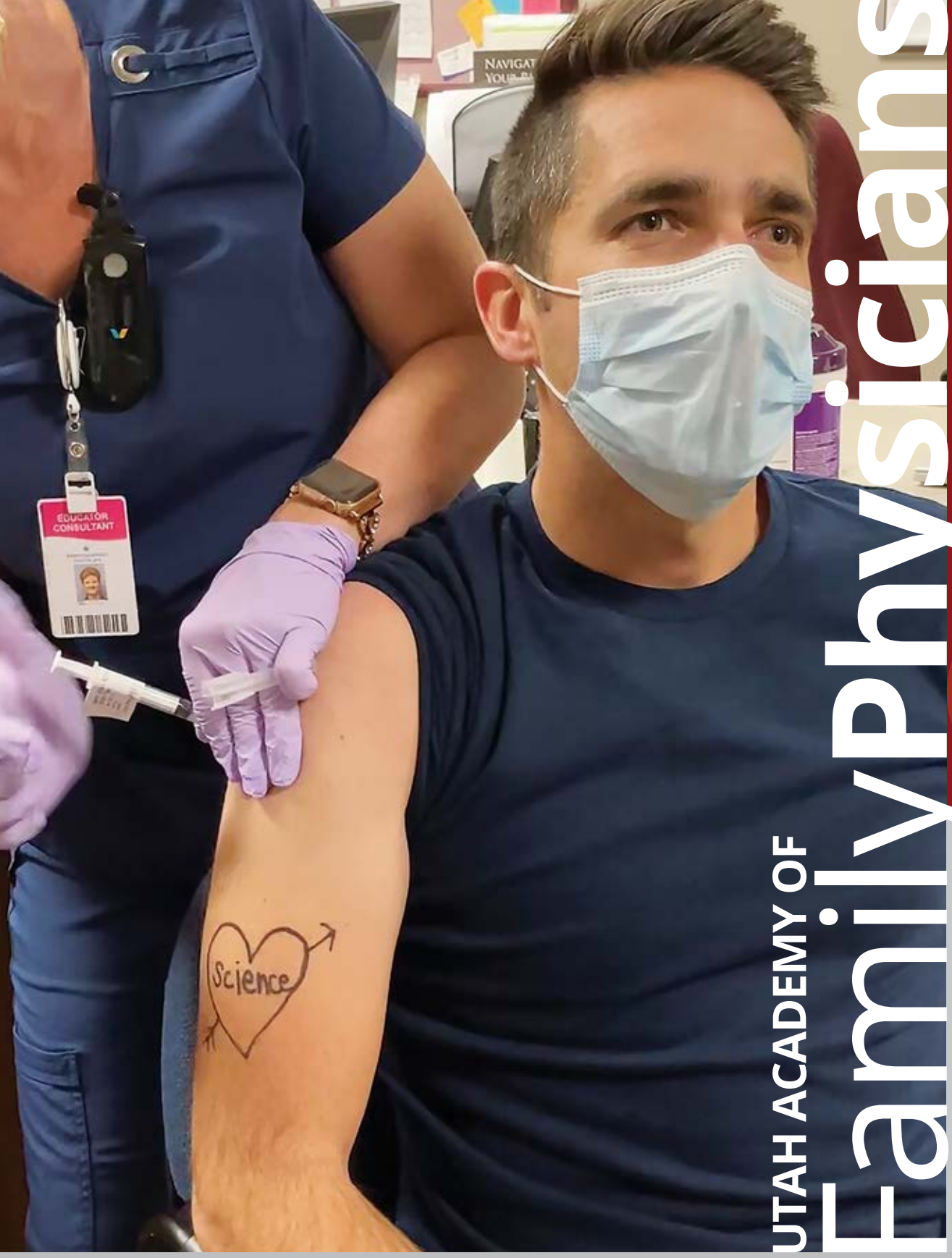

Utah Academy of Family Physicians Journal

UTAH ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR UTAH

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UTAH ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR UTAH

The mission of the Utah Academy of Family Physicians: To improve the health of all Utahns by advocating for and serving the professional needs of family physicians.

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Utah Early Hearing Detection and Intervention Milestones

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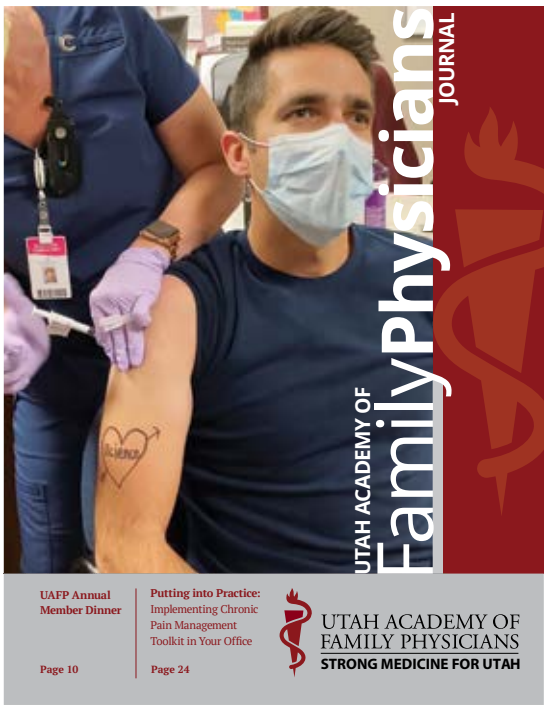

On the Cover:

Jesse Spencer, MD
Senior Medical Director, Family Medicine
Intermountain Medical Group

Maryann Martindale

Representation Matters

In a survey we conducted two years ago, advocacy was named as one of the top priorities Utah members wanted from their academy.

Advocacy is a critical component to the work we do at UAFP and it comes with great responsibility. We speak for our doctors who are busy treating patients, we speak for the students and residents who are learning and preparing for their careers in medicine, and we speak for our patients.

When advocating on your behalf, I always ask myself three questions:

- Will this promote or advance the practice of family medicine?
- Will this help our physicians in their practices and professional journeys?
- Will this improve or impact the health and wellness of our patients?

The third Wednesday of every month and for 45 days from mid-January to early March, I participate in legislative hearings. I listen to proposed legislation and testimony and speak on behalf of our doctors. But there is so much more behind-the-scenes work that takes place.

I recently had the opportunity to work with a legislator on a bill that, when passed, will provide an enhanced penalty when an act of violence is committed against a health care worker. By expanding enhancement from the previous emergency-only situation to all your offices, clinics, and your staff, we can give you more peace of mind that there is a greater deterrent to violence and harsh penalties should any still occur. It is a tragic side-effect of both the pandemic and the ever-growing contentious world we find ourselves in, but it is paramount that those of you providing care are protected.

We also work proactively on ways to provide better health outcomes for patients by seeking funding and support for programs that will help educate patients with early onset diabetes, promote anti-tobacco initiatives, provide resources for our aging population and accessibility for our patients with disabilities, to name just a few. Family physicians care for the whole person from birth until death and it is incumbent on us to advocate for patients across the full spectrum of life.

One of our primary focuses for the coming year is primary care and looking for ways, both legislatively and collaboratively, to increase the amount of money spent on primary care and prevention. It is no surprise that increasing primary care decreases overall health costs while increasing healthy outcomes, and we are busy educating legislators and stakeholders on ways to accomplish this.

> "The more we hear from our members, the better understanding we have of how to help and where to advocate."

Maryann Martindale, center, testifying in a legislative committee meeting in February 2020.

But, just as in all the work we do, our insight is only as good as our knowledge of what you need; what changes would benefit your practice and what initiatives could improve the health of your patients. I welcome input from you on issues you find important. I am here to listen and act on your behalf.

The more we hear from our members, the better understanding we have of how to help and where to advocate. In this fast-moving world where a lot of voices are competing for attention, representation matters, and we work hard to be the best representation possible for our Utah family physicians.

PRESIDENT'S MESSAGE

Chad A. Spain, MD, FAAFP

The past year has been tough, and we all have fallen victim to one stressor or another: COVID, mandates, administrative burdens, misinformation, patients delaying screening measures, and limitations in access to care. Sometimes it may feel overwhelming. You might be asking yourself why you're even practicing medicine when everyone is an expert in vaccines with a degree from Facebook University and a Master's in "I did my own research."

We need you, your patients need you, your family needs you. At times it may not feel like it, but you make a difference in the lives of those around you, and we need you at your best. That's why I want to talk about physician burnout.

A lot has been said on burnout and how to keep it at bay. Often, we are encouraged to take a vacation, go on a retreat, or engage in self-care practices. For some, that's great. For my colleagues facing physician and staff shortages, not so much. That's not even mentioning the day-to-day roller coaster that is being a family physician.

Recently, I was speaking to a patient of mine who was about to go on hospice. I had cared for her for over seven years, and she had just been diagnosed with metastatic lung cancer that had spread to her brain. She was telling me that her dying wish was to go rock hunting one more time in the hills of the state where she was born. We both knew that just wasn't possible. It is excruciating to care for a patient in this situation. It is difficult not to break down and cry with them. But we do not because we are their support system.

I got off the phone with her, silently acknowledging that this would likely be the last time we would have a conversation before she passes or is too weak to speak. I stared outside my office window and wondered how in the world I got involved in this job.

I feel confident that many of you have had a similar experience. You probably handle these types of interactions in between telling a patient good news, making dinner plans with your spouse, and trying to convince a patient to get the COVID vaccine. Sometimes you can relate a bit too well to Elizabeth "Eliza" Schuyler and just feel "Helpless."

The 2021 AAFP FMX virtual conference contained an excelled burnout lecture by Dr. Corey Martin titled "The Science of Gratitude." You can watch the lecture through the AAFP FMX On Demand right now; I'm happy to wait. Okay, fine, since I appreciate you taking the time to read this, I'll give you a summary. Dr. Martin's findings and recommendations can improve your mental health

(he has data to back him up, and I can attest with my personal experience as well):

1. Random Acts of Kindness: One simple act can improve your outlook for seven to 14 days!

2. Three Good Things: Each night for at least two weeks, write down three good things that happened to you before you go to bed.

