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WYOMING
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ABOUT THE COVER

PHOTO BY JANELLE ROSE

Matthew Boyer, DO, is the medical director for University of Wyoming Athletics.

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Earning our Patients' Trust

Rebuilding the physician community during a pandemic

BY JASPER JAMES "JJ" CHEN, MD

Why do we do what we do? What truly matters to us? What do we look forward to? How do we maintain hope when there is apparently not enough of it to go around?

I asked myself these questions during the pandemic. While far from over, it has catalyzed many things, including why we as healthcare providers would willingly choose to endure the moral injury of COVID-19, let alone the physical and physiological.

> Best is to preemptively teach students and residents in training about burnout symptoms and prevention, before it may be too late.

Truth be told, at the start of the pandemic, when it wasn't exactly clear how to best prevent the transmission of disease, I truly feared I was going to die. I bought all the N95 masks I could on eBay. My wife made me a face shield that now belongs in a museum of antiquity. Nevertheless, I did not shy away from working full-time on the inpatient psychiatric unit at Cheyenne Regional Medical Center. I did not personally regularly encounter COVID-positive patients as our unit policy was (and still is) not to bring over any patients requiring inpatient psychiatric hospitalization to our unit until they tested negative, exposures still occurred and the fear and uncertainty in our unit was palpable.

We are now at a very different time as compared to the beginning of the pandemic. COVID-19 has placed immeasurable burdens on all of us, our staff and our families. As healthcare providers, we are admittedly all—to some extent or other—burned-out. While it comes in various forms, some more insidious than others, it is something that the pandemic has made dreadfully worse.

A recent 2021 Survey of America's Physicians indicated that 80% of US physicians were impacted in a variety of ways by COVID-19, and that the pandemic continues to negatively impact the well-being of physicians and their patients a year later. Half of physicians surveyed experienced reduced income within the past year, a third experienced staff reductions, and nearly two-thirds experienced burnout, which is over a 50% increase since 2018.

As a psychiatrist, I prefer to prevent the onset of burnout and to alleviate the severity of it. Oftentimes the best approach to reducing burnout is a multipronged approach. Certainly therapy and/or medications may be very helpful. Equally, if not more beneficial, are peer

> If anything, the pandemic has taught us valuable and humble lessons in that if we weren't as resilient before, we ought to become more and more resilient going forward.

support groups and evidence-based professional training such as resilience training. Best is to preemptively teach students and residents in training about burnout symptoms and prevention, before it may be too late.

Poor physician well-being is consistently linked to poor healthcare outcomes. The aforementioned survey found that "it is in the public's interest to help maintain physician well-being and lower levels of physician burnout because healthy, engaged physicians generally provide better care than unhealthy, disengaged physicians."

Let's amply restore the bi-directionality of care in healthcare by encouraging our patients and more elements of our healthcare system to also care about us. We live in a world where we may simply have to earn our patients' trust as opposed to assuming that they will automatically believe in the rigor and merits of both our medical training and the preponderance of the scientific evidence.

If anything, the pandemic has taught us valuable and humble lessons in that if we weren't as resilient before, we ought to become more and more resilient going forward. Our own attitudinal, professional development and training is not enough, however. We need to train our patients to love us again and to restore their faith in our medical profession. We cannot ever take for granted the patient-doctor relationship.

Therefore, the clarion call to foster a truly therapeutic alliance between our patients and ourselves has never been more sorely needed. We can hope to reduce our individual burnout as providers by engaging in some of the highest coping mechanisms known to humankind, including humor, sublimation and altruism. Keen and active participation in civic life in our own communities and at the state level is one fulfilling way to do this.

In addition to connecting all of us, the Wyoming Medical Society plays an instrumental role in organizing our collective patient advocacy and self-advocacy efforts. I believe the WMS offers both formal and informal avenues to markedly decrease the potential for burnout to occur. Whether it is looking me up in the directory and letting me know how you're doing and how I can best help, to taking advantage of the Wyoming Leaders in Medicine program, a genuine highlight of my life, the WMS is here for you! Together, Let's Make Medicine Great Again!

grat·i·tude /ˈgradəˌt(y)o͞od/

A feeling of appreciation or thanks; the state of being grateful*

BY SHEILA BUSH

We closed out 2020 believing we had all truly endured the worst year ever, yet it wasn't long into 2021 before we realized that things would maybe get worse before they would get better. Reflecting on 2021 could leave many of us feeling depleted and searching for a dark corner to tend to painful wounds of moral injury.

No one would cast blame if we did just find said dark corner and stay there. From the onset of this pandemic a bright light was cast on science and medicine with unrealistic expectations for immediate answers, solutions and cures. When science did provide answers and solutions, attacks were launched and the moral characters of our physicians and scientists were questioned. All of this in addition to the personal struggles everyone has suffered this year with families and communities in turmoil over the all-consuming politics of this time. So, yes, that dark corner is justified and we all understand the desire to seek its retreat.

But hiding won't fix the challenges we face. In fact, that tempting dark corner will likely just make things worse. The great research professor Brené Brown would maybe tell us that right now, inside of all of this suffering and strife, is the best time to employ gratitude. Let's take this moment to lean into understanding the meaning and power of gratitude.

> Reflecting on 2021 could leave many of us feeling depleted and searching for a dark corner to tend to painful wounds of moral injury.

The Oxford English Dictionary defines gratitude as, "the quality of being thankful; readiness to show appreciation for and to return kindness." Robert Emmons, perhaps the world's leading scientific expert on gratitude, says gratitude has two key components. The first component is an affirmation of goodness and the second an acknowledgement that the sources of this goodness are outside of ourselves. Gratitude encourages us not only to appreciate the goodness in these gifts but to repay them and be the source of goodness for someone else. The sociologist Georg Simmel called this "the moral memory of mankind."

> We are hopeful that 2022 will be the year we will return to an in-person annual meeting where stories can be shared and relationships renewed.

WMS is looking to 2022 with hope and … you guessed it, a focus on gratitude. We have so much to be grateful for. We can be a source of goodness within our membership. We can extend the best of ourselves to our community and in return, we can focus on the kindness that comes back to us from our community.

We are hopeful that 2022 will be the year we return to an in-person annual meeting where stories can be shared and relationships renewed. Next year will be a year to celebrate as we commemorate the 25th anniversary of Wyoming joining to add the final "W" to make WWAMI what it is today.

Watch for big news this coming spring about moving the traditional WMS annual meeting from summer to the fall of 2022. WMS is partnering with the University of Washington School of Medicine, University of Wyoming and WWAMI to throw a party for the ages in Laramie culminating with a formal, black-tie gala to honor those who made WWAMI possible, those who continue to support its success and the incredible alumni practicing medicine and caring for patients across Wyoming. We hope you'll join us as we celebrate our past accomplishments and plan an even brighter future for our state.

**From the Merriam-Webster Dictionary*

Dr. Alexia Harrist

State health officer works for greater good

BY ROBERT MONGER, MD, AND WHITNEY HARMON

Photos courtesy of Dr. Alexia Harrist

Congratulations to Alexia Harrist MD, PhD, the Wyoming state health officer, our Wyoming Medical Society 2021 Wyoming Physician of the Year!

Dr. Harrist is not only a world class physician and public health advocate, she is also an adventurous, interesting, compassionate and strong person. She is someone that lives a full life and is the epitome of a servant leader.

Dr. Harrist was born and raised in Massachusetts and attended college at Yale University, and then completed a MD/PhD program at the University of Pennsylvania in Philadelphia from 2002 to 2010. Her PhD research studied the neuroscience of how HIV infects the brain.

Following the completion of her MD/PhD program Dr. Harrist completed a residency in pediatrics in Boston and then after residency stayed in Boston and worked for a year as a pediatrician in an urgent care clinic associated with an emergency department. It was during that time that she became interested in public health. She remembers regularly seeing children who came to the emergency department for treatment of problems such as asthma exacerbations that could have been prevented if they had had access to better outpatient healthcare, and she became aware of systemic issues such as families calling an ambulance for treatment of an ear infection because they didn't have reliable transportation to a doctor's office.

