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Happy New Year!

While serving as your CAFP President over the last 8 months I have had the chance to develop a personal interest in climate change, technology, and activism, and apply it to our professional organization at both the state and national level. I will share my activities below, but wanted to first take the opportunity to acknowledge how this happened. I had not planned to focus on climate change and health, it happened organically. I believe it was due to my CAFP activities taking me out of my daily routine at home and work. This allowed me exposure to ideas and people I wouldn’t have ordinarily interacted with; and there are a lot of energetic, inspiring people out there! It also gave my brain a new problem to work on, unrelated to diabetes or prenatal care at work or 3-year-old tantrums at home. And as CAFP president, I found I had a forum to create change with our organization.

As background, I have always had a personal interest in alternative energy technology and economics, as evidenced by the 3 hybrid cars I have owned and the residential solar I installed on my roof. But I hadn’t connected that interest and my sense of personal responsibility to environmental protection with my professional activities as a physician. That changed this year as I have been inspired by presentations on the effects of climate change by the Medical Society Consortium on Climate and Health https://medsocietiesforclimatehealth.org/, and how I can work as a physician to mitigate these effects.

This summer the CAFP Green task force investigated ways our organization can limit our carbon footprint. We underwent an energy efficiency audit arranged by our utility provider and approved changes in our office to decrease our overall energy consumption by approximately 25%. While the changes to our HVAC and lighting required initial capital outlay, we will recoup savings after 5-10 years given lower energy bills. We also investigated options for switching to renewable energy use and settled on purchasing 100% of our electricity through a share of a solar farm coming online in Colorado; this option was both fiscally and environmentally responsible. It is worth noting that the cost of large scale renewable energy installations for utilities has begun to be lower than that of other traditional energy sources. With these two changes, I believe the CAFP has become the ‘greenest’ AAFP state chapter.

As we made these changes in Colorado I also had the opportunity to influence national AAFP policy on climate and health. I presented a resolution that passed at the Congress of Delegates directing the AAFP to create a Clean Energy Goal. This was inspired by our CAFP activities, and in line with the many companies and municipalities that have already pledged to increase their use of renewable energy (for examples see http://there100.org/). I look forward to seeing that goal formalized in the coming year and am already working on new resolutions for next year. I also joined with a group of physicians interested in climate change and applied to form a Member Interest Group within the AAFP, where likeminded physicians can organize, share ideas, and take action to help prevent the negative health outcomes of climate change. We hope to have this group approved and active this spring (but if you would like to be added to the list of interested physicians please email me zachwacht1CAFP@gmail.com).

In addition to the above successes, the CAFP is also currently reviewing our investment policy to ensure it aligns with our values as family physicians. We have previously acted to remove tobacco companies from our portfolios, and now follow a socially responsible investment strategy; we are discussing if investment in fossil fuels aligns with our values and should be removed as well. We will additionally be considering if CAFP air travel should utilize carbon offsets (I’ve traveled much more this year with CAFP/AAFP activities than I do typically, and I believe air travel is one of the greatest causes of carbon pollution from individuals).

I chose to share all of this with you for a variety of reasons. First, I want to be transparent about what decisions we have made as a board. Second, I am proud of the willingness of the board to consider new ideas and take action to limit our environmental impact. Third, I hope that some of you may consider how you can take similar actions in your workplace or home to improve the health of our communities. Thanks for taking the time to read to the bottom—and best of luck extending yourself outside your daily routines! Be at the table, you can make a difference!
I hope you enjoyed the special anniversary issue that we put together for fall. It was a joy to look back at the many years of work we have accomplished together.

Because of that special edition I am recapping the results of the 2018 membership survey somewhat late, but rest assured we are already acting on your ideas.

Your number one ask for us was to address administrative burden. We were not surprised by this given the enormity of the issue and its far-reaching impacts, from increasing physician burnout to deterring medical students from choosing family medicine. In response to this we recently completed an additional survey asking you to give us more specific information about administrative burden—what are the pain points in the system and what changes would be most beneficial to you. We heard about the ways in which prior authorizations get in the way of treatment, the frustration of frequently changing formularies, and the exorbitant volume of medical necessity forms. We are using those results to shape our goals for the next year, from legislative and policy options to advocacy actions we can take with the private sector.

The membership survey is also a great way for us to collect immediately actionable data, like what topics you would most like to see at our Annual Summit. Expect to see your top choices, including dementia care, marijuana, and the state of healthcare in Colorado, at the 2019 Summit.

Finally, we noted that some of you are simply unsure of the work that we are doing, particularly those of you in rural areas and in private practice. Given that, we want to make sure we are making more of an effort to reach out in more diverse ways over the course of the next year. We know how challenging it is for those in rural areas and small practices to take the time to join us, either through our events or through activities like serving on the Board. We want to make sure all member voices are heard, even if you may not be able to take time off from work. Expect to see us visiting you locally and reaching out to personally communicate about any concerns you might have.

As always, if you have more ideas, concerns or questions you are always welcome to email me or any member of our staff. We are here to serve our members.
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COLORADO’S 2019 LEGISLATIVE SESSION: WHAT CAN WE EXPECT?

Colorado’s 2019 legislative session kicks off January 4th. With a new Governor and the Democrats taking control of the Senate, the stage is set for what will be an energetic session. On a historic note, for the first time in Colorado, women will make up a majority in the State House of Representatives.

CAFP has several priority issues and will be running three bills of our own this session to advance family medicine:

- **Increasing Investment in Primary Care**: CAFP will be running legislation again to double the investment in primary to 15% of the healthcare dollar, giving practices the resources to fully sustain Patient-Centered Medical Homes, hire care coordinators and social workers, and integrate behavioral health providers into primary care offices. Last year’s bill got caught in political maneuvering at the end of the session, but we are optimistic about the likelihood of its passage this year. The bill would in a significant way reorient healthcare in the state toward fully-resourced primary care.

- **Colorado Candor Act**: CAFP is leading legislation to provide an alternative to malpractice litigation. The Candor Act will provide legal protections for confidential communications between a health care provider or facility and a patient or the patient’s legal representative after an unanticipated health care outcome. Candor promotes open discussions so patients and their loved ones understand what happened and what steps may be taken to prevent similar outcomes where possible. Under certain circumstances, optimal resolution may include an offer of compensation. When a physician opts to engage in the Candor process, it can ensure swift resolution without years of being tied up in court. Any offers of compensation are not reportable, and the process will foster an environment of open communication between patients and their doctors.

- **Rural Workforce Preceptor Tax Credit**: 2 years ago, CAFP passed a law to enable rural preceptors of medical students to take a personal income tax credit of $1,000. The credit aims to increase the number of students experiencing rural medicine, because we know they
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**Our services include:** Comprehensive food allergy testing/challenge, exercise physiology and lung function testing, genetic and immune function testing for immunodeficiency, neuropsychological testing, sleep testing.
CAFP on the Go

This fall, CAFP hosted a legislative reception for candidates we supported in the 2018 election. 90% of the candidates CAFP supported were elected.

CAFP’s Deputy CEO for Policy & External Affairs Ryan Riehle presenting on primary care investment in Washington, DC.

CAFP staff presenting at St. Joseph Family Medicine Residency.

CAFP staff presenting at Fort Collins Family Medicine Residency.

Colorado leaders at the Western States Forum that took place during the 2018 Congress of Delegates in New Orleans, LA.

Many of CAFP’s leaders testified on important issues at AAFP’s 2018 Congress of Delegates including Board Chair Monica Morris, DO.

CAFP President Dr. Zach Wachtel presenting on primary care spending at the AAFP’s State Legislative Conference.

The CAFP hosted a Women’s Health KSA at our offices in December.

Dr. Monica Morris, CAFP Board Chair and Alternate Delegate served as a teller at the 2018 AAFP Congress of Delegates.
are more likely to practice in a rural setting when they’ve had exposure to one. CAFP will be bringing legislation to make this credit permanent, so we can continue to use this tool to boost rural preceptorships and close the gap in the rural workforce shortage.

