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VAPING IN COLORADO: WHAT FAMILY PHYSICIANS NEED TO KNOW
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YOU ARE THE KEY TO ZERO SUICIDE

45% of those who complete suicide see a primary care physician in the 30 days before they die.

The Journal of General Internal Medicine ‘Health Care Contacts in the Year before Suicide Death’ (June 2014 Vol 29 Issue 6 pp870-877) notes that nearly all completed suicides receive health care in year prior to death (83%), yet less than 25% had a mental health diagnosis in the month prior to death.

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<th>Name</th>
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<tr>
<td>Emily Aquila, DO</td>
<td>St. Anthony North, Denver (2021)</td>
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<tr>
<td>Sean Buck, MD</td>
<td>University of Colorado Family Medicine Residency, Denver, Health, Greenwood Village (2021)</td>
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<tr>
<td>Katie Doster, MD</td>
<td>North Colorado Family Medicine, Greeley</td>
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<td>Bryce Galbraith, MD</td>
<td>St. Anthony North Family Medicine Residency, Westminster (2020)</td>
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<td>University of Colorado Family Medicine Residency, Denver Health, Denver (2021)</td>
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<tr>
<td>Morgan Hungenberg, DO, PGY-II</td>
<td>University of Colorado Family Medicine Residency, Denver Health, Denver (2019)</td>
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### Student Representatives

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<tr>
<td>Bijan Ghafevari, CU</td>
<td>University of Colorado Family Medicine (2019)</td>
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<td>Leah Kellogg, CU</td>
<td>University of Colorado Family Medicine (2019)</td>
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<td>Mallory Krueger, RVU</td>
<td>University of Colorado Family Medicine (2019)</td>
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<td>Danielle Latte, RVU</td>
<td>University of Colorado Family Medicine (2019)</td>
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<td>Filiberto Morales, CU</td>
<td>University of Colorado Family Medicine (2019)</td>
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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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PRESIDENT’S LETTER

Happy New Year!

The new year brings a time for reflection and allows a natural time to check our bearings; A time to reflect on our prosaic routines and habits to be mindful of our trajectory and check to see if we are orientated in the right direction. I’ve personally never been big on New Year’s Resolutions, even though I continue to feel frustrated with myself that I yet again haven’t made it to the gym as much as I have planned, or haven’t ran over my lunch hour like I told myself I was going to do. With the best of intentions and with mixed results, I will vow to try to do better next week or reassure myself that just maybe I won’t work through lunch yet again tomorrow.

It’s likely self-recognition of my own struggles to make changes in my own life that allows the opportunity for me to be present and sit with my patients as they wrestle with how to make their own changes and improvements. We use the same motivational interviewing skills that our medical students are always eagerly wanting to practice and with empathy we support and facilitate goal-orientated patient-centered shared medical decision making. Optimistically we foster patient self-sufficiency and help them find the tools to check their bearings and course correct, empowering them to make needed changes.

I recently was introduced to the art of Xavi Bou. Mr. Bou is a Spanish geologist, photographer and environmentalist who wondered “If birds left tracks in the sky, what would they look like?” In his most recent project, “Ornitographies” he sets out “To make visible the invisible” and capture the elusive flight pattern contours that birds fly creating artistic “visual poetry.” He describes the project as inspired not only for his passion for birds but also his interest in capturing seemingly unnoticed moments and questioning limits of human perception. I encourage you to check out his art work and reflect on the hypnotic art he creates at his website: http://www.xavibou.com. Mr. Bou and the Ornitographies project sparked me to think about all the invisible paths we are able to make visible for our patients, and what a small shift or change in course can lead to.

We often don’t know what path our patients end up taking, what paths lead patients to us, or where their path may lead them, but the privilege to journey with and equip our patients continues to inspire me.

Organized medicine has often been criticized for either tilting at windmills or for not taking enough of a stand to facilitate change. However 2019 was a monumentous year for Colorado Family Physicians and our patients. With our unrelenting drive to further incentivize and compensate high-value Primary Care we have brought real changes. Focusing on improving access, quality, affordability and both the patient and family physician experience of health care, we were able to pass landmark legislation right here in Colorado that over the next few years will reshape our health care landscape. In the last seven months it has been my honor to help articulate your concerns and advocate for the health of Coloradoans as this legislation has been acted on and as related statutes are being formulated.

I would like to extend an invitation for you to be part of this change process. We are experts at providing comprehensive medical care to our patients, their families, and our communities. We use our medical expertise to help facilitate patient behavioral changes. We are uniquely situated to use that same expertise, and pair it with the stories of our patients, to educate, influence, and facilitate changing our state’s healthcare system. The 2020 Colorado Legislative session starts in just a few days and I hope that you join us in person at the Capitol as part of our ongoing Doctor of the Day program.

I look forward to see the tracks that you will leave behind, and the changes that we Colorado family physicians will continue to facilitate.

I leave you with the words of Nobel Laureate Bob Dylan “Please heed the call... as the times they are a-changin’.” Until next time, may this find you well.

John Cawley, MD, FAAFP
CEO’S REPORT: YEAR IN REVIEW

PRIMARY CARE INVESTMENT INITIATIVE (PCI) Passage of HB19-1233: This was a fantastic win for the CAFP and a great team effort by the CAFP physician leaders, staff, and lobbyists. It was truly the highlight of my career. The bill established the Primary Care Payment Reform Collaborative under the Division of Insurance. Stephanie Gold, MD, has been the CAFP’s representative on the Collaborative and has been doing a fantastic job in educating Collaborative members on primary care, and payment reform.

OTHER LEGISLATIVE WINS: The CAFP is very fortunate to have such a well-functioning legislative machine made up of our CAFP legislative committee, our lobbyist, and our Deputy CEO for Policy, Ryan Biehle. Ryan did a great job pushing the CAFP legislative agenda, working with our lobbyist, getting testimony when needed, organizing our Doctor of the Day, and overseeing all our policy work. It has been a great pleasure to work with Ryan, talk through our strategies, solve frustrating situations, and laugh. Another highlight of my career was the passage of the CANDOR bill, which set up an alternative malpractice system. It was truly the highlight of my career.

NEW MEMBER BENEFITS PROGRAM: We have completed two years of the New Member Benefits program including financial/loan repayment reviews, contract reviews, salary survey requests, and Annual Summit fee waiver requests. Retention of the new members who have used these benefits has increased.

CAFP OPERATIONS: We are always making the CAFP function better including bylaws amendments, committee descriptions and structure, and management. We also implemented a board member satisfaction survey, which has helped to improve our board meeting process.

CAFP LEADER SPEAKER TRAINING: CAFP Board leaders participated in a speaker training, which provided our leaders with tools to help them speak with conviction.

CAFP AUDIT: Every three years, the CAFP has a full audit, and a financial review is done on the other two years. Each year we implement additional policies and financial safeguards per the direction of the auditors to ensure that the CAFP is in a strong financial position and also a safe one.

STAFF MANAGEMENT: We have a terrific staff, and I am very proud of each of them for how dedicated they are to CAFP’s mission. The interns we had over the last year contributed a lot to the CAFP’s mission by their excellent work.

CAFP ANNUAL SUMMIT & CAFP FOUNDATION: Attendance at the 2019 Annual Summit was one of the highest ever. Attendees enjoyed the high-quality CME presentations. The CAFP Foundation’s 2019 Annual Summit made a profit and has shared that with the CAFP.

NEW GRANTS PROGRAM: The evaluation results from participants in the Foundation’s new marijuana grant project shows statistically significant results, a great win for us. This will help in our grant seeking.

The Foundation’s new diversity grant project received a planning grant from the AAFP Foundation. The program will establish Camp Primary Care for high school students to help them prepare for college and learn about Family Medicine.

CAFP FOUNDATION LEGACY GIVING: We developed and launched the new CAFP legacy giving program. Thank you to Jeff Cain, MD, who has put the CAFP in his will. We hope many others will join in acknowledging and contributing to the good work that the CAFP is doing.

