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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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MATERIAL IN ARTICLES AND ADVERTISEMENTS DO NOT NECESSARILY EXPRESS THE OPINION OF THE COLORADO ACADEMY OF FAMILY PHYSICIANS. OFFICIAL POLICY IS FORMULATED BY THE CAFP BOARD OF DIRECTORS AND CONGRESS OF DELEGATES.
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**Questions:** Martha Gonzales 602.747.4328

At the end of the day, **this** is where you want to be.
2019 - “I know we all miss this one year.”
We were carefree, celebrating with friends safely. Rarely were blue masks seen outside of a surgical suite. The US women’s soccer team won the World Cup. Greta Thunberg led climate protests, scolding world leaders for failing to address climate change. Thanks to vaccines, pediatric diseases were significantly reduced. A malaria vaccine was created. And, in the earliest days of 2020, I listened to a podcast about a little known virus that was devastating Wuhan.

2020 - “I couldn’t miss this one this year.”
I remember the uncertainty, the devastation, the phenomenal loss of life. The country and world banding together in shock and determination to overcome. Most supported our medical providers’ dedication and sacrifice. Most sacrificed by wearing masks and social distancing to protect the most vulnerable amongst us. Most optimistically rooted for scientists to create a protection from a once in a century scourge on a seemingly impossible timeframe. And then it happened, the pandemic left the realm of fact, science and medicine and became strangely political.

2021 - “But, I think I’ll miss this one this year.”
The media used the pandemic to its own ends. Facebook became science. Doing your own research meant reading social media blogs. Masks became muzzles, and social distancing became tyranny. Exhausted and demoralized medical providers were no longer trusted, until you got sick. The miracle vaccine was labeled a microchip tracker, sterilization, genetic manipulation, toxic and deadly. These false conspiracies traveled the world more quickly than the virus itself. And the deepest empathy wells were strained.

2022 - “Happy New Year?”
Few doubt the tenacity of COVID. However, I know the dedication of family medicine physicians, speaking truth to the fearful. One by one more people become vaccinated. More of our children are now becoming vaccinated. And hopefully the youngest amongst us will soon be protected. Thank you all for everything you do and sacrifice. I am optimistic that 2022 will “get this winter over with!”

---

November, 2021 Board Meeting Highlights

1. The CAFP continues to prioritize our COVID response. We are taking a three-pronged approach through 1) encouraging vaccination (including pediatric and booster administration); 2) encouraging stronger statewide indoor mask requirements; and 3) increasing access to COVID-19 treatments such as monoclonal antibodies.

2. As stewards of the CAFP and our financial future, the CAFP board adopted a revised investment policy statement to ensure our financial resources are invested using environmental, social and governance/socially responsible investing principles.

3. Following an August board retreat workshopping the strategic plan, CAFP revised its strategic plan to incorporate a more central objective of health equity through our three strategic priorities: 1) Advocacy; 2) Education; 3) Health of the Public and Member Engagement.
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Family medicine in rural Colorado sustains our communities from the mountains to the plains, and family physicians work in every county in the state to ensure patients have the care they need. We always aim to ensure CAFP represents the unique needs and interests of our rural members, and we have several projects on tap to do so.

Full scope family medicine remains a hallmark of rural primary care and we have many leaders in Colorado working to ensure that continues well into the future. There are headwinds, to be sure, but the case for comprehensiveness is strong. Bazemore et al. (2015) highlighted that comprehensiveness yields lower costs and fewer hospitalizations. On page 24 of this magazine you can read from Deutchman et al. (2021) that family physicians provide over 50% of all maternity care in rural areas. If the family physicians in your community face efforts to limit scope or rollback credentialing for procedures, we can serve as a resource to identify potential colleagues and expertise to help make the case for preserving your comprehensive practice.

An important factor in rural Colorado is, of course, the workforce. CAFP led a legislative effort to establish a $1,000 tax credit for rural preceptors in 2016, and we will again be bringing a bill this year to extend that credit for future years. We will also be supporting an effort to boost state funding by several million dollars for medical students in a rural track, as well as maintain funding for the five Rural Training Tracks run by Colorado’s family medicine residencies.

These advocacy efforts are part of a strategy bolstering the rural workforce, while another pillar of our advocacy focuses on information technology. We fought for and passed a bill to permanently extend coverage of audio-only telehealth, as well as permanently expanded coverage by Medicaid of telehealth services including those provided by federally qualified and rural health centers. This year, we are advocating to establish a $15 million health IT grant program proposed by Governor Polis for rural practices that could be used to shore up or acquire updated electronic health record systems, modernized equipment, and more.

