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IMPROVING CARE FOR PEOPLE WITH DISABILITIES
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AFTER A SUMMER OF WILDFIRES, AIR QUALITY MATTERS
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YOU ARE THE KEY TO ZERO SUICIDE

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

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

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Vision Statement:
Thriving Family Physicians creating a healthier Colorado.

Mission Statement:
The CAFP’s mission is to serve as the bold champion for Colorado’s family physicians, patients, and communities through education and advocacy.
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At the end of the day, **this** is where you want to be.

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As we are trying to come to grips with our “new normal” as individuals and a society, I am reflecting on what exactly “normal” is to begin with. Let’s face it... has there ever truly been a universal “normal?” I would argue that no, there has not. Humans come in many different colors, shapes, and sizes and who is to say that any of these are more of a norm than any other? Rather, I would like to propose that we need to recognize and embrace the differences that have existed since time immemorial now more than ever.

Over the past several years, I have had the opportunity through a variety of experiences to realize the privilege that society imparts on me as an educated, white, Judeo-Christian, heterosexual, cis-gendered person. I have struggled to understand why this gives me any privilege over the next person and have realized that it inspires me to take on the challenge of battling these social constructs for the good of us all.

I recently re-read one of my favorite books: Power of One by Bryce Courtenay. I was struck by a line: “racism is a primary force of evil designed to destroy good men.” To combat this evil force that clearly encompasses more than just race, it will take extraordinary effort from each and every one of us to better our world. As physicians, we see first hand how systemic social inequities have affected our patients and their health status, and need to take advantage of the privilege that society has given us to change this. We need to be leaders in educating and demonstrating to the public that we will no longer tolerate the social inequities that have put so many lesser privileged groups at increased risk of negative health outcomes.

It thrills me that as an academy we are taking steps to lead the charge in this realm and as you read this magazine, you will learn more specifics of the initiatives that CAFP is working on. I am excited that as a board we have had great conversations about the importance of moving the needle forward within the health equity continuum. The staff have taken our vision and helped turn it into a multi-pronged work plan so that we can accomplish this goal. Although our ultimate quest is to be able to offer everyone the best opportunity to be as healthy as possible, this will take years of hard work and help from as many of you as possible. We have started internally by working to recognize our individual and organizational biases, and incrementally we will go about changing our policies and practices so that we can be a force for good against all forms of bias and bigotry.

Because let’s face it, none of us are “normal.” It is time that we start appreciating the differences that exist between us as individuals, not allowing them to be used against any population, but to be a positive force that compels society to realize this variety of humans is actually what makes us equal!

---

**November Board Highlights**

We warmly welcome Erica Pike, CAFP’s new Director of Policy and Government Relations.

1. The CAFP Foundation Virtual Annual Summit will take place Thursday, April 15, 2021, to Sunday, April 18, 2021 via Zoom. Please visit cafpsummit.com for more information.

2. The CAFP Board focused on amplifying critical COVID-19 public health messaging, encouraging stronger stay-at-home orders, and ensuring primary care is at the table for vaccine distribution plans.

3. The CAFP Board created a taskforce to address racism and expand our work in diversity, equity and inclusion.
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In my first article in our fall magazine, I highlighted the glaring racial inequities in morbidity and mortality from COVID-19. The mounting data from this virus illustrates the reality of disparities across our healthcare system. It serves to underscore the imperative for CAFP, and each of us individually, to seek solutions.

In October, the board of directors took the vital step of holding a special meeting to discuss how CAFP can advance anti-racism, health equity, diversity, and inclusion. This fruitful discussion yielded a number of actionable steps CAFP will be taking in the coming year and beyond to dismantle systemic racism, ensure patients have access to equitable healthcare, and cultivate a more diverse and inclusive specialty that ultimately reflects the diversity of patients in Colorado. In the coming months we will implement several efforts to enhance CAFP’s work on this front:

• Adopting guidelines for CAFP’s continuing medical education (CME) programming that reflect both inclusive language and encourage consideration of health disparities under the respective CME topics. We hope to support learning both on disparities and on how to close the gap in health outcomes.

• Launching a CAFP Practice Award for Health Equity and Community Engagement. The award is intended to highlight and celebrate practices in family medicine that are making progress to reduce racial and other health disparities within their practices and communities. We wish to recognize outstanding work in the field, while at the same time building a community for sharing best practices to succeed in this work.

• Offering an Implicit Bias Training Workshop to assist family physicians in developing their own skills to identify and address implicit bias within their practice. This workshop will be offered during our Virtual CAFP Annual Summit in April.

• Amplifying the AAFP’s Center for Diversity and Equity resources to address the social determinants of health. We know so much of a person’s health is determined by their access to quality food, spaces to exercise and decompress, and many other social determinants of health. This Center was in fact created as a result of a resolution written by Colorado’s delegation to the AAFP Congress of Delegates in 2016. The resolution created a national resource for us, and we can continue this leadership to fully utilize the Center’s resources and improve health outcomes among underserved patients in Colorado.

