2020 LEGISLATIVE SESSION FEATURES PUBLIC HEALTH & HEALTHCARE COSTS
PG...10

UNDERSTANDING COMMONLY SEEN LIVER MASSES
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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.

The new West Springs Hospital is a resource for you and your patients. Our psychiatric staff is happy to consult regarding identification of mental illness and suicidal ideation. Should your patient need our services, we provide a world-class, state-of-the-art healing environment set amongst the majestic vistas of Western Colorado.

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Board Members

Term Expiring 2020
Melissa Devalon, MD, Monument melissadevaloncafp@gmail.com
Stephanie Gold, MD, Denver stephaniegoldcafp@gmail.com
Shannon Jantz, MD, Denver sjantz@gmail.com
Corey Lyon, DO, Denver corelyoncafp@gmail.com

Term Expiring 2021
Rachel Carpenter, MD, Denver rachelcarpentercafp@gmail.com
Cleveland Piggott, MD, MPH, Denver clevelandpiggott.ca@gmail.com
Roxi Radel, MD, Denver Roxanneraicalp@gmail.com
Abbie Urish, MD, Rangely abigailurishcafp@gmail.com

Term Expiring 2022
Josh Fung, MD, Denver Josh@canrca.org
Kyle Leggott, MD, Aurora kyleggott.ca@gmail.com
Lindsey Pearson, MD, Boulder lindseypearsoncafp@gmail.com
Karin Susskind, MD, Boulder karinsusskindcafp@gmail.com

Resident Representatives
Emily Aquila, DO, 2021, St. Anthony North, Denver emiliiaquila18@centura.org
Sean Buck, MD, 2021, University of Colorado Family Medicine Residency, Denver Health, Greenwood Village seanbuck@gmail.com
Katie Doster, DO, 2020, North Colorado Family Medicine, Greeley katieexnercafp@gmail.com
Kleen Herring, MD, 2020, University of Colorado Family Medicine Residency, Denver clemsonherring@gmail.com
Morgan Hungenberg, DO, PGY-II, University of Colorado Family Medicine Residency, Denver morgan hungenberg@ucdenver.edu
Allison Johnson, MD, 2020, University of Colorado Family Medicine Residency, Denver Health, Denver allison2johnson@ucdenver.edu
Leah Kellogg, MD, 2020, St. Joseph Family Medicine Residency, Denver leahkelloggdpc@gmail.com
Katharine Kelly, MD, 2020, University of Colorado Family Medicine Residency, Denver Health, Denver katharine.kelly@ucdenver.edu
Poorvi Pfening, MD, 2020 Swedish Family Medicine Residency, Denver poorvpfening@gmail.com
Lindsey Romero, MD, 2020, Southern Colorado Family Medicine Residency, Pueblo Lindseyromerocafp.com
Alexandra Targan, MD, 2020, University of Colorado Family Medicine Residency, University, Denver alexandra.targan@ucdenver.edu
Jesse Troutman, DO, 2021, St. Anthony North Family Medicine Residency, Westminster jessetroutman@centura.org

Student Representatives
Bijan Ghaffari, CU, 2019, bijanghaffari@ucdenver.edu
Leah Kellogg, CU, 2019 leahkelloggdpc@gmail.com
Katie Doster, RVU, 2019 katieexnercafp@gmail.com
Filberto Morales, Denver, CU, 2020 filbertomorales@ucdenver.edu
Katie Doster, RVU, 2019 katieexnercafp@gmail.com

Editor
Zach Wachtl, MD zachwachtlcafp@gmail.com

Legislative Committee Chairs
Craig Anthony, MD craiganthonycalp@gmail.com
Gina Carr, MD, MPH ginacarrcafp@gmail.com

Education Committee Chairs
Emily Garban, MD milygarbancafp@gmail.com
Corey Lyon, DO corelyoncafp@gmail.com
Karin Susskind, MD karinsusskindcafp@gmail.com

Health of the Physician and Public Committee Chair
Abbie Urish, MD abigailurishcafp@gmail.com

Contact Information for the CAFP
Colorado Academy of Family Physicians
2224 S. Fraser St., Unit 1
Aurora, CO 80014
phone 303-696-6655 or 1-800-468-8615
fax 303-696-7224 e-mail info@coloradoafp.org
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“I was treated by medical staff who could tell I was struggling with addiction, and they didn’t judge me.”

—Anna S. of Denver, CO
PRESIDENT’S LETTER

In his final work, published in 1638, Galileo Galilei posed a thought problem: what is the tallest cylindrical column one can build prior to it collapsing under its own weight? It was an interesting engineering problem, but I was always more fascinated by how it described the way small, seemingly sensible actions can make a system so impossibly complex it collapses.

Galileo set up his thought experiment by imagining a large column built horizontally between two supports. It needs to be raised into position to support a massive portico, but the workers are nervous that it may break in half as it rises, due to its heavy weight. So, one of them suggests adding a third support midway down its length. Surely, three supports are better than two, they reason. Yet, as the column is raised it cracks. That third support, rather than lending strength to the column, instead acted like a chisel. The added complexity made the system break.

The modern world, too, shows us that precautionary measures and safety systems don’t always have the intended effect. We aren’t strangers to the notion that with complex systems surprises often arise. In his book Normal Accidents, Yale Sociologist Charles Perrow argues that a conventional engineering approach to ensuring safety — building in more warnings, alarms, and “safeguards” — can add so much complexity that the system becomes prone to failure. He describes the example of Chernobyl, where a test of a new safety system with a simulated power outage triggered an unexpected chain of events that ruptured the nuclear reactor core, spraying radioactive material into the sky.

Safety features, alarms, and extra bells and whistles are no stranger to our everyday practice of medicine. Some of the features in my practice’s EHR are so disconnected from my daily practice they remind me of the stream-of-conscious style of VH1’s Pop-Up Video in the 1990s. A popular video like “Fly” by Sugar Ray would play while a series of non sequitur statements such as “A fly can climb a wall because of a chemical secreted from its feet” pop up on to the television screen. It was fun, but did not help me learn anything.

Consider: how many times did you get notified today that the Metformin you’re refilling might not be safe if the patient is pregnant, followed by a warning that it still might not be safe if the patient is breast feeding, followed by yet another warning that it might not be safe if the patient has renal failure, or heart failure, or pop-up warning that it might be confused with Mirabegron, Methylphenidate, or Metoprolol — and are you sure you didn’t really want to prescribe Mirabegron? Hidden in the middle there may have been a pop-up that we cared about — but if so, it was probably lost in all those alarms and mind-numbing pop-ups.

I doubt that it is surprising to anyone for me to note that our nation’s current healthcare system is complex. There is a cacophony of systemic, complex problems (and complex problematic systems), all with built-in reinforcements to support a system that has become dysfunctional and inequitable. These problems aren’t new. The cost of healthcare and equity of healthcare services are a long-running challenge. Moreover, we face systems that incentivize healthcare rather than the health of our patients, neighbors, or communities — to say nothing of the health or care of our peers or ourselves.

I believe that in our increasingly fragmented and sub-specializing world of healthcare, we Family Medicine physicians hold the keys to fix the system. Family physicians deliver care for the whole person, comprehensively, and indiscriminate of any particular body part or organ system. According to the AMA, there are over 130 national subspeciality medical societies and 122 official medical specialties — I feel confident that one couldn’t dream up a more complex system. Our patients, neighbors, communities, and peers all need the comprehensive, continuous care over a lifetime that Family Medicine physicians deliver. Looking at the numbers it is clear Family Medicine (and other primary care) bring exceptional return on investment to a community.

We need to work together with our sub-specialist colleagues to deliver comprehensive care, while keeping in mind that we have the best insight if, say, our 76 year-old patient really needs to be told to keep getting colonoscopy screenings. In Range: Why Generalists Triumph in a Specialized World, the investigative journalist David Epstein shows that increasingly sub-specialized experts can paradoxically create worse outcomes. He shares the story of a New York physician in the 1800s who specialized in Typhoid and was
lauded for his superb diagnostic skills. This physician went up and down rows of beds in the hospital ward feeling patient's tongues and, with astounding accuracy, predicted which patient would get typhoid fever more than a week before any symptoms began. As it turns out, the incubation period of typhoid is approximately a week (8-14 days) and this physician's “specialization” was more effective at spreading the disease with his bare, unwashed hands than Mary Mallon ever was. The narrow focus only on typhoid patients blinded him and his peers to understanding the larger forces driving its spread.

Family Medicine isn't just effective, it's a bargain. According to the Oregon medical home study, Family Medicine not only improves quality of care but decreases the total cost of care: for every dollar invested in primary care the total cost of care decreases by $13. Additionally, just a year ago JAMA reported that for every 10 additional primary care physicians that were added to a population of 100,000 people, the community saw an increased life-expectancy of 51.1 days (in comparison, adding a similar number of sub-specialist physicians only increased life expectancy by 19.2 days).

Here at the CAFP, after years of work, we championed passage of HB19-1233 to increase primary care investment in the state. We are working on the implementation of this monumental legislation, as well. The Colorado Division of Insurance recently announced its recommendation to implement affordability standards and announced an increase in the percent each insurance plan spends on primary care, as a percentage of the total cost of care! It is an enormous victory for Family Doctors, patients, and our communities.

