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MEGAN ADAMSON, MD, FAAFP
RUNNING FOR THE AAFP BOARD
OF DIRECTORS. SEE PAGE 42
The mental health of many of your patients is more vulnerable than ever. We are here to help, assisting patients to a safe and stable state for transition to lower levels of care and long-term recovery by offering effective treatment for adolescents, teens, adults and seniors.
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## Vision Statement:
Thrive 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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Banner Health is an EEO/AA - M/W/D/V Employer
I would like to thank you all for the opportunity to serve as the President of the Colorado Academy of Family Physicians. These are difficult times and I have spent the past year as president-elect working with our incredible past president, chair, board and staff in our fight against the COVID-19 pandemic. It is the year for me to serve as president, but I would like to emphasize that your academy is run by a team of extraordinarily talented and dedicated people. I will do my best this year to work for you in my new role on this team as president.

Lured by the strength of family medicine in this state, I moved to Colorado for my residency at St. Anthony. I love my job, my patients and continue to practice at Centura Health as adjunct clinical faculty at the residency. I have a wonderful wife and we celebrated the birth of our first child 15 months ago, the week before COVID-19 was declared a pandemic by the WHO. I still haven’t reconciled how many of my life changes are due to a new child, and how many are due to the new normal of my life changes are due to a new child, and how many are due to the new normal of the pandemic. It has been an isolated and stressful time for everyone.

I have witnessed first hand the struggles my clinic patients, friends and coworkers have faced, both physically and mentally. I have experienced many myself. However, we are winning this fight. The vaccines are scientific marvels, and are reducing viral transmission and death. There is an air of optimism as the days are getting warmer and longer. And, we as a society have learned a valuable lesson in how interconnected we all are. This has provided us with a unique opportunity to continue our cooperation for the greater good, in dare I say a post-pandemic era.

Practicing clinical medicine, I know we are not finished with this pandemic yet. My hospital has many unvaccinated yet otherwise young and healthy patients admitted for severe COVID-19 illness. I am seeing more patients with long covid infections dealing with persistent, debilitating symptoms. And we have many children under 12 years old who are still not eligible to be vaccinated. But, I am hopeful Coloradans will continue to protect the most vulnerable amongst us, getting vaccinated and continuing to wear masks when prudent.

I look forward to the near future, when patients can get their COVID-19 vaccinations at every family medicine clinic. This country has done a remarkable job with the vaccine roll-out thus far. However, those who desperately wanted the vaccine have largely gotten their vaccines. Now the difficult work begins. There is still an abundance of vaccine hesitancy regarding the COVID-19 vaccine in particular. Vaccine hesitant patients are most likely to be compassionately heard and reassured by their primary care physician. Our patients trust us. And it will be up to us to increase the vaccination rates in Colorado, thus saving more lives. Colorado is in a perfect position to lead the United States by example with vaccination rates.

Colorado embodies both the exceptionalism and struggles of the larger United States. We value our pristine outdoors, and yet are a productive energy creating state. We are about average for gun ownership per capita, but have sadly seen more than our fair share of mass shootings. We have a progressive front range, and a conservative frontier. Our purple state, with its mountain majesty, has the highest Presidential voting accuracy by state of the past twenty years. Sitting at 5280 feet, Denver is the city upon a mountain in America.

Colorado is a purple state, and as the family physicians of this state, the CAFP has a politically diverse membership. An organization as large and diverse as the CAFP will never completely satisfy every member’s personal objectives. However, it is precisely this diversity of membership and our shared values to improve the lives of our patients through science and compassion that makes our collective wisdom respected.

We can be an example, showing how it is still possible to work together resulting in incredible achievements. Family medicine physicians are uniquely positioned to lead this effort in the areas of health and wellness for all Coloradans. We implement it daily. When a vaccine hesitant patient is in our office, we know it is not productive to judge or critique. To persuade in medicine, you lead with the open ended question. “Please, tell me what about the vaccine causes your hesitation?” We can use this inclusive nature and the trust our patients place in us to strive towards near universal vaccine acceptance. Family medicine physicians are this country’s best hope of achieving herd immunity.

I am humbled by the trust you have placed in me this year with our wonderful academy. I encourage you all to get involved. Lend your voice to our collective wisdom, and make us that much stronger. Because while I have a position for a year on our board’s leadership team, you have a career for a lifetime in our wonderful state.

---

**Highlights from the May 15, 2021 Meeting of the CAFP Board of Directors**

1. The board went through a round of training and discussion to improve its listening to unheard voices on legislative issues, as well as implicit bias training for broader practice. There is a follow up implicit bias training for members planned for July 28th.

2. The board is excited to be supporting Megan Adamson, MD, FAAFP on her run for the AAFP’s Board of Directors (see her profile in this issue on page 43).

3. The 2021 Virtual Annual Summit was a roaring success. Save the date for next year in Estes Park, April 7th-10th!
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“The nation deserves nothing less than high-quality primary care for all, but creating such a system requires leadership, accountability, and a clear path forward to accomplish this work.” This declaration opens what will likely be the most significant, comprehensive report in decades on the state of primary care in the United States. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care was released this year by the National Academies of Sciences, Engineering, and Medicine (NASEM). The report renews a call on the national stage to advance primary care and lays out an implementation plan to realize the vision we hold for thriving family physicians and ensuring primary care is available to every individual and community.

The NASEM report is a roadmap for the country to achieve better health at a lower cost. It contains five overall objectives that are worth reviewing, but this article will focus on CAFP’s role in advancing two of these imperatives: 1. Pay for primary care teams to care for people, not for doctors to deliver services. 2. Train primary care teams where people live and work.

**Pay for Primary Care Teams:**

We have long known the value of primary care teams, and the NASEM report reinforces several key strategies we will work to carry forward. It makes the case for increasing the share of Medicare spending going toward primary care, with a goal of increasing primary care payments by 50%. We must build on the AAFP’s recent win in getting a 10% increase for primary care in Medicare reimbursements to close this gap.

The report also recommends states use their authority to convene multiplayer collaboratives to align on primary care payment models and it gives a boost to increasing the share of healthcare spending going to primary care. Colorado was at the vanguard of states to secure commitments to investing in primary care, and moving payers nationally to do the same will aid our progress. As a result of the family medicine-led primary care investment legislation in Colorado, health insurers are submitting their primary care implementation plans this summer and they are slated to increase their primary care investments in 2022. CAFP will be participating in the Division of Insurance’s review to ensure these increases are reflected.

Maintaining enhanced reimbursement can help address the sustainability issue practices have faced in team-based care when bringing on nutritionists, social workers and other behavioral health clinicians, and other care team members. In addition to the enhanced primary care investment, our focus is turning to maintaining accountability for that investment coming in the form of prospective, alternative payment models. The NASEM report’s recommendations and Colorado’s ongoing advocacy represent the accountability needed to ensure primary care teams are fully supported.