• Incorporating health equity as a key consideration when developing CAFP’s legislative positions, while bringing the family physician voice to influence greater equity through policy. One such effort already underway is the state’s Primary Care Payment Reform Collaborative, which released a report in December detailing how payment reforms can be used to advance equity and support in particular primary care practices who serve marginalized populations.

We know that no single initiative will immediately solve the wicked effects of entrenched racism within our social and healthcare systems, but we must work to reimagine and rebuild those systems. These steps are a start. Family medicine plays an immensely powerful role in shaping healthy communities already, and we can join together in the effort to make sure those benefits are realized by every person in our communities.
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Advocacy

CAFP Advocacy Update: Investment in Primary Care Gets a Boost

BY RYAN BIEHLE, MPA, MPH
EXECUTIVE VICE PRESIDENT AND CEO

After 5 years, CAFP’s advocacy to increase investments into primary care is paying off. Healthcare Affordability Standards were adopted by the Colorado Division of Insurance in December. These standards include requirements that insurance companies meet new targets for their spending on primary care. We have written before that only 5-7% of the healthcare dollar goes to primary care. Insurers now must increase their investment into primary care by an additional 1 percentage point in each of years 2022 and 2023. We estimate this will result in somewhere between $60-$100 million more annually for primary care.

These substantial investments are aimed at bolstering primary care and giving practices the necessary investments to support advanced primary care such as the Patient-Centered Medical Home. The adopted regulation reflects multiple years of work by the Colorado Primary Care Payment Reform Collaborative on which CAFP’s Vice President, Stephanie Gold, MD sits as our representative. The adopted regulation does not require a targeted percentage of these payments that must be paid through alternative payments (e.g. non-fee-for-service payments) as we had initially hoped. However, it does give guidance to insurers that additional investments in primary care should be made through alternative payment models (APM’s). We will continue to advocate for greater investments through APM’s. The COVID-19 pandemic underscores the imperative for our system to move away from FFS. Practice revenue took a significant nosedive in March and April of last year as elective procedures were halted, patients were afraid to go into the doctor, and practices turned to telehealth to bridge patient care. Had more payments been made through alternative payments at the time, practices would not have been so financially vulnerable to the whims of a major drop in volume. Moreover, beyond the financial impacts, APM’s are better suited to pay practices for keeping patients healthy rather than simply taking care of them when they are sick. The Division of Insurance does intend to modify the regulation in the future to encourage insurers’ movement toward APM adoption, however, they raised concerns that adopting a regulation on the matter now could be premature and could inadvertently harm primary care practices. The Payment Reform Collaborative’s annual report in December sets a blueprint for how this work could be advanced in the coming year.

The Collaborative’s report also sought to address the need to improve equity across the healthcare system. The report includes two preliminary recommendations on equity: 1) including equity in the governance of health reform initiatives, and 2) data collection to address health equity. The Collaborative’s research-to-date demonstrated alternative payment models lead to improvements in care, but they may leave certain populations behind. By focusing on equity at the forefront of payment reform recommendations from the Collaborative’s work, it can address and tailor APM implementation to close the gap in health disparities rather than further entrenching them.

CAFP was a leader in the field to increase primary care investments. Numerous state chapters of the American Academy of Family Physicians are now pursuing this work, including neighboring Nebraska, Utah and New Mexico. As states take up this important public policy initiative, spending on primary care is becoming a key system measure. As the adage says, “you can’t improve what you don’t measure,” and it’s long past time to increase resources to sustain a robust primary care system.

CAFP WAS A LEADER IN THE FIELD TO INCREASE PRIMARY CARE INVESTMENTS. NUMEROUS STATE CHAPTERS OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS ARE NOW PURSUING THIS WORK, INCLUDING NEIGHBORING NEBRASKA, UTAH AND NEW MEXICO.
This year, the Congress of Delegates met remotely. Your CAFP delegation convened in a socially distanced way, and participated in the discussions. CAFP’s resolution directing the AAFP to develop a position paper on climate change and health was successful. Our delegates also brought resolutions to shift AAFP policy toward a more supportive stance of a single payer system. While these did not ultimately pass, they yielded robust discussion and will likely be part of a multiyear effort to shape a system that is more affordable, accessible and equitable.
As we are writing this, 2020 is quickly (or more like very, very slowly) winding down.

Throughout the year, we at SNOCAP have felt the gravity of the year in many ways. We have been listening via phone calls with our community and patient partners; by surveying, reporting, and consultation with practices; by leading trainings and Boot Camp Translations by zoom and have expanded our virtual learning capacities; and we have laughed, cried, and supported our neighbors in a multitude of ways, both in community and at work. All in all, we want to say thank you. Thank you for all that you have done, are doing, and will do to continue these efforts.

As many of you know, SNOCAP partners with primary care and family medicine practices and residencies, as well as patients, community partners, and community organizations state-wide. Our partners are distinct and have different needs and resources. They live, work, and play in diverse locations; varied in culture, language, resource, livelihood, and living and working conditions. Below are just a few ways we’ve engaged to best address local needs.

