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UNDERSTANDING HOW THE CANDOR ACT
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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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PRESIDENT’S LETTER

It is an honor and privilege to be installed as the current President of the Colorado Academy of Family Physicians. It is a great and awesome time to be a family physician and it is indeed a humbling experience to give a face and voice to our stories and help guide the future of healthcare here in Colorado.

First, a bit about me. I’m originally from rural northeastern North Dakota and grew up on our multi-generational family farm. Our exposure to healthcare was the annual sports physicals at our country school and immunizations at the health department. I worked my way through school and attended medical school at the University of North Dakota in Grand Forks. I was set on being the next great organ system specialist/partialist and I didn’t even know what family medicine was. While picking my 3rd year clerkship schedule I asked the administrative secretary for medical education what the difference between internal medicine and family medicine was and her answer was a shrug followed by “I think in Family Medicine they take care of kids too.” Between being paired with some incredible mentors and divine intervention, I fell in love with Family Medicine. Residency at the Fort Collins Family Medicine Program at Poudre Valley Hospital brought me to Colorado. While a resident I worked as a leader in redesigning our clinic system to a Patient Centered Medical Home and led our NCQA recognition process. Upon completing my residency my family and I had become so enamored with Colorado there was no possible way we would leave, so we stayed in Fort Collins and I have been practicing comprehensive team-based care at Associates in Family Medicine ever since. Joining me in my current adventure are my co-pilots: my incredible wife Sara who is an elementary school educator, our children Owen (8) and Margaret (5), and our geriatric dog Mila.

I am proud that Colorado is looked at as a leader in healthcare policy and advocacy. This has been made possible by the years of hard work from all of you and the countless leaders that came before me. Colorado family physicians lead the nation in piloting and demonstrating the success of the Patient Centered Medical Home, we pioneered new payment models with the Comprehensive Primary Care Initiative (CPCI) and then later CPC+. We lead in advocating for Medicaid parity and pushing for payment reform.

I had the privilege of representing you by testifying on behalf of our Primary Care Investment Legislation during the 2019 legislative session, and had the honor to be present as Governor Polis signed it into law. None of these historic measures would have been possible without the passionate dedication of our incredible staff. I extend my gratitude to our team Raquel Alexander, Ryan Biehle, Lynlee Espeseth, Erin Watwood and our lobbyist Jeff Thormodsgaard and his team at Michael Best Strategies. With the historic passage of the Primary Care Investment Legislation and our continued leadership role in healthcare payment reform I’m ecstatic to see what we can do here in Colorado.

Here at the CAFP we believe that strong family medicine is the answer to address our current health concerns but recognize the fundamental need to address the root causes of disparities in health and wellness – addressing food deserts, sexism, disparities in education, institutional racism, xenophobia, and discrimination against members of the LGBTQIA+ community. For our academy to be the bold champion for Colorado’s family physicians, patients, and communities we reaffirm that health has no zip code. We will stand with for family physicians regardless of which demographic box is or is not checked. Colorado clearly needs a diverse group of family physicians to serve and care for its diverse communities.

It’s no secret that I’m a fan of family medicine. I want to personally extend an invitation for you to be involved with the CAFP. This fall we will be soliciting nominations for new board members. If you are interested in serving on our board please send our CEO Raquel Alexander (raquel@coloradoafp.org) or me a note and we’d love to talk more over a cup of coffee or tea. More information about joining the Board of Directors can be found on our website here: https://www.coloradoafp.org/join-board. Also, we are always looking for volunteers to join one of our committees. More information on our committees can be found on page 40 in this issue.

It is my hope that through all of our activities we make a difference not only in the lives of our members, but also in the lives of our patients. I hope that this article finds you well and I am looking forward to hearing from more members like you. Please reach out to me at any point at JohnCawleyCAFP@gmail.com.
Without question, a highlight of my career has been watching CAFP’s primary care investment initiative become law (see Ryan’s legislative report on page 8 for details). When Governor Polis signed the bill on May 16 I found myself reflecting on the years of work that led up to this moment.

Since the founding of the Colorado Academy of Family Physicians we have worked at the state level to promote family medicine and support our family medicine physicians. This has happened through our lobbying and public relations efforts, and through countless discussions with public and private organizations, community groups, and individuals representing all facets of the Colorado healthcare world.

For years we have pushed legislators and organizations to recognize how valuable comprehensive, high-quality primary care is. We have said over and over again that family medicine is the cornerstone of healthcare, and when physicians are equipped to do it well it changes lives, communities, and indeed our country for the better. People are healthier. Healthcare costs less. We begin to mend the broken system that has existed for much too long.

Many dedicated researchers have studied ways to better our system, and how increasing investments in primary care is a productive way to reach the goal of better, less costly care for all.

There have been bumps along the road, without question. This is our second year running the bill after similar legislation did not pass in 2018. However, that experience led us to the bill introduced this year, an improvement on the prior bill in many ways.

Our CAFP team worked tirelessly to push forward through the challenges. Our lobbyist Jeff Thormodsgaard, our Board of Directors led by President Zach Wachtl, MD, and our staff, in particular Deputy CEO for Policy and External Affairs Ryan Biehle, all dedicated countless hours.

Many of our members also took time away from their busy days to write letters to legislators and submit op-eds to local papers.

Finally, and most importantly, this legislation passed because of you. Being a member and supporting the CAFP with your dues meant that we had the funds to do this work. Every time you step into an exam room to care for a patient you are representing why this work matters. I thank every single member of the CAFP from the bottom of my heart, because every single member of the CAFP made this legislation happen.

My many years working with family physicians has shown me how much you care about the work that you do. It has also shown me how easy it is to feel frustrated and discouraged in the midst of challenges and administrative work. My hope is that the next time you feel frustration or discouragement you can remember the incredible impact you have on healthcare in Colorado, in big and small ways.

I look forward to the continuation of this work and sharing with you all that we accomplish together.

Raquel
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CAFP Puts Up Multiple Wins For Primary Care

It was a packed legislative session and among the most productive in recent state history. 598 bills were introduced, and 462 of these passed – a 77% passage rate. CAFP tracked and engaged in a total of 54 bills throughout the session. It was a banner year for CAFP at the legislature, with 3 CAFP-led bills passed into law.

3 CAFP-Led Bills Pass

Increasing Investments in Primary Care HB-1233. CAFP members have said payment reform is among the most pressing issues facing family physicians. After 3 years of work to garner state support for fully funding primary care, CAFP passed our premier legislation to set targets for insurers’ investments in primary care and accelerating payment reform. The Division of Insurance and Medicaid are directed to establish these targets through regulation. CAFP will be sitting on the Primary Care Payment Reform Collaborative established by the bill to set a definition of primary care and make recommendations on appropriate investment targets. We believe the amount invested in primary care should be doubled from the current 7% up to at least 15% of the healthcare dollar. These dollars will go to better support the PCMH, care coordination, integrated behavioral health, and other infrastructure needed to sustain advanced primary care practices.

The Candor Act SB-201 passed unanimously in collaboration with COPIC and the Colorado Trial Lawyers Association (CTLA). CAFP and COPIC approached CTLA to form an unprecedented partnership this year, which yielded a new alternative for patients and physicians when there is an unexpected health outcome. This is the second law of its kind in the U.S. that provides a framework for health professionals to offer voluntary, compassionate, honest, timely and thorough responses to unexpected health care outcomes. The Candor Act is designed to benefit patients, their families, clinicians and health care systems by formalizing the process of communication and resolution when unexpected events cause patient harm. Look for the Candor Article on page 18 of this issue for more information.

Rural Preceptor Tax Credit Extension HB-1088. CAFP worked with the Colorado Rural Health Center to successfully extend the $1,000 personal income tax credit for rural preceptors who train medical students. This credit aims to support rural primary care physician training and increase the number of medical students who ultimately choose to practice in a rural setting.

Other CAFP Priority Bills

Two bills were up for sunset review this year, meaning they would expire if not extended. The Medical Practice Act SB-193 was passed to continue medical licensure and the regulation of medicine in Colorado. The Professional Review Sunset SB-234 also passed, but not without months of roadblocks and stalling by CTLA. Our colleagues at the Colorado Medical Society and COPIC took lead roles in reauthorizing professional review, which plays a critical role in maintaining quality improvement in the state. It ensure physicians and health systems can self-report an adverse event.