She liked that public health is a way to combine both basic science and clinical service, and that public health would allow her to find a balance between her love of laboratory science and clinical work. She applied and was accepted into a two-year public health fellowship through the Centers for Disease Control and Prevention, joining the Epidemic Intelligence Service. Her CDC fellowship brought her to the Wyoming Department of Health where she began work on a variety of public health issues including tularemia outbreaks, Colorado tick fever infections and the fetal death surveillance system.

Through her public health work with the CDC, Dr. Harrist has gone on a number of fascinating international trips including traveling to rural Sierra Leone twice in 2014-15 to help fight the Ebola outbreak. On her first trip to Sierra Leone she worked on contact tracing, and then on her second trip she returned to help set up Ebola vaccine trials. She traveled to rural Brazil during the Zika virus outbreak in 2016, working with infants and mothers to better understand the relationship between Zika infection during pregnancy and congenital malformations. She was also a medical officer for tuberculosis outbreak investigations at the CDC in Atlanta for almost one year.

In March 2017 Dr. Harrist began work as the Wyoming state epidemiologist at the Wyoming Department of Health, and then in June 2017 she became the Wyoming state health officer.

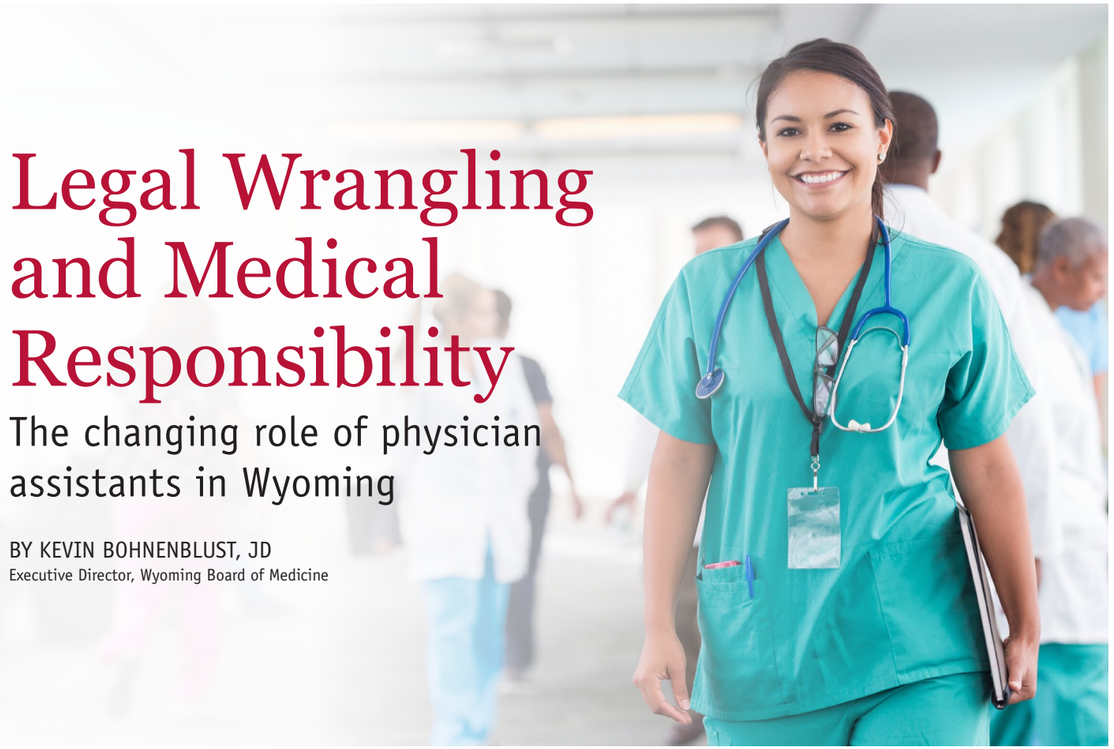
Prior to the COVID pandemic Dr. Harrist worked on many different public health issues in Wyoming including disease surveillance systems, responding to outbreak clusters, and working on prevention activities such as suicide and overdose prevention. In addition to her many responsibilities managing the Wyoming public health response to the COVID-19 pandemic, Dr. Harrist has been trying to not lose focus on other important public health issues.

Dr. Harrist is an avid distance runner and previously ran marathons on a regular basis, but because her schedule has been so busy over the past year she has cut back to ONLY running 5 miles per day during the week and 10-plus miles per day on weekends. She loves living in Wyoming and enjoys an active outdoor lifestyle including hiking, skiing, mountain biking, fly fishing and playing with her new dog, a standard poodle named Rocky.

She advises medical students to think creatively about what they want to do with their careers, and to not let themselves get boxed into one specialty. For students who may be interested in public health she suggests considering either a master of public health program or a CDC fellowship.

Dr. Harrist told us, "I love my job and working in Wyoming, and getting to talk to people—I love the personal interaction and connections between people that we have here in our state."

Congratulations to Dr. Alexia Harrist on being named the 2021 Wyoming Physician of the Year. She is an outstanding physician dedicated to improving public health here in Wyoming and certainly well deserving of this award.



Legal Wrangling and Medical Responsibility

The changing role of physician assistants in Wyoming

BY KEVIN BOHNENBLUST, JD
Executive Director, Wyoming Board of Medicine

With the passage of Senate File 33 by the 2021 Wyoming Legislature, practice by physician assistants took another big step forward in Wyoming. The profession has come a long way in 50 years, and the evolution has taken an interesting, if occasionally slow, path.

The profession now commonly known as "physician assistant" got its start in 1965, when four former Navy corpsmen entered a training program at Duke University. The concept arose from, among other places, a 1961 article in the Journal of the American Medical Association, calling for "an advanced medical assistant with special training, intermediate between that of the technician and that of the doctor, who could not only handle many technical procedures, but could also take some degree of medical responsibility."

In 1973, the Wyoming Legislature considered a bill creating "statutes related to physician support personnel." It defined a "physician support person" as a graduate of an approved program who was approved by the Wyoming Board of Medicine to perform medical services under the supervision or direction of a physician approved by the board. The bill limited physicians to supervising no more than two physician support persons at a time, and only provided for "certification" of physician support personnel—not "licensure."

Conspicuous by its absence in the legislation was the term "physician assistant." Instead, the bill interchangeably used the terms "physician's support person," "physicians support personnel" and "physician support personnel." The mixing of plural and singular, and especially the occasional use of the possessive apostrophe in "physician's," appeared to be a harbinger of semantic wrangling to come.

> The mixing of plural and singular, and especially the occasional use of the possessive apostrophe in "physician's," appeared to be a harbinger of semantic wrangling to come.

The legislation also reflected apparent concerns over scope of practice, as it stated: "Nothing in this act shall permit the practice of optometry … by physician support personnel, except those … who

are employed by a physician trained in eye care at his usual place of practice and who are under the physicians [sic] direct supervision." It also provided for an advisory committee on physician support personnel to the board of medicine, with a whopping eight members! The bill passed into law in 1973, then all was quiet on the legislative front for the next 14 years.

In 1987, a bill filed by Sen. Dan Sullivan and Rep. Craig Thomas substantially overhauled the Wyoming Medical Practice Act. This legislation set the foundation for the system of licensing of physicians and physician assistants and regulation of their professional practice that continues today. In addition to finally dropping the term "physician support personnel" in favor of "physician assistant," the bill moved the relevant statutory sections to their own "Article 5," entitled "Physician Assistants," within the Medical Practice Act. Although it added two seats on the board for "lay" or public members, physician assistants would have to wait another 14 years for that recognition. The bill reduced the advisory council to "at least" two physician assistants and two physicians, and specified that physician assistants had no prescriptive authority, but could "transmit prescription drug orders as the authorized agent of a licensed physician."