Beyond advocacy, we have opened many more opportunities for learning through CAFP’s Virtual Continuing Medical Education (CME) programming. These CME events take place twice per month, typically on Wednesday over lunch, so that members across the state can connect and learn the latest in medicine. Upcoming programs can be viewed at www.coloradoafp.org. We were also pleased to join the Farley Health Policy Center at the University of Colorado School of Medicine along with the Colorado Hospital Association in a case series to learn and build capacity to meet the challenges faced in rural clinics, and we look forward to additional opportunities through this partnership to strengthen rural health.

Finally, the CAFP staff look forward to once again visiting rural members over the summer to meet and hear directly how rural practice is going and how we can better meet your needs. The vital role family physicians play demands that we do all we can to ensure longevity in a rural career and a commitment to bringing new physicians to these communities. We strive to engage rural members through membership on the CAFP board, legislative and education committees, and we extend a warm welcome to you if you would like to join your colleagues serving in these capacities. And knowing the demands of rural practice, we always welcome your ideas, questions and input by simply reaching out to any of the CAFP staff.

BY RYAN BIEHLE, MPA, MPH, CAE
EXECUTIVE VICE PRESIDENT AND CEO
“This is an illness. We’ve got to remember that.”

Ozzie | In Recovery | Commerce City, CO

Learn more about how to treat opioid use disorder at LiftTheLabel.org/Training
BY ERICA PIKE, MS, DIRECTOR OF POLICY & GOVERNMENT RELATIONS

What We Can Look Forward to This Year

The Colorado Academy of Family Physicians is excited about advancing our 2022 advocacy agenda following a successful 2021 legislative session that also saw many regulatory accomplishments. As poet Miller Williams reminds us on the opposite page, we will bring both the lessons from the past and a renewed hope for the future into 2022.

In 2021, the Academy championed family physician values and priorities as we navigated challenging policies and circumstances related to the ongoing COVID-19 pandemic.

We spoke up against anti-vaccine legislation, which was defeated. We promoted policies that would decrease costs for patients such as the Prescription Drug Affordability Board, which will set upper payment limits on cost-prohibitive drugs. We sent over 150 letters to the Governor regarding the state’s ongoing COVID-19 response, which resulted in the CO Primary Care Provider Vaccination Grant Program that offered nearly 60 million dollars for providers to establish COVID-19 vaccination clinics.

But, the work continues. The news of the Omicron variant has us on alert, so we will continue advocating for access to COVID-19 treatments and preventive measures that can be taken to protect the health of Coloradans.

We will also be pursuing both short and long-term solutions to workforce shortages and extreme burnout that are crippling family physician practices across the state. Together with the Colorado Rural Health Center, we will be bringing the Rural Preceptor Tax Credit program before the legislature again to ensure the program’s continuity.

The CAFP will also be addressing the ongoing administrative burdens our members face by encouraging investments from the state for
providers to improve their health information systems and integrate the Prescription Drug Monitoring Program into their electronic health record system.

Finally, we will continue to champion statewide payment reform efforts through active participation and leadership in the Lieutenant Governor’s Office of Saving People Money on Health Care’s Alternative Payment Model Alignment Initiative and the Division of Insurance’s Primary Care Payment Reform Collaborative. We will also inform and advocate for legislative activities and budget requests that embrace payment models that improve reimbursement for high quality primary care delivery and reduce health disparities.

This is no short list of goals we have, and it will take all of us to advance this ambitious advocacy agenda. Stay up to date on how you can get involved by signing up for our monthly Advocacy Insiders newsletter at coloradoafp.org/advocacy-insider or by emailing Erica Pike, Director of Policy & Government Relations at erica@coloradoafp.org.

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Greetings again from SNOCAP-

As I write this, we just got back from a Thanksgiving break and are sweating our way through December before the winter holidays. We hope you had a chance to enjoy time with family and loved ones; virtually or in-person. Especially in the middle of the pandemic it’s important to do so. We are thankful of your support and all you do in your communities to contribute to health and wellness.

SNOCAP has stayed busy and in-touch with many of you. Many recently participated in the NAPCRG Annual Conference from November 19-23. We were virtually able to be in community with friends and colleagues from across the world! We also recently wrapped up an internal SNOCAP project looking at the patient perspectives of their primary care team burnout. Practice card study surveys just wrapped, and analysis is soon to begin. We are thrilled to share the results in the coming months.