3. Call or text at least one person each day who is meaningful in your life, and tell them so.

Dr. Martin's presentation is a great one. I have worked on following his suggestions and have noticed an improvement in my overall well-being.

Whether you follow these tips, take a trip to Disneyland, have a glass of wine, go for a run, or stop by your favorite burger joint, I encourage each of you to recognize when you're feeling down and/or burned out and commit to some daily self-care time. Not only is this good for your mental and physical well-being, it's good for the ones you love as well.

So, what are you waiting for?

Chad A. Spain, MD, FAAFP
IG.: chad_spain_md_FAAFP
chadspainmd@gmail.com

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Thank you for your service to the UAFP Board!

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Mission

The mission of the Utah Academy of Family Physicians: To improve the health of all Utahns by advocating for and serving the professional needs of family physicians.

Vision

The vision of the American Academy of Family Physicians and the Utah Chapter: To transform health care to achieve optimal health for everyone.

Interested in Becoming a Member of the UAFP Board in the Future? Contact us at boardchair@utahafp.org for more information.

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UAFP Annual Member Dinner

The annual UAFP member meeting and dinner was held on September 17. It was our first indoor, in-person member event since the pandemic and staff went to great lengths to ensure safety protocols were in place while also providing a virtual option for those unable to attend in person.

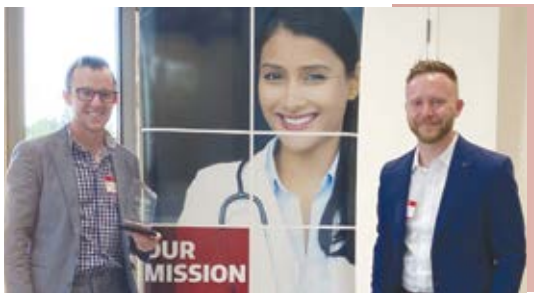
The evening kicked off with some comments from outgoing UAFP President, Dr. Isaac Noyes. Isaac has been a great example of leadership in action, always looking for ways the Academy can advance the practice of family medicine, especially during the pandemic.

Awards are always a highlight of the evening, and this year was no exception. We included a new award from AAFP – Boundary Breakers – one given to two physicians from each state who provided exceptional service during the pandemic. Dr. Alana Jonat, Infection Prevention Specialist with Community Health Centers Inc., Stephen D. Ratcliffe Clinic, and Dr. Michele Goldberg, Medical Director with Fourth Street Clinic were both recognized this year for their outstanding efforts.

The UAFP Family Medicine Champion of the Year Award was presented to Dr. Marc Babitz. This award is given to a person who advocates and champions the practice of family medicine. Dr. Babitz recently retired from the Utah Department of Health where he was a strong advocate, not only for family medicine, but for UAFP, providing wisdom and insight that helped guide our own advocacy efforts.

And our annual UAFP Family Medicine Physician of the Year Award was presented to Dr. Kurt Rifleman, Medical Director with Midtown Community Health Centers. Dr. Rifleman is beloved by patients, colleagues, and community members and has served as an inspiring example of what it means to be a family physician to countless students and residents over the years.

The meeting closed with comments from new UAFP President, Dr. Chad Spain. Dr. Spain inspired all to take pride in their work, to recognize the extraordinary responsibility family physicians have and to be mindful of the need to take care, personally.



Outgoing UAFP President Dr. Isaac Noyes with Incoming President Dr. Chad Spain

Boundary Breaker award winner Dr. Alana Jonat with new UAFP Incoming President Dr. Chad Spain

Boundary Breaker award winner Dr. Michele Goldberg with new UAFP Incoming President Dr. Chad Spain

UAFP Family Medicine Champion of the Year Award winner Dr. Marc Babitz

UAFP Family Medicine Physician of the Year Dr. Kurt Rifleman with outgoing UAFP President Dr. Isaac Noyes

Outgoing AAFP President Dr. Ada Stewart

We were joined virtually by outgoing AAFP president, Dr. Ada Stewart. Her remarks were poignant and timely, and she was kind enough to let us share them with you:

I am honored to bring you Greetings from the National Academy of Family Physicians.

Wow, what a year I have had … What an 18-plus months we have had! Who would have predicted I would be greeting you all virtually again? Thank you for giving me the opportunity.

Throughout this public health emergency, your national academy has been here for you, providing updated information related to COVID-19, being the go-to resource for you, your practice, your patients and your community. Throughout it all, our membership continues to be strong – 133,500 members strong – and I thank you!

The AAFP continues to advocate for you and address your priorities that include:

1. Reducing Administrative Burdens

2. Advocating for Health care systems and payment models that value primary care

3. Increasing overall payment

4. And Protecting Family Physician's interests with regard to non-physician providers

We continue advocacy efforts around financial relief, especially during this pandemic and stress, and the need to follow science.

We continue to FIGHT FOR FAMILY MEDICINE. Just this week I joined the Group of Six representing over 590,000 frontline physicians to Advocate around Medicaid Parity, The Integration of Behavioral Health and Primary Care, the Need to Advert the End-of-Year Medicare Cuts to Physicians and Maternal Mortality, to name a few.

As we advocate, one must recognize how COVID has definitely changed the way we advocate – writing numerous letters on behalf of our specialty, our members, patients, and communities, and meeting virtually, just as I am meeting with you this evening. But no matter what the method, the goal is still the same: "FIGHTING FOR FAMILY MEDICINE."

In May of 2021, AAFP praised the NASEM Report which recommends **an increased investment in and access to high-quality primary care.** The report, of which AAFP was one of the sponsors, stated **"Primary care is the key to transforming health care in America."**

Primary care is the only discipline of medicine where a greater supply is equated to better health outcomes, longer life expectancy and lower costs. NASEM's report is the result of nearly 18 months of research and work to examine the role that primary care should play in the U.S. health care system. Its recommendations include:

1. Pay for primary care teams to care for people, not doctors to deliver services.

2. Ensure that high-quality primary care is available to every individual and family in every community.

3. Train primary care teams where people live and work.

4. Design information technology that serves the patient, family, and interprofessional care team.

5. Ensure that high-quality primary care is implemented in the United States.

With this report, we recognize it is time to change the conversation about primary care and finally deliver to the American people a health care system that prioritizes their health. That is why our organization, along with other key partners, came together to form **Primary Care for America** (primarycareforamerica.org), a collaboration focused on demonstrating the value of primary care, the need for increased primary care investment and the importance of innovation in primary care delivery and payment models.

In coming together, we stated "We can't wait another 50 years, or even another day, to deliver comprehensive, continuous and coordinated primary care to improve the health of all Americans."

This campaign will seek to educate policymakers, health care thought leaders, purchasers and employers and health care influencers on the value of primary care to individuals, communities, vulnerable populations and the health care system. One of the focuses is to position primary care as a solution to the major policy challenges, including health disparities and to increase the investment in primary care.

As we look to transform healthcare and the future, we will continue to work hard to address diversity,

Member Dinner | Continued on page 12

Member Dinner | Continued from page 11

equity, and inclusion (DEI). And as we work to achieve this, we will continue to provide the necessary resources to help us all succeed in achieving health equity.

Your Academy with continue to be here for you, your patients, and your community. We will continue to work to preserve the sacred patient-physician relationship. We will continue to promote science. We will continue to be there for ALL our members.

I am grateful for our Academy, our diversity of minds, thoughts, ideas – because it just makes us who we are – we are family medicine. Remember: what we do is sacred – we make a difference in the lives of our patients, in our communities, in the boardroom, and in D.C.

Thank you for all for all you do every day – thank you for your sacrifices.

> Your Academy with continue to be here for you, your patients, and your community. We will continue to work to preserve the sacred patient-physician relationship. We will continue to promote science. We will continue to be there for ALL our members.

Calling all Authors!

Are you interested in having a piece featured in an upcoming edition of the UAFP Journal? We publish twice a year, in the spring and fall each year.

Is there an issue area you are passionate about? Whether you want to write about physician wellness, practice improvements, rural medicine, or diversity, equity and inclusion – we want to hear from you!

Please email Barbara Muñoz, UAFP program director, at munozb@utahafp.org with your idea and for more information.

Member Spotlight

Ben Wilde, DO, FAAFP

Teaching OMT 2020-21

Family Disc Golf

First, a Little Bit About Dr. Wilde

I grew up in rural Worland, Wyoming, the oldest of seven children. My wife and I met at the University of Wyoming and now have five children ranging in age from two to 16. Although most of my free time is spent engaging with my family and their interests, my personal interests include reading, playing the piano, and getting outdoors whenever possible.

The Journey to Becoming a Physician

I earned a B.S. in Health Sciences at the University of Wyoming. I attended medical school at Midwestern University – Arizona College of Osteopathic Medicine in Glendale, AZ. I stayed an extra year as a pre-doctoral teaching fellow of osteopathic manipulative medicine and then completed my residency with Southern Illinois University in Quincy, IL.

Choosing Family Medicine

How/when did you choose family medicine as your specialty? What are some of the aspects of family medicine that drew you to it?

My father, a chiropractor, inspired my earliest interests in a career in medicine. I saw the positive impacts he had on his patients' health and the way his patients appreciated him. This fascinated me. I noted, however, the limitations of a chiropractor's scope of care and determined that I wanted to do so much more. I concluded that family medicine gave me the fullest potential to meet the wide-ranging needs of my patients. I appreciate that I am prepared to care for my patients medically, surgically, mentally and emotionally, in a wide variety of settings.

Did you consider another specialty? If so, what made you ultimately choose family medicine?

When I began medical school, I felt certain family medicine was for me. But when I started into my third-year clerkships, I found myself enjoying each specialty immensely. For a few months, my interests shifted first to ophthalmology and then to physical medicine and rehabilitation. Ultimately, the inherent variety of family medicine and the potential of long-term physician-patient relationships brought me back to family medicine.