Impacts to Clinical Practice

Opioid CME Requirements SB-228: The legislature again placed a heavy focus on addressing the opioid epidemic. This opioid bill included a number of prevention provisions and appropriated $4.38 million for public health and awareness efforts. Among the provisions was a requirement for any opioid prescriber, including physicians, to take up to 4 hours of substance use disorder training every 2 years. This requirement is subject to Medical Board rulemaking. CAFP will advocate for existing training and continuing medical education to count toward this new requirement. CAFP will also offer qualifying trainings at its CME events.

Physician Assistant Supervision HB-1095: Physician Assistants pursued legislation to expand the number of PAs on the Medical Board by 1 member, hold a majority ownership in a practice, and increase the number of PAs that can be supervised by a physician from 4 to 8. CAFP amended this language to ensure any physician supervising more than 4 PAs would have sole discretion to take on that supervising responsibility, and no employer could make it a condition of employment. CAFP and the Colorado Medical Society also successfully amended the bill to exclude the proposal for PA’s to hold a majority ownership in a practice.

SB-073 created a Statewide Advance Medical Directives System, allowing physicians to upload and access advance medical directives when needed.

SB-079 E-Prescribing Controlled Substances adds a state requirement beginning in July, 2021 for practices to electronically prescribe controlled substances. Rural and solo practices have until July, 2023 to comply. Some exemptions apply, including for physicians who write fewer than 24 controlled substance prescriptions annually, or for temporary IT failures. This law follows on the heels of a recently passed federal law requiring practices who take Medicare to e-prescribe.

Prior Authorizations HB-1211 was championed by the Colorado Medical Society with CAFP support. The bill will require insurers to 1) use prior authorization criteria that are current, clinically-based and consistent with other payers’ criteria; 2) respond to prior authorizations within 2 days, and consistent with other payers’ criteria; 3) inform the physician of denied or deemed incomplete; and 4) publicly post data regarding the insurers’ prior authorization approvals and denials.

Public Health

While there were multiple public health successes this session, one significant disappointment was the failure of HB-1312 to Strengthen School Immunization Requirements and reduce “convenience” exemptions from vaccines. CAFP supported this bill alongside the American Academy of Pediatrics – Colorado Chapter and the Colorado Immunization Coalition. While the bill failed this year, we are already in discussions to find a path forward next legislative session.
We had two major public health wins on nicotine and tobacco. **HB-1076 Adding Vaping to the Clean Indoor Air Act** was signed into law, prohibiting vaping in public indoor spaces. **HB-1033 Allowing Local Regulation of Nicotine** also passed, enabling local governments to tax and regulate nicotine products without foregoing state tobacco tax funds.

**HB-1122 Maternal Mortality Review Committee (MMRC)** codifies the state’s volunteer MMRC, allows the Committee to review maternal deaths sooner than the current 3-year lag in data, and enables the Committee to now apply for federal funding, which was previously prohibited due to the lack of subpoena protections for Committee documents and discussions.

**Youth Mental Health Education & Suicide Prevention HB-1120** allows minors 12 years of age or older to seek mental health services without the consent of a parent or guardian.

**Child and Youth Behavioral Health System Enhancements SB-195** directs the state Medicaid Department to pursue federal funding for wraparound behavioral health services for children and youth, and to improve coordination of behavioral health services and supports across state agencies.

### Health Care Costs and Coverage

In addition to CAFP’s Primary Care Investment legislation, several other sweeping bills were passed to address health care costs and coverage. **HB-1004** sets Colorado on the path to offer a **State Coverage Option** akin to a Medicaid buy-in. The option’s premium, cost-sharing, coverage, and provider reimbursements will be determined following a stakeholder, study and implementation process over the upcoming year. The related **SB-004 Address High Cost Health Insurance Pilot Program** is a state employee health plan buy-in option, and will be offered to a limited number of individuals in the mountain communities. The newly created state **Reinsurance Program HB-1168** will stand up reinsurance for the small group and individual insurance markets in Colorado. Acting essentially as insurance for insurers’ high cost claims, the reinsurance program will cover high cost cases and enable a reduction in premiums between 15% in the Denver Metro Area to 35% on the Western Slope and Mountain Communities.

**The Health Care Cost Savings Act HB-1176** directs the State to study several healthcare financing systems including a single payer state system.

**HB-1216 Reduce Insulin Prices** caps patients’ cost sharing for insulin at $100 per month, regardless of the dosage. **SB-005 Import Prescription Drugs from Canada** directs the State to pursue a prescription drug importation program, which is contingent on federal approval. **HB-1174 Out-of-Network Charges**, dealing with “surprise bills,” limits the charges by physicians who are out-of-network but treat a patient in an in-network facility.

**Mental Health Parity HB-1269** strengthens insurers’ requirements to cover mental health services on par with physical health services. The bill adds enforcement mechanisms to ensure coverage is in parity.
CAFP ON THE GO

Advocacy

CAFP President John Cawley, MD, testifying in support of HB-1233, to increase the investment in primary care.

CAFP Member Kelly McMullen, MD, testifying in support of HB-1211, to reduce the prior authorization burden.

CAFP on the Go

Several groups came together to testify on behalf of HB-1233, to increase the investment in primary care, including Kelly Erb from the Colorado Rural Health Center, Deb Judy from the Consumer Health Initiative, Dave Denovellis from Medicaid, and Dr. David Keller from the American Academy of Pediatrics - Colorado Chapter.

C AFP President John Cawley, MD, receiving the pen used to sign HB-1233, to increase the investment in primary care, into law.

C AFP Chair Zach Wachtel, MD, President-elect Gina Carr, MD, President John Cawley, MD, together at the AAFP's Annual Chapter Leader Forum.

C AFP Alternate Delegate Monica Morris, DO, presenting CAFP's Stop & Imagine Youth Marijuana Prevention Curriculum.
NEWLY INSTALLED AND VETERAN BOARD MEMBERS CAME TOGETHER FOR THEIR FIRST MEETING IN MAY.

GOVERNOR JARED POLIS SIGNING HB-1233, TO INCREASE THE INVESTMENT IN PRIMARY CARE, INTO LAW.

CAFP PRESIDENT JOHN CAWLEY, MD, SPEAKING AT A RALLY TO ENCOURAGE LAWMAKERS TO RESEARCH GUN VIOLENCE.

AAFP PRESIDENT JOHN CULLEN, MD, FAAFP, JOINED CAFP LEADERS FOR DINNER DURING THE 2019 ANNUAL SUMMIT.

COLORADO LEADERS, STAFF AND DELEGATES ATTENDED DINNER TOGETHER DURING AAFP’S ANNUAL CHAPTER LEADER FORUM / NATIONAL CONFERENCE OF CONSTITUENCY LEADERS.

CAFP PAST BOARD MEMBER WILSON PACE, MD, FAAFP, TESTIFYING IN SUPPORT OF THE CANDOR ACT, TO IMPROVE PHYSICIAN-PATIENT COMMUNICATION AND RESOLUTION AFTER AN ADVERSE EVENT, ALONGSIDE PATIENT ADVOCATE PATTY SKOLNIK, JEAN MARTIN OF COPIC, AND DAVID WOODRUFF OF THE COLORADO TRIAL LAWYERS ASSOCIATION.
HIGHLIGHTS FROM THE 2019 ANNUAL SUMMIT

Thank you to everyone who joined us for the Kentucky Derby-themed 2019 Annual Summit, First Place to Family Medicine, in Fort Collins.

We invite everyone to join us in Estes Park for the 2020 Summit, happening April 16-19, 2020 at the Stanley Hotel. Save $100 on your registration now with coupon code FIRST. Visit www.coloradoafp.org/summit2020.
This May, SNOCAP was excited to be involved again with the CAFMR Rocky Mountain Research Forum. This year, CAFMR welcomed resident teams to present their research projects to a panel of five judges in a “Shark Tank” format. Six Shark Tank groups shared their work in a format that was engaging and informative. The top three teams were given awards for their hard work and presentation. Teams were competing for a top prize of a scholarship to the NAPCRG conference in Toronto, Canada. SNOCAP was happy to be part of the program again this year and was thrilled to hear each of the Shark Tank presentations this year. We were also happy to see the wide range of topics presented in breakout or poster session. Great job to everyone!

SNOCAP truly honors and appreciates relationships built through mechanisms such as the CAFMR Rocky Mountain Research Forum and is excited to partner with residents and residency sites that might not have participated in Practice-Based Research Network (PBRN) research in the past. Thank you to those of you who took the time to meet Don and Mary at this event.