Medical Practice Act and Peer Review
In addition to these priority issues led by CAFP, we will be heavily engaged in legislation impacting the practice of medicine and professional, or peer, review. The Medical Practice Act must be reauthorized to continue the regulation of medicine in Colorado, ensuring integrity in the licensure process, quality care, and public safety. We will also advocate to reauthorize the Colorado Professional Review Act to maintain the confidentiality of peer review when an unexpected health outcome occurs. This legal protection ensures we can foster a culture of reporting and continuous quality improvement throughout the state.

Health Care Coverage and Medicaid Buy-In
The affordability of healthcare and health insurance remains a top issue for Coloradans. We expect proposals will come forward to study or implement a state-level “public option” using the Medicaid program infrastructure. CAFP recently conducted a survey of our members on this Medicaid buy-in option and are currently evaluating the results to assess our position if such a measure comes forward. Key considerations for us will include physician reimbursement rates, the impact on health coverage options and covered benefits, and the impact on healthcare costs.

These are just several policy proposals coming forward. Others will include:

- Further efforts to address the opioid crisis, including e-prescribing and substance use disorder prevention
- Creating a family medical leave insurance program for employees without sick leave
- Healthcare and drug price transparency legislation
- A reinsurance program to ease insurance premiums by limiting insurers’ risk from high cost claims
- Strengthening the state Maternal Mortality Review Committee
- Creating a statewide advance directive registry

You can have a voice in CAFP’s work on these issues and more by contacting ryan@coloradoafp.org to join the CAFP Legislative Committee, which meets by conference call twice per month on Thursday evenings. And sign up to be Doctor of the Day at the Capitol to see the legislative process in action. You can sign up online by going to www.coloradoafp.org and clicking the Advocacy tab.

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Most of us in this country have a deep connection to an immigration story—our own. My ancestors are recent immigrants on my dad’s side, but I’m 10th generation US American on my mom’s side. The further back our immigration story starts, the easier it becomes for us to forget this, but that unique story strongly defines who we are today. However, a close examination of our personal history, put into the broader context of our collective history, quickly reveals that all immigration stories were not created equal.

While immigrants of all statuses, ethnicities, and backgrounds are seemingly under attack these days, it’s also clear that some immigrants are being attacked more than others. From Latino parents unfathomably being separated from their children, to migrants from a handful of predominately Muslim countries being banned from the United States, to skyrocketing rates of deportations of migrants from African countries (ICE, 2017). The common thread among these headlines highlights what history has continued to show us—that people of color are the targets of unjust policies and practices.

Historically, white immigrants have been provided certain rights and privileges, like citizenship status or the ability to own land. Immigrants of color, on the other hand, have faced blatant persecution, including more prominent examples, like the internment of over 100,000 Japanese Americans during World War II, and less well-known examples, like the kids of Latino migrant farm workers being sent to separate “agricultural-and vocational-based schools” right here in Colorado. Today, many people and news outlets use the offensive slur “illegal” to describe immigrants without documentation, which is problematic in a number of ways. And, President Trump has repeatedly lashed out against immigrants of color, calling Mexican immigrants “animals” and African countries “shitholes.”

Importantly, these pervasive narratives perpetuate untrue myths about the people of color on the receiving end of these attacks. Myths, such as the one that says immigrants commit more crimes than non-immigrants, are both factually wrong and morally repugnant. In fact, immigrants not only commit less crimes, unauthorized immigration is likely a main driver behind the lowering violent crime rates (Washington Post, 6/19/18) over the past few decades. These narratives are being used by powerful people and systems to influence the development and enforcement of our immigration policies and rationalize their explicit racism.

Immigration status directly influences health outcomes and public health, by limiting access to care, transportation, and other basic human needs. All of this ends up placing a disproportionate, and cumulative, toll on communities of color and contributes to persistent health inequities. Until we clearly root out the inherent racism that is the foundation of our immigration policies, we will unlikely create an immigration system that is fair, just, and that creates a viable pathway for more immigrants to call the US home—something a vast majority of us, regardless of our political views, say we want (Gallup, 2018).

Right now, the majority of people putting their lives and bodies on the line to protest and work against these injustices are the people whose lives are at stake—not those of us with the privilege to watch from the sidelines. It’s the Congolese woman who scaled the Statue of Liberty to call for an end to ICE. It’s the people of color who show up for Families Belong Together marches at much higher rates than their white allies. It’s time for the health care system and other systems of power to get involved and show up for their communities, too. Our fight for health equity depends on it.
Here, this is a

SUBMARINE

Or a spaceship. Or a movie theater. Before the MRI that will help Dr. Michael Handler and his team plan Jacob’s seizure surgery, Jacob transformed the room into an ocean. It reduced his anxiety and eliminated the need for sedation, making this procedure safer. The end result: a calm environment for Jacob and more accurate results for the neurosurgery team at one of the top 10 children’s hospitals in the country.
PHYSICIAN REVIEW SITES

EXERCISE CAUTION AND RESTRAINT IN DEALING WITH NEGATIVE ONLINE COMMENTS

With the prominence of social media and websites that offer customer reviews, there are endless opportunities for sharing one’s opinions. However, the legitimacy of these opinions and making decisions based on them can be a charged discussion, especially when it comes to medical care. For physicians, negative reviews can be frustrating because of concerns about how these may impact patient satisfaction scores or may not reflect the actual care provided. There is reason to be concerned. A recent Mayo Clinic Proceedings study\(^1\) showed that non-physician variables—such as interactions with desk staff, appointment access, waiting time, and billing—can appear to reflect unfairly on negative physician reviews.

While you can’t control what is posted, you can control how you react and take steps to deal with this issue.

A January 2016 Medscape article\(^2\) titled, “Trashed on the Internet: What to do Now” offered this advice regarding physician review sites:

- Recognize that negative reviews can happen to any physician.
- Most review sites allow you to submit a complaint if you believe a comment is fraudulent; they may be able to track down the IP address of the reviewer and, if the post is illegitimate, remove it.
- Reviews that sound irrational to you are likely to sound irrational to others.
- If you respond, keep it polite, general, and only respond once; be sure any response is HIPAA-compliant—some providers who have responded to negative reviews have inadvertently made the mistake of revealing protected health information.
- Many reviews focus on a provider’s indifference, bedside manner, or customer service rather than his or her medical skills. Consider these types of comments as opportunities to improve your practice.

Other actions to consider when monitoring your online reputation:

- On a regular basis, do a search on your name and/or the name of your practice to see what comes up.
- Set up Google Alerts (www.google.com/alerts) for your practice name and the names of your physicians.
- If you are listed on a physician review site, review your profile to make sure the information is up-to-date and accurate.
- Some review sites provide resources to help encourage your patients to post reviews. For example, Healthgrades offers postcards to give to patients that include a personalized link they can use to complete a survey about you.

Some Popular Online Physician Review Sites

- www.healthgrades.com
- www.vitals.com
- www.ratemd.com
- www.yelp.com
- www.angieslist.com

\(^1\) JAMA. 2014;311(7):734-735. doi:10.1001/jama.2013.283194
\(^2\) http://www.medscape.com/viewarticle/851005
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**OBSERVATION VERSUS SURGERY AND WHEN TO WORRY ABOUT TORSION**

Ovarian cysts occur frequently in children and adolescent girls and may be discovered due to symptoms, routine physical examination or incidentally through imaging studies. Historically, ovarian cysts and masses discovered in children and adolescents were removed surgically, often involving removal of the entire ovary. During the last decade, however, the management of ovarian masses has shifted toward a more conservative approach with ovarian preservation. The reasons for this are likely multifactorial, including advances in radiologic imaging, the identification of tumor markers, and an increase in the availability and accessibility of pediatric and adolescent gynecologists within pediatric healthcare systems.

Benign ovarian masses are classified as either non-neoplastic or neoplastic. The majority of non-neoplastic cysts in this population are physiologic, and can further be classified as simple or follicular, corpus luteum, hemorrhagic, or paratubal cysts. These cysts may be diagnosed as a result of acute pain, or they may be discovered incidentally during routine physical examination or imaging. At the time of diagnosis, if there is high concern for torsion, surgical exploration is required. However, if torsion is not suspected, the majority of non-neoplastic cysts can be managed expectantly with serial ultrasound imaging. Reimaging after eight to twelve weeks often reveals resolution of the cyst. Some adolescents will then elect to start hormonal suppressive therapy to prevent future cysts, but this decision should be individualized and discussed with the treating gynecologist. Hormonal suppression does not cause regression of existing ovarian cysts.