**Training Primary Care Teams:**

In 2021, more medical students than ever before matched into family medicine for a total of 4,493 entering family medicine residencies. This growth is a milestone for the specialty, and Colorado’s residency programs play a vital role as they all successfully matched this year. The NASEM report makes the critical case that we must still do more to ensure the diversity of family medicine and interprofessional teams reflect that of their patients. Reorienting incentives like loan repayment and salaries, as well as overhauling graduate medical education (GME) funding to support community-based primary care training, are two key strategies.

Medicare’s revaluation of Evaluation and Management codes takes an important step on the salary front. CAFP is coordinating with AAFP to provide employed physicians with resources that make the case to your employers for increased production-based pay. The revaluation more accurately reflects the value of the work you already do, and health systems should account for that in employment contracts.

Family physicians in Colorado are also leading the charge to reimagine GME funding that supports the workforce we need. CAFP supported the Colorado Association of Family Medicine Residencies in reinstating $1 million in state funding for residencies that suffered cuts in the middle of the pandemic. That funding contributes to our state-funded rural training tracks. A number of Colorado’s family physicians are also working through the GME Initiative to reintroduce the federal Rural Physician Workforce Production Act.

State lawmakers are asking crucial questions about how training programs are recruiting and graduating physicians of color, and what more can be done. Our Diversity, Equity and Inclusion taskforce will be guiding discussions such as this as CAFP embarks on a strategic planning refresh this fall. We will be taking a close look at what else we can do to ensure that primary care teams reflect the diversity of their patients, and that high-quality primary care is available for all.

HIV Nexus is a new comprehensive website from the Centers for Disease Control and Prevention that provides the latest scientific evidence, guidelines, and resources on:

- Screening for HIV.
- Preventing new HIV infections by prescribing PrEP and PEP.
- Providing treatment to people with HIV to help improve health outcomes and stop HIV transmission.

To access CDC tools for your practice and patients, visit:

www.cdc.gov/HIVNexus
This has been an active spring with multiple steps taken to implement regulatory and legislative changes that impact family physicians on both a state and federal level.

**Colorado Medical Board Protects Confidentiality in the Peer Health Program:** On May 20, the CO Medical Board adopted Confidential Assessment and Monitoring of Voluntary Treatment Through The Designated Peer Health Provider, to clarify eligibility and reporting requirements for physicians who seek confidential care and treatment. The Academy has provided feedback on earlier editions of the policy to the Board, submitted letters of support on the improvements made and the value of the policy for our members, and a half dozen members have engaged in the stakeholder meetings related to this effort. The adopted policy ensures that regardless of what provider offers the peer health program, there are clearly defined eligibility guidelines for confidential treatment. CAFP Board President, Craig Anthony, MD, said of the policy, “The CAFP strongly supports this program and policy. It will encourage more physicians to seek earlier treatment, increasing patient safety.”

**COVID Response:** A milestone in the state’s recovery from the COVID-19 pandemic came after months of advocacy from primary care physicians across the state demanding increased access to COVID-19 vaccines. CAFP staff and board members have been active in addressing the vaccine shortage in primary care clinics with the Colorado Department of Public Health and Environment and Governor Polis’ office (see graphic on next page). Plus, nearly 70 of...
our members sent direct letters to Governor Polis regarding how critical it is for our state’s recovery that primary care be included in vaccine distribution efforts. With 43% of Coloradans fully vaccinated, it will take our local doctors in communities across the state to work to overcome vaccine hesitancy and barriers such as transportation to an appointment or getting time off to receive the vaccine. To that end, the CDPHE is explicitly recruiting primary care clinicians to support vaccine access and administration across the state so we hope you will consider becoming a vaccine administrator today. Email: cdphe_covidvax@state.co.us for more information.

Tackling Health Inequities Through Policy: Colorado’s legislature has taken steps to address the social determinants of health by going upstream to address the root causes of health inequities in our state. Despite most legislative activities happening virtually, family physicians have been at the virtual table discussing considerations for our patients and primary care on bills that range from COVID recovery to telemedicine to the cost of prescription drugs.

Specifically, nearly 30 CAFP members submitted letters to their Senators regarding their support of Senate Bill 175, which would create a prescription drug affordability board that would be an independent review panel that has the authority to set upper payment limits on cost prohibitive drugs, saving patients money and making many prescriptions more affordable.

The CAFP attended the virtual Family Medicine Advocacy Summit hosted by the American Academy of Family Physicians on May 19th. Ten Colorado family physicians and residents participated and met with all nine members of our delegation or their staff. During the event, members advocated for Medicaid pay parity for primary care services, extension of telehealth coverage following the end of the public health emergency, and reduced financial barriers to care for Coloradans.
CAFP (VIRTUALLY) ON THE GO

CAFP BOARD MEMBER KYLE LEGGOTT, MD PRESENTS AT THE 2021 VIRTUAL ANNUAL SUMMIT ABOUT OPIOID POLICIES.

JERRICA KIRKLEY, MD, PRESENTS AT THE 2021 VIRTUAL ANNUAL SUMMIT ABOUT GENDER AFFIRMING CARE.

A AAFP PRESIDENT-ELECT STERLING RANSONE, MD, FAAFP, SPEAKS TO THE CAFP MEMBERSHIP ABOUT UPCOMING EVENTS AND PLANS FOR THE ACADEMY AT THE NATIONAL LEVEL.

CAFP BOARD MEMBER ROXI RADI, MD, LEADS A DISCUSSION AT THE 2021 VIRTUAL ANNUAL SUMMIT ABOUT HEALTH EQUITY AND ANTI-RACISM.

R. SCOTT HAMMOND, MD PRESENTS AT THE 2021 VIRTUAL ANNUAL SUMMIT.

A BIG CROWD OF ATTENDEES AT THE 2021 VIRTUAL ANNUAL SUMMIT.
“The medical community can help support people with opioid use disorder. When they’re in withdrawal, making sure they come back to you is really important, and letting them know they can come back no matter what. It’s essential to be able to educate people.”

—Dr. JK Costello
Person in Recovery

Be the positive influence that helps someone with opioid use disorder find recovery. Learn how to connect someone to effective treatment at LiftTheLabel.org/Training
Greetings from SNOCAP-

We hope everyone remains happy, healthy, and well. It’s been a long 15 months and counting since COVID-19 began in the US, and a lot of pain and progress have woven their threads throughout.

