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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The last 12 months have shown us record snow falls, avalanches, floods, and another disappointing end to the Broncos season, all followed by a global pandemic, an invasion of Miller moths of biblical proportions, and ongoing systemic brutality towards people of color. A good friend recently reflected on the senseless chaos we find ourselves in, “The air has a palpable anxious feel to it... People need something beautiful to happen soon!” He couldn’t be more right: people do need something beautiful to happen soon. His reflection led me to recall a quote from the movie A Beautiful Day in the Neighborhood that seemed nearly ubiquitous on social media the last few months. In the movie, Tom Hanks portrays Mister Rogers, and he says, “When I was a boy and I would see scary things in the news, my mother would say to me, ‘Look for the helpers. You will always find people who are helping.’”

As family physicians we are often those helpers – the ones running in first with our nurses and the other members of our healthcare team. Helpers are everywhere, though, and the last few months have reminded me of that. Recently, I lost track of my daughter while skiing and while we fervently searched the resort for her, a kind soul drove her back to our neighborhood and dropped her off with neighbors. The following week, a close friend asphyxiated on a piece of steak in his salad but received nearly immediate CPR from a bystander in the airport restaurant (he has recovered fully). Only a few days after that, while traveling home from Steamboat with our children, my wife came upon a young man who had flipped his car on the ice and rolled off the road. He was unscathed (his new rear-wheel drive car was totaled), and my wife gave him a ride home to the front range; due to road conditions and car trouble herself they coasted in to Walden with a dead car and ended up stranded there for 24 hours. It sounds like the start of any good horror movie, but my family and Joe became fast friends, and spent the day playing card games and survived a close encounter with a feral cat in the gas station -- and now it is one of our children’s favorite stories to share.

Other than rebuking the adage of “Don’t get in cars with strangers” these recent experiences have helped reinforce my faith in humanity.

Despite the implementation of social distancing, telemedicine and virtual visits have presented an intimate opportunity to meet with patients in their homes and their personal spaces. They have shared with me exquisite needle point quilting, a folded flag sitting on the mantle, cherished four-legged family members, and a family’s bare kitchen. We must get close, dive deep, and sometimes even get dirty if we are to wholeheartedly care for patients and allow them space to be safe – an important first step for care that allows us to begin to address the social determinants of health. These experiences have opened my eyes to a more accurate picture of my patients and their lives. We cannot care for our patients, our neighbors, and communities from afar.

These experiences opened my eyes to how much I still have to learn, even from patients whom I thought I knew quite well after a decade of care – one patient shared her passion for the bassoon (including a professional world tour 50 years ago). At the same time, I also have been allowed to see the deep wounds I would have never seen on the most thorough physical examination. I have found myself not only better understanding my patient’s life story but also becoming a better physician for them after these shared experiences.

In February of this year, Arthur Brooks PhD, a professor at the Harvard Kennedy School of Government and the Harvard Business School, said that he feels that contempt is the biggest crisis currently facing the nation. He was on to something. Regardless of cause, we have become increasingly conditioned to fear the “other” so adamantly that polarization and contempt poison our ability to disagree with each other. Brooks uses Arthur Schopenhauer’s definition of contempt as “the unsullied conviction
of the worthlessness of another” and in his research uses this contempt as the reasoning why fights and conflicts are so bitter, and cooperation seems increasingly rare and at times impossible. But there is a way out: Brooks described three steps we can take to help rid us of our current culture of contempt:

1. Love your enemies, and if you are unable to – fake it.
2. Reject contempt, and be accountable to rejecting contempt (no eye-rolling).
3. Go out looking for contempt so we can share our values.

My kids and I recently listened to a podcast discussing mollusks and pearls. In the wild, an irritant (either a grain of sand, but more often a parasitic larva) gets into the body of a mollusk. The mollusk recognizes this irritation and responds by slowly secreting a mixture of calcium carbonate and conchiolin called nacre onto the invading object. Over time, layer after layer of nacre is deposited on the irritant, entombing it. In the process, the developing pearl is rolled around in the mollusk’s body allowing a smooth and round pearl to form.

I love the visualization that the mollusk takes this invading substance and creates something beautiful and cherished. I believe that just maybe our current healthcare system is like a mollusk, and if so, I can’t wait to see the beautiful outcome from the current boulders and parasites that have invaded our ability to care for and journey alongside our patients.

The CAFP – we only exist because of you. We share your stories with our legislators, work on policies that further health care equity for all. We shout your stories from the rooftops and through every media outlet that you don’t have a mask or other basic needs to keep your team or patients safe in the midst of this pandemic. We family physicians are the answer to the inequitable healthcare system. Diverse family physicians in every community are boldly caring for Colorado. We welcome everyone’s story, we are here for you, we see you, and we hear you. Colorado is grateful for you and we are healthier because of you.

Please join me in welcoming your new CAFP Board of Directors. The new board of directors, including our new president Gina Carr, MD, who will be installed virtually on Wednesday, August 5 as 12:15 pm by AAFP President-Elect Ada Stewart, MD. I would like to personally invite everyone to join us (check your email for details). At the same event we will also be recognizing the CAFP members who have earned the degree of Fellow of the American Academy of Family Physicians.
I am retiring on Dec. 31, 2020 after 33 wonderful years with the Colorado Academy of Family Physicians.

My job with the CAFP has never been about me. It has been about elevating Family Physicians and the practice of Family Medicine. The profession is now valued and respected more than it was 33 years ago, and I hope it continues to be elevated and venerated.

We have built a great AFP chapter, and I am very proud of what we have accomplished. Our work has been strengthened because of our outstanding past and present staff – past staff Tina Disorbio, Teresa Schreiner, Angel Perez, Sarah Roth, and Lynlee Espeseth, and current staff Ryan Biehle, Erin Watwood, and Josh Foust. And of course, our fabulous lobbying team – Jeff, Wes, and Jennifer.

Family Physicians like you are compassionate, brilliant, highly educated, life-long learners, and most importantly you are so kind. Your healing abilities come partly through your ability to connect with your patients through healing relationships. You are an example for all humanity and exemplify what is great about this world. I have always considered you, Family Physicians, the Angels and Saints of this world. I have long said that you are my heroes, especially during these times of crisis.

We have also had amazing presidents. These leaders have volunteered their time to guide the CAFP and also to read the thousands of emails I have sent to them.

And board members, past and present, thank you for serving. There have been many decisions made by your board of directors that have guided our Academy. Thank you for your wisdom.

And to you our CAFP members, thank you for your support and thank you for all you do for the people of Colorado!

Thank you to my dear family and friends for your love and patience when I had meetings to attend – my son, Shane, thanks for helping set up the exhibit hall when you were only 6 years old, and later for cooking vegan meals when I had evening conference calls.

My spiritual meditation teacher, Supreme Master Ching Hai, advised that we approach our work, any job, with reverence. That has been easy to do, working with Family Physicians. You have all of my respect. You are awesome.

Thank you for a career that has filled me with passion and purpose. I thank God for the blessing and privilege of being able to serve you all of these years.

I still have work to do before I retire and look forward to training the new CAFP executive.

Thank you for all you do. May God Bless you.

May 2020 Board Meeting Highlights

The board met virtually, due to the pandemic. Here are the talking points summarizing the proceedings.

1. We know everyone is in crisis and we hear you. We are advocating for the needs of family physicians at the state level and aggregating resources to help members. One way we can help is by more fully understanding member needs, so please keep an eye out for the annual membership survey.