SNOCAP staff has aligned with CCTSI Community Engagement Core and ACCORDS who have been putting on a quarterly Community Engagement Forum. Recent topics have included working with the Future Leaders of Community Engaged Research, the relevance of Community Based Participatory Research for Promoting Health Equity during COVID-19, and Maintaining Community Connections and Relationships during COVID-19. You can find recordings of past forums at: https://cctsi.cuanschutz.edu/community/programs

For nearly 6 months, SNOCAP has been an active member of Family Medicine United for Colorado, a collaborative between the University of Colorado Department of Family Medicine (DFM) which includes SNOCAP, the Colorado Academy of Family Physicians (CAFP), and the Colorado Center for Primary Care Innovation (CCPCI). Family Medicine United for Colorado can help you through this pandemic and create a comprehensive family medicine resource for the future. The group has worked hard over the past few months to create tools and resources to share, in addition to offering a free consultation. Follow this link to learn more and seek consultation: https://medschool.cuanschutz.edu/family-medicine/community/family-medicine-united-for-colorado

Lastly, we wanted to share information about an important SNOCAP study. Opioid dependence and Opioid Use Disorder (OUD) is a disease that afflicts many of our patients. HOMER is a study to fill a gap in the evidence around effectively treating OUD with MAT in primary care. HOMER helps Family Medicine take the lead in creating crucial new evidence that our practices will be able to use to overcome the opioid epidemic. This study responds to primary care providers’ questions and concerns about MAT induction comparing recovery outcomes for patients randomized to medication assisted treatment (MAT) inductions done in the office, observed over telehealth, or at home. HOMER will recruit 100 practices throughout Colorado and nation-wide, in partnership with the AAFP’s National Research Network. HOMER will help determine if certain patients are better candidates for one induction method over others based on individual characteristics and circumstances. Read more about the inspiration for this study at https://bit.ly/HOMERinspiration.

MAT resources are available to practices; compensation is available for practices and patients. Be a part of the community that helps provide the science around MAT care in primary care. For more information, view study flyer at https://bit.ly/HOMERinfo or contact project leads Linda Zittleman, MSPH and Don Nease, MD at homer@cuanschutz.edu.

We hope to continue to partner with many of you as we move into 2021. Reach out, we’d love to chat!

Join the SNOCAP bi-monthly newsletter: bit.ly/SNOCAPnewsletter
Follow along on Twitter: @SNOCAPpbrn
Email Don Nease: Donald.nease@cuanschutz.edu

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The provider-patient relationship is critical to quality care, especially now, in an age of heightened uncertainty. Communicating effectively is one of the most important skillsets any provider can have, and continuously improving your capacity for relationship building will benefit you and your practice for years to come.

**Cultivate Empathy Through Effective In-Person Communication**

Empathy is the ability to show that you understand or even share the feelings of another person. Showing authentic empathy helps patients feel heard, understood, and supported. Foundational to empathy is the ability to see a situation from the patient’s frame of reference. As doctors, for example, we know that infections can occur after surgery, but for a patient, that’s not routine at all and can be very scary.

Once you’re looking at a situation through your patient’s eyes, practice reflective listening. When you listen reflectively, it means you make eye contact while your patients talk, show genuine interest in what they say, listen without interrupting or interjecting, and summarize what they said to make sure you understand and validate their concerns.

**Communicate Effectively via Phone and Digital Channels**

When it comes to showing empathy and ensuring that patients understand their health status and recommended treatments, video calls enable you to use eye contact and read patients’ facial expressions. But what about when you’re limited to telehealth via phone or a text-only chat online?

If you’re communicating via chat or phone, you’ll probably need to ask more questions in order to assess

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**COPIC has launched a podcast called Within Normal Limits: Navigating Medical Risks. Hosted by Eric Zacharias, MD, an internal medicine doctor and physician risk manager with COPIC, the podcast offers insights for physicians and medical providers on pitfalls to avoid and best practices to improve patient care. Each episode is around 20 minutes and focuses on conversations between Dr. Zacharias and other medical experts/physicians who provide practical guidance through detailed analysis and case study reviews.**

*Within Normal Limits* is available on popular platforms such as Apple Podcasts, Google Podcasts, and Spotify. You can also go to www.callcopic.com/wnlpodcast for more information. New episodes will be posted throughout the year, so we encourage you to subscribe and hope you enjoy the podcast.

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the situation, determine a course of action, and make sure your patient understands. You can say, “Okay, so this is what we recommend, and these are the risks—Why don’t you tell us what you understood about that?” Additionally, if you don’t have the benefit of using your own facial expressions to communicate empathy and validate patient concerns, you’ll need to use empathy statements to show you understand (for instance, “That sounds frustrating—I would be asking the same questions you are.”).

