ANNOUNCING THE 2019 CAFP AWARD WINNERS

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Vision Statement:
Thriving Family Physicians creating a healthier Colorado.

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

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Having scored high on the Maslach Burnout Inventory whenever I have taken it in the last several years, I have often tried different activities to promote self-awareness and mindfulness. And I must admit that I usually do well for a week or two, but the habit never seems to stick. So I took the opportunity of an overdue deadline to write this (my last president’s letter) as a chance to share an act of mindfulness in a new way for me: gratitude published publicly!

- I am thankful for my family. My wife has supported my volunteer work and crazy hours (Medicine and OB inpatient call make a M-F 8-5 job an unusual concept) while I attempt to find my career path at my FQHC. Not to mention med school and residency…I couldn’t have done it without her. My 6-year-old son has helped me see excitement in nearly everything, and my 4-year-old daughter teaches me about love and stubbornness. I love you all.

- I am thankful for the relationships I have built with my patients, some whom I have cared for since I left residency. I value the insight into their lives that I have gained over the years, helping me to better understand their perspectives, struggles and joys. I am honored by the trust they place in me to listen and advise, and am humbled by their understanding and compassion towards me if I am wrong.

- I am thankful for my work family at Clinica Family Health. The fellow family physicians, obstetricians, NPs, PAs (and one lone pediatrician who retires this month!) are a constant source of support, consultation, and even commiseration (because sometimes that is what is needed). I am awed as well by the sense of mission to care for the underserved and compassion for our patients that our staff comes to work with every day.

- I am thankful for the life opportunities that being a family physician has afforded me. I am grateful for the comfortable roof over my head, food to eat, health and health insurance, financial stability, and the time and money to travel with my family. I think about these things nearly daily in reflection on the great challenges my patients face every day; it is why I continue to practice in my setting.

- I am thankful for the big picture thinkers, aspirational leaders, and overall do-gooders whom I have worked with at the CAFP. It has been a great learning experience, and I am certain that those who follow me will continue advancing family medicine and the health of our communities. I am grateful for the opportunity to stretch (out of) my comfort zone while leading our organization this year.

Physician wellbeing and burnout have roots both in the individual and the system, and we must address both aspects if we hope to fix this problem. Please know that you can talk with your colleagues if you are struggling; if I have learned one thing it is that family physicians are here to support each other! Also please consider investigating the resources available from AAFP’s Physician Health First initiative: https://www.aafp.org/membership/benefits/physician-health-first.html.

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COLORADO ACADEMY OF FAMILY PHYSICIANS
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Advocacy
CEO’S REPORT

Spring is for Recognizing Colorado Family Medicine Leaders

Spring is always an exciting time at the CAFP because we get to recognize so many excellent family medicine leaders.

First, we are very excited to announce our 2019 CAFP Awards Winners:

Family Physician of the Year:
Glen Kotz, MD, Basalt

Family Medicine Teacher of the Year:
Kathryn Boyd-Trull, MD, CU

Family Medicine Resident of the Year:
Claire Bovet, MD, St. Joseph

You can learn more about each of the winners starting on page 34. We had excellent nominees for each of the awards, and it is a great reminder that we have many wonderful family medicine physicians, teachers and residents in our state.

We are also pleased to announce the Board Members selected as part of our 2019 elections. Our membership has chosen the following physicians:

Jen Feng, MD
Kyle Leggot, MD
Corey Lyon, DO
Lindsey Pearson, MD

Dr. Lyon served a previous term on our Board and we are excited to welcome him back. Drs. Leggot and Pearson previously served as resident members, and we are looking forward to their insights as they continue on as active practicing physicians. Dr. Feng is a new addition to the Board, and we look forward to her fresh views as we continue our work.

Thank you to all members who voted in the elections. It remains one of the best ways you can have a say in the work our organization does!

Finally, we will be recognizing all of our award winners and board members, as well as members who are receiving their Fellowship, on Friday, May 3 as part of our Annual Summit that runs from May 2-5, 2019 in Fort Collins. You can see a full agenda for the Summit on page 18. We are looking forward to welcoming many of you there.

Wishing you a warm and rejuvenating Spring.

Raquel

3 Updates from the January CAFP Board Meeting

1. CAFP is pleased to be taking a very proactive role at the Capitol this year, running 3 bills. The first bill will extend the Rural Preceptor Tax Credit, the second is designed to continue our work to increase primary care investment, and the third introduces the Colorado Candor Act, a patient-centered alternative to lengthy and costly malpractice lawsuits. More information about all of these efforts will be shared via our magazine and email communications.

2. We are taking steps to measure the diversity of the broader Colorado membership, and recruit board members to ensure leadership reflects this diversity. Watch for more information on this initiative in the future.

3. Registration for the CAFP Summit in Fort Collins, happening May 2-5, is open. Learn more and register now at www.coloradoafp.org.
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Healthcare is taking center stage in the legislature this year, but you might also have heard a number of other big issues hitting the headlines. Governor Polis is leading an effort to fund full-day kindergarten at an estimated cost of $220 million, and Senate Democrats are spearheading major reforms of the state’s oil and gas laws. The latter effort caused the Senate to stall in a battle of brinksmanship, when Republicans maneuvered to have a 2,000 page bill read in full on the Senate Floor. The Democrats skirted the move by having three computers read the bill simultaneously, and that move led to Senate Republicans filing a lawsuit asserting a violation of the Colorado Constitution. The results of that suit are pending, but we have plenty of healthcare business still on the docket.

CAFP is running three bills this year to advance family medicine:

- **Increasing Investment in Primary Care**: Representatives Froelich and Caraveo (a pediatrician) introduced House Bill 1233, which aims to double the statewide investment in primary to 15% of the healthcare dollar. The bill would in a significant way reorient healthcare in the state toward fully-resourced primary care, supporting our physicians, the Patient-Centered Medical Home, and of course access to advanced primary care for Colorado patients. The bill has a ways to go through the legislative process, but we have the support of the specialties and consumers, and we believe the Governor’s office is likely to support in the coming days.

- **Colorado Candor Act**: CAFP is leading legislation to provide an alternative to malpractice litigation, and the Colorado Trial Lawyers Association is jointly supporting the bill with CAFP. The Candor Act will provide legal protections for confidential communications between a physician and a patient who experiences an unanticipated health care outcome. When a physician opts to engage in the Candor process, it can ensure swift resolution without years of being tied up in court. The process will foster an environment of open communication between patients and their doctors without the threat of litigation. And if appropriate, it can result in an offer of compensation to the patient.

- **Rural Workforce Preceptor Tax Credit**: CAFP is working to extend the existing Rural Preceptor Tax Credit, worth $1,000 annually for rural physicians who precept medical students. HB-1088 received unanimous support from the House Rural Affairs Committee, and it has since made it through the Finance Committee. This issue is a lesson in advocacy as we nearly lost the bill in Senate Finance over concerns from legislators that the credit was ineffective and directed to preceptors rather than students. After persuading House Finance to delay the bill, we launched a CAFP SpeakOut and brought in physicians and students to testify about the importance of gaining rural experience while in medical school. Students with a longitudinal experience in rural medicine are far more likely to return to practice in a rural area than students who only live and train in an urban setting for the 7+ years of medical training.

**Medical Practice Act**

The Medical Practice Act must be reauthorized this session to continue the regulation of medicine in Colorado, ensuring integrity in the licensure process, quality care, and public safety. Senate Bill 193 continues the Act. Importantly, CAFP testified to ensure the introduced bill removed a troubling provision. The proposed provision would have allowed the Colorado Medical Board to take disciplinary action against a physician who has been accused, but not convicted, of committing a criminal act. The Medical Board already has authority to protect patients in cases of an imminent threat, and the provision would have jeopardized physicians’ right to due process. CAFP supports SB-193 as introduced and will be monitoring it closely throughout the legislative process.

**Health Care Coverage and Costs**

The affordability of healthcare and health insurance remains a top issue for Coloradans. The Medicaid Buy-In or public option bill, HB-1004, is nearing the finish line. It passed the House of Representatives with bipartisan support, and it cleared its first hurdle in the Senate, getting through Health Committee on a 3-2 partisan vote. The bill requires the State Medicaid Department to develop a proposal outlining the design, costs, benefits, and implementation of a state option for health care coverage utilizing Medicaid infrastructure. While the details of the coverage offering and reimbursements are to be determined, the aim is to offer a more affordable insurance option for Coloradans that can compete with – but not drive out – private insurance plans around the state. CAFP supports
the bill with the understanding that reimbursement rates would need to be in parity with Medicare, at a minimum.

**Public Health**

- A still-to-be introduced bill aims to strengthen vaccine laws to include tighter personal belief exemptions, patient education regarding the risks of not vaccinating, and adding the full list of ACIP-recommended vaccines to school immunization requirements.

- CAFP is supporting two bills addressing nicotine and youth vaping. HB-1033 would allow local governments to regulate and tax nicotine products without incurring the current state penalty for doing so. Currently, local governments will lose state tobacco tax revenues for even attempting to regulate tobacco products. HB-1076 adds vaping to the Clean Indoor Air Act to protect the public from harmful secondhand vapor.