2. Welcome to the new members of the board. Kathleen Cowie, MD, Vivian Jiang, MD, and Michael Walery, MD, plus resident members Sydney Davis, MD, Danielle Eves, MD, Jordan Harbaugh-Williams, MD, Eric Kim, MD, PhD, and Michael Renee, DO. We also want to welcome Sam Altman as our student representative.

3. The board is continuing to recruit for an Executive Vice President to replace Raquel at the end of this year.

4. This pandemic has highlighted the affordability crisis for primary care. We are dedicating more effort toward centering primary care in policy discussions, and forming a “radical change” working group to work on structural changes that will support this change in how primary care is provided and paid for that will address the future beyond COVID-19.

We Want to Hear from You

Family Physicians face a variety of circumstances across our state, and capturing everyone’s voice is important to us. So, if your voice is not being represented in these pages, please let us know! We are open to your article ideas, pitches, and feedback at any time. We are here to serve our members and to be bold champions for Family Medicine in Colorado. Send your thoughts and ideas to Joshua Foust, Director of Communications, Marketing, and Membership: joshua@coloradoafp.org.
FAMILY LEVEL HEALING
THE FOUNDATION OF EQUINOX COUNSELING & WELLNESS CENTER

Our unparalleled commitment to delivering clinically sophisticated programs has created a new step in the continuum of mental health care. We have taken the best components of residential treatment, wilderness therapy, and holistic milieu services—providing youth and families a safe, healing, compassionate treatment experience.

Our multi-disciplinary team of clinicians, evaluators, and parent coaches help youth, young adults and families who are experiencing complex psychiatric, emotional, and behavioral health issues. These issues are often related to anxiety, depression, suicidality, and mood disorders in combination with Autism Spectrum Disorder, ADD/ADHD, and Executive Function Disorder. As Colorado’s premier transition and aftercare program, we’re passionate about delivering results to families seeking therapeutic intervention. For over 10 years, Equinox has been serving clients both regionally and nationally.

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www.EquinoxCounseling.com

The Academy’s advocacy work is often discussed in terms of our action on state legislation. To be sure, that is a substantial part of our portfolio. But the nature of CAFP advocacy is truly about something larger. It is about translating family physicians’ expertise and experience in our communities to leadership at a state level. It is about elevating and empowering our members. It is about leveraging influence to improve the health of patients.

Over the past several months, as the COVID-19 pandemic disrupted American society, our daily routines have changed but the nature of our work has not. We have felt the feebleness exposed in our healthcare system: a shortage of PPE that threatens the safety of our members and their families; a dearth of testing that has stifled our ability to fight the crisis; a system so reliant on fee-for-service that primary care practices are forced to cut salaries and lay off staff when they are needed most. A unified voice for family physicians to stand up and guide us through this crisis is more important than ever.

CAFP President John Cawley, MD, and our Board leadership led CAFP to be among the first to call on Governor Polis to issue a Stay-at-Home order as the wave of COVID cases grew in Colorado. We conveyed the message in multiple letters to the Governor, press interviews, and letters to local health departments. The order was one of the most important steps to slow the spread of the disease, and the family physician voice was integral in leading the chorus to take this difficult, but necessary action.

One of our chief concerns is the financial hardship felt by so many practices and individual members. Our Communications Director, Joshua Foust, developed a resource page on the CAFP website for members to access financial help through federal CARES Act funding. And we heard you when members told us payment for telehealth would make or break your practice’s ability to survive. We and many others pressed Medicaid to cover audio-only telehealth visits and allow Community Health and Rural Health Centers to provide telehealth services. CAFP was also tireless in urging the Division of Insurance to compel insurers to finally pay for telephone visits – crucial to advancing health equity for those without broadband or access to a smartphone. We helped draft and put our full might behind state legislation to make these telehealth policy changes permanent in the state. I am happy to report that legislators overwhelmingly supported this effort and as of this writing, it only awaits a signature from the Governor.

While the early weeks and months of the pandemic were focused on crisis response, our leaders are now looking to scale up efforts to overcome the crisis.
and emerge from it with a stronger primary care system. A workgroup of our Board is examining what critical reforms could be made in the coming months and years to realize affordable, equitable and accessible healthcare, while helping family physicians thrive. Stephanie Gold, MD, Member-at-Large on the CAFP Board, serves as our representative to the state’s Primary Care Payment Reform Collaborative, and she has continuously pushed for more investment in primary care. The Collaborative informed state regulations that were proposed in draft form just before the pandemic hit the U.S. Their adoption would result in commercial insurers investing $60 - $100 million more annually into primary care practices, while requiring a shift to 50% of payments through non-fee-for-service payment models.

We have continued to be active on the legislative front. The legislature was suspended for two months, and returned in mid-May to complete their work. The General Assembly is constitutionally obligated to pass a budget, which is their top priority. A surplus several months ago has turned into a $3.3 billion budget deficit (10% of the total state budget). Our lobby team thwarted an attempt to cut state family medicine residency funding by $4 million (50% of the state residency funding), instead mitigating the impact to a $1 million cut. Medicaid provider rates were cut by 1% across the board, a relatively positive outcome compared to the last recession when rates were cut 5%. While we cannot be happy with these outcomes, we were able to prevent the worst.

We have been a prime champion of a bill to strengthen state vaccine policies and increase vaccination rates, Senate Bill 163. The pandemic underscores both the health and economic impacts of the unchecked spread of disease. An outbreak of Measles or other vaccine-preventable disease would only compound the crisis today. The bill ultimately passed after 2 years of work. The bill is based on the principle of “equal effort” to getting a vaccine. It requires those who wish to exempt from school entry vaccine requirements to consult their physician or complete an online module on the dangers of not vaccinating prior to completing a uniform vaccine exemption form.

CAFP president, John Cawley, MD, Legislative Chairs Gina Carr, MD and Craig Anthony, MD, the CAFP Legislative Committee, CAFP Board and staff work tirelessly for our members. We will continue to do so as we all strive to overcome this difficult moment in history. We welcome you to join our Legislative Committee by reaching out directly to me. Most importantly, we would like to thank you for serving on the frontlines and giving your patients the compassionate care you provide each and every day.
CAFP ON THE GO

John Cawley, MD, FAAFP, speaks on a webinar with Colorado State Representative Yadira Caraveo.


U.S. Senator Michael Bennet meets with CAFP, AAP, ACOG and CMS about the need for financial relief to practices amid COVID-19.

Colorado Governor Jared Polis addresses the CAFP membership, with CAFP President John Cawley, MD, FAAFP, and CAFP President-elect Gina Carr, MD.
Kids are incredibly different. They need incredibly different care.

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.
Dear Colorado Family Physicians & friends,

The origins of practice-based research networks (PBRNs) lie in the recognized value of information and evidence from the field of community practices as opposed to information from the ivory tower of academic medical centers. This “sentinel” function was evident in the name of the first national PBRN, the Ambulatory Sentinel Practice Network (ASPN).

During this time of COVID-19, SNOCAP has been striving to serve that sentinel function by gathering important information on the work of our community practices, their needs and their successes. As we write this our fifth bi-weekly survey report was just released and we are distributing results to over 900 individuals including state policy makers.

You can access our full COVID-19 response information at: https://medschool.cuanschutz.edu/family-medicine/community/practice-based-research-networks/covid-work-and-resources. Briefly, we’re finding that nearly all of our practices are experiencing financial stresses at this time; ranging from layoffs and furloughs, cutting practicing days or hours, reducing staff time, and applying for grants, such as the Paycheck Protection Program and others. We have heard that many primary care practices are partnering with local public health offices, especially in rural parts of the state. While there are many notable lessons learned in these reports, our last spoiler is that nearly 98% of practices that have been responding to surveys are practicing telehealth at some level. This is a huge step from where practices were pre-COVID.