The decision to proceed with surgery for cysts that do not resolve spontaneously is generally based on the patient’s symptoms, physical examination and imaging findings. Although size thresholds are often discussed by providers, the literature does not support a single size threshold as an indicator for mandatory surgical exploration.

Ovarian neoplasms are much less common than non-neoplastic cysts, accounting for approximately 1% of all tumors in children and teens. Most ovarian neoplasms are benign; fewer than 10% are malignant. In girls and adolescents, the majority of these benign ovarian neoplasms are mature cystic teratomas (dermoid cyst), serous and mucinous cystadenomas. The majority of malignant neoplasms in children and teens are germ cell in origin, compared with epithelial cell tumors which account for most malignant neoplasms in adults. Ultrasound is the imaging study of choice to distinguish between these masses, with assessment for cystic and solid features, as well as Doppler flow to look for increased vascularity which frequently occurs with malignancy. Tumor markers for germ cell tumors (LDH, AFP, HCG and Inhibin) are useful when imaging studies suggest malignancy. Surgery is always recommended in the setting of an ovarian neoplasm as it will not spontaneously regress. However, surgical intervention is still directed towards preservation of the ovary, with unilateral salpingo-oophorectomy reserved only for masses with a high suspicion for malignancy.

It is important to note that torsion can occur with a cyst of any size, particularly when long utero-ovarian pedicles are present. The embryologic ovary originates at the level of the 10th thoracic vertebrae and descends to the true pelvis by puberty. Prior to menarche, the ovary is an abdominal organ and therefore, the normal ovary is more susceptible to torsion on the naturally elongated utero-ovarian pedicle. After menarche, most cases of torsion occur in the setting of an ovarian cyst or mass that causes the enlarged ovary to twist on its smaller, vascular pedicle. Signs and symptoms of torsion include the sudden onset of lower abdominal pain, nausea, vomiting and low-grade fever. Ultrasound evaluation most consistent with ovarian torsion includes size discrepancy in ovarian volumes, peripheralization of follicles, and centralized edema. Doppler flow can be utilized to evaluate for blood flow to the ovary, but should be interpreted with extreme caution as 30% of cases of acute ovarian torsion in the adolescent patient will still demonstrate normal Doppler blood flow to the ovary.

An attempt should always be made to salvage the torsed ovary by untwisting the vascular pedicle, thereby allowing reperfusion of the ovary. If a cyst is present, it should be removed to prevent recurrence. Ovarian sparing surgery is always preferred given the long-term risks of unilateral oophorectomy. The potential negative effects of oophorectomy include an increased risk for earlier menopause, premature ovarian failure, diminished ovarian reserve and fertility, and long-term adverse effects on bone health, sexual functioning and cardiovascular health. Regardless of the necrotic appearance of the ovary at the time of surgery, detorsion with surveillance is the recommended management as most ovaries will show return of follicular activity. After detorsion, reimaging of the ovary can be performed several weeks later to assess for return of ovarian function.

It is also important to recognize that sometimes the fallopian tube alone can be twisted on its pedicle. If not recognized in a timely manner, it can also adversely impact an adolescent’s future fertility. In a case series published by our Adolescent Gynecologists at Children’s Hospital Colorado, > 90% of teenage girls with isolated tubal torsion has documented normal blood flow to the ovary, making the diagnosis particularly challenging. In our case series, the triad of a simple paratubal cyst, normal blood flow and pain out of proportion to exam was highly predictive of isolated tubal torsion and something that we look for routinely to better assess and surgically manage our patients.

For consultation, referral of diagnostic delmmas contact the Children’s Hospital Colorado Pediatric and Adolescent Gynecology team through One Call at 720-777-3999.
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NRCE TRIALS AND TRIBULATIONS

If you currently or wish to begin performing Commercial Driver Medical Examinations (CDMEs) for the Federal Motor Carrier Safety Administration, you are no doubt aware of some of the difficulties that have arisen in the last several months. I am writing this article to give you some background, explain what happened, where we are, and what to do going forward.

Many of us thought that this was going to be a short-lived problem. Surely the issues could be fixed within weeks, as we were told repeatedly. As time went on, the FMCSA staffers began to hold teleconferences with stakeholders telling us to be patient. Examiners expressed concerns about how this was disrupting their ability to efficiently provide these services. Other potential new examiners were distraught that they were unable to register and complete their certification process as the website was necessary to accomplish this. Some clinics contacted their congressmen in an attempt to speed the “fix it” process up; but on one FMCSA stakeholder phone call, the FMCSA asked that this not occur as they were spending too much time responding to Congressional inquiries into the problem. Sadly, the website continued to be inoperable until June 22, 2018 at which point a new, partially functional website was introduced.

Around November 28, 2017 or so, several examiners and examiner administrative assistants began to notice aberrations in the examination report upload process to the National Registry of Certified Medical Examiners (NRCME) website. The website was shut down on November 30, 2017 as there was suspicion that it was hacked. We were advised that no data was compromised. Since that time, there has been no official confirmation that the site was indeed hacked, although it is no secret that this is exactly what occurred.

No Medical Examiner (ME) nor Medical Examiner Administrative Assistant (MEAA) was thus able to upload examination information, which created a great backlog and headaches for all stakeholders involved. For example, my clinic has 577 exams that were backlogged.

This new, partially active website currently allows the following:

1. Ability to look up certified examiners (good for drivers and companies)

2. Ability of the examiner to upload exams (but not the administrative assistant)

3. Ability for a NEW examiner to register for an NRCME number AFTER one completes a training course (this is different from before, because previously, an examiner desiring initial certification could register for an NRCME number at any time; now there is a stepwise instruction to do training first, registration for an NRCME # second, and taking the examination last)

4. A new website security process that requires one to register and use a login.gov account

As you may know, there was also a new rule that was to go into effect also on June 22, 2018 requiring the exam to be uploaded within 24 hours of its completion (sorry, yes this also includes weekends, so you might want to think twice about scheduling that exam as the last slot on Friday afternoon!). Obviously, with all these problems and all this chaos, that deadline and conformation will not be enforced and the FMCSA is
not going to penalize anyone until the entire website is functional.

Yet another problem ensued once the new website was active. Examiners entering the expiration date of the certificate noticed that the new website did not save the date accurately, as it was usually one day off. The FMCSA recently posted this message regarding this problem:

“As you are probably aware, there was a problem with the examination and birth dates when uploading results of CMV driver exams to the National Registry. The problem has been resolved and FMCSA will correct the examinations entered prior to the resolution. Therefore, MEs do not need to take any action to correct previously entered examination results and may resume uploading results.”

I would encourage NRCME examiners or potential examiners to go to the following webpage that details the new logon.gov process and has links to the webpage progress issues as well as announcements regarding the June 22 rule (and other useful information):

https://www.fmcsa.dot.gov/Regulations/Medical/National-Registry-Certified-Medical-Examiners

Lastly, there have been many questions about the 5 year re-training requirement for examiners. Those of you who took an initial training course in 2013 are probably wondering, “When and where should I do this?” Originally, it was thought that CME providers, like the IAFP, would be allowed to conduct these re-training courses. However, in early 2017, the FMCSA put out a notification that instead, it would be conducting its own web-based retraining program, and that its program would be the only one authorized for this purpose. This was surprising to many CME providers. The problem is that no such course currently exists, and my contacts have told me that there is no such course that is currently being planned. Not surprisingly, most of the FMCSA assets are probably being devoted to this website mess. So, all I can tell you is to “stay tuned” on this; one thing that I can tell you is that your certification is not in jeopardy. The FMCSA has made it clear that they will not de-certify anyone for not receiving their 5 year re-training within the requisite time frame.

As always, if you have more detailed questions, contact me at douglas.martin@unitypoint.org
The 28th Annual Balance Conference for Women Physicians, “Practice Pearls”, was held August 2-5, 2018 in Breckenridge, Colorado. We attended as a dyad sponsored by the CAFP Foundation’s Martha Illige Scholarship. In our Family Medicine Residency program we serve as team leaders of the Wellness Committee, spearheading efforts to improve well-being for all who work within our program. In attending the “Practice Pearls” conference we hoped to further explore various methods to help support our endeavors in promoting work-life balance.