Until 1995, physician support personnel, and later physician assistants, were "certified," not "licensed." That year, as part of another broad update of the Medical Practice Act, the Legislature changed physician assistant "certification" to "licensure," and established passage of the certification examination administered by the National Commission on Certification of Physician Assistants (NCCPA) as the sole testing requirement to receive a license. The legislation provided that contact via telecommunications between a physician assistant and the supervising physician was adequate to show "ready availability" of supervision, provided the board found that the contact was "sufficient to provide quality medical care." The scope and relative autonomy of practice as physician assistant continued to grow at this time, with this language added to the Medical Practice Act:

> *A physician assistant assists in the practice of medicine under the supervision of a licensed physician. Within the physician/physician assistant relationships, physician assistants exercise autonomy in medical decision making and provide a broad range of diagnostic, therapeutic and health promotion and disease prevention services. The physician assistant may perform those duties and responsibilities delegated to him by the supervising physician when the duties and responsibilities are provided under the supervision of a licensed physician approved by the board, within the scope of the physician's practice and expertise and within the skills of the physician assistant.*

The Wyoming Legislature advanced the physician assistant program by huge strides with a deceptively short bill that passed in 2001. For the first time, in addition to the physician assistant advisory council, a physician assistant would be a full member of the board of medicine. The bill did not give physician assistants full prescriptive authority, retaining the "agent of the supervising physician language," but modified a prohibition on PA prescribing of Schedule II controlled substances to permissive authority to prescribe Schedule II through Schedule V medications.

> Until 1995, physician support personnel, and later physician assistants, were "certified," not "licensed."

Perhaps most significant, though, was this new language describing the scope of physician assistant practice in Wyoming:

> *Physician assistants are healthcare providers and shall be considered healthcare providers for all provisions of state law. Physician assistants shall be considered agents of their supervising physician in the performance of all practice related activities, including, but not limited to, the ordering of diagnostic, therapeutic and other medical services.*

Elsewhere in healthcare licensing, 10 years after the adoption of the original "physician support personnel" certification legislation, the Legislature modified the Wyoming Nursing Practice Act to recognize and license "advanced practitioner[s] of nursing." Starting in 1983, advanced professional registered nurses could perform "advanced nursing acts and … medical acts in collaboration with a licensed or otherwise legally authorized physician or dentist, in such a manner to assure quality and appropriateness of services rendered." In 2005, the Legislature repealed the "collaboration" requirement, giving advanced practice registered nurses full autonomy, including prescriptive authority, in Wyoming.

Legislation proposed by the Wyoming Association of Physician Assistants in 2020 set the stage for the latest stage of evolution in physician assistant practice. The bill was introduced in the 2021 General Session as Senate File 33, and its primary sponsor was Fred Baldwin, PA-C, the chairman of the Senate Labor, Health and Social Services Committee.

Based on the "Optimal Team Practice" model promoted by the American Academy of Physician Assistants, the biggest impact of the bill is that physician assistants who are NCCPA certified no longer require physician supervision to practice in Wyoming. It also changed the scope of a physician assistant's practice from one who "assists in the practice of medicine under

the supervision of a licensed physician" to "an individual who practices medicine."

New graduates of physician assistant programs who have not achieved NCCPA certification will still need to be supervised by a physician, or a physician assistant with at least five years of experience, who is approved by the board of medicine. The requirement for certification will end when the physician assistant passes the NCCPA examination.

The bill deleted the decades-old language stating that physician assistants may prescribe "only as an agent of the supervising physician." The physician assistant advisory committee to the board of medicine is also modified to require a majority of its members be physician assistants.

Due to the complex nature of the board of medicine's licensing database, and the need to make substantial revisions to it to reflect the changes made in SF 33, the Legislature made the law effective on January 1, 2022. Critical among those changes is removing the automatic conversion of a physician assistant's license from "active" to "inactive" status if the physician assistant doesn't have an approved supervising physician, which the majority of physician assistants will not have starting next year. Online forms, including those for initial license applications and renewals, will also be modified to implement the changed supervision requirements.

Until January 1, 2022, though, all physician assistants continue to require physician supervision in order to practice in Wyoming. For that reason, during the physician assistant license renewal period beginning in mid-October 2021, the board's forms will continue to require PAs to list their approved supervising physicians. The renewal forms will also ask physician assistants for their NCCPA certification status to ensure compliance with the revised supervision requirement that applies only to uncertified physician assistants starting on January 1st. The licensee look-up feature on the board's web page will also be modified to show current supervising physicians only for those physician assistants who are not NCCPA certified, and the historic (pre-2022) supervising physicians for all physician assistants.

Last, but certainly not least, the board will undertake a substantial revision of Chapter 5 of its Rules and Regulations. That will focus primarily on removing language related to physician supervision of physician assistants, but will also update the license application process rules. As always, the board will seek input from the Wyoming Association of Physician Assistants and the Wyoming Medical Society on the drafting of the rule changes.

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As for those four Navy corpsmen, they must have made a good impression. Fifty-six years later, the Navy is actively recruiting with a description on its website for physician assistants who would like to "serve globally in hospital settings, aboard aircraft carriers and bring the best in U.S. healthcare on humanitarian relief missions. Your skills in medicine are needed to keep our sailors healthy so they can continue to carry on operations every day."

Caring for Cowboys and Cowgirls

Dr. Matthew Boyer's Door is Always Open

UW Athletics Medical Director invests time and technology into every student athlete

BY JOANNE MAI
PHOTOS BY JANELLE ROSE

University of Wyoming Athletics Medical Director Matt Boyer, DO, stands outside of the High Altitude Performance Center on the university campus in October.

It's Thursday afternoon in the middle of football season. In a building a few feet from the end zone of the University of Wyoming's War Memorial Stadium, Matthew Boyer, DO, sits at his desk and looks out the window. It's not the 50-yard line of Jonah Field that he sees.

With a warm smile, he raises a hand and waves through the glass of the interior window to some football players who have just arrived at the athletic training room outside his office. They are not here to see Dr. Boyer in his professional capacity as University of Wyoming Athletics' medical director, at least not today. Instead, they greet him through his open door as though they are seeing a teammate, "Hey, Boyer!" They grab some weights off the rack along the wall and start stretching on the rubber mats that line the floor.

Dr. Boyer says he's happy with his office in the heart of the High Altitude Performance Center. From this vantage point, he sees and gets to know the more than 1,000 student athletes he's here to serve. And that's just the way he likes it.

"Before I arrived, UW was like most universities," Dr. Boyer says of his appointment in July 2015, as UW's first in-house team physician. "There was a physician who would come a couple of days a week and see athletes either before or after office hours.

"Although this provided much-needed care for the athletes, it's care that is limited to certain times of the day," Dr. Boyer continues, explaining that he is one of a handful of dedicated university sports physicians nationwide. "I am on-call 24/7 for the athletes and club teams."

Her first major injury

Being available is important to Dr. Boyer and something the students appreciate.

About nine months ago, UW sophomore Track & Field thrower Logan DeRock tore her ACL and needed to have surgery. It was the first major injury that the former Colorado 4A high school All-Conference and All-State athlete in three sports—volleyball, lacrosse and track & field—has ever suffered.

"Dr. Boyer and his team have been very helpful in the recovery process," she says. "They have been in communication with my surgeons and have collaborated to create a plan that Dr. Boyer can adjust based on my prognosis."

She says she likes that she's been able to talk with Dr. Boyer.

"We have discussed recovery and what the year will look like for me at length," says DeRock, who throws shot put, discus, hammer, javelin and weight. "He has been a go-to for me with any questions or concerns that I have had."

Although she's had the support of her family, including her mom, who was a University of Hawaii volleyball player, and her older brother, who also competes for UW Track & Field as a thrower, she says it's nice to have a medical professional overseeing her care.

Logan DeRock is a Track & Field athlete at the University of Wyoming. Photo courtesy of the University of Wyoming.