All in all, I’m a big fan of and I’m a big believer in Family Medicine. Marble columns in the 1460s, the

Typhoid Outbreak of the late 1800s, Chernobyl nuclear disaster in 1986, and now Healthcare. The specialty of Family Medicine is the answer to our current health care woes. I invite you to join us on this journey as we serve as the bold champion for Colorado’s Family Physicians, Patients, and for all of Colorado work through advocacy sharing our

stories, our patient’s stories and education. It has been an absolute honor and privilege to serve you as the CAFP President this last year. I hope this finds you well.

---

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](http://www.colopma.org) to locate a foot & ankle specialist, too.
CEO'S REPORT: COPING WITH COVID-19

These past two months have seen tremendous upheaval in our workplaces, our clinics, and our personal lives. The COVID-19 virus is disrupting so much, it is easy to lose track of what we can do to support and encourage each other.

At the Academy, we want to be there for our members, to ensure Family Medicine remains protected and effective on the front lines of securing our communities’ health. We have been curating a resource page on our website (https://www.coloradoafp.org/covid-19-resources/) that is updated whenever we can find relevant or useful information. If we can improve that, please let us know.

Our role at the Academy is to be your champion and your voice. We sent Governor Polis a letter, re-printed below, laying out our concern for the state’s Governor Polis a letter, re-printed below, laying out our concern for the state’s health. We have been curating a resource page on our website (https://www.coloradoafp.org/covid-19-resources/) that is updated whenever we can find relevant or useful information. If we can improve that, please let us know.

We emailed the contents of that letter to all of you. Our big asks for Governor Polis were:

• Call on individuals in the general public to Stay Home. Avoid gatherings of any size through social distancing, and stay home except for necessities. Such a call is prudent to achieve maximum mitigation of the spread of Coronavirus, to ensure our health system capacity is not strained beyond its limits. We are aware of multiple health clinics and health systems already facing critical supply shortages. Dramatically slowing the spread now will ensure our health system can care for those who get COVID-19 or have other healthcare needs.

• Issue clear and concise guidance for clinics facing Personal Protective Equipment (PPE) shortages, and increase the speed at which requests for PPE can be fulfilled. As community spread has increased, some facilities around the state have already stopped testing or limited testing to only patients meeting inpatient criteria. If testing is to be expanded, primary care clinics will increasingly be tasked with this role and need the equipment and guidance to safely do so.

• Clarify outpatient setting testing protocols and communications to doctors. As patients have been directed to their doctor by governments and media, the lack of availability of PPE and guidance on safety procedures to prevent spread to other patients in the clinic are slowing community clinics’ ability to respond. CDPHE should work with community practices as well as larger systems to implement the rapidly changing guidance on testing or limited testing to only patients meeting inpatient criteria. If testing is to be expanded, primary care clinics will increasingly be tasked with this role and need the equipment and guidance to safely do so.

• Issue clear and concise guidance for clinics facing Personal Protective Equipment (PPE) shortages, and increase the speed at which requests for PPE can be fulfilled. As community spread has increased, some facilities around the state have already stopped testing or limited testing to only patients meeting inpatient criteria. If testing is to be expanded, primary care clinics will increasingly be tasked with this role and need the equipment and guidance to safely do so.

As I write this, we have begun seeing movement on these common-sense requests, especially on social distancing.

Beyond this direct advocacy, we are also trying to spark discussion and peer advocacy about social distancing. But there may be other ways we can help you – whether it is facilitating a place where you can communicate successes, challenges, needs, and resources, or relaying your concerns to the government. We are here for you and will support you however we can.

Please, be in touch with us if we can help during this crisis. We are here to help.

Highlights from the February 2020 Board Meeting

• Introducing Joshua Foust, the new Director of Communications, Marketing and Membership. Joshua joined the CAFP staff in December 2019. He got his B.A. in International Relations at the University of Colorado, Boulder and his M.A. in Communications at Johns Hopkins University, where he specialized in public and media relations. Previously, he worked in non-profit communications in Washington, DC, as well as the Department of Defense and in journalism. He’s thrilled to be a part of the CAFP family.

• Colorado has a new CME requirement for addressing the opioid epidemic. The board wants to provide an opportunity for members to meet this requirement, so the annual summit will allow streaming a CME session dedicated to opioids. A link will be generated before the summit so those who want to log in may do so.

• CAFP’s primary care investment advocacy is paying off. The Colorado Division of Insurance has recommended the state implement a 1% point increase in primary care spending per year for the next two years (2021-2022). In addition, the Medicare fee schedule is being adjusted to better pay primary care doctors.

We Want to Hear from You

CAFP is committed to serving our members and being bold champions for family medicine in Colorado. We want to make sure your voice is heard. So, we are launching a Letter to the Editor section where you can start a dialogue with us about the content in our magazine. For each issue, we will publish a selection of your thoughts about family medicine, practice enhancement, and new ideas for advocacy and member activities. Send your thoughts to Joshua Foust, the director of communications, marketing, and membership:joshua@coloradoafp.org
The 2020 legislative session kicked off in early January and despite it being an election year, there are no holds barred when it comes to addressing the healthcare concerns of Coloradans. The COVID-19 pandemic caused the legislature to shutdown for at least 2 weeks at time of publishing. As a result, the fate of legislation in this update has become even more uncertain. However, CAFP continues to advocate on Family Physician legislative priorities as the situation evolves, in addition to our advocacy on COVID-19. From a state public option, to capping prescription drug prices, to required coverage of PT, infertility treatment, and diagnostic colonoscopies, lawmakers are pressing forward with bold and big policy proposals.

Public Health:

Following the defeat of a bill to tighten vaccine exemptions in 2019, CAFP is championing an effort through SB20-163 to tighten requirements for vaccine exemptions. Governor Polis has notably indicated his support for the bill, whereas he did not support the version last year, and we are optimistic about its likely success. Colorado has the worst immunization rates for MMR in the country, and we consistently rank among the bottom states for all immunizations. The legislation adopts an evidence-based approach to reduce convenience exemptions by requiring “equal effort” to exempt. Parents will continue to be able to exempt their child from required school vaccines, but they must make “equal effort” to vaccinating by either going in person to local public health, their physician, or completing an online module about the risks of not vaccinating. A standardized form then must be signed and submitted for the patient to be exempt. Several anti-vaccine bills were introduced as well, but we worked alongside partners such as the American Academy of Pediatrics – Colorado Chapter, and Children’s Hospital Colorado to defeat these.

CAFP is working to advance two bills to reduce the use of tobacco and vaping, particularly among youth. HB20-1319 would ban flavored nicotine and other tobacco products, which evidence shows are predominantly targeted toward and appeal to youth. HB20-1001 would raise the legal age of sale for nicotine products to 21, license nicotine retailers, and requires products purchased online to be picked up at a licensed retailer. After a decades-long fight against harmful tobacco use, there has been a recent uptick in youth nicotine use. We believe these bills will help curb that increase and get us back on track.

Opioids remain a top priority of the legislature and another 5 bills were introduced that came through an interim legislative committee on substance use disorders. HB20-1085 Prevention of Substance Use Disorders permanently extends the 7-day acute opioid prescribing limit, adds benzodiazepines to the list of drugs for which a PDMP check is required, and applies similar prescribing limits to benzos. CAFP supports the bill, which also includes a key CAFP priority that we have sought to secure for several years. It requires coverage of at least 6 nonpharmacological pain treatments through physical therapy, occupational therapy, chiropractic and acupuncture visits at the lowest cost sharing tier. These alternative pain treatments also must be covered without requiring prior authorization.

Healthcare Affordability

Affordability took center stage a year ago when Governor Polis released his Roadmap to Saving People Money on Healthcare. The legislature similarly made healthcare costs a top priority, and CAFP passed its signature Primary Care Investment (PCI) legislation to set statewide primary care spending targets that increase the investments that health insurers, Medicaid, and state employee health plans make in primary care. We have made significant progress in that bill’s implementation, led by Dr. Stephanie Gold on the CAFP Board. It has resulted in recommendations that include an annual 1 percentage point increase (absolute increase) in primary care investments. Division of Insurance rules are expected to require this increase of insurers starting in 2021, infusing an estimated $60-100 million more into primary care to support the PCMH, care coordination, integrated behavioral health, and the like.

Other prominent efforts are underfoot to address costs. A statewide public option is being proposed that would drive down premium costs by 7-20% in the individual market by setting hospital reimbursement rates, as well as cover an additional 18,000 Coloradans. However, that rate setting has drawn strong opposition from hospitals. Required insurer participation to offer the option is also drawing opposition from the insurance industry. CAFP is carefully evaluating our role in shaping a potential public option. Expanding coverage and lowering costs are long-held policies of the academy, so we are working to ensure any option that may be adopted puts primary care first. The Colorado Hospital Association has proposed an alternative to the
public option, called a Total Cost of Care (TCC) model. The proposal would set a growth cap on healthcare costs across the entire healthcare industry in the state, versus, for instance, setting only hospital rates. Other states have adopted a TCC model with some success at constraining cost growth, so CAFP is reviewing this proposal alongside the public option.

Several bills also aim to tackle prescription drug costs. HB20-1160 Drug Price Transparency aims to have insurers, drug companies, and pharmacy benefit managers report pricing information to the state, as well as require insurers to pass on any drug company rebates in the form of premium reductions. SB20-107 Drug Production Cost Analysis would require pharmaceutical manufacturers to report information to the state so that a report analyzing the production costs of the highest cost drugs can be generated. SB20-119 Expand Canadian Drug Importation Program would allow this program, which CAFP supported and was established in 2019, to import prescription drugs from other countries if needed and if permitted under federal law.

