarships to students and residents to hearing member frustrations over maintenance of certification. All of those issues he has taken to heart, and is eager to continue working on.

Finally, Dr. Bender wishes to continue to be a source of guidance for the American Academy of Family Physicians through undeniably challenging times.

"Our nation needs a unity message," says Dr. Bender. "The Academy serves a robust and diverse workforce. Our power is when we come together in the Congress of Delegates, find consensus, and find that we are indeed rowing in the same direction. I am honored to be a part of the process as a leader in the Academy, and I will do everything in my power to continue that leadership message so we can continue to be the bold champion of family physicians."

2018 MATCH® RESULTS FOR FAMILY MEDICINE

The American Academy of Family Physicians' (AAFP's) brief analysis of the family medicine results of the annual National Resident Matching Program (NRMP) Main Residency Match® (NRMP Match) provides a snapshot of a major input into the primary care workforce pipeline.

2018 NRMP Match Highlights

- 3,535 medical students and graduates matched to family medicine residency programs in 2018, the most in family medicine's history as a specialty, and 298 more than 2017.
- Of those matches, 1,648 positions were filled with U.S. Seniors, an increase of 118 since 2017, yet still fewer than the historical peak (2,340 in 1997), and only 9.3% of U.S. Seniors matching.
- Family medicine offered 3,654 positions, 276 more than 2017, yet only 12% of positions offered overall, far off the goal of at least 25% by 2030.
- This is the ninth straight year that the family medicine match results climbed year-over-year, and the second largest year-over-year increase during that stretch.

Key Takeaway

While the NRMP Match results continue a nine-year trend of increasing numbers of positions offered, filled, and filled with US Seniors in family medicine, the pace needs to exceed dramatically to reach 25% of all residency positions in the Match filling with U.S. graduates in family medicine. The U.S. medical education system is far from delivering the medical workforce needed in the country it serves, and whose taxpayers fund it. The composition of residency training positions must reflect the composition needed in the workforce, and as such, needs to increase steeply in family medicine, primarily, and other primary care and a few subspecialty care specialties. Educational pipelines need to incentivize, recruit, and support a more diverse medical student population that better represents the U.S. population and that is more likely to choose primary care careers and serve in underserved areas. Substantial increases in the family medicine and primary care workforce are needed to improve the health of Americans and the sustainability of the health care system.

Photo via AAFP.

A Closer Look at the 2018 NRMP Match Results

A total of 30,489 PGY-1 positions were offered in all medical specialties in the 2018 NRMP Match, and 29,249 were filled. Of those, 17,740 were filled with seniors in Liaison Committee on Medical Education (LCME)-accredited U.S. schools of medicine (U.S. Seniors).

In the 2018 NRMP Match:

- Family medicine* offered 12.0% and filled 12.1% of the total positions
- The overall fill rate in family medicine was 96.7%
- The fill rate for U.S. Seniors in family medicine was 45.1%

**Includes family medicine-categorical, plus combined programs: emergency medicine-family medicine, family medicine-osteopathic neuromusculoskeletal medicine, family medicine-preventive medicine, medicine-family medicine, and psychiatry-family medicine.*

Looking Forward

The nation's family physicians, through representation in organized medicine, are calling for 25% of all residency matches to be graduates of U.S. medical schools—both allopathic and osteopathic—into family medicine by the year 2030. This vital and ambitious goal was envisioned and is supported by the eight family medicine organizations that represent Family Medicine for America's Health.

Achieving this goal will take both reform of the nation's graduate medical education system to provide

the composition of training opportunities that reflect the workforce needs of the U.S., as well as societal and educational support of transformed pathways to and through medical school such that U.S. medical graduates reflect the diversity—in the broadest sense of the term—of the U.S. population.

Cultural and systematic shifts such as what the family medicine community is calling for take time. Yet, the nation's primary care workforce shortage is already affecting patients and communities in every single state and exacerbated with each passing day. Family medicine is calling for dramatic changes to be implemented immediately, building with each year, toward the 2030 goal.

The family medicine community commits itself to leading and supporting this change, partnering with the public and private sector, medical schools and residencies, sponsoring institutions, policymakers and public officials, payers, communities, and their patients to change the trajectory.

