Does your care philosophy include a patient-centered, quality approach?

Peak Vista Community Health Centers offers exceptional medical, dental and behavioral health care throughout 26 health centers in Colorado’s Pikes Peak and East Central regions. Peak Vista’s mission offers unique opportunities for a fulfilling career that impacts the underserved communities close to home.

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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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Edition 61

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PRESIDENT’S LETTER

It is hard to believe that summer is already winding to an end, our children are back in school, the fields are being harvested, and the weather is a bit chillier.

This summer afforded time for many adventures, but one of my favorites was traveling to the fictional community of Port William, Kentucky through the work of author Wendell Berry in Jayber Crow. Berry is able to transport the reader to share in the intimate details of Port William and the characters that he describes as “members” of the community. We watch as they journey through life and witness their hometown transition from a traditional agrarian community to one shaped by the rise of agribusiness.

While I don’t draw any lines between the change of family farming in the south to the current state of medicine in Colorado, the sense of community the reader is immersed in and the journey they are taken on echoes our unique role as family physicians. Similar to the main character Jayber (the barber of Port William), we are invited in to the sacred and intimate portions of our patient’s lives. We walk alongside patients for multiple generations, just like the characters of Port William experience with each other. Additionally, throughout the text a recurring theme of community and place emerge, highlighting a refrain that one’s work ought to be rooted in and a response to the place and time they are in.

The CAFP is firmly rooted in doing work for communities throughout Colorado, championing our patients and Colorado family physicians. Throughout the summer your Academy has been busy working with our partners on developing innovative means to care for our patients and support our communities, while working to reduce potential threats to our community and our ability to practice.

Over the summer we worked with the Department of Health Care Policy and Financing and the Insurance Commissioner’s Office to shape and implement the public health insurance option, as established this last legislative session by HB19-1004. We felt that this public health insurance option should be rooted in primary care. It should invest a larger amount of the total cost of care in primary care, offer first dollar coverage for primary care services, move to coordinated quality metrics between all insurance providers, address unnecessary administrative hurdles including prior authorization for generic pharmaceuticals, and use advanced payment models, as opposed to just fee-for-service payments. We advocated that this should be open to any Colorado resident and for the benefit to be designed to allow for both behavioral and physical health care coverage, including contraceptive health services.

I was able to work with others from the AAFP to push our Colorado elected officials to address firearm related injury and death. Between recurrent school shootings and massacres across our country we have seen that no one is immune to harm from firearms, yet the Dickey Amendment in 1969 prohibited study of firearm violence. While in Washington D.C. at the Family Medicine Advocacy Summit we met with Colorado legislators and staffers and asked for appropriations funding for the study of and then implementation of policies that look at gun violence as a public health concern. A few days later we joined leaders from the Colorado chapter of the American Academy of Pediatrics, the Colorado chapter of the American College of Physicians, and the Giffords Center in hosting a Rally to Fund Gun Violence Research at the Denver Civic Center Park, rallying over 200 physicians and numerous community members to call upon our Congresspeople to fund research on how to end gun violence. Family physicians are no strangers to treating patients that are affected by gun violence, where the majority of gun injuries are self-inflicted or accidental. With our patient’s stories in mind we demanded that gun violence be treated as a public health issue to be studied and acted on so we can find means for safe and responsible gun ownership. I’m also pleased to announce we’ve recently moved forward to collaborate with the American Foundation for Firearm Injury Reduction in Medicine (AAFIRM) to actively work to find lasting solutions to curb the epidemic of firearm violence both here in Colorado and across the whole United States.

Right here in our community we have the Aurora Contract Detention Facility where adults and possibly some children are currently being detained by ICE. We recognize that immigration policies can limit access to comprehensive primary care and other vital health care services. We joined with the AAFP to recommend that health care systems should meet standards of care without compromising immigrant persons’ rights. Our board took action to support policies that mitigate the health disparities created with detention of immigrant peoples and developed a task force to further explore how interested members can be involved and advocate for these members of our community.

We carry the stories our patients share with us, and then use them to help enact change in our community, be it focusing on community infrastructure, public health concerns, or addressing systemic barriers to social determinates of health.

As autumn is now upon us, I’ll end with this quote by Wendell Berry in Jayber Crow:

“Telling a story is like reaching into a granary full of wheat and drawing out a handful. There is always more to tell than can be told.”

Until next time, may this find you well.
I always appreciate the fall, because it is a time to reflect on the work we did over the year, beginning with the legislative session, our Annual Summit, and all the important projects that come after.

As we have for the past few years, we ran our membership survey this summer. This survey continues to give us incredibly valuable data. Many of our key markers like membership satisfaction remain steady, which we are happy to see. Indeed, many of the areas we survey remain largely positive and consistent.

In previous years an area we recognized needed addressing was our communications with rural members. Specifically, that you needed to know we are listening to you and interested in some of the unique challenges you face.

As a direct result of that feedback we hit the road this summer for a series of stops across rural western Colorado. A full recap of that trip can be found on page 34. And rest assured eastern Colorado, we will be visiting you soon as well!

We were happy to see the satisfaction of our rural members increase on the survey this year. My hope is that indicates you found these visits valuable, as we most certainly did.

Additionally, in past years we recognized the need to better serve young physicians entering the workforce, particularly as the workforce landscape continues to change. In response to this feedback we introduced our New Physician Benefits Package two years ago. Visit www.coloradoafp.org/benefits for a refresher on the great services this package offers. As we continue to see steady growth of our organization and great engagement from young members, my hope is that this signals we are appropriately meeting your changing needs.

Another area we really dug into this year was how we are communicating to you, and if our communications are what you need. I think the overwhelming response to this was simply that you are extraordinarily busy. We can certainly relate in our office. The flood of emails and even paper mail can get overwhelming on the best of days. To that end, we don’t seek to communicate more, we seek to communicate smarter. Our goal is to deliver the information you need when you need it (which may not be the same information another member needs).

Finally, you may have noticed a few more demographic questions were added to the survey this year. This was very purposeful, as our Board of Directors wants to ensure they are representative of our diverse membership, be it geographic diversity, racial diversity, gender diversity, practice model diversity, etc. In many areas we are doing well, but three areas we would love to have additional Board members from include rural communities, solo practice physicians, and physicians who have been in practice for a number of years. On page 12 you’ll find a call for Board nominations. It is my hope that many of you will consider applying.

As always, this survey is just one way we seek to solicit feedback from you. Every member of our staff is always open to your phone calls, emails or even personal visits. This is your Academy, and it is our job to shape it into what you want and need.

I wish you a happy and peaceful holiday season and end of year.
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Paying for Primary Care: Our Reform Agenda

Payment reform regularly hits the top of the list of issues our members want CAFP to tackle. We view this reform to include (1) increasing payment for primary care, while (2) decreasing the reliance on fee-for-service (FFS) payments. Recent evidence shows 90% of payments to primary care are still FFS. This vexing reality is why we spearheaded the effort to successfully pass legislation that increases the investments that insurers, Medicaid, and state employee health plans make in primary care. I'll talk more about how we expect this legislation to accelerate payment reform, but it is also just one piece of our broader payment reform advocacy. Our agenda hits many different levers to pull us out of the FFS quagmire.

On a state level, we have advocated for:

- **Passing Primary Care Investment legislation to hold payers accountable for investing at least 15% of their spending in primary care, and to target the increased payments through non-FFS Alternative Payment Models.**
- **Designing the proposed state public health insurance option to pay primary care at a minimum 135% of Medicare, and to pay through Alternative Payment Models like Medicare's new Primary Care First.**
- **Shaping Medicaid's Alternative Payment Model that is investing the $56 million “primary care bump” into alternative payments.**

On a federal level:

- **Supporting a revised Medicare Physician Fee Schedule that will increase the value of primary care services, raising allowed charges for family medicine by 12%.**
- **Supporting Medicare's new Primary Care First payment model, which is modeled off of the American Academy of Family Physicians (AAFP) proposed payment model for primary care.**

**Alternative Primary Care Payments that are Higher than Current Levels:** We have written many times about the need to at least double our systemwide investment in primary care to 15% of total healthcare spending. This will better support primary care practices and lower overall costs. But the bill we passed, HB-1233, also directs the Primary Care Collaborative in the Colorado Division of Insurance to advise on how the additional dollars invested in primary care should be paid through non-FFS, alternative payment models (APMs). The bill sets up a framework to direct insurers to spend an increasing share of their primary care payments through per member per month, PCMH, or other similar payments. For instance, if 90% of payments today are FFS, we should march toward 80% of payments that are FFS next year, and so on. HB-1233 ensures we get an annual primary care spending report to hold the system accountable for moving away from FFS and toward a greater share of APM payments. This transition, while it must be done carefully to avoid disruption to practices, is essential to incentivizing value-based care over volume-based care.