**Use a Robust Informed Consent Process—Not Just a Form**

Informed consent is much more than just a legal imperative, it’s a chance to improve communication and help patients get the most out of their medical care. For informed consent to be effective, you need a thorough communication process that accompanies any relevant forms. It is important to distinguish between the process and the paper. The process is where you ensure your patients understand and helps to increase their compliance in their treatment.

When patients understand a recommended treatment and its indications, risks, benefits, alternatives, and the risk of not proceeding, they’re more likely to comply with treatment plans and experience improved outcomes. It is also important to have the informed consent conversation yourself as the treating provider and never delegate it, though other providers can supplement the process and documentation.

**After an Adverse Outcome, Focus on the Patient’s Needs**

Transparency, honesty, and effective communication are all critical to maintaining strong relationships with patients—particularly after an adverse outcome. When results aren’t what you or the patient hoped for, empathetic communication and being there for the patient and their family become indispensable.

A valuable tool in these situations are communication and resolution programs, which are designed to address the patient’s needs, protect the provider-patient relationship, and prevent lengthy legal action in the wake of an unexpected outcome. The goals are to be honest and open about what happened and offer patients and families the chance to ask questions and get answers.

---

**During COVID-19, managing blood pressure is essential**

Here are things you can do to keep your patients healthy:

- **Talk with your patients about their blood pressure.**

- **Teach your patients to monitor their blood pressure at home.***

- **Encourage your patients to take their regular medications.**

- **Encourage your patients to seek emergency care if they need it.**

*Medicare reimburses self-measured blood pressure (SMBP) claims as of January 1, 2020.

Get Tools, Protocols and Action Guides for implementing SMBP at MillionHearts.hhs.gov

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When someone with a disability enters your office, how do you respond?

Much of what we know about working with people with disabilities we learn through experience - sometimes painfully for you and your patient. Instead, you have an opportunity to learn about disability issues from people with disabilities. This educational opportunity will enhance your relationships and improve the clinical outcomes for those in your care.

People with disabilities are as diverse as every other group and represent 12.6% of people in the United States. As we age, that percentage increases dramatically. For people aged 65 to 74, 24.4% have a disability, and over 75, it spikes to 47.5%. One out of four people over the age of 65 will have a disability that will need your attention.

Established in 1990, the Colorado Cross-Disability Coalition (CCDC) advocates for disability rights. We fight for social justice for people with disabilities and work with individuals, service providers, businesses, and government agencies, to ensure we have equal rights and equal access. We are run by individuals with Cerebral Palsy, MS, Autism, brain injuries, mental illness, blindness, deafness, and so much more – a true cross-disability. We know those of us with disabilities have a lot to offer, and our motto is “Nothing About Us Without Us.”

NextFifty Initiative promotes independence and dignity for the aging population, including low and moderate-income persons, individuals with physical, cognitive, and behavioral disabilities, by encouraging and supporting innovative, affordable, and coordinated services and initiatives.

Together these two organizations collaborated with Jeff Cain, MD, Patrick Page, MD, and others, creating this unique training opportunity.

There are two modules in this self-paced online course:

- Disability is Not a Tragedy: Explore what impact you have on how individuals see themselves and delve into how changing attitudes and behaviors creates a new and more equitable relationship.
- Tools for Independence: Learn ways you can help your patient overcome barriers to allow as independent a life as someone wishes or can have.

Both modules contain two short videos and quizzes to help you create a plan for implementing change - lessons that will improve your care of people with disabilities in meaningful and tangible ways.

In addition to useful information and free AAFP prescribed credits, we also offer you support beyond the modules to integrate these changes into your practice successfully.

The Disability Cultural Training Course will help you answer questions important to your relationships with patients with disabilities.

For example:

Which of these situations are acceptable and which aren’t?

1. Saying to someone who is blind, “Let’s go and see what we can find.”
2. Telling a person in a power wheelchair to, “Walk with me to the next room.”
3. Saying to a specialist when asking for input, “Susan has a physical disability.”

The answer is all of these examples are perfectly fine. But language can be damaging and divisive if you don’t know what you should or should not say. Respectfully ask uncomfortable questions and establish a relationship based on respect and an even power balance.
It would be nice to believe we treat each person equally based on who someone is and not how they look or something they can’t do. But the unfortunate reality is hundreds of years of negative stereotypes filter our perception and direct our actions without realizing it. For example, have you pushed someone’s wheelchair without asking first? Or, have you finished someone’s sentence before they could get the words out? In both cases, we assume that person would rather have assistance than continuing to struggle. That assumption is wrong on two points. One, we perceive these actions as a struggle when often they aren’t. Two, we that what we are offering is wanted.

Perhaps you judged someone’s intelligence by the way they speak? We tend to be quick to assign a level of intelligence based on language skills. But there are many people for whom communication may be difficult and it in no way reflects their knowledge, mental capacity, or comprehension.

Society reinforces these stereotypes daily. Think about the superheroes whose alter egos have a disability. Or the sitcom where the lead character is disabled for one episode. And the “disability con” like the character Verbal Kint in the film The Usual Suspects, who fakes a limp to convince others he is helpless, causing people to overlook him.