At the tail end of November, we launched our 11th COVID-19 Response Survey for practices state-wide. If you have been tracking along with SNOCAP for some time, you may know that we spent a great deal of time from March 2020-January 2021 surveying practices and reporting on how COVID-19 was affecting practices, patients, and the wonderful work done in partnership. If this is sounding new and interesting to you, you can learn more by visiting: https://bit.ly/SNOCAPCOVIDwebsite.

Other COVID-19 work that SNOCAP has been engaged in is their Colorado Community Engagement Alliance (CO-CEAL) where, among other activities, we are conducting five rapid Boot Camp Translations to develop materials in five diverse communities across Colorado to address COVID vaccine hesitancy. Follow our @Colorado_CEAL Twitter account to track the progress on this important work.

We’re sure you have a lot in the works as well. Please reach out and let us know what’s going on in your neck of the woods! Until then, that’s all for this quarter. Thanks for all of your work and please stay safe. We’ll get through this!

Join the SNOCAP bi-monthly newsletter: bit.ly/SNOCAPnewsletter
Follow along on Twitter: @SNOCAPpbrn
Email Don Nease: Donald.nease@cuanschutz.edu

Best wishes!
Don, Mary & the entire SNOCAP Team
PATIENT ACCESS TO MEDICAL RECORDS

BY COPIC’S PATIENT SAFETY AND RISK MANAGEMENT DEPARTMENT

In the era of open access, patient portals, and new information blocking rules, patients now have the ability to demand documentation of their visits with medical providers. Besides just wanting to review their records, patients sometimes make these requests for issues such as workers’ compensation, divorce and custody controversies, life or disability insurance application reviews, and ongoing legal proceedings. In each situation, sensitive information and potentially adverse comments in the record may result in unfavorable consequences for the patient.

Under HIPAA’s Right of Access, patients have the right to review (free of charge) and receive a copy (for a reasonable, cost-based fee) of their medical and billing records and any other records that are used to make decisions about a patient.

A patient’s right to access his or her electronic medical information was further expanded with the Information Blocking Rule under the 21st Century Cures Act (“Cures Act”) that went into effect April 5, 2021. Upon request, patients and other permitted requestors may now request “immediate” access to a large segment of their medical records and can demand that the information be downloaded to an app of their choosing. Additionally, under the Information Blocking Rule, providing access to other treating physicians (for treatment purposes) must also be provided without undue delay.

For example, under the Information Blocking Rule, providers should be aware that the Office of the National Coordinator (ONC) has made it clear that lab and test results must be immediately provided, upon request, once those results are available to the facility or practice. It is no longer permitted to delay access until after the physician or other provider has had a chance to review the results. The ONC has also made clear that access to other treating physicians to requested medical records must be provided, without delay and without requiring a HIPAA authorization form.

A list of the most common records that a provider is not required to produce (i.e., patients do not have a right of access) includes:

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

A common myth is that you cannot provide copies of another provider’s records that are contained in your records. This is not true. A HIPAA FAQ specifically states that a provider can produce such records and, in fact, it may be a violation of the right of access if you do not do so when requested by the patient.

The Privacy Rule and the Information Blocking Rule require health care providers to provide access to the records in the form and format requested by the patient, if readily producible in that form and format, or if not, in a readable hard copy form. For example, under HIPAA, if a patient requests an electronic copy of a paper record, the provider is required to scan the paper information into an electronic format.

- **Under HIPAA:** Physicians are required to provide the records in a “timely” manner (as soon as reasonably possible, but no later than 30 days after the request which will likely be reduced to 15 days under a current proposed amendment).
- **Under the Information Blocking Rule:** Access must be provided “immediately” or “without undue delay.” While the terms are not defined, commentary from the ONC makes reasonably clear that access must be provided within minutes or hours. Several days to provide access will not be acceptable. Further, ONC has made clear that compliance with HIPAA’s timeframes will not be a defense to an Information Blocking violation.

At Optum Colorado, we are guided by the Quadruple Aim of enhancing patient experience, improving population health, reducing costs, and delivering exceptional provider experience.

Creating opportunities for physician growth and leadership development—while maintaining a healthy work life—are fundamental to that fourth provider element. Allowing physicians to work at the top of their license is the best way to improve lives.

**Physician Growth**

As a provider, you’re caring for patients on the front line. We believe that investing in growth and development is critical to your future.

Whether you are starting out, a seasoned provider, preparing for your first leadership position, or have aspirations for advanced leadership, we offer programs spanning clinical, professional, and leadership development which you can customize to your own interests and pace.