We have made many new connections recently; new voices are being brought forward to join in on conversations. We would like to extend a warm welcome and encourage you to continue participation with SNOCAP. Here is a link where you can sign up for our bimonthly newsletters to learn more: bit.ly/SNOCAPnewsletter

Thank you for the continued support through the years. Please reach out if you have questions, needs, or want to know more about what PBRN work looks like here in Colorado. If you’re in the Denver metro area, we’d love to grab coffee! If you’re further out, plan a virtual meeting with us by Zoom or invite us to visit you and your practice! We’d love to chat!

Wishing you well-

Donald Nease and Mary Fisher
Donald.nease@ucdenver.edu
Mary.fisher@ucdenver.edu

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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 FP's (with or without OB) to join a comprehensive team of professionals providing out-patient care for the underserved population.

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• System focus on patient and provider well-being
• Non-profit status means continuing reinvestment
• Autonomy in your practice
• Access to research and academics
• Robust compensation & total rewards

At the end of the day, **this** is where you want to be.
Despite decades of refinement of diagnosis, intraoperative, and postoperative care for congenital heart patients, mortality remained high for many complex congenital heart lesions, with mortality remaining above 25 percent for neonates and infants until the 1990s. After the mid-1990s, mortality dropped to less than five percent for this young population (5). With this dramatic improvement in care the last two decades, the number of survivors with complex congenital heart disease reaching adulthood has rapidly increased, and now there are more adults than children with moderate and complex congenital cardiac defects (6).

Few of these adults, however, can be considered cured, with most having a higher mortality compared to aged matched controls (7). Lifelong care of adult congenital heart survivors by experts in congenital heart disease therefore remains important. A milestone population study has shown that those ACHD patients in care of ACHD specialty centers had lower mortality than those cared for by non-ACHD specialty centers (8).

Variation in practice patterns between ACHD centers throughout the United States raised concerns that not all ACHD programs may be providing as good of care as provided by the international centers involved in this milestone study. Therefore, in an effort to set this minimum standards care for ACHD centers across the country, the Adult Congenital Heart association, a patient advocacy nonprofit organization, in partnership with ACHD specialists from across the country, has developed an accreditation program for ACHD Centers, setting a minimum standard of care. Colorado’s Adult and Teen Congenital Heart (CATCH) program, which spans both Children’s Hospital Colorado and University of Colorado Hospital, was honored to serve as one of the pilot programs for this accreditation process. The CATCH program is one of 24 programs that has received comprehensive care center accreditation, and remains the only such program in Colorado.

With rapid growth of this population, combining both the complexity of their congenital heart abnormality along with adult onset medical problems, the American board of medical specialties developed a new subspecialty of adult congenital heart disease. The first board exam was offered in 2015. Through 2019, cardiologists from either a pediatric cardiology or an adult cardiology background who have experience in caring for these patients have been eligible for this board certification. After 2019, board eligibility requires an additional 2-year advanced fellowship in Adult Congenital Cardiology after either a pediatric or adult cardiology fellowship. The CATCH program was one of the first 5 of such training programs to receive accreditation from the accrediting council for graduate medical education (ACGME). Currently 20 such programs exist across the country.

Unfortunately, throughout the United States, more than 60 percent of these adult survivors with congenital heart disease are not in the care of congenital heart disease experts which, as already stated, has been shown to lead to increased mortality and preventable morbidity. Reasons for this large number being lost to care are many. First, many of these survivors and their physicians are unaware of the presence of these specialized ACHD care providers and programs, and the impact on outcomes they have shown to provide. Secondly, many of these people have the understanding that they were fixed with their surgery as a child (sometimes mistakenly told so by their pediatric cardiac surgeon or cardiologist) and are not aware that lifelong care with an adult congenital expert is required. When problems arise, these survivors understandably believe that any adult-trained cardiologist or cardiac surgeon can treat their issues. While this is true for some, most adult trained cardiologists and cardiac surgeons are not familiar with the variety of cardiac issues that may be present for a specific lesion, and often fail to treat all the issues.

A common example of missed opportunities for addressing comprehensive care for these patients lost to follow-up are those who develop new onset arrhythmia and seek care. Arrhythmias are common problems dealt with by cardiologists and electrophysiologists in non-congenital heart survivors, and such physicians are quite capable treating these arrhythmias in the non-congenital population. This may involve performing an ablation or placing an automatic implantable cardiac defibrillator (AICD). What physicians are not usually familiar with is the unique variations of these patients’ heart that alter the approach to such procedures, let alone addressing underlying, otherwise asymptomatic hemodynamic issues that frequently are at least partially responsible for the development of these arrhythmias. Chronic heart volume loading from severe valve regurgitation drives more electrical changes in the heart, and untreated will ultimately lead to chronic congestive heart failure. While most adult community cardiologists are familiar with such problems in normally developed hearts, they are not as familiar in recognizing...
and understanding the unique approaches developed to evaluate and treat these in congenital heart patients. Failure to address all these issues (usually not done outside congenital centers) will lead to more recurrent arrhythmias and permanent heart failure.

With recent advances, fewer of these patients will require repeat open heart surgery. New transcatheter therapies have been developed that may make it possible that less than half of pulmonary valve replacements need to be done surgically, hence decreasing morbidity, and anxiety for many patients. When surgery is needed, it has been shown that when performed by congenital heart surgeons, such as those present in the CATCH program, mortality is much lower.

With only 302 ACHD board-certified physicians within the United States at this time, we are blessed to have recruited and retained seven physicians trained in the care of these complex ACHD patients. This has allowed us to provide such care throughout our 7-state region. What we pray for now, is that patients and providers throughout our region learn about the need for these people to be evaluated and cared for by such centers like ours, allowing us to treat and prevent many of the long-term problems that occur with neglect.

In the CATCH program, we have been able to develop clinics at both Children’s Hospital and University of Colorado Hospital five days per week, in addition to outreach clinics in Billings, Montana, Casper and Cheyenne, Wyoming, Loveland, Colorado, Colorado Springs, and soon Grand Junction. Our hope is that this will remove some barriers to specialty care, and bring survivors back into care, maximizing long term health and the highest possible functional status. The CATCH team can be reached by community providers for consult and referral through OneCall, 720-777-3999. For additional education on presentation and clinical management of congenital heart disease patients see the Charting Pediatrics Podcast, Season 2 Episode 26, on Apple Podcasts, Spotify or Google Play.


An Overview of the Colorado Candor Act

Recently passed legislation offers a new approach to addressing adverse outcomes with patients.

Nobody wants to see an adverse outcome in health care, yet despite best efforts, these types of incidents occur. How providers deal with them and address the needs of patients is important because the provider-patient relationship forms the foundation of health care. Now, medical providers and facilities in Colorado have a new option to utilize in these situations—the Colorado Candor Act.

The recently passed Colorado Candor Act establishes a voluntary framework for health care providers and facilities to offer compassionate, honest, timely, and thorough responses to patients who experience an adverse health care incident. It is designed to benefit patients, their families, clinicians, and health care systems by formalizing a non-adversarial process where there can be open communication about what happened, why it happened, and what can be done to prevent this in the future. Under certain circumstances, the process may include an offer of compensation.

Where Did the Legislation For the Act Originate?

The Colorado Candor Act emerged from discussions between the Colorado Academy of Family Physicians (CAFP) and legislators at the beginning of the 2019 state legislative session. CAFP served as a strong advocate for the health care community and its patients by highlighting the benefits of Candor. CAFP worked closely with other stakeholders, including the Colorado Trial Lawyers Association and patient safety advocates, to garner support for this bipartisan measure that passed as legislation (SB 201).

What Types of Incidents Qualify Under the Colorado Candor Act?

Adverse health care incidents arising from or related to patient care resulting in the physical injury or death of a patient.

What Types of Medical Providers and Facilities Can Utilize the Colorado Candor Act?

Physicians, physician assistants, podiatrists, licensed practical and registered nurses, advanced practice nurses, pharmacists, and others who are licensed, certified, registered or otherwise permitted to provide health care services in Colorado.

In addition, hospitals and health care facilities including clinics, community health centers, community mental health centers, surgical centers, and residential care or nursing homes are eligible to participate jointly with a health care provider involved in the adverse health care incident.

How Does the Candor Process Work?