- The state’s Long Acting Reversible Contraception (LARC) program has reduced unanticipated pregnancy and abortions by over 50%. The state funding for this program is always a budget priority for CAFP, but the added impacts of Trump Administration rules restricting Title X clinic funding makes this budget issue a big one this year. Proponents for the LARC program are advocating for an additional $3.5 million that would backfill federal funds if lost, or expand the program if federal funding is maintained.

- Medical Marijuana remains a perennial issue, and two bills CAFP has opposed for years are likely to pass. HB-1028 would allow medical marijuana for the treatment of autism, and SB-013 would allow it for the treatment of conditions for which an opiate could be used. CAFP, the American Academy of Pediatrics-Colorado Chapter and others were able to secure a veto from Governor Hickenlooper of last year’s bill regarding marijuana for treatment of autism, but it is highly unlikely Governor Polis will veto this year.

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.
COLORADO FAMILY PHYSICIAN

Advocacy

CAFP ON THE GO

CAFP PRESIDENT-ELECT JOHN CAWLEY, MD, ATTENDED A GATHERING WITH THE COLORADO CHAMBER OF COMMERCE, "COLORADO IN 3D."

DR. MARK DEUTCHMAN AND ALEC KERINS, A 2ND YEAR MEDICAL STUDENT WHO ROTATED IN LAKE CITY, TESTIFYING IN SUPPORT OF CAFP’S BILL TO EXTEND THE RURAL PRECEPTOR TAX CREDIT FOR PRIMARY CARE PROVIDERS WHO PRECEPT MEDICAL STUDENTS.

MONICA MORRIS, DO, AND ZACH WACHTL, MD, WERE RECOGNIZED AT CAFP’S MARCH BOARD MEETING FOR THEIR SERVICE AS BOARD CHAIR AND PRESIDENT, RESPECTIVELY.

VIRGINIA RICHEY, DO, WAS RECOGNIZED AT CAFP’S MARCH BOARD MEETING FOR HER SERVICE AS A BOARD MEMBER.

CAFP BOARD MEMBER MELISSA DEVALON, MD, TESTIFYING ON THE MEDICAL PRACTICE ACT IN COLORADO.

CAFP’S PRESIDENT-ELECT JOHN CAWLEY, MD, AND DEPUTY CEO FOR POLICY AND EXTERNAL RELATIONS RYAN BIEHLE PRESENTED ON COLORADO’S PRIMARY CARE INVESTMENT INITIATIVE AT AAFP’S MULTI-STATE CONFERENCE.

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CHRIS KOLLER, OF THE MILBANK MEMORIAL FUND, PREVIOUSLY THE INSURANCE COMMISSIONER FOR THE STATE OF RHODE ISLAND, JOINED THE CAFP TO DISCUSS PRIMARY CARE INVESTMENT WITH LEGISLATORS AT THE STATE CAPITOL.

BENJAMIN KUPERSMIT, OF KUPERSMIT RESEARCH, PRESENTED TO THE CAFP BOARD OF DIRECTORS IN MARCH ON THE RESULTS OF CAFP’S RECENT ADMINISTRATIVE BURDEN SURVEY.

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Who Does the Health Care System Care About?

By Chris Lyttle, Senior Policy Manager, Center for Health Progress

My earliest health care system memory is going to my family doctor’s office. Dr. Brown was one of the few black physicians in my hometown who owned their own practice. Every employee, from the intake specialists on the frontline to the nurses scribbling notes between appointments, were from the same neighborhoods and reflected the demographics of the people they served. I was a patient for north of 20 years and I never left feeling unheard, unseen, or dismissed. It wasn’t until I moved away from home and needed to find new medical providers that I learned how unusual Dr. Brown’s practice was.

After about a year of “adulting,” I began to have intense panic attacks and depressive episodes so severe I couldn’t pull myself out of bed for days at a time. In a society that often associates mental illness with instability and black bodies with violence, I feared being seen as a threat more than losing sleep and connection to others. I tried keeping it to myself and navigating the valleys and peaks through willpower alone, but as my condition worsened and the darkness got darker, it became apparent that I could no longer function this way. Yes, the stigma was (is) real, but the darkness was more real. So, I decided to learn more about my condition and how to get treated.

At that point, I had no reason to believe that my health care experience would be any less supportive than those of my childhood, but that changed quickly. One therapist made it a point to express his shock, mid-session, that I attended college without a basketball scholarship, before insisting I reconsider my goal to become a CEO, because I will struggle to survive on my own. A nurse practitioner refused to consider changing the medication I loathed, even after it began to leave me too foggy to focus at work or in class, because she thought it couldn’t be as bad as I claimed and that I should care more about being “stable.” Unlike countless other black men with mental illnesses (which often goes undiagnosed, let alone treated1), I was able to advocate for myself to get the appropriate care I needed. However, my path to good health led me through a thorny underbrush of dismissive indifference that left me with a suspicion that maybe our health care system doesn’t care about black people.

Good intentions aside, there is no shortage of peer-reviewed research demonstrating the enduring legacy of racism in health care and confirming that my experience is neither unique nor limited to behavioral health care for many people of color. One of the clearest examples of our collective failure to value people of color is the alarming mortality rates of black mothers and infants across the country. Studies have shown that African American women are three to four times more likely to die giving birth than similarly-situated white women, and that infants born to African American mothers die at twice the rate of infants born to white mothers2. African American women who received prenatal care still lost their babies at significantly higher rates than white women who received no prenatal care3. While the United States overall has relatively high infant and maternal mortality rates, rates for white mothers and infants are comparable to other wealthy countries while rates for African American mothers are similar to less-developed countries.

Racism continues to have an outsized impact on how much people of color will earn, on where they will live, on their access to care3, and the quality of care they receive when they do have access4. It continues to shape our health care system, just as it has shaped every other institution in our country, and it’s a darkness we must confront or it will drag us all down with it. If you’re ready to fight back, say it with me: black lives matter. Op-eds are submitted by CAFP members and others in the health-care community. They do not necessarily reflect the opinions or policies of the CAFP or AAFP. If you are interested in submitting an op-ed please contact Lynlee Espeseth at lynlee@coloradoafp.org.

1 “Black & African American Communities and Mental Health.” Mental Health America, www.mentalhealthamerica.net/african-american-mental-health
The 2018 AAFP Congress of Delegates was held in New Orleans, LA from October 7th through October 10th. The biggest news from our state was the candidacy of Dr. John Bender for AAFP President-elect. Dr. Bender had a tremendous team present at the Congress, anchored by his loyal and energetic clinic staff and family. Dr. Bender gave a great speech and did well in the question and answer section. However, in the end, the election tilted towards the Ohio candidate of Dr. Gary LeRoy, who was elected as President-elect. Dr. Bender’s concession speech included strong words of support for Dr. LeRoy, as he considers Gary a great friend, and he believes that the Academy will be well represented. He also threw out kind words for Dr. Carl Olden, the other candidate in the race, and his other partner on the board for the last 3 years.

Other elected leaders at the Congress included:

Speaker of the Congress -- Alan Schwartzstein, M.D., of Oregon, Wis.

Vice Speaker -- Russell Kohl, M.D., of Stilwell, Kan.


New physician Board member -- LaTasha Seliby Perkins, M.D., of Alexandria, Va.

Resident Board member -- Michelle Byrne, M.D., M.P.H., of Chicago

Student Board member -- Chandler Stisher, of Brownsboro, Ala.

During the first few days of the Congress, individual resolutions were discussed in the reference committees, reviewing items that were later discussed and acted upon by the overall congress. The actions during the Congress were reported every day by the AAFP News. For complete information about the actions at the Congress, go to www.aafp.org, and search under AAFP News, 2018 Congress of Delegates.

Highlights include:

Long discussions about medical aid in dying, with the delegates approving a policy of “engaged neutrality” toward the subject. Academy leadership released a statement on the topic.

“The action taken today allows the AAFP to advocate for engaged neutrality on this subject at future AMA House of Delegates meetings,” said AAFP President Michael Munger, M.D., of Overland Park, Kan. “Through our ongoing and continuous relationship with our patients, family physicians are well-positioned to counsel patients on end-of-life care, and we are engaged in creating change in the best interest of our patients.”

Another resolution delegates adopted during the business session called on the AAFP to create a policy opposing segregation of patient care within the health care system and health care institutions by race, insurance status or other demographics. Additionally, this resolution tasked the Academy to develop materials and provide education through the EveryONE Project to increase awareness about how racism is manifested through institutional policies and how segregated care within the health care system is a cause of racial disparities in health outcomes.

Resolutions around healthcare reform and single payer options were discussed and debated. A resolution introduced by the New York State AFP urged the AAFP to consider a single-payer national health system as a viable option and to educate family physicians about such a system. Many attendees spoke in favor of the resolution. Daniel Neghassi, M.D., of New York, N.Y., expressed concern for his patients.

“Seeing people who can’t access the care they need is really frustrating as a family doctor, and having insurance is not enough if people can’t afford copays and deductibles,” he said.