Looking Back

A few procedural changes to the NRMP Match process are reflected in the results of the program this year and in recent history, meaning that variances and trends do not purely represent actual changes in the physician workforce pipeline. As the U.S. graduate medical education system moves toward a single accreditation under the Accreditation Council for Graduate Medical Education, the results of the NRMP Match reflect residency programs and positions moving to the NRMP. The 2018 Match reflects this more than any year since the SAS announcement in 2014, as the American Osteopathic Association Intern/Resident Matching Service saw its first decline in participation since the announcement. This means that a portion of the growth in family medicine in the NRMP Match does not reflect new training positions, but rather the shift from one matching service to another. The NRMP's All-In Policy, instituted in 2013, also caused a change in the way programs offered their positions, with programs that had previously only offered a portion of their positions in the NRMP Match now offering all of their positions in the Match. Again, some of the increases for family medicine, and overall, in the years since then have been a result of a shift in how positions were filled rather than reflective of new training opportunities or an increasing workforce.*Photo via AAFP.*

PROPOSED BYLAWS CHANGE FOR MEMBER CONSIDERATION

The CAFP board of directors is proposing the following bylaws change regarding filling vacancies on the CAFP board of directors. The CAFP board would rather not have members fill only a one-year vacancy and then possibly lose that experience by not being voted onto the board again at the next election.

Procedure:

Article XII – Amendments

These Bylaws may be amended, repealed or altered in whole or in part by a majority vote at any duly organized meeting of the CAFP. Any five (5) or more members may propose Bylaws or Amendments to Bylaws. The proposed change shall be emailed to each Board member at least ten (10) days before the time of the meeting which is to consider the change. At least thirty (30) days prior to said meeting, the staff executive shall provide notice of the availability of proposed amendments to all CAFP members. Such notice shall be sent by email or published in an official publication of the CAFP sent to the entire membership, shall include a summary of all proposed amendments and shall set forth a mechanism by which any member may obtain a copy of all proposed amendments.

Current Bylaws wording: Article VI, Section 2: Vacancies on the Board of Directors may be filled by appointment by the Board of Directors; provided, however, that such appointment shall terminate at the next annual meeting, at which time the members shall present a nominee for the unexpired period, if any.

Proposed wording: A one-year vacancy on the Board of Directors may be filled by the board of directors based on the prior election results and recommendation of the nominations committee for the one year term plus an additional three-year full term. A two-year vacancy may be filled by the board of directors by appointment with input from the nominations committee, provided, however, that such appointment shall terminate after the two years. ~~at the next annual meeting, at which time the members shall present a nominee for the unexpired period, if any.~~

If you have any concerns or changes to this proposal please contact raquel@coloradoafp.org. Thank you.

WELCOME NEW MEMBERS

The CAFP would like to welcome the following new members who joined our organization in March, April and May.

NEW AND RETURNING ACTIVE MEMBERS

DAVID BUBIS, MD
SHANE CASS, DO
KYLA KROFTA, MD
JEFFREY LEININGER, DO
BRETT LINDAU, DO
VICKY MATHWIG, MD
SANDRA MCCOWEN, MD
LINDSEYMETCALF, MD
PAVITRA PATEL, MD
SNEHAL REDDY, MD
JOHNNY SHEN, MD
CHRISTEN VU, DO
MATTHEW BEAL, MD
RYAN FISHER, MD
KRISTOPHER MURPHY, DO
YVONNE NELSON, MD
NATHANIEL CHAPPELLE, MD
DOUG GOLDING, MD
VIKAS REDDY, MD
SHANTELL TWO BEARS, MD
TONY WILLSON, MD