A brief overview of the process is as follows:

1. The process is initiated by the health care provider.
2. The written notice must be sent to the patient within 180 days of the incident.
3. The notice must include specific details about the patient’s rights and the nature of the communications/discussions under the Colorado Candor Act.
4. Under the Colorado Candor Act, health care providers and facilities may investigate and communicate about how the incident occurred and what steps are being taken to prevent a similar outcome in the future.
5. As part of their assessment, health care providers and facilities can determine whether an offer of compensation is warranted.
6. To facilitate open communication under the Colorado Candor Act, discussions and offers of compensation under the Act are privileged and confidential.

Can a Patient Still File a Lawsuit After a Candor Discussion?

The Colorado Candor Act does not limit a patient’s ability to use the legal system. Patients can choose to withdraw from the Candor process at any time. However, the discussions and communications that occurred during the Candor process, including any offers of compensation, remain privileged and confidential. Under the Act, an offer of compensation does not constitute an admission of liability. In addition, if a patient chooses to accept an offer of compensation, a provider or facility may require a patient to sign a release of liability, so he or she cannot bring a subsequent lawsuit.

What Reporting Requirements Apply to the Colorado Candor Act?

Because no payments are made as a result of a written complaint or claim demanding payment based on a practitioner’s provision of health care services, incidents handled through the Candor process are not required to be reported to the National Practitioner Data Bank.

Patients participating under the Colorado Candor Act do not waive their right to file a complaint with the relevant licensing board or the Colorado Department of Public Health and Environment, which oversees health care facilities. Where indicated, a provider’s actions can also be addressed through Colorado’s professional review process for physicians, PAs, and APNs, or a facility’s quality management process for other licensed health care professionals.

States outside of Colorado may require notification of incidents where there is compensation under the Candor process for providers who are licensed in those states, including through the Interstate Medical Licensure Compact.

What are Some of the Other Benefits of the Colorado Candor Act?

A health care provider or health facility that participates in open discussions under the Act may provide de-identified information about an adverse health care incident to any patient safety-centered nonprofit organization for use in patient safety research and education. Such a disclosure does not constitute a waiver of the privilege for open discussions and is not a violation of the Act’s confidentiality requirements.

The Colorado Candor Act goes into effect as of July 1, 2019. The Colorado Academy of Family Physicians will work closely with partners, such as COPIC, to provide additional information and resources about the Act and how to utilize it in the coming months.
Here is my list of things we attempted to fix in health care this year:

The high costs of health care and its effect on individuals, businesses, and our national economy

The variability or lack of access to health care for some members our communities

The realities of fee for service reimbursement

The volume of menial tasks that get lumped together under "administrative burden" that we are required to do every day.

The attack on joy in our profession because of all the above

The opioid crisis, substance use disorders, the obesity epidemic, gun violence, or really any chronic physical or mental illness

I admit, that’s sort of a depressing list of huge issues, and an odd way to start off our Annual Report. But perhaps it caught your attention enough to read this message! I joined the C AFP Board some 10 years ago wanting to make a difference outside of my exam room. I wish I could say we fixed one of the major issues above. But this year I am proud to say that we have tackled parts of many of those issues and are working on making change. I will let the subsequent pages of this report highlight the successes we have had (and there are many) in each of our three areas of focus: Advocacy, Education, and Health of the Physician and Public.

It has been my honor to be involved in the C AFP’s activities as Board Member, Legislative Committee Member, and now Chair, as we attempt to fix the big picture issues of the day. The organization has also given me a platform to investigate and develop personal leadership skills in an area of my own interest- the role of the physician combating climate change, for which I am grateful.

So I encourage you to be involved with the C AFP in the future. Why?

You can be a part of fixing one of the big problems listed above. And even see progress be made!

Maybe you have a different list of things that need fixing. You can learn and access tools to advocate for the change you believe in.

Maybe you don’t really have a strong passion for any of our areas of focus. I suspect that if you engage you will find yourself something you never envisioned [like myself and the topic of climate change].

The staff and board members are dedicated, intelligent, and fun to spend a few Saturdays a year with [which is really important]!

So our to-do list for this year looks a lot like my first list above. And I am excited to see us all tackle it for ourselves, our profession, our patients and our communities. Because that is why we are Family Physicians.

Zach Wachtl, MD
2018 Membership Statistics

2,598 Members

- **1,618** Active Members
- **271** Resident Members
- **476** Student Members
- **190** Life Members
- **4** Supporting Members
- **33** Inactive Members
- **6** Transitional Members

2018 Financial Data

The CAFP continues to be very stable financially. In 2018 the organization continued our goal of investing and utilizing member dues responsibly. This included moving to socially responsible investment portfolios and making sustainable updates to our office space.

Current Assets: $768,682.40

Fixed Assets: $353,196.44

**Total Assets:** $1,121,878.84

**Total Liabilities:** $162.62

Total Income: $621,995.74

Total Expense: $617,687.89

**Net Ordinary Income:** $4,307.85
CAFP hosted a legislative reception for candidates we supported in the 2018 election. 90% of the candidates CAFP supported were elected.
Testifying Outcomes

SB-022 limits an initial prescription for opioids to 7-days and requires a PDMP check for the 2nd fill. CAFP supported. The bill passed and was signed by the Governor.

HB-1365 CAFP President-Elect testified in support of the Primary Care Investment Initiative to double payer investments in primary care. The bill passed the House Health Insurance Committee 11-2, but was defeated in Legislative Council by a tie vote.

HB-1136 adds inpatient and residential treatment to the Medicaid benefit to treat opioid addiction. CAFP supported. The bill passed and was signed into law by the Governor.

HB-1284 allows pharmacists to inform patients if the cash-pay price of a drug is cheaper than the price under their health plan, by prohibiting so-called “gag clauses” in contracts between pharmacists and prescription benefit managers. CAFP supported. The bill passed and was signed into law by the Governor.

SB-214 would have put a lifetime cap of 5 years on Medicaid coverage, while adding work requirements to be eligible for Medicaid. CAFP opposed the bill, which was defeated on a bipartisan vote of 3-2 in the Senate Health Committee.

HB-1260 sought to increase prescription drug price transparency by requiring pharmaceutical companies to submit drug prices to the state and notify insurers and patients in advance of a 10% increase in a drug’s price. CAFP supported the bill, which was defeated on a vote of 3-2 in the Senate State, Veterans and Military Affairs Committee.

AF Williams family medicine interns sit in Senate committee chairs as Dr. Jeff Cain of Colorado speaks about family medicine advocacy and using their stories to make change.
2018 marked the first year CAFP authored legislation to increase the investment in primary care in Colorado. This legislation, modeled after successful work done in states including Oregon and Rhode Island, would measure the amount of money spent on primary care in Colorado, and bring that number up to a minimum of 12 to 15 percent. While the legislation was not passed in 2018, the CAFP built a coalition of supporters around the work, brought attention to this important issue, and laid the groundwork for the legislation to be passed in 2019.

Zach Wachtl, MD, testifying in support of CAFP’s Primary Care Investment legislation.

Op-Eds appeared in newspapers across Colorado in support of CAFP’s primary care investment initiative.
Doctor of the Day By the Numbers

2018 saw continued growth of the Doctor of the Day program at the State Capitol. Family physicians treated legislators, staff and visitors, and offered a first-hand example of how important family doctors are.

- 30+ Patients Treated at the Capitol
- 53 Doctor of the Day Participants
- 43 Out of a Possible 83 Days Covered

2018 Colorado Primary Care Collaborative (CPCC) Convening

Leaders in healthcare and payment reform from across the US gathered together for CPCC’s 2018 Convening: Not Someday. Today. Making Primary Care Payment Reform a Reality in Colorado.
2018 CAFP Annual Summit

The 2018 Annual Summit was all about celebrating family medicine. The CAFP marked our 70th anniversary in style, joined by wonderful attendees, speakers and exhibitors at the Cheyenne Mountain Conference Center in Colorado Springs.

2018 CAFP Award Winners

Family Medicine Physician of the Year
Gary Knaus, MD

Family Medicine Resident of the Year
Cleveland Piggott, MD, MPH

Family Medicine Teacher of the Year
John Lee Miller, MD

Patient-Centered Innovation Award
Roaring Fork Family Practice
Engaging Students & Residents

The CAFP hosted a casual get together with the medical students and family medicine residents attending AAFP’s National Conference in Kansas City. This event helps students understand what the Colorado chapter can provide in conjunction with the national organization.