Disability is not a tragedy. Disability is part of one’s identity, but it does not define a person. Individuals with disabilities do not need or deserve pity, nor are they to be admired simply for existing. When we assume that someone needs our help and act on that assumption, we demonstrate our belief that “normal” is better. This belief is called “Ableism.” [https://cdrnys.org/blog/uncategorized/ableism/]

Instead of succumbing to Ableism, this training session will introduce you to Disability Pride [https://ncil.org/disability-pride-toolkit-and-resource-guide/] - the idea that people with disabilities are proud of their disabled identity. It focuses on the social model of disability, which empowers the individual and is more favorable than the medical model.

To register for the CCDC Disability Cultural Training course, go to https://canvas.instructure.com/enroll/WXWR3L. The offer for free credits is valid only until 02/05/2021, so don’t wait.

Let us know if you have any immediate questions or concerns: email Angela Nevin, Director of Training, at anevin@ccdconline.org for assistance.

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• Treatment of diabetic foot conditions
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TRAINING:
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Most Americans support vaccination policies
Findings from a survey of almost 2,000 American adults conducted in 2019 published in the American Journal of Public Health indicated a strong support for policies on vaccination, with 72 percent strongly or partially supporting mandatory childhood vaccination, 60 percent strongly or slightly opposing religious exemptions, and 66 percent strongly or moderately against personal belief-related vaccine exemptions. Nevertheless, 20 percent said they “do not believe in vaccines” (tinyurl.com/y2xkqwyn).

About half of pediatric offices have policies to dismiss vaccine refusers
A survey of 300 American pediatricians reported that 51 percent have a policy to dismiss families that refuse childhood vaccines, with 37 percent saying they often dismiss families for refusing vaccines and six percent said they would dismiss a family for choosing to spread out crucial early vaccines. The results were published in JAMA (tinyurl.com/yyatmxtd).

Dramatic reduction in measles cases
While most of the attention on communicable diseases in the U.S. this year has been focused on the devastating coronavirus (SARS-CoV-2 or COVID) pandemic, another of our ongoing headaches – measles – appears to have taken a break. 2019 was a horrible year with more than 1200 cases reported in the U.S., the highest in a year since the 1989-1992 resurgence (tinyurl.com/y6ytgvg5). The U.S. would have lost its official “elimination” status with the WHO had the outbreak continued for just one more month (tinyurl.com/y267hms4). This year has seen a dramatic drop in measles. As of October 16, 2020, the CDC has only reported thirteen cases for this calendar year (tinyurl.com/y58t72jx). The CDC warns these case totals are provisional and could change. Nonetheless, the current “quiet stretch” has persisted long enough that it seems reasonable to mention it by way of very much needed encouragement for all health professionals.

Could the reduction in measles cases be a welcome by-product, at least in part, of the COVID-related precautions our nation has taken such as limiting travel, limiting social interactions, social distancing, and the increased use of hand washing/sanitizers and facial coverings? We believe that to be likely even despite the significant decrease in measles vaccinations due to disruptions in health care services caused by COVID. In our opinion, the largest single factor responsible for this year’s decline is the reduction in international travel. For the last several decades, a stream of measles importations from parts of the world where measles is still endemic, has fueled the occurrence of outbreaks here, particularly among unvaccinated groups.

So, how can we keep measles from making yet another comeback as the COVID pandemic recedes and people resume more in-person interactions? Clearly, we will need to work hard to make up lost ground in routine vaccine coverage. In addition, until a safe and effective COVID vaccine is both available and widely distributed, we and our patients will need to follow any updated public health recommendations from the CDC or CDPHE.

Can the flu vaccine make COVID worse?
The CDC’s Advisory Committee on Immunization Practices (ACIP) issued updated influenza vaccine recommendations in the Morbidity and Mortality Weekly Report calling for everyone ages 6 months and older without contraindications to get the vaccine for the 2020-2021 flu season. Influenza vaccine shortages are NOT expected this year due to increased production. Vaccination is critical this year because it may mitigate stress on the U.S. health care system, already under strain from the COVID-19 pandemic (tinyurl.com/yy5yyua0). Some of your patients may be concerned about a theory from anti-vaccination groups that influenza vaccination will make a bout with COVID worse because of “virus interference.” The concept is that if the immune system is “busy” making antibodies in response to a live vaccine, it may have less “attention” to give something else that comes along. However, this hypothesis is not supported by the best evidence. See tinyurl.com/ybrpkfeg for a “fact check” article.

According to ACIP, getting the flu shot this winter, if anything, is especially important because of the accumulation of reliable clinical or epidemiologic evidence to the contrary. Here is another example: A study from Sweden published in the Annals of Internal Medicine (tinyurl.com/yy5zmlod) found no difference in the rates of ASD in children born to mothers who received a flu vaccine during pregnancy and those mothers who did not receive the vaccine. The study examined records from nearly 40,000 infants with prenatal exposure to flu vaccine (specifically for the H1N1 strain) and over 29,000 infants with no vaccine exposure (tinyurl.com/y3m2lg53).