> "It would have been hard to not have a team doctor at my side with recovery."

"It would have been hard to not have a team doctor at my side with recovery," she says. "I think that I would have been behind or rushing into where I should be without someone who is greatly educated in their scope of practice. He has been a great addition to my athletics career."

DeRock, who says she chose to be a thrower because she wanted to have control of her successes as an athlete, has been attending practice daily, even though she can't practice yet.

"I participate in an altered version of weights and I additionally do rehab at least three days a week," she says, adding that her goal is to be cleared to compete when she reaches the 9-months post-operation mark. "I will be able to compete with the team once indoor track season starts in mid-November."

She has been using the state-of-the-art facilities at the High Altitude Performance Center to aid in her rehabilitation. "I use the pools and the Normatec (compression) boots to help with soreness," she says. "Once I start heavy lifting, I will use the altitude simulation chamber. These are great additions to recovery because they help with limiting soreness and fatigue."

The whole person

A team of certified athletic trainers along with a registered dietician and a wellness counselor all work on staff with Dr. Boyer and the rest of the sports medicine team to assist student athletes like DeRock. They coordinate with the dean of students and academic affairs to ensure that injured students have access to tutors and workshops to maintain their studies and coursework.

An injury or illness can take more than a physical toll. Dr. Boyer says some student athletes struggle emotionally too.

"A lot of them live with their teammates, so they watch everyone else go out to practice and they're sitting at home,"

Caring for Cowboys and Cowgirls

he says. “They can feel like they are losing their identity when they’re not going to practice or games.”

> “This is a tough age for most people,” Dr. Boyer says. “These athletes put a lot of pressure on themselves.”

DeRock says she’s fortunate that it hasn’t happened to her.

“My teammates are super supportive with the little accomplishments, like being cleared to upper body lift,” she says. “I am very independent so the hardest part of the injury was not being able to drive or put on my socks for the first few weeks. I attended meets with my family so I still was able to support [my teammates] the best I could.”

Being a part of a team is something that Dr. Boyer understands. He played football, track and soccer.

“I injured my foot and shoulder and it ended my collegiate career,” Dr. Boyer says. “I think that experience helps when I talk with students who have career-ending injuries. If I had never been in that position, it would be a different conversation. They know when someone understands them.”

But Dr. Boyer knows that being able to relate to the students isn’t always enough. He works with UW Counseling to refer student athletes that need the help of a professional counselor—whether it’s for emotional support to get through an injury or an illness or something else.

“This is a tough age for most people,” Dr. Boyer says. “These athletes put a lot of pressure on themselves. Mental health. Eating disorders. I’ve probably seen more mental health issues here than anywhere else probably because I’m here full-time with them.”

Building trust

In addition to attending practices and all the home games for the 17 UW varsity sports teams, Dr. Boyer tries to attend many of the UW club sport events. He also travels to every away game for football and the Mountain West championship games for men’s and women’s basketball.

That’s only part of his typical week.

He spends three full days and two half days each week in his office or in one of the two exam rooms next to it where he sees student athletes. The other two half days are spent in the university’s student health clinic where he’s available to see any student on campus, including student athletes who may want to see Dr. Boyer in a space away from their teammates.

Most people would find his schedule grueling. But not Dr. Boyer.

Spending so much time at practices and games is important, Dr. Boyer says, especially for international student athletes.

“They come from different cultures. If they only see you once in a while, they don’t trust you. But if they see you at their games and practices, and see you around, they know you’re going to be there and they develop a trust in you,” he says. “They become my adopted kids. And it’s nice that there’s someone on the sidelines for them when they’re so far from home.”

As for being in the office so much, Dr. Boyer thinks that’s important too.

The University of Wyoming expanded the Rochelle Athletic Center from 47,000 to 118,000 square feet, which includes the new High Altitude Performance Center addition.

“Live at high altitude and train low,” Dr. Mathew Boyer says. “It can help you run a little farther and faster.”

“They know I’ll be here and they can just stick their head in my office and ask a question,” he says. “And I can see them out there [through the glass] and say, ‘Hey, how’re you feeling today?’ You can see they’re not doing well. You can take care of what they need and they don’t have to wait two weeks until their next office visit.”

Developing a relationship with the athletes beyond what can be done in a clinical setting has been the most surprising aspect of the job for Boyer.

> “I see them as my kids and feel personally responsible for their well-being and success. I am heartbroken when they are sad and I am full of joy when they are successful.”

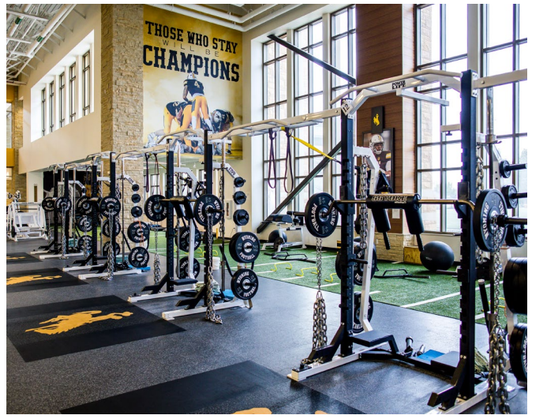
“These athletes, these students, are around my daughter’s age,” he says. “I see them as my kids and feel personally responsible for their well-being and success. I am heartbroken when they are sad and I am full of joy when they are successful.”

Having that kind of connection to the students seems to align with Boyer’s original vision for his career.

Compassionate care

“When I was in medical school I had a couple of different ideas of where I wanted to go with my studies,” he says. “I was interested in becoming a family physician and being a small-town doctor taking care of families and being able to have a close relationship with my patients. I also enjoyed surgery and working with my hands and the different tools. Through my rotations, I realized that I enjoyed just about everything associated with medicine and surgery which led me to emergency medicine.”

But it wasn’t just the clinical rotations that led him down that path.



Athletic trainers attend UW team workouts and practices and provide rehab and therapy to athletes after injury.

“When I was 10, my grandfather went to the hospital with chest pain and I never saw him again. He died of a heart attack” Dr. Boyer says. “As I rotated through an emergency medicine rotation, I decided I wanted to be the doctor that these patients in need of emergency services would see first and be able to provide compassionate care for them and their families.”

After completing his studies in osteopathic medicine at Oklahoma State University, Dr. Boyer went on to complete a four-year residency in emergency medicine in Oklahoma City, and then practiced emergency medicine/urgent care for seven years in Joplin, Missouri.

“The great thing about emergency medicine and urgent care is it prepares you for just about anything,” Dr. Boyer says. “I have seen all types of trauma, from sports injuries to high velocity automobile accidents. I have taken care of

Caring for Cowboys and Cowgirls

the not-so-emergent cold to meningitis and shock."

> "If you find something you did for free that you enjoy doing, you should do it for your career."

Finding his way to sports medicine

As a former collegiate athlete, he was drawn to helping with sporting events.

"I started covering sports events in medical school [in 1997] and this continued through internship, residency and the next 20 years," he says. "I have covered amateur, high school, NCAA division 1 and 2, and professional-level sports. There are very few sports I have not covered."

"Besides the college sports at UW, I have covered rodeo, professional bull riding, professional mixed martial arts, professional boxing, triathlons and marathons," he says. "These experiences have provided me the knowledge and skill to provide care for UW athletics and students."

Dr. Matthew Boyer watches a University of Wyoming football game against Ball State University from the sidelines at Jonah Field at War Memorial Stadium in September. Photo courtesy of the University of Wyoming.

Along the way, Dr. Boyer followed the sage advice: "If you find something you did for free that you enjoy doing, you should do it for your career."

Dr. Boyer completed a sports medicine fellowship in 2010 at Via College of Osteopathic Medicine while working with Virginia Tech. While there, he learned a lot about concussions, which he put to use while working with the athletics programs at the University of South Dakota and University of Sioux Falls. Years later, he tapped into his network of former professors, classmates, colleagues and mentors to bolster the University of Wyoming's concussion response program.