**Public Option:** In August, CAFP sent our recommendations to the State as they develop a statewide public health insurance option. Co-signed by the Colorado chapters of the American Academy of Pediatrics and American College of Physicians, our recommendations included a minimum physician reimbursement level for primary care of 135% of Medicare. We also urged the State to pay through a model aligning with the Advanced Primary Care - Alternative Payment Model. Developed by family physicians through the AAFP, the model will mark a major shift away from FFS (See the AAFP graphic for an overview of this four-pronged APM). The draft public option design will be available in early October and we will know more then about how the state proposes to pay for primary care. We will be keeping a close eye to encourage the State to take this opportunity to support primary care as the true bedrock of a better healthcare system.

**Medicaid APM:** In 2016 CAFP fought for and succeeded at passing the Medicaid primary care bump, a $56 million appropriation to keep Medicaid primary care rates at 87% of Medicare, rather than being cut to 73% of Medicare. Those dollars are being transitioned to the Medicaid...
APM that aims to pay for value-based primary care. Medicaid’s Track 1 of the APM offers up to a 4% bonus, based on quality measures, on top of primary care practices’ Medicaid FFS reimbursements. This is a start and somewhat aligned with Medicare’s MIPS, but we continue to push for further enhancements like implementing the promised Track 2 APM that would be a much more meaningful transition away from FFS, closely aligned with CPC+ prospective payments.

Medicare Fee Schedule: Last year, CAFP and AAFP opposed Medicare’s proposed fee schedule that would have collapsed E/M office visit code levels 2 through 4 into a single payment rate. We were successful in averting that code collapse, which would have dis-incentivized the care of medically complex patients and reduced payments to family medicine practices. Medicare is now proposing to maintain the E/M coding levels, and at the same time increase the value of those codes, such that family medicine is expected to receive a raise of 12% on Medicare reimbursements. The importance of this change is that it is a revaluation of the work of primary care, raising the Relative Value Units (RVU’s) associated with primary care services, rather than a run-of-the mill reimbursement increase. It acknowledges the complexity and value of the work that family physicians do.

Medicare’s Primary Care First Model: AAFP’s APM model formed the basis of Medicare’s new Primary Care First model. While not perfect, this model has the following features:

- Risk-adjusted population-based payment (ranging from $24 to $175 per member per month [PMPM] based on average panel risk).
- Flat visit fee ($50) for each face-to-face primary care visit with a primary care physician (procedures and vaccines will still be billable through fee-for-service).
- Upside performance-based payment that is potentially up to 50% of total revenue.
- Downside risk is capped at 10% of revenue. This incentive is intended to reduce costs and improve outcomes.

These are several of the ways we’re working to advance payment reform and increase payment to primary care. We always welcome our members’ input on how we can do more, so feel free to reach out to me with your ideas.

CAFP PINS WERE USED IN THE PUEBLO RESIDENCY GRADUATION CEREMONY. DR. ZACH SPINUZZI ANNOUNCED THEIR NAMES AND DR. STEPHANIE ZIMBELMAN DID THE ACTUAL PINNING.

THE CAFP PRESENTED TO THE RESIDENTS OF SWEDISH FAMILY MEDICINE RESIDENCY IN ENGLEWOOD ON MEMBERSHIP AND THE WORK OF THE ACADEMY.

THE CAFP BOARD OF DIRECTORS WELCOMED NEW AND CONTINUING BOARD MEMBERS TO A RECEPTION AT DRY DOCK BREWING.

A GROUP FROM COLORADO ATTENDED THE AAFP’S FAMILY MEDICINE ADVOCACY SUMMIT IN WASHINGTON D.C.

CAFP HOSTED A RECEPTION IN KANSAS CITY FOR STUDENTS AND RESIDENTS ATTENDING THE AAFP’S NATIONAL CONFERENCE OF FAMILY MEDICINE RESIDENTS AND MEDICAL STUDENTS.

MEMBERS OF CAFP’S EXECUTIVE COMMITTEE MET WITH CONGRESSMAN KEN BUCK TO DISCUSS HEALTHCARE ISSUES.
“My recovery therapists were very welcoming and loving. They made me want to put everything into it, and I did.”

—Ozzie C. of Commerce City, 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
CALL FOR NOMINATIONS:

Join the CAFP Board of Directors
Nominate a Family Physician, Family Medicine Teacher or Family Medicine Resident for CAFP’s Annual Awards

Board Nominations
Nominations for the CAFP Board of Directors are now open. To nominate yourself or someone you know for the Board of Directors, please compose 1-2 paragraphs explaining who you are, and why you are interested in serving on the Board (or who your nominee is, and why they would make a good addition to the Board). Please be sure to include the nominee’s city and type of practice.

We seek to have a diverse Board of Directors, and particularly encourage members from rural communities, private and solo practice, and physicians from diverse backgrounds to apply for the Board of Directors.

Nominations can be sent to Raquel Alexander, CEO, at raquel@coloradoafp.org. The deadline for nominations is December 1, 2019.

For more information about serving on the Board of Directors visit https://www.coloradoafp.org/join-board/.

Award Nominations
Nominations for the 2020 CAFP Awards are now open. The CAFP seeks nominations for Family Medicine Physician of the Year, Family Medicine Teacher of the Year, and Family Medicine Resident of the Year. All nominations are due by December 1, 2019.

For more information about the Awards, including nomination packets and directions for compiling a nomination, please visit https://www.coloradoafp.org/awards/.

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.

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• Flexible work schedule
• All licensure fees paid
• Relocation assistance
• CME allowance and 40 hours of time off
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• Average daily census per provider is 16-18 patients.

For more information visit http://www.pueblochc.org/ or contact: Laura Kelly at 719-543-8718 ext. 152 or email lkelley@pueblochc.org
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Email CV to: doctors@bannerhealth.com
learn more at bannerdocs.com
Greetings from SNOCAP-

You may notice something new on this page—SNOCAP has a new logo! We took feedback from many of our members and rebranded in the summer. We hope you like the new look—keep an eye out for us!

SNOCAP recently had three articles published in the Journal of the American Board of Family Medicine’s PBRN special issue! Released on September 10th, SNOCAP staff shares history, stories, approaches, and lessons learned. Be on the lookout for the following articles in press:

- Patient-Centered Research Priorities: A Mixed-Methods Approach from the Colorado Children’s Outcomes Network (COCONet)

We look forward to hearing your thoughts and reactions to these pieces. Please let us know if you have questions or would like to continue the conversation. Reach out in any of the ways, below:

Join the SNOCAP bi-monthly newsletter: bit.ly/SNOCAPnewsletter
Follow along on Twitter: @SNOCAPpbrn
Email SNOCAP Director Don Nease: Donald.nease@cuanschutz.edu
Email SNOCAP Network Manager Mary Fisher: mary.fisher@cuanschutz.edu

Hope to hear from you soon!
- The SNOCAP Team
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www.TheASAMAnnualConference.org
PEDIATRIC FEEDING DEVELOPMENT

Feeding, eating and swallowing are complex processes, with multiple underlying physiological, sensory, motor, behavioral and environmental influences. Studies suggest that feeding difficulties are evident in 25% of all children and in 70-80% of children with developmental disabilities or chronic medical challenges. Aside from consuming adequate nutrition for growth and development, normal feeding and eating are also part of social, emotional and cultural maturation.

Feeding, eating and swallowing difficulties are common and patients often first come to their family physician with concerns. A feeding problem can be present even when a child is growing normally. Teasing out the underlying cause can be challenging. It helps to first understand how normal feeding develops in infancy and early childhood, which is the focus of this article. Feeding involves more than just eating and includes coordination of the following six physiological and developmental systems:

**Physiologic Stability:**
Neurological development, Cardiopulmonary, GI System

**Motor Skills:** Oral motor, gross motor, fine motor, postural stability and movement

**Communication:** Expression, understanding and social language skills

<table>
<thead>
<tr>
<th>FEEDING IS MORE THAN JUST EATING:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physiologic Stability:</strong></td>
<td>Appropriate nutrition: Oral, tube, modified diet</td>
</tr>
<tr>
<td>Neurological development, Cardiopulmonary, GI System</td>
<td><strong>Motor Skills:</strong> Oral motor, gross motor, fine motor, postural stability and movement</td>
</tr>
<tr>
<td><strong>Social Interaction:</strong> Social emotional, Cognitive/learned behaviors</td>
<td><strong>Communication:</strong> Expression, understanding and social language skills</td>
</tr>
<tr>
<td><strong>Sensory Processing development:</strong> Tolerance of a variety of sensory experiences (tactile, auditory, visual, olfactory, vestibular and proprioceptive)</td>
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</tbody>
</table>

Children are able to learn to eat successfully when they have normal anatomy, well-coordinated muscle activity, appropriate sensory processing development, a supportive and predictable eating environment, and positive early feeding experiences. Differences in one or more of these areas can lead to feeding difficulties.