The Move to Southern Utah

Prior to coming to Southern Utah, I practiced medicine in my childhood hometown in Wyoming, providing both inpatient and outpatient care, working in the emergency room, and sidelining sporting events. On arriving there, I was surprised by how quickly my family and I were embraced by the community and integrated into several events and service opportunities.

The factor that finally persuaded me to leave my rural practice was the opportunity to teach future physicians at Rocky Vista University (RVU) in Ivins, UT. Teaching had long been a passion of mine, first recognized during my pre-doctoral teaching fellowship, and my position at RVU opened to me the door of academic medicine. In addition to my teaching and leadership roles at RVU, I have continued to care for patients at the Southern Utah Veterans Home, the Doctors Volunteer Clinic, and Intermountain InstaCares in the St. George area.

Ironman 2021

Teaching Future Physicians

What drew you to teaching?

My teaching opportunities in the past, such as the pre-doctoral teaching fellowship, gave me the insight that teaching is highly rewarding for me. In many ways, I view my students' academic successes and outcomes through the same lens I view my patients' medical successes and outcomes. The "aha moments" students have as they learn new concepts and skills, accompanied by the gratitude they express, keep me coming back for more. It is also very satisfying to know that I am helping train up the next generation of excellent physicians.

I have also found that teaching helps keep me honest about the medical care I provide my patients. When a student is by my side and is likely to ask why I have chosen a particular diagnosis or treatment, this creates in me a feeling of accountability and helps me ensure I am consistently using evidence-based best practices in my care. The point-of-care learning and discussion that so naturally takes place when precepting a student in the clinic is a preventive measure for me against complacency, apathy, and burnout. Plus, every time the student experiences something new, their excitement is palpable. This sincere enthusiasm reminds me of the great privilege and honor it is to be a physician.

What do you enjoy about it, and are there challenges?

One of the things I enjoy most about my career in academic medicine is the opportunity to innovate. I teach primarily in preclinical years one and two at RVU. The ways I studied and learned in school almost two decades ago are very different from how students study and learn today. The newer technology, including virtual reality and high-fidelity simulation, and online resources available to support their learning are fascinating. They allow us new ways to teach and structure the learning environment and process. One challenge related to this new technology is that often students face a "paradox of choice." Faculty can be instrumental in helping students customize their use of learning materials without becoming overwhelmed by the sheer volume of choices available.

What do you see happening with the future of medical schools, especially as it may relate to Utah?

Multiple new medical schools have recently opened their doors in Utah, resulting in significantly increased numbers of medical students training in hospitals and clinics across the state. Although the schools will innovate and use technology to train their students, nothing can really take the place of in-person face-to-face learning under the guidance of a mentor physician. Utah physicians now have more of an opportunity than ever to mentor and teach students, specifically family medicine, to inspire them to take a closer look at this important and rewarding specialty.

Some Thoughts on the Future of Family Medicine

How do we as a country/state ensure that there will be enough family physicians to meet the demand?

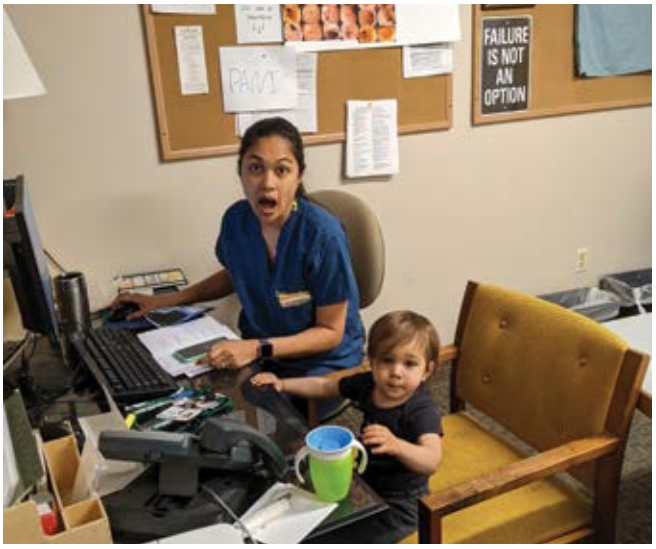
In my opinion, future interest in careers in family medicine must start with early outreach to students in their high school, undergraduate, and medical school years. The students need to see family physicians leading and having a positive impact at the one-on-one individual level, strengthening communities, and engaging with state and national policy. I believe the best and brightest of the students belong in family medicine, where they can make the greatest difference. With that mindset, I try to model a high standard of excellence in my teaching and leadership so students see and understand the degree of influence family physicians can have.

How can we encourage more people to pursue family medicine rather than a higher-paying specialty?

We must celebrate family medicine freely and effectively. I often have the chance to counsel students as they are choosing their medical specialty. I note that family physicians gain a large breadth of knowledge across multiple body systems, medical conditions and treatments. We also enjoy the privilege of acquiring a depth of knowledge in any system and condition of our choosing. The flexibility and variety afforded by a career in family medicine are unparalleled by any other specialty. I then remind them that, as a physician, they will be well compensated no matter what specialty they choose. Therefore, they should choose the medical specialty they enjoy the most, recognizing that their future happiness is more closely tied to their daily satisfaction than the money they will make.

Resident Spotlight

Lyly Tran, MD



The little bit of your story from the biography on the University of Utah family medicine residency site seems to only scratch the surface of what appears to be an amazing journey to medical school. Can you share a bit more of your story of that journey?

Oh man, My Story. It certainly has been long and convoluted. I grew up in low socio-economic and culturally diverse neighborhoods where English was spoken only by young children. I lived with my aunt in southern California for a few years as a baby until my mom could take me back to northern California, where I was born. We lived off food stamps and charity. My mom knew the tiniest bit of English; basically, she learned English with me once I started school. With her middle school education, she did her darndest to keep me ahead in math during elementary school and made me keep up my Vietnamese literacy. My brother (six years younger with a different dad) and I moved every year, around December/January, so I was perpetually the new kid in the middle of the year. I ended up going to four different high schools as well. Part of that was my own stupidity; I was a struggling teen, angry I had to straddle two cultures, so I rebelled. It didn't help that I moved so often and didn't have a stable support system. Not knowing me or my situation, the counselors often passed me over regarding wellness checks. I last lived with my mom when I was 14 and lived with other family members until I was 18. After high school, I somehow got accepted into a university. However, being the stupid teen I was, I allowed the acceptance to lapse and ended up going to a community college for the next few years. I struggled during that period, too, though I held several part-time jobs: at a restaurant, Big 5 Sporting Goods, Good Guys (an electronics store,) PetSmart, and Sears.

By the time I should have graduated from university, I became so mad at myself after four years of not completing anything. So I bribed myself: complete community college, and the end goal would allow me to go snowboarding all winter if I passed all my classes by the end of the year. I tried asking counselors at the community college for advice on redirecting my path to medical school, and I got a lot of, "maybe you should try for something easier." For both mental and financial support, I asked to move back in with part of my family. (The group I had been living/hanging with the past few years was not supportive of my goals.)

The University of California San Diego finally accepted me. During my three years there, I became very involved with a volunteer clerkship program that provided pre-health students clinical exposure in what was basically a CNA-type role. I ended up as the assistant director of the ICU division, where I coordinated various ICU volunteers, the training I piloted, and acted as liaison between the program and the hospital directors and staff. That position ultimately morphed into many meetings and paperwork and less one-on-one interaction with patients that I craved. I loved teaching but missed patient care.

I slowly transitioned into being a private caregiver for various patients, who were sometimes difficult but also absolutely lovely. I had several traumatic brain injury

(TBI) patients, some with different kinds of dementia, and some with multiple sclerosis (MS). I usually had one to two patients at a time. I supplemented that work with being a food delivery person and worked as a nanny and housekeeper. Those were some wild days and hectic schedules. I loved it.

I loved my patients but wanted to go to medical school and keep moving forward. I did not get any interviews the first time I inquired, so I applied for a postbaccalaureate to help "prove" I was ready for medical school. I busted my butt and made amazing friends at the University of California Davis' postbaccalaureate program, geared toward pre-medical students from underserved and underrepresented groups.

My boyfriend (now husband) stayed in San Diego and a long-distance relationship was hard, but we video chatted every day before the pandemic made it a thing! After postbaccalaureate, I returned to San Diego and resumed the previous work schedule while applying to medical school. During the next cycle, I finally got in.
OH NO, NOW WHAT DO I DO?-

I never envisioned anything beyond getting accepted; it had been my end goal for so long, but now I was a full decade older than most of my school peers. Yikes. But once again, I busted my butt. All credit goes to my now-husband who was all things a good partner should be: supportive, motivating, would not let me wallow too long in self-hatred, would not let me get lazy, made me put on real pants, made me coffee for all those exam days, and reminded me to talk about things other than school/medicine once in a while to make me feel like a person. And I did it – I completed medical school at Michigan State in Grand Rapids and made even more fantastic and lifelong friends. I also got married, and we started our family during this time.

Whew. Adulthood, here I am, I made it.

What are some factors that influenced your decision to become a doctor and pursue family medicine?

I was drawn to providing medical care as a kid because every human being at some point needs help, and one of the most basic ways to provide that help is through medical care. My disadvantaged upbringing and experiences as an adult give me a unique perspective and connection with my intended patient population. I felt the most significant impact I can make as a physician is with people who share the same roots.

When starting medical school, I still had a limited understanding of the various specialties. I knew that patients in underserved communities like mine often come to the emergency department (ED) as their source of primary care, so I looked first into emergency medicine and primary care. This quickly evolved into a strong passion for family medicine. The breadth of problems, age span, and the option of doing procedures appealed to my need for variety. It is essential to me that as a holistic-minded physician, I can address physical health along with

emotional and mental health, particularly in underserved communities where it may be challenging to make it to even one appointment consistently. This also fosters a stronger longitudinal relationship with the patient, as my team and I would be their "home base," whether or not they need additional specialists. As relationships grow, I have more opportunities to counsel, educate, and provide preventative care and health maintenance.