Neghassi argued that the current system is too complicated and wastes too much time.

“Imagine if we could spend that time counseling patients and listening.”

The Congress adopted a substitute resolution that asked that AAFP to make available, for educational purposes and policy programming, the data and conclusions contained in two reports from the AAFP Board of Directors: Board Report F to the 2017 Congress on a single-payer health care system and Board Report G to the 2018 Congress on health care for all.

Some of the other biggest news at the Congress was the American Board of Family Medicine’s announcement around its goal to pilot a longitudinal assessment option for recertification as an alternative to the 10 year “high stakes exam.” The new option is available and open for diplomates who are current with their continuous certification requirements and are due to take the examination in 2019. Based on the
CKSA, the longitudinal assessment pathway will deliver 25 questions online each quarter to diplomates who choose to participate. Those CAFP members who are not yet aware of this exciting option should go to the ABFM’s webpage at www.theabfm.org for the most current information on this option.

A resolution introduced by the Colorado and Arizona chapters dealt with the issue of all-payer claims databases (APCD) and their application to family physicians and their practices.

Colorado alternate delegate Tamaan Osbourne-Roberts, M.D., of Denver testified that, “I am clearly going to be a fan of big health data, not because it’s cool, not because it gives me a job, but because it has the power to revolutionize what we do. Claims data, when it comes to quality metrics and payment, in looking at those in big huge population health ways, is incredibly powerful, and incredibly powerful for family medicine. The one thing that continues to be really apparent is that whenever you look at primary care relative to our ‘partialist’ colleagues, you really begin to see that transparency helps physicians in general. But primary care physicians, in particular, stand out above the pack as a solution to a variety of different problems.”

In large part due to Dr. Osborne-Roberts’ testimony, the Congress voted to adopt the resolution, which directs the AAFP to study APCDs and their application to family physicians, including how they can assist family physicians in clinical practice, demonstrate the value of family medicine, and help to quantify the overall current spend on family medicine.

Finally, as this year has evolved, it has become even more clear that the actions of our CAFP delegation have had a profound influence on the AAFP’s policy and structure as a whole. In 2016 the CAFP introduced a resolution on health equity and diversity and called for the AAFP to formally establish a center for diversity at the AAFP, which was endorsed by the Congress. In February 2019, an article in Family Medicine (vol. 51, No. 2) commented on the launch of the AAFP Center for Diversity and Health Equity, stating “Prompted in part by a resolution passed at the AAFP 2016 Congress of Delegates, the CDHE was created to ‘create a culture of health equity’ through workforce development, multi-sector collaboration, research and advocacy. The creation ... reaffirmed the AAFP Board of Directors’ commitment to assuming a leadership role in addressing adverse social determinates of health and support health equity.”

A good idea borne out of passion and a commitment to your patients and your profession can grow as a resolution through the Congress into a movement that influences the AAFP for years to come. The CAFP and our delegation welcome your thoughts and ideas on those topics most important to you. We will work on your behalf to turn those ideas into action, so please send them to us as we prepare for the 2019 Congress of Delegates.

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A GOOD IDEA BORNE OUT OF PASSION AND A COMMITMENT TO YOUR PATIENTS AND YOUR PROFESSION CAN GROW AS A RESOLUTION THROUGH THE CONGRESS INTO A MOVEMENT THAT INFLUENCES THE AAFP FOR YEARS TO COME.

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SCENARIO 1: A PCP sees a patient who has just returned from Southeast Asia and is suffering from severe diarrhea. Later that day in the hospital cafeteria, the PCP bumps into a colleague who is an infectious disease specialist. The PCP asks his colleague “what is best to treat traveler’s diarrhea from Southeast Asia for a patient with a sulfa allergy?”

SCENARIO 2: A midwife calls an obstetrician (who she doesn’t know) and asks her to look at a patient’s fetal monitoring strip. It’s later in the evening and the midwife doesn’t want the obstetrician to see the patient and insists on just getting her advice.

Which of the above scenarios may increase liability risk for the physician who is being asked for his or her advice? Both of these situations are examples of informal consults, also referred to as “curbside consults.” But, there is a key distinction: one of the scenarios represents asking a colleague for more general information, while the other is asking for very specific advice on a patient.

In simple terms, a curbside consult is an informal solicitation of another physician’s advice or opinion. It is generally characterized by the following:

- Typically limited in scope.
- The physician being consulted doesn’t review the patient’s chart, talk to the patient, or examine the patient.
- Often times, it involves physician colleagues who know each other.
- The physician being consulted does not charge for his or her service or have a financial relationship for the consultation.
- The consults can occur on the phone, in person, or via email.

IS THERE A PHYSICIAN-PATIENT RELATIONSHIP?

This is the core question in terms of liability with curbside consults. Here are some factors that are examined in order to answer this:

- Does the consultant physician have a formal contract or agreement with the treating physician or the hospital/facility where the treating physician works?
- Is there a financial relationship (i.e., is your group paid to be on call or do you bill to answer the question)? Any financial remuneration is a key factor in establishing a physician-patient relationship, and if a court finds a monetary relationship with the consultant, there will likely be liability.
- How complex is the advice being sought? Low-risk consults would include general informational requests, no request for a diagnosis or testing, and non-specific advice. A question such as “how long should you be off of an anti-platelet drug pre-scope?” would be considered a simple, informational question. Whereas “when would you do surgery on this patient?” would require more details than a simple phone discussion.
- How much is the asking physician relying on the advice of the physician who is consulted? An “implied” physician-patient relationship may be established when a physician provides advice that changes a patient’s treatment plan, even if it is via another medical provider.
- An implied physician-patient relationship does exist if you are covering a patient for a colleague. This also applies for physicians who are supervising allied health professionals when the physician is responsible for making a patient care decision.

The more a physician being consulted provides advice specific to a patient, like ordering tests or adjusting medication, the more likely the physician may be exposed to liability or may be viewed as part of the care team.

CLARITY IN COMMUNICATION IS IMPORTANT

The requesting provider should be very clear and keep questions concise and general. They should also ask themselves if an official consult is warranted. Make sure you provide adequate information that is not colored by the answer you want. If you are asking for specific advice, offer the consultant a chance to officially see the patient.

On the part of the informal consultant, clarify whether your discussion is going to be documented in the medical record. If you believe the case warrants you officially seeing the patient, then say so. If the requestor is going to document your discussion, review the wording that they will be using.
Dear Colorado Family Doctors,

Our SNOCAP team is busy working on many projects throughout the state with the goal of together improving the health of our patients. We’re always learning about different topics, digging into new literature, and connecting up with practices state-wide.

Recently we’ve been working on many projects that have a rural focus. Did you know SNOCAP has two networks that focus specifically on practices in rural parts of the state? And that we have a third that has a strong focus on the San Luis Valley?

The High Plains Research Network (HPRN) has been working for over 20 years in the eastern plains to tackle issues specific to their rural needs. HPRN even has three local staff members that span the eastern third of the state to provide “boots on the ground” support for practices and patients. HPRN also has a very active Community Advisory Council (C.A.C.) that provides local expertise through which all HPRN-related work is run through.

SNOCAP’s newest network is Engaged in Achieving Change in Health Network (PEACHnet) which focuses on the Western Slope. PEACHnet’s director, Anne Nederveld, is busy making new connections. PEACHnet has already engaged practices and patients in multiple types of projects. Practices have participated in card studies, which are a quick, low-burden method to gather feedback in a clinical setting from clinicians and patients about a particular health topic. Patients and other local community members have also partnered with PEACHnet to develop locally relevant, actionable messages and materials around Human papillomavirus (HPV) using the Boot Camp Translation process. Are you a practice located on the Western Slope and want to get more involved in the research world? Reach out to Anne: andrea.nederveld@ucdenver.edu

Lastly, the Colorado Research Network (CaReNet), which focuses on Federally Qualified Health Centers and Family Medicine residency programs, has a large practice population active in the San Luis Valley (SLV). CaReNet has been active in the SLV working with practices new and old on a variety of topics. This region of the state has participated in many groups recently, so CaReNet is fortunate to have strong connections and partnerships with practices large and small.

We want to take this opportunity to thank those of you who work in or with rural practices, congratulate those that have partnered with SNOCAP in these areas, and celebrate work that is occurring across all regions of Colorado.

All our best to you in 2019-

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

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**Join Colorado’s most dynamic physician team!**

New West Physicians is looking for a Full Spectrum Family Practice/Obstetrics physician to join our Broomfield practice. The largest primary care medical group on the Front Range, New West Physicians cares for 200,000 patients, offering continuity of care for the whole family, through all phases of life.