If you would like to be a part of future surveys please let us know by emailing Donald.Nease@cuanschutz.edu.

We want to highlight what is going on in some of the geographically-based PBRNs. HPRN in the eastern plains has started a weekly “HPRN NewsFlash” where they share updates from practices, share best-practices, pass along resources and materials, and highlight local stories and news articles. PEACHnet in Western Colorado is connecting with their entire list of practice and community contacts to check-in on needs and share resources as well. As PEACHnet is the newest SNOCAP PBRN, it’s great to see that they’re making so many wonderful connections during such a difficult time. Director Anne Nederveld was interviewed by a local news channel about the use of food banks during this time. (https://www.kjet8.com/content/news/570424941.html?ref=94) Lastly, in CaReNet’s San Luis Valley region, we’ve heard incredible stories of community coming together to fill in community gaps. A local group re-directed grant funds to provide food boxes for families, along with masks and hand sanitizer. They are doing what they can to interact with school children virtually, and started a virtual pen pal program between students and nursing home residents to ensure folks in care facilities have someone to talk to during this lonely time of no visitors being allowed in.

Lastly, SNOCAP partners each year with the Colorado Association of Family Medicine Residencies (CAFMR) for their annual Rocky Mountain Research Forum. This year’s forum was taken virtual, and we were happy to be included and were shocked by the turnout! SNOCAP was able to participate in judging their “Shark Tank” presentations, where resident groups share their research projects in a similar fashion to how people pitch their business ideas on the show Shark Tank. We were able to award the top three teams a prize and to thank them for their work on such incredible projects.

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: @SNOCAPbbrn
- 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
Health care is facing a continual changing environment surrounding COVID-19. As medical practices reopen, they are looking for support and information to help them navigate these changes. Below are some general guidelines and expert resources to provide assistance for physicians and medical practices during this time.

**Practice considerations**

Prior to reopening, medical practices should implement necessary steps to assure patient and staff safety. Assessing current and future PPE needs, sanitizing procedures, modifying schedules, and limiting visitors to minimizing contact are important considerations. The following are helpful links to guide a safe return:


**Patient considerations**

The practice should develop a policy for prescreening patients prior to presentation into the practice, usually through phone triage. The triage call script should include the recommendation for wearing a face mask, information on what the practice is doing to assure social distancing, and limitation of non-patient visitors when appropriate.

- In addition, providers should have knowledge of available COVID-19 testing sites in their location using available local and state public health guidance.

**Staff considerations**

Education and ongoing communication are integral to staff knowledge of changing COVID-19 recommendations to promote a safe working environment. Staff should be educated on signs and symptoms of COVID-19 and the importance of not presenting to work if signs and symptoms are present or if they have had direct contact with persons who have tested positive for COVID-19.

Staff should be screened regularly, and screening should be kept in a file separate from employee file. Office administrators should be aware of reporting requirements and the obligation to protect health care professionals during a pandemic. [www.ama-assn.org/delivering-care/ethics/obligations-protect-health-care-professionals](http://www.ama-assn.org/delivering-care/ethics/obligations-protect-health-care-professionals).

**Operational challenges**

Decreased revenue and employee costs during the pandemic has been a challenge to many practices. AMA has developed resources to help navigate workforce reduction, compensation changes, benefit modifications, and legal compliance during COVID-19. [www.ama-assn.org/delivering-care/public-health/making-tough-decisions-managing-practice-s-employee-costs](http://www.ama-assn.org/delivering-care/public-health/making-tough-decisions-managing-practice-s-employee-costs).

Please note that the information provided above was current at the time of submission of this article. Due to the ever-changing guidelines and regulations related to COVID-19 and variations on how different states are approaching this issue, please be sure to review the websites of the resources mentioned above to determine if updated information has been posted.
As communities begin to emerge from stay-at-home orders, the question of return to sports is on the minds of many. While professional and collegiate sports may take longer to resume play and allow spectators in the stands, youth sports organizations are hopeful that they may be able to lead the way in restoring a sense of normalcy to everyday life. Indeed, Mother’s Day weekend in the St. Louis area received national attention for hosting a youth baseball and softball tournament, with mixed reactions across the country. Given the unprecedented circumstances posed by the novel coronavirus pandemic, there is no definitive road map for success, but guidance is emerging to help shape the re-opening of youth sports.

Youth sports organizations and their members should be aware that information and guidelines related to COVID-19 are frequently evolving and are subject to change as we learn more about the virus. In addition, as there is not currently a cure or vaccine for COVID-19, there is no way to completely avoid risk of exposure, disease transmission, or serious illness, including death. Youth sports organizations should weigh the potential risks and benefits when considering resumption of training or competition. Risk is likely to vary by sport, related to the physical proximity of athletes and coaches, duration of close proximity, and total number of people present, so modifications to training and/or competition may need to be considered depending on local conditions and risk tolerance of the athletes and their families, as well as the organizations themselves. Coordination with public health officials is important to ensure that plans to resume participation are aligned with local public health orders, and that the local community is prepared in the event that resumption of play is accompanied by an increase in cases.

In order to resume any in-person training (even individual or small group sessions), youth sports organizations should develop protocols for screening and infection prevention measures, including a detailed cleaning and disinfecting plan. In addition, a COVID-19 response plan should be developed to ensure prompt action and communication in the event of illness or potential COVID-19 exposure. Finally, the need to gradually increase training volume and intensity should not be understated, as young athletes are vulnerable to overuse and acute injuries with return to play, especially for those who have been less physically active during the last few months.

- Additional resources related to return to sports:
  - CDC Considerations for Youth Sports
  - Aspen Institute Return to Play COVID-19 Risk Assessment Tool

Preventing to Return to Sports – Sports Physicals during and after COVID-19

There has been much discussion on a local, regional and national level regarding sports pre-participation physical evaluations (PPEs) and considerations around COVID-19. The National Federation of State High School Associations (NFHS) recently released a statement on PPE recommendations in the midst of COVID-19. The NFHS stated that there is increased concern with access to primary care providers (PCPs) and ability to obtain the required sports PPE to participate in sports during the upcoming 2020-21 academic year. Therefore, this unprecedented event allows for state associations to be flexible in their current requirements, while maintaining a balance among student safety, the benefits of athletic participation, and the burden on local PCPs. The NFHS went on to recommend, if needed, a one-year extension for any student who has a sports PPE that “expires” before or during the 2020-21 academic year.

The Sports Medicine Center at CHCO worked together with our Physicians Relations team to send out a survey to our Colorado PCPs for feedback on this topic. The survey was sent to PCPs in Northern Colorado, West Denver, South Denver and Denver Metro. Out of the 145 respondents, > 99% (144) reported that sports PPEs should be performed annually and in the medical home during this time. This feedback was vital during our discussion in the Colorado High School Activities Association (CHSAA) Sports Medicine Advisory Committee meeting regarding possible sports PPE extension in the state of Colorado. CHSAA will be upholding their bylaw to mandate the annual sports PPE this year. The Sports Medicine Center at CHCO believes the medical home is the more appropriate sports PPE setting to manage mental health issues, possible cardiac and/or pulmonary...
conditions that may arise after COVID-19 and many other aspects of adolescent care. CHSAA will also be recommending that young athletes have their sports PPEs performed in their medical home. CHSAA will not accept sports PPEs performed via telehealth or other forms of virtual visits during the COVID-19 pandemic.