We want to update you all on some new SNOCAP happenings. First off, thank you to those who joined the CAFP Summit back in April. It sounded like it was a fantastic and highly successful event. An extra thanks to those who stayed around to the very end to hear from us about the current practice-based research work going on state-wide. We have developed a number of new connections since then. Are you interested as well? Reach out!

As we know, this last year has been taxing on us all for a multitude of reasons. We have been working hard to see how we can work with others to strengthen partners and rebuild stronger than before. Beginning in mid-May, many of our SNOCAP partners began work on a project called Colorado Community Engagement Alliance (CO-CEAL) to work on COVID-19 and COVID-19 disparities. As you may know, some groups—especially African American, Hispanic/Latino, immigrants, and Native American communities—have suffered more than others. CEAL is a national network of partners working to reduce the burden of the disease on those who are hardest hit by it. Funding for CEAL comes from the National Institutes of Health (NIH).

Our state’s CO-CEAL is a partnership between the University of Colorado Anschutz Medical Campus, Servicios de la Raza, the Trailhead Institute, Immunize Colorado, Denver Public Health, Salud Family Health Centers, UCHealth, 2040 Partners for Health, Colorado Department of Public Health and Environment, and many other community-based organizations and individuals. Don Nease, our fearless SNOCAP Director, is working alongside Drs. Ron Sokol and Ricardo Gonzalez-Fisher as a multi-lead team.

This work will include many communities and community partners state-wide. We will be engaging these partners in both community surveying, network analyses, and a Boot Camp Translation process to develop

SNOCAP UPDATE

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messages and materials to convey information about COVID-19 and COVID-19 vaccination. We aim to make available the best, most accurate information about the spread of COVID-19, about recruitment and participation in clinical studies, about the safety and effectiveness of vaccines and treatments, and about any concerns that may come from false rumors; increase the use of preventive practices that can reduce the spread of COVID-19, especially in underserved communities, while offering timely access to proven new treatments; and increase the public's understanding of how science works—specifically, the medical research process and how treatments and vaccines are developed.

Work with CO-CEAL will help Colorado communities move medicine and medical evidence forward. We may be reaching out in the future to help get messages out to your own patients and community partners!

Join the SNOCAP bi-monthly newsletter: bit.ly/SNOCAPnewsletter

Follow along on Twitter: @SNOCAPpbrn

Email Don Nease: Donald.nease@cuanschutz.edu

Hope to hear from you soon!

-The SNOCAP Team

---

UnitedHealthcare has introduced a new program called UnitedHealthcare Care Coordination to help independent primary care providers with patient support.

UnitedHealthcare Care Coordination serves as an extension to independent primary care practices by coordinating care resources, like monitoring a patient's prescriptions, assisting with referrals to specialists, and coordinating care for patients who have complex medical conditions or who have been in the hospital. UnitedHealthcare Care Coordination is available to those patients who are UnitedHealthcare commercial members.

Here's how it works. A care team consisting of a clinical care coordinator and a clinical pharmacist will work in collaboration with the PCP to help with:

- **Referral Management**: A dedicated care coordinator will work with patients in need of a specialist visit to assist with scheduling with in-network, high-quality providers. The coordinator will track the referral to completion and work with the specialist to ensure that office visit or procedure notes are delivered to the PCP in a timely manner.

- **Medication Management**: After the PCP provides a list of patients who may benefit from an individualized comprehensive medication review, a dedicated clinical pharmacist will contact them to review their medications. The pharmacist will look for patient safety issues like drug-to-drug interactions, cost savings opportunities like brand-to-generic conversion or lower cost alternatives, patient education needs and medication alignment opportunities. The pharmacist can also provide pharmacy consultations as needed.

- **Transitions of Care Support**: UHC receives notifications on member hospitalizations. Using this data, the care coordinator will contact patients who have been discharged from the hospital to perform medication reconciliation, and to assist with scheduling PCP and specialist follow-ups.

- **High-Risk Member Management**: The care team will monitor the PCP's high-risk patients to ensure they not only are having an annual comprehensive medication review, but that they are also being seen on a regular cadence by their PCP.

By offering tangible support for practices that don't have the staff to assist them in some of these areas, the care team can help strengthen the relationships between patients and providers, ultimately improving care quality.

To participate in UnitedHealthcare Care Coordination, please contact Jennifer Urbonas, Market Director – UnitedHealthcare Care Coordination, 303-993-1716 or Jennifer.urbonas@uhc.com.
Suicide Prevention

Children’s Hospital Colorado has declared a state of emergency for pediatric mental health as the number of children and teens experiencing a mental health crisis has skyrocketed during the COVID-19 pandemic. In the last two years, Children’s Colorado has seen a 90 percent increase in demand for behavioral health treatment. Isolation and stress amid the pandemic have exacerbated low-level anxiety and depression among pediatric patients into suicide attempts.

“I’ve been in practice for over 20 years in pediatrics, and I’ve never seen anything like the demand for mental health services we’ve seen at Children’s Colorado in the past 15 months,” David Brumbaugh, MD, Children’s Colorado chief medical officer, said. “There have been many weeks in 2021 that the No. 1 reason for presenting to our emergency department is a suicide attempt. Our kids have run out of resilience — their tanks are empty.”

Family medicine providers are the medical home for half of the pediatric and adolescent population in the state of Colorado and a strong collaboration to address the growing mental health crisis is critical.

Suicide is a difficult topic for our society to address. Frequently, our instinct is to not talk about it unless a parent or patient brings the topic up themselves. There are pervasive myths that persist that talking about suicide with youth will “plant” ideas in their mind and increase the likelihood that they will consider and attempt suicide. Despite these concerns, the research in this area is robust and clear that talking to youth about suicide decreases the likelihood that youth will make a suicide attempt.

Understanding the power of having these conversations is essential for primary care providers because research indicates that 45% of patients who died by suicide visited a primary care provider in the month before their death. Because primary care physicians are the most likely group of professionals to interact with youth on a regular basis, it is important that we use this setting to assess for suicidal ideation on a regular basis in all patients seen for annual wellness checks. This is particularly salient for the state of Colorado where suicide is the leading cause of death in youth and young adults.

**Suicide in Colorado**

One striking statistic is that Colorado is within the top 10 states in the U.S. for death by suicide. Often people have a conceptualization of Colorado as a place of health and wellness, which disrupts the notion that mental health problems exist among the youth in our state. Despite these notions, we know that 24% of youth experience a major depressive episode each year and that 14% of youth have seriously considered suicide within the past year. There are several ideas for why rates of depression and suicide are so high in Colorado. There is no one specific reason to explain this phenomenon; however, a conglomeration of factors is likely to explain the increased rates of depression and suicide and youth in Colorado.