- Independent of hospitals and health plans, we make patient-centered decisions
- Our physicians share an innovative spirit and dedication to high quality healthcare
- Enjoy the sophisticated infrastructure necessary for effective Population Health Management
- Spend your time caring for patients, unburdened from the business of running a practice
- Competitive compensation and benefits program

Come join our award-winning team!  
Please email your CV directly to: resume@nwphysicians.com
Eating practices and emphasis on weight and body appearance are a major focus of our society today. Obesity rates in children, adolescents, and adults have been on the rise over the past several decades and the importance of diet on physical health has become an essential topic for health care providers to address with families. At the same time the prevalence of eating disorders has steadily been increasing. Currently the lifetime prevalence of anorexia nervosa is between .5 to 2% of the population with a peak age onset of 13 to 18 years. Anorexia nervosa also has a mortality rate of 5 to 6%, which is the highest of any psychological disorder. Bulimia Nervosa has a lifetime prevalence rate of .9 to 3% with a peak age of onset between 16 to 17 years. Bulimia nervosa mortality rates are estimated to be 2% with the risk of suicide and suicide attempts being much higher than other psychological disorders. It is also important to recognize that 5 to 10% of diagnosed eating disorders occur among males, a group that historically has been overlooked when screening for disordered eating attitudes and behavior. Taken together these numbers point to the vital role that primary care providers serve in screening for and addressing disordered eating and identifying eating disorders.

**Screening for Eating Disorders**

Eating disorders have a major impact on child and adolescent development and affect every organ system in the body. Therefore, it is important for primary care providers to recognize the psychological and physical impact of disordered eating that can occur at any weight. This is especially critical given early identification of eating disorders results in significantly improved outcomes and prognosis. An eating disorder could be present in any patient who presents with weight lost, unexplained stunting of growth or pubertal delay, restriction of certain types of food, or sudden and/or unexpected allegiance to vegetarianism or vegan diets. Additionally, recurrent vomiting, excessive exercise, trouble gaining weight, or body image concerns are all hallmark symptoms of eating disorders. As a starting point it is recommended that primary care providers adopt a standard screening process into wellness exams to screen for these symptoms. The **SCOFF** is a standardized set of screening questions that providers are encouraged to use and are provided below:

1. Do you make yourself *Sick* because you feel uncomfortably *full*?
2. Do you worry you have lost *Control* over how much you *eat*?
3. Have you recently lost more than *One* stone (14 lb/6.3 kg) in a 3-month period?
4. Do you believe yourself to be *Fat* when others say you are too *thin*?
5. Would you say that *Food* dominates your life?

One point for every “yes”; a score of 2 indicates a likely case of anorexia nervosa or bulimia.

**Assessing Severity**

When a patient is identified as at risk during screening it is necessary to complete further assessment to determine next steps for treatment. It is important to gather information from multiple data points to determine severity of symptoms as a majority of patients presenting with significant eating disordered behavior are likely to deny or rationalize their symptoms. Additionally, family members can unknowingly rationalize eating disorder symptoms or be unaware of the extent of symptom severity. Patients and parents should be interviewed separately and asked about historical and current eating practices, exercise habits, ideal weight beliefs, trauma, substance use, and family psychiatric history. Additionally, a record review of past and current medical and nutritional status is necessary to identify potential problems and may illuminate discrepancies if a patient is denying symptoms. If primary care providers are monitoring symptoms over time it is recommended that patients complete weight check ins wearing hospital gowns as some patients will hide objects in their clothing to increase their weight. After additional assessment is completed patients who are demonstrating impairment in functioning (e.g. academic, relational, adaptive skills) and/or have significant medical concerns should be referred for
specialized assessment to determine the appropriate level of care.

**Treatment Recommendations**

When possible, it is recommended that a patient be treated on an outpatient basis for eating disorder symptoms; however, there are times when more intensive treatment is needed which may include intensive outpatient, partial hospitalization, inpatient hospitalization, or residential treatment. Programs that utilize Family-Based Treatment (sometimes referred to as Maudsley method) should be prioritized as this approach has strong empirical support for the successful treatment of eating disorders.

**Referral Resources**

Children’s Hospital Colorado Eating Disorder Treatment Program is a valuable resource for providers in Colorado and surrounding regions. The program has been operating for more than 25 years and offers a comprehensive evaluation to determine an appropriate treatment plan based on individual patient needs. The program offers services across all levels of care (outpatient, intensive outpatient, day treatment, and inpatient) and utilizes Family Based Therapy. These services are available for children, adolescents, and young adults through age 21.

If providers are concerned that a comprehensive evaluation and treatment plan for eating disorder concerns is needed they can refer families to schedule an evaluation appointment with the Eating Disorder Program by calling 720-777-6200. Providers and families can also learn more about Children Hospital Colorado’s Eating Disorder Treatment Program by visiting the program’s website:


Finally, it can be helpful to provide families with additional resources at the national level which include:

- National Association of Anorexia Nervosa & Associated Disorders: http://www.anad.org/
- The Academy of Eating Disorders: https://www.aedweb.org/home

For additional educational updates for primary care providers on this mental health topic and others, check out Charting Pediatrics Podcast produced by Children's Hospital Colorado, available on iTunes, Spotify and Google Play.
THURSDAY, MAY 2

1:00 PM
AAFP Physician Health First Presentation
_Nicole Eull, PsyD_

Knowledge Self-Assessment: Women’s Health
_Nida Awadallah, MD_

BLS Skill Verification (1-2 PM)
_Kristin Paston_

4:00 PM
ACLS Course (2:15 - 3:30 PM)
_Kristin Paston_

5:00 PM
PALS Skill Verification (3:45 - 5:00 PM)
_Kristin Paston_

5:30 PM
“Place Your Bets” Welcome Reception

6:00 PM
Opioids- The Pain That Won’t Go Away
_Al Alan Lembitz, MD_

7:00 PM
Dinner on Your Own
FRIDAY, MAY 3

6:45 AM  Breakfast

7:45 AM  Conference Welcome & Announcements (Begins at 7:55 AM)

8:00 AM  Geriatrics Cluster Session
          Robin Yasui, MD

9:00 AM  Examining the Role of Family Physicians in the Early Recognition and Management of Chronic Heart Failure
          Randy Wexler, MD

10:00 AM “Horses & Hats” Expo Hall Derby Brunch

11:35 AM  Keynote Presentation: Reaching for Hope
           Sue Klebold

12:35 AM  Lunch: Awards Ceremony, Convocation, Board Installation, AAFP Update

2:05 PM  Exhibit Hall Break

3:05 PM  infoPOEMS
          Henry Barry, MD, Gary Ferenchick, MD, John Hickner, MD

5:40 PM
FRIDAY, MAY 3 CONTINUED

5:45 PM
Exhibit Hall Happy Hour

6:15 PM
Dine-Out Groups

END

SATURDAY, MAY 4

6:45 AM
Breakfast

7:45 AM
Conference Announcements (Begins at 7:55 AM)

infoPOEMS
Henry Barry, MD, Gary Ferenchick, MD, John Hickner, MD

8:00 AM
Break

infoPOEMS
Henry Barry, MD, Gary Ferenchick, MD, John Hickner, MD

10:00 AM
All Member Business Lunch, Legislative Update & ABFM Update

12:15 PM
Student & Resident Track: Box Lunch & IUD Procedure Lab
Hayley Marcus, MD

2:00 PM
Marijuana Panel Discussion
Speakers TBD

3:00 PM
Student & Resident Track: Financial Planning
Joe Matelich

Speakers TBD
SATURDAY, MAY 4 CONTINUED

3:00 PM
COPIC Talk: Doctor, We Have Received a Report of Misconduct-Responding in the #MeToo Era
Michael Victoroff, MD

4:00 PM
Poster Session & Derby Watch Party

6:30 PM
Dine-Out Groups

END

SUNDAY, MAY 5

6:45 AM
Breakfast & Resolution Writing Workshop
TBD

7:45 AM
Conference Announcements (Begins at 7:55 AM)

8:00 AM
Administrative Burden
Sarah Paraday & Ariana Fuentes

9:00 AM
Updates in Adult Immunization
Brian King, PhD, MPH

Student & Resident Track: Critical Care/Wilderness Medicine
TBD

10:00 AM
Break

10:15 AM
Pediatric Anxiety & Depression
Catherine Wolcott, MD & Kimberley Kelsay, MD

11:15 AM
Dermatology Showcase
TBD

12:15 PM
Annual Summit Closes

*TBD
*Presented by AbbVie
2019 Adult Vaccine Schedule Released: ACIP Highlights Influenza, Hepatitis A, Hepatitis B

In February the Advisory Committee on Immunization Practices (ACIP) released its 2019 immunization schedule for adults >19 years. Highlights include key changes for influenza, hepatitis B virus (HBV), and hepatitis A virus (HAV) (https://tinyurl.com/yahgl7l5).

Here are a few key points:

- **Influenza**: any licensed, age-, health-appropriate vaccine can be used. Live attenuated influenza vaccine (LAIV, FluMist Quadrivalent) is an option for adults aged <49 years (except persons with immunocompromising conditions or patients with a history of Guillain-Barré <6 weeks after previous influenza vaccine).
- **HBV**: Single-antigen recombinant HBV vaccine with a novel cytosine-phosphate-guanine 10-18 oligodeoxynucleotide adjuvant (Heplisav-B) is recommended for HBV prevention in adults aged >18 years. Routine administration is 2 doses, >4 weeks apart. Substitution in a 3-dose series with a different vaccine is acceptable, but vaccine from same manufacturer should be used to complete series when feasible. (NOTE: GoodRx lists 2 shots of Heplisav-B at about $470 and 3 shots of Energix-B at about $195 in the Colorado Springs area).
- **HAV**: homelessness is a new indication for routine, 2-dose single-antigen HAV vaccine (Havrix) or 3-dose combined HAV, HBV vaccine (Twinrix). Any not at-risk person may be vaccinated.