Scope of Practice

Several bills are proposing to shift or expand the scope of practice for various providers in the state. HB20-1061 HIV Prevention Measures aims to allow pharmacists through statewide protocols to prescribe and treat using PrEP and PEP HIV prevention medications. CAFP supports the public health objective behind this bill. We have also worked to amend the bill to ensure that the state nursing and medical boards are included in the process of developing such protocols, as diagnosis and treatment are the purview of physicians. This process ensures the guidelines for treatment, which include ongoing monitoring and labs, are regularly followed and the patient is connected back to their primary care provider who is the best person to manage their ongoing care. It is imperative that these medications are used appropriately to ensure the drug’s effectiveness and that resistance does not develop.

HB20-1216 the Nurse Practice Act Sunset was also introduced to continue nurse licensure in the state. We opposed a reduction in the number of mentorship hours required for an Advanced Practice Registered Nurse (APRN) to prescribe independently. The required hours were unfortunately reduced from 1,000 down to 750. We staved off a lower reduction and secured a commitment not to revisit the issue for 7 years, but the decrease is of grave concern as we look at the APRN total hours of training (between 2,800 - 5,350) compared to physicians (between 20,700 - 21,700).
KYLE LEGGOTT, MD, AT THE CAPITOL WITH MORGAN HUNGENBERG, DO, AND PEDIATRICIAN COLLEAGUES, TESTIFYING AGAINST HB-1239, A BILL THAT WOULD STIFLE OUR PUBLIC HEALTH RESPONSE TO A VACCINE-PREVENTABLE DISEASE OUTBREAK AND INTERFERE WITH THE PATIENT-PHYSICIAN RELATIONSHIP.

CAFP BOARD MEMBER GLENN MADRID, MD, TESTIFYING ON HB20-1216, THE HIV PREVENTION MEASURE, IN THE COLORADO LEGISLATURE.

JOHN BENDER, MD, TESTIFYING IN THE LEGISLATURE IN SUPPORT OF SB20-163, TO REDUCE THE VACCINE EXEMPTIONS BILL.

CAFP PRESIDENT JOHN CAWLEY, MD, PRESENTING AT THE 2020 MULTISTATE CONFERENCE.
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2020 has been off to a fast, busy, and productive start! The SNOCAP team has been working with many of you on new projects, working out details to launch others, is continuing to work to address 2019 priority topics from convocation, and is always trying to take note of new developments and changes that are needed to continue to develop and grow this crazy research network.

We are really looking forward to attending the annual CAFP meeting in Estes Park. It is our hope that this opportunity to participate is a way to continue to build bridges between SNOCAP, CAFP, and others to do more wonderful work for our communities, patients, and partners state-wide.

What are you needing from the SNOCAP team to get your practice or community to the next step? Plan a meeting or phone call with Don and Mary to share your thoughts or pitch your idea.

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 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 Manager Mary Fisher: mary.fisher@cuanschutz.edu

We sincerely hope to hear from you soon!

-The SNOCAP Team
FAMILY LEVEL HEALING
THE FOUNDATION OF EQUINOX COUNSELING & WELLNESS CENTER

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The Comeback Kidneys

WHY DOES BARIATRIC SURGERY HELP PROTECT THE KIDNEYS IN SEVERELY OBESE YOUTH WITH TYPE 2 DIABETES?

According to a U.S. renal data system report from 2016, diabetic kidney disease continues to be the leading cause of renal failure in the United States, accounting for approximately 45% of all cases that progress to end-stage and dialysis. At a time when other common causes of end-stage kidney disease are not increasing in prevalence, Petter Bjornstad, MD, says that information is particularly disturbing because it suggests more adolescents are developing type 2 diabetes. And compared to adult-onset type 2, youth-onset type 2 is markedly more difficult to treat.

“We don’t know why,” Dr. Bjornstad says, “but youth with type 2 have a more aggressive phenotype with greater insulin resistance and more rapid beta cell failure. They also have a higher rate of complications including diabetic kidney disease. And not only higher rates, but also earlier onset. That’s scary.”

Two previous, separate studies related to obese youth and type 2 diabetes are the foundation of Dr. Bjornstad’s current research to find a better cure for diabetic kidney disease.

One of those studies, led by Children’s Colorado pediatric surgeon Thomas H. Inge, MD, PhD, and funded by the National Institutes of Health, is called Teen-Longitudinal Assessment of Bariatric Surgery, or Teen-LABS. It prospectively evaluated outcomes of adolescents who underwent bariatric surgery at one of five U.S. centers.

It was knowledge of this study and its novel findings that led Dr. Bjornstad to hypothesize that youth who undergo bariatric surgery to manage other health impacts might also lower their risk of diabetic kidney disease. A secondary analysis of the data could likely tell him, but he needed a comparison group.

That led him to a study managed by Phil Zeitler, MD, PhD, chief of endocrinology at Children’s Colorado, called Treatment for Type 2 Diabetes in Adolescents and Youth, or TODAY. Funded by the National Institute of Diabetes and Digestive and Kidney Diseases, its purpose was to investigate strategies to achieve durable glycemic control through medical therapy.

After frequency matching the TODAY cohort with Teen-LABS, Dr. Bjornstad had a subset of obese participants from each study to follow for five years.

The Results

The focus was on two primary markers: elevated urine albuminuria excretion, or UAE, and hyperfiltration. Both are early signs of diabetic kidney disease.

Elevated UAE means a damaged kidney filtration barrier, and the kidneys release more protein into the urine. Beyond being a marker for kidney disease, it’s a strong risk factor for heart disease.

With hyperfiltration, the kidneys filter blood at a supraphysiological rate. That might be due, in part, to the fact that the body is spilling a large amount of sugar, and the kidneys respond by increasing their filtration of the blood — a counterproductive response. It’s an energy-expensive process and the kidneys ultimately can’t keep up.

After analyzing these markers, the magnitude of his findings was surprising: At five years out, he saw 16-fold lower odds for hyperfiltration and 27-fold lower odds for elevated UAE in those who underwent bariatric surgery compared to the standard medical group.

“We did expect people who underwent bariatric surgery to have better results, because we know it improves blood sugar, we know it promotes weight loss, we know it improves blood pressure, we know it has all these beneficial effects,” says Dr. Bjornstad, “so we obviously expected it to have a more favorable outcome than those who underwent standard medical therapy. But what we didn’t expect was the magnitude of the difference.”

The most obvious next question is, “Why?” And the answer, he says, could propel the industry toward new and better treatments for diabetic kidney disease. Digging deeper offers the opportunity to understand how weight loss surgery helps protect the kidneys.

“Because we don’t know yet. Is it all related to weight loss? No.”

He continued, “Is it all related to change in lipids and triglycerides? No. All these things play a role, but they don’t completely account for the difference we saw.”

Not everyone is a candidate for bariatric surgery. If he can figure out what’s causing the difference, maybe there’s a way to mimic the effect that surgery affords.

Where do we go from here?

Dr. Bjornstad and his team are forging ahead with the next phase of research, called IMPROVE-T2D, where they’re already enrolling youth who are scheduled for bariatric surgery. Participants will undergo a gold-standard renal physiology assessment both before and after surgery.

From a physiological perspective, researchers will use iohexol clearance to measure glomerular filtration rate — how well the kidneys are filtering blood. And through para-aminohippurate clearance, they’ll measure effective renal plasma flow, or the amount of...
blood that moves through the kidneys. These methods provide remarkably accurate information about kidney health, but they’re cumbersome and challenging from a technical standpoint.

“Few places currently use these methods in pediatric diabetes, if any,” says Dr. Bjornstad. “I truly don’t know of any other pediatric sites doing this in North America. We’re going one step further and looking at things in a new way. It may be more laborious, but we feel like it’s worth it. And we have the tools to do it right.”

Participants will also undergo a state-of-the-art, functional MRI so researchers can look at how much oxygen is in the kidneys.

Then, they’ll look at how much oxygen is being consumed by the kidneys, and they’ll look at the perfusion of the kidneys.

Metabolic factors are also a focus, including measuring beta cell function and insulin resistance. That’s in addition to looking at certain markers of mitochondrial function by metabolomics, looking at the heart, and looking for fatty liver. “So yes,” Dr. Bjornstad says, “it’s an extremely comprehensive assessment.”

But a comprehensive assessment like this will only get them so far.

“We need to know what’s actually going on at the tissue level. We need tissue and we need to leverage the advances that have been made in genetic medicine to really look at the code of the cells to see if we can see the differences or changes that bariatric surgery activates.”

And for that, they will work with Children’s Colorado interventional radiologists Patricia Ladd, MD, and Roger Harned, MD, to safely perform ultrasound-guided kidney biopsies. Once they have the tissue, they’ll send it off to measure the single-cell transcriptomics — a process that sequences out individual cells. With each cell, they’ll look at its code to see what genes are turned on and what proteins are translated. “It gives you an amazing chance to really understand what early diabetic kidney disease looks like at a molecular level,” says Dr. Bjornstad.

The biopsies are part of a larger, multicenter project by the NIDDK called the Kidney Precision Medicine Project. Its goal is to build a kidney tissue atlas to better understand the molecular- and tissue-level differences of different types of kidney disease. Children’s Colorado is the only current participating site that will glean pediatric data.