GOALS FOR 2020: We will continue to observe and work with the Primary Care Payment Reform Collaborative. There are major issues that we will be working on at the legislature including the nurse practice act sunset and immunizations. We are also planning to make another rural road trip to visit our members in eastern Colorado. If you would like us to visit your practice or meet with you, please let me know.

I thank God for the blessing and privilege of being able to serve you all these years. We have built a great AFP chapter, and I am very proud of what we have accomplished.
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CAFP 2020 Legislative Outlook

The 2019 legislative session was among the most productive health care sessions in recent memory. Health care affordability took center stage. In 2020, affordability will again be a chief priority for legislators looking to deliver for constituents, but public health will take a prominent role this year as well.

Vaccines: Colorado’s immunization rates have been dropping in recent years and we score worst in the nation for Measles immunization rates, recently dropping another percentage point to 87.4% in 2018. Last year’s bill to tighten personal belief “convenience” exemptions failed in the final days of the legislative session. This year, CAFP will be supporting a renewed effort alongside the American Academy of Pediatrics – Colorado Chapter, the Colorado Children’s Immunization Coalition, and State Representative Kyle Mullica, an EL Nurse, to again tackle this problem. One of the key reasons for low vaccination rates is Colorado’s relatively easy exemption process. Among other goals, the upcoming bill aims to achieve “equal effort” for an exemption. In other words, parents who are exempting their children today out of convenience would need to go to a physician or local public health agency to get an exemption form signed. The bill will not alter a parent’s ability to exempt should they hold a belief to do so, nor does it require any physician to sign personal belief exemptions.

Tobacco: An effort is underfoot to raise the legal age for sale of nicotine to 21. That effort has focused on municipalities around the state and has been largely successful, but we will be exploring whether a statewide age increase is possible this legislative session. With rising awareness of a dangerous, and sometimes deadly, vaping epidemic, policies to raise the age have become more tenable. 19 states have already raised the age, and evidence demonstrates the policy can significantly reduce youth nicotine use. A second effort to raise the nicotine sales tax may also be considered this year, although any tax increase requires a vote at the ballot and statewide tax increases have enjoyed little favor by the public in recent years. A 10 percent increase in the nicotine sales tax has been shown to reduce youth use by 7 percent, so the benefits are substantial if such a measure is viable at the ballot. Legislators and the Governor will certainly be weighing political viability before moving forward on this proposal.

Opioids: Legislators continue to attack the opioid epidemic, having completed a third round of committees during the interim that yielded another 5 bills to address the issue. In prior legislative sessions, they have passed bills including required Prescription Drug Monitoring Program checks by prescribers, required e-prescribing by 2021, or 2023 for rural and solo practices, and adding opioid training requirements for medical license renewal. One key opioid prevention bill that CAFP intends to support this year will allow patients access to alternative pain treatment coverage through their insurance. The bill includes up to 6 physical therapy and 6 occupational therapy visits, while eliminating prior authorizations for nonpharmacologic pain treatments as an alternative to opioids.

Health Care Costs: Last year, legislation passed to study and lay the groundwork to implement a public option. This resulted in a report to legislators on the parameters of that option, which as proposed would reduce insurance premiums by 9-18% around the state and increase the number of Coloradans who are insured. The proposal included many CAFP priorities such as pre-deductible coverage for primary care visits and increasing the share of the premium dollar spent on primary care. However, insurers and hospitals are largely opposed due to required participation by insurers to administer the option, and a proposed hospital rate cap of 225% of Medicare. CAFP has supported the general direction of the proposal to lower premiums, increase the number of insured, and maintain a primary care focus. We will remain active in the issue as it unfolds throughout the session.

Scope of Practice: The physician assistants (PA’s) passed a bill last year removing liability from under that of a physician when not directly instructed by a physician. At the same time, the supervisory relationship with the physician remained intact. However, the placement of this provision in the Medical Practice Act led to the unintended outcome of a PA then needing a separate liability policy. The PAs will be running legislation to clean up this error to avoid the need to pay duplicative liability premiums. The Nurse Physician Advisory Taskforce (NPATCH) is also up for renewal. This taskforce currently addresses scope of practice questions and offers a forum for more constructive debates on the topic. We previously helped create NPATCH to avoid legislative scope fights. However, we would like to see the reauthorization improve its effectiveness and shift the focus of its topics to enhancing team-based care.

On top of all our legislative work, CAFP will continue to influence the state’s implementation of our Primary Care Investment Initiative. Following passage of our priority legislation last year, the first recommendations from that bill are out. The recommendations are set to include a requirement for insurers to spend 1 percentage point more of the healthcare dollar on primary care each year for 2 years. Further increases will be evaluated beyond that. With only 5-7% of the total healthcare dollar currently spent on primary care, this will represent substantial movement toward appropriately resourcing primary care.

We look forward to a successful legislative session and hope you can join us at the Capitol! You can sign up for Doctor of the Day to see our legislature in action at https://www.coloradoafp.org/doctor-of-the-day/.
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CAFP On the Go

CAFP Leadership participated in the Western States Forum during the AAFP’s Congress of Delegates.

CAFP CEO joined other chapter executives from Western states for the Women of the West Meeting, where best practices from across chapters were discussed.

CAFP hosted an event for medical students and family medicine residents as part of Primary Care Week at Dry Dock Brewery in Aurora.

CAFP hosted a Preventive Health Knowledge Self-Assessment Workgroup at our office in Aurora. A great way to pack in some last-minute CME.

The CAFP received the Leadership in State Government Advocacy Award from the AAFP for passing the Candor Act during the 2019 legislative session.

CAFP’s delegates, Brian Baca and Neely Madrid, MD, at the AAFP’s Congress of Delegates.

CAFP on the go.
“When you’re treated with respect and dignity, it makes all the difference in the world.”

—Cory B.

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
From the 22nd to the 25th of September, the CAFP delegation attended the AAFP’s 2019 Congress of Delegates in Philadelphia, Pennsylvania. By way of background, as annotated on the AAFP’s website, The Congress of Delegates (COD) “is the Academy’s policy-making body. Its membership consists of two delegates and two alternates from each constituent chapter and from the member constituencies including new physicians, residents, students, and other constituency groups represented at the National Conference of Constituency Leaders.”

Every year, the CAFP delegation works with its Board Members and our CAFP members to create and develop resolutions for introduction at the annual Congress of Delegates. In preparation for the COD this year, our CAFP chapter presented four resolutions for consideration. The first was Resolution 212, which requested the AAFP to divest its investments from fossil fuels to the greatest extent possible. Our second was Resolution 503, which requested that the AAFP advocate for universal adaptation of standard claims data and universal use of all-payer claims database information – essentially making it easier for Family Physicians to report data and receive payment and feedback because everyone would be operating off of the same data set. Our third was Resolution 602, which asked the AAFP to create a specific category of CME related to “Health Systems” at AAFP events, which would allow for educational programming to include the latest information on health systems, health reform, and cover issues like single-payer and public options for CME credit. Our final Resolution was 607, which asked the AAFP to work with the ABFM in improving the support of residents affected by residency closures related to market force and hospital consolidation. Our chapter felt that this was an unaddressed need as the number of residency closures across the US has been increasingly associated with forces outside of program and resident control (as opposed to the “more traditional residency closures related to poor program and resident performance”).