What is the Effectiveness of Recombinant Zoster Vaccine Compared with the Live Vaccine for the Prevention of Shingles?

According to American Family Physician (tinyurl.com/yc5n6nza), recombinant zoster vaccine (Shingrix) will prevent shingles in 96 percent of persons 50 to 59 years of age, 97 percent of persons 60 to 69 years of age, and 91 percent of persons 70 years and older for at least three years (number needed to treat = 33). It is 91 percent effective at preventing postherpetic neuralgia in patients 50 to 69 years of age and 89 percent effective in those 70 years and older. In comparison, zoster vaccine live (Zostavax) is only 51 percent effective in preventing shingles and 67 percent effective in preventing postherpetic neuralgia.

This Year is a Bad One for Measles

Literally the day we went to press (March 27), a New York county announced banning all unvaccinated minors from public places, where more than 10 persons are intended to congregate, including schools, stores, and places of worship, amid a prolonged measles outbreak (tinyurl.com/y3kqeb34). Public health officials want to contain an outbreak of measles.
that began in October; the longest outbreak in the United States since before measles was declared eliminated in 2000; 153 cases have been confirmed including complications including premature labor and hospitalizations. In general, up to one in 20 children infected with measles will contract pneumonia, one in 50 will have encephalitis, while one in 1,000 will die (tinyurl.com/y34hszud).

Although 17,000 vaccinations have been administered in the county during the outbreak, close to 6,000 unvaccinated children will be shut out of schools. As far as we know, such action is unprecedented. But it follows our previous argument in this column that parents who choose to not vaccinate their children do not have the right to allow their children to be unknowing carriers of significant disease into the public.

This year, 314 cases of measles have been reported nationwide in fifteen states according to the CDC. There were 372 cases in 2018, which was more than triple the number the previous year. In addition to New York, there have also been recent outbreaks in Texas, Illinois, and California, and at least 62 cases in Washington/Oregon, where the vast majority of whom are age 10 or younger. Fifty-four (87%) occurred in unvaccinated children, six had unverified immunization status, and one had received only one dose of the MMR vaccine.

Officials say the outbreaks are “boosted by lower-than-normal vaccination rates in what has been called anti-vaccination U.S. ‘hot spots’” (tinyurl.com/y7dkr4qw) and “sparked by travelers who bring the virus back from other countries, as the virus finds fuel in pockets of unvaccinated people” (tinyurl.com/y7w4uc39). “There are large outbreaks in many countries in Europe, as well as a very large outbreak in Israel, and so people need to be protected before they travel,” wrote Dr. Jan Zucker. “The increase in measles cases in Orthodox Jewish communities of Brooklyn demonstrates the importance of getting children vaccinated on time to prevent measles and not put other children at risk,” said New York City Acting Health Commissioner Dr. Oxiris Barbot (tinyurl.com/yc3wwa53).

Another report from the World Health Organization and the CDC (tinyurl.com/y7w4uc39) warns that the number of measles cases around the world, particularly in Latin America, the Ukraine, and Europe, is on the rise, partly fueled by parents refusing to vaccinate their children. In the case of Latin America, the increase in cases “was partly attributable to an economic calamity afflicting Venezuela, where many public health services have stopped or are mired in dysfunction” (tinyurl.com/y7w4uc39).

“Measles is one of the most contagious viruses. It’s so contagious that nine out of ten people will catch measles if they’re in the same room as someone who has measles,” said Dr. Tanya Altmann (tinyurl.com/yc3wwa53). Measles is highly contagious and can linger in the air for up to two hours after an infected person has left the area” (tinyurl.com/y728of63). Dr. Altmann added, “Diseases like measles can travel very quickly across the country. It just takes one person on an airplane to infect 90 percent of unvaccinated people on that airplane and fly to any other state around the country. The take-home message is to make sure your children are up-to-date on vaccines.” (tinyurl.com/yc3wwa53).

An analysis of U.S. measles measured...
outbreaks since 2000 reported “that vaccine refusers are disproportionately represented in early stages of outbreaks.” This means “people who deliberately go unvaccinated can provide the critical mass of susceptible individuals that can help start outbreaks that vaccination would otherwise have prevented.” The article concludes “as the vaccine-refusal rate inches up, public health authorities, physicians, and parents need to pay attention to clustering as well as overall rate of vaccine refusal. Otherwise, we are likely to continue to see more and larger outbreaks” (tinyurl.com/yc3wwa53).

We would certainly encourage the CAFP as part of the Colorado Children’s Immunization Coalition (CCIC) to work with the Colorado legislature to eliminate parental exemptions that potentially put children at risk.

FDA Approves Vaxelis 6-in-1 Vaccine for Children

A report in Becker’s Hospital Review (tinyurl.com/yd2ys2d6) announced the FDA has approved a 6-in-1 intramuscular vaccine (Vaxelis) for use in children aged 6 weeks through <5 years. The 3-dose series protects against diphtheria, tetanus, pertussis, poliomyelitis, hepatitis B, and invasive disease due to Haemophilus influenzae type B. The series should be followed by 1 additional dose of pertussis vaccine.

The obvious benefit is that this combination vaccine will significantly reduce the number of injections necessary. Approval was based on noninferiority demonstrated in two US clinical studies of children randomly assigned to standard vaccination or Vaxelis at age 2, 4, and 6 months; all also received rotavirus and pneumococcal vaccinations.

According to the FDA, Vaxelis should be used with caution in children with

(1) a history of fever ≥4 0.5°C (≥ 105°F), hypotonic-hyposponsive episode, or persistent, inconsolable crying for ≥ 3 hours within 48 hours after pertussis-containing vaccination and

(2) a history of seizures within 3 days after pertussis-containing vaccination.

The FDA also cautions that

(1) Guillain-Barré syndrome risk may be increased if prior case was diagnosed within 6 weeks of tetanus toxoid-containing vaccination,

(2) some premature infants have experienced postvaccination apnea, and

(3) this vaccination may interfere with urine antigen tests for H influenzae type B.

Adverse events may include irritability, crying, injection site pain, somnolence, injection site erythema, decreased appetite, fever, injection site swelling, and vomiting.

Report: More Children Need HPV Vaccination

An additional 14 million teens must receive two doses of the human papillomavirus vaccine between 2018 and 2026 to reach the American Cancer Society’s goal of 80% being up to date by their 13th birthday, researchers reported in the journal Cancer (https://tinyurl.com/y8uylf8e). A study in the Journal of Infectious Diseases (tinyurl.com/ybqrvc9d) reported nearly 43.4% of adolescents ages 13 to 17 have been given complete human papillomavirus vaccination. Researchers also found higher odds of up-to-date HPV vaccination among teens with a single health provider. Pediatrics (tinyurl.com/ydaw8o73) found an 80 percent reduction in human papillomavirus strains among teen girls and young women who received the quadrivalent HPV vaccine. No wonder children whose parents viewed an informational video regarding HPV vaccine risks and benefits had a threefold increased likelihood of receiving HPV vaccination within two weeks (https://tinyurl.com/y9ueqyqn).
Whitney, born nine weeks early, had to be sent home on oxygen.

Her breathing problems persisted and required frequent visits to the emergency room. But ever since her mom took her to National Jewish Health, Whitney’s days have been free of troubles and full of smiles.

At National Jewish Health, the nation’s leading respiratory hospital, our pediatric specialists incorporate the latest research and treatments to help kids get back to being kids. **We breathe science, so you can breathe life.**

Appointments available within 48 hours for Front Range pediatric patients. Physicians can refer patients by calling our physician line at 800.652.9555 or visiting njhealth.org/professionals.

**Breathing Science is Life.**

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**Pediatric conditions we treat include:** Allergies (such as anaphylaxis, drugs, foods, rhinitis, urticaria, and venom), asthma, atopic dermatitis, autoimmune/autoinflammatory diseases, eosinophilic esophagitis, gastroesophageal/laryngopharyngeal reflux, immunodeficiency, pulmonary diseases, recurrent infections, sleep disorders, sinusitis, vasculitis, vocal cord dysfunction, wheezing in infants.

**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.
THE ASTANA DECLARATION: A RENEWED COMMITMENT TO PRIMARY CARE AND WHAT IT MEANS FOR US

In October 2018, the World Health Organization held the Global Conference on Primary Health Care in Astana, Kazakhstan. This conference marked the 40th anniversary of the Alma Ata Declaration with the goal of renewing the commitment of WHO and all its member nations to primary care and universal health coverage. For those who may not be familiar with the Alma Ata Declaration, this was a declaration signed in 1978 at the International Conference on Primary Health Care and emphasized the importance of primary health care in achieving “health for all.” It is considered a major milestone in the field of public health and in advancing primary health care.