Overall, it’ll likely be at least another year or maybe even closer to 18 months before they have enough information from IMPROVE-T2D to analyze. Dr. Bjornstad emphasizes that they’ll need to harmonize data collection and analyses with what researchers are doing at other sites so they can compare. But Children’s Colorado is unique in performing these progressive methods in obese adolescents and young adults with type 2 diabetes.

“And it’s incredibly multidisciplinary,” he says. “Interventional radiology, radiology, endocrinology, nephrology, bariatric surgery — all these departments and sections are working together to do truly innovative research. That’s rare, and it speaks volumes to what our Research Institute is able to do here.”

The research “Effects of Surgical Versus Medical Therapy on Diabetic Kidney Disease Over 5 Years in Severely Obese Adolescents with Type 2 Diabetes” was published in the American Diabetes Association journal Diabetes Care in January 2020.

Jef Ott, Sr., is a writer at Children’s Hospital Colorado.
WHAT’S WRONG WITH THIS NOTICE?
Scams Targeting Physicians

From illegitimate representatives who claim to be “official Medicare agents” to fake prescription discount cards, there is no shortage of scams that are connected to health care. In addition to going after patients and general consumers, scammers have also directly targeted medical providers. The following is an abbreviated version of an actual notice that a physician received. Can you spot the things that would raise concern about the legitimacy of this letter?

AMERICAN BOARD OF PULMONARY DISEASE
51 N. 3rd STREET, SUITE 103
PHILADELPHIA, PENNSYLVANIA 19106
E-mail: certification@linuxmail.org

IMPORTANT NOTIFICATION REGARDING ALL CERTIFICATION IN PULMONARY DISEASE: COMPLETE REQUIREMENTS BY JUNE 25, 2019 IN ORDER TO PREVENT A CHANGE IN DIPLOMATE STATUS. THIS IS A MANDATORY REPORT AND YOU ARE ON RECORD HAVING FAILED TO PREVIOUSLY REGISTER, AND MUST COMPLY.

Dear Doctor Smith,

Certification Status Verification of Diplomates requires, in order to continue having Diplomate status: for Medicare, Obamacare, the new enforcement of the U.S. Code Title 18 Section Number1861, [42 U.S.C. 1395x] Part E, by the United States Government, enforcement has already begun closing down hospitals in the state of Idaho and requires filling out list of hospitals presently being used, listing of states where you are licensed, statement regarding any malpractice cases recently filed against you, and certification confirmation fee payment of $500 for Pulmonary Disease Certification Status Verification at this time.

Payment with check or money order made to: American Board of Pulmonary Disease. Certification Confirmation Registration Form and Fee should be received no later than June 25. Certification Confirmation Registration fee is fully tax deductible. We request that the matter of registration be taken care of as soon as possible. There are no extenuating circumstances.

CERTIFICATION CONFIRMATION REQUIRED FORM
PREFERRED SPELLING OF NAME AND DEGREE: 
E-MAIL: 
OFFICE PHONE:
LISTING OF STATES WHERE YOU ARE LICENSED:
LISTING OF HOSPITALS PRESENTLY USED:
STATEMENT REGARDING ANY MALPRACTICE CASES FILED AGAINST YOU IN PAST YEAR:
STATEMENT OF ALL BOARDS CERTIFYING YOU:
DATE OF LAST CERTIFYING OR RECERTIFYING EXAMINATION IN ANY MEDICAL SPECIALTY:
SIGNED _____________________ DATE __________

SEND THIS FORM, SIGNED AND DATED, AND FEE OF $500 MADE TO: AMERICAN BOARD OF PULMONARY DISEASE

AREAS OF CONCERN
1. There is no such organization as the American Board of Pulmonary Disease.
2. The email address is not legitimate and there is no phone number or contact person listed.
3. The terminology used is highly suspect:
   a. No credible medical organization would reference “Obamacare.”
   b. The phrase “hospitals presently being used” is not accurate.
   c. There is no such thing as a Pulmonary Disease Certification Status Verification.
4. The format of the letter is very awkward—one long paragraph and inadequate space to provide answers on the form section—and there are several typos.
5. There are numerous references to sending a payment (with no option to pay by credit/debit card) and a sense of urgency to respond.

Similar to scams that target general consumers, there are common tactics that we see used: impersonating official organizations, attempting to adopt formal terminology specific to a group of people, and trying to create a sense of urgency to avoid legal/disciplinary action.

**GUIDELINES TO CONSIDER IN ORDER TO PROTECT YOURSELF:**

- Know that organizations, such as the DEA, will never contact practitioners to demand money or any other form of payment.
- Recognize that there are numerous ways to impersonate officials. With the DEA scam, tactics included callers using fake badge numbers or names of well-known DEA senior officials as well as falsified numbers on caller ID that appear as a legitimate DEA phone number.
- Remember that certain information provided (e.g., license number, patient information, or other personal details) to make a request seem legitimate may be something that can be found via open access sources online or through social media.
- Poor grammar and/or typos are often dead giveaways seen in scams.
- If you are placed in a high-pressure situation, don’t get caught up in feeling you need to respond immediately. Ask for the person’s contact info so you can get back to him or her.
- Examine the sender’s info with scrutiny; does the email seem legitimate? Is there appropriate contact information that can be verified?
- Never provide sensitive information about yourself and/or your patients.
- Report any suspicious activity to relevant organizations (DEA, medical or specialty boards, FDA, etc.).
- Be sure to inform your staff members of potential scams, what to look for, and how to handle them.
At the end of January 2020, the CAFP Foundation provided me with a scholarship to attend the Society of Teachers of Family Medicine 2020 Conference on Medical Student Education to give a presentation with Dr. Roberto Silva, Richard Nakano, and Sean Wickers.

Our presentation introduced conference goers to the curriculum reform that is a part of the rural longitudinal integrated clerkship (LIC) at the University of Colorado School of Medicine (http://bit.ly/2wHWaWd).

Along with four other rural track students, I participated in a new pilot program called the ILMC, or Integrated Longitudinal Medicine Clerkship. It is a 6-month program focusing on an integrated clerkship in rural areas of Colorado like Lamar, Delta, Wray, La Junta, Alamosa and Del Norte.

Our curriculum focused on 5 clerkships: Inpatient/Outpatient medicine, OB/GYN, General surgery, and Emergency medicine. The project that we focused on examined whether students who participate in rural clerkships either meet the core clinical requirements of the clerkships as determined by the school of medicine and clerkship directors, or if they obtain an equivalent level of understanding.

We found that all students participating met all the competencies required of the school for third year students on these clerkships (except for HIV, though we still met that requirement via required readings). All of the participating students appreciated the opportunity to have more one-on-one interactions with preceptors – most of whom are family medicine physicians.

This pilot program showed that students can experience many of these clerkships by following family medicine physicians and did not require internists or even full time OB/GYN or emergency physicians to meet these requirements.

We also found that students appreciated being one of a few if not the only student at these clinic sites – which made it easier to perform or first-assist on procedural skills like surgical procedures. Overall, we had an overwhelmingly positive experience and the data we obtained will help to plan and adjust the future curriculum of the ILMC in rural Colorado.

Looking ahead, we plan to expand the program to include additional clerkships such as neurologic care, psychiatry, and pediatrics which are currently completed at non-rural sites.

Your donations to the CAFP Foundation enable students like Sami to attend conferences, present their research, and advance family medicine. Consider donating here: http://bit.ly/2TsCPAn.
Kids aren't just tiny adults. From the way they breathe, to the way they think, to the way they metabolize medication, kids’ bodies and minds are completely different. That’s why, when they need a hospital, they need one that’s just for them. At Children’s Hospital Colorado, we’ve got the medical expertise, specialized equipment and understanding of kids’ minds and emotions to treat them exactly how they need to be treated: like kids.
CAFP advocacy for family physicians during #Covid19Colorado

As the foundation of our health care system, Family Docs are vital to keeping our communities healthy. CAFP is advocating for you during this pandemic.

**PRACTICE**

We are aggregating policies, resources, and best practices, and advocating for better PPE supplies.

**POLICY**

We successfully advocated for Governor Polis to implement social distancing policies.

VISIT COLORADOAFP.ORG/COVID-19-RESOURCES FOR MORE INFORMATION
We're making business banking easier.

At PNC, our team of dedicated Healthcare Business Bankers understands your business challenges and the important role that cash flow plays in your success. That’s why we offer a range of solutions to help optimize management of your practice’s revenue cycle and payables, so your business can run with less complexity and payments can be received promptly.

Learn more at pnc.com/hcprofessionals or by calling 877-566-1355
**Vaccine News You Can Use**

**Millennials Are Least Likely to Receive Flu Shot, in Part Because of Anti-vaxxers**

NBC News reported (tinyurl.com/wfl3hh5) that the American Academy of Family Physicians (AAFP) surveyed 1,000 adults across the U.S. about influenza and found that millennials were the least likely to receive flu vaccines compared to other generations. According to the survey, 55 percent of millennials said they did not receive the flu vaccine this season often because they forgot or said they did not have time, but the survey also found that 61 percent of “millennials familiar with the anti-vaccination movement said they agreed with at least some of those beliefs.” In addition, the survey also suggested that “many parents aren’t getting the facts right about flu vaccines. Nearly 60 percent of polled moms and dads said that their child has missed at least one flu shot. One-fifth of those parents were concerned the shot would somehow make their child sick, and 10 percent said they didn’t think the flu is serious enough of an illness to warrant a vaccine.” Obviously, we family physicians can educate both groups in our offices.