As with other developmental skills, feeding is a process learned over time and is learned in conjunction with other developmental skills. The following chart outlines the expected skills necessary for successful eating as a child grows. Feeding skills outside of these parameters may be an indication that a child’s feeding is not progressing as expected.

If the underlying cause(s) of a patient’s feeding problem can be identified, subsequent intervention is more likely to be successful. Many times a problem is multifactorial and would benefit from a team approach within the context of a child’s medical home. Some patients can be successfully evaluated and managed in primary care but others will require consultation. When would it be time to consider referring a child in your practice for a feeding evaluation versus other intervention? It is important to note that feeding and swallowing evaluations are not the same. Referrals for these evaluations assess different concerns.

The following list provides some indicators to where feeding evaluation and/or intervention may be of benefit:

- Chronic poor growth compromised nutritional status based on World Health Organization (WHO) or Centers for Disease Control (CDC) growth charts
- Food refusal: This can include a variety of behaviors such as verbal refusals, throwing foods, and distraction and/or avoidance behaviors during the meal time
- Decreased variety of oral intake: This can include refusal of particular food groups and/or age-appropriate food textures
- Decreased volume of oral intake: A child may not be taking enough food by mouth to meet their nutritional and hydration needs.
- Transition from tube feeding to oral feeding
- Prolonged feeding time
- Difficulty transitioning to developmentally appropriate solid foods: From liquids to purees, or from purees to table foods
- Persistent gagging, vomiting, or choking while eating
- Sensory processing difficulties
- Oral-motor delays or impairments: This can be caused by structural compromise to the oral-facial anatomy or skills may be delayed for other reasons
- A history of gastroesophageal reflux, constipation, or other gastrointestinal problems leading to discomfort with feeding
- Medical conditions including, but not limited to: allergies, respiratory health, neurological factors, sensory factors, premature birth, genetic/metabolic conditions

*CONTINUED ON PAGE 18*
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For more information, visit LifePointHealth.net
**Typical Feeding Development**

<table>
<thead>
<tr>
<th>Age</th>
<th>Skill</th>
<th>Texture</th>
<th>Volume</th>
<th>Positioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 months</td>
<td>Infant brings 1 or both hands/bottle to mouth while being held</td>
<td>Liquid</td>
<td>Breastfeeding</td>
<td>Fully supported head, neck and body; slightly reclined</td>
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<td></td>
<td></td>
<td></td>
<td>• 1st month: 10-12 feedings per 24 hours.</td>
<td>Caregiver present providing support *avoid bottle propping with pillow</td>
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<td>• 2-3 months: 8-10 feedings per 24 hours.</td>
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<td></td>
<td>Formula/expressed breast milk:</td>
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<td></td>
<td></td>
<td></td>
<td>• 1st month: 16-24 ounces</td>
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<td></td>
<td>• 1-2 months: 22-28 ounces</td>
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<td></td>
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<td></td>
<td>• 2-3 months: 24-32 ounces</td>
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<tr>
<td>~4-6 months</td>
<td>Introduce spoon feeding/ fed by caregiver</td>
<td>Cereal, smooth purees (similar to stage I baby foods)</td>
<td>Breastfeeding:</td>
<td>Sitting with caregiver support or supported in a highchair</td>
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<td></td>
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<td>• 7-9 feedings in 24 hours</td>
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<td></td>
<td>Formula/expressed breast milk:</td>
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<td>• 4-6 feedings in 24 hours</td>
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<td>• 28-32 ounces</td>
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<td>Iron fortified infant cereal by spoon: at 6 months of age</td>
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<td></td>
<td></td>
<td></td>
<td>• 1-2 Tablespoons of single grain cereal mixed with breast milk or infant formula</td>
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<td></td>
<td></td>
<td></td>
<td>• 1-2 times per day</td>
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<td>*Primary nutrition from breast milk or formula</td>
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<tr>
<td>~6-8 months</td>
<td>Opens mouth in anticipation of food</td>
<td>Cereal, smooth purees, variety of pureed foods similar to stage II baby foods</td>
<td>Breastfeeding:</td>
<td>Sitting in highchair with tray and foot support</td>
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<td></td>
<td></td>
<td></td>
<td>• 4-6 feedings in 24 hours</td>
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<td></td>
<td>Formula/expressed breast milk:</td>
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<td></td>
<td>• 3-5 feedings; 24-32 ounces in 24 hours</td>
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<td>Solids:</td>
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<td></td>
<td>• Grains: 2-4 Tablespoons, twice per day</td>
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<td></td>
<td>• Vegetables: 2 Tablespoons, twice per day</td>
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<td>• Fruits: 2 Tablespoons, twice per day</td>
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<td>• Proteins: 1-2 Tablespoons, twice per day</td>
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<td>Water: Up to 2-4 ounces per day</td>
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<td>*Primary nutrition from breast milk or formula</td>
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<tr>
<td>~8-10 months</td>
<td>Infant holds and bangs spoon. Can bring small pieces of food to mouth with fist ed grasp</td>
<td>Cereal, smooth purees, variety of pureed foods similar to stage II baby foods</td>
<td>Breastfeeding:</td>
<td>Sitting in highchair with tray and foot support</td>
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<td>• 4 or more feedings in 24 hours</td>
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<td>Formula/expressed breast milk:</td>
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<td>• 3-4 feedings; 24-30 ounces</td>
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<td>Solids:</td>
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<td>• Grains: 2-3 Tablespoons per day</td>
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<td>• Vegetables: 3-4 Tablespoons, twice per day</td>
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<td>• Fruits: 3-4 Tablespoons, twice per day</td>
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<td>• Proteins: 2-3 Tablespoons, twice per day</td>
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<td>Water: 2-4 ounces, twice per day</td>
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<tr>
<td>~10-12 months</td>
<td>Can bring food to mouth with finger grasp, reaches for spoon, introduce open, sipper and/ or straw cup for practice</td>
<td>Pureed foods, dissolvable solids, very soft solids</td>
<td>Breastfeeding:</td>
<td>Sitting in highchair with tray and foot support</td>
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<td>• 3 or more feedings in 24 hours</td>
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<td>Formula/expressed breast milk:</td>
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<td>• Grains: 2-3 Tablespoons per day</td>
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<td>• Vegetables: ½ cup, twice per day</td>
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<td>• Fruits: ½ cup, twice per day</td>
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<td>• Proteins: 1/4 cup or 1 ounce, twice per day</td>
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<td>Water: 2-4 ounces, twice per day</td>
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<tr>
<td>~12-14 months</td>
<td>Beginning self-feeding with a spoon, gains skill with an open, sipper and/ or straw cup</td>
<td>Pureed foods, dissolvable solids, soft solids</td>
<td>Offer all of the below 3 times a day, and choose 2 of the below during snack times:</td>
<td>Sitting in highchair with tray and foot support</td>
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<td>• 4 ounces of milk; no more than 24 ounces of milk per day</td>
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<td>• ¼ cup fruit</td>
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<td>• ¼ cup vegetable</td>
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<td>• ¼ slice/piece, or ¼ cup of a grain</td>
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<td>• 1 ounce of protein or 4 ounces of a dairy food</td>
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CONTINUED ON PAGE 20
Providing a special kind of care, a different kind of hope.

We believe the care and support we provide is about living each day to the fullest, and that every patient and their family deserves consistent expert care and compassionate personal attention.

We can help! 719.633.3400

- Hospice care is available wherever a patient calls home, including assisted living & skilled nursing centers
- Pikes Peak Region's leading hospice & palliative care provider for nearly 40 years
- Only nonprofit, community-based advanced illness provider in El Paso & Teller Counties
- Only hospice care provider in El Paso County with a dedicated in-patient unit
- Specialized program for Veterans, including Veteran-to-Veteran volunteers
- Comprehensive grief support for loved ones for up to 13 months
If a child in your care is demonstrating concerns listed below, then an evaluation for an evaluation of swallow function may be indicated:

- Coughing and or choking while drinking liquids
- Concerns about a child’s overall pulmonary health (chronic oxygen requirement or frequent lower respiratory illnesses)
- Neurological or medical condition which may suggest swallowing dysfunction
- Resistance to drinking liquids
- Persistent concerns about growth and weight gain in light of above concerns

If you are interested in further resources for learning about feeding issues in pediatric patients, Children's Hospital Colorado has an excellent weekly podcast series, Charting Pediatrics (childrenscolorado.org/chartingpediatrics). You can find Charting Pediatrics Podcast on Apple Podcasts, Spotify, Google Play, or wherever you like to listen to podcasts.

Children's Colorado Feeding and Swallowing Program is also available to partner with your practice for consults and referrals.

For additional information or questions about feeding and swallowing concerns call 720-777-6168 or toll free through One Call at 800-525-4871 or e-mail Dr. Laura Pickler at Laura.Pickler@childrenscolorado.org. In addition, Children's Colorado has a dedicated phone line for family physicians for your convenience to address any other concern; that phone number is 720-777-3980.