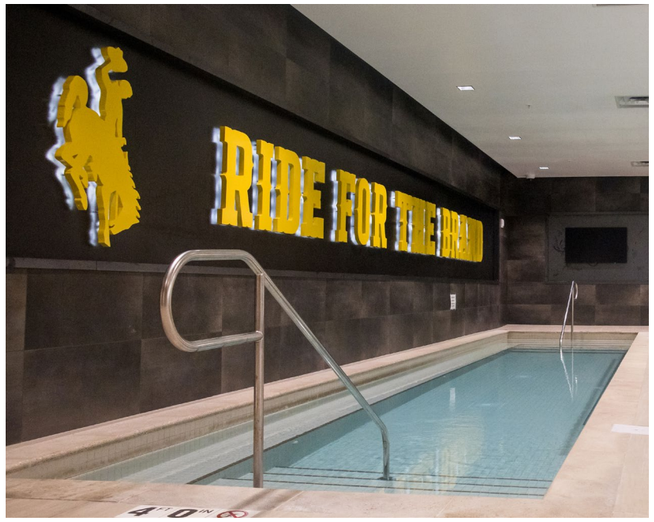
"When I arrived to UW [in July 2015] they did have a concussion program in place. However, it was not as robust as I felt it could be," he says. "At that time, the university was only doing baseline concussion testing on certain sports. There was not a physician with specialized concussion training on staff to evaluate the testing or the athletes."

Dr. Boyer thought Cowboy and Cowgirl athletes deserved more.

"We started to test all athletes in all sports for baseline concussion testing," he says. "We have three different tests the athletes go through prior to clearing them for participation. If the athlete sustains a concussion, they have to pass all of their baseline tests, they have to be back to their same level of functioning in school and finally, they have to pass their return to play."

But it isn't just about testing.

"I met with the dean of students office to make sure they were aware of our concussion program and [to see if they could provide] any accommodations the athletes might need for class while recovering from the concussion. Our academic department is involved to help them through the concussion. The concussion program is much more of a university-wide program now."



The athletic center provides pools that accommodate full teams, compression suites and altitude simulation chambers.

And it isn't just for varsity athletes.

"We also use the same accommodation form and similar process for our club sport athletes," he says, which means more than 1,000 student athletes at the university can access support that will provide wrap-around care during the recovery process.

Dealing with the recent COVID-19 pandemic was a completely different process.

"There was no one with experience dealing with something like this, so I had to research different sites to come up with something based on the most current research and recommendations," Dr. Boyer says. "I sat in my office one weekend and wrote up an eight-page document on how I thought we could best have athletes stay in Laramie, practice and compete. I worked with administration, coaches, athletic trainers, training table [a cafeteria for student athletes], our dietician and academics to try and make this happen."

It wasn't easy.

"We had some think our process was too strict, we had some think our process was not strict enough," he says of the initial plan developed for when students could return to campus in the fall semester of 2020. "We had positive cases and we had to limit activity for some sports due to outbreaks. However, we did not have to cancel any competitions due to positives at UW."

That wasn't the case for some of the other teams UW was scheduled to play against.

"This year has been a little different," he says. "Our policies have been more lenient to allow for more social interaction between athletes while still trying to limit positive cases."

He says he saw the impact of limiting the number of people student athletes could be around in the previous year. Restricting contact to just teammates helped build camaraderie but also made players feel isolated from the rest of campus.

"We kept teams away from teams," he says. "But it made it hard to form relationships. That's why you go to college—to make relationships."

Ironically it may be his relationship with the student athletes that accounts for such a high COVID-19 vaccination rate amongst student athletes.

"Some teams are fully vaccinated, despite not requiring the vaccine," he says. "The professional teams are requiring it, so many of the scouts want to know if players are vaccinated. The students come to us and ask questions. I tell them it's my job to give you information. Not to convince you."

He says the student athletes know the impact that COVID can have on their athletic career.

UW ATHLETICS BY THE NUMBERS

17	Number of varsity sports teams at University of Wyoming
400	Athletes compete in NCAA sanctioned sports at UW
600	Athletes participate in UW Club Sports
11	Varsity/NCAA team athletic trainers
1	Club team athletic trainer
1	Physician

Caring for Cowboys and Cowgirls

"There are a lot of strong opinions on COVID," he says. "However, if one of my athletes or staff is positive, they are still required to be out for 10 days. Ten days during the season can be devastating to the athlete and the team."

A total of 1,000 athletes participated in sports at the University of Wyoming. Of those, 600 participate in club sports and 400 compete in NCAA sanctioned sports.

Understanding that 10 days can have a major impact on a short sports season is just one of the reasons that Dr. Boyer is able to connect with the student athletes.

"I am able to get to know the athletes and they get to know me," he says. "They meet me at their physical, see me at games and see me on campus. There is a trust between us. They know I have their best interest in mind. The athlete comes first. I treat the athlete as I would my own children. If I need to spend more time with an athlete, I will. They are not treated like a number to push through as fast as possible to get to the next one. I do have a schedule, but anyone can see me at any time and we will work them in either during regular hours or after hours as needed."

A team to care for a team

Although it may sound like Dr. Boyer does it all, he is the first to point out that he relies heavily on a team at the university and in the private medical community.

"Most of the minor injuries are seen and taken care of by our certified athletic trainers. They also are the ones who provide the therapy and rehab to our athletes after injury," he says. "They are present at workouts and practices sometimes 12-14 hours a day and most of the time 7 days a week. They are irreplaceable and I could not do what I do without them."

Dr. Boyer also works with mental health providers on campus and off. More recently, the university has added a registered dietician for the athletes' cafeteria [and to provide individual counseling for allergies and/or training needs], a wellness coordinator, and performance coaches to help keep athletes in condition to help prevent injury and succeed in sports.

"We also have a great relationship with Ivinson Memorial Hospital," he says. "We needed COVID testing last year on short notice and they were instrumental in helping us with the demand for testing. They also are more than accommodating for our athletes whether it is for labs, imaging or emergency visits."

Technology and recovery

Some may wonder why Dr. Boyer is so involved with the non-injury medical care of the athletes. He says it's part of his specialty training.

"Some medications aren't allowed for the athletes to be on or they may increase the chances of soft tissue tears or raise blood pressure," he says. That specialty training also helped UW provide the latest in technology and equipment when it expanded the Rochelle Athletic Center from 47,000 to 118,000 square feet, which includes the new High Altitude Performance Center addition.

"Pools that accommodate full teams for recovery, compression suits and altitude simulation chambers for strength and conditioning help athletes prevent injury and help them when coming back from injury," says UW Associate Athletics Director Tim Harkins. "Our altitude can be disadvantageous when you're trying to recover from an injury. The athletes can go in the chamber and train in what feels like a lower altitude."

A team of certified athletic trainers along with a registered dietician and a wellness counselor all work on staff to assist student athletes.

Dr. Boyer says that training at lower altitude is easier on the body, especially as it recovers from injury or illness.

"Live at high altitude and train low," he says. "It can help you run a little farther and faster."

"Live at high altitude and train low," he says. "It can help you run a little farther and faster."

It's something he knows well. Dr. Boyer grew up in Laramie before moving away at the age of 14.

"I would come back at least once a year to see my grandmother and father," he says. "I have always been a fan of UW athletics since I was in third grade when Charles Bradley [former UW Basketball Coach] came to my class and talked. He was bigger than life and I kept his poster on my wall for years."

Dr. Boyer knows Laramie is a good place to raise kids, so he was grateful for the opportunity to come back.

"I have always wanted to work for a university team where I can donate all of my time to the athletes and not have the conflict with a private practice schedule," he says, adding that it's really about helping the students. "I hope they know that if they need someone that you're there. Some of them growing up didn't ever go to doctors. Some of it is trying to convince them that they can turn to you and ask for help."