Maternal flu vaccination not tied to ASD risk in infants
For a number of years, suspicions that autism spectrum disorders (ASD) are linked in some way to any of several immunizations have persisted among anti-vaccine folks despite the contrary. Here is another example: A study from Sweden published in the Annals of Internal Medicine (tinyurl.com/yy5zmlod) found no difference in the rates of ASD in children born to mothers who received a flu vaccine during pregnancy and those mothers who did not receive the vaccine. The study examined records from nearly 40,000 infants with prenatal exposure to flu vaccine (specifically for the H1N1 strain) and over 29,000 infants with no vaccine exposure (tinyurl.com/y3m2lg53).

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combination of the flu and COVID-19, both for the health care system and individuals (what some are calling a potential “twindemic”). As we all know, influenza itself is very significant morbidity and potential mortality. Furthermore, influenza can significantly weaken someone’s overall health status and make them even more susceptible to complications should they be unfortunate enough to have both influenza and COVID-19 together/

Study: Flu vaccine reduced hospitalization of children

A study in Pediatrics reported that the influenza vaccine reduced influenza-related hospitalizations by 41 percent and influenza-related ED visits by 51 percent among youths ages 6 months to 17 years during the 2018-2019 U.S. influenza season (tinyurl.com/y4wbd88).

Great news on HPV vaccines

The CDC published data from the 2019 National Immunization Survey in Morbidity and Mortality Weekly Report showing that coverage with one or more doses of the human papillomavirus (HPV) vaccine rose from about 68 percent in 2018 to over 71 percent in 2019, while the percentage of adolescents who reported being up to date with their HPV vaccination series increased from about 51 percent to over 54 percent. This improvement is critical as a Swedish study of almost 1.7 million females reported “the HPV vaccine substantially reduced a woman’s risk of developing cervical cancer, especially in women who were immunized at a younger age” (tinyurl.com/y5qeroph). The findings, published in the New England Journal of Medicine (tinyurl.com/y6h4zjv9) reported the vaccine “reduced the chances of developing invasive cervical cancer by almost 90 percent over an 11-year period.” Wow!

New summary for meningococcal vaccines

An ACIP report in Morbidity and Mortality Weekly Report (tinyurl.com/y62vghrb) summarizes recommendations for meningococcal vaccines – clarifying its recommendations and providing new ones on booster doses of serogroup B vaccine for patients at greater risk. The report showed that coverage with one or more doses of MenACWY increased from about 86 percent to almost 89 percent during the same period (tinyurl.com/y3vh2jez). ACIP recommends routine administration of a MenACWY vaccine for all people ages 11-18 (a single dose administered at 11 or 12 years followed by a booster dose at age 16). The recommendations also contain additional guidance for children who receive their first dose of MenACWY at or before age 10, children at increased risk for meningococcal disease, and adolescents and young adults who receive their first dose of MenACWY at age 13 or older. In addition, booster doses of serogroup B vaccine are needed for patients at greater risk.

Immunizations in Pregnancy: Updated Recommendations

American Family Physician has a nice update on this topic (tinyurl.com/y4jyxel). It’s critical for family physicians to address vaccines with pregnant women (even if we do not provide prenatal care) because of the significant benefits to the mother and infant and the current low vaccination rates during pregnancy. In summary:

• Immunizations to Target include influenza, Tdap.
• Immunizations to Consider include Hepatitis A, hepatitis B, and meningococcal.
• Immunization to Avoid include most live attenuated vaccines. However, inadvertent MMR or varicella vaccination should NOT be considered grounds for pregnancy termination. HPV and herpes zoster vaccines are not live vaccines; however, they are currently not recommended because of a lack of safety data (not because of documented risk). Lastly, yellow fever immunization is the exception to this rule as the CDC recommends it if the pregnant woman must travel and is at high risk of infection based on location, season, and planned activities.
• Immunizations for the Future may include vaccines against group B streptococcus and respiratory syncytial virus for pregnant women, with the goal of protecting against these leading causes of severe infections in infants.

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[Image 215x68 to 363x207]
Like many of us, my personal feelings and interactions with the US health care system are complicated and often conflicting. Both my mom and I would likely not be alive without the health care we received in times of crisis; my mom for an aggressive cancer and me for a traumatic injury. I am forever indebted to the providers whose care saved our lives.

At the same time, our care came at significant financial cost for my whole family, which we are still navigating all these years later. I've also witnessed the direct physical and mental harm the health care system can cause, including when the system failed my sister and father in very painful ways as they were going through health crises of their own. I am still unpacking that medical harm, especially the ways in which the health care system stripped my family members of their humanity. Add to these personal experiences the devastating inequities in outcomes being perpetuated by the health care system on communities of color, with little to no accountability, and my outrage outweighs my gratitude on most days.