During clinical rotations, my favorite moments were spread out: the different outpatient clinics addressing prevention and chronic conditions counseling, complex cases in the operating room, completely unpredictable days in psych (where I worked with chronic mental health patients with schizophrenia and bipolar disorder), and the ever-changing ED. Luckily for me, family medicine is a specialty that allows me to continue to have all these different experiences (this is what I jokingly refer to as my "professional FOMO").

What was it that drew you to apply for residency at the University of Utah? How has your experience been there?

I previously applied to medical school here, mainly because we love winter sports and have a few friends out here. I decided to check it out for residency as well for similar reasons. There were several things I was specifically looking for in a residency and a few things that surprised me about Utah. I definitely wanted a blend of academic and community medicine, strong relationships with other residencies in the area, and strong obstetrics. What I was also looking for but was pleasantly surprised by in Utah was so much diversity (way more than expected,) a large refugee population, and transgender health care. What ultimately tipped the scales was the resident relationships and focus on resident wellness. The residents genuinely seemed to like each other, had such amazing things to say about each other and the residents we interact with from other programs. This program had the best quality of life focus of all the residencies I was seriously considering. We were now a family of three, so I had to consider the

Resident Spotlight | Continued on page 18

quality of life for my family as well. While there are certainly days when I'm not loving being a resident, I am incredibly grateful to be here and absolutely feel like I made the right decision to come here.

In your biography on the University of Utah site, you also mention that your interest areas include education advocacy for disadvantaged youth and their parents, being a high school student medical interest mentor, and working with immigrant and other underserved populations. What does putting those interests into practice look like for you?

Yeah! I grew up in immigrant and low SES communities, so that's always been "home" to me. I always participate in things geared toward disadvantaged families because I came from one, and I REALLY wish that I had crossed paths with more professionals growing up. My cousins and I are the first ones to finish high school and go to college. I'm the first one to receive an advanced degree, so there was no way to ask anyone in our family for any kind of guidance about school (other than "go to it!").

Being from a low SES background and fighting that, and now having studied all about it, I understand and feel the struggle from many different angles. I try to reach out to families; the young kiddos to get them excited, the teens to try to bring them back from the dumb decisions they're making, and parents to help educate and break the cycle. I've been the kid with food stamps, with thrift stores and knock-off clothes. I received corporal punishment for most of my childhood (mom is from the old country, which is how she was raised). I've briefly been in the foster system and fought viciously to stay with my baby brother every single minute. I've been the truant, smoked cigarettes for 14 years, and participated in over-drinking and illicit substances. But I also finally graduated not only from high school but college. And incredibly, also medical school – and I am now a doctor. It took me years, but I successfully quit smoking. I found an absolute saint, we got married, and now we have an almost 2-year-old who is way too smart for our sanity. Somehow along the way, I cut out all the deviant habits and behaviors and forced myself to evaluate what kind of person I wanted to be, with a lot of mental and emotional support from my brother and my husband. These are the stories and struggles that I can share with my mentees, peers, and patients. I think it's important to know that you can keep trying, even if you've messed up over and over, and trying won't always work but when it does it's worth it.

If you talked to young adults considering medicine as a career, why would you tell them to consider family medicine?

The hugs. Just kidding, we live in COVID times. I love family medicine because there are so many ways for you to mold it to exactly what you love and help the patients for whom you feel the most passion. You can choose inpatient, outpatient, or a combo. You see every human in

"The relationships with patients take time, but it's so gratifying to follow someone over the years, be their medical advocate, and watch them progress in managing whatever conditions they struggle with. You also get to take a step back and look at the whole patient, rather than just one aspect of them, and you have an opportunity to help any human being."

residency, but you can choose which population you want to work with afterward, whether you want to focus on geriatrics, women's health, sports medicine, or a billion other directions. There are procedures you can do if you like that. And, you get to learn a bit of everything! The relationships with patients take time, but it's so gratifying to follow someone over the years, be their medical advocate, and watch them progress in managing whatever conditions they struggle with. You also get to take a step back and look at the whole patient, rather than just one aspect of them, and you have an opportunity to help any human being.

Medical Student Spotlight

Alyssa Lolofie

A Bit about Alyssa

My name is Alyssa Lolofie. I'm a Samoan American medical student at the University of Utah. I grew up in Murray/Holladay with my parents and my sister, Kali. As a child and teen, I danced hula, which I appreciate now because I learned about and stayed connected with my culture. I went to the University of Utah and earned a B.S. in Biomechanical Engineering with a minor in Chemistry. I was always interested in science and knew that I also wanted a career where I could work with people; medicine is the best mix of both. These days, keeping up with my hobbies is hard because I feel like I'm always so busy with school, but when I have time, I like to spend it with my friends and family, bake, and travel. I'll have more time this winter, so I'm thinking about re-learning how to ski since I haven't skied in almost 20 years.

The Path to Medicine

I was always interested in science, but my interest in medicine developed later in my teens. Science and mathematics were fun; there was always something more to learn and discover. What I knew about science told me that careers included researching things in a room all by myself or very few people, and I wanted to talk to people. So, I kept looking and found that medicine was a great combination of science and human interaction, and I decided that becoming a physician was the job for me. In high school, I took a class called "the block" – a combination of math and physics – and each year, I expanded on what we learned. By my senior year of high school, I took combined AP Calculus II and AP Physics A/B. The teachers for this class were so supportive of me and pushed me to continue pursuing science in college. Their intervention and support helped me apply for scholarships (like ACCESS for Women in Mathematics and Science) that would shape my education.

During college, I had the opportunity to research in a lab at the Moran Eye Center. I found out quickly that basic science research was fun but lonely, and actually sitting in a room doing research by myself was not for me. While science is fun, working with people is more important for me. At the University of Utah, I enjoyed applying science to medicine with a degree in Biomedical Engineering. Still, after I graduated, I wasn't sure that I wanted to do more school. I took a few years off, continued to work as a research assistant, and volunteered weekly at the Hope Clinic. (The Hope Clinic is a free medical clinic for uninsured and low-income patients in Midvale, UT, fully staffed by volunteers.) The providers at this clinic are also volunteers, but it wasn't just the medical care they provide that was so impressive to me. They're donating time each week to see patients, educate pre-medical students, and create a deeper connection with the communities they are serving. I found my love for medicine again and felt ready to go back to school.

Medical School at the University of Utah

I grew up in Utah, with a lot of my family around, and when it came time to apply to medical school, I didn't want to leave. My Polynesian community and the community I had made for myself as a pre-medical

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student are very important to me, and I liked the idea of getting to do medical school close to home. Overall, I've enjoyed my time at the University of Utah School of Medicine. I found many great and lasting friendships, built community within my class and the School of Medicine as a whole, and found my voice in advocating for medical students of color. As co-president of the Family Medicine Interest Group and Pacific Islander Medical Student Association, I created safe places and a feeling of community among the student body.

Choosing Family Medicine

I came into medical school thinking about family medicine but wanted to keep an open mind throughout the process. However, in my third year of medical school, I started with pediatrics and loved it! I did rural family medicine and loved it! I enjoyed psychiatry, neurology, and internal medicine. Surgery was fun, but I knew that general surgery wasn't for me by the end of my first six-hour surgery. Mid-way through my third year, I was pretty positive that I wanted to pursue family medicine and was excited to do the parts of family medicine I enjoyed as a family medicine physician.

I love full-spectrum medicine and want to work with a community where the families and I are a team! Often when people start seeing a doctor, it's a family medicine physician. These doctors are first in line to meet with patients, create lasting and trusting relationships, and start a conversation about their health. The increase in medical students going into family medicine is important because for the general public, finding one good doctor they can relate with, trust to go to for medical advice, and to help them become invested in their own health is so important. Creating relationships with my patients, working together to treat or prevent chronic disease, and being a part of a community is why I was drawn to family medicine. Having worked

with so many different health care providers (not just physicians) and getting to emulate the way they connect with their patients makes me proud to be going into family practice.

The Critical Importance of a More Diverse and Inclusive Physician Workforce

On a recent rotation, I saw a name with Polynesian origins on a list of new admits, and I felt a sense of excitement for the workday. I walked into the room to see a smiling middle-aged man whose foot was covered with a bandage, underneath which he had a diabetic ulcer. As we connected over our shared culture, I explained the pathophysiology behind the formation of his ulcer, the importance of controlling his diabetes, and the necessity of continued follow-up care. The patient was going to be discharged later that morning, and upon leaving, he said, "The next time we see each other, we'll go eat." I left with a warm, contented feeling: sharing a meal is how Polynesians show love for one another. And this interaction solidified my interest in family medicine – connecting with patients and helping them understand their illness, with the knowledge that in doing so, I am strengthening the health of a community.

The role of professional physician associations to ensure a more diverse workforce is tough to determine, but I also think it's an important question to ask. Right now, educating current family practice providers and health care workers on diversity and cultural practices in their patients is essential to help increase patient satisfaction. Having a provider who understands where you're coming from is important in making patients feel included as members of their health care team. Programs with the ability to help students of color, students from historically excluded and lower-income populations should be cognizant of their privilege and work to create pipelines or educational opportunities for these students early in their academic careers. One mentor from medical school actually did not know that becoming a physician was a career option for him until he was well into college. Sadly, this is the case for many other students that come from ethnically diverse backgrounds. Programs that teach these students about science and medicine in K through 12 can help them know that they can pursue careers in health care and often encourage them to continue their education after high school.

Invest in Utah's Health, Invest in Primary Care

Jeff Chappell, M.D., is the Medical Director of the Wayne Community Health Center, a federally qualified health center located in Bicknell, Utah, the most remote health care delivery site in our state. Dr. Chappell has served in the Bicknell area for over 30 years and has a large geriatric panel. Over time, he had begun to experience a clear, disincentive need to see medically complex patients … the PA's (physician assistants) would see lots of colds, sore throats and UTIs, and their numbers looked better – my numbers were lower."