First, access to mental healthcare is limited within Colorado so there are a variety of youth with mental illness who are not identified as having a mental disorder and if they are, there is difficulty connecting them with care. Second, states that have high gun ownership often have higher rates of suicide within the population, which speaks to the importance of step 6 in safety planning, which is addressed later in this article. Finally, there is some research that suggest that individuals living at a higher elevation have higher rates of depression. Outside of these factors are other variables related to family history, social media use and resiliency factors available to youth.

Regardless of why, we know that suicide is an epidemic in the state of Colorado and primary care providers are best positioned to reduce the risk through systematic screening of suicide symptoms as part of sick and wellness visits.

**Screening for suicide**

There are several effective and nonproprietary measures for assessing suicide in youth available to primary care providers. These include the Columbia Suicide Severity Rating Scale (C-SSRS) and the Ask Suicide Screening Questions (ASQ). Both measures can be administered to youth within less than five minutes and are able to reliably and validly identify suicide risk. The C-SSRS and ASQ are both available in a variety of different languages.

There are many practices that also utilize the Patient Health Questionnaire 9 for Adolescents (PHQ-A) to identify depressive symptoms and suicide risk. Although the PHQ-A is an effective tool for assessing depressive symptoms, the C-SSRS and ASQ are more effective in flagging patients who are suicidal, and it is recommended that practices use these measures as an adjunct to the PHQ-A and not utilize the PHQ-A in isolation to screen youth for suicidal ideation.

Currently, Partners for Children's Mental Health, a non-profit organization dedicated to improving systems of care for mental health services for youth in Colorado, is offering training and implementation support for integrating the ASQ screening tool into primary care practices. Please contact info@pcmh.org for information on how to enroll your practice in this project.
Safety planning

In the event that primary care providers experience working with a suicidal patient, it is important to engage in supportive practices to stabilize the patient. For patients that are high risk, which means they are endorsing suicidal ideation with a plan and intent, providers are instructed to send the patient to an emergency department for crisis care. For patients who are medium to low risk, (ideation with or without a plan but no intent), it is recommended to engage the caregiver and patient in safety planning.

Safety planning consist of completing information in six core areas, which include:

1. Identifying warning signs
2. Listing coping strategies
3. People and social settings to provide distraction
4. People who I can ask for help
5. Professional agencies I can contact during a crisis
6. Making the environment safe (removing or locking away medications, guns, etc.)

The Stanley Brown Safety Plan is a well-established tool that providers can use. Additionally, there are a variety of apps that patients can download for safety planning that are free and easily accessible via their smartphones. These strategies can be helpful in best supporting patients with suicidal ideation without needing to escalate care to an emergency department. As primary care providers become more comfortable and adept at using these screenings and support tools, we can hope for a decrease in the rate of death by suicide in our youth in the state of Colorado.

For additional discussion about suicide prevention in primary care listen to Teen Suicide: Risk Factors, Screening and Prevention (S1:E24) on the Charting Pediatrics Podcast on Apple Podcasts, Spotify or wherever you listen to podcasts.

References

2. Association of Clinicians for the Underserved, Suicide Prevention in Primary Care A Toolkit for Primary Care Clinicians and Leaders
3. News Now, Study Suggests that Suicide Rates Increase with Altitude
**HANDLING UNSOLICITED TEST RESULTS**

**SCENARIO A: Pre-existing physician-patient relationships**

CASE 1

Your 47-year-old patient self-referred for a heart scan after his older brother had a myocardial infarction. You have taken care of this patient for at least 20 years and you last saw him three years ago for a routine physical exam that was unremarkable including normal labs. He also saw a cardiologist approximately five years prior to evaluate palpitations. The heart scan results revealed an Agatston score of over 300, placing the patient in the highest risk category for coronary heart disease and future myocardial infarction. Your office received a fax with the results from the walk-in heart scan clinic.

In this case, since there is an existing physician-patient relationship, you should assume responsibility for contacting the patient to discuss the meaning of the results and a plan of action. This could be an office appointment, a telehealth visit, or a phone conversation. Alternatively, you could refer the patient to the appropriate specialist for interpretation of the test result and determining the course of action, regardless of whether the patient self-referred for the test.

Additionally, you should not assume that the cardiologist who the patient saw before has either received the heart scan results or is acting upon them (even if the report explicitly states a copy is being sent there). Since you have direct knowledge of the at-risk test result, the best practice would be to follow up with the patient directly and not assume some other physician is following up.

Although the preceding scenario would not warrant urgent evaluation, the test results do reveal potential risk factors for major adverse events such as heart attacks or strokes. Arranging for communication with the patient regarding results and next steps, even though you did not request the tests, ensures appropriate follow up occurs.

You may be in a physician-patient relationship that is not necessarily obvious. For example, accepting a capitated payment from a health plan on behalf of a patient may establish a physician-patient relationship regardless of whether you’ve actually seen that patient. You should be aware of this potential issue in your practice setting.

**SCENARIO B: No established physician-patient relationship**

If no relationship exists, you may choose whether or not to accept the patient into your practice:

- If you accept the patient, first contact the patient and assume all the obligations of interpretation, monitoring, and follow-up of the diagnostic test.
- If you choose not to enter into a physician-patient relationship, return the original test to its source or the diagnostic center responsible for it. If you do this, use a statement such as “This is not a patient in our practice. Please use your data to inform the patient for appropriate physician referral or follow-up.”

This action would also be appropriate if you receive tests results in error (e.g., by fax or mail). Calling the sender directly to notify them of the misdirected result has the best chance of getting the information to the patient and the proper provider for appropriate treatment and follow-up. Critical test results may require more diligence to ensure the information gets to the appropriate provider in a timely manner.

**What should you do for documentation in this scenario?**

Although there is no legal duty, in the interest of patient safety there are some suggested steps you should take in returning an unsolicited diagnostic test:

- You should keep a log that documents the date the test was received, the patient’s name, the action taken in returning the test to the sender, and who the sender is.
- It is recommended that you fax the test information back so you will have documentation that the information was faxed to the appropriate test source and received.
It’s been quite a year for us all, and the way in which CAFP delivers the CME, meetings, and other events has had to change. I wanted to give all of our members an update about where we are, and what to expect in the future.

In the past year and a half, popular buzzwords in the CME meetings industry have included: ‘pivot’, ‘reevaluate’, ‘reimagine’, and ‘flexibility’. Meeting planners base a lot of their event development on past history: we book room blocks based on last year’s numbers, and build budgets based on how many showed up for meal functions.

The COVID-19 pandemic threw all of that into doubt, and with a great deal of sadness we ended up canceling the 2020 Annual Summit. However, there is opportunity in loss, and shifting our events to meet virtually provided a new opportunity to reach members we might not have had the chance to have met before.