**Fewer Americans Believe It’s Important to Vaccinate Children Than in the Past**

A recent Gallup survey (tinyurl.com/sb5s9aj) reported, “Fewer Americans believe it’s important for parents to get their children vaccinated than in the past.” Results showed “that in 2019, 84 percent of Americans said they think it’s extremely or very important that parents get their children vaccinated – down from 94 percent in 2001.” While “about nine in 10 adults said they’d heard a lot about the medical advantages of childhood vaccinations, the survey shows ... more people reported hearing about potential disadvantages of vaccines.” The Gallup report says this suggests anti-vaccination arguments “are still getting through [and] perhaps explaining why public support for vaccines remains lower than at the start of this century.” Again, we FPs can be the ones to educate our patients of all ages.

**800 Unvaccinated School Kids Told to Stay Home**

ABC News reported (tinyurl.com/s87dqaz) that nearly 800 Seattle students were not allowed to return to school on their first day back after winter break, because they aren’t vaccinated against measles. The move came after Washington legislators passed a law last year that eliminated parents’ personal option to exempt their children from the measles, mumps, and rubella vaccine. Seattle Public Schools started with 7,000 unvaccinated students among approximately 54,000, officials said. After holding a series of free vaccination clinics and sending warning letters to 2,274 students, advising that they’d have to stay home if they weren’t vaccinated by January 8, that number fell significantly. Students must show proof of either having had the vaccine or of having an upcoming vaccination appointment. As we’ve argued in the past, parents that don’t want to have their children vaccinated for non-medical reason should be able to do so, but they then forego their right to bring their children into public spaces where they can serve as unwitting carriers of potentially fatal disease.

**California Law Eliminating Nonmedical Vaccine Exemption Improves Vaccination Rates**

Newsweek reported (tinyurl.com/wl2cedcz), “A California law stopping parents from citing religious or philosophical beliefs to opt out of vaccinating their children has improved rates of” vaccinations, researchers concluded after examining “county-level data on measles, mumps and rubella (MMR) vaccine coverage from 45 different state public health departments between 2011 and 2017,” and from 17 states between 2010 and 2017.” The study revealed that after the adoption of Senate Bill 277, “MMR coverage in California rose by 3.3 percent, nonmedical exemptions dropped by 2.4 percent, and medical exemptions went up by 0.4 percent.” What’s more, “overall vaccination coverage rose by 4.3 percent, nonmedical exemptions by fell by 3.9 percent, and medical exemptions grew by 2.4 percent.” HealthDay added (tinyurl.com/sgzek95) that in high-risk counties “where vaccination rates had been low enough to set the stage for disease outbreaks,” rates of vaccination “improved by 10 to 20 percent,” the study revealed. The study was published in PLOS Medicine (tinyurl.com/ryxf7q2). We believe it’s time for Colorado legislators to follow the wise, sensible, and public-protecting steps enacted by other states like California.

**AAFP Seeks Fewer Administrative Burdens Linked to Vaccines**

AAFP News reported (tinyurl.com/wwl28gv) that the AAFP has encouraged HHS to make a priority of reducing the administrative burdens linked to vaccine administration and ensure EHR vendors are responsible for providing standardized, interoperable immunization functionality without creating a financial hardship for physicians and other users. The letter said all children and adults should be immunized, and that public and private payers should cover all immunizations recommended by the AAFP without copayments or deductibles.

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CDC Proposes Expanded HCV Screening Recommendations

MedScape reports (tinyurl.com/use94vq) the CDC has proposed expanding recommendations for hepatitis C testing to universal screening for all adults ages 18 and older at least once in their life. The recommendations, which are open for comments, also include screening all pregnant women during each pregnancy, routine periodic testing for people with ongoing HCV risk factors and testing anyone who requests it regardless of whether they disclose their risk factors for the disease. Stay tuned for future news about this.

New ACIP Recommendation for Use of Pneumococcal Vaccines in Adults Aged ≥65 Years

In 2014, the Advisory Committee on Immunization Practices (ACIP) recommended the 13-valent pneumococcal conjugate vaccine (PCV13) in series with 23-valent polysaccharide vaccine (PPSV23) for all adults aged ≥65 years. In late 2019, based upon accrued evidence, ACIP changed the recommendation for PCV13 use in adults. ACIP now recommends a routine single dose of PPSV23 for adults aged ≥65 years instead of both interventions. They further recommend ‘shared clinical decision-making’ for administration of PCV13 to persons aged ≥65 years who do not have an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant, and who have not previously received PCV13. If a decision to administer PCV13 is made, the 2014 guidelines should be followed, whereby PCV13 is administered first, followed by PPSV23 at least 1 year later.

This is one of those situations where the evidence for benefit for a relatively expensive and complex intervention is equivocal enough that ACIP has defaulted to ‘shared clinical decision making’—kind of a code term for ‘we really do not want to commit.’ We believe that PCV-13 in series with PCV-23 is the ‘gold standard’ if the patient has the means to pay and wants maximal protection.

CDC Data Show Many Pregnant Women Lack Needed Vaccinations

The CDC’s Morbidity and Mortality Weekly Report (tinyurl.com/sgvhquq) found about 65 percent of mothers said they had not received the seasonal influenza and tetanus, diphtheria and acellular pertussis vaccines before or during pregnancy. The highest vaccination rates were seen among women who were offered vaccination or referred for vaccination by their health care professionals. For FPs not providing maternity care, we still often see women who are pregnant or could become pregnant. Whenever possible, we should provide the needed and indicated vaccines (and let their maternity care provider know we’ve done so), or, should we not have the vaccines, educate them on this recommendation.

FPs Have Easy Access to Current Immunization Schedules for Patients of All Ages

Each year, the AAFP and the ACIP collaborate to develop recommendations for the routine use of vaccines in children, adolescents, and adults in the United States. You, your colleagues, and your staff can always view the most current immunization schedules by age group at tinyurl.com/y2lxdttl.

No MMR Vaccination for Many US Youths Before International Travel

Reuters reported that “only 41.3 percent of youths ages 6 months to 18 years received the measles, mumps, and rubella vaccine during clinical visits before traveling overseas, according to a study in JAMA Pediatrics (tinyurl.com/t8okucj). Researchers found that clinician decision and parental or guardian refusal were the most prevalent reasons for nonvaccination.

Maternal Measles Antibodies Only Protect Babies for a Few Months or Less

NBC News reports (tinyurl.com/t9rtzo6), “Doctors have known that mothers pass on measles immunity to their babies ... leading to the belief that infants are protected against the disease for most of their first year of life.” However, a recent study of blood samples from 200 babies “found insufficient levels” of measles antibodies “in 20 percent of newborns, 92 percent of 3-month-olds, and all of the 6-month-olds.” The study was published in Pediatrics (tinyurl.com/spq3lqd).

ACIP OKs Use of Tdap Vaccine as Substitute for Td

With a unanimous vote (tinyurl.com/sxtfrrg), ACIP is recommending the Tdap vaccine as a Td vaccine substitute, including for the decennial Td catch-up vaccination for people ages 7 and older. ACIP also recommends Tdap for pregnant women (for each pregnancy), and tetanus prophylaxis for wound management in nonpregnant individuals with previous Tdap immunization. This change will offer FPs increased vaccination flexibility and reduced costs.
Understanding Commonly Seen Liver Masses

BY GIRIDHAR VEDULA, MD

Introduction:
A liver mass is identified as a focal solid or cystic abnormality that can be differentiated from the surrounding parenchyma by imaging techniques. Over the past few years the detection of these lesions has increased dramatically due to imaging of the abdomen for different reasons. The differential diagnoses of liver lesions remain broad and may range from benign asymptomatic lesions (e.g. hemangiomas) to malignant neoplasms (e.g. Colorectal metastatic lesions or primary liver malignancy). The diagnosis can be better elucidated based on clinical history, imaging findings and occasionally pathology evaluation by biopsy.

An incidental lesion identified in an asymptomatic patient is usually benign, and are most commonly hemangiomas, cysts and focal nodular hyperplasia. However, a history of cancer may suggest metastatic foci in the liver. A clinical history of cirrhosis or primary sclerosing cholangitis may suggest a primary hepatocellular carcinoma or intrahepatic cholangiocarcinoma respectively. Specific imaging characteristics can identify the difference within these different entities. Multidisciplinary care is essential in the coordination and delivery of care for these complex patients.

In the following sections we will outline the epidemiology, clinical presentation, diagnoses and treatment of commonly seen liver masses.