Annually, the Congress elects new officers and three members to serve on the Board of Directors for the following 12 months. AAFP members are welcome to participate in hearings of the five reference committees: Advocacy, Education, Health of the Public and Science, Organization and Finance, and Practice Enhancement. Reference committees are committees of the COD that consider business (resolutions) items referred to them for recommendation to the COD for debate and action. These events play out during the two- and one-half-day meeting of the COD, which is held before the AAFP Family Medicine Experience. In addition to reference committee discussions, the Congress agenda includes addresses from AAFP officers, resolutions from chapters, and reports from the Board of Directors and commissions. On Sunday at this year’s COD, the CAFP delegation participated in 3 significant events. In mid-afternoon, the Delegates and Alternate Delegates met with the Board of Directors Candidates and the Officer Candidates in the “Meet the Candidates Session,” finding out more about each of them through questions and answers as they rotated among the candidates. Later that evening, the CAFP Delegation attended the “Western States Forum. That group represents a collection of Chapter leadership from multiple Western states and allows the group to discuss resolutions and common areas of interest. Next year, in Chicago, Colorado, will be the “host” and hopefully will give the event a real Rocky Mountain experience. Later Sunday evening, the group attended the AAFP’s Town Hall, led by the officers including Mike Munger, John Cullen, Doug Henley, and Gary LeRoy. The town hall was standing room only and allowed over 300 attendees to hear the AAFP leaders speak on the Academy’s efforts around payment reform, the challenges of family physicians practicing to the extent of their training, and decreasing the overall administrative burden on family physicians. John Cullen, who practices in rural Alaska, illustrated the challenges facing rural Family Medicine physicians—which are understandable to all of us who practice in Colorado. He highlighted a few worrisome trends that he believes family physicians have a role in helping our country solve. For example, it is more dangerous to deliver a baby in the US now than it was 20 years ago. There is a disproportionately negative impact of travel time on OB care. It’s clear that rural patients and others who have a travel time for OB care greater than 1 hour have poor outcomes. People who live in rural areas, and people of color, have poorer OB outcomes and the rates of those adverse outcomes are increasing.

On Monday, the official Congress of Delegates events got underway, with opening remarks from the AAFP officers. Among the speakers was Doug Henley, the current Executive Vice President, and CEO. His comments were particularly noteworthy as this Congress is his last one due to his planned retirement. He told a wonderful story about a French Physician, Dr. Roger LeForctie, who was killed by the Nazis for standing up for what he believed was right, and in the process saved the lives of thousands of Jewish and Gypsy children otherwise destined for the concentration camps.

CONTINUED ON PAGE 14 >>
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Doug’s comments were particularly inspiring, and I urge all of our members to go to the AAFP’s website at https://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2019/2019AddressesforDrHenley.pdf for the full text of his speech, which was very passionate and moving.

After the opening comments and general business, the Congress adjourned into the reference committee hearings. During the hearings, the Colorado delegation testified in support of our sponsored resolutions. That work continued into Tuesday, where the resolutions were presented to the full Congress for discussion and disposition. Ultimately, our resolutions fared well. Resolutions 212, 602, and 607 were all referred to the AAFP Board of Directors for further action. This will likely result in the resolutions being assigned to various AAFP Commissions (such as the AAFP Commission on Education) for research and action, and represents a good outcome for us. Resolution 503 was adopted by the full COD and will become an action item and incorporated into AAFP policy. Overall, we were pleased with the results.

On Wednesday, the AAFP elections were held for our future leaders, and the results were as follows. The Congress of Delegates elected Ada Stewart, M.D., of Columbia, S.C., to be the Academy’s president-elect. Other election results were as follows:

- Speaker of the Congress -- Alan Schwartzstein, M.D., of Oregon, Wis.
- Vice Speaker -- Russell Kohl, M.D., of Stilwell, Kan.
- Directors -- Andrew Carroll, M.D., of Chandler, Ariz.; Steven Furr, M.D., of Jackson, Ala.; and Margot Savoy, M.D., M.P.H., of Newark, Del.
- New Physician Board member -- Brent Sugimoto, M.D., M.P.H., of Richmond, Calif.
- Resident Board member -- Kelly Thibert, D.O., M.P.H., of Columbus, Ohio
- Student Board member -- Margaret Miller, of Johnson City, Tenn.

After all the years that we have been attending the COD, we remain impressed by the ability of our Academy to work together and forge new policy and new directions. The AAFP is so large it is like trying to turn an aircraft carrier, and fortunately, so many involved AAFP members and AAFP chapters stay energized and on-task in doing the work of our profession. I want to close with a few of my favorite quotes from Dr. Doug Henley’s speech, which I think resonate with all members of the Colorado Academy Family Physicians. First, “Comprehensiveness and continuity in family medicine must mean ‘being there’ with our patients when and where they need us – the hospital, the office, the home, the nursing home, online, wherever. Evolving technologies may redefine what ‘being present’ means and how it is accomplished – but it must remain as a defining characteristic and promise of our specialty”; next, “Our cause is right because we seek to restore that sacred space – that healing relationship – between patient and doctor” ; and finally, sharing Doug Henley’s thoughts on the importance of our work: “Our cause is right because as family physicians we must not and will not be silent on the things that matter in health care. Things that matter – like remembering the words of Dr. King when he said – “of all the forms of inequality, injustice in health care is the most shocking and inhumane” – so as family physicians, I believe we share a belief – as old as the scriptures and as clear as our constitution – that we are all worthy, we are all equal, and we all count. And so, we stand for health equity and overcoming social, racial and other forms of injustice in health care.”

The CAFP Alternates and Delegates consider it a privilege to represent all of our CAFP members at the annual AAFP Congress of Delegates, and we look forward to next year’s Congress in Chicago. Please reach out to us with any ideas for future resolutions or actions that you would like for us to pursue.

Brian Bacak, MD, FAAFP
Glenn Madrid, MD, FAAFP
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Twelve Recent Publications That Could Change The Way You Practice And Treat Children And Adolescents With Ent-Related Issues

The 12-members of faculty at the Department of Otolaryngology at Children's Hospital Colorado are not only busy clinicians but fulfill their academic mission in advancing the fields of otolaryngology and pediatrics through clinical research. The culmination of these efforts is scientific publications, and the faculty have chosen particular papers from the past 18 months that might be of interest and impact to the practicing primary care clinician to aid in the care for children and adolescents with ENT concerns.


This was a retrospective review of the Children's Hospital Colorado primary ciliary dyskinesia (PCD) database to assess the impact of rhinosinusitis in terms of surgical intervention and hospitalization. While the overwhelming majority of PCD patients were diagnosed to have sinusitis, the development of complications, as well as the need for surgical intervention and sinusitis-related hospitalization, were limited. The authors concluded that surgical intervention for this population, therefore, should be highly individualized.


This study examined the relationship of rare malignant tumors presenting in the pediatric head and neck with heritable cancer disorders. Li-Fraumeni syndrome is associated with early-onset neoplasia and the development of recurrent primary tumors. The appearance of rare tumor types or in unusual locations in children should prompt caregivers to consider the presence of potential hereditary cancer disorders. Chemoradiation should be used judiciously in this population. These relationships are important for caregivers to recognize, as heritable cancer disorders affect treatment decisions and methods of surveillance.


This study published the results of a 2017 ASPO survey on the practice patterns of pediatric OTO MDs before the publication of the 2019 AAO/HNS clinical practice guideline on Tonsillectomy in Children. It highlighted that clinicians were not aligned with the CPG. The threshold for overnight observation when a preoperative polysomnogram has not been performed may be too low. An educational campaign is necessary to update clinicians who take care of children on the new evidence-based guidelines and to update clinicians who take care of children on the new evidence-based guidelines.

Take home: Pediatricians should be aware of the 2018 AAO/HNS clinical practice guideline on Tonsillectomy in Children so they can be an advocate for their families.

CONTINUED ON PAGE 18 >>
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One of the biggest challenges for a cleft palate surgeon is managing and counseling families with infants who are struggling to breathe due to their craniofacial anomaly. This investigation evaluated the effect of sleep position on obstructive apnea–hypopnea index and gas exchange. There was no consistent improvement in respiratory indices or oxygenation in the non-supine position compared to supine. Parents are tempted to place their infant in the prone position since they appear less restless, and clinicians may recommend prone position since theoretically, it displaces the tongue forward and opens the airway. The American Academy of Pediatrics (AAP) safe infant sleep practice guidelines specifically discourages infant sleep in both lateral and prone positions.

Take home: We advocate for a sleep study to verify that there are objective improvements in OSA before deviating from the AAP guidelines for safe sleep and having an infant with a cleft palate sleep in a non-supine position.


This study is the largest review to date evaluating hearing and temporal bone findings in children with Septo-Optic Dysplasia (SOD). It found that 11% of children had hearing loss, which was most commonly bilateral and sensorineural in origin. Chronic otitis was also present in this group, with over half (57%) requiring tympanostomy tubes. This was the first study to report cochlear nerve deficiency and aural atresia in this population. These results suggest that otitis and hearing loss are more common than previously reported in SOD children. Recommendations for otologic monitoring in SOD patients were suggested based on the results of this study.