Our transition to live, virtual CME has gone better than I ever expected, with a strong turn out and a steady slate of brilliant speakers. There is no way to reproduce the same energy, warmth, and collegiality that I love to see at our in-person meetings, but I was so grateful to see our members adapt and accept the temporary new-normal of virtual meetings.

As the pandemic forged on in 2020, our Board and Education Committee met several times to discuss plans for the 2021 Annual Summit. With the uncertainty of the roll out of vaccines, the decision was made to host our very first Virtual Annual Summit. While we used some of the content from our 2020 program, we added new content in the form of a Diversity, Equity, and Inclusion workshop and created a new exhibitor and sponsor program. Our expectations were that of nervousness and curiosity. Would people show up? Thankfully, they did and they enjoyed the event.

As the CAFP Director of Education, Events, and Meetings for the past 8 years, I will forevermore refer to our CME as pre, current, and post pandemic programming. It will be a time in my life where I was pushed to try new things, make the best of a shaky situation, and take pearls of wisdom to the next CME programs I produce. I’m proud of our membership for being flexible and kind during this historic period. While virtual CME content has been a nice filler, we are very excited to start planning our 2022 Annual Summit at the Historic Stanley Hotel in Estes Park. Save the date to reunite: April 6 - 9, 2022. Visit our Annual Summit page to register.

Here’s to the future!

---

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Sheraton Sand Key Resort

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Finding Victories During a Challenging Year

CAFP President Gina Carr, MD, MPH

I highly doubt anyone will argue that 2020 was a unique year for all of us! It brought a set of unpredictable circumstances, and life at times was extremely challenging. However, I am proud that as an organization the CAFP rose to those challenges and tried to make the best lemonade we could.

One of our most significant victories was a successful transition in leadership that took place in October 2020. Following Raquel Alexander’s retirement announcement, we completed a nationwide search for our next leader. Although it was hard to say goodbye to our gracious leader for the past 33 years, we found a rising star amongst our ranks in Ryan Biehle, who has transitioned seamlessly to his new role as Executive Vice-President/CEO. Additionally, to fill the role that Ryan left, we added Erica Pike to our team as our new Director of Policy and Government Relations.

Given the new reality of safety from a distance, board meetings and CME offerings were made virtual and, while different from previous gatherings, we still took care of necessary business. Further, as you may have noticed, this has led to a more robust development of virtual CME offerings. This is an excellent demonstration of how our staff turned a challenge into an opportunity and created new ways to meet our member’s needs!

Although the 2020 legislative session began like most others, it experienced serious upheaval in light of the pandemic. However, despite the shift required to address the COVID-19 crisis, we maintained our presence at the Capitol and fought for initiatives to benefit both our members and patients. Some wins included the continuation of telehealth rules initiated during COVID, advances in paid sick leave for workers, and continued work on the Primary Care Investment initiative implementation tasks. Together, these signal significant hope that primary care is in an excellent position to continue to advocate for changes in our healthcare system that benefit all Coloradans.

Finally, a couple other highlights from 2020 include: 1) a new format for the national congress of the AAFP, conducting its usual business completely remotely in October. This provided a safe opportunity for CO delegates to continue to participate in important decision making at the national level while avoiding the risk of travel and large-group gatherings. 2) CAFP board and staff embarked on a diversity, inclusion, and equity learning track that will continue over the years to come. Not only is this endeavor exciting and timely, but provided us something extremely important to focus on outside of the immediate needs the pandemic demanded.

As hard as 2020 was in many ways, I like to believe that these victories demonstrate how there is always hope. Moreover, that the future depends on how WE rise to the challenges that are presented to us. Here’s to continuing to rise to the occasion for a better future for CO family physicians and patients!

Sincerely,
Gina Carr, MD, MPH
Finding One for all of us! It brought a set of unpredictable circumstances, leadership transitions, and gatherings.

Finally, the concept of telehealth benefit the continued virtual learning of physicians and patients! However, we noticed an extremely significant reduction in member dues. Although the pandemic demanded a couple of wins for the members, the CME initiative continued. The CME Foundation continues to fund the critical healthcare professional education necessary for胜利.

Sincerely,

Ryan

Assets:

**Short Term:** $64,076 (5.5%)

**Intermediate Term:** $420,138 (36.4%)

**Long Term:** $328,360 (28.4%)

**Political:** $4,709 (0.4%)

**Fixed Assets:** $338,265 (29.3%)

Income and Expenses:

**Total Income:** $617,807

**Total Expenses:** $623,230

**Net Ordinary Income:** -$5,423
In 2020, family medicine faced unprecedented challenges due to the COVID-19 pandemic, yet membership stayed constant. In addition to the challenges of pandemic response, our members took an active role in advocating for both family medicine and the health of the public.

We work every day to be your “bold champion,” and are grateful to have not seen the same drop-off in memberships as many other organizations. Thank you to all the Colorado Family Physicians!
Advocacy

Advocacy is at the core of CAFP’s mission.

In 2020, as the COVID-19 pandemic deepened, we grew our advocacy and achieved important wins for family medicine.

Strengthening Vaccine Laws

CAFP was a leading advocate for Senate Bill 163 that strengthened Colorado’s vaccine requirements. It requires “equal effort” for Coloradans wishing to get an exemption from school vaccine requirements, such as speaking with their physicians about an exemption or completing an online educational module about vaccine safety and efficacy. It also established a uniform vaccine exemption form that must be completed. These measures have been shown to increase vaccination rates in other states that have implemented them.
What We Accomplished

Expanded Telehealth Coverage

CAFP successfully advocated for the Colorado Division of Insurance to issue emergency rules in the early days of the COVID-19 pandemic to guarantee coverage for audio-only telehealth services. We also worked with a coalition of supporters to draft and pass Senate Bill 20-212 to codify this expansion of telehealth coverage. The law permits Federally Qualified Health Centers and Rural Health Centers to bill telehealth as an encounter, as well as requires insurers regulated by the state and Medicaid to cover audio-only telehealth services. 120 CAFP members contacted their legislators to urge support of this important legislation, the importance of which was underscored by the need for telehealth during the COVID-19 pandemic.
In 2020, the normal legislative session in Denver was altered significantly. As a result, our popular Doctor of the Day volunteer program went virtual. Despite this, our members stepped up, and we thank every one of them listed below!