NEW STUDENT MEMBERS

CORIN ARCHULETA
HUNTER ARONSON
RIANNON ATWATER
LYNDSEY BABCOCK
NICK BIANCHINA
AMRITA CHAGER
TIMOTHY CHILTON
CLAIRE CLIFTON
TATE CORRELL
LANCE FRANK
ABHINAV GUPTA
LAUREN HEERY
BROOKE JOHNSON
LAKSHMI KARAMSETTY
VEERAL KATHERIA
COLTON LEAVITT
DANIEL LEV
ELIZABETH LINXWILER
LISA MOORE
MICHAEL MOUBAREK
DEVAN PARTRIDGE
EMIL PATEL
KYLE PHIPPS
MICHAEL POSER
TIFFANY REBAK
KANJANI SHUKLA
ANDREA THOMAS
TYSON TORGERSEN
THEA TRAN
GRAEY WOLFLEY
ASHLEY WOODWORTH
ZACHARY WUTHRICH
JASON ZHANG
HEROS AMERKHANIAN
RICHARD ANDERSON
ELLIOTT ANTMAN
DANIEL BERNET
CHRISTOPHER CANARIO
ADAM CARROLL
RACHEL CARROLL
BRENT FOWLER
NISA FRASER
FRED GONZALES
PENELOPE ANNE HERDER
JARED JOHNSON
MICHAL KLEPADLO
ANDREW LAMP
DANIELLE LATTES
COLLEEN MAHER
SHELBY MESTNIK
IAIN MILLER
CHELSEA MOODY
TARAH NELSON
SAMANTHA OLSEN
CHRISTINE REMPEL
ROBERT SEAWELL
NICHOLAS SLOAN
ANDREW TOBLER
MATTHEW TORRES
ASHLEY TOUSSAINT
JACLYN ANDERSON
KAILY BAER
STACEY HEINDL
ALISSA LENZ
COLLEEN LONG
ROBERT MELLER
BAO TRAN NHAN
CHRISTINA VELASCO

NEW RESIDENT MEMBERS

JENNI ADAMS, DO
AMY BEAUPREZ, MD
MARGARITE BECHIS , MD
ABRIA BONNER, MD
ERIK BOWELL, MD
PAOLA CASILLAS, MD
STEPHEN CHEUNG, DO
BRYAN DAHMS, MD
DANIELLE EVES, MD
ZACHARY GASTELUM, MD
LAURA GIBBONS, DO
KELSEY HEINRICH, MD
HALEY HOFFMAN, DO
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KATHERINE KLEIN, MD
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BRINGING ADDICTION TREATMENT AND HOPE TO RURAL COLORADO

BY LYNLEE ESPESETH

Addiction continues to ravage rural Colorado communities. Opioid, alcohol and methamphetamine use disorders have devastating effects on patients, and treating these conditions can leave rural providers feeling isolated and overwhelmed.

A new program based out of St. Mary's Family Medicine Residency in Grand Junction wants to change that. The telehealth program they have developed offers hope, connection, and quality care to both patients and providers.

The program's participating specialists Dr. Ryan Jackman and Tonya Cook spoke with the CAFP about the difference they want to make across western Colorado and beyond.

CAFP: Tell us more about the program.

Initially the goal was to provide a service that has limited availability on the Western Slope, namely addiction therapy. However during the grant development process the scope was expanded to include psychopharmacology and management of controlled substances based on the number of questions from providers in those topic areas. The PATH (providing access to telehealth) program was started in September 2017 and will continue with grant funding through September 2019. The participating specialists are Dr. Ryan Jackman, a family medicine trained physician who is also board certified in addiction treatment, and Tonya Cook, a clinical pharmacist. The PATH grant is based out of St. Mary's Family Medicine Residency program in Grand Junction, CO. From there 12 clinics throughout the Western Slope have up to 5 hours of support each month.

Goals include development of telehealth infrastructure, further development of clinicians, and provision of direct patient care services. Distant sites log into the telehealth platform for one or two hour blocks at a time. During each distant site's designated block of time referred cases are reviewed in a provider to provider consultation, or with the patient joining the session as a co-visit. Sites are also offered assistance with troubleshooting the telehealth platform/technology, answering billing questions, and assisting with the development of local policies.

CAFP: Was the program a response to our state's opioid crisis?

While the opioid crisis is a component of the program's aim, it was not the sole driver of developing the PATH program. Given that western Colorado has a high number of small towns and cities, there is a certain degree of professional isolation that occurs among providers. This can make caring for chronic conditions all the more difficult to address when you, as a provider, are really the only realistic option for this person to receive regular care. Referrals are only so feasible when hindered by miles. This is the reality that caused us to propose offering telemedicine consults for both addiction medicine and psychopharmacology to 12 clinics in western Colorado. The patients that need these services are in every community in western Colorado, but the number that are receiving them is hampered by mileage. Taking the service to the patient, where they are, through telehealth seemed like a more realistic way to deliver these services, while involving the providers that will be working with them, hopefully to allow for improved continuity.