During the CHSAA Sports Medicine Advisory Committee meeting, some concerns were raised regarding athletes that do not have an established PCP or do not have health insurance and rely on annual mass sports physicals. Those individuals without PCPs will be encouraged to establish PCPs. CHSAA plans to release guidelines on holding limited sports PPEs in high schools that are in accordance with state and local guidelines on social distancing for those athletes with access issues. Mass physicals will be discouraged and we hope this continues after COVID-19 as we prefer young athletes see their PCPs annually for well-child care visits and sport PPEs.

Although we are still learning about the potential complications following COVID-19 infection, there are initial recommendations related to cardiac screening prior to return to sports, published recently in the British Journal of Sports Medicine and by the American College of Cardiology. These recommendations are based on expert opinion and will need to be validated by future research, but are important for primary care providers to be aware of when providing care for young athletes, whether related to acute illness or sports PPE.

References:

COLORADO PODIATRIC MEDICAL ASSN. DBA
COLORADO FOOT & ANKLE SOCIETY

SCOPE OF PRACTICE:
• Diagnosis and Treatment of Sports injuries of the Foot and Ankle
• Surgical and Conservative Treatment of Chronic Foot and Ankle Pathology such as arthritis
• Surgical Corrections: fractures, reconstructions, bunions, hammertoes, flatfeet, total ankle replacements, etc.
• Management of Acute Infections: toenails, puncture wounds
• Treatment of diabetic foot conditions
• Diagnosis and Treatment of foot and ankle skin pathology

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

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

CONTACT:
To locate a podiatrist close to you: call 303-881-8837, or email colofas@gmail.com. Web site: www.colopma.org

For additional COVID-19 provider resources visit childrenscolorado.org/covid19
The Scope of Physician Cybersecurity

Imagine getting an email from a colleague with a hyperlink to a website. It isn’t clear what the link is, but you think, we are colleagues, so it’s probably important. So, you click on the link and read, but something feels off. The website seems amateur, filled with banner ads and popups, and the content isn’t relevant to your work. You close the tab and go on with your day.

But soon, you notice patient records have odd access dates, unrelated to their visits to the office. You start to see a flood of spam emails coming into your account, and your financial records show some unusual transactions. Soon, accounts start to get locked, and you ask your IT services provider to help fix your system. They tell you that you have been attacked.

This is a scenario that happens to hundreds of physicians every month. It is called phishing, and it is the most common form of cybersecurity attack in the world. In a phishing attack, a malicious entity pretends to be an organization or a help desk. When a specific identity (someone trusted – a colleague, supervisor, family member, or friend) is being impersonated, the attack is called spear phishing. Either way, the goal is to get the target to click on a link, or open an attachment that will install malicious code on a computer and compromise it for further exploitation.

Depending on how a clinic is linked together, a single computer compromise can allow personal information (such as dates of birth or social security numbers), or even financial records to be “skimmed” for use by the attacker. In 2019, the FBI and Department of Homeland Security warned that this style of attack was growing in frequency and represented potentially billions of dollars of losses for organizations. Or, it can be used to inject ransomware onto the office computer network, whereby a malicious piece of code encrypts a computer system and will only allow access to data once a ransom is paid. In the 21st century, healthcare providers must navigate a tricky dilemma. The rise of electronic records and electronic transactions, as well as Internet-of-Things (IoT) devices, which do everything from continuous glucose monitoring to daily step tracking, have created an enormous amount of data that help doctors diagnose and treat patients. But this rise has also created new vulnerabilities that leave offices more vulnerable to attack than when files were kept on physical pieces of paper.

The COVID-19 crisis has exacerbated this dilemma. Family physicians have embraced telehealth to continue seeing patients during restrictive stay-at-home orders, and government agencies like CMS have granted technical exemptions to allow physicians to rapidly pivot to providing health visits remotely. While this has provided immediate relief for physicians, it has created a new kind of technological vulnerability that doctors must navigate to stay secure.

The result is that physicians have access to an astonishing amount of data about their patients, and more is available seemingly every month, yet it isn’t always clear how that data can be secured. There is a clear need for physicians to treat cybersecurity of their offices seriously.

A Culture of Security

The highest cybersecurity risk facing any organization is human, not any technology. The reason why phishing is such a common method of attack is that it doesn’t rely on an unsecured device to work. Phishing uses a technique called social engineering, which exploits our instincts to be open and helpful to colleagues, to gain illicit access to computers. The good news for physicians is that this means there is no pressing need to stay at the cutting edge of a technological arms race to secure every device from every attack. Instead, building a culture of security is the best way to mitigate and minimize the risk a practice’s computer systems face.

Attackers can attack anyone in an organization – not only the physicians, but also the nurses and staff. It can send attacks to the office, but also to home computers and to mobile phones. Android phone users are particularly vulnerable. According to a November 2019 story in Wired, 29 Android phone makers shipped phones with 146 known vulnerabilities in the previous year. iPhone users also face vulnerabilities, but at a smaller scale.

Cybersecurity has “expanded the scope of patient wellness to include protecting technology, networks, and databases that enable uninterrupted and accurate patient care. This includes securing computer systems, protecting data, and training personnel to be cyber-vigilant,” according to an HHS report on healthcare industry best practices. This means everyone who works in healthcare should take cybersecurity seriously, and it should be reflected in the culture of your office.

Building a culture of security starts with building awareness and training. Just as we have evolved building security to include number pads at the door, webcams, and automated security systems, cybersecurity is a process – not a one-off event. While building strong security practices can feel overwhelming, the mindset with which we approach security can put much of the problem into focus and make it feel manageable.

Perform a Security Audit

Start by taking a baseline audit of your current systems:

- Who owns your data?
- Do you store data locally or in the cloud?
- Are your data encrypted? If so, who has the keys? If not, who knows where it is stored?
- How often do you verify it is intact and haven’t accessed improperly?
- Consider how you back up data – is the backup medium HIPAA compliant?
- Is it on-site or off-site (off-site is far more secure)?
- Do you regularly update your computer operating system, firewall, antivirus, and phone? Nearly 34% of all system breaches happen because software was never updated. Start patching your software now, and you won’t regret it later.
Just by taking that baseline, you might notice some areas where you can improve security. Try to pick the top three and start working your way through them. This can be a time-consuming process, but it is worthwhile to know where and how protected your data are.

Create Better Password and Email Habits

Once you have a security baseline, think about how you and your colleagues interact with your computers. We all use passwords to access systems, databases, programs, or websites. But keeping those passwords secure requires a bit of planning.

• Think about your password “hygiene,” or how easy it is to guess. Policies that require constant password updates can, paradoxically, make a system less secure as people create easier-to-remember passwords to keep up. Instead, use a password manager to generate strong passwords for applications, systems, and accounts.
• If you combine a password manager with two-factor authentication, the password manager makes passwords impossible to guess, and two-factor authentication prevents a malicious actor that learns the password from breaching the system.

Let’s return to the scenario from the top of this article. You have probably received an unusual email address next to a familiar name, a strange domain name, misspellings, or unusual icons. This is a familiar name, a strange domain name, received an unusual email address next to the top of this article. You have probably noticed some areas where you can improve security. Try to pick the top three and start working your way through them. This can be a time-consuming process, but it is worthwhile to know where and how protected your data are.

Have a Plan

Do you have a fire or flood insurance and response plan? Statistically, you are more likely to face a cybersecurity breach than a fire or flood – so take it as seriously as you do physical damage to your office. Creating a plan now allows for a rapid response later – you do not want to be thinking through how best to mitigate a cybersecurity breach on the fly. You need to have a response plan for cybersecurity breaches. The FCC has created a tool to help organizations address specific needs – use it as an inspiration.