(Virtual) Doctor of the Day

Jenni Adams, DO
Katherine Anderson, MD, FAAFP
Julie Ansell, MD
Craig Anthony, MD
John Bender, MD, FAAFP
Gina Carr, MD
Cory Carroll, MD
John Cawley, MD, FAAFP
Carolyn Sze-Yun Chen, MD
Harish Chintan, MD
Howard Corren, MD
Kathleen Cowie, MD
Troy Curtis, MD
Lauren DeAlleaume, MD
Timothy Dudley, MD
Brian Erly, MD
Mary Fairbanks, MD
Jennifer Feng, MD
Ryan Flint, DO
Issacc Fonken, MD
Carolynn Francavilla, MD
Nicholas Gamble, MD
Joshua Garfein, MD
Stephanie Gold, MD
Douglas Hallmark MD
Robin Harland, MD
Meagan Harper, MD
Lakshmi Karra, MD
Kyle Leggott, MD
Emily Lenherr, MD
Huy Ly, MD
Glenn Madrid, MD
Phillip Mendoza, MD
Blaine Olsen, MD, FAAFP
Laura Patton, MD
Lindsay Pearson, MD
Gina Phillips, MD
Robert Price, MD
Cleveland Piggott, MD
Roxanne Radi, MD
Amy Rinner, MD
Alison Schmerling, MD
Edward Shuherk, MD
Barry Sundland, MD
Karin Susskind, MD
Philip Weber, MD

What We Accomplished
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Expanded Telehealth Coverage
Every year, CAFP celebrates its members who exemplify the transformative power of family medicine to improve the lives of their patients and communities. In 2020, we identified three physicians who live the values of family medicine.

Alan-Michael Vargas, MD (LEFT), the Vice Chief of Staff at Grand River Health in Rifle, CO, was named Family Physician of the Year.

Keith Dickerson, MD (CENTER), faculty at St. Mary’s Family Medicine Residency in Grand Junction, CO, was named Teacher of the Year.

And finally Daniel Dyer, MD (RIGHT), a resident at North Colorado Family Medicine Residency in Greeley, CO, was named Resident of the Year.

Each one of these physicians exemplifies the talent, dedication, and deep care that family physicians bring to their communities.

We are so proud of our members, their compassion, and their dedication to serving their communities. Thank you!
In 2020, we said a bittersweet farewell as Raquel J. Alexander, who led the CAFP for 33 years, retired. Always fond of calling family physicians “the Saints and Angels of this world,” she left behind a legacy of continuous growth in membership, service, and policy impact. She also shepherded the CAFP to become a national leader of innovation, advocacy, and membership retention among other AAFP state chapters - a testament to her leadership and vision. Thank you so much for your tireless service to family medicine, Raquel, and we all wish you the happiest retirement.
As difficult as it was, the pandemic forced us to cancel the highly anticipated 2020 Annual Summit. We shifted our events to live virtual programming via the Zoom platform one to two times a month. In addition to allowing us to engage in direct advocacy with officials (see above), we provided webinars about Colorado Department of Public Health and Environment Covid Updates, Covid Testing, Opioid programming, Evaluation & Management Updates, Medical Misinformation, Vestibular Dysfunction, Dementia Care, and Legislative issues.

As we waded into uncharted waters, our members registered, attended, and engaged with speakers and other attendees. It has proven to be so successful for our membership that we will continue to integrate virtual learning and events into the future.
CAFP
Board of Directors
Terms beginning May 1, 2020

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(3rd term, two congresses, 2020 & 2021)
Glenn Madrid, MD, Grand Junction – term expires 2021
(2nd term, two congresses, 2020 & 2021)

Alternate Delegates
Tamaan Osbourne-Roberts, MD, Denver – term expires 2021 (3rd term, two congresses, 2020 & 2021)
Zach Wachtl, MD, Denver – term expires 2020 (1st term, two congresses, 2019 & 2020)

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Sydney Davis, MD, Family Medicine Resident, PGY-2, University of Colorado Family Medicine Residency
Katie Doster (Teixeira), DO, 2022, North Colorado Family Medicine, Greeley
Danielle Eves, MD, PGY2, SFMR
Jordan Harbaugh-Williams, MD, MPH, 2022, North Colorado Family Medicine, Sunrise Track
Allison Johnson, MD, 2021, University of Colorado Family Medicine Residency, Denver
Health, Denver
Leah Kellogg, MD, 2022, St. Joseph Family Medicine Residency, Denver
Katharine Kelly, MD, 2021, University of Colorado Family Medicine Residency, Denver
Health
Eric GR Kim, MD, PhD 2021, University of Colorado Anschutz School of Medicine
Michael D. Renele, DO, PGY-2, North Colorado Family Medicine

Student Representatives
Sam Altman, 2022, CU
Mattie Brand, 2022, RVU
Ross Tanick, 2022, RVU
Kiyomi Daoud, 2022, CU (awaiting confirmation)
Christine Krentz, 2022, CU

As difficult as it was, the pandemic forced us to cancel the highly anticipated 2020 Annual Summit. We shifted our events to live virtual programming via the Zoom platform one to two times a month. In addition to allowing us to engage in indirect advocacy (see above), we provided webinars about Colorado Department of Public Health and Environment Covid Updates, Covid Testing, Opioid programming, Evaluation & Management Updates, Medical Misinformation, Vestibular Dysfunction, Dementia Care, and Legislative issues. As we waded into uncharted waters, our members registered, attended, and engaged with speakers and other attendees. It has proven to be so successful for our membership that we will continue to integrate virtual learning and events into the future.
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For more information or to apply, please contact Andrea Hughes-Proxmire at 303-565-6104 or Andrea.C.Hughes-Proxmire@kp.org.
Four vaccines likely to be missed

During this last year, vaccination against the novel coronavirus SARS-COV-2 to prevent coronavirus disease (COVID) has dominated not only the headlines but also the thought processes of most adults, about immunization. A danger exists that other important vaccines for adults will be neglected. Because COVID vaccination has, for the most part, been an issue for adults rather than children, adult immunizations are likely at more risk of being missed than childhood immunizations.

In fact, a CDC study published in Morbidity and Mortality Weekly Report (tinyurl.com/4egb9ckm) tracked decreases in routine vaccinations during the COVID pandemic among Medicare beneficiaries, comparing data from January to July 2019 and January to July 2020, with declines of 70 to 89 percent seen in mid-April 2020, compared with the previous year’s rates. Asian Medicare beneficiaries had the biggest decline in vaccinations, compared with beneficiaries of other ethnicities.

The current CDC-recommended schedule (tinyurl.com/252h6zpb) includes about a dozen different vaccines, depending on whether you count measles/mumps/rubella as one or three, and how you count the different serotypes of meningococci, for instance. About half are recommended only for certain age groups of adults; about another third are recommended only for those with certain medical or other risk factors. Each family physician who cares for adults should be familiar with the schedule and should have in place office practice routines to ensure that any patient whose age or condition calls for a certain vaccine, is offered it.