CAFP hosted a student and resident networking night at Dry Dock Brewery in Aurora to give the next generation of Colorado family physicians a chance to meet each other, engage with CAFP leaders, and enjoy some well-earned relaxation.
New Youth Marijuana Prevention Program

STOP AND IMAGINE
PREVENTING MARIJUANA USE IN COLORADO YOUTH

Responding to a growing need recognized by Colorado family physicians, educators and health officials, the CAFP developed Stop & Imagine: Preventing Marijuana Use in Colorado Youth.

Stop & Imagine is modeled after the Tar Wars program and brings a family physician into Colorado 4th and 5th grade classrooms to talk with students about marijuana use. The program utilizes fun activities and positive reinforcement to engage students in its message.

Green Initiatives at the CAFP

The CAFP recognizes both the health and financial benefits of sustainable, environmentally friendly practices. Under leadership from the Board of Directors, spearheaded by Board President Zach Wachtl, MD, the CAFP implemented many sustainable practices in 2018. This included having an energy efficiency audit conducted in our office, moving to a more efficient HVAC and lighting system and moving to purchase 100 percent of our electricity from a solar farm. These changes will have paid themselves off in a little over five years, representing a sound financial investment, as well as a healthy one.

In addition to the work in our own office, Dr. Wachtl presented a resolution that passed at the 2018 Congress of Delegates in New Orleans, asking the American Academy of Family Physicians to set a Clean Energy Goal for their organization as well.
CAFP Board of Directors

Officers
Chair/Past President – Monica Morris, DO, Denver
President - Zach Wachtj, MD, Denver
President-elect – John Cawley, MD, Ft. Collins
Vice President – Gina Carr, MD, Buena Vista
Secretary/Treasurer – Craig Anthony, MD, Denver
Member-at-Large – Alan-Michael Vargas, MD, Parachute
External Relations/Awards Committee Chair – Tamaan Osbourne-Roberts, MD, Denver

Term Expiring 2019
Corey Lyon, DO, Denver
Roxi Radi, MD, Denver
Virginia Richey, DO, Wheat Ridge
TJ Staff, MD, MPH, Denver

Term Expiring 2020
Melissa Devalon, MD, Monument
Stephanie Gold, MD, Denver
Matthew Mullane, MD, MPH, Denver
Alan-Michael Vargas, MD, Rifle

Term Expiring 2021
Rachel Carpenter, MD, Denver
Cleveland Piggott, MD, Denver
Karin Susskind, MD, Boulder
Abbie Urish, MD, Rangely

Delegates
Brian Bacak, MD, Highlands Ranch – term expires 2019
Glenn Madrid, MD, Grand Junction – term expires 2019

Alternate Delegates
Tamaan Osbourne-Roberts, MD, Denver – term expires 2019
Monica Morris, DO, Denver – term expires 2019

Resident Representatives
Andrew Clithero, MD, 2019, North Colorado Family Medicine Residency, Greeley
Kyle Leggott, MD, 2019, University of Colorado Family Medicine Residency, Denver
Lisa Matelich, MD, 2019, St. Mary's Family Medicine Residency, Grand Junction
Julie McKenzie, DO, 2019, St. Anthony North Family Medicine Residency, Westminster
Lindsey Pearson, MD, 2019, Rose Family Medicine, Denver
Lindsey Romero, MD, 2021, Southern Colorado Family Medicine Residency, Pueblo
David Stuart, MD, 2019, St. Mary's Family Medicine Residency, Grand Junction
Jessica Zha, MD, 2019, University of Colorado Family Medicine Residency, Denver

Student Representatives
Bijan Ghaffari, CU, 2019
Leah Kellogg, CU, 2019
Filiberto Morales, Denver, CU, 2020
Sara Schuster, Denver, CU, 2019
Say Hello

twitter.com/COAFP

facebook.com/coloradoafp

coloradoafp.org/blog

Colorado Academy of Family Physicians
2224 S. Fraser St. #1, Aurora, CO 80014
303-696-6655
www.coloradoafp.org
“Being treated with genuine compassion and care got me into recovery.”

—Blair H. of Denver, CO

You can be the positive influence that helps a person with opioid addiction find recovery. Learn how to connect someone to effective treatment at LiftTheLabel.org/Training
One of my first jobs out of college was assisting older adults with their application for the Supplemental Nutrition Assistance Program (SNAP), also known as food stamps. Through these meetings, I had the chance to connect with people about their families, their lives, and their health concerns.

Most of the individuals I met with were living off a fixed monthly income, which they had to carefully manage in order to pay for food, housing, and medication. For low-income individuals, this often forces decisions between immediate needs and their health. According to Hunger in America 2014, 66 percent of food insecure households who receive assistance from Feeding America must decide between purchasing food or purchasing their prescriptions, because they cannot afford both. That means the true cost of health care is much higher than we think.

To learn more, Center for Health Progress, along with local partners and other groups across the country, were funded by the Robert Wood Johnson Foundation to research the cost of health care, and how cost barriers can be talked about and addressed in health care settings. Community members, in partnership with researchers, developed and tested cost-of-care messaging. We then worked with clinic and community care sites to improve workflows to support provider-patient conversations about cost. Over and over again, it was found that when patients consider the cost of health care, it goes far beyond the direct cost of seeing a provider, paying for their prescriptions, and getting laboratory tests or procedures. Patients consider the cost of care to include a variety of additional “hidden” costs.

First, there are indirect costs of care, such as transportation to the hospital or clinic, lost wages due to time off, and child care while the parent is at an appointment. These are out-of-pocket costs still associated with accessing health care, they’re just not paid to the health care system. The health care system can help lower indirect costs by developing care options that require fewer visits, utilizing telehealth and other off-site care options, providing transportation assistance, and connecting patients with community resources.

Second, there are competing costs, such as bills, food, and housing. These are the costs that force decisions for patients—should they see the doctor or pay the electric bill? Pick up that prescription or have a roof over their head? The health care system can help minimize these impossible choices by helping patients prioritize elements of their care plan and modifying care options to reduce costs.

All of this requires that providers have more conversations with patients about the cost of care, which is something our research shows both patients and providers want. It also shows why it’s important the health care system advocate for policies that will reduce indirect and competing costs for patients—such as living wages, paid leave, public transportation, and other supports for hardworking Coloradans.

The research supports what I learned during my work with SNAP applicants—many Coloradans find it difficult to balance the many demands on their time and financial resources, and it makes the true cost of health care much higher than most providers and policymakers currently understand. To ensure we have a health care system that works for all Coloradans, we need to change how we think about health care costs and how the health care system responds to patient’s needs.

- Full study: http://annals.org/aim/article/doi/10.7326/M18-2140
- Resources for providers: https://essentialhospitals.org/cost-care/practice-briefs/
The Colorado Academy of Family Physicians is pleased to announce a new membership benefit: My Green Doctor. This free program shows how to add environmental sustainability to your offices. It requires your office manager or you to add only five minutes of Green Team business to each regular staff meeting. You will save money -- as much as $2000 per doctor per year-- as you adopt wise environmental practices. In addition, there are free brochures, posters, and other tools for teaching the office staff, patients, and families. My Green Doctor helps us prepare our patients for the health effects of climate change.

We recommend that you register with My Green Doctor and ask your office colleagues to register as well. Registration is free, safe, and takes under two minutes: https://www.MyGreenDoctor.org. The site is for all healthcare professionals, not only physicians. Your office will receive a free certificate for the waiting room just for registering.

Your office manager will learn how to start a Green Team that meets for five minutes as part of each usual staff meeting. Every meeting is scripted in the “Meeting-by-Meeting Guide” so that there is nothing for your manager to study in advance. The office will read the “Ten Reasons to Go Green” and use the “Meeting-by-Meeting Guide” to make gradual improvements. You can qualify for the Green Doctor Office Certificate in just six weeks! The $250 certificate is free to you as a member of the Colorado Academy of Family Physicians.

My Green Doctor is a practice management tool that is designed by doctors, is science-based, and is comprehensive. It is used by hundreds of offices in 50 countries because it really works. Check out this new, free CAFP membership benefit.
Colorado has made tremendous gains in insurance coverage in recent years, but consumers often run into barriers and challenges using their insurance once they have it. This can include issues with out-of-pocket costs, claims denials, surprise out-of-network billing, and more. For older adults, post-enrollment issues are especially common. Because of high utilization of health care services, adults over 50 often face issues with access and affordability, and subsequently are at risk of financial insecurity.