Each annual meeting itself provides an opportunity to network with women physicians of many generations and specialties from different areas of the country. “Practice Pearls” proved to be a blend of wellness-type workshops or activities as well as talks on a variety of medical practice themes.

The initial wellness activity allowed participants to get to know each other and reflect on the women who had impacted them along the course of their life journey. Each woman wrote thank you notes to those she wished to recognize and the conference organizers then mailed these. A welcome opportunity to re-connect with past mentors or colleagues, this project also proved to be an excellent exercise in gratitude expression, for which there is supporting research on its impact in several avenues of well-being.

Each morning of the conference started with yoga for those interested and a group meal. Balance group member Cathy Luh, MD who has been practicing yoga for nearly 20 years, led yoga sessions. These sessions helped participants relax their bodies and minds using deep breathing techniques while gently working on skills to hone physical balance. In lieu of yoga, some participants would take early morning walks through the nearby forest and then join the other members for the shared morning meal.

Educational sessions focused on topics such as an historical and contemporary review of Influenza, by Dr. Lynn Zills, as well as an in depth conversation regarding Addiction and Compassionate Pain Management with Dr. Sandy Cohen. In her lecture, “Moving Towards Retirement”, Dr. Jane Kano, explored the various intricacies and challenges that retirement poses for all physicians. In approaching, and after entering into retirement, “work-life balance” takes on a new meaning and continues to have profound implications for physician well-being. This lecture was thought provoking and the topic may generate some interesting research in the future.

Additional discussions promoted physical and mental well-being with Dr. Doris Gunderson sharing her journey of becoming a long-distance runner to participate in the Copper Canyon Ultra Marathon in Mexico. The group also discussed the book The Heart, a Novel by Maylis de Kerangal and viewed and discussed the movie Lady Bird.

“Practice Pearls” did not formally examine current practice efforts or...
contemporary research into methods for improving physician wellness as we had hoped it might. However, it did create opportunities for attendees to share time together in a non-medical setting and consider ways in which we all can strive to engender a healthier “work-life” balance. As we continue directing projects for our own residency wellness program, we appreciate the insights garnered through such meetings as those hosted by the non-profit organization, Balance for Women Physicians.

The societal and personal expectations of balancing work, managing a family and practicing medicine continue to be greater challenges for women physicians. Unfortunately, “finding balance” is somewhat of a castle in the sky since there are rarely enough hours in a day to take care of everything to one’s satisfaction. As an example, female physicians are more likely to cut back professionally to accommodate family obligations. Studies have shown that female physicians in dual physician households work 11 fewer hours per week, while there is no difference in the hours worked by men. Female physicians with young children spend nine more hours per week on domestic activities than their male counterparts.

Another challenging difference is how female physicians choose to practice. The practice style of many women physicians, particularly family medicine women physicians, is strongly relationship based. This leads many to struggle with time pressures in clinic because of their relationship-centered care. In addition to time restraints, the current system of reimbursement can make this method of practice especially challenging. Time spent with more needy or high risk patients, dealing with social issues and advocating for the patient receives little to no remuneration.

In her book “Wonder Women”, Debora Spar examines the amalgamation of the numerous roles that women have historically shouldered plus the new roles and opportunities created by second-wave feminism. As she notes, there has been an “unanticipated double whammy that confronts women today [...]” which often leads to a pattern of thought that “anything less than ‘all’ in their lives is proof only of their own shortcomings.” An unhealthy cycle of failure, blame and guilt thus ensues when we inevitably, inherently fall short.

Given these challenges it is imperative that together we continue to explore various methods to support our endeavors in “finding balance”, but perhaps more importantly, work toward creating an open dialogue which encourages us to be more self-forgiving of our humanity.
Could a partnership between a non-profit restaurant and family physician clinics work to address food insecurity? Let’s consider the issues and opportunities.

Food insecurity affects nearly 630,000 people in Colorado. Feeding America reports that more than 80,000 people living in Denver County are food insecure. Food insecurity refers to the inability to afford nutritionally adequate and safe foods – enough food for an active and healthy life. With inadequate food supplies, dietary variety decreases and consumption of energy-dense foods increases. People living with food-insecurity consume fewer weekly servings of fruits, vegetables, and dairy. These dietary patterns are linked to the development of chronic disease, including hypertension, hyperlipidemia, and diabetes.

According to the US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, food insecurity is a key issue in the Economic Stability domain – the first of the five place-based domains of the Healthy People 2020 Social Determinants of Health topic areas.

Federico Roncarolo, MD PhD, Postdoctoral fellow in the Public Health Research Institute at the University of Montreal and Louise Potvin, PhD, Professor in the School of Public Health at the University of Montreal in their article, Food insecurity as a symptom of a social disease, analyzing a social problem from a medical perspective (Can Fam Physician. 2016 Apr; 62(4): 291–292), present food insecurity within a medical context, encouraging a better grasp of this issue and an understanding of the role of the family physician in addressing food insecurity. The authors believe that family physician clinics are ideal settings to promote the help that patients experiencing food insecurity need; while a referral to community services by family physicians might increase patients’ willingness to participate in community programs. As an example, the authors suggest that the co-location of health care and social services such as on-site emergency food boxes can increase accessibility and patient use of services and improve program efficiencies.

So All May Eat (SAME) takes a unique approach to addressing food insecurity through the SAME Café in Denver. Based on the belief that everyone deserves to eat healthy, locally-grown food regardless of ability to pay, this participation-based, non-profit restaurant serves nutritious meals six days a week in exchange for contributions of time,
produce, or money. The Café menu offerings, which change daily, include two soups, two salads, and two pizzas, with at least one vegetarian choice in each category. Gluten-free and vegan options are also available.

Founded in October 2006 with the mission of creating community through access to healthy food, the Café succeeds with the help of many regular volunteers assisting in the daily operations of the Café, the donations of hundreds of pounds of produce given through partnerships with local gardens and farms, and the generous financial support from the community.

Last year, the Café served more than 11,000 meals at its E. Colfax location near downtown Denver. A $50,000 grant this fall from the Colorado Health Foundation provides the essential support for the operation of a food truck – a vehicle that will help the Café serve an expected 75% more healthy meals in neighborhoods beyond the E. Colfax area. In addition to the meals served, the food truck will also include a mobile food market component, offering ready-to-use fruits and vegetables, recipes, serving suggestions and additional ingredients. This mobile food market service will give people an opportunity to try a vegetable or fruit in a meal, decide if they like it, and have the necessary resources to re-create the meal at home.

What if So All May Eat partnered with family physicians and brought the SAME Food Truck to family physician clinics or offices to serve meals and offer fruits and vegetables to patients? Could a partnership between a non-profit restaurant and family physician clinics work to address food insecurity?

More information about SAME Café and how you can be involved is on their website: https://www.soallmayeat.org.

Nate Flory is the volunteer coordinator and intern at SAME Café. Nate moved to Denver from Pittsburgh, PA to be a full-time volunteer at SAME for a year of service through the Urban Servant Corps.

Ann Cohen is the development coordinator for SAME through her service with the Ignatian Volunteer Corps. She retired in 2016 from her nutrition faculty position at the University of Missouri-Columbia and brings her over twenty years of experience with foundation and government funding for food and nutrition program development to her work at SAME.
The Colorado Academy of Family Physicians Foundation (CAFPF) serves two important goals. First, to inspire the next generation of Colorado family physicians. Second, to engage physicians within communities across Colorado to improve the health of all people.

Supporting the Next Generation of Family Physicians

Much needs to be done to strengthen the family medicine pipeline. While your Foundation is tackling this issue on many fronts, we continue to believe in the power of connecting students and residents with family physicians in their practices.

Because of the generosity of our members, we are able to continue to engage personally with many students and residents in Colorado. 100% of donations made to our Foundation go directly to scholarships that send medical students and family medicine residents to our Annual Summit.

The Summit is a wonderful opportunity for students and residents to take part in educational seminars, network with Colorado physicians, visit with recruiters in our exhibit hall, and see what practicing family medicine in Colorado is all about. Due to a significant increase in student and resident participation in recent years, a special student and resident track was implemented at the Summit in 2018 and will continue this year. The track includes education, in which students and residents are most interested, including procedural workshops and financial/student loan guidance. Additionally, we host a social gathering with student and resident attendees and CAFP leadership to give students and residents the opportunity to learn more about the CAFP and family medicine in a relaxed and fun atmosphere.