Optum Colorado is actively engaged in the Clinician Experience Project which is dedicated to helping clinicians drive successful outcomes via app-based progressive skill-building to enhance the patient experience, fuel team collaboration, and develop clinical leadership. Physicians joining the Optum Colorado family, which includes New West Physicians in Denver, Optum in Colorado Springs, and Mountain View Medical Group throughout the Pikes Peak region, are automatically enrolled in this innovative program which now comprises over 50 health systems and 20,000 clinicians.

**Physician Leadership**

Physician-led medical groups empower physician leaders both in local markets and at the national level. Physician leadership, expertise, and insight identify opportunities to increase high-value care and create more efficient clinical pathways. A key tenet of an improved system is facilitating clinician-directed organizational strategy and planning.

At Optum, this provider-led approach is implemented...
through shared Clinical Governance. The Physician Executive Council is tasked with tackling important pieces of the Quadruple Aim and helping set organizational strategy while Optum’s Clinical Councils bring together physicians, clinicians, and other leaders to drive tactical decisions about our long-term operational approaches. These councils ensure we are deliberate in empowering our clinicians to drive how care is provided.

**Physician Wellness**
Our team-based model places clinicians at the center and surrounds them with the tools and support they need. However, with 45% of doctors feeling at least one symptom of burnout, it’s essential to recognize the emotional, physical, and professional demands placed on health care providers which have been further heightened by the emotional exhaustion of the COVID-19 pandemic. Assuming responsibility for the health of patients is inherently stressful, though not necessarily negative. As resilience in the medical field is a tall order, intentional practice of mindful awareness is needed to keep clinicians functioning at their healthiest.

Clinicians are human, vulnerable to the same issues they diagnose in patients, such as depression resulting from isolation or stress contributing to cardiovascular disease.

We’re investing time and resources to help our providers and to improve their overall physical, spiritual and emotional health. Foremost is a workplace that enables providers to spend more time doing what they were trained to do—providing excellent care to patients, while reducing managerial and cumbersome tasks—and maintaining proper staff levels to reduce stress on physicians in the first place.

We’re taking steps to identify and heal the hectic, disconnected medical office by implementing well-studied methods in creating positive workplace cultures and providing free access to “Sanvello,” a one-stop wellbeing app with resources in self-care, peer support, therapy, and coaching needed to help improve mental health.

After all, healthy clinicians are more capable of providing high quality patient care, and a positive workplace is more likely to retain staff, make fewer mistakes, and have higher patient satisfaction.

**Consider the difference you could make.**

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ACIP Recommends Pfizer-BioNTech COVID Vaccine for All Children 5-11 Years of Age

On November 2, 2021, I (RF) listened to most of the day’s presentations and Advisory Committee on Immunization Practices (ACIP) debate on whether the Pfizer-BioNTech COVID vaccine, recently approved for children 5-11, should be universally recommended. The results of a Phase II-III trial involving approximately 3,000 vaccinees and 1,500 placebo controls were presented. No safety concerns were identified in the trial, though the presenters freely admitted that the trial was not powered to detect rare adverse events.

The Pfizer reps, Centers for Disease Control and Prevention (CDC) officials, and committee members relied substantively on the overall safety record of a similar vaccine now received by a few hundred million adolescents and adults in the U.S. Immunobridging criteria – that is, demonstration that the immunogenicity of this vaccine in the children was equal to or better than that seen with the adult vaccine whose efficacy is known – were met.

FDA did not require efficacy data to issue an Emergency Use Authorization for this vaccine. However, Pfizer did have some efficacy data: 90 percent in the trial, calculated from the observance of 16 COVID cases in placebo recipients and 3 cases in vaccinees, with follow-up about 3 months in half the group and two weeks in the other half.

ACIP members and liaison representatives were unanimous in their sentiment that these findings were sufficient to support a universal recommendation for children. Public comments were heard, roughly half pro and half con. The objections included 1) concern about governmental mandates which could be tied to ACIP recommendations, 2) a sense that follow-up had not been long enough, and 3) a sense that COVID disease in the vast majority of children was not severe enough to warrant taking the risks. CDC officers pointed out that though rare, tragic COVID deaths in 5-11 age children had occurred, and the available data suggested that a majority of these could have been prevented with vaccine.

At the end of the day, the vote to recommend was unanimous. The vaccine dose is 10 mcg (compared to 30 mcg in the adult formulation) and has a different stabilizer (promethamine instead of PBS). Two doses three weeks apart are required. See tinyurl.com/y42t58uz for more detailed information, including slides from the presentations given at the meeting.