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**Yampa Valley Medical Associates, P.C.**

**Family Medicine**

Come join Yampa Valley Medical Associates, a multispecialty primary care practice in beautiful Steamboat Springs, Colorado!

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970-879-3327 or jobs@yvma.com

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**Education & Practice Enhancement**

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<thead>
<tr>
<th>Age</th>
<th>Skill</th>
<th>Texture</th>
<th>Volume</th>
<th>Positioning</th>
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</thead>
<tbody>
<tr>
<td>~15-18 months</td>
<td>Child scoops food and brings spoon to mouth with some loss, continues skill development with cup drinking (open, sipper and/or straw cup)</td>
<td>Pureed foods, dissolvable solids, soft solids, some solids</td>
<td>Offer all of the below 3 times a day, and choose 2 of the below during snack times: • 4 ounces of milk; no more than 24 ounces of milk per day • ¼ cup fruit • ¼ cup vegetable • ¼ slice/piece, or ¼ cup of a grain • 1 ounce of protein or 4oz of a dairy food</td>
<td>Sitting in booster or highchair at the table with foot support</td>
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<tr>
<td>~18-24 months</td>
<td>Child feeds themselves with a spoon, uses cup independently</td>
<td>Pureed foods, dissolvable solids, soft solids, solids</td>
<td>Offer all of the below 3 times a day, and choose 2 of the below during snack times: • 3-4 ounces of milk; no more than 24 ounces of milk per day • ¼ -½ cup fruit • ¼-½ cup vegetable • ½ slice/piece, or ½ cup of a grain • 1 ounce of protein or 4 ounces of a dairy food</td>
<td>Sitting in booster chair at the table</td>
</tr>
<tr>
<td>~2 -2.5 years</td>
<td>Child brings spoon to mouth, has completed transition from bottle/breast to sippy, straw and/or open cup.</td>
<td>Pureed foods, dissolvable solids, soft solids, solids</td>
<td>Offer all of the below 3 times a day, and choose 2 of the below during snack times: • 3-4 ounces of milk; no more than 24 ounces of milk per day • ¼ -½ cup fruit • ¼-½ cup vegetable • ½ slice/piece, or ½ cup of a grain • 1 ounce of protein or 4 ounces of a dairy food</td>
<td>Sitting in a child size chair or a booster chair at the table</td>
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</tbody>
</table>
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.
Requirements for Diplomates who Began the Continuous Certification Process: 2011 and Beyond

Congratulations on your status as a Diplomate of the ABFM! We are proud to partner with you in pursuing lifelong learning, self-assessment, and clinical improvement. This signals to your patients and colleagues that you are actively working to keep up with the rapidly changing medical literature and are distinguishing yourself from other medical providers. The certification process stresses the importance of participation in activities that evaluate your ongoing learning and practice improvement efforts. Participation in these activities promote clinical excellence and benefit you and your patients.

If you successfully completed the Family Medicine Certification Examination in 2011 or later, you are participating in the continuous Family Medicine Certification process. Continued maintenance of your certification status depends upon meeting the following requirements within each 3-year stage deadline.

- Complete a minimum of one (1) Knowledge Self-Assessment (KSA) activity
- Complete a minimum of one (1) Performance Improvement (PI) activity for clinically active physicians (PPM or approved alternative)
- Complete additional approved self-assessment or PI activities to reach a minimum of fifty (50) points

**50 Points**

- Complete one hundred and fifty (150) CME credits (minimum 50% from formal activities awarding Division I credit)

**Complete one hundred and fifty (150) CME credits (minimum 50% from formal activities awarding Division I credit)**

- Continuously comply with ABFM Guidelines for Professionalism, Licensure, and Personal Conduct which includes holding medical license(s) which meet the licensure requirements of the Guidelines

**Professionalism**

- Submit the annual process fees

**Submit the annual process fees**

- Successfully complete the Family Medicine Certification Examination every ten (10) years

**Examination**

[www.theabfm.org](http://www.theabfm.org)
As long as you continue to meet your 3-year stage requirements, you will be listed as a board-certified family physician on the ABFM website. If you are not able to meet these requirements for any 3-year stage, you will be listed as “not certified” on the ABFM website until you reenter the certification process. You will have three years to complete the required activities and regain your certification status. Once these activities are completed, you will again be listed as board certified, with the break in certification history listed as part of your history.

If you are unable to complete all previously lapsed activities in the next 3-year stage, you will need to complete the Certification Re-Entry Process in order to regain certification. This includes successfully completing the Family Medicine Certification Examination.

The ABFM offers flexible payment options for the continuous certification process through your online Physician Portfolio, which allows for payment as you progress, or prepayment for future years any time. Prepayment allows you to lock in a fixed cost for all the years you pay for, and future year prepayments are fully refundable. Once you pay the fees for a stage, you can access any activities available in your Physician Portfolio and can complete as many as you would like for no additional fee. The CME credit awarded with the activity does not have an additional cost. We are pleased to let you know that the cost of the continuous certification process has been a flat annual rate since the inception of the program, even with the addition of new activities.

For more specific information regarding ABFM Family Medicine Certification requirements, please login to your Physician Portfolio on the ABFM website. We have capable staff who serve in our Support Center that can answer any questions that you may have or direct you to the right person who can meet your needs. You may contact us at 877-223-7437 or help@theabfm.org for assistance.

Fall Family Medicine Review
October 28 - November 1, 2019
Anschutz Medical Campus | Aurora, Colorado
Information & Registration
Visit: https://medschool.cuanschutz.edu/education/cme

Offerings for 2019
» 20 Lectures and 20 Workshops
» Group KSA on Hypertension
» Needs derived topics including:
  • What’s new in antibiotic therapy
  • The opioid dependent patient
  • Treatment resistant anxiety and depression
  • Diagnosis and management of hypertension
  • Importance of non-verbal communication in medicine
  • Radiology made simple: a case-based discussion
  • Caring for the geriatric patient
  • Replace his knee! Clear him for me…
  • Dysfunctional uterine bleeding
  • Viral hepatitis: 2019
  • Child injury prevention: epidemiology to practice
The Self-Directed Performance Improvement (PI) Project pathway allows you to report customized improvement projects, regardless of the scope of care you deliver. This pathway can be used to satisfy the Performance Improvement requirement for continuing certification. Some key things to know about this pathway:

- You may report a project you conducted alone or participated in within a single practice group, an ACO, or other larger group practices
- You can use this pathway whether you see patients in a continuity setting, or if you are providing non-continuity episodic care (e.g., hospitalist, telemedicine, locums, urgent care, emergency department, etc.)

**What information will you need to provide?**

- **The start and end date of the improvement project.** Your credit is applied as of the end date of the project, once it is confirmed to have met the ABFM PI Requirements.
- **If externally funded, how the project was funded.** The project must meet the ABFM Industry Support policy that prohibits pharmaceutical and device manufacturer influence on activities for certification credit.
- **The relevant topic areas for the project.** Select one or more topic areas to categorize the project.
- **What problem or gap in quality was the project intended to address?** An example of a gap might be influenza vaccination rates in your practice that were consistently lower than the national standard, resulting in an increased frequency of flu among your patients.
- **As a result of identifying the gap in quality, what did the project aim to accomplish?** An aim statement is a clear, quantifiable goal set within a specific time-frame. It states what you tried to change, by how much, and by when. An aim statement is broken into three parts:
  - **What did you try to change?** (e.g., we aimed to improve our practice’s influenza vaccination rate)
  - **What was your improvement goal?** (e.g., improving our rate to 85% compliance)
  - **What was the timeframe for this to be accomplished?** (e.g., within 9 months)
- **What measures were used in the project to evaluate progress?** Measures are directly related to the aim statement, showing whether a project’s changes are resulting in improvement. An example measure might be:
  - **Measure Name:** Influenza vaccination compliance
  - **Goal:** 85%
  - **Data Source:** Electronic Medical Record
  - **Collection Frequency:** Monthly
  - **Number of Patient Records:** 25 or more
• **The results of the improvement project.** Provide the baseline and follow-up percentage or number meeting the stated measure(s).

• **The interventions or changes that were made during the project.** An example intervention might be education for your clinical staff on the importance of this vaccine, added compliance check in the patient’s Electronic Medical Record, and utilizing pamphlets on this vaccine in well-patient visits.

• **How were you involved in the project?** Were you the project leader? Did you review the data periodically to assess improvement? Were you part of the team that designed the project and reviewed the results? Were you an active participant in deciding on the intervention(s)? Demonstration of active involvement in the improvement process is necessary for approval of a self-directed activity.

**Ready to get started?**
Login to your ABFM Physician Portfolio at [https://www.theabfm.org](https://www.theabfm.org), select Access Performance Improvement Activities from the main screen, and choose the **ABFM Self-Directed Performance Improvement Project: Clinical**.