Dr. Boyer's door is always open.

Full-spectrum Medicine

Dr. Megan Olson Embraces Experience

Blazing the trail for the resident rural training track in Thermopolis

BY GAYLE M. IRWIN

Dr. Megan Olson is finishing her residency in Thermopolis as part of the rural training track. PHOTO BY PAUL RUHTER

Recognizing a need for family medicine doctors in small Wyoming communities, the University of Wyoming's Family Medicine Residency Program in Casper has developed a new rural training track to place its doctors-in-training in Thermopolis, and Megan Olson, MD, is the first resident to enter the program.

"National studies show residents who train in the rural training tracks, the majority of them—75 plus percent—are doing full-spectrum family medicine in a small town," said W. Travis Bomengen, MD, site director for rural track training in Thermopolis. "With that, and considering where we are in Wyoming with the age of our primary care forces in some of the smaller communities, we would like to try to do that for the state: recruit and keep some of our own."

The family medicine residents in the RTT spend their first year in Casper and then their second and third years in Thermopolis. Wyoming native and University of Wyoming graduate Dr. Megan Olson is blazing that trail ... and enjoying the journey.

"It's medicine like you don't see very many other places," the second-year resident said. "There are four family medicine doctors [in the community], and one general surgeon. They take care of the health of the entire community. The family medicine docs there not only see patients in-clinic, they rotate as hospitalists. They cover the emergency room. They deliver babies, they do C-sections. They go to the training rooms at the high school and do sports medicine. They're at the nursing homes. It's full-spectrum like I haven't seen anywhere else. I've really enjoyed it."

Learning full-spectrum medicine

Dr. Olson's day begins at Hot Springs Health Hospital, seeing patients and checking on any babies she delivered and their mothers. Afterward, she may spend time with a specialist, such as a cardiologist or orthopedic doctor, or have her own clinic. She also visits nursing homes and schools. Additionally, she takes a shift a week and one weekend a month at the hospital, including the emergency room. On Wednesdays, she travels to Worland to hold a clinic.

"It's more of a true-life, what you would be doing once you're done with your residency experience," said Dr. Bomengen.

The variety appeals to Dr. Olson.

"One of the things I enjoy about the program in Thermopolis is that I get to do a little bit of everything every day," she said. "I like being in a place where the family medicine docs have the ability to cover everything."

She added, "I like the challenge of being out of your comfort zone, but you have to figure it out and do what's best for your patient—I find that really rewarding," Dr. Olson said. "That's something you don't get in a town like Cheyenne. I've been involved in some really amazing cases that many second-year residents wouldn't likely have been very involved in."

A recent U.S. Department of Agriculture Rural Development Community Facilities loan program assisted the Thermopolis rural track training program in many ways. The agency awarded $21.3 million to the Hot Springs County Hospital District, "the largest Community Facilities loan awarded in Wyoming to-date," according to the agency. The hospital's expansion and renovation created all new patient care areas including new inpatient rooms, delivery suites, emergency rooms, trauma rooms, two new operating room suites and pre- and post-operative care areas.

> "I like being in a place where the family medicine docs have the ability to cover everything."

"The USDA grant funding for the hospital project definitely had a positive impact on the RTT residency," said Dr. Bomengen. "The timing was coincidental that the new facility was finished as the first resident was arriving on site. But this definitely helped us with our recruitment as well as patient satisfaction."

Drs. Travis Bomengen and Megan Olson are part of a small group of physicians who live and work in Thermopolis. PHOTO BY LISA BOMENGEN

Additional learning experience

In addition to serving Thermopolis residents and learning full-spectrum medicine, Dr. Olson has also traveled to larger cities to learn specialty skills, including emergency pediatrics in Denver and high-risk obstetrics in Spokane. Working with women, children and babies brings her deep satisfaction, she said.

"There's something about delivering a baby," Dr. Olson said. "Your hands are the first ones to touch that child. The joy that you see on mom's face—she works so hard, whether it's a vaginal delivery or a C-section. Just to have the honor to be there for that experience and for that life-changing moment for that family—it's really incredible!"

That word describes her residency experience so far.

"It's been incredible—that's the best word for it," she said. "I have a lot of autonomy there, which is really great for learning purposes. But I also get to run ideas past my supervising docs, and I get that instant feedback. The one-on-one time we get with our supervising doctors is really helpful. They're always there to make sure you're making good decisions and to catch you if you stumble."

She said she is considering doing another away-track for two weeks of NICU training, either in Billings or Denver to "be more comfortable taking care of those sick kiddos who need to be stabilized."

Full-spectrum Medicine

Adding another resident

A second resident will arrive in Thermopolis in 2022, he is currently training in Casper. Dr. Olson looks forward to welcoming him.

"There will be two of us instead of me by my lonesome," she said. "We'll bring some camaraderie to the program, and we'll focus on the education side of things when there's two of us."

Another benefit: an additional medical professional.

"It's more manpower in a small town, which is nice," Dr. Olson said.

"Our goal is to train the residents for full-spectrum family medicine so they can go out and practice in a community like Thermopolis or Torrington, Wheatland, Newcastle or Worland," Dr. Bomengen said. "We're looking to populate the rural communities in Wyoming with well-trained physicians that are going to be there for the long haul."

Dr. Megan Olson is finishing her residency in Thermopolis as part of the rural training track. PHOTO BY LISA BOMENGEN

Although he admitted not all residents trained through the rural track will stay in the state, the hope is they will set up practice in other small communities in the west.

> "We're looking to populate the rural communities in Wyoming with well-trained physicians that are going to be there for the long haul."

The Wyoming WWAMI medical school program also has a longitudinal training track for third year medical students in Thermopolis (the TRUST program) and so a year from now there will be a medical student as well as two family medicine residents training in Thermopolis.

Looking ahead

Dr. Olson envisions continuing the work she is currently doing in Thermopolis.

"When I picture my career after residency, honestly, it looks pretty similar to what I do now," she said. "I would love to keep up the full-spectrum practice. I like clinic, I love seeing patients in the hospital. The OB is a huge thing for me. No matter what I do, I want to be delivering babies and doing C-sections because that is really fulfilling. It's one of the favorite things I do in my job."

Serving as a family medicine doctor has many rewards, Dr. Olson added.

"It's such a unique opportunity to really serve the community," she said. "You do that in multiple aspects of medicine, but you then get to see your patients in the grocery store, checking out at the gas station—it stretches far beyond the bounds of the hospital. A lot of the docs take care of their kids' teachers or best friends—that's a really unique side of things: how involved you are in the community in a program like this. That's a really special thing and something that I really enjoy."

She praises the program for the preparation toward her dream to become a doctor.

"I know I'll walk away with excellent training, and I will be comfortable going out and doing full-spectrum medicine by the time I'm done," Dr. Olson said. "I couldn't be happier to be in this program and be the trailblazer, so to speak."

uchealth

Remote Deep-Brain Stimulation Programming Saves 'Money and Miles' for Patient with Parkinson's Disease

Newly approved Abbott system enables telehealth consultation and adjustment to deep-brain stimulation for Parkinson's disease.

When Craig Overman's Parkinson's medications no longer kept his symptoms under control, he became a textbook candidate for deep-brain stimulation or DBS.

Then, he benefited from treatments so new that they're not even in medical textbooks yet. That cutting-edge technology—remote programming and adjustment of the electrical stimulation that makes DBS work—was approved by the U.S. Food and Drug Administration in March.

For Overman and his wife Susan, who live in Newcastle, Wyoming, a five-and-a-half-hour drive from UCHealth University of Colorado Hospital on the Anschutz Medical Campus, fewer trips to the hospital have been a particular blessing.

"It has saved me time and money," Craig said.

The deep-brain stimulation itself has saved him much more than that.

Craig, now 62, had operated heavy equipment in open-pit coal mines for 37 years as of 2015. That's when a friend noticed Craig's arm wasn't swinging when he walked. A neurologist diagnosed early-stage Parkinson's disease. Craig went on with his life until Parkinson's made that hard to do.