Because of these compounding, often conflicting experiences, I feel morally obligated to demand radical accountability and fundamental change in our health care system. I know not everyone feels this way. When I talk about Center for Health Progress's health care accountability work, people share similarly mixed emotions, but generally stop short of calling for a wholesale redesign of our current system. Polling confirms this, as a majority of Americans have a positive view of medical providers and generally believe the health care system is working for their family. And even though over half of all people in the US now favor Medicare for All, support wanes as people get into the details, such as how their private health insurance would be replaced by public health insurance, yet increases again when people learn they can keep their provider. All of this suggests that people really do want the health care system to change and improve, but they struggle to maintain that resolve when that change might affect the things about the current system that they like and have control over.

These mixed emotions have been heighten during the COVID-19 pandemic. We’ve collectively celebrated the brave and skilled health care workers who are on the front lines fighting this terrible virus. However, we’ve also had to continually reckon with the systemic racism inherent in our health care system, death and case rates that reflect this systemic racism, record profits of health insurers during the pandemic, hospitals laying off hundreds of employees while paying CEOs millions, and our biggest hospitals cashing in on billions of dollars in government aid while safety net clinics and rural hospitals suffer.

The persistent racial health inequities, significant financial harm, and other traumas faced by families in their interactions with the health care system, alongside the shameless pandemic profiteering by some of the biggest players in the system, should be more than enough to spark a mass movement of people calling for change and accountability. But that movement hasn’t materialized in real terms yet. What will it take? For one, we need to practice both/and thinking. We can allow ourselves to BOTH honor the many great individuals and organizations inside our current health care system who save lives and care deeply about their patients AND demand a new system that prioritizes people over profits, tackles systemic racism head on, and invests in things that actually create health.

More than anything though, we need to find tangible ways to wrest the immense political and financial power away from the current actors in the health care system who will always preserve their self-interest and multiply their power, no matter the cost. As Frederick Douglass declared over 160 years ago, power concedes nothing without a demand. Our demands cannot be isolated, or one-off. We need a large, national movement of people power that makes coordinated, clear, bold demands of the entrenched power of our current health care system.

Let this movement be both a celebration of the heroes and heroics of US health care, and a constant reimagining of a new system that prioritizes human wellness and dignity over all else. The realization of this movement will depend on our ability to hold both of these as true and necessary at the same time. Are we up for the task?
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.
This past year saw heartbreaking fires across vast areas of our beautiful state. Many of us watched ominous clouds billow above the horizon, turning the sky a burnt yellow. The loss of homes, businesses, and communities was extraordinary.

Some time ago, the CAFP asked its members to create briefing notes about public health issues. One, reviewed by member Carolynn Fracevallia-Brown, MD, focuses on the importance of monitoring air quality for healthy patients. It includes guidance that family physicians can use to help their patients know when they need to be examined, and how we can try to protect our lungs from atmospheric particulate matter.

It is reprinted below.

**Living Healthy: Air Quality**
Air quality can impact lung and heart health. Temperature inversions and acts of nature, such as the wildfires recently experienced in Colorado, can impact the quality of air, causing health challenges.

**What is Air Pollution?**
Air pollution is basically when the air is dirty. The two most common types of air pollution that affect people are ozone and particulate matter.

Ozone is a gas and ozone pollution comes from things like automobiles and power plants. It can be confusing to think about ozone pollution because we also hear about protecting the ozone layer. The natural ozone higher up in the atmosphere protects us from UV light. But when ozone gas is in the lower level of the atmosphere where we breathe it can irritate and injure our lungs. Ozone pollution is usually more of an issue on warmer days and is worse in the afternoon and evening.

Particulate Matter pollution is caused by things like smoke, soot, dust, and chemicals. For example, wildfires...
in Colorado are a source of particulate matter pollution. Temperature inversions occur in Colorado and can make pollution worse. Temperature inversions occur when there is warmer air higher in the atmosphere where there should normally be cooler air. This warm air acts like a lid to trap the pollution.

Who is at risk to get sick from Air Pollution?
People with heart disease, Chronic Obstructive Pulmonary Disease (COPD), asthma, the elderly and children are at the most risk to have health problems related to Particulate Matter pollution. If air pollution levels get too high they can affect healthy people as well, especially if they are outdoors a lot or doing heavy activity outside.

What can I do to protect myself from Air Pollution?
Visit this website regularly to determine the air pollution in the area you live in: http://airnow.gov/ There is a map of the U.S. that shows areas with poor air quality or you can put your zip code in for more specific information. This information is also often provided with local weather forecasts. When you hear air pollution is high where you live, you should limit your time outdoors and keep windows shut, if possible. When outside avoid heavy activity that makes you breathe heavily. Try to breathe through your nose -- it’s your body’s natural filter.

When do I need to see my Family Physician?
If you or someone you are taking care of has increasing shortness of breath, difficulty breathing, coughing, wheezing, or poor energy seek medical care. Especially if you or someone you care for has COPD, asthma, heart disease, is elderly or a child as air pollution can cause breathing difficulties for these people.