New Recommendations for Pneumococcal Vaccine in Older Adults

For some time, efforts to improve on the prevention effectiveness of the vaccine against pneumococcal infections have been ongoing. A vaccine (PPSV23) made from the bacterial polysaccharide capsule has been available since 1983. It is so named because it contains 23 of the serotypes most often responsible for invasive disease (tinyurl.com/hen4m2u3).

However, polysaccharide alone, in a vaccine, does not stimulate the immune system as well as a molecule composed of polysaccharide linked (“conjugated”) to a protein. Conjugate vaccines for both pneumococci and Hemophilus influenzae have replaced plain polysaccharide vaccines in infants and children, and would do so in older adults as well if they covered enough pneumococcal serotypes. Gradually, the number of serotypes represented in pneumococcal conjugate vaccines has grown.

When the conjugate vaccines had just 13 (PCV13), the disadvantage from the missing serotypes approximately balanced the disadvantage of the less robust immunity from using PPSV23. In mid-2021, a conjugate vaccine with 15 serotypes and one with 20 serotypes were licensed. These shift the balance of benefits.

In its October 20 meeting, the ACIP unanimously voted to recommend:

- PCV20 by itself or
- PCV15 followed by PPSV23 for
  - adults aged 65 years or older who have not received a pneumococcal conjugate vaccine before or whose vaccination status is unknown and
  - people aged 19 to 64 years who have an underlying medical condition or other risk factors and who also have not received a pneumococcal vaccine.

PCV20 holds the advantage of nearly as broad a coverage as PPSV23, with much better efficacy. One can thus get nearly the “best of both worlds” with a single shot. See tinyurl.com/ym2pfs36 for further details.

Undervaccination tied to pertussis risk among children

Infants are most susceptible to severe pertussis disease. Complications include encephalopathy, pneumonia, seizures, hospitalization, and death. The CDC reported 307 deaths from pertussis between 2000 and 2017. Children younger than two months accounted for 84 percent of those deaths. In 2018, pertussis incidence per 100,000 was 72.3 in infants younger than 6 months and 32.7 in infants aged 6 to 12 months, compared with 1.4 in persons aged 20 years or older. Since widespread use of the Bordetella pertussis vaccine began, incidence of pertussis cases has decreased more than 75 percent compared with the prevaccine era.
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Unfortunately, data show that only about half of pregnant women receive Tdap, leaving many women and their very young infants at risk for pertussis. A recent study (tinyurl.com/2xpv2xh3) in JAMA Network Open underscored the additional increased risk to infants and children from undervaccination with DTaP. An editorial (tinyurl.com/45wj9eu4) about the study discussed the findings that undervaccination (receiving fewer than the recommended doses at a given age) and delayed receipt (not receiving doses within the time frames recommended by the CDC) of DTaP vaccine increased the risk of pertussis 4.8-fold for the primary series in infants and young children, 3.2-fold for the second-year reinforcing dose, and 4.6-fold for the prekindergarten booster.

Fortunately, the study showed that a small delay in administration had no apparent effect on risk if the number of doses was received in an age-appropriate manner. However, the researchers found that pertussis incidence was higher among children aged 2 to 5 years who did not receive the prekindergarten booster. They also found that school-aged children are core spreaders who help sustain pertussis transmission chains due to increased contact rates.

Older children and adults can transmit pertussis to those at risk for complications. Parents, most often mothers, are commonly identified as the source of pertussis in infants, as are siblings. With waning immunity, vaccinated siblings and caregivers can still transmit pertussis to infants aged six months or younger.

The editorial concluded, “Decreases in routine vaccination mean children and their communities face an increased risk for outbreaks of vaccine-preventable diseases. With close to four million births per year in the U.S., pregnant women also must receive the Tdap vaccine during the 27th through 36th week of each pregnancy, preferably during the earlier part of this time period, which lowers the risk of pertussis in babies younger than 2 months by 78 percent.

More parents mentioning safety concerns when deciding against HPV vaccination for children

A recent study in JAMA Network Open (tinyurl.com/4wvtn28m) of over 39,000 unvaccinated adolescents inquired as to whether safety concerns about human
papillomavirus (HPV) vaccine for children were aligned with the available safety surveillance data for the vaccine.