In time, he lost his ability to operate trucks; walking became increasingly difficult, and fatigue and sleep problems, common Parkinson's symptoms, crept in. He could no longer go bowhunting, camping, four-wheeling and fishing with his grandson Hayden. And the levodopa medication he was taking played havoc with his digestive system.

"I had no ambition. Things I really enjoyed, I didn't want to do anymore," Craig said.

By April 2020, Craig's neurologist in Rapid City, South Dakota, referred him to Dr. Drew Kern, a University of Colorado School of Medicine and UCHealth movement-disorders neurologist.

After an in-depth discussion with Kern, Craig and Sandy made the decision to pursue deep-brain stimulation. Determining who is a good candidate for DBS is vital and involves comprehensive testing over two days. During this time, Craig also met with Dr. Steven Ojemann, a fellowship-trained stereotactic functional neurosurgeon at UCHealth University of Colorado. The result: DBS would work well for him, but COVID-19 delayed procedures until January 2021.

He needed three procedures. During the first and second, doctors implanted the electrodes on the right and left sides of Craig's brain. During the third procedure, specialists placed the battery under the skin just below the collarbone.

In early April, the Overmans were back at the hospital for Kern to program the DBS device. Programming involved adjusting the amount and location of electrical current flowing to Craig's subthalamic nucleus. After the adjustment, Craig's gait, a shuffle before the appointment, appears normal.

Once the FDA approved remote programming and adjustment of Craig's controller, he could use an iPhone or iPad to connect with Kern or others to do telehealth visits and make programming adjustments.

In mid-May, Kern and Craig video chatted, Craig did some prescribed movements, and Kern made some minor adjustments. Craig was the first patient in the region to receive remote DBS programming.

Craig Overman is back at his grandson's games, and is supporting his granddaughter Payton's soccer and basketball endeavors.

"I mean, he's been doing everything," Susan said. "The other day, he power-washed the deck and he stained it, and we're getting new windows, and he's out mowing the lawn."

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Does Your Organization Follow Best Practices for Documentation?

Documentation serves as a defense against allegations of malpractice and is the primary mechanism for communication among clinicians and care teams. Constellation—a growing portfolio of medical professional liability (MPL) insurance companies that includes MMIC, UMIA and Arkansas Mutual—illustrates why documentation is critically important in healthcare.

Documentation deficiencies lead to settled claim

A 32-year-old woman was admitted by her family physician (FP) to the hospital for induction of labor at 41 weeks, 4 days. She had a detailed birth plan including the use of a birthing ball. The FP ordered intermittent electronic fetal monitoring (EFM) during labor to allow the use of the birthing ball. The labor and delivery (L & D) nurses' efforts to monitor the fetal heart rate (FHR) were hampered by the woman's firm insistence on adherence to her birth plan and the use of the birthing ball. Nursing notes were made every 30 minutes; however, key discussions with the mother were not included in the documentation and therefore not communicated to the FP. The woman refused most monitoring attempts despite explanations of the rationale for monitoring the baby's FHR during rapidly progressing labor.

After birth, the baby was diagnosed with hypoxic ischemic encephalopathy, spastic quadriplegia and cerebral palsy. Years later the woman filed a malpractice claim alleging a delay in recognition and treatment of fetal distress resulting in permanent neurological injury. Due to documentation deficiencies, especially the lack of documentation of her refusal to be monitored, and the team communication breakdowns, the claim was difficult to defend. The claim settled with a payment made to the woman on behalf of the hospital and the FP.

Malpractice claims with documentation deficiencies

An analysis of Constellation malpractice claims reveals that communication breakdowns occur in 35% of claims and represent 38% of costs. Documentation deficiencies contribute to 15% of claims and account for 22% of costs.

In their 2020 National CBS Report, The Power to Predict, research conducted by Candello (a division of CRICO) shows that the odds of a malpractice claim closing with a payment increase by 76% when there is insufficient documentation. Claims that had absent or insufficient documentation closed with payment 56% of the time compared to 30% for all cases, and 5% of these claims closed for $1 million+ compared to 4% for all claims.

Best practice quality documentation starts with the FACTS:

- Factual—specific, objective, respectful, descriptive
- Accurate—precise, descriptive, measurable, mutually-understood
- Complete—thorough, chronologic, clear, includes communications
- Timely—prompt, immediate, can include appropriate late entry/addendums
- Special situations—distinguished by unusual characteristics

Improve documentation in your organization

1. Assemble a diverse work group to:
   - Study current documentation systems and identify ways to improve
   - Develop and implement policies that guide the care team with documentation expectations
2. Educate clinicians and care team members on your documentation standards using actual documentation deficiency case examples
3. Periodically audit medical records for adherence to standards
4. Engage care team members to coach peers when they see nonadherence with documentation standards
5. Encourage care team members to report barriers to meeting documentation standards
6. Quality documentation is a critical factor in reducing harm events and supporting your care in the event of a malpractice claim. Read more at ConstellationMutual.com/blog

PREMIER
Bone & Joint Centers

Introducing Matt Fournier, MD

Premiere Bone and Joint Centers are proud to bring an expert physician into our practice. Dr. Matt Fournier is a fellowship-trained orthopedic surgeon specializing in sports medicine, including traumatic and degenerative conditions of the shoulder, hip, and knee.

Dr. Fournier obtained his medical degree from the University of Washington as a part of the WWAMI medical education program, where he earned honors acknowledging his dedication to clinical education and community service. Dr. Fournier then underwent a rigorous orthopedic residency at the world-renowned Campbell Clinic in Memphis, Tennessee. The Campbell Clinic was the first orthopedic residency founded in the United States, and is the source of "Campbell's Operative Orthopedics," which is considered a definitive orthopedics textbook worldwide. While in training Dr. Fournier received the Hugh Smith Clinical Research Award as a result of his significant contributions to academic orthopedic surgery. After residency, Dr. Fournier chose to further his education with a one-year fellowship in sports medicine and winter trauma at the Lake Tahoe Orthopedic Institute. Dr. Fournier has authored numerous, peer-reviewed academic articles and has presented his work to regional, national, and international audiences.

Matt Fournier, M.D.

In addition to numerous community sports teams, Dr. Fournier has had the opportunity to work with a number of collegiate and professional sports organizations, including:

- Memphis Grizzlies (NBA)
- Memphis Redbirds (AAA Baseball)
- University of Memphis Tigers (NCAA Division I Athletics)
- Rhodes College (NCAA Division III Athletics)
- University of Nevada Wolf Pack (NCAA Division 1 Athletics)
- US Ski and Snowboard Team
- The Rock and Roll Marathon
- Dr. Fournier is a member of Wyoming Leaders in Medicine.

He was born and raised in Cheyenne and is a proud Wyoming Cowboy. He is excited to move back to Laramie with his wife, Abby, and two daughters, and looks forward to caring for patients from all over Wyoming.

Cheyenne Regional Medical Center

CRMC Offers New Procedure to Help Treat Cryptogenic Strokes

BY DR. ABDUR KHAN, DR. ATMAN SHAH AND DR. ARUNPTREET KAHLON
Interventional Cardiologists
Cheyenne Regional Heart & Vascular Institute

On October 14, 2021, the Cheyenne Regional Heart & Vascular Institute, a service of Cheyenne Regional Medical Center, performed a procedure to treat patients with a heart condition known as a patent foramen ovale. The procedure can help people who have had a stroke that may have been caused by this condition. This was the first time for the procedure to be performed in Wyoming.

What is a patent foramen ovale?

Before birth, a baby's heart has a natural opening in the wall between the left atrium and right atrium (the upper chambers). This flap-like tissue opening is called the foramen ovale. The foramen ovale allows oxygen-rich blood from the mother to bypass the baby's lungs, which do not function until birth. When the baby is born, the foramen ovale normally closes and seals within a few months. If the foramen ovale does not close completely, the opening is called a patent foramen ovale (PFO).