In 2018, Dr. Chappell's practice started participating in an alternative payment model with Medicare that pays the clinic to focus on preventive care and deliver most care to Medicare patients in the family practice clinic setting. By investing in high quality care coordination and nursing contact with patients at risk for worsening health, the practice prevents unneeded hospital visits or expensive specialty services. These savings support payment to the health center for staff that helped Dr. Chappell and the PAs manage their Medicare patients with complex health needs more closely. The switch in focus to paying for prevention also enhanced Dr. Chappell's experience of his leadership role as a highly-trained family physician to his system: "My value is as a resource to the mid-levels. In a few minutes of discussion [with the PA] I can avoid a $1,500 MRI or a $3,000 ER visit. My value to my organization has increased."

What if all payers paid for primary care prevention and fostered value for the experience and broad scope of family medicine physicians leading their teams?

Background

Relative to other developed western nations, the United States underspends health care dollars in primary care. On average, the United States spends 5%-7% on primary care as a percentage of total health care spending compared to Organization for Economic Co-operation and Development (OECD) countries that average 14% spending. (Jabbarpour, et al., 2019)

Utah has historically benefitted from better health outcomes and lower than average healthcare costs compared to national averages but has been seeing rising costs in the past few years. The Kem Gardner institute reported in January 2019, "Utah's health care expenditures are growing at one of the fastest rates in the country." (Summers, 2019) Utah has also seen rising rates of preventable conditions like prediabetes that are now equal to nationwide rates. (Public Health Indicater Based Information System (IBIS), 2020)

Investment in delivery of primary health care will bend the curve. The National Academies of Science, Engineering, and Medicine (NASEM), arguably the most highly respected scientific body in the nation, published a report this summer (2021), "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care." (McCauley, Meisnere, Robinson, & Phillips, Jr., 2021) The report says, "Primary care is the only component of health care where an increased supply is associated with better population health and more equitable outcome," it argues for more funding, research, and development of the primary care workforce. Even though primary care provides 55% of ambulatory services in the US, it represents only 5% of total health care spending. (McCauley, Meisnere, Robinson, & Phillips, Jr., 2021) Despite the ability to manage the increasing numbers of patients with complex chronic conditions, family physicians are not reimbursed to outfit the kinds of offices and teams that proffer the best quality services. Practices like Dr. Chappell's could do even more if private payers invested in prevention. Higher primary care payments from fee for service payers would "support our team care model and allow us to pay the wages that we need to pay to have this level of staff. We are competing with other local employers."

The NASEM report shows that the work that family physicians do and how we are paid are getting attention at the highest levels. NASEM shares steps to advance primary care, for example, paying for teams of caregivers that deliver the long-term, high-quality outcomes our patients deserve, increasing access with an emphasis on telemedicine, and training a primary care workforce where they will practice (rural areas, underserved urban areas, and FQHCs like Wayne Community Health Center). The report also calls for health information technology systems that meet the

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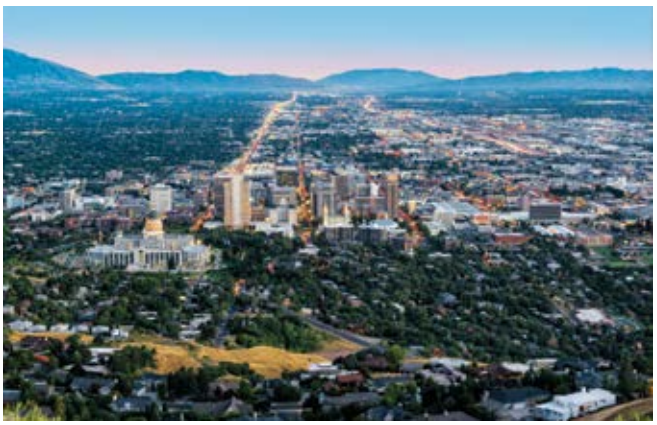
interoperability needs of primary care, a much higher bar than the current design delivers. Primary care access is described as foundational to reaching the goals of equity and success for ALL Americans.

Utah's Primary Care Spend

The NASEM report calls for a state-by-state measurement of primary care spending as a percentage of all health care spending — a task that has begun in Utah. Benchmarks will then be used to track the success of initiatives designed to increase the percent investment in preventive and primary care services. Last fall, the UAFP brought together multiple stakeholders and using national standards, developed our own Utah Primary Care Spending Report using 2018 and 2019 All Payer Claims Data collected by the Utah Department of Health Office of Health Care Statistics.

Using standardized methodology from the Maine Quality Forum and Medicaid, Medicare, and commercial claims data from Utah's robust All Payer Claims Database, the Utah Department of Health Office of Health Care Statistics calculated the spending for Utah's total, primary care and non-primary care health services for 2018 and 2019. The results show that Utah is only spending 6.5% of all health care dollars on primary care services rendered by primary care clinicians.



The results show Utah percent of healthcare spending on primary care is about average for the United States as reported in multiple national and state reports. (Jabbarpour, et al., 2019) The UAFP is working hard to have this data produced year after year as we work to advance investment statewide with help from AAFP and state partners committed to sustainable effective primary care delivery in all geographies. Several other states are farther along in this journey than Utah and are already seeing terrific benefits.

Rhode Island's Journey

The road to improved primary care spend can be long. Rhode Island started their work in 2004 with the creation of an Office of the Health Insurance Commissioner (OHIC). The OHIC was given the substantial task of improving health care in Rhode Island with authority to determine appropriate courses of action that health care systems would be required to follow. As part of their work, the OHIC studied health care systems, health plans, and levels of primary care spending, and compared Rhode Island's results to data from other states.

Realizing that spending on primary care was disproportionately low, and that increased spending could significantly reduce overall health care costs, Rhode Island set about to increase the money spent on primary care. The OHIC required health plans to increase primary care spending by one percentage point per year from 2010 to 2014. In order to prioritize innovation rather than fee schedule manipulation, insurers were required to submit plans and measurements showing how they were achieving this increase. The goal was not to simply move dollars on a balance sheet but to achieve real results by prioritizing primary and preventive care.

Dr. Andrew Saal, Chief Medical Officer at Providence Community Health Centers, detailed how they implemented their increased primary care spend. "In Rhode Island that 10% commitment to primary care took the form of infrastructure dollars to assist large and small primary care groups to develop several essential functions. The dollars themselves flowed through a new program called the Care Transformation Collaborative https://www.ctc-ri.org/. This joint venture included members from primary care, commercial payors, the state Medicaid Office as well as the state health insurance commissioner. To participate, a practice first had to pursue NCQA designation as a Patient Centered Medical Home. From there, the participating practices began to build infrastructure such as nurse care management and practical data exchange to evolve toward the concept of an "advanced practice medical home."

These initiatives led to real growth in spending for primary care from 5.7% in 2008 to 9.1% in 2012, for an absolute increase of $18 million. Over this same period, total healthcare expenditures fell 14% or $115 million. By phasing in an increase in primary care spending, Rhode Island showed a savings of over five dollars for every dollar spent on primary care. (American Academy of Family Physicians (AAFP), 2021)

Dr. Saal also highlighted the benefits to payers of increasing primary care and creating a team-based model, "The dollars supported the direct exchange of patient level data directly to the payors. Our clinicians utilized the patient-level data to identify patients with gaps in care and needing preventative services. The payors saw a huge benefit in no longer having to perform thousands of chart audits to obtain "HEDIS hybrid data" – all three Rhode Island Medicaid MCOs earned 4.5 Quality Stars thanks to the collaboration."

The Rhode Island OHIC evaluates the progress with regular reports and is continuously looking for new and innovative ways to save money while improving health care outcomes for its citizens. Some of their most recent regulations require insurers to: (Block, 2021)

- Spend at least 10.7% of their total health care spending on primary care. At least 9.7% must go toward direct primary care spending (reimbursement to providers), with the

> "An ounce of preventative services is indeed worth tens of millions of dollars of savings. By placing primary care back at the center of our population health strategy, Rhode Island has been able to re-energize primary care to anchor our state's health care system. Not surprisingly, you'll find many of our clinical strategies in the recent NASEM report 'Implementing High Quality Primary Care – Rebuilding the Foundation of Health Care.' Rhode Island's primary care spend helps to reinforce the quadruple aim of health care: higher quality, happier patients, lower cost, and perhaps most importantly decreased clinician burnout."
>
> — *Dr. Andrew Saal, Chief Medical Officer at Providence Community Health Centers*

balance paying for administration of primary care medical homes and the state health information exchange.

- Make practice support payments to encourage and sustain patient-centered medical homes (PCMH). Practices seeking PCMH designation shall receive both infrastructure and care management payments, while those meeting the PCMH standards receive the care management payments. The actual amounts are negotiated between the insurers and practices.

- Support and promote integration of behavioral health into primary care practices.

What is Next?

The UAFP, UDOH, and our coalition partners are working on educating payers, lawmakers, and advocates on the benefits and long-term cost savings associated with increased primary care spend.

Working together to bring more resources to the kind of care family physicians deliver and to join this national movement to advance health, prevention and team-based care is our goal.

Dr. Chappell and his team at Wayne Community Health Center will continue to invest in the highest quality staff to deliver the right care to their patients. Higher payments mean his staff can continue to expand services like coordination of care for patients with Opioid Use Disorder and recalls for everyone in the practice that needs immunizations or patient-centered diabetes care. Utah is positioned to take the next step. The best patient care possible is always the goal: increased primary care spending to support team-based advanced practice medical homes, we will lower total cost of care while also achieving better personal and public health.

For more information, visit our website at: utahafp.org/investinprimarycare.

By Sarah Woolsey, MD, MPH, FAAFP
Director Family Health and Preparedness,
Utah Department of Health and

Michael K. Magill, MD
Chairman, American Board of Family Medicine

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Putting into Practice:

Implementing Chronic Pain Management Toolkit in Your Office

By Darlene Petersen, MD, and Brian Hunsicker

The Centers for Disease Control and Prevention guidelines state:

An estimated 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription. Chronic pain has been variably defined but is defined within this guideline as pain that typically lasts more than three months or past the time of normal tissue healing. Chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment or condition, injury, medical treatment, inflammation, or an unknown cause.