Define Terms

Do you know the difference between an incident and a breach? The difference matters in terms of what response is necessary. Think through what sorts of attacks you might face, and how that can affect the response you plan. A stolen password might be more important than a stolen credit card, depending on how each is used – this is why that baseline audit is so important in developing the knowledge of what is at risk and what is not.

A Response Workflow

Once you have an idea of what an incident looks like, you need to be able to detect one when it happens. This can be through regular monitoring, integrity checks, or having a program scan your systems to see if there is unexpected activity. Most smaller clinics don’t have the resources for this, so explore an IT services company that offers security checks.

Next up, identify which roles need to be filled, and who has the responsibility for achieving the plan. There is probably a role for who communicates with law enforcement and vendors, for someone managing patient relations, plus public relations, mitigation, and so on. Be as thorough as you like, and you should print the response plan and store it in a binder, so you aren’t locked out of it during a security breach.

There are two final considerations in the response plan: reporting and reflection. There can be different reporting requirements for an incident as compared to a breach – HHS considers a ransomware attack as a presumptive breach with HIPAA implications. Consult with a lawyer to ensure you are meeting mandatory reporting requirements.

Reflection after the incident is important, too. Many of the procedures and policies mentioned above are straightforward to implement and will protect against most forms of attack, but they are not bulletproof. Something will eventually go wrong – after all, humans are the weakest part of any security system. We will always be able to find ways to refine and improve our behavior in ways that minimize risk and understanding what went wrong will let you learn lessons to ensure it won’t happen again.

Don’t Delay – Take Security Seriously Now

Cybersecurity is a complicated challenge, but it is also one we are all equipped to meet. Most attacks are not technologically sophisticated, they just take advantage of common psychological shortcuts. By updating our understanding of those shortcuts, and how we relate to the computers we use daily, we can take concrete measures to lower our risk and mitigate the effect of a potential attack.

Endnotes

5. https://www.fcc.gov/cyber planner
Kids will spend 13 minutes watching gerbils ride a train. How about two minutes to brush their teeth?

Brushing for two minutes now can save your child from severe tooth pain later. Two minutes, twice a day. They have the time. For fun, 2-minute videos to watch while brushing, go to 2min2x.org.
ANNUAL REPORT
COLORADO ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR COLORADO
2019
2019 WAS A BANNER YEAR

The Colorado Academy of Family Physicians continues to be a strong organization representing family physicians through educations, advocacy, practice development, as well as championing both health of the public and the physician.

In 2019, healthcare took center stage in Colorado. Building on decades of work, the CAFP has been working with legislators to highlight comprehensive, high-quality family medicine as the foundation of healthcare. Countless research studies and demonstration projects showed that with a strong, well-funded primary care force people are healthier and total healthcare costs much less. The Primary Care Investment Legislation was signed into law in May, and since then we have been working with the state on implementation.

Partnering with the Colorado Trial Lawyers Association, we led legislation that provided an alternative resolution to malpractice litigation—it passed both the Colorado House and Senate unanimously. We were also able to extend funding for the Rural Preceptor Tax Credit program and protect the confidential peer review process. This year’s Doctor of the Day program had the most participation that we’ve ever seen and remains a lauded service that we provide to legislators and staffers.

The Annual Summit moved from Colorado Springs and started its journey around the state in Fort Collins, where we had record attendance and participation. We partnered with My Green Doctor, a free program for you to combat environmental health disparities by adding environmental sustainability to our practices.

Nationally, CAFP worked with family physicians by helping them to champion Primary Care. We collaboratively worked with several other organizations to find lasting solutions to curb the epidemic of firearm violence. We also worked on GME reform, including the development of Teaching Health Centers.

Lastly, our beloved CEO, Raquel Alexander, announced that after 33 years at the helm of our academy she will be retiring at the end of 2020. We had planned a time to celebrate her at the 2020 Annual Summit; however, as it was cancelled, we are working on other plans to celebrate her and her amazing leadership. The CAFP board is currently conducting a national search for a new Executive Vice President to lead the Academy.

I would personally like to thank every member of the CAFP as well as all of the CAFP board members and staff. Your continued support of the Academy’s efforts is a tremendous investment in the future of Family Medicine and frankly in the future of our nation's health care system success.

John Cawley, MD, FAAFP

MORE INFO: HTTP://WWW.COLORADOAFP.ORG
CAFP continues to be financially stable by prioritizing socially responsible investments. In 2019, we reallocated some short-term and long-term funds into intermediate-term for increased flexibility, staying within budget.

CAFP ASSETS AS OF DECEMBER 31, 2019

TOTAL INCOME: $622,407
TOTAL EXPENSES: $612,710
NET ORDINARY INCOME: $9,698

(RIGHT) CAFP leaders gathered in Washington, D.C. for the AAFP’s Family Medicine Advocacy Summit.
Our goal is to be your “bold champion” during the unprecedented challenges facing Family Medicine. Through advocacy to advance Family Medicine at the state capitol, plus education, events, and training, we work every day to represent you.

2,632 TOTAL MEMBERS

ACTIVE ..........1,635
RESIDENT ...273
STUDENT ......474
LIFE .............208
SUPPORTING ....3
INACTIVE .......36
TRANSITIONAL ..3
YOUR VOICE MATTERS

Family Physicians have a powerful voice, and 2019 showed what we can accomplish by speaking out. Every bill CAFP members testified for was passed into law.

Through dozens of meetings with healthcare organizations, testifying before the state legislature, hundreds of letters, plus op-eds, and letters to the editor, family physicians made enormous strides in 2019 toward making Family Medicine more affordable, more equitable, and more accessible for all Coloradoans.

OUR SUCCESSES

CAFP leadership led to the passage of 3 bills that support and enhance primary care:

• HB-1233 Primary Care Investment
• HB-1088 Rural Preceptor Tax Credit
• SB-201 Candor Act

CAFP advocacy also led to the passage of bills to regulate vaping and continue professional review. Almost 150 Members took action, writing over 230 letters to legislators. Our leadership was endorsed by 23 other healthcare organizations.

Your continued membership makes this success possible. Thank you!
CAFP Board Member Melissa Devalon, MD testifying on the Medical Practice Act in Colorado.

Members of CAFP’s Executive Committee met with Congressman Ken Buck to discuss healthcare issues.

CAFP leadership attended the Western States Forum during the AAFP’s Congress of Delegates.
Doctor of the Day

is our unique volunteer opportunity with state lawmakers to highlight what family physicians are all about. In 2019, volunteers spent 45 days educating and serving legislators, their staff, and visitors.

CRAIG ANTHONY, MD
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CLAIRE BOVET, MD
TEDDY BROSS, MD
MARCUS BUTTON, MD
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BARRY SUNDLAND, MD, FAAFP
ALAN-MICHAEL VARGAS, MD, FAAFP
ELISE YERELIAN, MD

“During the session, legislators and staff are working long and unpredictable hours, so when people get sick it’s often difficult to be able to visit a regular physician. We are grateful to have a Doctor of the Day on hand to visit and prescribe medications when needed, so that we can get back to good health and back to work quickly. The Doctor of the Day program is a helpful resource for the legislature, and we appreciate the efforts of the Colorado Academy of Family Physicians and the doctors who participate to make it possible.”