The following discussion will highlight four vaccines that we deem especially likely to be missed. The first two of these are routinely recommended for all adults; the other two are recommended for adults 50 years of age and over, and 65 and over, respectively.

1) COVID or no COVID, influenza is with us long term and kills many, especially older people and those with chronic medical conditions. Though the vaccine efficacy varies widely with how well matched the vaccine strain is to that of the predominantly circulating virus, and usually is a lot lower than we might like (tinyurl.com/779yj3w), it almost always provides a significant degree of protection against serious disease, hospitalization, and death. Family physicians should encourage every one of their patients to receive the influenza vaccine every fall.

2) Once a primary series of DPT has been completed (in childhood, for most Americans) a booster every ten years will suffice, except in the case of a contaminated wound, pregnant women, or in the event of a pertussis outbreak (see the next story). We concur with the suggestion that the mid-decade birthday (35, 45, 55, etc.) is an excellent mnemonic to keep us and our patients from forgetting Tdap boosters.

3) Zoster vaccine (Shingrix®), though a bit painful (by both of our personal experiences) is by far preferable to experiencing a bout of shingles. The vaccine is highly efficacious and needs a two-dose series (four weeks to six months apart) only one time. It should not be confused with the live varicella-zoster vaccine (Zostavax®) that is no longer marketed in the U.S. It is recommended to be received at age 50 or for anyone 50 or over without a medical contraindication, who has not received it already, regardless of prior receipt of the Zostavax vaccine.

4) Finally, pneumococcal vaccine is recommended for those over age 65. Both a 23-valent polysaccharide vaccine (Pneumovax®) and a 13-valent conjugate vaccine (Prevnar®) are available. The tradeoff between these is that the 23-valent vaccine (by definition) provides protection against a broader array of strains, but the conjugate vaccine triggers a more robust immune response (tinyurl.com/aeeyz5ut). CDC recommends that all individuals over 65, without a medical contraindication, receive the 23-valent vaccine, and that clinicians can choose to administer PCV-13 to them in addition, at a different time—usually one year later. Children already receive PCV-13 as part of their routine schedule.

Unless your patients work in a health profession, they are unlikely to remember to ask for all of these immunizations on time on their own. No good substitute exists for a robust patient reminder system or having your staff check with each patient at each visit—including acute visits. Let us do all we can to prevent the illnesses we can, so that we can concentrate on treating the rest of them!

ACIP approves 2021 Immunization Schedules

The 2021 adult and child/adolescent immunization schedules have been approved by the Advisory Committee on Immunization Practices (ACIP) of the CDC and are accessible at tinyurl.com/1nu36o8p. Recognizing the difficulty of finding information in footnotes, ACIP introduced simpler and more prominent notes to clarify recommendations. Schedules for adults and children have similar designs, each with clear instructions on the cover page. Here are some key points for your practice:

• Wound management: Persons with three or more doses of tetanus-toxoid-containing vaccines
  o For clean and minor wounds, administer Tdap or Td if more
than 10 years since last dose of tetanus-toxoid-containing vaccine.
- For all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine.
- Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown.
- If a tetanus-toxoid-containing vaccine is indicated for a pregnant woman, use Tdap (now routinely recommended to all pregnant women with each and every pregnancy preferably in early part of gestational weeks 27–36).
- Since 2019, ACIP has said either Tdap or Td may be used in situations where Td only was previously recommended, as this increases point-of-care flexibility. Therefore, many FPs stock Tdap only and not Tdap and Td.
- Live influenza vaccines should be avoided in people who have received oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous five days, or baloxavir within the previous 48 hours, received oseltamivir or zanamivir within the previous 17 days.
- The intranasal quadrivalent live attenuated influenza vaccine (FluMist®) should not be used in children younger than two years, and the quadrivalent recombinant influenza vaccine (Flublok®) should not be used in people younger than 18 years.
- There is a new quadrivalent meningococcal vaccine option against meningococcal serotypes A, C, W, and Y (MenACWY) which is a polysaccharide tetanus toxoid conjugate vaccine (MenACWY-TT® or MenQuadfi®; ≥ 2 years). It joins two others: a polysaccharide diphtheria toxoid conjugate vaccine (MenACWY-D® or Menactra®; 9 mos to 55 years) and an oligosaccharide diphtheria CRM197 conjugate vaccine (MenACWY-CRM® or Menveo®; 2 mos to 55 years). ACIP recommends MenACWY vaccination for the following groups:
  - Routine vaccination for adolescents aged 11 or 12 years, with a booster dose at age 16 years.
  - Routine vaccination of persons aged ≤ 2 months at increased risk for meningococcal disease (dosing schedule varies by age and indication, and interval for booster dose varies by age at time of previous vaccination):
    - Persons with certain medical conditions including anatomic or functional asplenia, complement component deficiencies, complement inhibitor use, or HIV infection.
    - Persons at increased risk during an outbreak (e.g., in community or organizational settings, and among men who have sex with men [MSM]).
    - Persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic.
    - Unvaccinated or undervaccinated first-year college students living in residence halls.
    - Military recruits.
    - Infants weighing less than 2,000 g born to mothers negative for hepatitis B surface antigen (HBsAg) should receive an initial hepatitis B vaccination at hospital discharge or one month of age, whichever comes first.

**Study links flu vaccine to lower COVID risk**

A study in the American Journal of Infection Control (tinyurl.com/yxwck9jf) found that people who received the flu vaccine had 24 percent lower odds of testing positive for COVID compared with those who were not vaccinated. The findings, based on data from 27,201 people, showed that flu-vaccinated patients who contracted COVID were less likely to require hospitalization and if hospitalized had shorter hospital stays and were less likely to need mechanical ventilation. Researchers did not identify significant differences in the need for intensive care or mortality between flu vaccinated patients and unvaccinated patients with COVID. The apparent link between flu vaccination and potential protection against COVID could be due to trained immunity, a process in which vaccinations activate an adaptive immune response of T-helper cells that may attack a similar antigen in the future. For those hesitant to receive a COVID vaccine, the influenza vaccine should be promoted to reduce the burden of disease during the pandemic.

**Pneumococcal vaccines effective against otitis media**

Researchers examined 223 otitis media cases along with 1,370 control subjects and found that both the 7-valent and 13-valent pneumococcal vaccines were effective against complex otitis media caused by targeted serotypes among children ages 5 to 35 months. The findings were published in Clinical Infectious Diseases (tinyurl.com/2szuwuat).