Physicians report multiple barriers to appropriately managing chronic pain, including lack of time, training, increased scrutiny on opioid prescribing, and fear of patients developing opioid use disorder. In addition to these concerns, several studies have reported increased physician burnout in the management of chronic pain from a lack of patient self-management skills. From Carole Upshur, EdD, and colleagues in "Primary Care Provider Concerns about Management of Chronic Pain in Community Clinic Populations":

> *"Despite the unfavorable reports about pain education and low satisfaction with pain treatment, PCPs did not identify provider expertise and health system factors (e.g., difficulty of diagnosis, lack of evidence-based guidelines) as the most important obstacles to treating patients with chronic pain. Instead, patient compliance and behavioral factors were rated as more problematic."*

Using a systematic evaluation in chronic pain management, including implementing the resources found in the American Academy of Family Physician's (AAFP) chronic pain management toolkit, allows for physical, mental, and functional evaluation of patients who suffer from chronic pain. After completing a thorough evaluation, a physician can determine appropriate medication and additional treatments and therapies that can be taken to improve self-management skills.

In March 2014, AAFP launched the Chronic Pain Toolkit, giving physicians multiple resources in one location that are easily accessed and downloaded.

The Chronic Pain Toolkit is divided into five sections:

- **Pain Assessment** gives an overview of appropriate strategies and diagnostic tools used to support chronic pain assessment in patients.
- **Functional and Other Assessments** discuss supporting tools and methods for the diagnostic assessment of functional activity and other coexisting conditions, including the patient's emotional and mental health, quality of life, and other psychosocial factors.
- **Pain Management** provides details on strategies and considerations for effective management of acute and chronic pain.
- **Opioid Prescribing** covers the prescribing of opioids as it relates to the treatment of chronic pain and includes information and resources on safe prescribing practices, risk mitigation and monitoring, opioid conversion and tapering tools, and specific resources for patients.
- **Opioid Use Disorders: Prevention, Detection and Recovery** offers a brief overview along with resources in support of opioid use disorder prevention, recognition and assessment, and treatment and recovery.

Application

Determining which patients are appropriate for evaluation is key. The more inclusive the application of the pain management toolkit within a physician's practice allows for clearer guidelines for staff and improves patient safety. Avoid common misperceptions that short-acting opioids or morphine milliequivalents (MME) less than 90 can be excluded from pain management evaluation because the patient is deemed lower risk. Protocols should be clear and nondiscriminatory, including all patients meeting the criteria for chronic pain.

Barriers to Implementation

Often cited as barriers for not managing chronic pain are the lack of time or familiarity with resources provided, patient behaviors, and increasing scrutiny over controlled substance prescribing. Overcoming these barriers can improve adherence and patient safety.

Lack of Time

Lack of time is commonly cited as a reason for not using validated scales and tools provided in the toolkit. Consider implementing only one tool at a time. If no standardized guidelines are in place in your current practice, start with having each new patient complete a patient agreement. Set a goal to have existing patients complete patient agreement over the next three to six months.

With EHRs creating a system when refills for controlled substances are initiated, physicians are prompted to complete necessary documentation after 90 days have passed from the date of initiation. Training staff to automatically facilitate this process as part of the patient follow-up visit can increase the adoption rate.

With recent updates in E/M coding, physicians can bill for time spent reviewing medical records, previous treatments, and imaging in addition to the time spent with the patient. This allows physicians to be compensated for the extra work and time required to evaluate often medically complex patients.

Review the chronic pain management toolkit and determine what tools best fit your practice setting. Develop a chronic pain management packet for all new patients and existing patients with similar time frames for completion. Review workflows within the clinic setting, introduce during the first visit, complete at next follow-up visit, and schedule additional time for "chronic pain management review."

The sample packet includes a brief pain inventory, Promis scale v1.2 Global health, ORT, and patient agreement.

Lack of Familiarity with Guidelines/Tools

When implementing any new clinic procedure or protocol, particularly with medically complex patients, resistance is to be expected. One technique that can be helpful to increase the use of validated scales provided in the toolkit is encouraging physicians to take the questionnaires themselves or administer them to a family member. This seems simple, but it works. It can be done quickly and, once familiar with the tools, the physician can determine which ones best suit their individual practice. For example, does this give you the information you need to know about your patient? Will it also increase your familiarity with scoring?

** Barriers and facilitators are listed from most frequently (top) to less frequently (bottom) reported by participants. Originally published in Pain Medicine; reprinted with permission.*

Patient lack of self-management skills is increasingly reported as a source of burnout among physicians providing pain management care. For example, treating underlying depression with a multidimensional approach has shown to increase patient compliance and the ability to engage in nonpharmacologic behaviors to manage pain and reduce reliance on opioid pain medication. Using tools such as a brief pain inventory and global health scales provides insight into the patient's overall level of function. Using motivational interviewing helps patients set achievable goals.

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Table 1: Barriers and Facilitators to Using Pain Self-Management Strategies *

Barriers	Facilitators
Pain interferes with self-management	Improving depression after treatment
Over-reliance on medications	Supportive family and friends
Limitations related to depression	Support groups with peers
Lack of tailoring to meet patient needs	Support from nurse care managers
Fear of activity	Social comparison
Ineffective pain relief from some strategies	Being a proactive patient
Lack of care manager support after study done	Positive thinking
Stressors	Positive affirmations
Time constraints	Improving one's self-esteem
Lack of motivation or self-discipline	Goal setting and achieving goals
Lack of support from friends, family, or employers	Providing a menu of different strategies to use
Limited resources (e.g., transportation, financial)	

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Safe Prescribing and Monitoring

Nearly 70 percent of drug overdose deaths in 2018 involved opioids, with two-thirds of overdose deaths involving a synthetic opioid (excluding methadone). In addition to the risk of overdose, patients prescribed opioids for chronic pain are at an increased risk for developing an opioid use disorder (OUD). Safer opioid prescribing by physicians and other clinicians is effective at reducing the risk of OUD.

In the 2019 National Survey on Drug Use and Health, 1.4 million persons abused or were dependent on prescription opioid pain medication.

As Deborah Dowell, MD, and colleagues reported in the CDC's Weekly Morbidity and Mortality Report announcing the guideline for prescribing opioids for chronic pain: "For example, a recent study of patients aged 15–64 years receiving opioids for chronic non-cancer pain and followed for up to 13 years revealed that one in 550 patients died from an opioid-related overdose at a median of 2.6 years from their first opioid prescription, and one in 32 patients who escalated to opioid dosages >200 morphine milligram equivalents (MME) died from an opioid-related overdose."

With new guidelines and increased scrutiny, physicians may be hesitant to provide appropriate pain management with opioid medications. Developing a structured protocol for monitoring and compliance in your clinic can set clear expectations for patients and reduce frustrations for staff and physicians. This includes, but is not limited to, written procedures on the frequency of urine drug screens, PMP searches (staff or physician accesses*), medication count protocol, review of an opioid management plan, collaborative information, and taper procedures. Before increasing medication dosages, determine if a functional evaluation has been completed and documented and if this improves function or if this is considered palliative.

(In Washington, a PMP query must be completed before the first refill or renewal of an opioid prescription; at each transition phase; periodically based on the patient's risk level; and when providing episodic care to a patient who you know to be receiving opioids for chronic pain.)

Table 2: Components of a Risk Mitigation Plan
• Developing an opioid management plan
• Providing patient education
• Screening urine for drugs
• Reviewing PDMP data
• Counting pills
• Scheduling more frequent monitoring visits

Identifying Opioid Use Disorder

How does a physician diagnose addiction in the setting of chronic pain?

A simplified but practical way to assess for signs of an OUD is the 4Cs framework:

Table 3: 4Cs Framework**
• Impaired control over pain medication use
• Compulsive use
• Continued use despite harms (consequences)
• Craving

** *American Academy of Family Physicians. Opioid prescribing for chronic pain. Accessed Jan. 11, 2021.*

- Identify a patient's existing or former substance use disorder via clinical interview 4C's and DSM 5, collateral interview, medical records, and screenings prior to prescribing opioids for pain management.

- Re-evaluate opioid prescriptions after non-fatal overdoses and discuss risks of continued use.

For patients who have a history of substance use disorder, initiating opioid therapy referral to an addiction specialist or reviewing AAFP's OUD practice manual can be helpful.

These are tools, not a decision. When a patient presents with unexpected results after a urine drug screen or medication count, this should trigger a change in a treatment plan, i.e., more frequent follow-up, additional testing etc., not the discontinuation of care. Patients are more likely to disclose OUD when they know that you can help them. With the U.S. Department of Health and Human Services announcing the waiver exemption on April 27, 2021, family physicians are in a unique position to not only diagnose but treat OUD when it occurs with limited barriers in place. Having a systematic approach can increase patient safety, improve patient compliance, and increase patient and physician satisfaction.

Darlene Petersen, MD, is the Medical Director at Rock Run Family Medicine in Roy, UT.

Brian Hunsicker, director of external affairs for the Washington AFP, contributed to this article.

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Family Medicine Worth the Wait for GME Award Winner: Melanie Dance

Melanie Dance, MD, MPH, remembers March 15, 2019, differently than most of the nearly 3,900 other medical students and graduates who matched into family medicine that day. There was no Match Day celebration at a medical school and no highly anticipated envelope to open with family.

Dance dropped off her three children at school, parked her car and waited, alone, for a life-altering email. "Having had the experience the year before of not matching, I knew there was a good chance I might never match," said Dance, a third-year resident who teared up recalling her match with St. Mark's Family Medicine Residency in Salt Lake City. "I realized that might mean I could never be a doctor again, and I had missed it for a long time. The reality that I could and would be a doctor again was a really big deal."

Dance had actually matched once before. After graduating from the University of California-San Francisco School of Medicine in 2006, she headed home for surgical residency at the University of Utah. Dance's husband remained in California to finish medical school while she started residency with their first child in tow.

Dance said her breast milk dried up during her first week of residency because she didn't have time to pump, and she rarely saw her infant daughter awake. Midway through her second year of training, she made the difficult decision to walk away.