The study found that from 2015 to 2018, the proportion of parents who cited safety concerns as their primary reason not to initiate the HPV vaccine grew from 13.0 percent to 23.4 percent. This trend was seen in 30 states. Over the same time period, the adverse event reporting rate for the vaccine decreased from 44.7 percent to 29.4 percent. The reporting rate for serious adverse events did not change.

It should be noted that this study included only unvaccinated adolescents; therefore, the change in level of safety concerns can be interpreted only by comparison to other reasons for not receiving the vaccine. The changes over time in either direction between vaccine acceptance and vaccine refusal were not evaluated. Nonetheless, the discrepancy between perceptions of adverse event risk, and documented adverse event risk is real, and needs to be countered by sensitive, factual education initiatives.

**CDC data: Majority of adults missed routine vaccines in 2018**

According to a May 2021 report in CDC’s Morbidity and Mortality Weekly Reports (MMWR) (tinyurl.com/v34svf8z), a majority of adults in the U.S. went unvaccinated for one or more vaccine-preventable diseases during the 2017-2018 season.

In fact, if receipt of an influenza vaccine within the past twelve months is included in order to score an individual as “up to date on recommended vaccines”, the report showed that only 20.2 percent of over 25,000 respondents qualified. The up-to-date rate varied widely by age, at

- 26 percent for 19-49 years,
- 7 percent for 50-64 years, and
- 23 percent for those over 65.

Non-receipt of a herpes zoster vaccine was a primary driver of the low rates in 50-64 year olds, since the subunit zoster vaccine is recommended starting at age 50. The racial and ethnic disparities in coverage that we have, unfortunately, come to expect in surveys of health care utilization, are seen in nearly every table of the publication. Black and Hispanic respondents are less likely to be up to date than White respondents.

The deficits are due to a combination of failure to keep up with recommended routine care visits, and failure to administer recommended vaccines when visits do occur. Patients and clinicians will need to decide that admittedly rare events are worth preventing if they can be prevented with relatively little cost or hassle. It is a matter of being honest with ourselves.

---

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Increasing Quality of Healthcare for Individuals with Physical Disabilities:
AN ONLINE CURRICULUM FOR PRACTITIONERS

In February 2022, a new CAFP-accredited online course will be available to healthcare professionals aimed at increasing their knowledge and skills to provide quality care to individuals with long-term physical disabilities. The course, “Disability-Competence Curriculum for Healthcare Providers,” developed by the Chanda Center for Health, an organization delivering and advocating for services to improve health outcomes for persons with physical disabilities, provides an in-depth look at ways individual healthcare professionals, their medical teams & administrative staff can better serve this population as members within the system of care, which include those with spinal cord injury, brain injury, spina bifida, and more.

Why Disability-Competency in Healthcare?
Persons with disabilities are considered a health disparity group, in that they are subject to avoidable inequities in access, and in the quality of, health services. While concerns around transportation, communication, and insurance are contributing factors, the knowledge gap amongst physicians in serving individuals with disabilities is the primary contributor to this inequity. In 2009, a report by the National Council on Disability noted “the absence of professional training on disability competency issues for health practitioners is one of the most significant barriers to preventing people with disabilities from receiving appropriate and effective health care.”

How is this Possible?
Some healthcare professionals, in their daily work to provide care, struggle to fully incorporate the structural or cultural needs of persons with disabilities. People with disabilities are humans too, and yet...

There is the Americans with Disabilities Act (ADA), a civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including employment, schools, transportation, and all public and private places that are open to the public.

There is Section 510 of the Rehabilitation Act, which includes a provision to amend the original Rehabilitation Act to “address access to medical diagnostic equipment, including examination tables and chairs, weight scales, x-ray machines and other radiological equipment, and mammography equipment... The standards are to address independent access to, and use of, equipment by people with disabilities to the maximum extent possible.”

OHSA has reported that one major source of injury to health care workers is musculoskeletal disorders (MSDs). In 2017, nursing assistants had the second-highest number of cases of MSDs, with an incidence rate more than five times the average for all industries because of proper equipment not being available to perform healthcare to those with disabilities.

Advocates and lawmakers have made disability competency required by law, but to date, and despite “breaking the law,” some of the largest healthcare delivery methods & facilities do not offer true disability competent care. Although realistically, who can blame
them? There is no state or federal body that officially assesses and enforces them to demonstrate their disability competency. Additionally, many healthcare professionals do not know where to begin. So, as a healthcare community, we will continue to reinforce to our healthcare professionals that skirting the law is okay because there is no enforcement, which comes at the disparity of those with disabilities. Or, will we as a healthcare community, embark on a path of brave leadership?