- Former Speaker of the House of Representatives Crisanta Duran.
Students who participated in the CAFP’s Stop & Imagine program (TOP), which works to educate Colorado’s youth in preventing marijuana use, made their own marijuana prevention posters after hearing from family physicians.

In the summer of 2019, CAFP staff went on a Rural Road Trip to visit with members across the western half of the state (LEFT). Beyond the joy we felt at getting to know some of you better, we also learned a lot about the challenges you face.

CAFP values our members, and hearing from you informs how we engage in advocacy, education, and planning. This trip reaffirmed our belief that family physicians are uniquely qualified to care for communities, and we will continue to center that message in our discussions with legislators, organizations, as well as patients.
Every year, CAFP celebrates its members who exemplify the transformative power of family medicine to improve the lives of their patients and communities. In 2019, we identified three physicians who live the values of family medicine. Claire Bovet, MD (LEFT) was named Family Medicine Resident of the Year. Katheryn Boyd-Trull, MD (CENTER) was named Family Medicine Teacher of the Year. And Glenn Kotz, MD (RIGHT) was named Family Physician of the Year. We are so proud of our members, their compassion, and their dedication to serving their communities. Thank you!

The 2019 Annual Summit, hosted at the Hilton Ft. Collins, was a roaring success, bringing together physicians, residents, and students to learn, network, and enjoy time among colleagues. The theme this year was First Place to Family Medicine, and had a Kentucky Derby style. Thank you to all who attended!
Education is a core function of CAFP. Through the annual summit, KSAs, and countless CME opportunities, we are dedicated to helping family physicians engage with the latest research and enhance their skills as doctors.

We also support doctors engaging with the broader policy and medical community. In 2019, CAFP members attended the AAFP’s Family Medicine Advocacy Summit in Washington D.C. (TOP LEFT), where they met with legislators and learned how to become powerful advocates for family medicine. Closer to home, the CAFP presented to the Swedish Family Medicine Residency in Englewood on membership and the work of the Academy (TOP RIGHT) to better engage with our resident members. Colorado leaders, staff and Delegates attended dinner together during AAFP’s Annual Chapter Leader Forum / National Conference of Constituency Leaders (BOTTOM LEFT).

Finally, the University of Colorado School of Medicine Family Medicine Interest Group was recognized by the AAFP for the 2019 Program of Excellence Award for their exemplary efforts to grow and support interest in family medicine.

Learn more at our website: http://www.coloradoafp.org.
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Securing PPE

• The local Office of Emergency Management (OEM) is the central clearing house for gauging need and directing state resources to assist with procurement. Find a list of OEMs throughout the state here: https://www.colorado.gov/pacific/dhsem/local-emergency-managers.

• To apply for pre-vetted PPE vendors on the Colorado marketplace, visit this website: https://energize-colorado.com/get-ppe-and-supplies/.

• There are two mask decontamination centers – one in the Brighton area and one in the Montrose area. Fill out an enrollment form here: https://www.battelle.org/inb/battelle-critical-care-decontamination-system-for-covid19.

Telemedicine

• The AAFP has created a detailed telemedicine resource page that has CMS guidance, toolkits, vendors, and billing codes. You can find that here: https://www.aafp.org/patient-care/emergency/2019-coronavirus/telehealth.html.


Practice Help


• Ariadne Labs has issued a toolkit for managing serious illness while remaining safeguarded from COVID-19: https://covid19.ariadnelabs.org/serious-illness-care-program-covid-19-response-toolkit/

• The CARES Act created assistance programs for individuals and businesses during the pandemic. Michael Best has posted a resource page for navigating this assistance: https://www.michaelbest.com/Practices/CARES-Act-Relief-Resource-Center.

• COVID-19 Just-in-Time ECHO for Primary Care: https://project-core.echolorado.org/Series/Registration/258.
Are You Being Social, on Social Media?

As the COVID-19 pandemic drags on and we continue to substantially limit our in-person contact with others, it is natural to gravitate to social media as a way to feel connection and agency. In fact, social media can be a powerful tool for physicians to urge healthy choices and promote public health. Here are some tips for how physicians can use social media effectively.

Basic Principles
Social media is fun and empowering, but it has some downsides. It is a public forum, so everything you post online, even if it’s “private,” can be made public eventually (so do not post any HIPAA information, ever!). Be wary of trolls, or people who intentionally post provocative comments to elicit a strong reaction. Try not to engage too often with marketing disguised as user feedback, and understand that bots, which are automated programs that mimic human behavior, can sometimes disrupt conversations. Check on your followers from time to time to make sure you aren’t being flooded with these nuisance accounts.

Be social
The “social” part of social media isn’t empty phrasing. The entire point of social media is to relate to others, preferably of like-minds, and to form a community. Social scientists have found that when in-person contact is limited, many people experience stronger friendships with online friends than people they know in real life. Use this to your advantage!

Being social means being friendly. Most people tend to form relationships online with those who are like themselves, whether in terms of temperament, interests, hobbies, or knowledge – try to incorporate that principle into how you form relationships online. It is a bad idea to follow people you disagree with, especially the trolls, as this can quickly escalate. No one likes being around an argumentative person in real life – the same principle applies to Twitter.

Understand the Networks
Different social media networks are best used for different things.
- **Twitter.** This isn’t the largest social media network, but it can easily be the most impactful. Twitter is where journalists live, and there is a thriving community of people participating in the public discourse on public health and other healthcare-related issues.
- **Facebook.** The most popular social networking site in the world. While Facebook has robust advertising tools for clinics and practices looking to grow, the best usage for individuals is personal and focused on friends and family.
- **LinkedIn.** Think of it as Facebook-for-work. LinkedIn is how you can strengthen connections with peers and connect through professional meetings. Try not to accept friend requests from people you don’t recognize – it can quickly lead to a flood of unwelcome messages from recruiters.
- **Instagram.** This service, which is wholly owned by and increasingly integrated into Facebook, is a visual medium focused around sharing photographs and graphics. With a large user base rivaling Facebook’s, it promises vast reach as a marketing tool.
- **Sermo.** Sermo is one of a family of physician-focused social networking tools. A private network with a miniscule membership (around 550,000), it requires proof of an MD or DO degree in order to join. It functions as a discussion board where physicians meet and debate healthcare topics.

Everything Is Marketing
Social media companies use high-minded language to describe themselves, but they are all oriented around a single purpose: serving advertisements. Some do this by selling metrics to firms based on user behavior and some offer direct access to users based on keywords, but the goal is the same: selling ads.

Physicians can use this to their advantage by bringing knowledge, empathy, and experience to a public debate. Because social networks grow their ad revenue by encouraging user interaction, users that have a lot of conversations can build influence. The downside to this is that argument is more reliable engagement than enlightened discourse – a painful lesson that is better to learn now before you wind up in the center of a spiraling outrage storm.

This also means that physicians can use social media to promote their businesses and improve their standing in search engines. The process of using social media in this way is called online reputation management, and it is a project CAFP takes seriously. Stay tuned for more material on this front later in the year.

Have Fun
Despite all the warnings, social media is fun. It is a powerful information service, and you will meet people you enjoy and relate to when you start to use it. Just remember that you are communicating publicly, and it will quickly turn into an enjoyable, empowering experience that enhances your personal and professional life.
Toward a Vaccine for SARS-CoV-2: What Are the Challenges?

To date, expert sources, both official and unofficial, have offered a bewildering array of conflicting explanations for the virology, pathophysiology, and epidemiology of SARS-CoV-2, the virus that causes CoVID-19. Recommendations for clinical management and public health control measures have likewise been anything but unanimous. None of us have seen anything close to this in our lifetimes. Our experiences with influenza, measles, hantavirus, Ebola virus, SARS, and MERS are not much help in guiding a response. SARS-CoV-2 is, indeed, novel and required us and our patients to do many “things” we have not done before.