![Image of a user interface for the ABFM Physician Portfolio](image)

**Need help?**
Contact us for assistance with selecting an improvement project you have already completed or identifying improvement opportunities in your scope of care.

- Email: help@theabfm.org
- Phone: 877-223-7437

Considerations for Law Enforcement Interactions

Healthcare providers may experience interactions with law enforcement personnel that create uncertainty around their responsibilities to patients, including the duty to protect patients’ privacy. Law enforcement personnel are tasked with ensuring public safety and conducting criminal investigations.

When these duties intersect as they relate to patients in the health care system, providers should understand how to meet their obligations while respecting the requests of law enforcement personnel.

Situations that providers may encounter with law enforcement include treating a gunshot wound, reporting child abuse or neglect, possible threats to public safety, and if there is a crime on the premises of a medical facility or practice.

PROTECTED HEALTH INFORMATION UNDER HIPAA

Before disclosing patient information to law enforcement, a provider should consider whether it is protected under the federal Health Insurance Portability and Accountability Act (HIPAA) rules, which provide privacy protections for individually identifiable health information held by health care providers and their business associates. HIPAA “covered entities” include health care providers who transmit any health information in electronic form in connection with a transaction covered under the HIPAA regulations.1

Protected health information (PHI) includes individually identifiable health information transmitted or maintained in electronic media or any other form or medium.1 Individually identifiable health information is information created or received by a health care provider that identifies the individual and relates to the past, present, or future physical/mental health or condition of an individual; the provision of health care to the individual; or payment for the provision of health care to the individual.1

WHO IS CONSIDERED A LAW ENFORCEMENT OFFICIAL?

As outlined in the HIPAA Privacy Rule, a law enforcement official means an officer or employee of any agency or authority within the U.S., who is empowered by law to: (1) Investigate or conduct an official inquiry into a potential violation of law; or (2) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.2

Law enforcement officials include (but are not limited to):

- Police officers and state troopers
- Sheriffs and sheriffs’ deputies
- District attorneys

1. Health Insurance Portability and Accountability Act
2. National Health Data Breach Notification Rule
The default position under HIPAA is that PHI cannot be disclosed without the patient's authorization, but there are some exceptions relevant to law enforcement, including where reporting is required by state law.

**KEY CONSIDERATIONS FOR ANY LAW ENFORCEMENT INTERACTION:**

- **Don’t be afraid to ask for identification.** Have they properly identified themselves? If the law enforcement official is not known to the provider, the provider must verify the identity and authority of the person. Processes should be in place for in-person, phone, and email interactions.

- **Share your side of the situation.** Explain your understanding of the situation and the laws (HIPAA, etc.) that govern your actions of what you can and can’t do.

- **When trying to decide which federal or state law applies, the more restrictive one will likely apply.** In general, if there is a state or federal law that is more restrictive than HIPAA (more protective of a patient’s privacy), providers are required to comply with the more restrictive law.

- **Document the details.** Obtain any documentation or statements from the person requesting protected health information (PHI) when these documents or statements are relied upon to make the disclosure.

- **Respect law enforcement and the challenges they are dealing with.** Do not physically interfere with law enforcement officials or provide them false or misleading information.

- **Don’t provide more information than what is necessary.** Unless disclosures made to law enforcement are required by law, they should be held to the “minimum necessary” standard. This means that when using or disclosing PHI, the HIPAA-covered entity or provider must make reasonable efforts to limit PHI to the minimum necessary to accomplish the purpose of the use, disclosure, or request. A provider may rely upon the representations of a law enforcement official that the information requested is the minimum necessary for the stated purpose.

More details regarding disclosures for law enforcement purposes under HIPAA can be found at: [www.hhs.gov/hipaa/for-professionals/faq/disclosures-for-law-enforcement-purposes/index.html](http://www.hhs.gov/hipaa/for-professionals/faq/disclosures-for-law-enforcement-purposes/index.html)

- [1] 45 C.F.R. § 160.103
- [2] 45 C.F.R. § 164.103
- [5] 45 C.F.R. § 164.502(b)
Colorado: It’s time to end unscientific and immoral vaccine exemptions

As of July 22, there were almost 1200 confirmed measles cases in 30 states, according to the Centers for Disease Control and Prevention (CDC), the greatest number reported in the U.S. since 1992 and since measles was declared eliminated in 2000. In Colorado, there has only been one confirmed case of measles, which occurred after a Denver resident traveled abroad earlier this year. However, health experts have said the state’s low vaccination rate makes Colorado vulnerable to a possible outbreak (tinyurl.com/y39perlm).

On June 14, Colorado media outlets declared, “Polis’ order takes aim at Colorado’s worst-in-the-US measles vaccination rate” (tinyurl.com/y39l36m9), informing us Governor Jared Polis had issued an executive order intended to tackle the potential crisis. Colorado Department of Public Health and Environment (CDPHE) data show rates for the measles-mumps-rubella (MMR) vaccine had dropped to 87.4 percent (ranking Colorado 50th in the nation for MMR vaccination rates for kindergartners), adding, “In parts of the state, rates are ‘dangerously low,’ below 20 percent,” far below the CDC’s recommended rate of 95 percent, considered necessary to protect a community from disease outbreaks through herd immunity (tinyurl.com/y39l36m9). And, as a result, “9,400 children in Colorado last year sought care for vaccination-preventable illnesses, at a cost of some $55 million.” (tinyurl.com/y39l36m9). Fortunately, there have been no deaths...yet.

Despite Polis’ executive order, he “calls himself ‘pro-choice’ on the issue of vaccines and said he supports Colorado families’ right to make their health care decisions without a ‘heavy-handed mandate’ from the state. Unfortunately, this not only makes no scientific or moral sense, but our Governor is not learning from the mistakes of others.

Also on, June 14, the AP ran stories that due to outbreaks of vaccine-preventable disease, states are increasingly eliminating non-medical (personal, philosophical, and religious) exemptions. When it comes to religious exemptions: “California removed personal belief vaccine exemptions for children in both public and private schools in 2015, after a measles outbreak at Disneyland sickened 147 people and spread across the U.S. Maine ended its religious exemption earlier this year.
Mississippi and West Virginia also do not allow religious exemptions.”

The AP added that in New York, “The Democrat-led Senate and Assembly voted to repeal the (religious) exemption, which allows parents to cite religious beliefs to forego getting their child the vaccines required for school enrollment. Governor Andrew Cuomo, a Democrat, signed the measure minutes after the final vote. Even with New York’s move, similar exemptions are still allowed in 45 states, though lawmakers in several of them have introduced their own legislation to eliminate the waiver” (tinyurl.com/yyv3g5b6).

We believe it’s time for Colorado to do the same. Indeed, we would agree with Bronx Democrat Jeffrey Dinowitz, the New York bill’s Assembly sponsor, when he correctly pointed out, “I’m not aware of anything in the Torah, the Bible, the Koran, or anything else that suggests you should not get vaccinated. ... If you choose to not vaccinate your child, therefore potentially endangering other children ... then you’re the one choosing not to send your children to school” (tinyurl.com/yyv3g5b6). In other words, parents should have the right to not have their children vaccinated; however, with that decision, which then increases the odds that their unvaccinated child could harm others (in essence, becoming a ticking time bomb), they will also be choosing to forego their right to bring those children to public events – school, sports, theater, or even their faith communities.

Science-Based Medicine writes, “Politicians now just need to do their jobs, to protect the public health (one of the fundamental missions of government), and not to cave to small special interest groups. These outbreaks do give us a window of opportunity to marshal the political will to craft proper regulations. The antivaxxers have left us no other choice” (tinyurl.com/y23p2sye).

We again encourage the CAFP, as part of the Colorado Children’s Immunization Coalition (CCIC), to work with Governor Polis and the Colorado legislature to eliminate parental exemptions (philosophical, personal, and/or religious) that put Colorado children at risk.

**Immunization laws work, but must legislate to prevent professional chicanery**

Public health officials have known for a long time that so long as an organized locus for enforcement exists (such as the point of entry to school) that strict and clearly written immunization laws result in significant increases in vaccine coverage. California’s recent experience bears that out. In 2013, the “up to date rate” for kindergarteners for all required vaccines was 92.8 percent (below the CDC’s recommended 95 percent). However, after the negative national publicity from the 2014-15 Disneyland measles outbreak legislators responded in 2015 by eliminating the option for “personal belief” exemptions. By the fall of 2016, the “up to date rate” was 95.6 percent, effectively achieving “herd immunity,” critical for a disease such as measles, which has an uncanny ability to find and infect susceptible children and adults, even when widely scattered among an immune population.