If you are interested in learning more about this work and making a contribution to the Foundation, visit www.coloradoafp.org/foundation.

Improving the Health of Communities Across Colorado

The CAFP has a long history of improving the health of the communities we serve, and we have been excited to explore important ways to expand this good work.

Foundation projects which include focusing on specific community needs within a public health focus are supported by grant funding, offered by foundations and other organizations across Colorado and nationally. Exploring how we can increase our work in this area has brought about both unique challenges and opportunities. The Foundation recognized that there are gaps in many areas. Our “sweet spot” is when we can identify a gap that can and should be addressed in a way that is unique to the capabilities and scope of family medicine physicians.

An excellent example of this is a youth marijuana prevention curriculum developed and run by the CAFP called “Stop & Imagine: Preventing Marijuana Use in Colorado Youth”, designed to reach 4th and 5th grade students. You may find it surprising to hear that for young people who are not yet in middle and high school, there is a significant lack of resources that talk about marijuana in smart, age-appropriate ways. This is particularly true in some of Colorado’s rural communities, which are some of the same communities seeing the highest rates of youth marijuana use. Providing a readymade turn-key program for the community Family physician to implement is one way to provide facts and leadership in guiding awareness of the effects of marijuana. Knowing all of this, the CAFP developed the “Stop & Imagine” curriculum and began running a pilot of the program this fall. We are gathering data from these pilot presentations to gauge the impacts of this curriculum on students and have so far been very encouraged by the enthusiasm others have about family physicians doing such work.

I am very excited about the work of the CAFPF and look forward to updating you in future issues of Colorado Family Physician about our commitment to you to support your improving care in your community.
NEW WEB RESOURCE AVAILABLE  
TO HELP COLORADANS WITH FUTURE MEDICAL PLANNING

Colorado Care Planning (www.ColoradoCarePlanning.org) is a new comprehensive website to help Coloradans of all ages find information for future medical planning. Launched in July 2018, this public website is directed by Hillary Lum, MD PhD in the Division of Geriatric Medicine at the University of Colorado Anschutz Medical Campus. ColoradoCarePlanning.org provides free resources like Colorado-specific advance directives including a Medical Durable Power of Attorney form and a living will. Informed by input from Coloradans including community members, Veterans, healthcare practitioners, and others, the website has a roadmap with an overview of advance care planning. The roadmap guides visitors along a path to think about their values, choose a medical decision maker, write down their wishes, make medical choices, and share wishes with others. There are also resources for individuals with different needs – for example, Spanish-speaking individuals, family members, and individuals with dementia. Because advance care planning can bring up additional topics such as housing and caregiving, the website also provides Coloradans with local community resources.

Family Medicine physician, Dr. Helenka Stone, found the website to be useful not only for her patients but also for her own young family. As a physician at Salud Family Health Center, having these resources translated into multiple languages is invaluable for her patients. The website can be easily translated into Spanish and many of the resources are available in multiple languages. Ultimately, what is most valuable to Dr. Stone is that the website “pulls together all of the relevant advance care planning documents in Colorado” and “may be the only website like this for any state.” Dr. Stone reflected on the importance of having care planning conversations with patients and noted that clinicians are “expected to have these conversations with patients, this website makes it easy to walk through the process with patients.” When asked about why it is so important to have these conversations with patients, Dr. Stone referenced her time in the inpatient setting where these conversations were stressful and often times resulted in an outcome that Dr. Stone believes may not have been what the patient would have chosen. Dr. Stone recommends sharing this resource with your organization so that they can share with providers and setting up reminders in the Electronic Health Record system for the health care team and patients.

Dr. David Nowels, a Family Medicine physician and the Hospice and Palliative Medicine Fellowship Director at the University of Colorado School of Medicine, echoed Dr. Stone’s remarks. He believes that the website “offers a variety of resources relevant to Colorado for patients and their families.” He described the accessibility and importance of the online platform to supplement his conversations with patients, “I think most folks can and do access online materials and I think the range of resources on the ColoradoCarePlanning website will be useful to many people and their families to supplement and fill out the discussions I have.” He recommends adding the website to the After Visit Summary (AVS) and sharing it with the Care Manager and Social Worker in the practice. Dr. Nowels remarked that “One of the biggest issues primary care practices must address is the connections between the practice and the community – this website can help bridge that gap for the practice and their patients.”

Healthcare teams members describe www.ColoradoCarePlanning.org as an easily navigated resource, useful for both clinicians and for patients. When Megan Prescott, LCSW, first visited the site she was impressed by how it guided people. “The website is a great place for people to land for all kinds of information. It links to resources that help craft conversations for patients and families who may initially feel apprehensive about the topic or need guidance around what to consider. It has printable Colorado directives that are grounded in goals and values, particularly helpful for future wishes, as future scenarios can be difficult to imagine - specifically the Easy to Read Colorado Advance Health Directive.”

Jackie Glover, PhD, a member of a hospital ethics committee, describes how her knowledge of the website (professionally) enabled her to personally help a friend during a critical time. “My friend was facing end of life decisions and was afraid her wishes wouldn’t be known or carried out. I directed her to the website to find tools and she was able to schedule a visit with her primary care provider armed with information, particularly about the Colorado MOST form. She was able to make her wishes known.”

Visit www.ColoradoCarePlanning.org to see for yourself. As Glover concluded, “It’s wonderful to have one repository of information.” For questions about the website or to explore how you can share this with your patients, email coloradocareplanning@ucdenver.edu.
HEPATITIS C TREATMENT IN COLORADO

Family physicians in Colorado are on the front lines in the battle against a destructive enemy: chronic hepatitis C virus infection. While we have had the longstanding role of screening for and diagnosing hepatitis C virus (HCV) infection, the sheer burden of patients with chronic HCV infection coupled with the availability of new, well-tolerated and highly effective curative treatment mandates that each of us establish a system within our practices for either referring our hepatitis C patients to providers who treat chronic hepatitis C or develop expertise in treating this infection ourselves. Project Echo Colorado offers an exciting, free resource for family physicians in Colorado who are interested in developing their capacity to treat HCV infection within their own practice.

While the precise prevalence of chronic hepatitis C and incidence of new HCV infections in Colorado is difficult to determine, the Colorado Department of Public Health and Environment (CDPHE) does maintain a surveillance database for hepatitis C that provides us with useful estimates (1). Between 1993 and 2016, over 100,000 cases of chronic hepatitis C infection were reported. Each year 3000-4000 new cases of chronic HCV and 25-40 cases of acute HCV infection are reported. Since acute HCV infection is often asymptomatic, it is estimated that for each reported case there are approximately 13 unreported acute cases of HCV infection in the community. This implies that there may be over 500 new HCV infections per year adding to the already large number of people already living with chronic hepatitis C.

The hepatitis C virus was initially isolated in 1989 and by the late 1990s interferon therapy was developed as a potential curative treatment. Unfortunately, interferon treatment was difficult to tolerate and often did not cure the infection. Modified treatment regimens using pegylated interferon and ribavirin increased the percentage of patients who were cured but the tolerability of these regimens remained poor. A true therapeutic breakthrough has occurred over the last several years with the development of direct-acting antiviral (DAA) therapy. These drugs are highly effective leading to eradication of HCV infection in over 95% of treated patients. They are also very well-tolerated and easy to administer as once-daily oral medications rather than injectable therapy needed with interferon. An important caveat to DAA therapy has been the very high cost of these antiviral drugs leading to insurance-based barriers to treatment.