When is having a PFO a concern?

About 25 percent of people, or one in four individuals, has a PFO. In rare instances, this small opening can allow a blood clot to pass from the right to the left side of the heart. If the clot travels to the brain, it could block a blood vessel, resulting in a stroke.

How do doctors determine if a PFO may be the cause of a stroke?

About 87 percent of strokes are "ischemic," meaning that they are caused by a blood clot blocking a blood vessel in the brain. About one-third of ischemic strokes are from an unknown cause and are called cryptogenic strokes. About 40 to 50 percent of people who suffer from a cryptogenic stroke have a PFO. When a PFO is found in someone who has suffered a cryptogenic stroke, the PFO is often determined to be the cause after ruling out other competing causes.

How is a PFO detected?

A transthoracic or transesophageal echocardiogram is often used to determine if someone has a PFO. During this procedure, a wand-like device is held on the patient's chest. The wand, or transducer, creates sound waves that produce images of the heart. Doctors review those images to see if the patient has a PFO.

When should a PFO be closed?

Doctors may advise that a PFO be closed in people who are young and have had a cryptogenic stroke to decrease the risk of recurrence.

How is a PFO closed?

One way to close a PFO is for an interventional cardiologist to insert a device that plugs the PFO. The device is inserted on the end of a catheter and is commonly performed in a cardiac catheterization lab.

The U.S. Food and Drug Administration has approved transcatheter closure of PFOs to treat patients who have had a cryptogenic stroke. Studies show that PFO closure is superior to medications alone in preventing a second stroke.

Bios:

Dr. Adbur Khan *completed his internal medicine residency in Ohio at the University of Toledo. He completed his cardiology fellowship at the University of Louisville and his interventional cardiology fellowship training in Boston, Massachusetts, at the prestigious Massachusetts General Hospital, which is a teaching affiliate of Harvard Medical School.*

Dr. Atman Shah *is in medical practice at the University of Chicago in Illinois. He obtained his fellowship in cardiovascular disease at the University of California in 2005 and his interventional cardiology fellowship at UCLA Medical Center in 2006. Dr. Shah has served as the director of the Coronary Care Unit at the University of Chicago for several years. Dr. Shah has enjoyed his time working with the cardiology team at CRMC and is exploring becoming a permanent part-time member of the team.*

Dr. Arunptreet Kahlon *completed his internal medicine residency at SUNY Upstate Medical University in New York, his cardiology fellowship at the University of Louisville in Kentucky and his interventional fellowship at William Beaumont Hospital in Michigan.*

Suicide Prevention and Primary Care

BY JENNA GLOVER, PHD
Assistant Professor of Psychology at the University of Colorado School of Medicine
Children's Hospital Colorado Pediatric Mental Health Institute

Children's Hospital Colorado has declared a state of emergency for pediatric mental health as the number of children and teens experiencing a mental health crisis have skyrocketed during the COVID-19 pandemic. In the last two years, Children's Colorado has seen a 90 percent increase in demand for behavioral health treatment. Isolation and stress amid the pandemic have exacerbated low-level anxiety and depression among pediatric patients into suicide attempts.

"I've been in practice for over 20 years in pediatrics, and I've never seen anything like the demand for mental health services we've seen at Children's Colorado in the past 15 months," David Brumbaugh, MD, Children's Colorado chief medical officer, said. "There have been many weeks in 2021 that the No. 1 reason for presenting to our emergency department is a suicide attempt. Our kids have run out of resilience—their tanks are empty."

Suicide is a difficult topic for our society to address. Frequently, our instinct is to not talk about it unless a parent or patient brings the topic up themselves. There are pervasive myths that persist that talking about suicide with youth will "plant" ideas in their mind and increase the likelihood that they will consider and attempt suicide. Despite these concerns, the research in this area is robust and clear that talking to youth about suicide decreases the likelihood that youth will make a suicide attempt[1].

Understanding the power of having these conversations is essential for primary care providers because research indicates that 45% of patients who died by suicide visited a primary care provider in the month before their death[2]. Because primary care physicians are the most likely group of professionals to interact with youth on a regular basis, it is important that we use this setting to assess for suicidal ideation on a regular basis in all patients seen for annual wellness checks. This is particularly salient for the state of Colorado where suicide is the leading cause of death in youth and young adults.

Suicide in Colorado

One striking statistic is that Colorado is within the top 10 states in the U.S. for death by suicide. Often people have a conceptualization of Colorado as a place of health and wellness, which disrupts the notion that mental health problems exist among the youth in our state. Despite these notions, we know that 24% of youth experience a major depressive episode each year and that 14% of youth have seriously considered suicide within the past year. There are several ideas for why rates of depression and suicide are so high in Colorado. There is no one specific reason to explain this phenomenon; however, a conglomeration of factors is likely to explain the increased rates of depression and suicide and youth in Colorado.

First, access to mental healthcare is limited within Colorado so there are a variety of youth with mental illness who are not identified as having a mental disorder and if they are, there is difficulty connecting them with care. Second, states that have high gun ownership often have higher rates of suicide within the population, which speaks to the importance of Step 6 in safety planning, which is addressed later in this article. Finally, there is some research that suggests that individuals living at a higher elevation have higher rates of depression[3]. Outside of these factors are other variables related to family history, social media use and resiliency factors available to youth.

Regardless of why, we know that suicide is an epidemic in the state of Colorado and primary care providers are best positioned to reduce the risk through systematic screening of suicide symptoms as part of sick and wellness visits.

Screening for suicide

There are several effective and nonproprietary measures for assessing suicide in youth available to primary care providers. These include the Columbia Suicide Severity Rating Scale (C-SSRS) and the Ask Suicide Screening Questions (ASQ). Both measures can be administered to youth within less than five minutes and are able to reliably and validly identify suicide risk. The C-SSRS and ASQ are both available in a variety of different languages.

There are many practices that also utilize the Patient Health Questionnaire 9 for Adolescents (PHQ-A) to identify depressive symptoms and suicide risk. Although the PHQ-A is an effective tool for assessing depressive symptoms, the C-SSRS and ASQ are more effective in flagging patients who are suicidal, and it is recommended that practices use these measures as an adjunct to the PHQ-A and not utilize the PHQ-A in isolation to screen youth for suicidal ideation.

Currently, Partners for Children's Mental Health, a non-profit organization dedicated to improving systems of care for mental health services for youth in Colorado, is offering training and implementation support for integrating the ASQ screening tool into primary care practices. Please contact info@pcmh.org for information on how to enroll your practice in this project.

Safety planning

In the event that primary care providers experience working with a suicidal patient, it is important to engage in supportive practices to stabilize the patient. For patients that are high risk, which means they are endorsing suicidal ideation with a plan and intent, providers are instructed to send the patient to an emergency department for crisis care. For patients who are medium to low risk, (ideation with or without a plan but no intent), it is recommended to engage the caregiver and patient in safety planning.

Safety planning consists of completing information in six core areas, which include:

1. Identifying warning signs
2. Listing coping strategies
3. People and social settings to provide distraction
4. People who I can ask for help
5. Professional agencies I can contact during a crisis
6. Making the environment safe (removing or locking away medications, guns, etc.)

The Stanley Brown Safety Plan is a well-established tool that providers can use. Additionally, there are a variety of apps that patients can download for safety planning that are free and easily accessible via their smartphones. These strategies can be helpful in best supporting patients with suicidal ideation without needing to escalate care to an emergency department. As primary care providers become more comfortable and adept at using these screenings and support tools, we can hope for a decrease in the rate of death by suicide in our youth in the state of Colorado.

For additional discussion about suicide prevention in primary care listen to *Teen Suicide: Risk Factors, Screening and Prevention (S1:E24)* on the Charting Pediatrics Podcast on Apple Podcasts, Spotify or wherever you listen to podcasts.

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