However, legislators and public health officials were in for a rude surprise. Since California passed its ban on non-medical exemptions, “the number of medical exemptions tripled” (tinyurl.com/y23p2sye). How did this happen? “The law just created an

CONTINUED ON PAGE 30>>
industry of unscrupulous doctors giving away medical exemptions. In San Diego one doctor is responsible for one third of the medical exemptions given. They are sometimes just sold to patients or given with little justification (tinyurl.com/y23p25ye).

The result was predictable. Last fall the percent of California kindergartners who had received all their shots fell for the second year in a row to 94.8 percent – both a statistically and clinically significant drop – as personal exemptions are being replaced by the deceitful medical exemptions. In some zip codes it is as low as 19 percent. The soaring rate of unscrupulous medical exemptions has not gone unnoticed. In May the California Senate passed a bill that would set statewide standards for medical exemptions that now moves to the State Assembly (tinyurl.com/y6bpsx5e).

Meanwhile, the rest of the nation continues to struggle with frequent and sometimes large measles outbreaks. Pockets of unimmunized children and adults – usually because of anti-immunization sentiment of one kind or other – fuel the spread of disease. Colorado politicians need to respond firmly and efficiently with vaccine requirements that are not easy to evade (tinyurl.com/y5bvgmd).

When personal, religious, and/or philosophical vaccine exemptions are eliminated, Colorado should learn from California. We cannot simply leave exemptions up to the discretion of individual practicing physicians, because even one outlier can effectively veto the law by indiscriminately giving out or selling exemptions. There must also be a standard in place on what counts as a medical exemption. There must be enforcement. Doctors found to be dispensing excessive, unwarranted, or illegal vaccine exemptions should be investigated in exactly the same way as doctors who write disproportionate opiate prescriptions. We already have an enforced standard of care – it just needs to be applied to vaccine exemptions.

Spread of Measles in Europe and Implications for US Travelers

U.S. travelers to the European region should be up to date on measles immunization and other recommended vaccines, researchers at the CDC recommend in a special report (tinyurl.com/y2hl7e84). France, Italy and Greece – all particularly popular countries for U.S. vacationers to visit – have particularly high numbers of cases, as do Georgia, Russia, Serbia, and Ukraine.

New guidance from the Advisory Committee on Immunization Practices (ACIP) on HPV and pneumococcal vaccines

In its June 2019 regular meeting, the ACIP updated its recommendations to “fill some gaps” in clinicians’ understanding of how to “catch various populations up” when they have not received the needed human papillomavirus (HPV) and pneumococcal (PPSV-23 and PCV-13) vaccines. Briefly, the ACIP has now completed the process of “harmonizing” recommendations for men and women for HPV vaccine, so that clinicians do not have to remember two sets of rules. HPV vaccine is recommended for all boys and girls starting from age 11-12 (and can be given as early as age 9). Anyone 26 or under who has not received the vaccine previously, should receive it at the first opportunity. From 27 through 45 years of age, the decision is left to be made cooperatively between patient and clinician (what has been formerly known as a “permissive” recommendation). In this case, ACIP deems the risk not high enough for a universal recommendation, while also recognizing that some adults remain at significant risk due to new or changing sexual practices and partners. The ACIP trusts patients and clinicians to work together to evaluate the need for vaccine (tinyurl.com/y5p5wm9n).

Occasionally (this also happened a few times during RF’s tenure on the ACIP), the members cannot talk their way to a consensus on a particular issue and a split vote results. This June, ACIP considered whether the 2014 recommendation to give 13-valent pneumococcal conjugate vaccine (PCV-13) to all adults 65 and over (in addition to PPSV-23 which senior adults have gotten for a long time) still made sense. The new factor here is that as cohorts of children receiving PCV-13 as infants and toddlers have aged into middle childhood, circulation of pneumococcal bacteria has declined. Thus, the likelihood that senior adults may be exposed has decreased, and so in turn the utility of the vaccine in that population has also decreased. The pneumococcal working group (composed of some ACIP members, CDC staff, and other experts who have spent the most time studying the issue) did not reach a consensus, but rather outlined two options and left the final decision to the full ACIP, which voted 8-6 to rescind the universal recommendation for PCV-13 in senior adults, but to make it instead a “permissive” recommendation – a decision to be discussed between patients and their clinicians.

This kind of recommendation always has both advantages and drawbacks. On the one hand, in the absence of a clear public health mandate, it invests trust and responsibility in the individual clinician. This affirms the sanctity and value of the practice of medicine. On the other hand, some clinicians have expressed discomfort in the absence of clearer guidance (tinyurl.com/y5vylkya).
“He died because he’s Black!” screamed his mother, inconsolable in the intensive care unit as her unresponsive teenage son underwent a formal neurologic examination. We had done all that we could. Mr. M had experienced a cardiac arrest for unknown reasons at home, and his mom felt the emergency medical technicians treated her son differently, possibly even withholding care, because of his race. She already knew what the result of the neurologic testing would be, as did I, a 2nd-year family medicine resident at the time. Now I’m an assistant professor, and I still remember the despair in that mother’s voice and the weight of her statement.

His mother may be right. The report Unequal Treatment showed us that health care disparities still exist among racial and ethnic groups even when you control for income, age, insurance, and severity of medical condition. Regardless of the facts of Mr. M’s clinical course, his mother lost a son that day. Her trust and view of the health care system will never be the same. Our health care system often fails people that look like Mr. M. It fails people that look like me.

Being new faculty and the only Black, male member in our department of family medicine (DFM), which comprises over 200 faculty, comes with its share of challenges and opportunities. I love what I do. I’m so incredibly grateful that I found a job where they pay me to do what I love: care for patients and teach the next generation of physicians. I find that to be a great privilege and honor. However, I pay close attention to what opportunities I take on, as I try to minimize the “minority tax” I have to pay.

The minority tax refers to the extra responsibilities placed on minority faculty in the name of diversity. This tax is extremely complex, and it is sometimes self-imposed by faculty due to a sense of responsibility they feel. For example, as a young faculty member in medical education, I know a day will come when I have to decide if I’ll be the one implementing curriculum or the one creating it. I worry that my ability to develop curriculum and essentially create change will be limited by my own obligation to make sure students of color see faculty that look like them. Nationally, only 4 percent of full-time faculty in academic medicine are Black/African American, Hispanic/Latino, or Native American/Alaskan Native.

Being an example for students of color is something I don’t take lightly. However, I have mixed emotions at times. I’m happy to stand with them in solidarity on issues that disproportionately affect them and people that look like them, but it can be emotionally exhausting at times — never more so than at last year’s White Coats for Black Lives annual die-in on the medical school campus.

During our demonstration, I felt a variety of emotions. Pride, as I lay on the ground with over 50 medical students, residents and other faculty as we reflected on dire outcomes inequity has in our society and the importance of health professionals using their power and their voice to advocate for change. Sad that not a single one of my family medicine colleagues was out there with me. Tired, as I reflected on the long road ahead to achieve equity for all people. Determined to continue to advocate for equity, diversity, and inclusion (EDI) in medicine, starting with my own DFM.

Though family medicine boasts to be a specialty that advocates EDI, I was disappointed in the work happening in my own DFM. When I brought up some of my concerns with my department chair, to my surprise, he agreed. Additionally, he provided support and a stage to make improving EDI a priority in our department. I, along with some of my colleagues, formed a working group with that mission, and we called ourselves the Justice League.

Through the Justice League, we’re changing the culture of the DFM and have a lot of accomplishments and ongoing endeavors in less than a year of work, including the following:

- Changing our mission, vision, and values statement to reflect our verbal commitment to EDI.
- Providing monthly education sessions to DFM personnel on issues of EDI in medicine and how they can make change.
- Reinvigorating a conversation among our researchers on how we incorporate EDI in all of our research.
- Changing our website to make EDI more visible.
- Collaborating with our clinical affairs team in changing their hiring practices.
- Analyzing our health outcomes based on race and ethnicity at our largest clinic.
- Conducting a climate survey to take a hard look at ourselves and areas of improvement.
- Partnering with an outside consultant to do a training on racism in medicine.
- We’ve successfully advocated for a new formal leadership position at our department with dedicated funding.
- Lastly, we’re working on a strategic plan for the next stages of this work.

I’m incredibly proud of the work we’ve done and know we have so much more we can do both inside and outside of our department. More importantly, I look forward to seeing the impact of this work and our future work will have on my colleagues, medical students, and our community.

Though I have little faith that we’ll get to equal treatment in this country, I am proud to be someone fighting to close the gap, one step at a time.

1 https://www.nap.edu/catalog/10260/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care
**AN UPDATE FROM CAFP’S DELEGATION TO THE AAFP’S NATIONAL CONFERENCE OF FAMILY MEDICINE RESIDENTS & MEDICAL STUDENTS**

**Kenneth Herring, MD, Resident Delegate, University of Colorado Family Medicine Residency**

“Decisions are made by those who show up.” It’s a quote that has been attributed to Benjamin Franklin, Martin Sheen, and virtually everyone in between, but my first exposure was by way of Dr. Russell Kohl this summer at National Conference.