The intersection of health care access and financial security is central to the work of the Colorado Consumer Health Initiative (CCHI). We are a statewide, non-partisan, non-profit membership organization that works towards equitable access to high-quality, affordable health care for all Coloradans. One year ago, in response to pervasive issues in post-enrollment navigation, CCHI launched its Consumer Assistance Program (CAP). The program empowers Coloradans to navigate their health insurance challenges and improve their financial security by providing direct education and assistance with coverage, access, and billing issues. To date, we have worked with 257 consumers across 20 counties to save $606,057 in medical bills, with another $646,034 pending. Clients have a variety of insurance statuses, including private insurance, Medicare, Medicaid or CHP+, and uninsured. The majority of the issues that we work on with clients have to do with medical bills in collections, balance billing, and claims denials. We also assist with enrollment issues, service denials, hospital financial assistance and charity care issues, coverage terminations or coverage denials, charge disputes, and affordability issues - including premiums, out-of-pocket costs and other expenses.

Using a community-driven approach, our Consumer Assistance Program enables CCHI to advocate for public policies that strategically address the pre and post-enrollment issues in health care that we are informed of through our direct connections with consumers. As a result, the knowledge gained by working with individuals through our Consumer Assistance Program informs the work of our strategic engagement and public policy teams to drive responsible, proactive policy-making aimed at solving issues consumers are facing first-hand.

In doing so, our model allows for the strategic elevation of the stories of Coloradans in health care policy discussions. This includes empowering and assisting Consumer Assistance Program participants in writing opinion pieces and blogs, testifying at the capitol, speaking out on social media, and sharing their stories with reporters. As a result, consumers directly advocate for legislation to address the health care barriers they’ve encountered, and gain experience that enables them to share their knowledge of this process with their communities.

This approach centers the consumer as the expert and leverages their lived experience to inform powerful policy-making that will have a tangible impact on access, affordability, and equity in health care. Although this past legislative session included myriad bills that addressed health care equity, access, and affordability, some of the key bills linked to our Consumer Assistance Program included legislation protecting consumers from surprise out-of-network balance billing (HB19-1174), addressing drug price transparency and affordability, especially in relation to insulin (HB19-1216, SB19-005, HB19-1296), hospital financial transparency (HB19-1001), exempting primary residences and wages from liens and garnishment for medical debt (HB19-1145, HB19-1089, HB19-1189), increasing affordability in health insurance through a state health coverage plan and a reinsurance program (HB19-1004, HB19-1168), and strengthening protections for consumers around free-standing emergency rooms (HB19-1010). Consumers from our CAP program were directly involved in advocating at the capitol, writing letters to the editor, submitting written testimony, and testifying in person on some of these bills. Many were passed and signed into law, and you can see our full legislative
scorecard to learn more. We are thrilled that consumers had a central voice in advocating for quality, affordable, accessible health care in Colorado this session, as leveraging consumer stories is integral in all of our public policy work.

We also work to influence insurance regulations that protect consumers and work towards more transparency, quality, and accountability for insurance plans in the state. Consumer stories from our Consumer Assistance Program are central in guiding this work to regulate the health insurance industry. In influencing regulation at the Division of Insurance, we can prevent pre and post-enrollment issues from being so pervasive. This past year, regulatory advocacy directly related to our Consumer Assistance Program included protecting consumers from the deceptive marketing of short-term plans (Regulation 4-2-59). Responsible regulation makes sure that Coloradans are informed, get access to quality coverage, and are able to use their insurance without fear for their financial security while getting the care they need.

Legislative and regulatory advocacy to strengthen our health care system in Colorado would not be possible without the community connection CCHI has to consumers through our Consumer Assistance Program. Furthermore, our program enables us to see the impacts of our advocacy work and continue to hold industry and government accountable to equitably providing the best quality, most affordable health care possible to all Coloradans.

We are so proud of the work we have done to protect consumers and further access to quality, affordable health care in Colorado this year. In November 2018, CCHI received the “Get Wise” Consumer Protection Award from the Colorado Department of Regulatory Agencies (DORA). The award recognizes the direct assistance CCHI is providing to consumers navigating health care services, hospital financial assistance, billing, and coverage issues and the advocacy work it does to pair this direct service with systemic policy change. We are grateful for this recognition of the hard work we are doing to champion the voices and rights of consumers across Colorado in our health care system, and look forward to another year of strategic collaboration with consumers, community partners, coalition organizations, and public officials. This coming year, we hope to strengthen the work of our program by adding additional staff capacity and an earned revenue stream that will enable us to sustainably provide access to our services for as many Coloradans as possible.

Special CME Programs

Medical Review Officer Training

Comprehensive MRO Training and AAMRO Certification Exam (Friday–Sunday)
Nashville, TN August 9–11, 2019
Las Vegas, NV December 6–8, 2019
Approved for 21.75 AAFP prescribed credits

NEW! Advanced Comprehensive MRO (Recertification) Training and Certification Exam (Saturday–Sunday)
(1.5 Day Program—Certified MROs only)
Nashville, TN August 10–11, 2019
Approved for 13.25 AAFP prescribed credits

800-489-1839 www.aamro.com
All AAMRO training programs include the latest information on hair, sweat, oral fluids, and interpretation of opiates in the field of drug and alcohol testing.
The Pediatric Hexavalent Vaccine – Fewer Shots for Children

Over the last four decades, many new vaccines have been developed against several more of the serious infectious diseases of childhood. As a consequence, the routine vaccine schedule in the ﬁrst two years of life has become incredibly expensive and complex compared to “the old days.” Each new vaccine comes with a solid track record in clinical trials, and most of them have proved themselves excellent in terms of safety and efﬁcacy over time. However, parents and clinicians alike have struggled with the challenge to keep children current with the recommended schedule.

Though we do not have hard data to prove it, the “wisdom on the street” in our experience has been that nursing staff ask, “What can we do to minimize the number of sticks at each visit?” We are not surprised that parental concerns regarding the number of vaccines received at a single visit is a well-documented reason for delaying or refusing vaccines (tinyurl.com/ytyzt00tk). Even parents who favor vaccines ask, “What can be done to minimize the number of times we have to bring our child in for shots?”

Combination vaccines are an attractive solution, so long as they are affordable and so long as all the components are safe and efﬁcacious when given together. These can sometimes be “big if’s.” For instance, the combination Measles-Mumps-Rubella-Varicella vaccine has been found associated with a slightly higher risk of febrile seizures compared to MMR and varicella vaccines given separately (https://tinyurl.com/y68537xk). Some Hemophilus B conjugate vaccines have been found less efﬁcacious when given with DTaP (https://tinyurl.com/y25o7vtf).

In December, 2018, Vaxelis™, the ﬁrst six-in-one pediatric vaccine, protecting against diphtheria, pertussis, tetanus, polio, hepatitis B, and Hemophilus type B, was licensed in the U.S. by the Food and Drug Administration (https://tinyurl.com/y2yge2mb). Interestingly, this vaccine is a joint venture of two competing vaccine manufacturers – Merck and Sanofi Pasteur. The responsibility for making the different components, promoting the product, and tracking adverse events is shared between the two companies.

According to data presented at CDC’s Advisory Committee on Immunization Practices in February 2019, immunogenicity and safety of the combination product is comparable to those of its component parts (https://tinyurl.com/y5p78y8). Hopefully, its efﬁcacy over the longer term will be equally positive, since the components have been shown to be efﬁcacious for some time.

This hexavalent vaccine is one of the latest efforts to reduce the number of shots children need. In addition, this vaccine will help simplify giving vaccinations in our ofﬁces and reducing the number of vaccines that need to be ordered, stored, and shipped. In addition, the vaccine will not require more volume per injection than a single vaccine (tinyurl.com/y5qso8z). What it will cost is not clear at this point.

We regard this hexavalent vaccine as an important step forward in helping parents and clinicians meet the demands of the routine immunization schedule. Assuming it is reasonably priced, we join ACIP in recommending it be used as soon as supplies are commercially available (estimated as 2020 – https://tinyurl.com/y6jiqzum).

Measles outbreaks a reminder of Colorado Legislature’s vaccine malfeasance

We found an editorial in the Aurora Sentinel Editorial (tinyurl.com/y2yerlhv) very convicting:

A potential public health disaster … underscores why Colorado must end its perilous philosophcal exemption to mandatory immunization. … (The national) measles outbreak … speaks to the damage ignorant and irresponsible parents are causing in communities across the nation – including Colorado.