What Could Brave Leadership Look Like?
With the goal of this article being informative, direct, and factual, it could be read as someone being accusatory and complaining. I want to thank you for being a physician. As a woman living with a spinal cord injury since 1991, I have seen brave leadership within the healthcare community, and while I have been a recipient of such positive leadership, I have also been a “victim” of the lack of leadership around disability competency. Amid the gratitude for my achievements, I must simultaneously grieve the setbacks. I have settled in a place where I have created a balance between the two. As a healthcare colleague and leader, I thank you for going into the business of caring for others and ask you, as physicians, to join in reducing health disparities for people with disabilities by:

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• Management of Acute Infections: toenails, puncture wounds
• Treatment of diabetic foot conditions
• Diagnosis and Treatment of foot and ankle skin pathology

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Make yourself familiar with the National Council on Disabilities efforts with the Joint Commission and Center for Medicaid and Medicare Services (CMS)

Chanda Center for Health: www.chandacenter.org

Increasing Quality of Healthcare to Individuals with Physical Disabilities: An Online Curriculum for Practitioners: Insert link to online curriculum.

National Council on Disabilities

Americans with Disabilities Act (ADA)

Section 510 of the Rehabilitation Act
Newly-Published Study Documents Importance of Family Physicians in Rural Maternity Care

Reprinted with permission from the Journal of Birth Issues in Prenatal Care

Rural families face barriers when accessing prenatal care and delivery due to many factors, creating "maternity care deserts." In some locations, the rural hospital has stopped delivering babies due to economic or staffing deficiencies. In others, the rural hospital has closed entirely. Fortunately, Family Physicians are the most widely-distributed physicians throughout the U.S. and are therefore best positioned to maintain maternity care access. The degree to which rural communities depend on Family Physicians for much or all of their maternity care has not been well documented until now.

We formed a collaborative group of researchers to answer these questions:

1. Who are the clinicians, including Family Physicians, delivering babies in rural hospitals?
2. What is the relative contribution of different types of clinicians, including Family Physicians, to rural maternity care access?
3. What are the types and numbers of locations where Family Physicians are the ONLY clinicians providing maternity care?
4. What would be the impact on rural families if Family Physicians stop providing maternity care?

We studied access to rural maternity care in ten states. There were 216 rural hospitals in those ten states and we were able to obtain the necessary data for 185 (85.6%) of those hospitals. We defined hospitals as rural if they were located in a county or census tract designated as rural by the Health Resources & Services Administration (HRSA). Of those 185 hospitals, 116 were Critical Access Hospitals (CAH). (CAH have no more than 25 inpatient hospital beds, are located more than 35 miles from the nearest other hospital (15 miles if by mountainous or secondary roads), have an average length of stay no more than 96 hours and offer 24/7 emergency services.)

We collected data covering a 5-year period (2013-2017) including the hospital size, maternity services provided, number of births and whether Obstetricians, Family Physicians or Certified Nurse Midwives provided them. We also collected data on the distance to the nearest hospital where maternity services would be available if not provided locally including vaginal delivery, vaginal birth after cesarean (VBAC) and cesarean delivery (CS).

The table below summarizes our findings regarding the rural hospitals where maternity care services are provided and who provides those services. During the study period, a total of over 12,000 births occurred annually at the rural hospitals and the percentage of those babies delivered by Family Physicians remained relatively constant at 54% to 56% each year. In 67% of hospitals, babies were delivered by Family Physicians and Obstetricians. In 27% of hospitals, Family Physicians were the ONLY physicians providing maternity care; the majority of those hospitals are CAH.