In this study, we examined the clinical course and culture results for 131 children who underwent incision and drainage of lateral neck abscesses over two years at Texas Children’s Hospital. Streptococcus infection was rare (8%), and almost half of the patients had methicillin-susceptible Staphylococcus aureus (MSSA) in culture. The most common outpatient empiric oral antibiotic was clindamycin. There was a high rate of clindamycin resistance
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in this population (18%), which seemed to be population-based, not induced by individuals’ previous use of clindamycin. With the increased rate of MRSA, and therefore more frequent use of empiric clindamycin, this is not surprising. Based on these results, we recommended considering alternative therapies for initial inpatient management of pediatric neck abscesses that fail outpatient treatment based on the low rate of Strep. species and your local hospital’s antibiogram.


This was a multidisciplinary guideline to identify quality improvement opportunities in managing children under consideration for tonsillectomy and to create clearly stated and actionable recommendations. The guideline has 15 action statements that provide comprehensive evidence base recommendations for children who are being evaluated or will be undergoing a tonsillectomy.


This paper is a review of recent literature supporting the use of multidisciplinary care for children with a tracheostomy.


This study investigated the weight changes following a tonsillectomy for 78 children with Down syndrome. Studies have demonstrated that non-syndromic children gain weight following a tonsillectomy. Obesity increases the risk of having either persistent OSA or recidivism after successful surgery. Our data revealed that a tonsillectomy does not alter the BMI trajectory regardless if the OSA resolved or not.

Take home: Tonsillectomy does not increase the risk of children with Down syndrome to become obese.


This paper is a review of the natural history and medical management of decannulated children.


There is a growing movement in the care of complex children to integrate care into dedicated teams. This paper reviews the clinical as well as the financial benefits to patients, healthcare organizations, and payers when care is delivered in this fashion.

Children’s Hospital Colorado Otolaryngology physicians can be reached for consult and referral through OneCall, 720-777-3999, or 719-305-3999 in Colorado Springs. Laura Pickler, MD is the Children’s Hospital Colorado Chair of Family Medicine, laura.pickler@childrenscolorado.org.
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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.
This case illustrates several of the issues that may arise when patients demand unnecessary tests. A list of common questions and general advice follows:

**What am I obligated to do for a patient who demands a test that I think is unnecessary?**

A simple answer to this question is that, in any given scenario, physicians are held to the medical standard of care. This is defined as “what a reasonable and prudent physician with the same or similar training in similar circumstances would be expected to do.” As experienced physicians may know, each situation can have myriad complicating factors so that when there is a judgment call regarding a cognitive medical decision, there is a “range of acceptable practices.” However, in a situation where a patient demands an unnecessary test, the physician is held to the standard of care.

**What if the patient is persistently demanding and will not accept my refusal to order a requested test?**

Although it is next to impossible to reduce the complexities of how to handle such an encounter to a single piece of advice or a simple algorithm, a physician should understand that, foremost, he or she is an advocate for the best care for their patients. Sometimes, the best care is not necessarily what the patient is demanding. It is important to understand the patient’s underlying reasoning for wanting the study in the first place since addressing this may put the patient at ease. For instance, in the above case, a discussion acknowledging that having three friends with closely occurring cases of cancer would be unsettling and prompt most people to ask if they should be doing more to screen themselves. If the patient persists despite reasonable efforts to educate as to why you decline to order the requested test, then it may be reasonable to refer the patient to another physician for a second opinion.

**What if, despite my best efforts to convince a patient that he or she does not need a test, I give in and order a test that I believe is unnecessary?**

If ordering the test it is not harmful, and could reasonably be justified that in that particular scenario, and it is within the “range of acceptable medical practices” to do so, then it might be considered within the standard of care. In such a case, it would be useful to outline your thought process as to why you are ordering the test despite believing it is unnecessary such as “…although I discussed the risks with Mr. Jones of ordering an MRI, including incidental and benign findings that might lead to more and risky testing, and that the best science tells us that the test is not valuable and may be harmful, I think he has significant and ongoing anxiety about not being tested which is having adverse effects on his health, and in this case, it is reasonable to order the MRI since he clearly understands why I recommend against it.”

An informed consent discussion with a patient where you outline why the test is being done, the potential risks to the patient, your reasons for advising against it, and your reasons for ordering the test anyhow might be helpful to have in the patient’s chart in the event of downstream adverse events.

**Do any medical organizations have statements regarding unnecessary tests?**

The AMA’s Code of Medical Ethics states that “Physicians should not recommend, provide, or charge for unnecessary medical services.”
Is the Health Care System Ready To Be Truly Patient-Centered?

Every time the “rate this app” feature pops up on my phone, I feel a tinge of annoyance, but technology companies are clearly on to something. They ask for customer feedback constantly because they know what other industries are just catching onto: the people who use your service or product know best what’s working with it and what’s not. The health care system is starting to ask for feedback from customers, but it turns out that the system might not be ready to hear it.

Patient-centered care has long been a buzzword in health care. The idea is that each patient needs a care plan that works, especially for them and their life circumstances. And when done well, patient-centered care seems to improve outcomes. At Center for Health Progress, we’re trying to take the concept of patient-centered care one step further. We believe patients and community members, especially those most affected by poor outcomes and health inequities, must be centered as experts in the design and transformation of the health care system. This means that, at a minimum, health care systems need to start asking their customers directly for feedback any chance they get, and their feedback needs to be trusted and addressed. It also means that potential customers of the health care system need to be engaged in program design and system-transformation efforts as expert consultants from the very beginning.

Over the last two years in Adams County, we did just this. In partnership with community clinics, and with research and advocate partners, we worked closely with patients and community members as they developed messages and communication tools that aimed to increase and improve conversations between patients and providers about the cost of health care. We then worked with the clinics to integrate the tools into their clinical workflows and tested their impact and effectiveness. Our research, published recently in the Annals of Internal Medicine (https://annals.org/aim/fullarticle/2732822/community-designed-messaging-interventions-improve-cost-care-conversations-settings-serving), shows that the tools largely worked. After clinics incorporated the tools, patients better understood what their care would cost and felt the tools improved the quality of care they received.

However, our findings also identified a challenge to patient-centered design efforts: patients and providers disagreed about the effectiveness of the tools. Patients who used the tools strongly agreed that they helped start conversations about the cost of care. Providers disagreed. This key finding suggests that, despite our work to center patient expertise in health intervention design efforts, providers may not be ready or receptive to this type of change.

There are many reasons providers might be unreceptive to patient-designed interventions. One reason is differences in life circumstances and experiences between patients and providers that often play out across race and class lines. To be sure, white, economically secure, highly-educated professionals who currently hold nearly all of the power in the health care system will always struggle to truly understand how their patients who don’t share similar privileges and power experience their products and services.

It’s clear that health care leaders and providers need to start asking their patients more directly how they can improve—and trust their feedback.
Greetings from SNOCAP

What have we been up to since our last article? There have been many things going on with SNOCAP, but we’d like to highlight two milestones:

The High Plains Research Network has hired a new director to lead research and community efforts in the Eastern Plains! We are pleased to introduce you to Dr. Tamara Oser:

“Having spent time as a practicing family doctor in rural Pennsylvania, I am excited to have the opportunity to work with patients and other stakeholders to improve the health of rural communities in the state that I have always considered home. My first day of work was getting to participate in an HPRN Community Advisory Council meeting, and it was hands down one of the best days of the amazing career I have been lucky enough to have. I’m excited to continue to work with them and the practices in eastern Colorado!”

Dr. Oser is an Associate Professor of Family Medicine at the University of Colorado-Anschutz Medical Campus and Director of the High Plains Research Network. She was born and raised in Colorado, then moved to Maryland to complete her undergraduate degree at the University of Maryland, College Park. She completed medical school and residency at the University of Pittsburgh School of Medicine. Her training and subsequent experience in Family Medicine have emphasized a holistic approach to patient care, viewing the patient in the context of their life circumstances, including not only their health, but also their personal beliefs, interests, culture, and relationships. Her research interests are diverse but focus on the psychosocial aspects of living with health conditions such as diabetes, community engagement, and peer support through social media, and integrating diabetes technologies into primary care.