Shockingly, Colorado ranks near the bottom of states for rates of child immunization compliance. It’s unnerving because the state has one of the highest proportions of highly educated parents in the nation. But a large number of parents, and previous state lawmakers, have fallen victim to a pervasive ruse undermining immunization rates and public health.

That ruse is a regularly discredited study run by a discredited doctor who fallaciously tied autism to childhood vaccinations. The U.S. media irresponsibly published the claims despite experts exposing the author’s poor science, helping to legitimize them. There is not one reputable pediatrician, pediatric organization, hospital, clinic or researcher that does not vehemently work to debunk the autism lie and beg parents to vaccinate their children.

Now, huge swaths of the public are at dire risk across the nation. Measles is not an inconvenience. It can easily be deadly to children and adults with compromised immune systems who depend on “the herd” to remain disease free through mass immunization. It can be deadly to healthy children, too.

But states like Colorado have succumbed to ignorant parent pressure and continue to allow anyone to keep from vaccinating their child and attend public schools.
without a valid medical reason. In Colorado, it’s actually easier to say that you don’t want to vaccinate your child than to prove that you have.

Lawmakers should immediately adopt a recent California measure, which requires vaccination of all children without a valid medical issue or prohibits that child from attending public schools. Likewise, programs such as league sports, Boy Scouts, and others should also require immunizations or valid medical exemption to help protect all children.

In the two years California has adopted the measure, compliance has nearly returned to safe standards. Real scientists and medical professionals are unequivocal: The purported autism danger of childhood vaccines are lies. Dangerous lies. In a state where real science rightfully rules decision making on so many issues, it’s past time to let science guide the state back toward mandatory vaccination.

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.

**Federal government may be forced to step in on state vaccination exemption laws**

FDA Commissioner Scott Gottlieb, MD, says, “If states don’t tighten vaccine exemption laws, the federal government may step in,” adding that states granting wide exemptions for vaccines are “creating the opportunity for outbreaks on a scale that is going to have national implications” and may eventually “force the hand of the federal health agencies” (tinyurl.com/y5y5ot4t). Medical groups “including the American Medical Association, the American Academy of Family Physicians and the American Academy of Pediatrics have for years opposed vaccine exemptions” (tinyurl.com/yyyo5be9). AMA President-elect Patrice A. Harris, MD, argues that “protecting community health in today’s mobile society requires that policymakers not permit individuals from opting out of immunization solely as a matter of personal preference or convenience” (tinyurl.com/yyyo5be9).

**Journal article offers FPs guidance on vaccine-hesitant parents**

Guidance published in Canadian Family Physician (tinyurl.com/yy53fb95) may help family physicians who have vaccine-hesitant parents in their practices. The article’s authors cite research indicating that more than 60 percent of Canadian parents go online to find information on childhood immunizations, calling this figure “concerning” because vaccination information found on websites and social network groups is often deliberately misleading or negative. However, the same research indicates that more than 50 percent of parents receive vaccine information from their physicians, and more than two-thirds said they thought health care professionals such as family physicians were the most reliable and trustworthy source of this information.

Findings such as these highlight the important role family physicians can play in counseling parents and building up their confidence in vaccines, the authors contend. Reflecting previous research that has suggested multipronged interventions are most effective, the authors offer several evidence-based tips for talking with parents about vaccinating their children:

CONTINUED ON PAGE 38 >>
**Start early.** It’s important that physicians talk with parents about vaccines during prenatal visits and the first few postnatal appointments to educate them about vaccinations and provide them with fact-based materials or links to reliable websites.

**Present vaccination as the default option.** A presumptive approach that assumes parents will immunize their child has been shown to be more effective than a participatory approach, which can offer vaccine-hesitant parents more opportunity to resist vaccine recommendations.

**Be honest about side effects.** When parents ask about possible adverse effects of vaccination, provide them accurate information and reassure them that a robust vaccine safety system is in place.

**Tell parents stories.** Supplement scientific facts with personal experiences -- for example, physicians can tell parents what they do for their own children regarding immunizations.

**Build trust with parents.** Showing respect, displaying empathy and tailoring information to each parent helps ensure vaccine compliance.

**Address the pain associated with vaccination.** Inform parents about what pain can be expected after vaccination and reassure them that any vaccination-related pain is typically mild and transient.

**Focus on protection.** Emphasize to parents that vaccinations not only protect the child but reduce the likelihood of outbreaks, which helps to protect the community at large.

The article also provides tables that offer the following information:

- sample statements that physicians can use in conversation with parents,
- answers to commonly asked questions,
- online resources that provide the latest vaccine-related information for health care professionals and parents, and
- interventions to reduce vaccination-associated pain.

**Social media battle outbreak of bogus vaccine claims**

The AP reported, “internet companies are trying to contain vaccine-related misinformation they have long helped spread. So far, their efforts at quarantine are falling short” (tinyurl.com/yxbx5ekv). Searches of social media “turn up all sorts of bogus warnings about vaccines, including the soundly debunked notions that they cause autism or that mercury preservatives and other substances in them can poison and even kill people.” Experts worry the spread of bad information is contributing to the return of deadly diseases such as measles.

Nevertheless, USA Today reports Facebook “says it will reduce distribution” of vaccine misinformation “and provide users with ‘authoritative information’ on the topic” of vaccine safety, effectively “following the lead of Pinterest, which has blocked all searches using terms related to vaccines or vaccinations as part of a plan to stop the spread of misinformation related to anti-vaxx posts” (tinyurl.com/y4tm989w).

The AP story adds, “Facebook says it will take its cue from global health organizations, such as the World Health Organization and the U.S. Centers for Disease Control and Prevention, which have publicly identified verifiable vaccine hoaxes.” The social media company indicated that “if groups and pages spread those hoaxes, they won’t appear in recommendations or in predictions functions when searched for in Facebook.” Also, “ads with similar information will be rejected.”
You believe your child can be anything. But what if his body says he can't?

Here, we have the best spine surgery outcomes in the region.

Hunter's spirit was unstoppable. Until a 90-degree curve threatened to paralyze him for life. As the first pediatric facility in the region to use 3D technology to treat scoliosis, only Children's Hospital Colorado had the expertise to rebuild a spine as strong as his spirit. By creating an exact replica of his spine, Hunter's multidisciplinary team of specialists was able to practice and perfect a complex surgery that got him back on his feet. Pediatric orthopedics is just one of our many nationally ranked specialties, which proves there's no other choice when it comes to your child.
If you’re a policy wonk who loves CNN, or someone who wants to see bigger, broader change on the state level, this is the committee for you. The CAFP Legislative Committee discusses key policy issues for the CAFP to focus on and turns those issues into action at the legislature.

Committee Contact:
Ryan Biehle, MPA, MPH, Deputy CEO for Policy & External Affairs
ryan@coloradoafp.org
303-696-6655 x 117

If you’re passionate about the health of the community you take care of and your physician colleagues, the CAFP Health of the Physician and Public Committee would love to have you. Discuss critical public health issues you see in your community, shape grant-funded projects for the CAFP Foundation to pursue, and discuss ways to help physicians deal with emerging issues like violence in the workplace and finding career fulfillment.

Committee Contact:
Lynlee Espeseth, MPH, Director of Communications, Marketing & Membership
lynlee@coloradoafp.org
303-696-6655 x 116

Are you interested in helping family physicians be lifelong learners? Maybe you plan the best BBQ on your block? The CAFP Education Committee is a great place to help choose what topics are featured at our Annual Summit, plan additional events, and make sure all physician voices are represented in CAFP’s educational efforts.

Committee Contact:
Erin Watwood, Director of Education, Events & Meetings
erin@coloradoafp.org
303-696-6655 x 114

Students and residents, this is your opportunity to share what kind of events and support you want to see from the CAFP! While all members of the CAFP are invited to join the CAFP Resident & Student Activities Task Force, we particularly encourage students and residents to participate. The group will help design the student and resident track at the CAFP Annual Summit, as well as other events just for students and residents.

Committee Contact:
Erin Watwood, Director of Education, Events & Meetings
erin@coloradoafp.org
303-696-6655 x 114

For more information on these committees visit https://www.coloradoafp.org/cafp-committees/.