<table>
<thead>
<tr>
<th>State</th>
<th># Hospitals in study sample</th>
<th>Average # Beds per Hospital (Range)</th>
<th># Critical Access Hospitals in study sample</th>
<th>% (N) Hospitals where FPs and other physicians deliver</th>
<th>% (N) Hospitals where FPs are the ONLY delivering physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>13</td>
<td>27 (11-74)</td>
<td>9</td>
<td>92.3% (12)</td>
<td>38.5% (5)</td>
</tr>
<tr>
<td>Colorado</td>
<td>19</td>
<td>37 (9-100)</td>
<td>11</td>
<td>73.7% (14)</td>
<td>21.1% (4)</td>
</tr>
<tr>
<td>Idaho</td>
<td>7</td>
<td>22 (15-25)</td>
<td>7</td>
<td>85.7% (6)</td>
<td>57.1% (4)</td>
</tr>
<tr>
<td>Minnesota*</td>
<td>38</td>
<td>23 (12-25)</td>
<td>38</td>
<td>97.4% (37)</td>
<td>42.1% (16)</td>
</tr>
<tr>
<td>Missouri</td>
<td>24</td>
<td>74 (18-244)</td>
<td>7</td>
<td>54.2% (13)</td>
<td>8.3% (2)</td>
</tr>
<tr>
<td>North Carolina</td>
<td>37</td>
<td>137 (21-452)</td>
<td>9</td>
<td>16.2% (6)</td>
<td>5.4% (2)</td>
</tr>
<tr>
<td>Oregon</td>
<td>22</td>
<td>45 (21-176)</td>
<td>14</td>
<td>59.1% (13)</td>
<td>18.2% (4)</td>
</tr>
<tr>
<td>Utah</td>
<td>13</td>
<td>25 (9-54)</td>
<td>9</td>
<td>92.3% (12)</td>
<td>46.2% (6)</td>
</tr>
<tr>
<td>Washington*</td>
<td>10</td>
<td>25 ( )</td>
<td>10</td>
<td>90.0% (9)</td>
<td>70.0% (7)</td>
</tr>
<tr>
<td>Wyoming</td>
<td>2</td>
<td>25 ( )</td>
<td>2</td>
<td>100.0% (2)</td>
<td>0.0% (0)</td>
</tr>
<tr>
<td>Overall</td>
<td>185</td>
<td>57 (9-452)</td>
<td>116</td>
<td>67.0% (124)</td>
<td>27.0% (50)</td>
</tr>
</tbody>
</table>

*Minnesota and Washington provided data for Critical Access Hospitals (CAH) only

VBAC was offered in 77 of the 185 hospitals (43%) and family physicians provided VBAC in 33 of those 77 hospitals. There was a wide range in the percentage of hospitals offering VBAC, from 16% in Colorado to 60% in Washington. Nearly all hospitals offered CS with these exceptions: Alaska 62%, Minnesota and North Carolina 92%, Oregon 96%, Washington 80%. Overall family physicians provided CS in 46% of hospitals overall, ranging from 11% in North Carolina to 100% in Wyoming.

In the case of hospitals that did not offer VBAC or CS, we determined the distance to the nearest hospital that provided those services. In 32% of such cases, VBAC was available 26 to 50 miles away, in 31% the distance was 51 to 100 miles away and 31% more than 100 miles.

A main aim of this study was to determine the impact on access to maternity care if Family Physicians would stop delivering babies in the locations where they now do so. Family Physicians delivered babies in 124 of the 185 hospitals in this study (67%) delivering nearly 7000 each year. Even more significantly, FPs were the ONLY physicians providing maternity care in 50 of those 124 (40%). To further describe the impact on access
to maternity care if Family Physicians did not deliver babies in locations where they are the ONLY physicians delivering, we analyzed driving distance to the nearest hospital offering maternity care. We were able to do this driving distance analysis for 29 hospitals, excluding some for which data was not available and excluding the most remote hospitals in Alaska which would require air transport rather than automobile driving. In the case of those 29 hospitals alone, the round-trip distance to nearest care averaged 86 miles, would impact 2958 births per year and would require over two million miles of driving for prenatal care and delivery.

Our study was not designed to examine outcomes or quality of rural versus urban maternity care nor to compare care provided by Family Physicians to that of Obstetricians. Previous studies have documented comparable outcomes in rural and urban locations and equal outcomes by Family Physicians and others, including CS.

This study demonstrates that Family Physicians are essential to rural maternity care access and that rural Family Physicians are providing important access to VBAC and CS. In the most rural locations, Family Physicians constitute the ONLY solution to maternity care access since Obstetricians rarely locate there. We found only eight locations where Family Physicians and Certified Nurse Midwives practice together, but that model could increase the rural maternity care workforce by jointly providing prenatal care and vaginal births with surgically-capable Family Physicians available to perform CS when needed.

Based on this study, we recommend:
• Medical schools must admit and support more students interested in practicing rural Family Medicine
• Family Medicine residencies must continue training residents in both uncomplicated and complicated maternity care
• Recruitment and retention of Family Physicians who provide maternity care must be a priority of rural hospital administrators and workforce planners.
• Obstetrics and Family Medicine training programs should collaborate to provide surgical training for Family Physicians who commit to rural practice

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The full article is available at this link: https://onlinelibrary.wiley.com/doi/epdf/10.1111/birt.12591

Citation: The impact of family physicians in rural maternity care.
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