Yet one refrain is heard consistently throughout: “We must do all these “things” until we get a vaccine.” Until we get a vaccine. You can hear the implied messages: We MUST have the vaccine; we WILL have the vaccine.” Yet, the truth is getting the vaccine will be difficult and will take time.

While SARS-CoV-2 vaccine development is moving much faster than we consider “normal,” it understandably seems slow to those who are on the front lines fighting the pandemic epidemiologically and clinically.

In this brief article, we will not try to deal with the politics nor the logistics of large-scale vaccine manufacture, distribution, and prioritization – nor its acceptance by a sometimes-suspicious public. We will simply list the major hurdles that lie between “we need this” and “we have one.”

Four “immunologic approaches” to vaccines for SARS-CoV-2 have, to date, reached the stage of trials in humans. A review in the New England Journal of Medicine (tinyurl.com/sntcz4e) has further details, including a table that shows the approaches currently in process.

To be useful, a vaccine must first be shown to be safe, then to be immunogenic, and then to be effective. Each hurdle can be understood as a barrier to one of these three goals.

In the case of SARS-CoV-2, clearly, we face two of the familiar safety priorities as with any vaccine: the product must not cause an intolerable level of adverse effects, and it must not cause the disease that it is trying to prevent.

The first hurdle is depicted in the 1999 rotavirus vaccine, and the second hurdle was dramatized by the Cutter polio vaccine incident in the 1950s. Fortunately, none of the four SARS-CoV-2 approaches uses live coronavirus, so getting CoVID from the vaccine will not be an issue.

However, SARS-CoV-2 vaccine faces an additional safety issue: the vaccine must not cause an overreaction by the immune system that will make the patient just as sick, if not sicker, than a CoVID-19 infection. In its most severe form, immune system overreaction is known as a “cytokine storm” (see tinyurl.com/rgskrdb). Because this phenomenon has caused some of the more deadly complications of CoVID-19, it is something to watch out for in vaccine recipients.

Immunogenicity per se is probably the least formidable barrier to a vaccine, because many possible candidate preparations can be tested in the laboratory simultaneously, both in vitro and in animals. Those showing promise can be moved ahead to clinical trials.

Efficacy is, as always, a more difficult challenge. In the case of CoVID-19, the picture is complicated because the facts about how an individual’s immune system responds to this virus, over time, are still emerging. Will antibody from a first infection protect against a subsequent infection? And if so, for how long? If natural infection with the virus does not render long term immunity, we can scarcely expect a vaccine to do so.
Further, we know that many “strains” of SARS-CoV-2 have been identified (see tinyurl.com/tljvajqm). The key question is, do these “different strains” behave essentially as one in terms of immunity for the patient (like measles)? If so, strain identification may be useful for tracing patterns of spread of the virus but will not help assess susceptibility for the patient.

But what if this virus is more like influenza? What if infection with one strain gives limited and inconsistent protection against others? Can you imagine trying to come up with a new coronavirus vaccine every year, trying to stay ahead of mutations and strain changes?

Finally, a vaccine must undergo the rigors of phase 3 testing (see tinyurl.com/7ovbxrww for a review of the stages of clinical trials). The immunization must be carefully evaluated for possible uncommon side effects. Efficacy must be assessed in a large sample people of varying ages and conditions – over about a year – to show results that will predict performance after marketing and distribution.

This timeline cannot be safely collapsed. This is why we have to continue the uncertain combination of social distancing, telemedicine, testing, contact tracing, and trials of treatment regimens for CoVID-19 for at least this year and next.

In the meantime, we all hope and pray that if we do see an encouraging downslope of the epidemic curve this summer, the virus does not adopt an influenza-like seasonal pattern and come back with a vengeance in the fall.

The good news is that researchers around the world are moving quickly to meet these challenges, and if past successes against emerging pathogens is any indication, we will come up with the tools to neutralize this virus as well. In the meantime, we are confident that the family medicine community will do its part to keep itself, its colleagues and coworkers, its patients, and our communities as safe and healthy as possible.

Survey: 84% of adults see childhood vaccinations as vital

In a 2019 Gallup survey, only 84% of adults rated having their children vaccinated as “extremely important” or “very important”, compared with 94% in 2001. Madalyn Schaeften, MD, a 2019-2020 AAFP Vaccine Science Fellow, describes her strategy for talking with patients about vaccinating children as presenting facts simply and positively.
< Continuing from Page 37

She “let the parents know that I believe in the vaccines and that I have given them to my children because I know that they are the best way that I can protect them from serious harm” (more details at tinyurl.com/yblaxf5v).

Many young children not getting timely immunizations

Parents of 37% of children ages 19 months to 35 months do not follow the recommended schedule of the CDC Advisory Committee on Immunization Practices (ACIP), but rather go by “alternate” or “unknown” immunization schedules for their children. Fewer than 60% were up-to-date on all vaccines recommended by the ACIP, according to a study in Pediatrics (tinyurl.com/y7af3m9r or tinyurl.com/yavp94nn).

Pregnant women on Medicaid less likely to receive recommended vaccinations

Pregnant Medicaid patients are far less likely to receive the vaccines recommended to protect them and their babies compared to those with private coverage based upon vaccination data from 341 adult women. The study found 68.6% of pregnant women with private insurance received Tdap compared to just 13.4% of those on Medicaid. In addition, 70.4% of pregnant women with private insurance received an influenza vaccine, versus about half that number on Medicaid. The study was published online in the CDC’s Morbidity and Mortality Weekly Report (https://tinyurl.com/yapzjd26).

Public trusts health care professionals for health info

Ninety percent of New Jersey residents responding to a survey said they prefer seeking health information from a physician, compared to 80% who seek information from nurses, 70% from family, friends, and websites, and about 33% seek information from television, a newspaper, or the radio. A surprise to us was that only about 20% reported using social media for health-related information. Of course, seeking information from a source does not always indicate trust. This study found that for those seeking information from doctors and nurses have 90% confidence in that information, while only 10% are confident in information from social media (tinyurl.com/y7y97vgm).

About 75% of parents want restrictions on unvaccinated patients in their doctor’s office

According to a Newsweek report, “Almost three-quarters of parents want their child's doctor to place restrictions on unvaccinated patients from visiting their office, according to research.” The article added, “A nationally representative total of 2,032 parents with at least one child aged between 0 to 18 filled out the C.S. Mott Children's Hospital National Poll on Children’s Health,” which found that “28 percent of parents said the doctor's office should ask the parents of unvaccinated children to find them another healthcare provider.” Additionally, 41% of the parents reported being “somewhat likely” or “very likely” to switch physicians if their children’s physician attended to youths whose parents refused all vaccinations. Another 30% said their physician should reject treatment for children of vaccine-refusing parents, while 43% wanted to know if patients at their physician's office had not received any childhood vaccinations (tinyurl.com/y78pc8cf and tinyurl.com/yatmeh4t).
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As family medicine looks to a future filled with uncertainty over unemployment, and underinsured patients, the importance of cost is only going to grow. A recent wellness visit for a new patient highlighted many of these challenges and pointed to a worrying gap affecting how vulnerable members of our communities can access care.

When seeing a patient, first impressions can tell a lot. This patient, whom I shall call Alice to protect her privacy, was small—her medical record showed she was barely 5 feet tall—and looked frail. She sat in one of two chairs in the consulting room and smiled as I entered. I smiled back as I sat on the stool provided for my use and asked her how I could help.