Cystic Lesions
A wide array of cystic lesions may be identified in the liver. These can range from simple cysts to complex cysts related to infection and cystic neoplasms of the liver and can vary in size and symptomatology.

a. Simple cysts: The real prevalence of the cyst is unknown, though some reports suggest a range of 18 to 24%. These are often identified during incidental radiologic procedures and can be solitary or multiple. The origin of the cyst is related to abnormal cuboidal biliary epithelium, and therefore produce serous fluid. Rarely these may be in communication with the biliary system. While they are most often asymptomatic, they may become symptomatic if they are associated with increased size. Symptoms are often pain (since the cysts are associated with capsular stretch of the liver) and early satiety (due to obstruction of hollow viscus). In a symptomatic patient, treatment often involves surgical resection or percutaneous sclerotherapy.

b. Infectious cystic lesions: Infectious cysts in the form of pyogenic hepatic abscesses are frequently seen in the setting of biliary infection, or secondary to gastrointestinal infections such as diverticulitis and appendicitis. Clinical suspicion is based on presence of symptoms such as fevers, chills and abdominal pain. Cross-sectional imaging of the abdomen will identify fluid collection in the liver with irregular borders, occasionally multilobulated and with evidence of localized hepatic necrosis. These abscesses tend to be polymicrobial and will often include Klebsiella and Streptococcus species. Occasional amoebic abscesses are seen due to Entamoeba histolytica. Optimal treatment includes antibiotics directed to the organism along with percutaneous drainage. In a complex abscess collection, sometimes, multiple drains may be indicated, and occasionally surgical debridement may be appropriate.

c. Mucinous Cystic neoplasm: These used to be called cystadenomas and are uncommon. They are different from simple cysts because

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of histological elements like biliary epithelium and dense fibrous stromal tissue. They are often multi-lobular with internal echoes on imaging studies. Approximately 15% of these lesions will have some evidence of malignant transformation and present as cystadenocarcinoma. Treatment for these lesions is surgical.

iii. FNH is comprised of hyperplastic hepatocytes that are thought to develop around an aberrant and dystrophic artery. On cross-sectional imaging they have a characteristic central scar. We do not routinely perform surveillance imaging for these lesions. Occasionally patients will complain of pain in which case surgical options and less invasive approaches (embolization and ablation) may be explored1,2.

b. Metastatic Disease

Commonly encountered solid masses of the liver are metastatic foci from the colon, stomach, pancreas, breast and ovaries. Presence of these lesions should prompt an evaluation of hollow viscus and other organs. Imaging characteristics of these lesions is highly variable depending on the cell of origin of the cancer. Surgical resection of both the primary and the liver lesions may be warranted depending on the kind of cancer. There is clear survival advantage with colorectal, neuroendocrine, renal cancers and ocular melanoma. Metastatic tumor resection for other indications is still controversial.

c. Primary Liver Cancer

i. Hepatocellular Cancer

Hepatocellular carcinoma (HCC) is the most common primary liver malignancy. In the United States the incidence of HCC is rising, with an estimated 74,000 new cases and 34,000 deaths in 2018. Over 40% of HCC cases are associated with chronic HCV infection. The incidence of HCC is higher in men with a male to female ratio of 2:1. HCC are seen in patients with cirrhosis and should undergo surveillance screening. American Association for the Study of Liver Diseases (AASLD) guidelines instruct us to perform ultrasounds with AFP every 6 months in patients with the diagnosis of cirrhosis. Presence of a lesion would then further direct care in the form of cross-sectional imaging. Contrast-enhanced CT or MR will demonstrate pathognomonic features in the lesion that help identify hepatocellular carcinoma. Classic arterial enhancement with portal venous washout will prompt an evaluation of hollow viscus and other organs. Imaging findings and can be solitary or multiple. Patients with glycogen storage disease and in metabolic syndrome have a greater propensity to present with these lesions. Often seen in young females and these lesions typically are responsive to estrogen-containing medications. Exposure to oral contraceptives, anabolic androgens and hyper-estrogen state such as obesity resulted in increased growth. Complications associated with the presence of these lesions include rupture with bleeding and malignant transformation. Contrast enhanced cross-sectional imaging will ideally identify these lesions, however ultrasound may also be utilized to characterize these lesions. Biopsy of these lesions is typically not indicated due to characteristic appearance on cross-sectional imaging. Size of the lesion typically dictates management. Lesions greater than 5 cm in women warrants surgical excision, but if these lesions are under 5 cm, they may be followed at 6 months to ensure stability. If these lesions do not grow over this period they may be followed annually. Lesions of any size in males warrant surgical evaluation and resection due to the higher risk of malignant transformation in men. These men should be counselled on abstaining from the use of exogenous androgens.

 Solid Lesions

a. Benign lesions

i. Adenomas are benign and are occasionally associated with symptoms. They are typically seen as incidental findings and can be solitary or multiple. Patients with glycogen storage disease and in metabolic syndrome have a greater propensity to present with these lesions. Often seen in young females and these lesions typically are responsive to estrogen-containing medications. Exposure to oral contraceptives, anabolic androgens and hyper-estrogen state such as obesity resulted in increased growth. Complications associated with the presence of these lesions include rupture with bleeding and malignant transformation. Contrast enhanced cross-sectional imaging will ideally identify these lesions, however ultrasound may also be utilized to characterize these lesions. Biopsy of these lesions is typically not indicated due to characteristic appearance on cross-sectional imaging. Size of the lesion typically dictates management. Lesions greater than 5 cm in women warrants surgical excision, but if these lesions are under 5 cm, they may be followed at 6 months to ensure stability. If these lesions do not grow over this period they may be followed annually. Lesions of any size in males warrant surgical evaluation and resection due to the higher risk of malignant transformation in men. These men should be counselled on abstaining from the use of exogenous androgens.

ii. Hemangioma are typically seen during laparotomy, incidental imaging or at autopsy. These lesions appear slightly more often in females, in up to 20% of the general population1. They are often solitary and can be identified by ultrasound or a contrast-enhanced cross-section imaging. They can become symptomatic when they reach a certain size. The lesions should not be biopsied because of radiologic accuracy in predicting this pathology as well as an increased risk of bleeding. If these lesions are under 5cm, further work-up is not indicated. However, if they are greater than 5cm, a 6- to 12-month scan is recommended. In the absence of growth, no further work-up would be indicated. Patients should be counseled that the risk of rupture is exceedingly rare. Symptomatic hemangiomas or hemangiommas to demonstrate growth need further work-up in the setting of a multidisciplinary hepatobiliary center2.

iii. FNH is comprised of hyperplastic hepatocytes that are thought to develop around an aberrant and dystrophic artery. On cross-sectional imaging they have a characteristic central scar. We do not routinely perform surveillance imaging for these lesions. Occasionally patients will complain of pain in which case surgical options and less invasive approaches (embolization and ablation) may be explored1,2.
Lesions are characteristic for HCC. Once a diagnosis of HCC is established, treatment determination is often best left to centers that can offer transplant as a potential therapeutic measure. Multidisciplinary care is imperative for effective care and is identified within the NCCN guidelines in the care of primary liver malignancy. Staging guidelines are outlined by the Barcelona Clinic Liver Center (BCLC). These guidelines effectively stage the disease and offer potential treatment options based on overall liver function. The scope of treatment includes surgical resection, liver transplantation, local regional therapy in the form of ablation, chemoembolization, radiation embolization and external beam radiation.

ii. Cholangiocarcinoma are cancers that originate in the biliary epithelium. These can arise intrahepatic, perihilar or in the distal biliary tree. The treatment strategies for these lesions is dependent upon location. Because symptoms tend to occur late, these tumors present in advanced stages. Symptoms such as jaundice, pruritus, clay colored stools and dark urine are oftentimes seen. Patients with primary sclerosing cholangitis have an increased incidence of cholangiocarcinoma. Treatment strategies for these lesions include surgical resection, chemotherapy and occasionally liver transplantation. Care for these complex lesions are best served within a multidisciplinary tumor board.

Summary: This basic outline is meant to serve as an overview of commonly encountered lesions in the liver. Subtle radiological differences can distinguish the benign from the more ominous lesions. Multidisciplinary evaluation of these lesions is critical for safe and effective care in these patients. Collective wisdom of the group can help patients navigate the appropriate portal for care. Additionally, this enhances the patients’ experience by avoiding additional scans and testing.

Dr. Giridhar Vedula is a hepatopancreaticobiliary surgeon with Centura Transplant at Porter Adventist Hospital, in Denver, Colorado.

References
If Not Me, Then Who?
Daniel Dyer, MD, has been named CAFP’s 2020 Resident of the Year

When he was in high school, Daniel Dyer, MD, went to Uganda on a missions trip. It sparked something in him. “My eyes were opened to how much need there is out there,” he says.

But having the desire to serve marginalized people only got him so far. “I wanted to help people in a specific way,” he says. “I wanted them to have hope.”

A mentorship program exposed him to practicing medicine as a service. It inspired him to begin a college internship at Hennepin Medical Center in Minneapolis. “Watching people transition from being unable to live in a healthy way, to finding some degree of healing and hope despite injury and disease, convinced me I had to go into medicine,” he says.

By the time he began medical school at Creighton University, in Omaha, Nebraska, Dr. Dyer had decided family medicine was the best way he could serve people. “It is the most integrated into the community,” he says, “and it seeks to serve the whole community, from newborn to nursing home.” The appeal of medicine as a community service complimented his desire to serve needy communities.

At Creighton, Dr. Dyer led a Hepatitis-C screening and treatment program at the student-run clinic in Omaha, which initiated treatment for more than 30 homeless people. He also directed service programs for refugees and other marginalized people.

As a part of the program, he would eat dinner with some of the patients at the shelter. Hearing their stories helped him to build relationships with them. “The continuity of relationship can bring trust and hope to people in terrible situations,” he says.

“Whatever I do within medicine I want to serve those who are on the edges of society,” he adds.

Now in his final year at the North Colorado Family Medicine Residency, in Greeley, CO, Dr. Dyer has focused on serving marginalized people. “Daniel helped us develop a new, extensive curriculum in the global health track,” Jeffrey Cook, MD, a faculty physician at NCFM says. “His sense of social mission is something he feels in every fiber of his body.”