Recap from our yearly SNOCAP Convocation:

SNOCAP Convocation is a convening of practices, patients/community members, researchers, and other partners. We came together on September 20th and 21st to share struggles and successes, find community with others, and plan for future work together.

This year we focused on the voices of our practices and patients that have participated in SNOCAP work in the past to see how others can learn from their experiences and hear lessons learned “from the field.” Ashley Espinoza, Christin Sutter, Kristen Williams, and Sandi Garcia, all from rural areas of Colorado, got on stage to discuss their role in community, practice, and PBRN work. They also answered questions from the other participants in the room. This session was new this year and was a huge hit! Highlights from this session include:

- Involve community members or patients early and listen and react to what they have to say. Each practice and community functions differently; it’s good to remember that one process or communication style won’t work the same way for everyone.
- Remember that many practices have other projects going on simultaneously; see how projects can fit into ongoing work instead of being in competition.
- Approach your practice partners to see what their needs are—talk to them often and come out for a visit!
- Work with patient advisory groups, whether it’s with a specific PBRN or one associated with a practice; they’ll give insight into what’s going on in their local community.

Additionally, SNOCAP members shared issues that are arising as priority topics in their areas of the state. The three topics that arose in 2019 were: Mental Health/Substance Use, Discrimination, and Gun Violence. These big, broad topics were discussed in small breakout groups to see what the issue was, why it is an issue or why it exists, and what SNOCAP and others can do to work to begin addressing these priority areas. The other priority topics were noted and will be kept for further use in the future.

Want to stay involved and hear more from SNOCAP?

We look forward to hearing your thoughts and reactions to these pieces. Please let us know if you have any 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

Hope to hear from you soon!

-The SNOCAP Team
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VAPING IN COLORADO: WHAT FAMILY PHYSICIANS NEED TO KNOW

Vape products are threatening to erase decades of progress in tobacco control and addict a new generation of Colorado youth to nicotine. The use of vapor products (such as e-cigarettes, JUUL) can be a divisive and controversial issue. Vaping advocates see these products as a healthier alternative to cigarettes with the potential to help people quit smoking. Meanwhile, most public health officials are concerned about youth addiction, vaping as a pathway to smoking, and dual-use of vapor devices alongside combustible cigarettes among smokers who aren’t quitting entirely. The jury is still out on the long term health impact of vaping. But, as a physician, there are a few important facts about vaping that are helpful to know: Colorado has the highest rate of youth vaping in the country², vaping devices, and unidentified contents are making previously healthy people suddenly and severely ill; and dual-use of both combustible cigarettes and e-cigarettes has negative health outcomes. Physicians and clinical care teams can make a significant difference in helping patients quit tobacco and prevent pediatric patients from starting.

Problem: Youth addiction

Vaping is portrayed as a tool for adult smokers to quit, but in Colorado, the overwhelming number of vape users are youth and young adults. In 2017, one in three Colorado seniors in high school reported vaping in the past month². Almost half of Colorado high school students who vape (44%) report that they bought their vape themselves, either online or in a brick and mortar location. More than 95% of vaping products sold in US convenience stores contain nicotine. The most common devices today look like small computer flash drives and come in mint flavors and go by the brand named Juul, which always contain nicotine in high amounts. The majority of young people who use Juul don’t realize it contains nicotine. Nicotine has neurotoxic effects on the developing brain. The youth who vape expose their developing brains to nicotine, putting them at risk of addiction, mood disorders, lowered impulse control and decreased attention and learning ability⁴. Youth who vape are also more likely to engage in other risky behaviors including alcohol and other drug use and risky sexual behavior⁴.

Solution: Youth addiction

Physicians should screen all youth, parents, and caregivers for e-cigarette use and exposure. Ask specifically about vaping (JUULing) in addition to screening for smoking and other tobacco use because youth may not associate vaping with tobacco. Physicians can then advise on vaping, nicotine, and addiction, and recommend quitting. They can also consider screening teens who vape for associated high-risk behaviors (substance use and risky sexual behaviors). There are currently no clinical practice guidelines that address how clinicians should help young patients who want to quit vaping. NRT has not yet been shown effective for quitting smoking or vaping in the adolescent population, although some clinicians are prescribing these products off-label to help young people manage withdrawal symptoms. To refer youth to help, the Colorado QuitLine is a good option. The QuitLine now serves youth as young as 12 years old, is confidential, and addresses vapor use. It is crucial that youth are aware that their tobacco use history is confidential. Clinicians should also affirm choices not to use nicotine products. A more detailed protocol for Asking, Advising, and Referring can be found at Tobacco Free Colorado’s healthcare provider page.

Problem: vaping illness EVALI

Recently, an outbreak of severe lung injury, called by the acronym EVALI has been linked to vapor product use. Patients presenting with this illness have reported symptoms such as cough, shortness of breath, or chest pain; nausea, vomiting, abdominal pain, or diarrhea; fever, chills, or weight loss. There are no standard regulations for vape manufacturers, and the Food and Drug Administration (FDA) does not currently regulate ingredients or production standards for vapor products. As such, the Centers for Disease Control and Prevention (CDC) is still investigating the cause of this outbreak, but as of November 2019, more than 2,000 cases have been reported along with 42 deaths, with 11 cases and 0 deaths in Colorado. The CDC has identified vitamin E acetate in THC (marijuana) vaping devices as a possible culprit, but they recommend refraining from both nicotine and THC vaping while their investigation continues. To keep up to date on Colorado cases, visit: https://www.colorado.gov/pacific/cdphe/vaping-lung-illness

Solution: vaping illness EVALI

Physicians should follow the CDC’s guidance for evaluating and caring for patients with vaping associated lung
injury. Other helpful steps include advising patients to discontinue the use of vaping products, referring to, or providing, behavioral counseling and FDA-approved medications for nicotine addiction, and providing a referral to treatment for patients with marijuana use disorder. Physicians are advised to report suspected cases of EVALI to their local and/or state health department.

**Problem: adult use of e-cigarettes and dual-use**

The Centers for Disease Control and Prevention (CDC) states that e-cigarettes may benefit adult smokers who are not pregnant, as long as they completely replace cigarettes and any other smoked tobacco products. However, in Colorado, just over 5% of the adult population in Colorado use these products, and only 2% of adults have fully switched from smoking to vaping, conferring minimal health benefits. Smoking even one cigarette per day is linked to a 57 percent increase in risk for coronary heart disease and a 31 percent increased risk of stroke in women (the risk for men is similar, but slightly lower)\(^3\).

**Solution: adult use of e-cigarettes and dual-use**

Tobacco dependent adults should be offered or referred to evidence-based, FDA-approved tobacco dependence treatments. The Colorado QuitLine and Health First Colorado, Colorado’s Medicaid program, provide free counseling and cessation medications for Coloradans addicted to any form of nicotine. If the patient is committed to using vaping as a smoking cessation aid, counsel them to stop using combustible tobacco completely.

**Key takeaways for physicians**

Physicians can make a positive impact on vaping in Colorado. Whether it is preventing youth use, diagnosing and treating potential cases of EVALI, or discussing vapor products with adult users, physicians can play a part in addressing vaping. Tobacco addiction is a chronic, relapsing condition that may require multiple tries to quit. Physicians can make a difference by encouraging quitting, normalizing relapse, and providing tailored medication and counseling.

**Resources:**
- CDPHE vaping guidance for providers
- CDC interim guidance for healthcare providers
- Colorado Medical Society policy on youth vaping
- Contact your local public health agency or ask any questions to the state tobacco program at Tobacco Free Colorado.