One of the critical links in the battle against chronic hepatitis C infection now that effective treatment is available is simply identifying those living with the infection. This responsibility lies primarily with family practitioners and other primary care providers. The natural history of chronic hepatitis C infection for most patients is many years, often 20 to 30, of asymptomatic infection prior to the development, in 20 to 30% of patients, of advanced liver disease. Presently it is estimated that some 50% of patients with chronic HCV do not know that they have the infection. The Centers for Disease Control and Prevention (CDC) recommends both risk-based and age-cohort screening for chronic hepatitis C (2). Risk-based screening focuses on screening people recognized as having a risk factor for infection such as intravenous drug use or blood transfusion prior to the availability of HCV screening of the blood supply. While risk-based screening is still appropriate, it has been shown to miss up to 75% of cases of chronic HCV infection. Therefore, in 2012, the CDC recommended one-time age-cohort screening for people born between 1945 and 1965, the so-called baby boomer cohort. The rationale for this recommendation is that the baseline prevalence of chronic hepatitis C in this age-group is 3-4% compared to the 1% prevalence of other age-groups. All family practitioners should be actively screening our baby boomer patients and patients with other risk-factors for HCV infection.

Presently, hepatitis C treatment with DAA regimens has been the purview of specialists, usually hepatologists, gastroenterologists and infectious disease specialists. There is evidence, however, that chronic HCV infection can also be treated successfully by primary care providers trained to treat the infection (3, 4). One of the initial efforts in this realm was implemented during the interferon treatment era in New Mexico where hepatitis C specialists at the University of New Mexico used live video teleconferencing technology to partner with primary care providers in rural and underserved areas to support

ASSISTANT PROFESSOR OF FAMILY MEDICINE
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patient treatment by their primary provider rather than having the patients travel great distances to be treated in the specialty center (3). This model, called Project Echo, has been implemented in numerous other areas of the country including Colorado.

Project Echo Colorado hosted a training course on the treatment of chronic hepatitis C for primary care physicians and advanced practice providers in 2018 and will have more sessions in 2019. Project Echo courses are provided free of charge and are eligible for CME credit. The hepatitis C treatment course links primary care providers to hepatologists and infectious disease physicians and a family physician facilitator affiliated with Denver Health and the University of Colorado via real-time video conferencing technology. The group meets together for four one-hour weekly sessions during the lunch hour. During each session, a 20 minute presentation is given by a hepatitis C specialist followed by plenty of time for questions and discussion amongst the course participants and faculty. The course is designed to focus on preparing participants to be able to prescribe and monitor HCV treatment successfully in their own practices. Teaching sessions are directed toward practical topics including basic epidemiology of HCV, natural history of the disease, preparing the patient for treatment including staging their degree of liver fibrosis, choosing the appropriate DAA regimen and practical information regarding obtaining prior authorization for antiviral therapy. Course participants can continue to access the Project Echo specialists via e-mail after the course for ongoing support. The Project Echo Colorado website provides further information at www.echocolorado.org.

The next several years provide a window of opportunity for our patients with chronic hepatitis C to be treated and cured of this potentially life-threatening infection. We should maximize our efforts to screen all of our baby-boomer patients and other patients at-risk for hepatitis C. And for those with HCV infection, we must provide linkage to care or even provide curative care ourselves. Our HCV patients’ wellbeing depends on it.


The Last Flu Season was Fatal to a Record Number of Children

A CDC report in August (tinyurl.com/ycur5shmq) indicated that the 2017-2018 flu season was, for children, “one of the deadliest since federal health authorities began tracking pediatric deaths 14 years ago.” According to the Washington Post, “Only the 2009 swine flu pandemic, which killed 358 children, was worse” (tinyurl.com/y8uxfknb). The AP reported, “About half of the deaths were in otherwise healthy children (ranging in age from 8 weeks to 17 years)” (tinyurl.com/y3k4h1m). Last year’s flu season “wasn’t a pandemic, but it was long—19 weeks”—and “also was unusually intense, with high levels of illness reported in nearly every state for weeks on end.” According to the CDC, “about 80 percent of the fatalities were among children who hadn’t been vaccinated.” All the more reason for us FPs to encourage influenza vaccine in our practices and communities.

Court Rules that New York City can Require Children in Licensed Day Cares to Receive Flu Vaccine

This summer the highest court in New York state ruled unanimously that New York City’s Board of Health can mandate that children between the ages of six months and five years who attend day cares and preschools licensed by the city receive the flu vaccine. Health Commissioner Mary Bassett said the decision was “great win” for the city’s children.

AAP and ACIP Disagree on Whether Children Should Flu Shot or Nasal Spray

Despite some changes to the quadrivalent live attenuated influenza vaccine (LAIV4; Flu Mist Nasal Spray) to boost effectiveness, the American Academy of Pediatrics (AAP) advises that children receive inactivated vaccine (flu shot) for the 2018-19 flu season (tinyurl.com/y9wddv4). The ACIP had recommended against the use of LAIV for the 2016-17 and 2017-18 flu seasons because the vaccine’s influenza A (H1N1) component wasn’t protecting people against that influenza strain.

Of course, all children aged 6 months or older should be vaccinated where not contraindicated, remembering that the nasal spray is not recommended for children with certain chronic medical conditions or those less than two years old. Intranasally administered LAIV4 has been a popular choice for parents to request for their children because it avoids an injection. However, CDC and AAP have NOT recommended LAIV4 in past 2 seasons due to weak coverage of Influenza A. So, the manufacturer changed the vaccine with the goal of bumping up the antibody response and vaccine effectiveness against Influenza A strains. Based on manufacturer and other data the CDC greenlighted reintroduction of FluMist for the 2018-2019 season.

AAP, after reviewing the same data, disagreed with ACIP, advising that children should still only receive the shot with inactivated influenza virus. The AAP says, “The injectable form of the vaccine … was shown to be more consistently effective against most strains of the flu virus over the past several flu seasons.”

AAP recommends that only when the shot is absolutely declined should the LAIV4 nasal spray be offered with the caution that children could be at higher infection risk with this option. In our opinion, health professionals choosing to allow parents to choose the Flu Mist for their children, under the rubric that any immunization is better than none, may still wish to consider asking parents to sign an informed consent note noting that they were informed of the increased risks of the nasal spray.

New Guidelines Greenlight Administering Flu Vaccine to All Egg Allergic Patients

Individuals with egg allergies can safely receive an influenza vaccine without any precautions, according to updated practice parameters created by the American College of Allergy, Asthma, and Immunology (ACAAI) and the American Academy of Allergy, Asthma, and Immunology (AAAAI). The authors state, “There is strong evidence that egg allergic individuals can safely receive IIV or LAIV if the latter vaccine is recommended for use once the concerns regarding efficacy have been resolved. Presence of egg allergy in an individual is not a contraindication to receive IIV or LAIV. Influenza vaccine recipients with egg allergy are at no greater risk for a systemic allergic reaction than those without egg allergy. Precautions, such as choice of a particular vaccine, special observation periods, or restriction of administration to particular medical settings, are not warranted and constitute an unnecessary barrier to immunization. Vaccine providers and screening questionnaires do not need to ask about the egg allergy status of recipients of influenza vaccine.”

New Flu Vaccine Only Slightly More Effective than Traditional Shot

According to a study by the FDA to the ACIP, the new flu vaccine Flucelvax—which is made by growing viruses in animal cells—was only a little more effective “in seniors this past winter than traditional shots.” While overall vaccines barely worked at all in keeping people 65 and older out of the hospital, with roughly 24 percent effectiveness, Flucelvax was about 26.5 percent effective in that age group.” CDC flu expert Brendan Flannery said, “The big problem is still the same—we need better vaccines. But these incremental improvements are very important.”

Flu Vaccine for the Elderly

What should we FPs do with our elderly patients when it comes to influenza vaccination? CDC has a nice patient education handout here: tinyurl.com/y8hkdjld. The CDC wants to remind us and our elderly patients that they bear the greatest burden of severe flu disease. In recent years, for example, it’s estimated that between 71
percent and 85 percent of seasonal flu-related deaths have occurred in people 65 years and older and between 54 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people in that age group. The vaccine can reduce these numbers at least 25 percent.

The CDC also reminds people 65 years and older that they can get any injectable flu vaccine (flu shot, but not the nasal spray) that is approved for use in that age group. However, there are two vaccines designed specifically for people 65 and older:

1. A “high dose flu vaccine” (Fluzone High-Dose) is designed specifically for people 65 and older and contains four times the amount of antigen as the regular flu shot. It is associated with a stronger immune response following vaccination (higher antibody production). Results from a clinical trial of more than 30,000 people showed that adults 65 years and older who received the high dose vaccine had 24 percent fewer influenza infections as compared to those who received the standard dose flu vaccine.