Focusing on community service is fundamental to his approach for medicine. Dr. Dyer brought his experience in treating Hepatitis-C to NCFM “virtually singlehandedly,” Dr. Cook says. He provided education to patients, staff, and providers about screening for the disease and then treating it. He oversaw the implementation of a diagnostic point-of-care test for in-office screening. Using an online ECHO module, he expanded the resident physician training about evidence-based Hepatitis-C treatment.

“This training may be his lasting legacy at NCFM,” Dr. Cook says.

When it came time to choose an elective rotation, Dr. Dyer dreamed big. In December of 2018, he wound up a Kudjip Hospital, about 45 minutes outside of Mount Hagen, the third largest city in Papua New Guinea. Under the guidance of Mark Crouch, MD, he learned about practicing medicine in austere conditions.

“One time, I drove in a van out to the smaller villages,” he says. “Mount Hagen is a good-sized town, but it becomes rural very quickly.”

At a tea plantation in the western Highlands, he saw dire need. Children who had traveled for almost three days came to him to get help. These children lived days away from even temporary medical attention. Emotion turns his voice upward as he explains the experience. “It was difficult to see, but very motivating,” he says. “I want to see these kids have better opportunities, better care.”

As Dr. Dyer worked with the local nurses, he learned their stories, too – just as he did with the homeless in Omaha, the refugees in Greeley, the low-income patients in Minneapolis. Growing up in Papua New Guinea was not easy, especially for the women. “Those stories they told me changed me,” he says. “It reminded me that medicine needs to serve the most vulnerable.”

This heart for serving his community comes from his faith. “Daniel was instrumental in helping another resident find support during a very difficult time,” Neil Gamblin, MDiv, an elder at his church, says. “His faith motivates him to serve others.”

More immediately, Dr. Dyer’s heart for service drives his approach to seeing patients. “Daniel is so dedicated to giving his all for his patients, every single visit,” David Smith, MD, the program director at NCFM says. “Our world needs more physicians like him.”

“God cares deeply about those who are suffering,” Dr. Dyer says. “Healing is not just addressing the body; it is traveling through life with people.” At NCFM, he has journeyed with patients and providers alike. “I have been so humbled and amazed by the faculty and my fellow residents. I learn so much from other people’s empathy and care,” he says. “going those extra miles, it motivates me to make a better person – and a better doctor.”

When he completes his residency, he will be returning to Papua New Guinea as a part of the Post-Residency Program with Samaritan’s Purse. Working internationally is a new skillset for him, but he couldn’t imagine being anywhere else.

“People deserve the chance to go live a full life,” he says. “Medicine is one way I can help them do that.”
A Passion for Service Through Family Medicine

Alan-Michael Vargas, MD, has been named CAFP’s 2020 Physician of the Year

When Michael Vargas, MD – “I don’t really use my first name,” he tells me – walks into a room, you can’t escape his presence. A gregarious and passionate speaker, he quickly launches into his philosophy of medicine.

“My patients don’t have anyone else,” he says. “I have to be there for them.”

Dr. Vargas views his life, and his practice, as serving the community. “You have to love the place you live,” he says, as he launches into a description of his adopted hometown that effuses his love of place and people. From the dramatic landscape – he is an avid snowboarder – to the kind-hearted people he treats every day, Dr. Vargas clearly loves his community.

Growing up in the Bronx, he hadn’t planned on practicing rural medicine. At 13, his family moved from the city to an area of upstate New York surrounded by dairy farms. Whenever he or his brother would get sick, they’d see the local family physician. But they would also see him at the grocery store, at school events. “He was an integral part of our lives, of all his patients’ lives,” Dr. Vargas says.

The residency at Mt. Sinai trained Dr. Vargas to be the first and last resort for patients. It struck him as an interesting approach for approaching urban medicine. “Even though I was in a large city,” he says, “I was taught not to depend on specialists and to fall back on myself as the sole champion for my patients.”

It let Dr. Vargas combine his love of service with becoming a part of his patients’ lives – just like his childhood doctor. “I knew I wanted to be just like him,” Dr. Vargas says. “I wanted to be integrated into my patients’ lives as their friend, their advocate, almost like a member of the family.”

Yet, practicing medicine in Rifle is not always easy. Rural doctors face a lot of challenges doctors in more urban settings do not. “Think about the internet,” Dr. Vargas says. “We don’t always have the bandwidth to upload a complete medical report with imagery.” The challenges he faces bringing care to people helped him to realize how much infrastructure is taken for granted in other settings.

Many of his patients don’t have access to a computer, either – after all, a computer doesn’t feel necessary if you’re stuck on a dialup connection. And when cellular service is slow, a smart phone doesn’t make sense for many people. With no computer and a flip phone, how can a patient reliably access their electronic medical records?

The challenges he faces bringing care to people prompted him to get more involved with rural health policy as chair of the Colorado Rural Health Center. “The dynamic of medicine has changed,” he says. “I want other doctors to bring their patients’ voices forward and to step into their role as leaders.”

“We deserve to be heard,” he adds. Too often, the needs and concerns of rural patients do not get picked up as equally important to patients in more densely populated areas. “Advocacy is so important,” he says. “The challenges we face as doctors, and people face as patients, are so much more difficult now.” Affordability, access, employment wages – all can affect how someone is able to access primary care.

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Addressing that gap is something Dr. Vargas puts in time to address, and his patients have noticed. Building emotional intimacy of treatment has defined and shaped his approach to medicine. “He will sit down and truly listen to you,” Kim Wisdom, one of his patients, says. “The personal connection he builds with us is like nothing else. He isn’t ‘just a doctor,’ he’s beyond that. He takes the time to have humor and warmth, and not just tick off a bunch of boxes.”

“The attentiveness really is unexpected,” Fred Burdick, another patient, says. “Dr. Vargas takes the time to sit down with me, explain what’s going on in layman’s terms, and listens. I’ve never experienced that from another doctor, who takes the extra time to help me work through my health issues.”

The time to listen to patients is difficult for many family physicians to build into their schedules. “Often, it can feel like you’re reduced to a referral service for a specialist,” Dr. Vargas says. “You have to fight that everyday so you can champion your patients.”

“It’s not just about this one meeting,” he says. “It’s about your life. It’s about your care. It’s about you.”
Keith Dickerson, MD, did not want to be a doctor at first. “I went into electrical engineering for my undergrad,” he says. After graduating from Drexel University, in Philadelphia, he worked as an engineer for a year. “It didn’t take,” he says, laughing slightly. “It wasn’t for me.”

Graduate school seemed like a good way to shift directions. Returning to Drexel, Dr. Dickerson looked to biomedical engineering but found it unfulfilling. He walked away from his PhD fellowship and decided to pursue medical school instead. He accepted a scholarship from the U.S. Air Force to attend the Medical College of Pennsylvania. “It was crazy,” he says of the decision to walk away from a full ride. “I had no financial support to attend medical school, but I felt this calling toward medicine – clear as day.”

“I initially wanted to be a radiologist,” he says. “But it wasn’t clear at first that I made the right decision.”

As a child, Keith Dickerson grew up near doctors. His mother, herself a nurse at a family medicine clinic, would bring him and his brother to play in the doctor’s office up the street. The two doctors for the clinic both lived within half a block, and he would play with their children in the backyard. “Family medicine is family history for me,” he says. His older brother, Don, had become a family doctor years earlier – and served as a model for the diverse career paths a family medicine doctor can have. Dr. Dickerson realized he had to leave engineering because, having grown up surrounded by family medicine, it just felt right.

Now, as an attending physician and faculty at the St. Mary’s Medical Residency, in Grand Junction, CO, Dr. Dickerson sees family medicine as a privilege. “Being a family doctor is a sacred duty, something I feel so lucky to experience,” he says. The human connection with patients is a driving force that brightens his stories and animates his voice. It is a passion he imparts to the residents he mentors.

“Here’s the thing with family medicine,” Dr. Dickerson says. “Medicine is focused on people: getting to know them, their life story, what led up to their being who they are. It is endlessly fascinating.”

This sense of privilege is one he imparts to his students. Many young doctors find the continuity of care aspect of family medicine appealing, he says. But as student there are not many opportunities to develop a long-term relationship with a patient. Even as a resident, the doctors are lucky if they get three years with someone. “I am in year 15 of practicing medicine in Grand Junction, and this is better than I could have ever imagined,” he says. That sense of privilege drives his approach not only to medicine, but to teaching as well.

It is clear Dr. Dickerson loves to teach, and he has loved it since he was a resident. “I knew in my second year,” he says, as chief resident he loved the teaching. “You never learn something as well as when you’re teaching it.” “Bring your authentic self to the patient encounter, and you will find joy in the experience,” he says.
Feeling joy in the practice of medicine is as important to Dr. Dickerson as the specific medical knowledge he imparts to his residents. As he teaches inpatient medicine, that joy seems to catch on. “I will take your love for inpatient medicine with me to my next practice,” one wrote in a handwritten card. “Thank you for pushing me to always do the right thing for the patient and the system.”

The card is a “moment of sunshine,” as he puts it. He collects as many moments of sunshine as he can. “Sunshine has to be a part of your teaching,” he says. “Medicine is a lot of hard work and you need to acknowledge and revel in the good. It makes processing the painful experiences much easier.”