Alice seemed cautious as she produced a list of her concerns, and as she spoke, I could hear her wheezing from across the room.

As I began the checkup, Alice walked me through the challenges she faced. She had an ache in her lower abdomen and had some discomfort every time she passed urine. The sole of her left foot was painful, which she claimed was caused by a callus, and she wanted a referral to a podiatrist. Despite the painful callus, she said she wanted a prescription for diabetic shoes (her previous pair was so ill-fitting it caused her pain, so she had stopped wearing them).

It struck me that she must have had difficulty hearing, as sometimes she would continue talking about a topic even when I asked her a question. She had me repeat my questions multiple times.

As I performed the examination, I noticed a number of red flags. In the three months since her last office visit, Alice had briefly stopped taking Glipizide for Type 2 Diabetes—an effort to manage side effects that made her blood glucose soar. After one and a half weeks she was taking it again but unsure whether it was okay or not. Furthermore, her wheezing was noticeable, but she never drew attention to it, even though there were other symptoms she was up front about discussing.

I saw she had hypertension and her blood pressure was elevated in the office that day, but she did not mention either issue on her list of issues to take care of. The wheezing suggested to me a struggle with asthma, but Alice did not once bring it up. I carried out some office tests and labs which showed old ECG changes and confirmation that she had a UTI. I also found an undiagnosed heart murmur and a mild loss of sensation in her feet.

Alice and I needed to discuss how to manage these issues. I referred her to a podiatrist to have the callous removed and ordered her new diabetic shoes. We spoke about her cardiac murmur—she had not wanted to address her full suite of symptoms, especially if it involved paying for medication. We spoke about her hearing loss—she had wanted to investigate.
further, but she declined as she was “feeling fine.” She wanted to refill her diabetic medications, but worried about the cost of treating her UTI and hypertension. After learning of the additional risk posed by her diabetes, she agreed to treat the hypertension.

One reason I could get her to treat those issues was cost -- she could probably get the antibiotic and antihypertensive prescriptions for about $4.00 each. But other conditions were not as easy to address -- over the course of her hourlong visit, she repeatedly referenced the cost of medication as a reason why she either did not want to or was hesitant to refill medication.

This concern over cost meant Alice suffered with constant wheezing – I saw a reference to Ventolin in her record, but she said she could not afford its cost. “It’s been a while,” she told me, since she had directly treated the wheezing, but said she preferred to take her chances and hope the symptoms would resolve on their own.

My clinic happens to be next door to a pharmacy, so I paused Alice’s visit to go talk with them. They could get her generic Albuterol at a cost of $23 and Flovent HFA for $31. Back in the exam room, Alice said she could afford that, so I wrote her prescriptions for both.

If only it were this easy. Alice’s insurance denied the Flovent HFA but offered to cover the powder form (Diskus) instead. I relented and changed the prescription, but the visit has bothered me ever since.

Alice’s visit is not an uncommon one, especially for physicians who see a higher number of patients with limited income. When people should be easing gently into what are likely to be the twilight years, they are also more likely to be thinking about the health costs associated with living day to day.

There is absolutely no reason why anyone should have to forego a medication because they cannot afford it. I know that medication can be made more affordable than they currently are – the same companies make the same drugs overseas for far less than what they charge here. I can see the commercial desire to make a large profit off of these drugs – they are expensive to create and test, and are not free to manufacture.

But then I look back to Alice, and how she suffered through unnecessary pain because of that price structure. I cannot see a moral reason to impose that suffering on someone who just wants to walk down the street without agony or wheezing. As a physician, it pains me to see our healthcare system so unwilling to serve patients, choosing instead to serve corporate boardrooms. We need to be better about addressing primary care’s affordability crisis – it’s the best way to safeguard our patients.

Francis Thompson, MD is a practicing Family Physician and has recently served as the Medical Director of a large Correctional Facility in Colorado. He practiced obstetrics/gynecology and family medicine in the U.K. for several years and served as Associate Faculty for a Family Medicine Residency Program.

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Jeffrey Cain, MD, FAAP, did not start his career planning to fund a family medicine resident scholarship. “But looking back, I had always wanted to connect students and residents with each other,” he says. “And, to connect them to the values of family medicine.”

When Dr. Cain was a second-year family medicine resident at the Mercy Family Medicine Residency Program in Denver, he received an unexpected scholarship to the American Academy of Family Physicians National Conference of Students and Residents. “The Academy wasn’t really on my radar at the time,” he says, “but the scholarship came with a plane ticket and a hotel and I thought I’d check it out.”

The conference inspired him. “Dr. Rick Richards gave a talk about how the tobacco industry was using sophisticated advertising to target and hook the very kids that I was seeing in my clinic. And just as importantly, how family physicians could work together to help prevent it. Hearing him speak about the power of family physicians engaging in advocacy really fired me up. I wanted to take action.”

When he got home from the National Conference, Dr. Cain reached out to the Hall of Life at the Denver Museum of Natural History and helped co-create the Tar Wars program, a comprehensive tobacco prevention education program for 4th and 5th graders. Since then, Tar Wars has grown through the leadership of the CAFP and the AAFP to over 50 states and has reached over 10 million children.

“Through our Tar Wars collaboration with the Colorado Academy of Family Physicians and the AAFP, I became motivated to increase my work with our state and local Academies,” he says. Because of the nature of both organizations being mission-based organizations, Dr. Cain was attracted to collaborate with them to improve healthcare and to try to improve society, eventually serving as a president of both groups.

“My work with the Academy opened my eyes up to the broader potential of family medicine,” he says. “It expanded my horizons to what we as family docs can do together in our larger community.”

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And it all started with a scholarship. “I would not be where I am today without the CAFP and that scholarship to the National Conference. My hope is to be able to contribute so students and residents can have the chance to be inspired the same way I was,” he says. “to help give them that same kind of spark.”

A couple of years ago, Dr. Cain disclosed reluctantly, he finally got around to creating a will, and was struck by what the process and reflecting on his life revealed. “I was looking at the gifts I have recieved, trying to sort out what is really important to me, and how to pay it forward,” he says. He decided to give the CAFP Foundation a Legacy Gift, a portion of his estate dedicated to supporting students and residents going to the same AAFP National Conference that had so profoundly affected his life.

Legacy Giving is one way that family physicians can build long-term support for family medicine advocacy and education. Each year, the CAFP supports several students and residents in their careers in family medicine by offering scholarships and other forms of financial support for them to attend conferences, present research, and participate in advocacy and education events. This support exists through the generous support of physician members like Dr. Cain, whose legacy gift will help the CAFP continue this support for years to come.

Inspiring the next generation is important to him. An enthusiastic vintage airplane pilot, Dr. Cain flies out of a small airport north of Denver. One of his biggest joys is to take children into the air for the first time to show them the wonder of flight. “It’s really the same theme. My hope with these flights is to inspire kids to see what is possible in their own lives,” he says. “You can see eyes light right up when they realize, ‘I can do this.’”

Not all residents know how they want to shape their profession. “Spending my career around residents it’s easy to see their values and know that they are here for the right reasons. After having been shaped so profoundly by the CAFP scholarship – I couldn’t help but think it is time to pay it forward to help them grow their skills to reach their own full potential.”

“The Academy is a mission-based organization,” Dr. Cain says, “and I continue to believe in our vision: to transform health care to achieve optimal health for everyone.”

If you are interested in legacy giving, please visit https://www.coloradoafp.org/cafp-foundation/.
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