The U.S. survives “near miss,” maintaining its measles elimination status

Outbreaks of measles in the United States in the last few years, resulting from overseas importations, have challenged the public health system in a way not seen for well over a decade. After reaching lows of 37 and 55 cases nationally in 2004 and 2012 respectively (tinyurl.com/y33j79xc), the case count has exploded to 1,250 this year – and the year is not over. Some of this is because measles transmission has intensified in some world areas to which travelers are likely to go – but most of the blame is due to pockets of inadequate immunity in the U.S., which officially eliminated indigenous transmission of measles in 2000. According to the World Health Organization, a country can claim elimination so long as no outbreak resulting from an importation lasts for more than a year. In early October, a multi-month measles outbreak in New York state was conquered just in time to meet this deadline (tinyurl.com/y33jwqhh). However, the message is clear: if family physicians do not increase our vigilance without patients, these outbreaks will continue to threaten a key health accomplishment in our country.

Too many Colorado schools do not have measles vaccination rates high enough to stop the disease from spreading

The Wall Street Journal reports (WSJ, tinyurl.com/y69th2sq) thousands of schools in the U.S. have measles immunization rates below 95 percent, the level needed to stop the disease from spreading. The article says that the majority of schools have rates of at least 90 percent, while some schools have rates close to 50 percent. In Colorado, which still allows medical, religious and philosophical exemptions, the WSJ reports that during the 2017-2018 school year, the estimated MMR vaccination rate is only 88.7%. Many Colorado counties are below the WHO and CDC recommended protective level of 95 percent, including all counties along the I-25 and I-70 corridors. You can find the schools in your area that are not protected at a WSJ generated map found at tinyurl.com/yx9lz3s6. The bottom line: our HPV vaccination efforts with our patients are working. But we could do better, because ...

Studies: Measles can cause lasting damage to immune system

The issue of under-immunization with measles in Colorado is underscored by two recent studies reporting that “even when patients recover, [measles] can inflict lasting harm on their immune systems.” The studies were published in *Science* (tinyurl.com/y3yu6q6d) and *Science Immunology* (tinyurl.com/y5fv8wsu). The researchers reported the stunning finding that measles can destroy “up to half of the existing antibodies that protect against other viruses and bacteria.” As a result, “people, especially children, who get measles become much more vulnerable to other germs that cause diseases such as pneumonia and influenza that they had previously been protected against.” The researchers refer to the effect as “immune amnesia.” For example, in the study published in *Science*, researchers “showed that children infected with measles lost between 11 percent and 73 percent of their antibodies after infection.”

Vaccine introduction reduced HPV prevalence in teens, young adults

Adolescents ages 14 to 19 and young adults ages 20 to 24 had 86 percent and 71 percent lower prevalence of the HPV serotypes included in the quadrivalent vaccine, respectively, a decade after the HPV vaccine was introduced in the US, researchers reported in the Journal of Public Health (tinyurl.com/yx9lz3s6). The bottom line: our HPV vaccination efforts with our patients are working. But we could do better, because ...

Pediatricians give stronger HPV vaccine recommendations than we FPs do

Although pediatricians and family physicians often recommend HPV vaccination, recent survey data published in *Pediatrics* (tinyurl.com/yrarasub) suggest that we family physicians do not always use the strongest recommendation and do not always recommend the vaccine for younger adolescents.

Allison Kempe, MD, MPH, at the University of Colorado School of Medicine, told *Infectious Diseases in Children* (tinyurl.com/ymif26ng), “Our data show that many providers(sic) are not introducing the HPV vaccine in the same way as they do the other adolescent vaccines — Tdap and meningococcal conjugate vaccine — that are also recommended at ages 11 to 12 years.” She adds, “A ‘presumptive’ recommendation means you introduce all the vaccines in the same way with the assumption that there won’t be resistance to them. This results in higher rates of vaccine acceptance by parents.”

Kempe and colleagues surveyed pediatricians and family physicians, finding family physicians gave strong
recommendations less often than pediatricians. Pediatricians were more likely to always or almost always use a “presumptive” style when discussing HPV vaccination compared with family physicians (65 percent vs. 42 percent; P < .0001). Nearly one-quarter of family physicians and 16 percent of pediatricians always or almost always used conversational discussion style.

Kempe said, “Most pediatricians (89 percent) and family physicians (79 percent) noted that more teenagers aged younger than 15 years were completing the HPV series after the two-dose recommendation was made.” She added, “One of the reasons for this publication is to make more physicians aware (they) frequently overestimate the amount of parental resistance they will encounter if they strongly recommend (vaccination), and the effectiveness of a strong presumptive recommendation by physicians.”

The CDC currently recommends that the HPV series can be given at age 9 years, but routine vaccination is recommended at ages 11 or 12 years.

Survey: Most Americans are unaware of cancers caused by HPV

A study of over 6,000 men and women published in JAMA Pediatrics (tinyurl.com/y43vattb) indicates “the majority of American adults are unaware that the most common sexually transmitted disease, HPV, or human papillomavirus, can lead to a variety of cancers.” The survey found that while “two-thirds of women 18 to 26 understood that HPV can cause cervical cancer,” only one-third of men in that age bracket knew about the connection between HPV and cervical cancer. Moreover, “overall, 70 percent of adults of any age were unaware of the link between HPV and other cancers.” Worse yet, the study reported that among people eligible for the vaccine, only 19 percent of men and 31.5 percent of women had been advised by their doctor to get vaccinated” against HPV.

CONTINUED ON PAGE 30 >>
Another group of researchers reported in *JAMA* (tinyurl.com/y3vekq3k) that “when young women and girls are vaccinated” against HPV, the “rates of HPV-related cancers dropped in unvaccinated men.” For example, the study found that “oral HPV infections declined by 37 percent among unvaccinated 18- to 59-year-old men between 2009 and 2016.”

All of these data point to the fact that we family physicians need to up our game in strongly advocating that our patients complete all recommended vaccinations.

### Effective Health Consultation for the Traveler

What is the most effective response for a family physician when a patient (or colleague) asks you, “What shots do I need for my upcoming international trip?” The basic information to answer that specific question is easily available from the CDC (see tinyurl.com/y84b3es3). Further, a simple Google search on “Travel Medicine Colorado” yields at least a dozen clinic facilities in more populous areas around the state offering specialized travel medicine consultation and services, if the patient’s travel plan requires them. For those living further outstate, a quick check of mid-sized Colorado cities reveals that at least two local health departments offer that specific service.

We, however, encourage family physicians to reframe the question for the patient. Rather than focusing specifically on “what shots do I need” (and that tends to make one think “shots against the ‘exotic’”), we believe the more productive question is “How can I best prepare for a healthy travel experience?” We suggest three principles to guide the conversation:

1) **Ask what the purpose of the trip is, and the kinds of activities the person will be undertaking, in addition to the usual “where, when, and for how long.”** This discussion can uncover risk factors related to food and water intake, vector exposures, and injury hazards, as well as potential exposure to communicable diseases not usually encountered in the U.S. Preventive recommendations and will involve many other precautions besides immunizations per se.

2) **Remind the individual that attention to the basic fundamentals of wellness can do much to ensure a safe and healthy trip.** This is an opportunity to talk about staying hydrated, planning for balanced and healthy meals (as best one can), getting enough sleep (taking time to manage time zone changes), finding ways to exercise and stay active, and washing one’s hands at the appropriate times. Global travel is an especially stimulating and challenging experience for most of us, and it is easy to forget about the basics and then wonder why one does not feel well.

3) **Use this for an opportunity to make sure your patient’s routine immunizations are up to date.** On most trips, the vaccine-preventable diseases to which one will most likely be exposed are those on the routine list. Because of their ease of transmission and their frequent occurrence around the globe, measles and influenza are the two most important to remember. CDC’s standard for “evidence of measles immunity is found at tinyurl.com/y5ppld6m. Basically, it is two doses of MMR vaccine for anyone born in 1957 or after, a Td or Tdap booster within ten years, and this year’s influenza vaccine.

These reminders are actually all the majority of travelers need.