Several years ago, after a difficult experience with death in his family, Dr. Dickerson was speaking with a former resident he had mentored. “Your joy is so important,” she told him. The passion for understanding the human condition, for loving where people were and meeting them there, extended to everyone both patient and resident alike.

One resident left a card, also in his office, expressing her thanks for how he “appreciated her introversion,” and met her learning needs. “You have played such a huge role in my development as a physician and clinical confidence,” she wrote. “Thank you for meeting where I am.”

More broadly, the openness to experience people’s lives and stories has profoundly affected him. In 2019, Dr. Dickerson saw six of his long-term patients pass away. While it was sad to see them pass, he felt like it was a privilege to walk their path with them. “Death is the inevitable outcome,” he says. “I was so lucky to share their lives.”

Dr. Dickerson keeps several handwritten cards in his office from a patient he saw every month for 15 years for his “sunshine folder.” They had spent a lot of time together over the years and formed a tight bond. The patient wanted to write a book about their life but couldn’t type. Dr. Dickerson helped transcribe their years of diaries and stories into type – and at their memorial service he read those passages aloud for their family.

“Work can and should be a meaningful part of your life,” he says, drawing a connection between his philosophy of medicine with his philosophy of teaching medicine. It’s okay to embrace work and to find joy in it, especially given how much time doctors spend at work. Helping the residents become lifelong lovers of their medical careers is “a core aspect of good medicine,” he says.

“This is our purpose,” he says. “Our work puts us in these lives, and it is a privilege. I want all of our residents to understand just how lucky we are to be a part of our patients lives.”

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Helping A Rural Community Manage Chronic Pain Medication

BY GLENN KLOTZ, MD, AND JARID ROLLINS, LCSW

Few things are as frustrating as when a chronic pain sufferer comes into the office for an early refill on their main medication. The negotiation over how much medication to refill needs to be balanced with the risk of a painful cycle of withdrawal or worse – the patient resorting to street drugs to manage their pain. Despite this frustration, listening to what your patient needs, and what fears might be constraining their choices in their community, is important to safeguarding their long-term health.

In the Roaring Fork Valley, south of Glenwood Spring, CO, our clinic, Midvalley Family Practice (MVFP) has been running an innovative program to provide more resources for people to access chronic pain management. While there are resources in the region to help, from federally qualified health centers to scholarship programs that help people identify and pay for residential treatment, a shockingly high number of residents in the area struggle with misusing substances. In one study, 31% of respondents self-reported addiction struggles, and we know that self-reported studies underreport use. Such a high addiction rate suggests that having access to services is simply not enough to address addiction in a meaningful way. More worryingly, it is strongly correlated with “deaths of despair,” which are attributable to a decline in psychosocial well-being over time. It has reached crisis levels in rural communities.

We began the pain relief group (PRG) 5 years ago as a space to listen and learn about the needs of those wrestling with chronic pain and, hopefully, find some new pathways for addressing substance misuse. In the PRG, participants learn from each other – building solidarity over a shared struggle is integral to healing both the body and the mind. An open group with long sustaining members and deep bonds, the group protects and advocates for itself in the community, with insurance companies, and in other settings where patients struggling with chronic pain need support. The PRG helps doctors as much as patients -- much like our patients struggling with chronic pain, healthcare professionals can burn out on the deaths of despair that we see affect our patients. Fortunately, the physician’s office can be the place where change begins not only for the patient but for the community.

MVFP is an integrated care clinic that serves individuals and families in the Roaring Fork Valley and serves as a key entry point in a recovery-oriented system of care. We serve a wide swath of diverse individuals, from those on Medicaid and Medicare to privately insured folks. While MVFP refers patients to many organizations for added support, we often hear them express confusion about where to seek help for themselves or family members struggling with substance use and opioid use disorder. We set out to radically change these dynamics in the Roaring Fork Valley with support from a year-long Rural Communities Opioid Response Program (RCORP) planning grant.

We wanted to bring a strategic plan to the Roaring Fork Valley about how to address the growing opioid crisis in the western
Rockies. We teamed up with regional health connectors and recruited organizations doing the work, but the centerpiece of our program is reaching individuals in the community who had struggled with addiction. The strategy of seeking those in recovery has been an incredible lesson in the power of listening and just how far off experts can be.

Concordantly, MVFP held 4 listening sessions with those in recovery to understand the needs of the community. One of the surprising results from those sessions was how misinformation amongst Latinx immigrants can lead to skepticism of addiction recovery. For years, the refrain in the RFV was that we needed more bilingual counselors to reach those seeking recovery who were limited English speakers. While this is certainly the case, many of the migrants participating told us that in some areas of Mexico people called treatment and rehab “torture,” which made them initially skeptical of seeking help for addiction.

If we hadn’t taken the time to listen to this community, we would not have known that some people faced social pressure about treating addiction – an insight that can help us design more effective interventions.

These few examples highlight a question that every provider must ask: how should I listen? Clearly, listening is important and inherent to our work helping both the individual and the community, but there are effective ways to start listening as well as systematic ways to join the qualitative and the quantitative into a coherent approach to addiction. First, establish a way of listening that you can easily adapt to different groups, from size to cultural. We used world café as it organizes discussion in small groups and encourages those less inclined to share in a large group to open up. The information gathered in these groups is then collected, categorized and studied, and sent out to create an impactful message.

Too many people in our community are unaware of how to get help, despite many providers saying they have an open-door policy for people seeking treatment. Providers need to get outside of the clinic mentality and understand that health and life goes on outside, meeting people where they are instead of waiting for them to come into clinic. In doing so, we have found new ways to provide help to our community.
As part of the CAFP Discount Program, the following companies are offering special pricing and opportunities to CAFP members.

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**FEBRUARY 27 – MARCH 1 | AUSTIN**  
Omni Austin Hotel at Southpark  
4140 Governors Row  |  Austin, Texas 78744  |  $139 per night  

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<tr>
<td>Dermatologic Procedures</td>
<td>Feb. 27-28</td>
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<td>Mastering Protocols for Optimization of HRT</td>
<td>Feb. 27-28</td>
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<td>Suturing</td>
<td>Feb. 27-28</td>
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<td>Train the Trainer—Point of Care Ultrasound</td>
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<td>Aesthetic Procedures</td>
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<td>Contraceptive, Women’s Health, and Vasectomy Procedures</td>
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<td>Hospitalist Procedures</td>
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<tr>
<td>Joint Exam and Injections with Ultrasound Guidance</td>
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**JULY 23 – 26 | HOUSTON**  
JW Marriott Houston by The Galleria  
5150 Westheimer Rd.  |  Houston, Texas 77056  |  $124 per night  

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<tr>
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<td>Joint Exam and Injections</td>
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<td>Mastering Protocols for Optimization of HRT</td>
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<td>Allergy Testing and Immunotherapy for Primary Care Physicians</td>
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<td>SMART (Sideline Management Assessment Response Techniques)</td>
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<tr>
<td>Splinting and Casting</td>
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**SEPTEMBER 17 – 20 | DALLAS**  
Marriott Dallas Las Colinas  
223 West Las Colinas Blvd.  |  Irving, Texas 75039  |  $133 per night  

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<td>Mastering Protocols for Optimization of HRT</td>
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<td>Wound Care Management and Advanced Suturing</td>
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<td>Joint Exam and Injections with Ultrasound Guidance</td>
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**DECEMBER 10 – 13 | PHOENIX**  
Hyatt Regency Phoenix  
122 North Second St.  |  Phoenix, Arizona 85004  |  $169 per night  

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<td>X-Ray Interpretation</td>
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<td>Contraceptive, Women’s Health, and Vasectomy Procedures</td>
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For complete course information and to register, go to [www.NPIInstitute.com](http://www.NPIInstitute.com) or call (866) 674-2631 today.
The CAFP would like to welcome the following new and returning members who joined our organization in September, October and November.

### WELCOME NEW MEMBERS

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<tr>
<th>ACTIVE</th>
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<td>VICTOR ADAN, MD</td>
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<td>KATE BRIDGES, MD</td>
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<td>WILLIAM COOPER, MD</td>
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<td>RYAN EICHHORN, DO</td>
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<td>PATRICK HUFFER, MD</td>
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<td>CARRIE HUTCHINSON, MD</td>
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<td>AMITY ONDERS, MD</td>
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<td>GARRETT JORDAN</td>
<td>JOSHUA WOELFLE</td>
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</table>
We help kids get back to being kids.

For children with asthma, allergies, eczema, food allergies, respiratory or pulmonary illness, hope is right here in Denver. At National Jewish Health, the nation’s leading respiratory hospital, our pediatric specialists incorporate the latest research and treatments to help kids get back to being kids. **We breathe science, so you can breathe life.**

Appointments available within 48 hours for Front Range pediatric patients. Physicians can refer patients by calling our physician line at **800.652.9555** or visiting [njhealth.org/professionals](http://njhealth.org/professionals).

**Breathing Science is Life.**

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

**Our services include:** Comprehensive food allergy testing/challenge, exercise physiology and lung function testing, genetic and immune function testing for immunodeficiency, neuropsychological testing, sleep testing.
Why COPIC

COPIC’s innovative 3Rs Program (Recognize, Respond, and Resolve) aims to preserve the physician–patient relationship when an unanticipated outcome occurs.

Unprecedented knowledge of provider and patient needs. That’s why.