"I loved being a doctor," she said. "I loved surgery, but I just could not make that work with our family situation."

Being a mother changed Dance's perception of health care and what she wanted when, and if, she could return to it.

"Once I had my own family and got involved in my own community, I recognized all the different ways that health affects people," she said. "Motherhood makes you more patient, and I was in a better position to talk to people about their health and how their family affects their health. Those things have become so real for me that I wanted to include that as part of what I did in the future, and that made primary care a really obvious choice. It has been the best fit for me."

Dance tried to keep a foot in science and medicine, teaching physiology at a community college for nine years and volunteering as a health coach and diabetes educator at a free clinic.

When the youngest of her three children started elementary school,

> Motherhood makes you more patient, and I was in a better position to talk to people about their health and how their family affects their health. Those things have become so real for me that I wanted to include that as part of what I did in the future, and that made primary care a really obvious choice. It has been the best fit for me."

she went through the Match in 2018. She applied to every family medicine program in Utah but did not match. She followed up with all four programs to ask what she could do differently or better, but three of the programs told her not to bother because she had been out of school too long for them to consider her application.

"I knew what my application looked like to other people," she said. "It looks like I had a 10-year hole."

St. Mark's, a small, community-based program that takes just four residents per year, encouraged her to try again. Dance made the most of her opportunity, serving on the program's GME committee and as a chief resident, as well as the resident member of the Utah HealthCare Institute Board of Trustees. Her duties as chief include scheduling the residents and serving as the official liaison between residents and faculty.

"I want to make sure that our residents who are breastfeeding have a schedule that is going to accommodate that because no one gave that to me when I was breastfeeding a baby during my first residency," she said. "Medicine isn't helpful for women and mothers in a lot of ways. If there's a way that I can help with that based on my life experience, I want to be a part of that."

Dance said she has learned a lot from younger residents but hopes they can also benefit from her experience.

"That's what's so beautiful about medicine, is that it's a community of learning," she said. "Family medicine, in particular, doesn't have to be a hierarchy of learning. It can be, look at who has different experiences and different skills, and learn from a person who knows a lot about a certain topic. Be humble enough to learn from people who might not be as advanced as you are in your career but still have so much to offer."
Dance completed her Master's in Public Health in June and will graduate from residency next summer.

"They have been so complementary," she said. "Family medicine and public health have to go hand in hand, and it has been so beneficial to me to be able to get the formal training in public health because I've used it every single day as part of being a family medicine physician."

Dance researched and created a tool implemented this summer to screen patients for challenges related to social determinants of health. For her efforts and perseverance, Dance was one of 12 winners of the AAFP's Award for Excellence in Graduate Medical Education.

She offered this advice for people who don't match their first time through the process: "Keep trying. It was difficult to step away, but it's been worth it to come back."

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The Beautiful Sound of Complaining

By Mark Wardle, DO, FAAFP

Let's be honest: there is little – if any – beauty about complaining. Few things can turn us off from another person faster than hearing them complain. Unless, of course, it is something you agree with, then complaining can become addicting. Fellow complainers build off each other, validating each other's point and adding fuel to the fire.

And we don't even realize how often we do it.
Social media has become a huge magnet for complaining. Protected behind a screen, we call out everyone: from the neighbor to the waiter to the president. With the power of limited consequences, we write open letters, post rants, and pass judgments. And it spills over from e-life to real life, negatively affecting our mental health and wellness. Have we become a society of complainers? We seem to be able to find the wrong in anything. In a day of ponies and rainbows, it is all too easy to focus on the manure and the rain. We obtain information at the touch of a button and pick up dinner without getting out of the car, so it is easy to expect that we should always get what we want when we want it. Where once we had to leave a message on a home telephone and wait until the person we called returned home to check it, we now, after three minutes of an unanswered text, send repeated texts that say, "Hello?"

But what if we could turn that around? What if the grating and depressing sounds of complaining could become beautiful? I am not suggesting we somehow learn to love complaining and hearing others complain like we sometimes learn to like certain foods, such as vegetables. Instead, I suggest that when we catch ourselves (or someone else) complaining, instead of continuing, stop, step back, and turn that complaint into gratitude. We can turn complaining into a positive trigger, a signal that prompts us to reflect on just how much we have and be grateful.

The phone battery dies: What an amazing piece of technology we have in the palms of our hands.
Stuck in traffic: Aren't we lucky to own a car, to be able to listen to the radio while sitting here, not to mention how lucky we are that we have someplace to go like work, home to family, etc.

The kids made a mess with their toys – we get the idea!
It is a form of mindfulness: taking a moment, creating space between us and the situation, and intentionally choosing our response. Certainly, this is a practice worth incorporating into our lives. Mindfulness has been shown to improve our stress response and can have positive effects on our mental health. But that doesn't make it easy. Triggers can help. Triggers can be powerful allies in creating all sorts of healthy habits. For example, brushing

our teeth can trigger us to floss, shutting the car door triggers us to put on our safety belt, and commercials or ads can be triggers to stand up and stretch. So to make "complaining" a trigger for gratitude, we can say: when I want to complain, or I hear others complaining, I will think of one related thing for which I am grateful.

Have you ever said, "I am so grateful I have so much stuff to complain about?" Seriously though! We have so many blessings, freedoms, and opportunities we take for granted. Many of our complaints, though not all, come because we are used to having it so good that our abundance and conveniences have become commonplace expectations. And even those things that are actual inequities and injustices, disasters and tragedies that rock our worlds both globally and personally, things we fight for and fight against, even those things could, with effort, become positive triggers. Although it may be hard, what if, instead of focusing on the negative, we used these opportunities to remind ourselves of just how great we have it, to focus us on the good we can do, the friend that supports us, or the progress we've made? Can we see the beauty in that? Just ponder the power that level of gratitude would bring into our lives.

This will take effort, and intention, and even some self-compassion when we don't quite get it right. But imagine the impact on our lives, on our mental health and personal wellness, and even the influence we might have on others, if we just took a moment, when hearing that sound of complaining, to take the inconvenience, the problem, the mess, and yes, even the tragedy, and let it remind us of all the wonders we have in our lives. Then bask in that gratitude. That would be a beautiful thing.

Dr. Wardle is Assistant Professor of Primary Care Medicine, Director of Medical Spanish Elective, and Co-Director of Global Medicine Track at Rocky Vista University – Southern Utah Campus in Ivins, Utah.

Utah Early Hearing Detection and Intervention Milestones

By Stephanie Browning McVicar, AuD, CCC-A

The Utah Early Hearing Detection & Intervention (EHDI) milestones are for every newborn to be screened and rescreened if necessary before 14 days of age. Newborns who do not pass their rescreening (usually done as an outpatient at seven to 10 days of age) should:

- Be tested for congenital cytomegalovirus (CMV) infection via PCR testing before 21 days of age utilizing urine or saliva; and

- Have an audiological diagnostic evaluation by an audiologist with expertise in infant testing before three months of age.

For those diagnosed as deaf or hard-of-hearing, it is imperative they be enrolled in early intervention (EI) services before six months of age.

The family physician (FP) plays a key role in ensuring infants in their care meet these milestones in order to give them the best chance of developing early communication and being mainstreamed in kindergarten. The FP is also instrumental in medical home monitoring auditory/speech/language milestones to catch pediatric late-onset hearing loss.

Although almost all newborns are screened for hearing in Utah, most current state data shows only 77% of infants requiring a diagnostic audiological evaluation receive one before three months of age, and only 63% of infants diagnosed as deaf or hard-of-hearing (DHH) enroll in early intervention before six months of age.

How can an FP help the infants in their care achieve these important EHDI milestones?

1. If an infant did not pass their newborn hearing screening, be sure the family brings their baby back to the birth hospital for their outpatient rescreening no later than 10 days of age.

2. If the infant fails their repeat screening, they should have CMV testing completed before 21 days of age and be referred to an audiologist with expertise in infant testing as soon as possible.

3. If an infant is diagnosed with middle ear effusion and does not pass their diagnostic auditory brainstem response (ABR) evaluation because of it, be sure the infant returns to the audiologist for a repeat evaluation after any middle ear treatment, even if they are in the care of an ENT. Many infants fall through the cracks when middle ear effusion is involved, as the ENT often tells the family that the infant "is fine" after the fluid resolves. Further, the ENT does not stress the importance of completing audiological follow-up to ensure the infant has normal cochlear function

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> The Utah Department of Health's Children's Hearing Aid Program (CHAP) provides hearing aids to financially eligible children under six years of age who do not have insurance coverage for amplification. For more information, go to health.utah.gov/chap.

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4. For those infants diagnosed as DHH, check to be sure the audiologist referred them to early intervention. The specialized provider of Part C EI services is the Utah School for the Deaf and Blind Parent Infant Program, otherwise known as PIP. Family enrollment is low for these services in Utah; please encourage the family to take advantage of these very important FREE services. Infant hearing loss should be treated like the neurodevelopmental emergency it is, and the sooner intervention is initiated, the better the child's developmental outcomes.

Utah diagnoses two infants per thousand newborns with hearing loss every year, but not all children can be identified through newborn hearing screening. Three times the number of children at birth are diagnosed with hearing loss by the time they enter school (http://www.jcih.org/posstatemts.htm). For many of these children, their parents and physicians do not know they are at risk for late-onset hearing loss. For this reason, there is growing recognition of the importance of early childhood hearing screening.

How can an FP help in the identification of these children?

1. Monitor speech/language and hearing/auditory milestones at every well-child visit.

2. If a parent/daycare/preschool voices concern about a child's hearing, take it seriously and refer to a pediatric audiologist right away. "Wait and see" is not an acceptable strategy.

3. Realize sometimes a little one's behavioral issues can be a sign of hearing loss. See #2 above.

4. Late-Onset Hearing Loss Week will occur annually from May 4 through May 10. Resources for you and your families can be found on the Olive Osmond Hearing Fund website: https://www.hearingfund.org/lohl-awareness.