2. An “adjuvanted flu vaccine” (Fluad) is made with MF59 adjuvant which is designed to help create a stronger immune response to vaccination. In a Canadian study of persons aged 65 years and older, Fluad was 63 percent more effective than regular-dose unadjuvanted flu shots.

3. There are no randomized studies comparing Fluad with Fluzone High-Dose. Therefore, CDC and ACIP have not expressed a preference for any flu vaccine indicated for people 65 and older. Their cost is about the same.

Of course, the high dose and adjuvanted flu vaccines may result in more of the mild side effects that can occur with standard-dose seasonal shots. Mild side effects can include pain, redness or swelling at the injection site, headache, muscle ache and malaise.

And, don’t forget: when your patients age 65 and over are getting their flu shot, be sure your staff checks on and updates their pneumococcal vaccine status. Have your staff remind seniors that people who are 65 years of age and older should also be up to date with pneumococcal vaccination to protect against pneumococcal disease, such as pneumonia, meningitis, and bloodstream infections. Remind your seniors that pneumococcal pneumonia is an example of a serious flu-related complication that can cause death.

Public Support for Vaccines Falling

A survey by Research America in May found that public support for vaccines has fallen among Americans since 2008 (tinyurl.com/ybzm4cqe). Among 1,000 people asked, “How important do you believe vaccines are to the health of our society today,” 70 percent responded, “very important,” and 22 percent responded, “somewhat important.” This sounds good until you realize that in 2008, “80 percent said they were very important and 17 percent said somewhat important.” In addition, the survey found that the percentage of Americans who strongly believe they have benefited from the development of vaccines over the past 50 years has dropped from 75 percent a decade ago to 59 percent.” Obviously, we FPs still have some work to do educating our patients.

CDC Midyear Report: 107 Measles Cases Seen in 21 States, DC

A CDC report this fall indicated 21 states and Washington, D.C., had 107 confirmed cases of measles from January 1 through July 14 of this year. As you might expect, the vast majority of the patients had not received a measles vaccination. The numbers are higher than this time last year, as 118 cases were reported in all of 2017 (tinyurl.com/yatrjjdz).
Throughout my (RF) public health career, hepatitis A has been the occasional “unwelcome visitor” to my radar screen of responsibilities and priorities. It is not a candidate for worldwide eradication like polio. Though it spreads rather easily by the fecal-oral route, it has less potential to cause community-wide epidemic crises than measles or influenza. It does not feature a long-term infectious carrier state portending disability or shortened life as do hepatitis B, hepatitis C, and HIV. However, I have had two “brushes” with hepatitis A that I would rather have avoided.

About two decades ago, as epidemiologist in a local health department in a mid-sized city, I helped investigate an epidemic of hepatitis A that was small by national standards (possibly 50 cases) but caught enough media and public attention to call into question the adequacy of our response. Following CDC recommendations, we interviewed cases, tracked down their personal and family contacts, and administered immune globulin at mobile clinics. Often, we found a person newly reported with hepatitis A who should have received prophylaxis as a contact to a previous case – but had not been identified when we had asked for “family or close contacts”.

We had failed to understand the nature of relationships and community contact among this low-income, transient – though not generally homeless – population. Today, this community would be an ideal place for hepatitis A vaccination.

A few years later my friend, a retired academic colleague, contracted hepatitis A at a restaurant in the large city where he lived. He sustained severe liver damage and was, for a time, on a list for liver transplantation. Miraculously, he recovered without needing the transplant, and interestingly, testified that his hypercholesterolemia disappeared as he recovered. Nonetheless, I wish that this gentleman had received the hepatitis A vaccine before his retirement, when it was first licensed.

I received the hepatitis A vaccine in the 1990s as part of my preparation for overseas travel. It cost me several hundred dollars at the time – even with administration costs, more expensive than on CDC’s current private sector price list – about $60 for the two-dose pediatric series and $130 for two doses for adults (TinyURL.com/ybyhmz9y). The efficacy of this vaccine is one of the highest of any on the routine schedule (see a thorough review of the disease and vaccine by CDC at TinyURL.com/yarblz3y)

Since 2006, hepatitis A vaccine has been recommended for all children as a two-dose series given at 12-23 months of age (TinyURL.com/y7wzm2r and TinyURL.com/ych3xqo9). Thus, immunity to hepatitis A in this country is now widespread in children up through middle school age.

In lesser-developed countries (and in some U.S. populations), many adults have natural immunity to the disease. This is because hepatitis A, like polioviruses and other similar RNA viruses, often causes asymptomatic infection in young children who live, play, and grow up in less than ideal sanitary conditions. However, in the U.S. and in other developed nations, sanitation has been good enough for long enough that a substantial proportion of older adults now lack immunity to hepatitis A.

This virus, unfortunately, reserves its most severe consequences for those who become infected at older ages. Such was the case with my friend. At the other end of the economic spectrum, as we saw in the outbreak I described, younger and middle-aged adults may not have been infected as children but experience conditions which may expose them to hepatitis A now.

We have learned that the Advisory Committee on Immunization Practices has now added persons experiencing homelessness to the priority list of older children and adults who should receive hepatitis A vaccination (meeting minutes not yet published).
I recently attended part of a day-long brainstorm session put on by 10.10.10. They bring a bunch of smart and entrepreneurial people into one room, pose ten “wicked” problems, and give them ten days to design new initiatives or business ventures that can tackle them. When I arrived partway into the event, I was assigned to the group working on the issue of health disparities in clinical settings. The brainstorming was rapid fire—who are the players? What’s the history of the issue? What are the constraints? What are the connected problems that have to be solved in order to make progress on this issue? We talked about institutional racism, the design of health care and coverage systems, and the social factors that influence a person’s health. Just as we were feeling completely overwhelmed at how intractable this problem is, lunch arrived. As I stood in line at the buffet with one of my fellow group members, he remarked that what we needed was a business case for health equity.

Well, there is a business case for health equity, and it’s pretty bulletproof. A study from the Joint Center for Political and Economic Studies calculated that from 2003-2006, the economic cost of premature death and health inequities for people of color was $1.24 billion. As if that number isn’t staggering enough, it 1) doesn’t include the cost of premature death and health inequities for women, LGBTQ people, people with disabilities, people living in rural areas, people who don’t speak English or weren’t born in the US, and others our system has harmed, 2) is based on data over a decade old, and 3) only includes direct costs to the system—not the indirect costs of lost productivity because sick people can’t do their best work and dead people can’t pay taxes (adding those in puts us in the trillions). In other words, if our system is keeping people from achieving their best health, we all suffer the financial consequences, and they’re massive.

However, the business case for health equity largely exists at the highest level possible in the US health care system. Where are the incentives (besides, you know, doing the right thing) for hospitals, clinics, providers, and others that hold power in our health care system to change their business practices to reduce health disparities? It’s not cheap—where does the money to pay for it come from? And it’s not easy—how do you rebuild the plane while you’re flying it? If a hospital wanted to truly reduce health disparities in its patient population as much as possible, it would need to start prescribing housing, food, transportation, and other goods required to live a healthy life. And the insurance companies their patients were enrolled in would need to pay for those prescriptions. The culture of the hospital would need to shift dramatically, with all staff taking implicit bias and anti-racism training, and have those messages continually reinforced through the words and actions of leadership. Internal hiring and employee policies would need to be re-written with an equity lens, increasing diversity and cultural responsiveness, and the policies that affect patients would require an even more critical eye. The hospital would need to be an outspoken advocate for social, economic, and racial justice, helping shift the public narrative. There would be changes to clinical protocols, modifications to electronic health record systems, and a considerable reallocation of resources. And that’s far from an exhaustive list.

So we do still need to create a business case for health equity—we need to change the system to make sure there are financial incentives to reducing health disparities. Reducing or eliminating our reliance on a fee-for-service model to pay for health care services will be a key part of this. When hospitals’ and providers’ pay is based on the quantity of services they provide, that incentivizes more health care—not better health. The movement to change this is called payment reform, and there are ways that payment and health care delivery models can be designed to drive health equity. Marshall Chin, MD, outlines five additional ways for a health care system to contribute to health equity: collect outcomes data by race and income, track outcomes and quality measures that matter to patients, support the safety net, invest in primary and preventive care, and pilot new and promising approaches to health care payment and delivery.