### ACIP committee votes to change pertussis vaccine recommendation

The CDC’s Advisory Committee on Immunization Practices (ACIP) voted to update its recommendation for the pertussis vaccine, allowing either the tetanus-diphtheria or tetanus, diphtheria and pertussis vaccine for the decennial Td booster, tetanus prophylaxis for wound management, or additional catch-up immunization doses for patients age 7 or older (tinyurl.com/y5nu8gnc). Given the issue of waning pertussis antibody levels over time, we believed updating with Tdap instead of Td is a reasonable option for most family physicians to consider.
Family Physician Wanted

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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 lkelly@pueblochc.org
The U.S. government’s once-a-decade population count is back this year. It is designed to be easy; it requires no preregistration, knowledge of issues, or understanding of how important the 2020 Census will be for the future of the population. Under the apparent uncomplicatedness of the census, lays a great deal of complications. An inclusive and effective 2020 Census is vital to improving economic justice and political equity in the state (1). The results will shape the landscape of political representation and federal funding for the next decade, and that includes healthcare. Indeed, the well-being of all communities, rural or otherwise, depends on it (2).

Census data will influence measures that guide the distribution of federal funds. Not only the population count is considered, but poverty levels and population age are equally important. Several health programs are making up $675 billion in federal money that is guided by census data. Medicaid, Medicare, SNAP, and WIC are just a few of the programs that will be impacted by the new census data (2).

Yet potential barriers that exist in the 2020 Census are acknowledged by the U.S. Census Bureau itself. In past years, the census was mailed to all known addresses, to be completed on paper and returned. This year, for the first time, the bureau intends to gather more responses online rather than on paper. This is a major problem for the most vulnerable residents (1). Populations at risk of being undercounted, those who live in poverty, living on tribal lands, and those living in rural areas are the least likely to have access to the internet. That is, the people who need the government programs and services whose funding is allocated using census data, are the least likely to respond to the census (3).

The Census Bureau will still use mailings and census takers to count those in areas determined to be the most challenging to count. To do this, both satellite imagery and records from other government agencies are used to generate and update the address list. This creates a problem for very remote or rural households that may lack traditional mailing addresses or receive mail at post office boxes. It is also more likely for residences to be hidden
from the main road, putting them at risk of being missed. In the 2010 Census, research suggested that not recognizing non-traditional housing, such as garages, barns, and campers, contributed to a significant undercount of Mexican immigrants. Additionally, census-takers found it difficult to count people living on tribal lands or reservations due to structural factors like high poverty, poor educational systems, and low internet penetration (3).

It's not hard to see how this could impact healthcare in rural Colorado. In Colorado, 47 of 64 counties are designated as rural or frontier areas (4). If we do not get an accurate population count because residents are either unable to complete the survey, or are afraid to do so due to their immigration status, the funding of healthcare and essential services will suffer.

The 2020 Census is fast approaching, and we all have a stake in ensuring a complete count. What can family physicians, specifically, do to support an accurate count? The U.S. Census Bureau has a variety of posters on their website you can download and post in your clinic. You could talk directly to patients about the importance of completing the Census. In areas where your patients are unlikely to have the internet at home, you could offer a kiosk with a computer or tablet just for filling out the census. What other ways could rural family physicians, and the CAFP at large, do to support the 2020 Census?

References


We greatly appreciate your referrals and the trust you place in us for patient care. We value continued communication about our mutual patients.

About Doctors of Podiatric Medicine:

Training:
4 years of medical school (often attending classes with MDs and DOs),
3 years of residency and additional fellowship training (1-2 years) as desired

Scope of Practice:
Surgical correction of a number of foot & ankle problems, implants including human cells to promote healing and medical devices to stabilize conditions, treatment of breaks and fractures including stabilization, diagnosis and treatment of diabetic foot conditions including neuropathy, diagnosis and treatment of certain foot cancers.

Your foot & ankle specialist communicates often with a patient's primary care physician especially if the patient is diabetic or has other conditions treated by a medical specialist. The patient's primary care physician often refers patients to a podiatrist for specialized care and treatment.

Foot & Ankle surgeons are medical staff members of nearly all Colorado hospitals, surgery centers and medical plans including Medicare.

Contact:
To locate a podiatrist close to you, contact colofas@gmail or call 303-881-8837.
You can visit our web site: www.colopma.org to locate a foot & ankle specialist, too.
REMEMBERING CAFP MEMBER AND PAST BOARD MEMBER EARL J. "SKIP" CARSTENSEN, MD

Earl J. “Skip” Carstensen, MD, earned his wings on the evening of October 23, 2019 at the age of 75. He worked hard for them after being diagnosed with leukemia last year. As a family physician for 48 years, Skip dedicated his entire life to relieving the sufferings of his fellow humans. He brought a helpful, curious and lighthearted spirit to everything he did and everywhere he went. He considered every acquaintance a friend, and he always defaulted to seeing the good and the positive in everyone and everything.

Skip is survived by his wife, Jane Elizabeth McCarty Carstensen; children, Timothy Earl Carstensen and Mary Elizabeth Carstensen Freivogel; grandchildren, Jacob Daniel (J.D.) and Nolan John Freivogel; and siblings, Timothy Eric Carstensen, Thomas (Tom) Dale Carstensen, James (Jim) Michael Carstensen, and Margaret (Peggy) Carstensen Hughes. He was met by a large welcoming committee in heaven, which included his father Earl H. Carstensen and mother Joyce M. Callaghan Carstensen, as well as his son, John Bradley Carstensen, and numerous other relatives, friends, and family dogs. Silly costumes and a good bottle of Scotch whisky were likely also involved. Skip was born on December 3, 1943. He grew up in North Platte, Nebraska and attended St. Patrick’s High School before moving on to Creighton University for both undergraduate education and medical school. He was a proud member of Iota Kappa Epsilon fraternity. He graduated with his medical degree in 1968.

His years at Creighton were very special as they blessed him with lifelong friendships, countless memories, and a wonderful woman named Jane. After a successful first date on a Friday the 13th, Skip and Jane became married in May of 1967. During his family practice residency in Minneapolis, they welcomed their first son, Tim, in 1968. The family then moved to Keams Canyon, Arizona while Skip served in the Indian Health Service, where they added their son John to the family in 1970. Their daughter Mary joined in 1976 after they had settled in the Denver area. Beagles Tippy and her successor Murphy were also an important part of the Carstensen family.

Skip loved his time as a family physician in Aurora and was known for his old fashioned, patient-centered care. He contributed to the local medical community in many ways, including as a Board Member of the Colorado Academy of Family Physicians. After he retired in 2016, he enjoyed spending time helping his son Tim build and install beautiful custom carpentry.

Friends and family will always remember Skip for infinite reasons, including his unique sense of humor, strong affinity for practical jokes, and incessant love of crepes, pastries, and coffee. Coffee shops provided him with great opportunity to speak to complete strangers and ask them about their lives.

In lieu of a traditional funeral, the family had a celebration of life. If you would like more information, please email Skip’s daughter, Mary, at mefreivogel@gmail.com.
THE HEALTH IMPACTS OF LGBTQ DISCRIMINATION

My son turned three this summer, and before each annual check-up, his doctor has us fill out a questionnaire about his development. The questions are about his ability to speak in full sentences, throw a ball overhand, draw lines and circles, and other benchmarks for kids his age. On this year’s list, there was one question that caught me off guard: does he know whether he’s a boy or a girl? The implication is that there is a right and a wrong answer—it’s not asking whether or not he has determined how he identifies yet, but whether he can answer “correctly.”

Considering he makes references multiple times a day about how he’s a big boy now, I know he’s absorbed the countless subtle and explicit messages he’s been bombarded with since birth, both from his family and society as a whole. He regularly assigns pronouns (“he’s doing this,” “she’s over there,” etc.) based on appearance, and will ask me whether someone is a boy or girl if he’s not sure. Similarly, when he sees family structures different than his own, he struggles to wrap his head around the idea of something like two mommies and no daddy. Try as we might to expose him to the rainbow of ways a family can be composed, the dominant image of mom, dad, and kids is reinforced to him constantly as he moves through the world.