By: Carolynn Francavilla-Brown, MD
This information is provided as a public service by the Colorado Academy of Family Physicians. For more information on asthma, COPD, or other diseases and conditions, visit the American Academy of Family Physicians’ consumer website at www.familydoctor.org

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Like most 15-month-olds in daycare, my daughter has had 6 colds this year. And every time I have her tested for COVID-19. Many thought I was being ridiculous, but one day, after one day of a runny nose, she tested positive. It was a vindication I never wanted. But one I was not completely surprised by.

As a family physician, I have cared for many COVID-19 patients (even as young as 10 months) whose only symptom was a runny nose. In truth, when the CDC listed nasal congestion as a symptom of COVID-19, I was hesitant to test every patient with the sniffles. Doctors are trained to think critically and to judiciously utilize testing resources. But, I now recognize that if our case numbers are ever going to go down, we all need to stop fearing the test.

If you develop even one COVID-19 symptom- please do not hesitate. Go get tested, not just for yourself but for your community. Yes, the COVID-19 symptoms are extensive and common. Most of you are likely to develop a runny nose, cough, fever, chills, shortness of breath, fatigue, muscle aches, loss of sense of smell/taste, sore throats, nausea, vomiting or diarrhea at some point by the end of this year.

It is always possible that your symptoms are from those leftovers you ate or the smoke from the fires. But America is relying on you to make sure you aren’t spreading a dangerous illness. Testing is now widely available and at many places, such as the health center where I work, with no out of pocket cost. Testing might not change your treatment but it can prevent you from unknowingly infecting someone else- someone who unfortunately could become much sicker than you.

Testing is one way to protect your loved ones and neighbors. But wearing your mask is just as important. My husband and I tried our best to avoid COVID-19- we socially distanced and wore masks as much as possible. So far, we have both tested negative. But infection does seem inevitable considering my baby loves sneaking up on me with affectionate “dinosaur” kisses.

My baby could not wear a mask. I am incredibly grateful that she is doing well, and hopefully, thanks to early detection, we prevented her from spreading it to our friends and family.

I am proud to fight on the frontlines against COVID-19. Please help me in this fight and wear a mask, socially distance and get tested without hesitation. Frontline workers, babies, and the most vulnerable are counting on you.

Dr. Stephanie Sandhu is a Family Medicine Physician and the Associate Director of Clinical Quality and Clinical Risk Mitigation at Stride Community Health Center. She is a member of the Colorado Academy of Family Physicians and a 2014 National Pisacano Scholar.
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I Can’t Move On, But I Can Rise Up

I remember driving home from work on November 11, 2016 and needing to stop to get gas. This should have been a fairly routine stop, but I had just read about a group of white men harassing a Black woman at a gas station. They had felt empowered by the rhetoric coming from the President-Elect and had chosen to act on it. I remember the fear, looking over my shoulder, as I waited for someone to shout at me for daring to be a Black woman in a public space.

In 2009, my boss told me we were in a post-racial world now that Obama was the president. I knew then, just as I knew in 2016, and what
so many white people are realizing now, that the racism that has run beneath the surface of our country is as alive today as it ever was.

Over the past several months, I set out to figure out a way to move past the mounting tensions and divide in our country. Maybe that is just what I was raised to believe I should do, what many young Black girls are taught to do: bury the pain, fear, and sadness deep down and put on a brave face because there is work to do. Even for this article, I set out to write about how I intend to bridge the deep divides, to forgive and unite and do my part to connect across differences so we can move on toward health equity as a country. But the truth is, I have not moved on. How do I, as a Black woman, see the humanity in those who so often fail to see my own?

My humanity has always been under attack. “All men are created equal” was never intended to include me, and that’s clear in everything from the wage gap for Black women, to the disparities in maternal mortality rates, to Breonna Taylor and the countless other black women murdered at the hands of police. This is not a failure of our systems and institutions: it is a feature of them. They are working exactly as they were designed. Watching the results from the election roll in reminded me that many white people are okay supporting the status quo, even as it harms people of color, as long as it continues to benefit them.

And that’s why I can’t just move on. The people who deny my humanity do so because US laws, policies, systems, and institutions have always encouraged it. We have been split into factions, kept segregated from each other, and told there are differences between us, so that we fight each other instead of those who would keep us all down. And if we can’t admit we have a problem, we’ll never be able to change it. There is no moving on, just continuing the same vicious cycles we’ve always been forced into.

So, instead of moving on, I’m rising above. The cycles won’t break themselves, but when we come together as a movement for health equity, we are powerful enough to shatter them. I’m learning to wield my voice as a tool of justice. I’m learning my own value and refusing to let anyone undercut it. I’m learning how to stand in my own power, backed by the power and strength of my community, and fight for our collective liberation. And I’m learning to believe we can rise above this together.
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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, behavioral health, 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.