In regards to addiction in particular, western Colorado isn't unique in how it is experiencing a rising number of substance use disorders while facing a shortage of providers who are available or who feel prepared to care for this chronic disease. While the opioid crisis is bringing much needed attention both statewide and nationally to the disease of addiction, Colorado is facing even higher rates of alcohol use disorder, and methamphetamine

use disorder is still rampant in western Colorado. PATH is allowing providers in these more isolated communities to reach out on behalf of, and often alongside their patients, to get evaluation and recommendations on these conditions. As far as how PATH is addressing opioids? I think the biggest impact that we are being able to have is to educate providers and patients regarding chronic pain and chronic opioid therapy. We are seeing patients who have been on prescription opioids for decades who are now being told they need to come off opioids. The providers are hearing the message that opioids are not the best treatment option for their patients, but the patient has been on these medications for so long that both they and the patient feel stuck. We are able to come in and provide individualized reviews of patients and discuss whether the patient is just dependent on opioids and help address a taper plan, or if the patient has developed opioid use disorder and would be a good candidate for an opioid agonist therapy like buprenorphine. Whether in individual case reviews or in telemedicine visits with the patient and provider, PATH is providing practical and actionable answers for patients and providers.

CAFP: Why might family physicians be interested in this work? Is there a point of contact for our members who might have more questions?

Of the 12 clinics that the grant has allowed us to work with, 11 are primary care clinics. Far and away it was the family physicians that reached out and expressed interest in participating in the program when enrollment was advertised. Often times, this interest was born out of the fact that family physicians are caring for chronic pain syndromes in high numbers, and many have inherited patients who are on chronic opioid therapy. So many physicians in Colorado are struggling with what to do about these chronic opioid regimens in their patients, and so this type of service is a win-win for the provider and the patient. Attending CME lectures on proper opioid prescribing can only go so far to address the idiosyncrasies and needs of the individual patient you see in clinic on opioids. Being able to sit down with your patient and discuss this difficult clinical scenario with other providers with specific training seems to make that discussion easier and seems to be improving patient buy-in. Unfortunately, the site enrollment is now closed, but should other groups have interest in the particulars of setting up the program we would be happy to share with them the process.

Primary investigator of the PATH grant is Tonya Cook, PharmD and can be reached at tonya.cook@sclhs.net.

CAFP: There are a few telehealth efforts in the state (for example the ECHO program). How does your program compliment or offer a unique service next to such programs?

The PATH program offers not only case based mentorship much like the ECHO program, but also co-visits with the patients. The combination of education, case review and direct patient services allows for site and provider development. Each distant site has also been able to tailor how their block of time is utilized. For example, one distant site may choose to focus on controlled substance management including mentorship in suboxone induction and maintenance. Another site may allot more of their time for psychopharmacology and polypharmacy management. Ultimately the goal is to compliment the efforts of other programs while offering access to both a physician and a pharmacist. In addition, distant sites can assess whether or not telehealth is an appropriate platform for their practice without committing a large amount of resources.

CAFP: Anything else about the program or your work you would like to include?

There are numerous efforts statewide to be able to address opioid prescribing, opioid use disorder, and co-occurring mental health disorders. The PATH grant has been able to be involved in coordinated efforts with other projects such as the IT-MATTTRs project out of the University of Colorado which is expanding buprenorphine waiver training in Colorado. As opioid use disorder is identified in patients, the lack of available buprenorphine in these communities becomes apparent to the participating providers, and when it is a little closer to home we have observed these same providers wanting to get training to provide for their patients. To date we have trained at least one provider in 5 of the 12 sites and have plans to host more trainings alongside IT-MATTTRs due to provider driven interest. While it was not a planned outcome, the format of PATH has allowed for mentoring and oversite among providers that has caused many to feel more comfortable with prescribing buprenorphine.

The range of cases has been interesting to say the least. It's always a little reassuring to see you are not the only one with patients who are challenging to care for, and the collaboration process helps to ease the workload. Through the work some sites as a whole have become more comfortable caring for patients with opioid or other use disorders. It's a good day when a patient is able to reach needed care through telehealth. It's a great day when a provider also shares how they've applied what they've learned to other patients.

THE PATH PROGRAM OFFERS NOT ONLY CASE BASED MENTORSHIP MUCH LIKE THE ECHO PROGRAM, BUT ALSO CO-VISITS WITH THE PATIENTS.

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