However, it is no secret that we have yet to achieve health for all and that the goals outlined in the Alma Ata declaration have not yet been realized. Thus, on this 40th anniversary, a new declaration from Astana was released to reaffirm the commitment of participating nations, WHO, and Unicef to primary health care to achieve universal health coverage, the Sustainable Development Goals, and true “health for all” in all nations around the world.

As we continue to advocate for increased primary health care (PHC) spending in Colorado and the US as a whole, this is a prime moment while the eyes of policy makers and public health officials are on Astana to continue to craft
WE NEED ALL HANDS ON DECK TO STAY INVOLVED, SUPPORT THE WORK OF OUR CAFP LEGISLATIVE TEAM, AND CONTINUE TO ADVOCATE FOR OUR SPECIALTY, INCREASED PHC SPENDING, AND UNIVERSAL HEALTH CARE COVERAGE.

legislation and present data that support this. A Colorado bill (supported by the CAFP) to increase PHC spending last year did not pass committee, but perhaps now with Astana on our side, we can make strides in this fight. Furthermore, Astana inarguably asserts the vital importance of universal health coverage (UHC) in achieving its goals. We should seize upon that commitment to advocate for UHC in our state and our nation. As the world commits to these ideals we need to ensure that our state and nation take the necessary steps to meet them.

Lastly, while Astana makes a bold commitment to primary health care, it leaves Family Medicine out of the mix. Earlier drafts included Family Medicine specifically as a specialty poised to meet these needs, but our specialty was ultimately removed from the declaration. This highlights the important work we need to continue to advocate for Family Medicine on an international stage as a key primary care discipline that is necessary to achieve health for all.

Our work is certainly cut out for us. As Dr. Andrew Bazemore asserted during his plenary session at the AAFP Global Health Summit this fall, the question now is how do we ensure that the road from Astana goes further and makes more progress than that from Alma Ata that fell short? We need all hands on deck to stay involved, support the work of our CAFP legislative team, and continue to advocate for our specialty, increased PHC spending, and universal health care coverage. Only then will we be able to achieve health for all Coloradans and all our patients here and around the world.

To affirm your commitment or that of your organization to primary care, please visit http://apps.who.int/primary-health/commitments/

Family Physician Wanted

Pueblo Community Health Center, an FQHC, located in the family-oriented, multicultural town of Pueblo, CO is seeking full or part-time FPs (with or without OB) to join a comprehensive team of professionals providing out-patient care for the underserved population.

We offer:
- Competitive annual salary (dependent on experience and with additional productivity-based incentive enhancement)
- A comprehensive benefits package including a generous health plan and dental insurance, paid time off, eight clinic holidays, and a 403(B)-retirement plan with match
- Flexible work schedule
- All licensure fees paid
- Relocation assistance
- CME allowance and 40 hours of time off
- Loan repayment opportunities available
- Average daily census per provider is 16-18 patients.
HEALING THE RELATIONSHIP BETWEEN HEALTHCARE AND TECHNOLOGY

AS PHYSICIANS STRUGGLE TO WORK WITH COMPUTERS FOR THE GOOD OF HEALTHCARE, COLORADO FAMILY PHYSICIAN MARC RINGEL, MD, EXPLORES THE WAY TO A BETTER FUTURE IN HIS NEW BOOK.

The relationship between healthcare and technology is a complicated one. Indeed, you may have heard it said that healthcare is the only industry that has been made worse by information technology.

And yet, technology holds many opportunities for physicians and healthcare, if only it can be harnessed for good.

This is the topic of a new book by Colorado family physician Marc Ringel, MD. The book, Digital Healing: People, Information, and Healthcare, explores how the digital revolution has impacted healthcare. It examines both the good and the bad, and explores what a better path forward might look like.

For Dr. Ringel, the potential that technology holds for healthcare is very encouraging. His personal experiences across a long a career in family medicine have been a lesson in what technology can and cannot replace.

Dr. Ringel began his family medicine career in the National Health Service Corps in Yuma, CO. When he reflects on that time, he remarks how overwhelming the need for information in a rural community was. This was during the late 1970’s, when quality medical information just wasn’t easily available. He convinced the Yuma District Hospital to spend $1,000 on a core library of medical reference books (things were cheaper then). He tore out articles from the medical journals he received, categorized and filed them into folders for easy reference. He also depended heavily on the knowledge of other specialists, only a phone call away, when his own information could only take him so far.

As his career progressed, Dr. Ringel joined the faculty of North Colorado Family Medicine, the residency program in Greeley, which focuses on training family physicians to practice in rural communities. His own experience had taught him that a sense of isolation is a significant deterrent for physicians who might otherwise practice in rural areas. If doctors feel they will lack the connection and support they need, convincing them to practice in Colorado’s smaller communities is a lost cause.

That is why Dr. Ringel was excited that his teaching coincided with the early digital revolution. Now there was an opportunity for doctors in rural communities to have easier access to information, to stay better connected with colleagues, and to feel less isolated.

However, it didn’t take long for this newfound wealth of information to turn into a burden for physicians, contributing to the burnout many family physicians face today.

“We are all trying to drink from a firehose,” says Dr. Ringel. “There is so much potential in having this information at our fingertips to help us take care of patients, but we sometimes lose track of the patients themselves in the equation.”
Dr. Ringel acknowledges that computers truly are better than humans at some things, like storing, searching and displaying vast amounts of information and identifying patterns. But there are things that only humans can understand, no matter how advanced artificial intelligence may become in the foreseeable future. Those human factors are where family physicians truly excel, with skills like understanding family, community, language, culture, and ethics, as well as touch and compassion.

Unfortunately, the way technology has been integrated into medical practice isn’t allowing computers to do what they do best while supporting physicians to do what they do best. “There are lots of things computers do well, like tracking and reminders. They can make teamwork easier,” says Dr. Ringel. “They should leave us to do what we do best as human beings. Computerized systems could be helping us to be better listeners, because we don’t have to keep in mind every possible drug interaction or every diagnosis that a symptom could signal while conversing with a patient. Instead, doctors are in front of the computer screen, not looking at their patients. We aren’t always learning the things that the computer can’t, from the answers elicited by the simple, open-ended questions doctors are taught in training to ask, like ‘How are you doing?’”

Digital Healing: People, Information, and Healthcare explores these issues and potential roads forward. Dr. Ringel admits there are no perfect answers.

So, what can be done? Dr. Ringel posits that by looking at the broader picture we can start to understand the root of the problem and the systemic changes that need to happen to heal the relationship between technology and healthcare.

Dr. Ringel suggests that it’s not necessarily the technology that is the issue, but rather the motivations of the systems using the technology. United States healthcare is the costliest and systems using the technology. United corporations and institutions seek to make fragmented improvements with a focus on profits or on narrowly-defined quality targets, the technology is harnessed to serve those ends. The result?

When new studies and recommendations come out, doctors spend more and more time checking off more and more boxes in the EMR. But all this measuring is not leading to better outcomes.

“We are looking at a bunch of little pieces while losing sight of the whole. It’s a reflection of medicine having been taken over by bean counters, not by the people on the frontlines of care. Today doctors spend more time in front of computer monitors than in front of patients. Electronic medical records are cited as the number one cause of the burnout that afflicts nearly half of family physicians,” says Dr. Ringel.

Dr. Ringel also points to a lack of collaboration among healthcare technology companies and their customers. He recently attended the Healthcare Information and Management Systems Society (HIMSS) national meeting and walked a path through the exhibit hall that was 13 miles long. There he saw over a thousand companies chasing billions of dollars. Each of them has a niche. But there is no overall vision, not among the vendors and not among their customers.

Looking to the future, Dr. Ringel feels encouraged by the generation of digital natives entering the healthcare workforce. When he worked with the Department of Family Medicine at the University of Colorado School of Medicine and at the nurse practitioner program at the University of Northern Colorado, supporting students and preceptors in rural communities, he would tell the preceptors that in less than a month their students would show them EMR shortcuts they never thought of. The ability of these students to work with technologies is important. But they also must remember that patients are at the heart of family medicine. When facility with technology is combined with the desire to connect with patients, great things can happen.

“As a doctor, the connection you have with the patient begins the moment you walk in the door. Your presence alone is healing. And of course, medical science really does make people better. Information technology has the potential to supercharge both the science and the healing,” says Dr. Ringel. “As a family doctor I’ve consistently gotten back from patients at least as much as I’ve given. It’s a privilege to be a physician.”

Dr. Marc Ringel’s book can be found on Amazon at: https://www.amazon.com/Digital-Healing-People-Information-Healthcare-ebook/dp/B07DRNF3J5/ref=sr_1_1?keywords=B001K6E2QG&qid=1551976559&rd=1&s=gateway&sr=8-1

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Fact:
Knowing if you have HPV—especially the most dangerous strains, HPV types 16 and 18—can help protect you from developing cervical cancer.