Even if we can create a compelling business case for health equity, though, it won’t matter if we don’t change ourselves, too. If humans were solely motivated by financial incentives, the world would be a very different place. The (often unconscious) desire for power and social status drive otherwise well-intentioned people and organizations to make decisions that go against their financial interests, but sustain their privilege. And ultimately, we can only achieve health equity if we work together to solve the root causes of health inequities, like institutional racism and systemic oppression—and we’ll need a lot more than ten days to dig into those wicked problems.

This is our life’s work at Center for Health Progress. It’s why we’re building grassroots power to hold the health care system accountable for changing—applying pressure from the bottom up. It’s also why we’re influencing legislators and health system leaders to use their power to institute change at the top. This is hard work. And heart work. And we’re looking forward to partnering with you to do it.
COLORADO FAMILY PHYSICIAN

REMEmBERING DR. MARTIN KIERNAN

Colorado family medicine sadly lost one of its distinguished members to Parkinson’s Disease on June 6, 2018. Robert Martin Kiernan, M.D. was a family physician, educator, advocate and tireless leader for family medicine. He was born in Le Mars, Iowa and grew up in Alton, Iowa. He graduated from the University of South Dakota and University of Colorado Medical School and then proceeded to residency at North Colorado Medical Center in Greeley. He started a private practice with Richard Wageman, M.D., in Monument and then decided he needed a change, and chose to be the Program Director for St. Joseph Family Practice Residency for 22 years. He drove all those years from Monument to Denver, so as not to uproot his family, but always said he didn’t mind because he loved to drive his Cadillac! He was known by his residents for his Witticisms and practical advice including his “Rules of Life,” as well as advocating for the residency program and its patients. Through that position, he was responsible for training over 100 residents in family medicine, many of whom are still in the state. He was also responsible for creating many more opportunities for his residents to experience what it means to be a family doctor by developing collaborative relationships with several charity care organizations outside the walls of the clinic including Jefferson County Public Health where he worked one day a week for many years.

For his next career change, he was Director of Medical Education at Penrose-St. Francis Hospital in Colorado Springs where he facilitated the CME programs and worked tirelessly to expand the reach of medical education to physicians in more remote areas of the state through the use of tele-medicine. During his tenure there he served a dual role as Physician Advisor for Utilization Management. He retired from there in 2015.

Dr. Kiernan served on the Colorado Academy of Family Practice Board of Directors, including positions as Chairman and President, from 1975-1995. He founded and served as President of the Colorado Academy Family Practice Foundation from 1990-1995. During his tenure, he worked to improve the lives of all family physicians in Colorado. He also served on various committees for the American Academy of Family Physicians from 1978-1992.

His community-minded activities also extended outside of medicine, as he served on the Board of the Lewis-Palmer School District in Monument. In his “spare time” he loved to play the piano, golf, tinker in his well-organized garage and most of all, spend time with his beloved family. One of his favorite expressions was “I’m into creating memories” …and that he did...for all who knew him.

Dr. Kiernan leaves his wife, Sue, his daughters, Mollie, and Jill, and 4 grandchildren.

Throughout his lifetime, Dr. Kiernan touched the lives of hundreds of doctors, thousands of patients and we owe him a debt for his long service to our state, and to family medicine.

“He cared, and it mattered.”
Thank you to the CAFP for supporting scholarships for students and residents to attend AAFP’s National Conference of Family Medicine Residents and Medical Students. As the Resident Delegate for Colorado I had the opportunity to engage in the Resident Congress of Delegates. During the Congress we elected the resident members of the AAFP national committees (Government, Global Health, AAMC, Congress of Delegates, etc.), thus continuing to ensure that residents are involved with the work the AAFP does nationally. In addition, we wrote and submitted resolutions to the Resident Congress on health care as a human right, sat on reference committees to hear testimony on resolutions, and spoke for and/or against resolutions in the Congress.

These opportunities allow residents a voice in AAFP policy making by following the same protocol and system as the AAFP Congress of Delegates. While at the Congress of Delegates and FMX in October, I was able to witness the passage of a resolution which was a version of a resolution we had passed earlier in the Resident Congress. That experience reinforced the importance of sending students and residents to the AAFP National Conference and to engage in the leadership opportunities provided. I am so thankful that the CAFP supports their members in this way and hope that they continue to do so in the future.

Member Recognitions

Congratulations to Kyle Leggott, MD, for receiving the 2018 AAFP Award for Excellence in Graduate Medical Education.

Congratulations to Corey Lyon, DO, FAAFP, on being appointed to the AAFP's Commission on Health of the Public and Science.

Do you have exciting news about yourself or a colleague that you would like recognized by the CAFP? Contact Lynlee Espeseth at lynlee@coloradoafp.org or 303-696-6655 x 116.
WELCOME NEW MEMBERS

The CAFP would like to welcome the following new and returning members who joined our organization in June, July, August, September, & October.

STUDENT MEMBERS

WILLIAM DEWISPEL AERE
MARIO HERNANDEZ
GRETA KREIDER CARLSON
PIERCE LEW IE N
DANIELE MARCY
JESSICA VO
AARON YEARSLEY
ABDEL ALBAKRI
MADISON BERMAN
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KATY LEHENBAUER
YUINA SATOH
HAYDEN SPRINGER
MORGAN STANLEY
TIFFANY TAHATA
JUSTIN THAI
BLAKE VOLKMER
KATIE YAMAMURA
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MEGAN ADAMSON, MD, FAAFP
JOSHUA BAILEY, MD
AARON BUZARD, MD
BRENDA CAMPOS-SPITZE, MD
JAY CIOTTI, MD
DEIDRE DIETZ, MD
REBECCA HAINZ, DO
JEFFREY KETCHAM, MD
STEPHANIE LAPE, MD

CONTINUED ON 36>>
Annyeonghaseyo! I had the privilege of recently traveling to the 22nd WONCA World conference held in Seoul, South Korea. For those who are not familiar, WONCA is the world organization of family medicine. Every two years they host an international conference bringing together family medicine residents and providers from around the world to learn about primary care practice and innovations in other countries. As part of their initiative to strengthen family medicine across the globe, WONCA started the Young Doctors’ Movements (YDM) to support students, residents, and new physician graduates in family medicine. Each region of the world has its own Young Doctors’ Movement comprised primarily of residents and new graduates who are advancing primary care and family medicine in their respective countries. The first YDM was established in Europe in 2004 and is called Vasco de Gama. The last YDM to be formed represents the U.S., Canada, and Caribbean and is known as Polaris. As the resident representative to the AAFP’s Center for Global Health Initiatives board I have the honor of sitting on the Polaris board as the American resident representative. This has afforded me many incredible opportunities including traveling to Korea this fall.

This year WONCA hosted its first ever Young Doctors’ Movement Preconference. This brought together students, residents, and new physicians from around the world for a day to learn about the YDM’s in each of our regions, spend time discussing the similar joys and challenges of family medicine in our respective countries and healthcare systems, and socializing at an evening barbeque. This was an incredible opportunity to meet my colleagues from nearly every country where family medicine is practiced from the UK to Chile and from Holland to Nepal. What I took away from this (and the entire WONCA conference) is that support and enthusiasm for family medicine is strong—young doctors see value in advancing primary care and are energized to fight for increased primary care spending, to improve access to care for our patients, and to advocate for a seat at the table with other specialists and policy makers in our nations. The more we talked, the more I realized while family medicine might look slightly different in each country, the challenges we face in advancing our specialty and advocating for our patients are incredibly similar. As always, the takeaway was clear: we are stronger when we work together and share our successes.

I hope you too will join us in this work by connecting with your family medicine colleagues around the world. For any students, residents, or new physicians who are 5 years or less out from residency, I invite you to join Polaris at https://www.wonca.net/groups/YoungDoctorsMovements/JoinYDM.aspx (or simply email me at lauren.c.bull@ucdenver.edu). Membership is free and we would love to have your involvement and support. For those further along in your career, I hope you will become a WONCA member and support the YDM’s that are shaping the future of family medicine. The world is a small place and becoming smaller every day. Through these connections we can ensure that primary care and family medicine continue to be valued and advanced across the globe.
Members

ACTIVE MEMBERS CONTINUED
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