Congratulations to the University of Colorado Family Medicine Interest Group for receiving a 2019 Program of Excellence Award from the American Academy of Family Physicians!
Family physicians are a very caring and thoughtful group, our choice of profession makes that abundantly clear! I believe many of us think about the legacy we will leave behind long after our days of practicing family medicine are over. How can we impact the future of family medicine, the physicians who will serve Colorado, and the patients who will need care?

One way to leave a lasting mark is to participate in the Colorado Academy of Family Physicians Foundation’s (CAFPF) Legacy Giving Program. This program allows physicians to support the foundation by giving a gift of stocks, bonds, real estate, retirement assists, or other funds. These gifts are directed to the CAFP in a physician’s will.

Why do these gifts matter? Every single dollar given to the CAFPF goes directly to students and family medicine residents to support them in attending family medicine-focused events, including the CAFP’s own Annual Summit. Students who are exposed to family medicine are more likely to choose family medicine. Family medicine residents who make strong connections in Colorado are more likely to practice here. The Foundation’s goal is to foster this interest and connection by showing students and residents all that is good about family medicine, specifically family medicine in Colorado.

Your gift will support students and residents and foster their interest in Colorado’s primary care community for years to come.

To learn more about legacy giving and what your options are you can visit the legacy giving section of CAFP’s website at https://www.coloradoafp.org/cafp-foundation/ or contact CAFP’s CEO Raquel Alexander at raquel@coloradoafp.org or 303-696-6655 x 110.

BY CISSY KRAFT, MD
PRESIDENT, COLORADO ACADEMY OF FAMILY PHYSICIANS FOUNDATION

FAMILY PRACTICE PROVIDED ME THE BEST POSSIBLE JOB FOR A FULL CAREER. I CONTINUE TO SUPPORT THE FOUNDATION ON A REGULAR BASIS SO THAT THERE WILL BE A SOLID GROUP OF WELL TRAINED AND ENTHUSIASTIC FAMILY PHYSICIANS AVAILABLE TO GUIDE MEDICAL CARE IN AMERICA WHEN OUR HEALTHCARE SYSTEM FINALLY BECOMES WHAT IT NEEDS TO BE.

- ROGER SHENKEL, MD

I FELL IN LOVE WITH FAMILY MEDICINE AFTER BEING ABLE TO ATTEND A FAMILY MEDICINE CONFERENCE. THAT CONFERENCE WAS MADE POSSIBLE DUE TO A SCHOLARSHIP FROM MY STATE AAFP FOUNDATION. IN ORDER TO HAVE A STRONG PRIMARY CARE WORKFORCE, WE NEED TO INVEST IN OUR STUDENTS AND RESIDENTS. I’M A PROUD DONOR TO THE CAFP FOUNDATION AND HAPPY TO DO MY SMALL PART IN HELPING THE NEXT GENERATION OF FAMILY PHYSICIANS!

- CLEVELAND PIGGOTT, MD, MPH

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THE IMPORTANCE OF TRAINING FAMILY PHYSICIANS IN RURAL COMMUNITIES

BY RILEY STANTON, CAFP MARKETING AND COMMUNICATIONS INTERN

Just under three-quarters of Colorado communities are classified as rural or frontier, with over 750,000 potential patients. Rural physicians see more patients per provider than their urban counterparts. Overall physician shortages in rural areas create access to care discrepancies, with rural patients having less access to preventative care. This lack of access can lead to poor health outcomes and delays in diagnosis and treatment of chronic conditions. The demographics of rural populations include patients who are older, poorer, less educated, and more likely to contend with adverse environments that compound these disparities.

The health care provider shortage also challenges rural Coloradans who need access to mental health services; 22 of 47 rural counties do not have a licensed psychologist. A rural physician may be the only provider a patient sees to treat a mental health condition. Due in part to reduced access to preventive and mental health care, rural Coloradans have higher rates of teen pregnancy, opioid overdoses, and suicide than state averages. Opioid overdoses are particularly troubling as the death toll from overdose and rates of newborn opioid addiction continue to rise. More Coloradans died from a prescription drug overdose than use of illicit drugs, killing one person every 9.5 hours. Fatal overdoses occur more frequently in rural areas which account for 9 of the 10 counties with the highest overdose rates. The reasons behind this are not fully understood, but rural county demographics that include older patient populations with more chronic pain and limited availability of alternative therapies may be factors.

To achieve an adequate supply of physicians to support a healthy population in rural settings we must recruit new physicians to rural medicine. That’s not news to family physicians both urban and rural, and neither is the fact that this task is no easy feat, with less than 3% of medical school students expressing a desire to practice in a rural setting. The data reflects why training students and residents in rural areas is so vital. When training occurs in rural environments residents develop competencies within a rural context.

Although participation in a Rural Track does not require a rural residency, these programs turn out more rural physicians than medical school programs without a rural emphasis. Yet, while the mean percentage of RT graduates entering rural practice in 2013 was 44% (range=30-65%), this signifies only 1 in 2 RT students will eventually practice in a rural location. To improve RT outcomes, the most successful programs focus on providing community-based clinical education to students of rural origin interested in primary care or family medicine. There is strong evidence to support that students with a rural upbringing are more likely to practice in rural communities, something many rural physicians know anecdotally to be true.

Rural residencies can be more adaptive to learning objectives than programs at large hospitals. Rural residents enjoy a variety of learning opportunities and may have a patient suffering a heart attack nearby.

“AS A MEMBER OF THE RURAL TRACK WE ARE AFFORDED MANY OPPORTUNITIES TO IMPLEMENT SKILLS AND KNOWLEDGE EARLIER IN OUR TRAINING. AS A FIRST-YEAR MEDICAL STUDENT I WAS EQUIPPED WITH A GREATER NUMBER OF PRACTICAL SKILLS AND DUE TO THE NATURE OF RURAL PRACTICE, WAS ALSO REWARDED WITH GREATER TRUST AND AUTONOMY FROM MY RURAL PRECEPTOR. I WAS ABLE TO PRACTICE SUTURING, INJECTIONS, AND WAS EVEN FIRST-ASSISTANT ON SEVERAL O.R. PROCEDURES.”

-UNIVERSITY OF COLORADO SCHOOL OF MEDICINE RURAL TRACK GRADUATE
in the same week they gain skills in obstetrics, orthopedics, and respiratory care. Rural clinics may not have specialists on call, broadening the scope of practice. This gives the resident a more robust experience than they may see in an urban setting. The experience also exposes the resident to life in a rural community, such as community pride in its schools, annual events and recreation activities6.

Hosting a resident at a rural practice benefits the community, as well as the trainee. Rural clinics training residents report benefits to the surrounding community through their resident’s participation in community-based projects and collaboration with local health organizations. These projects allow residents to foster relationships with local organizations and feel connected to the community. Community members often identify rural residents as role models to youth, sometimes inspiring them to pursue careers in rural health as well7.

Family physicians are a vital aspect of Colorado’s rural and frontier communities. They provide a breadth of services and their ability to adapt and evolve to meet community needs once established in their practice is often a product of a successful rural residency that fostered their interest in rural medicine4. The future of rural population health in Colorado depends on continued and increased training of family physicians in the communities that need them most.

1. Center, Snapshot of Rural Health in Colorado. 2019: Aurora, CO.
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The CAFP would like to welcome the following new and returning members who joined our organization in March, April and May.

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- Brian Baker, DO
- Trina Bancroft Begay, MD
- Elizabeth Belson, MD
- Candace Brown, MD
- Donald Dickman, MD
- Jason Eversole, DO
- Barton Giesel, MD
- Jeanne Haberer, DO
- Michele Hannagan, DO
- Natalie Kunsmans, MD
- Gurvinder Mangat, MD, CCFP
- Ruchi Mathur, MD, MPH
- Salil Mathur, MD
- David McClellan, MD
- Kellan Miller, MD
- Jill Neiman, MD
- Rollin Odem, MD
- Christina Palmer, MD
- Christian Stob, DO
- Katherine Wiegert, MD
- Muthanna Yacoub, MD

**RESIDENT MEMBERS**

- Ranjot Basram, DO
- Abraham Benavides, MD
- Matthew Bonello, DO
- Bradley Brown, DO
- Keely Burke, MD
- Shawneeca Burke, MD
- Sarah Doucette, MD
- Daniel Edmondson, MD
- Jodi Fitzgerald, MD
- Jeannie Folan, MD

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- Rachael Gollub, MD
- Connor Harmann, MD
- Conner Hosner, MD
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- Queenter Kisang, MD
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