If you are 30 or older, ask your healthcare provider about getting an HPV test with your Pap test. Learn more at www.healthywomen.org/hpv.

This resource was created with support from Roche Diagnostics Corporation.
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There’s no running from cancer. Thankfully, there is running after.

*Here, we have the best pediatric cancer outcomes in the region.*

A bump on Markus’ knee revealed itself to be more than just a badge of 12-year-old boyhood. It was cancer. And with it came a question: would he ever run again? Markus had the fight in him. Only we had the team of experts to back him up. Surrounded by our pediatric oncologists—and the only ranked program in the region—Markus beat cancer and is running strong toward a bright future. Pediatric oncology is just one of our numerous nationally recognized specialties, which proves there’s no other choice when it comes to your child.
CAFP members Dr. Stephanie Gold and Dr. Larry Green have co-edited a book designed to help family physicians integrate behavioral healthcare into the primary care setting. Among the many contributors are Dr. Frank deGruy from the Department of Family Medicine and Dr. Scott Hammond and Caitlin Barba, MPH, of Westminster Medical Clinic in Westminster, Colorado. Here, Drs. Gold and Green shared more about the book and how it can benefit family physicians.

CAFP: Tell us more about the book you edited. What is the focus and what might family physicians learn from reading it?

Drs. Gold & Green: This book is an evidence-based guide for primary care physicians and others in the primary care clinic seeking to integrate behavioral health and primary care. The book covers what integrated behavioral health is, what the journey to get to integrated care looks like in a real life practice, essentials of working together as an integrated care team, the kind of leadership that is needed in a practice to integrate care, how and what to measure to monitor progress, and the policy limitations and workarounds to get it all done.

CAFP: Tell us more about the contributors. What sort of contributors did you seek out for this book to enrich the materials?

Drs. Gold & Green: We sought out local and national experts to author the chapters. We are lucky here in Colorado to have so many leaders in integrated behavioral health and primary care. Our local authors include Caitlin Barba, MPH, Practice Administrator at the Westminster Medical Clinic; Frank deGruy III, MD, MSFM, Chair of the Department of Family Medicine at the University of Colorado; R. Scott Hammond, MD, Medical Director of the Westminster Medical Clinic; Stephanie Kirchner, RD, practice transformation program manager at the University of Colorado; and Ben Miller, PsyD, Chief Strategy Officer at the WellBeing Trust and former director of the Eugene S. Farley, Jr. Health Policy Center.

CAFP: What is the history / background behind the book? How did you both come to be co-editors?

Drs. Gold & Green: The book stems from a paper we wrote together, along with CJ Peek, on lessons learned from the Advancing Care Together (ACT) project. ACT included 11 urban and rural, small and large practices across Colorado, working over 3 years to integrate care as they saw fit for their practice and patient population. We were contacted by Springer publishing in response to the paper and submitted a book proposal on their suggestion. It turns out that while there are a number of books written for behavioral health clinicians on the diagnostic and treatment skills needed for practicing in primary care, there isn’t a lot out there for primary care physicians looking at the practice transformation perspective. We sought to fill that gap with this book.

CAFP: How has your clinical experience impacted this book or your desire to work on it?

Dr. Gold: I’ve trained and worked in a clinic with integrated behavioral health and primary care, and I can’t imagine doing things any other way. We see so many behavioral health issues – depression, anxiety, addiction, trauma, insomnia – where we are able to provide better care working as a team. Our behavioral health partners are skilled not only in providing therapy but also supporting screening and diagnostic evaluation, counseling on health behavior change, and helping get to the bottom of medically unexplained symptoms. It just makes intuitive sense to me that this is how we all can and should provide better primary care.
Dr. Green: I had the good fortune of doing my residency in Rochester, N.Y. with Gene Farley in one of the first family medicine residencies. We had a new-fangled thing called a nurse practitioner, pharmacy faculty, social work and folks like George Engle surrounding us, and this imprinted me with a collaborative approach to practice that has persisted throughout my career. Going from New York to Arkansas, I had trouble coping without this sort of team and leaned on a psychologist working for the Veterans Administration, and nurse practitioners weren’t legal yet. Denver and the medical school and department of family medicine faculty have consistently worked together with behavioral health experts, and daily practice provided the constant stimulus to improve the care of people with mental, emotional, and behavioral problems. Add to this my family experiences with depression, anxiety, panic, and suicide and you have a formula for being motivated to get over our arbitrary professional boundaries to take better care of the large number of people with mental, emotional, and behavioral problems whom we have the opportunity to serve. Integrated care is just superior care. And like we added to the title of our book, “your patients are waiting.”

CAFP: What are your goals or hopes for the book and how family physicians can utilize it?

Drs. Gold & Green: We hope that other family physicians thinking about or working on integrating behavioral health into their practice will find guidance here that they will be glad they read before moving farther on their path. Our authors have a wealth of learned wisdom that can make the journey to integrated care smoother.

CAFP: What more would you like family physicians to know about the book?

Drs. Gold & Green: This book is honest about how changing your practice to integrate care for people with mental, emotional, and behavioral problems is not a small adjustment; when accomplished, the practice is quite different. The current environments we work in are not necessarily conducive to making the transformation a reality for patients and practice staff. It takes courage and commitment, and it can be done. We have not yet found the practice that took this transformation to integrated care that wants to go back to the way things used to be.

Disclosure Statement: Dr. Gold and Dr. Green receive an honorarium as co-editors of this book.
When Dr. Katheryn Boyd-Trull was growing up in rural Colorado, physicians made a big impact on her small community. Many of the people in the farming and ranching driven economy had limited access to health insurance and limited access to care; but those challenges didn’t stop local physicians from going above and beyond for their patients.

Dr. Boyd-Trull experienced that first hand as a child, when her brother became very ill with Guillain-Barre syndrome. It wasn’t easy to deal with a condition that didn’t come with easy answers, but an exceptional physician in the community cared for him, even coming to their home to check-in and provide care. It was that experience that drove Dr. Boyd-Trull’s interest in becoming a family physician who would practice full scope family medicine and care for people with limited access to health resources.

While her path to family medicine was clear, Dr. Boyd-Trull’s path to teaching wasn’t as obvious. She wasn’t sure if she would be a very good teacher during her own education. Even so, she found herself drawn to the amazing people working in primary care education.

“You work on teams with every type of learner in primary care. During residency I realized I enjoy being a part of that and watching learners grow, and seeing what they will add to primary care,” says Dr. Boyd-Trull.

The opportunity to work one-on-one with diverse residents is one of the things that Dr. Boyd-Trull finds most rewarding about being a teacher.

“When you see someone really get something that they hadn’t grasped before, even some of the smallest things like body language and how a patient responds to that, when you can watch someone grow in their relationships with their patients, that is very rewarding,” she says.

The residents at the University of Colorado program are very thankful for the dedication to teaching that Dr. Boyd-Trull shows, and how that dedication has helped them grow.

“On an individual level, Dr. Boyd-Trull pays incredible attention to each learner: medical students and residents of different levels. She takes time, while on a busy inpatient service with us, to provide in-depth personal feedback. She continues to help us envision our goals and refine our trajectory throughout residency,” say the residents. “On a team level, she always takes time for high-quality dedicated teaching to help bolster our medical knowledge. She also helps us learn to support each other on the team by making wellness, communication, and respect a priority during weekly check-in sessions.”

“The residents know that when Katy is their attending they are going to have a day full of high-yield teaching in both the art and science of taking care of patients,” adds Linda Montgomery, MD, FAAFP, Program Director of the University of Colorado Family Medicine Residency. “I review all faculty teaching evaluations and Katy receives dizzyingly high marks from all of the students and residents who work with her.”

Dr. Boyd-Trull’s dedication to students is matched only by how passionate she is about making primary care the best it can be for the good of patients. She is known as a dedicated lifelong learner, an advocate for the most underserved and vulnerable, and was instrumental in the development of the Transitions of Care program that has been implemented into the entire UC Health system and has reduced readmissions by more than half.

Her approach in this work has been to focus on the story of one patient, and how that one story can translate to results across an entire health system.

“I am motivated by the one,” says Dr. Boyd-Trull. “The one patient in front of me that doesn’t have access to care or the one patient that passes because they couldn’t afford a medication. That resonates with people, they can connect with that. A person matters. If you can change things for that one person, it can amplify out to the broader system.”

For Dr. Boyd-Trull, it is primary care physicians that are the answer almost all of what is needed to make the broader health system better. Because of that, she has become known as a strong and often respectfully outspoken advocate for the specialty of family medicine.

“To say I’m very passionate about promoting family medicine, that’s an understatement,” says Dr. Boyd-Trull. “If you can take care of chronic illness and empower patients, their whole healthcare trajectory is changed. Family physicians can do so much, when you see people falling through the cracks, family medicine can cover 80 to 90 percent of what is happening. A good family doctor is absolutely the solution to most healthcare problems.”

Dr. Montgomery agrees that Dr. Boyd-Trull’s passion in this area is unmatched.