Lastly, the Utah Department of Health's Children's Hearing Aid Program (CHAP) provides hearing aids to financially eligible children under six years of age who do not have insurance coverage for amplification. For more information, go to health.utah.gov/chap.

The Utah EHDI program is here to help. Please do not hesitate to call (801) 273-6600 or email ehdi@utah.gov for guidance and/or resources.

Resources:
Health.utah.gov/ehdi
Health.utah.gov/cmv
Health.utah.gov/chap
Utahbabywatch.org
https://www.usdb.org/programs/deaf-and-hard-of-hearing/parent-infant-program-pip-for-deaf-and-hard-of-hearing-children/
https://www.asha.org/public/speech/development/chart/

Stephanie Browning McVicar, AuD, CCC-A is the EHDI Programs Manager with the Utah Department of Health.

Are You Licensed Where Your Patient is Located?

By Jeanne E. Varner Powell, JD
Senior Legal Risk Management Consultant, Mutual Insurance Company of Arizona (MICA)

Physicians and advanced practice professionals have over a year of clinical telemedicine experience under their belts but still have questions about the maze of legal, regulatory, and reimbursement requirements. Federal and state regulators have relaxed, waived, or modified telemedicine requirements during the pandemic, especially during shut-downs. As enforcement of these regulations resumes, practices and clinicians should review their telemedicine processes to ensure compliance.

Variations on a Theme

One of the most frequent telemedicine questions has many variations but can be summarized as whether a physician or advanced health care practitioner licensed and located in one state can provide telemedical care to a patient in another state at the time of the encounter.

Illustrating Questions about the Patient's Location

- Dr. Acton (licensed and practicing in Utah) has an established patient, Jenny, who resides in Utah and is on a 3-day business trip in New Hampshire. Jenny wants a telemedicine appointment while she is away.
- Dr. Bonet's (licensed and practicing in Utah) long-time pediatric patient, Jimmy, resides with his mother in Utah. Jimmy is visiting his father in North Dakota for the summer. Jimmy's mother requests a telemedicine appointment while Jimmy is in North Dakota and his mother is in Utah.
- Dr. Camara's (licensed and practicing in Arizona) established patient, Ann, lives in Michigan but spends winters in Arizona. Ann wants Dr. Camara to continue treating her via telemedicine during the months she is in Michigan.
- Nevada-based nurse practitioner Divata has taken care of a pediatric patient for many years. The patient and her family are in California for a week-long vacation. The mom asked for a video visit to assess and treat a rash on the patient's arm.

Location and Licensure Answers

When the patient is out of state, even temporarily, the answer is always the same. Physicians, advanced health care practitioners, and other licensed health care professionals have always had to comply with federal and state laws as well as state licensing requirements where the care is received – known as the originating site. In the examples above, the clinicians are not located or licensed in the state where the patient is located. Each state licensing agency oversees and disciplines the professionals it regulates. A physician providing care to a patient in Nebraska is subject to the rules and regulations of the Nebraska medical board. If the physician is not properly licensed in Nebraska, the physician may be practicing medicine in Nebraska without a license and subject to discipline.

A Utah-licensed and -located clinician treating a Utah resident visiting Nebraska could also be subject to other Nebraska laws and court rules. Should the patient file a medical professional liability lawsuit in Nebraska, the Utah physician may be required to defend a lawsuit there.

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Risk Solutions

The patient's location

Physicians, advanced health care practitioners, and practices should prepare now for patient requests for out-of-state medical care by considering the workflows for appointment scheduling, telephone triage, and telemedicine appointments. For telephone triage and telemedicine encounters:

- Screen for the patient's anticipated geographic location during scheduling;
- Before a clinician begins a telemedicine appointment or a telephone triage call, confirm the patient's physical and geographic location and document in the medical record; and
- If the patient's physical location is inappropriate, e.g., driving or steering a car, and the patient cannot immediately relocate, e.g., pull over and park, staff should reschedule the appointment.

As part of telemedicine appointment workflows, staff should also confirm:

- The patient or representative provided their informed consent for the telemedicine appointment, and their consent is documented;
- Intake forms or questionnaires are completed;
- The practice provided instructions for connection problems; and
- If appropriate, reasonable accommodations are in place for patients with disabilities.

Interstate medical licensure

Another consideration for workflows is the Interstate Medical Licensure Compact, in which member states have agreed to streamline and expedite licensure for out-of-state physicians. Physicians must have a full, unrestricted medical license in a Compact member-state. Physicians may designate that state as their State of Principal License (SPL) if one of the following applies:

- The physician's primary residence is in the SPL;
- At least 25% of the physician's medical practice occurs in the SPL;
- The physician is employed to practice medicine by a person, business, or organization located in the SPL; and
- The physician uses the SPL as the state of residence for U.S. federal income taxes.

In addition to meeting the SPL requirements, physicians applying for licensure through the Compact must not have a history of licensure disciplinary actions, a criminal history, a history of controlled substance actions against their license, or a license currently under investigation.

The Compact does not issue a single interstate medical license. Instead, participating states issue individual licenses. Physicians can select multiple Compact member states where they wish to be licensed but only need to complete one application. Member states include Alabama, Arizona, Colorado, Georgia, Idaho, Iowa, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Dakota, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.

Between April 2017 and August 2021, the Compact licensed 23,321 physicians. Details about eligibility, participating states, application, renewal, and costs (an initial non-refundable fee for the Compact and then the individual cost of a license in each state) are available on the Compact's website. **Under the Compact and state law, medical care is provided and received where the patient is physically located.**

Resources

Many of the state public health emergency orders that temporarily waived telehealth licensing requirements have ended. Others are on the verge of expiring. As a result, physicians, advanced health care practitioners, and practices should consider their workflows and licenses before patients call for out-of-state care.

For state-specific telehealth and licensing information, consult these resources from the Federation of State Medical Boards and Center for Connected Health Policy:

- Telemedicine Licensure Policies – Board by Board Overview
- State-by-State-Listing of Waivers and Other Modifications of Telehealth Requirements in Response to COVID-19
- COVID-19 Cross-state Licensing Page
- Professional Requirements Cross-state Licensing Page

In addition, call your medical professional liability carrier to confirm that your policy provides coverage when you render care to patients in other states.

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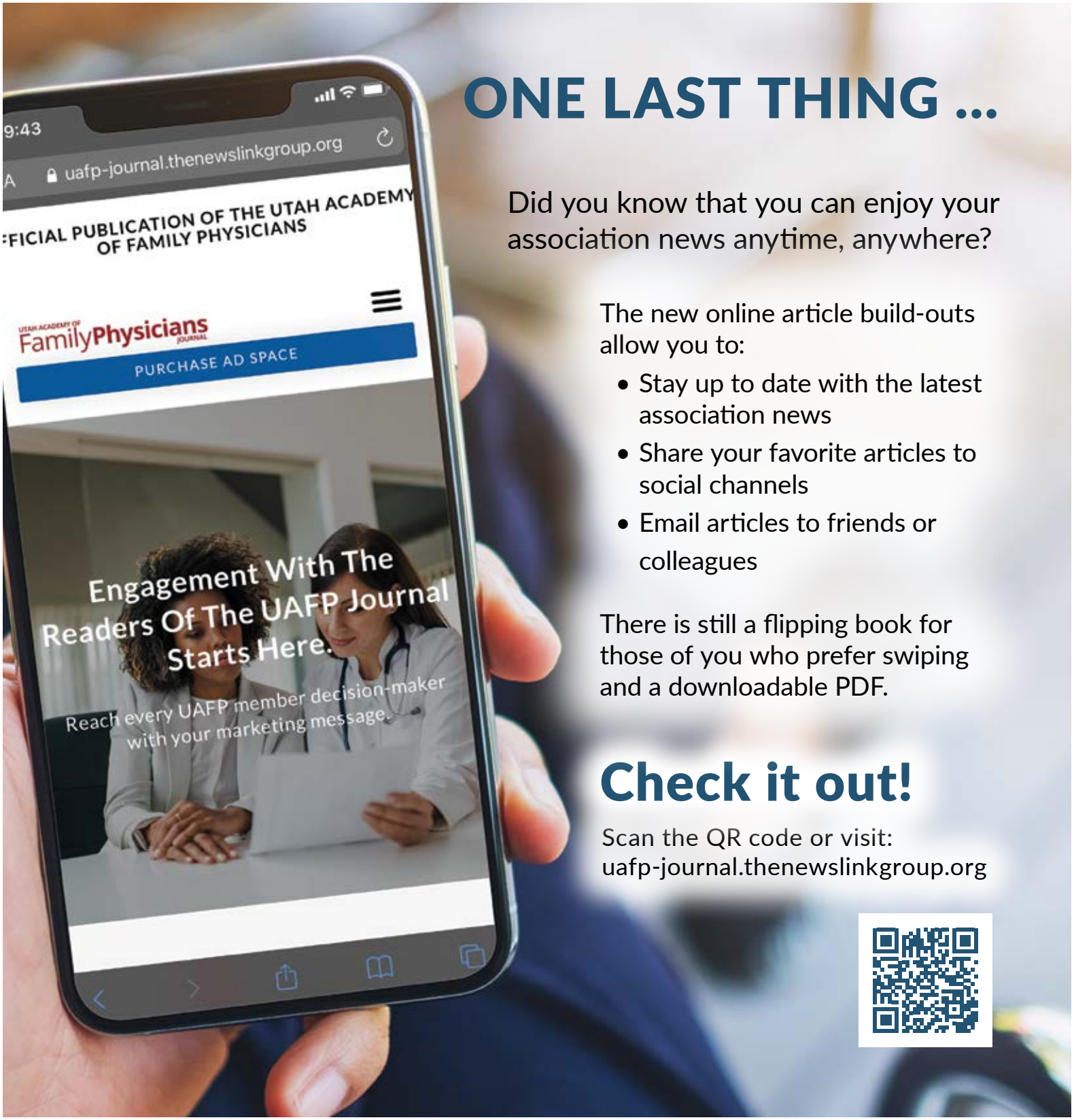

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