Exactly three years earlier, I rolled into Kansas City as a wide-eyed medical student from North Carolina. I shuffled around the Expo Hall for three days shaking hands, picking up flyers, and trying not to drip BBQ sauce onto my khakis during lunch breaks. While the conference did help whittle down the number of darts I had to throw at the map come application day, far and away the most memorable thing was just how overwhelmingly impressive the community and culture of family medicine came across.

Fast-forward to this year’s conference, and I had the pleasure of serving as the Colorado delegate to the resident congress. As a delegate, I had the opportunity to submit resolutions on behalf of the residents of Colorado. Furthermore, I sat on one of three reference committees in order to hear testimony for and against the resolutions proposed by various state chapters.

Both the residents and the resolutions put forth in the resident congress this year were ambitious, passionate, and bold. They pushed boundaries and conversation. The resolutions touched on everything from race and pharmaceutical pricing to payment reform and the Hyde amendment. Some proposals were patient-centered, such as increasing accessibility of buprenorphine, while others were especially near to residents, such as protections in the event of a residency closure.

The civil discord carried out in both the reference committees and the full resident congress is to be commended. While not all resolutions were passed, the experience was a great exercise in parliamentary process (which, thankfully, did not involve wearing white powdered wigs). I am thoroughly impressed with my fellow residents and their willingness to stand tall against seemingly immovable forces—their attempt to move the needle on difficult national conversations, all in the spirit of doing what is best for both patients and family physicians across America.

As Dr. Kohl charged us during our orientation to the resident congress, “decisions are made by those who show up.” Showing up takes time. Showing up comes with increased responsibility—it may even come with a price. But showing up starts conversations, addresses disparities, and makes positive change. For residents and family physicians, there has never been a better time to show up.

**Eric Kim, MD, PhD, Resident Alternate Delegate, University of Colorado Family Medicine Residency**

AAFP National Conference has always been a phenomenal experience. I started attending in 2017. Like most former medical students, I planned to focus on the booths. Instead I found myself drawn to the myriad skills workshops, the engaging talks, and of course the intricacies of congress. It was my honor this year to attend National Conference as the alternate delegate from the CAFP and continue to support meaningful actions by congress.

While in the past I pushed congressional resolutions in line with my own interests, this year I had the pleasure of engaging with our constituency and introducing resolutions that represented their interests as well. This engagement started before the conference with discussions between me, the CAFP formal delegate Kenny Herring, and CAFP board member Kyle Leggott. With Kenny, I learned of several single-payer related resolutions being worked on by CAFP members, and I had the opportunity to take one before the National Residents Congress. This resolution had a storied history with multiple years of work slowly building AAFP policy towards this ultimate goal. I learned a great deal about the framework of policy and slow interval changes that are necessary to bring new policy into alignment with old.

Kenny and I also had the pleasure of bringing new ideas from our constituency to congress. Polling our fellow residents, we found a strong interest in reducing barriers for use of buprenorphine in medication assisted outpatient therapy. I investigated a field I had not previously, learning about the history of the Drug Addiction Treatment Act and its creation of the Medication Assisted Therapy (MAT) waiver. Diving into AAFP policy which strongly supported access to MAT, I created and defended a resolution that pushed the AAFP to support deregulation of buprenorphine.

In addition, I was able to author and submit my own resolution to congress. Working off new data generated by my home institution among others, I submitted and defended a resolution supporting advanced training in electronic medical records (EMR) systems as a method to help reduce EMR related burnout. Technology policy is a field I have found to have fewer advocates amongst resident members. Pushing further refinement of AAFP policy towards technology use in clinical settings has been a continuing goal of mine since my first attendance, and it was a joy to continue this support.

At conference, I participated as a member of a resolution reference committee helping to review and present member resolutions for resident congress. Through this process, I learned a great deal about the inner workings of the Resident Congress and the processing that resolutions go through as they are considered. I participated directly in congress, speaking before the floor in collaboration with other delegates and resident members to support policy change. I caucused our attending resident members, presenting current resolutions to them and polling them to convey to congress what our constituents would like to see supported. Through these things, I learned about parliamentary procedure, the collaboration needed to create successful change, and the passions of all involved in this dynamic process.

Before my first participation, I never thought I would be much of a policy person. The machinations of a body like the AAFP Resident Congress from the outside seem dry, tired, slow, and unresponsive to an otherwise dynamic world. However, from the inside after years of participation, I’ve
learned that it is clearly anything but these things. It is a forum where the passions of people find voice. It is a framework through which people collaborate and generate complex policy from smaller ideas. It is an alliance of people who work to find consensus and move AAFP policy forward towards having the impact that we all want it to have on the world we share.

**Danielle Lattes, Student Delegate, Rocky Vista University College of Osteopathic Medicine**

I am very appreciative for the opportunity to be the student delegate for Colorado at the 2019 AAFP National Conference. It was a unforgettable experience and I learned so much. The congress is more than being the voice of medical students and address issues important to the family medicine specialty. As the delegate, I interacted with AAFP leadership, received hands-on leadership training, learned how to write resolutions, engaged in reference committees, and participated in parliamentary procedure. As long as you have passion for the family medicine specialty no experience is necessary (really), because this conference provides you with the tools you need to actively participate and understand the processes. This year I attended the reference committee orientation and volunteered to be part of a committee. After the resolution writing training session, I am eager and more confident to listen to my colleagues throughout this year and commit to resolution writing for the next conference. The best part of the conference is participating in the voting congress session, because the room lights up with extreme passion. I found myself inspired by many of the resolutions this year; each one was written with the intention of improving the health of the Academy, the patient and the student physician. Some of these included: Denounce Race-Based Medicine, Mental Health Disclosure on Health Care Credentialing and Licensing Applications, and Removing Barriers From Osteopathic Medical Students For Residency. That’s to name just a few! I encourage anyone interested in advocating for family medicine to volunteer to be a delegate and engage in creating an even better profession for family physicians and their patients.

**Marina Leith, Student Alternate Delegate, Rocky Vista University College of Osteopathic Medicine**

This year has been such a warm and exciting welcome into the family medicine community, largely thanks to the events and experiences that have been available to me as a student through the Colorado Academy of Family Physicians (CAFP). I first learned about the American Academy of Family Physicians National Conference (AAFP NC) this May, at the CAFP Annual Conference in Fort Collins. I heard over and over from students and physicians alike what a fabulous opportunity the NC is to learn more about family medicine, talk to like-minded medical students and residents, and connect with residency programs. Thanks to the generosity of the CAFP, I was able not only to attend the NC for the first time this July, but also served as an alternate delegate for the Student Congress, and represented students from our state alongside my friend and classmate, Danielle Lattes. As an alternate delegate, this was an amazing opportunity for me to see how the student congress functions, and to hear the ideas and passions of other medical students. Through this experience, I realized how involved the specialty of family medicine is in changing the healthcare system and in fighting for healthcare equality, and I discovered how influential we as medical students can be in this process. I realized that through the Congress, students are helping to create and implement healthcare policy that is changing the way we provide primary care on a national level, and that our opinions are heard all the way to Washington. Alongside Danielle, I also helped to elect the next year’s student representatives for organizations such as the AAFP Foundation, the Society of Teachers of Family Medicine, and many other organizations related to promoting family medicine and our values throughout the nation and the world.

I feel so grateful to the CAFP for the warm, welcoming community this organization has created. I am grateful for the opportunity to attend the AAFP NC, and even more importantly for contributing to my ever-growing excitement to practice family medicine is this amazing community of physicians.
This summer, to better understand the challenges our rural members face, the CAFP hit the road to visit rural practices across western Colorado and talk with members living and working in these areas.

BY LYNLEE ESPESETH, MPH

Over the last few years, via our membership survey and other platforms, our rural members have posed a question loud and clear:

“We are struggling. Do you care about us at all?”

The CAFP, both our staff and leaders, felt it was vital to do something about this. While we might not be able to fully understand what a day in your life looks like, we felt we owed it to our rural members to visit you, to see what your practices look like, to stay and eat and shop in the towns you call home, and to hear from you in-person or offer additional ways for you to send us your feedback.

This summer we had a wonderful time visiting practices across western Colorado. Erin Watwood, Director of Education, Events and Meetings, and Lynlee Espeseth, Director of Communications, Marketing and Membership, toured the southwest in June. Raquel Alexander, CEO, and Ryan Biehle, Deputy CEO for Policy and External Affairs, toured the northwest in August.

When available we met with groups of local members to hear more about your challenges and opportunities. When members weren’t available we dropped into practices with care packages for physicians and staff, including a small questionnaire physicians could fill out and return to us to help us understand what is happening at the individual practice level.

This trip was incredibly valuable. We met members new and old, learned more about your day-to-day life, and had the privilege of visiting many family medicine practices doing deeply important work in rural communities.