For the LGBTQ community, these ideas about what is “right” or “normal” have led to centuries of violence and persecution. Every one of our institutions—at one point or another—has operated in ways that have oppressed LGBTQ people, and the damage is far-reaching. In 31 states there are still no employment discrimination protections for transgender people. While the Supreme Court declared same-sex marriage legal in 2015, the precedent of denying and discrediting people’s relationships has left its mark; today private businesses and individuals continue to discriminate against same-sex couples. In Colorado, 41% of LGBQ people and 75% of transgender people report needing to educate their health care providers on LGBTQ-specific health needs. Fortunately, Colorado just passed a bill to ban conversion therapy for youth, but the health care system has a long way to go in being responsive to the needs of the LGBTQ community.

All these acts of discrimination, rooted in homophobia and transphobia, have long-term effects on people’s lives. Because of them, LGBTQ people are less likely to have access to higher education, larger salaries, safe housing, and other resources that make good health possible. They’re more likely to face barriers to good behavioral, oral, and overall health, from the toxic stress of stigma and violence to the denial of coverage for their health needs. This year, One Colorado released Closing the Gap: The Turning Point for LGBTQ Health, which highlights these health inequities and many others. It also includes a robust list of community- and advocate-generated recommendations that Colorado should begin exploring.

There’s much work to be done to create a more fair and just state for all LGBTQ Coloradans and their families. In addition to these priorities of data collection, provider education, access to care, and community outreach, I hope we’ll continue to look for ways to dismantle the ideologies that are at the root of the problem. I hope we’ll take personal action, like normalizing the sharing of personal pronouns and educating ourselves and our communities, as well as institutional action, like wielding organizational power to help pass more LGBTQ legal protections and rights. Together, we can ensure all Coloradans, regardless of sexual orientation or gender identity, have the opportunity to thrive.

Visit OneColorado.org to access the Closing the Gap report

Nurses House, Inc.

Nurses House is a 501(c)3 organization assisting RN’s in need. If you, or a nurse you know, are in need of financial assistance due to a health or other life crisis, please visit the website, call or email today.

www.nurseshouse.org 518-456-7858 x125 mail@nurseshouse.org
Help Your Patients to be Healthier by Saving Energy

When your patients use energy wisely, there is less air pollution created by the burning of fossil fuels to make electricity and other uses. This means cleaner air, less asthma, less cancer, and less heart disease. This month, the Academy’s My Green Doctor has a short guide for your patients, “Helping Children to Save Energy: A Guide For Parents.” You might print copies to share with your office colleagues and waiting room patients: https://www.mygreendoctor.org/helping-children-to-save-energy-a-guide-for-parents/.

My Green Doctor is a free membership benefit from the Colorado Academy of Family Physicians that is saving members money as their offices adopt wise environmental practices and share these ideas with their patients. Dozens of offices of Academy members use My Green Doctor. It adds just five minutes to each regular office staff meeting. My Green Doctor explains what to say and do at each meeting, so there is nothing for the office manager to study. Your patients will be impressed. Ask your office manager to register: https://www.MyGreenDoctor.org/.

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**Industry Leading Health Technology Consulting & Care Management Firm**

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CareVitality, Inc., a subsidiary of EHR & Practice Management Consultants, Inc., has a close working relationship with ambulatory practice and are well aware of their challenges and pain points, and have structured their service offerings around those challenges. These services can help your practice optimize the use of your EHR to meet workflow needs, meaningful use stage 2 and participate in value-based care initiatives. We have a special focus on the doctor, patient and family engagement-related services and include everything from implementing a patient portal and online scheduling to consulting services to help you improve your workflow, recurring revenue and patient outcomes.

We assist providers in creating a better work-life balance, alleviating much of the burden chronically ill patients place on your staff by utilizing our patient-centered clinical care team. Our Healthcare Technology and Care Management Services help improve the health of your patients and the wealth of your practice.

To learn more about CareVitality’s service offerings, please visit www.carevitality.com or call 1-800-376-0212.

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Have you updated to new EMV "chip reading" technology? As of the October 2015 liability shift, your practice is at risk if not. Best Card offers members a one-time $100* discount on new EMV terminals, with some available for as little as $259-100=$159 with 2-year warranty. *Discount prorated if processing <$8,000/month.

Email or fax your recent credit card statement to CompareRates@BestCardTeam.com or 866-717-7247 or to receive a detailed no-obligation cost comparison and a $5 Amazon gift card.

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**Health E-careers Network:** FPJobsOnline is the official online job bank of the Colorado Academy of Family Physicians and provides the most targeted source for Family Physician placement and recruitment. Accessible 24 hours a day, seven days a week, FPJobsOnline taps into one of the fastest growing professions in the U.S. Please visit www.FPjobsonline.com or call 1-888-884-8242! Mention you are a CAFP member to receive discount.
**WELCOME NEW MEMBERS**

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

<table>
<thead>
<tr>
<th>Active:</th>
<th>Jacob Barnes</th>
<th>Craig Murk</th>
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<tbody>
<tr>
<td>Kelly Arnett, MD, MPH</td>
<td>Brandon Bealer</td>
<td>Levi Myers</td>
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<tr>
<td>Anna Brou, MD</td>
<td>Rachel Bohlinig</td>
<td>Deepak Nallur</td>
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<td>Jennifer Caragol, MD</td>
<td>Mattie Brand</td>
<td>Karen Norling</td>
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<td>Bruce Conaway, MD, FAAFP</td>
<td>Jeremy Brown</td>
<td>Adrian Olson</td>
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<td>Spencer Cooperman, DO</td>
<td>Eric Carlson</td>
<td>Adam Panzer</td>
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<td>Nathan Culberson, MD</td>
<td>Kayli Costner</td>
<td>Franklin Powlan</td>
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<td>Jessica Devitt, MD</td>
<td>Frank Dang</td>
<td>Colby Presley</td>
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<td>Clay Duval, MD</td>
<td>Jennifer Daniels</td>
<td>Aaron Ridder</td>
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<td>Michael Duzan, DO</td>
<td>Nkolika Egbukichi</td>
<td>Colton Riner</td>
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<td>Kristen Harvey, MD</td>
<td>Joseph Fike</td>
<td>Susan Roberts</td>
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<td>Joedy Hulings, MD</td>
<td>James Frazier</td>
<td>Lisa Rocchio</td>
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<td>Courtney Isley, MD</td>
<td>Thomas Gerhart</td>
<td>Mary Savarese</td>
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<td>Vivian Jiang, MD</td>
<td>Paul Glasheen</td>
<td>Pritee Shrestha</td>
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<td>Carolyn Johnson, MD</td>
<td>Erika Hinricher</td>
<td>Harmanjot Singh</td>
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<td>Erik Kramer, MD</td>
<td>Alison Hixon</td>
<td>Quinton Sturdivant</td>
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<td>Robyn Kramer, MD, FAAFP</td>
<td>Hamid Hussaini</td>
<td>Emily Swenson</td>
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<td>Christina Pavelko, DO</td>
<td>Cyprien Jungels</td>
<td>Sarah Szybist</td>
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<td>Susannah Perkins, MD</td>
<td>Andrew Kamel</td>
<td>Dylan Therwhanger</td>
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<td>Colton Redding, MD</td>
<td>Grace Kim</td>
<td>Corey Walsh</td>
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<td>Shelby Sheldon Deuser, DO</td>
<td>Tesia Kolodziejczyk</td>
<td>Connor Weissner</td>
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<td>Ross Sheline, MD</td>
<td>Alexandra Koontz</td>
<td>Matthew Wilkins</td>
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<td>Morgan Shier, MD</td>
<td>Noelle Liska</td>
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<td>Lindsey Szymbaszek, MD</td>
<td>Charles Litch</td>
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<td>Joshua Taylor, MD</td>
<td>Anna Maciejko</td>
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<td>Jo Watson, MD</td>
<td>Jaron Maggard</td>
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<td>Cole Zanetti, DO, MPH</td>
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<td>Students:</td>
<td>Jessica Montalban</td>
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<td>Gabriel Aguero</td>
<td>Michael Murakami</td>
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<td>Austen Anderson</td>
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| Residents:                 |                     |                     |
| Collin Hafen, DO           |                     |                     |
Whitney, born nine weeks early, had to be sent home on oxygen.

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

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

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Whitney
Age 2
Diagnosis: Asthma

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

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