“Dr. Boyd-Trull is the most passionate advocate of family medicine I know. She sets an amazing example to our students, residents and attendings in how to be a proud family physician.”
COLORADO FAMILY MEDICINE RESIDENT BRINGS A DEDICATION TO KNOWLEDGE AND COMPASSION TO PATIENT CARE
CLAIRE BOVET, MD HAS BEEN NAMED CAFP’S FAMILY MEDICINE RESIDENT OF THE YEAR.

Caring for others has long been a part of Dr. Claire Bovet’s life. When she was young her mother had a medical procedure, and with a dad who was squeamish about medical issues, Dr. Bovet took on the role of assisting her mom recover. That experience got her interested in science and medicine, but she still wasn’t certain what her future would hold.

As she got older, her love of both discovering why things happen in the body and working with people and communities sparked her interest in becoming a physician. She enrolled in the University of Colorado School of Medicine unsure of what specially she would choose. However, after being paired with a family physician in Boulder as part of a rotation and seeing the work that physician did, including the ability to care for many generations of the same family, her decision to become a family physician was made.

As Dr. Bovet has progressed through residency she has developed a great passion for the challenges and opportunities that are a part of family medicine.

“It’s learning the science of medicine, but also the art of it,” reflects Dr. Bovet.

“We’re getting the skills to have tough conversations and work with patients through and beyond those difficult times. You build bonds in family medicine, and that can’t be replicated anywhere else.”

Dr. Bovet’s passions in family medicine also extend to obstetrics and caring for some of the most underserved patients.

“It’s so powerful to care for a woman during pregnancy, delivering the baby, and caring for that baby and the family,” says Dr. Bovet.

She also feels deeply connected to patients when she can help them beyond the walls of the clinic. Dr. Bovet has seen first hand the difference it makes when she can provide patients with resources on housing, food, affordable medication and transportation. Together with the healthcare she can provide, these resources have the power to make a meaningful difference in the lives of Dr. Bovet’s patients.

And without question, Dr. Bovet’s dedicated to both knowledge and compassion have not gone unnoticed.

“I have been on our faculty since 2007 and Claire is easily in the top five percent of residents with whom I have worked based on her medical knowledge and decision making, her leadership skills, and her compassion and empathy for patients and colleagues,” says Blaine Olsen, MD, FAAFP, Program Director of the Saint Joseph Family Medicine Residency Program.

“She has shown a commitment to caring for the poor and vulnerable and plans to continue this following her training. She has been a consistent and constant force for improvements in our residency program and through it all, has been a true pleasure to work with as a colleague.”

Dr. Bovet is currently completing her third year of residency, along with serving as Chief Resident. She will be staying at Saint Joseph for a fellowship in obstetrics, specializing in high risk pregnancies and cesarean sections. After her fellowship she plans to stay in the Denver area and work in a Federally Qualified Health Center so she can continue her work with vulnerable patient populations.

MEMBER REMEMBRANCES

The CAFP Notes the passing of Dean Gordon Smernoff, MD.

Obituary for Dean Gordon Smernoff, MD
Zikhrono L’vrakhah, may he be remembered as a blessing.
Born in Bingham Canyon, Utah, April 29, 1928, to Dr. Meyer and Kitty Smernoff.
Went to East High School in Denver, Denver University, University of Colorado - Denver, University of Nebraska Medical School.

Died January 14, 2019, in Denver, Colorado.
He was a family physician in west Denver at the Westwood Medical Clinic, where he practiced for 45 years (1958 - 2005), 15 of which were with his father.
He was a lifelong learner, every subject interested him.
Dean is survived by his wife of 65 years, Jo Smernoff, and by their children, Susan Smernoff (Barry Make, MD), Lisa Smernoff (Bill Hangen), David Smernoff, PhD (Cindy Russell, MD) and Eric Smernoff, PhD.
He is also survived by his brother Bernard Ross Smernoff and five grandchildren, Samuel Smernoff Byrne, Nika Smernoff (Hani Gazal), Bryn Smernoff, Nathan Smernoff and Kayla Smernoff.
From an early age, Dr. Glenn Kotz knew he wanted to be a doctor. A love of both intellectual challenge and creating lasting relationships drew him to family medicine, particularly rural family medicine. Over the last 29 years he has watched both his community of Basalt and the practice of family medicine change significantly, but a willingness to innovate and a dedication to patients and colleagues has kept him engaged and looking toward the future.

Dr. Kotz grew up in Bethesda, Maryland but had the opportunity to travel across the United States, including its rural communities. It was in those rural communities he felt the greatest sense of connection, and it made him passionate about practicing family medicine where he could truly interact with his neighbors and help them in a meaningful way.

While his passion for community hasn’t changed, much about where he lives and the business of providing healthcare has.

When Dr. Kotz began practicing in Basalt it was a farming and ranching community. He remembers the days of patients coming in weeks after suturing their own cuts or breaking a leg because they couldn’t afford to be away from calving. These days, many of the ranches (and the medical needs of the ranchers) don’t exist in the form that they used to. And like many rural communities across the United States, Basalt and its residents are facing a question about the identity of their community, and what their future holds in a quickly changing world. While this may seem to have little to do with healthcare, Dr. Kotz doesn’t see it that way. His patients are affected by their changing community, as is his practice and the work he does every day. Fostering a strong community with a strong sense of identity is something Dr. Kotz feels is extremely important to the wellbeing of his patients.

Dr. Kotz has also been exceptionally engaged in the transformation of healthcare that has occurred over the past 29 years. Early in his career, two seminal moments shaped his interest in working to change healthcare for the better. The first year he was in Basalt, a family came in to his practice with a sick child. Concerned the child might have meningitis, Dr. Kotz advised them to go to the emergency room. When he did a follow up call to the family to see if everything was okay, they told him they didn’t go to the emergency room because they were scared it would cost too much. While the child was thankfully okay, Dr. Kotz and his wife, Lisa Robbiano (a nurse practitioner), felt it was unacceptable for members of their community to go without care, and started a low-income clinic that served the community for many years.

Dr. Kotz’s experiences also helped him see that not only was the cost of healthcare a barrier, so too was the way day to day practice was being conducted. When sitting down with patients to talk about their lives, many would tell him the same things over and over: they had a donut and coffee for breakfast, a sandwich with mayonnaise for lunch, meat and potatoes for dinner, and they didn’t exercise. After every one of these visits Dr. Kotz would encourage his patients to make healthier choices, but how little they were doing to actually achieve it, and that something needed to change.

Those experiences planted the seed that became practice transformation in Dr. Kotz’s clinic, MidValley Family Practice. As an early adopter in practice transformation, Dr. Kotz has also been increasingly interested in
where to go next. Together with Dr. Scott Hammond, a family medicine physician in Westminster, he has led an initiative called ART2, which brings together early transformers who were and continue to be truly passionate about transformation for the good of the patient.

This transformation work has been very exciting and fulfilling for Dr. Kotz, as it has offered another way to connect with patients who are vocal about what receiving good care means to them.

“We offer the classic elements of integrated care, it is team-based and patient-centered,” says Dr. Kotz. “Our patients notice that. They feel more cared for and they will tell us that.”

For Dr. Kotz, witnessing the transformations that can occur when patients are truly getting their needs met, when they can see a behavioral health specialist and a nutritionist, is incredibly rewarding. Now Dr. Kotz sees the barriers to behavioral change being broken down, and for him it feels like instant positive feedback, knowing the lives of patients are changing for the better and his colleagues in the clinic are working together to make a difference.

And by no means is the work of Dr. Kotz and his colleagues done. They continue to seek out challenges and new ways to serve patients better. One of their current ongoing projects is learning to use the language of patients. Not just English, Spanish, or otherwise, but the actual way patients communicate based on their cultural, backgrounds and experiences. They have been working on this for over two years, and Dr. Kotz acknowledges it is incredibly challenging, and there is still a great deal to learn. The team is also working on a project with the American Academy of Family Physicians to improve their work communicating with immigrant patients. They also continue to seek grant funding to address public health-related issues they see across their community, including the opioid epidemic and loneliness.

While this work might sound overwhelming, Dr. Kotz finds it invigorating, and enjoys sharing the life of a rural family physician with residents who join the practice as part of their rotations.

“I tell residents they have to follow what their passion is,” says Dr. Kotz. “This is full scope medicine. We see every patient that walks through the doors and take care of the issues of the vast majority of these patients. Ninety percent of concerns are addressed in the family medicine office.”

Dr. Kotz has noticed that many residents walk away from their experiences in his clinic with tears in their eyes, seeing how important their work in a rural community can be.

And while Dr. Kotz is proud to be a face of much of the work that has happened to make his clinic such an impactful part of the community, he also acknowledges that providing great healthcare is not the work of one person.

“Every single person in the practice works to give the best care that they can. Everybody in the practice should see this as their award, I couldn’t do this without any of them.”
**ACTIVE MEMBERS**

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<td>NANCY STOUDT, MD</td>
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<td>DON TEATER, MD, MPH</td>
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<td>SAMEERAH WONG, MD</td>
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<td>ANDREW WOOD, MD</td>
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