One of the biggest lessons of the trip is that rural Colorado, and all the challenges and opportunities you face, is exceptionally diverse. One cannot simply lump rural Colorado together and hope to solve everyone’s problems, because your communities and practice situations are simply too different. We did come across some issues that were universal, but that seemed to be the exception, not the rule.

What did we hear the most?

First, not unlike your urban colleagues, payment is a problem. The lack of Medicare and Medicaid parity is a struggle. Some are still struggling to be paid by Medicaid at all. Some practices have had to let staff go. Some wonder every month if payroll will be made. For practices that are Federally Qualified Health Centers, sufficient funding continues to be a challenge.

Additionally, members didn’t need to be in a traditional practice setting for payment to be on their minds. Physicians who have moved to Direct Primary Care, while very much enjoying this model of practice, still have the stressors of building a livelihood in a small community and being not just a physician but a business owner as well.

Second, again not unlike your urban colleagues, burnout and administrative burden is a massive problem. You have to fight for prior authorizations for things your patients need like oxygen and sleep studies. Workers compensation denials, paperwork, trying to understand what a plethora of different payers require, it all takes up time you would like to spend doing just about anything else.

Another concern you shared was the message that nurse practitioners or physician assistants are suitable replacements for your care in rural communities. While these professionals are deeply valued members of the care team, your scope of practice as a physician is simply larger and can help prevent costly and inconvenient referrals to specialists.

From there, your feedback was often more varied. Much of what we heard depended on exactly where a practice was located. For example, physicians in mountain communities that are considered a highly desirable place to live don’t tend to feel like they are the only physician for miles, never able to take a vacation. Similarly, many of these same communities don’t tend to struggle with access to specialist providers in general, however, some of you did mention that you felt like you have an overabundance of specialists. Paying to live in these communities is often a struggle for staff at your clinics as rising housing costs push out individuals like nurses and front desk workers.
For some of you the opposite of all this was true. You lack help and support from other nearby primary care physicians, and specialty care is almost nonexistent. In particular, we heard that mental health professionals are often the most in-demand and yet the most lacking for your patients.

And for most rural communities specialist access for Medicaid patients is exceptionally challenging.

One point that was discussed in some communities (though not all) was that you are concerned new physicians coming to practice may not have had the experiences in training that will keep them from being overwhelmed in a rural community. It can be challenging for physicians to both train in a rural community and see a high enough volume of procedures (like births) to feel fully prepared to practice on their own. It can serve as yet another deterrent preventing physicians from coming to or staying in rural communities.

The challenges you set before us are not simple ones to fix. However, we are already looking for ways to dive in and make change a reality.

In terms of payment, the CAFP is again looking at legislation that would push Medicaid payments to be in parity with Medicare payments. We are also closely monitoring how the public option in Colorado will be implemented and are pushing for payments to be at least at 135% of Medicare. Finally, our Primary Care Investment Initiative continues to move forward, and will be a vehicle for directing more money into your practices to use as you need it.

We are also working on legislation that would help ease administrative burden. While still very much in the development phase, practical steps as we see them include setting timelines that dictate when insurers must get back to physicians on prior authorizations, ensuring clinical guidelines are used to evaluate prior authorizations (as opposed to the seemingly arbitrary system that exists now), and setting up a system to have better data on prior authorizations to see if they are even making a difference in health spending.

We continue to push the message that explains why family physicians are uniquely qualified to take care of conditions that other providers simply are not. We will ensure that this is the message heard by legislators, organizations, as well as patients.

Finally, we will continue to collaborate with the Colorado Association of Family Medicine Residencies, our two Colorado medical schools, and other organizations that seek to train and place family physicians in rural communities that need them most. We want to ensure we are placing family physicians in rural communities who are prepared to take care of patients and who will find fulfilling careers in rural locations.

The truth is that we may not be able to fully solve every problem you face, but we will work hard to address all of those that are in our scope to have an impact on.

Our overall message to rural members after these travels is that we hear you. We want better for you when you are struggling. We want to share your stories when you succeed. And our ears, eyes and office continue to be open. You are welcome to reach us at any time to talk, share your ideas, or check in on how this work is progressing.

And don’t worry eastern Colorado, we are headed your way soon as well!
The University of Colorado School of Medicine Family Medicine Interest Group was recently recognized by the American Academy of Family Physicians as one of 19 medical school Family Medicine Interest Groups to win the 2019 Program of Excellence Award for their exemplary efforts to grow and support interest in family medicine.

Award winners were recently announced at the AAFP National Conference of Family Medicine Residents and Medical Students in Kansas City, Missouri.

FMIGs are student-run organizations that provide opportunities for students to learn about and experience family medicine outside of their medical school curricula. FMIGs host events, workshops, leadership development opportunities and community and clinical experiences. These award-winning groups are breaking new ground with important initiatives such as starting pipeline programs for
students who are underrepresented in medicine and working with their school administration to change the curriculum to be more supportive of primary care.

“Making sure that medical students have an appreciation of family medicine is a key step to those students choosing family medicine for their career,” said Clif Knight, MD, senior vice president for education at the AAFP. “Excellent FMIGs such as these award winners are an important component in these efforts. This is essential to addressing the needs of our communities in order to improve health outcomes in a system that relies on a foundation of primary care.

All of this year’s award winners have done outstanding work giving students the opportunity to activate the knowledge they’ve acquired in the classroom, develop leadership skills that will serve them in their future practices and communities, and better understand the vital role that family medicine plays in our health care system.”

FMIGs are independent groups, governed by their host medical school and supported by faculty and staff with resources and support from the national FMIG Network administered by the AAFP.
WELCOME NEW MEMBERS

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

ACTIVE MEMBERS

JULIE BUCHNER, MD
STEPHEN COHEN, MD
SPENCER COOPERMAN, DO
VICTORIA CUMMINGS, MD
DAVID DAVID, MD, FAAFP
ABNER FERNANDEZ, MD
JEFFREY FOSTER, DO
ANGELA GIAMPAOLO, MD
DAVID GREENBERG, MD
RACHEL GRIFFITH, DO
FERNANDO GUARDERAS, MD
NETANA HOTIMSKY, DO
SCOTT ISBELL, MD
F. PAUL KNAPP, MD
HEATHER LINDER, MD
AARON LLOYD, MD
EDDIE LOWE, MD
WILLIAM MANARD, MD, FAAFP
MICHELLE MANG, MD
LAURIE MARBAS, MD
SERGIO MURILLO, MD
MATTHEW NELSON, DO, MPH
Marilyn Nguyen, DO
KERRY O’CONNOR, MD
SEAN OSER, MD
TAMARA OSER, MD
LINDSEY PEARSON, MD
YVONNE RODRIGUEZ-CONESA, MD
DESHEL SECREST, MD
EDWARD SHUHERK, MD
MICHAEL SOLOMON, DO
MARY ST. CLAIR, DO
BOGDAN STRAMBU, MD
STEPHANIE VOYLES, MD
MICHAEL WAlERY, MD
KELLY WESTHOFF, MD
SUSAN WILHOIT, MD
JOSEPH YANG, DO

RESIDENT MEMBERS

STERLING ADAMS, DO
HANNAH AHO, MD
KAILY BAER, MD
KRISTEN BEIKIRCH, MD
KIMBERLEE BURCKART, MD
ALLISON COSTELLO
KATHRYN DOSTER, DO
JOSHUA GILENS
JORDAN HARBAUGH-WILLIAMS, MD, MPH
BETHANY HILEMAN, MD
GABRIELA KALDAN, DO
LAKSHMI KARRA, MD, MS
SHAUNA KELLY, DO
GRACE KIM, DO
CHRISTOPHER KLEIN, MD
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SEAN LLEWELLYN, MD
NAINITA MADURAI, MD
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JEREMIAH MOON, MD
CHRISTOPHER NEWLAND, MD
CHELSEA ROBERTS, MD
LETICIA ROJAS, DO
ANDREW SCHMUTZ, DO
CHRISTIN THOMPSON, MD
MEGAN TOWNSEND, MD
CASEY WEISER, MD
DANIEL WELLS-PRADO, MD
GEORGIANNA WHITELEY, MD
MEGAN WILKINSON, MD
ZACHARY WRIGHT, MD

TRANSITIONAL MEMBERS

JEROME TREMBLEY
ELVIRA SOPHIA GONZALEZ, MD

STUDENT MEMBERS

HAYDEN COLLINS
WILLIAM CRAWLEY
JOSEPH FUCHS
ALEXIS Gerk
REBECCA GRENVIK
KARIMA HAMAMSY
MATTHEW HAMMOND
ARIEL HERNANDEZ
JASPER HUANG

Do you have exciting news about yourself or a colleague that you would like recognized by the CAFP? Contact Lynlee Espeseth at lynlee@coloradoafp.org or 303-696-6655 x 16.
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