CONTINUED ON PAGE 36 >>
Vaccine News You Can Use

<< CONTINUED FROM PAGE 35

**HPV infections declining because of vaccination**

CDC researchers examined data through 2018 and found that human papillomavirus vaccine-type prevalence decreased by 88 percent and 81 percent among females ages 14 to 19 and females ages 20 to 24, respectively, compared with prevalence before the introduction of HPV vaccination in 2006. The findings, published in the agency’s *Morbidity and Mortality Weekly Report*, also showed that HPV infections among sexually experienced females ages 14 to 19 dropped by 97 percent in those vaccinated and 87 percent in those who had not received the vaccine, which suggests herd effects. (tinyurl.com/c46exn77)

**Study: 37 million deaths prevented by vaccines**

Researchers examined vaccination programs in 98 countries and found that vaccines against ten major diseases – including hepatitis B, human papillomavirus, rotavirus and measles – averted an estimated 37 million deaths between 2000 and 2019 in low- and middle-income nations globally. The findings in *The Lancet* also showed that deaths from these ten diseases among children under age five years would be 45 percent higher without vaccination (tinyurl.com/ffzon3ab).

**FPs can help address vaccine hesitancy**

As the US shifts from too few COVID vaccine doses to a plentiful supply, patients who are hesitant about getting the shots will need personal engagement from a trusted primary care physician who can advise them about safety and efficacy, according to Kenneth Lin, M.D., who teaches family medicine at Georgetown University School of Medicine and is deputy editor of American Family Physician. “Not only are family physicians old hands at resolving patients’ uncertainty about established and newer vaccines, but we are also well positioned to mitigate mistrust about vaccines among patients of color and among younger Republicans who are skeptical about vaccine science and may underestimate their personal risk of becoming ill from the disease,” Lin said. The full story is at tinyurl.com/2na59a6b.
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A large part of my job is advocating for the needs of BIPOC communities in meetings with legislators and government representatives, and I am often one of the only people of color in the room. When a white physician says, “people of color don’t trust the health care system, it’s just their culture,” and heads nod around the room, I have to take a deep breath and speak up, reminding everyone that the basis of this mistrust is well-founded.

Recently, after one of these challenging meetings, I had a telehealth appointment with a specialist. In preparation, I’d spent time thoroughly gathering my thoughts so that I could effectively explain my medical concerns. Despite my best efforts, the doctor dismissed me at each turn, as if I did not know what I was experiencing. I could feel myself getting smaller and smaller. My continued attempts at explaining myself were met with increasing suspicion, ending in a thinly-veiled suggestion that I was drug seeking. At that point, I completely shut down, nervous that anything else I said would further convince him that I just wanted medications, and fearing that this would make it in my charts and lead to even worse interactions with providers in the future.

Less than an hour prior, I had been standing up for BIPOC communities to government officials and lawmakers and now I was completely shut down and dismissed. When I relayed the experience to my primary care doctor, she, likely with good intentions, said that I need to advocate for myself. But what does self-advocacy look like in health care as a Black woman? My attempts to advocate for myself are often viewed as being difficult, angry, or drug seeking. Black women who try to take charge of their health have been mocked, ignored, and reprimanded.

The narrative that often gets told around health disparities is that they are due to genetic differences between races, but race is a social construct. Health disparities are due to racism, and this impacts how people of color are treated by and interact with the health care system. When doctors ignore our pain because of the patently false stereotype that Black people have a higher pain tolerance, we suffer needlessly and develop a deep-seated mistrust of the health care system that is passed on through generations. I know that I am not alone in these experiences and I am privileged to be able to navigate the health care system to eventually get my needs met, but not everyone can.

We need systemic change within the places that care is delivered. We need legislation that will increase health equity and affordability. We need more doctors and other health care providers of color. We need health insurance that’s lower cost and higher quality, and will provide more coverage for the services that communities of color need most. We need to reduce medical debt, which is also a huge need for communities of color. We need the health care system to invest in the health of their communities. And we need to put people’s lives over profit.

Ultimately though, none of this will eliminate or even reduce the implicit racism that people of color face when we seek care or simply exist. Everyone within the health care system has a responsibility to recognize their role in upholding the status quo in health care which continues to devalue Black lives. At Center for Health Progress, our model of system change is rooted in community power, where those of us who are most directly affected by these injustices come together and lead in solidarity with allies to disrupt the status quo and reclaim our humanity and dignity. We deserve better. I deserve better. You need to be a part of leading this change, as someone who is directly affected or as an ally—reach out if you want to know how to get started!

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IN MEMORIAM

IN MEMORY OF BILL “FOZZY” FOSMIRE, MD

The firmament of family medicine dimmed a bit on March 13, 2021, when our teacher, colleague, mentor, friend, family medicine champion, and really good guy William Fosmire died of complications of multiple myeloma in Golden, CO. He died as mindfully as he had lived: aware, with his wife Brenda and adult sons George and Albert at his bedside, and attended by both colleagues and the residents he had taught and mentored.

Bill called Dallas, Texas home but having been born to a medical missionary surgeon father, he had lived in France, Africa and India before he was in kindergarten. He went to the University of Texas Health Sciences Center at San Antonio Medical School at an age when most people are still in college, graduating in 1983. He was a resident in general surgery at Baylor University Medical Center, where he was proud to be able to operate with his father. He left surgical residency to attend the University of Missouri at Kansas City Family Medicine Residency Program, completing his residency in 1988.

After completing his residency, Bill spent four years as the medical director of the student health program and an adjunct professor of medical microbiology at the University of North Texas, then moved to Colorado to join the St. Joseph Hospital Family Medicine Residency faculty in 1993. He taught and practiced medicine at St Joseph Hospital from that time on, serving as chairman of the Credentialing Committee and as a member of the Medical Executive Committee from 2008 until his death. He was a strong advocate for family medicine in each of these positions, including attending meetings at the state legislature regarding physicians’ issues. He was the interim director of the Family Medicine Residency Program in 2003-2004.

For the past 10 years Bill also was the primary care physician for participants at Laradon Hall, a residential facility for adults and children with intellectual and developmental disabilities. He received an appreciation award for his teaching and service there in the same month that he received the Physician of the Year award from St. Joseph Hospital in 2018. Bill also twice received the St. Joseph Hospital Family Medicine Residency Teacher of the Year Award. Bill taught over 200 family medicine residents during his career.

Bill became a member of the American Academy of Family Physicians in 1988 and a fellow of the AAFP in 1995. He joined the CAFP in 1993.

Apart from medicine, Bill was...
a dedicated husband and father. He was a founding parent of the Compass Montessori Charter school in Golden. He served on school committees and in his homeowners’ association. He played piano and guitar with enthusiasm and natural ability. Bill was captivated by small plane aviation, and earned a pilot’s license twice; although he stopped flying when he became a father he never lost his interest in aviation.

His friends and colleagues loved Fozzy, and his absence is felt deeply. As one of his former colleagues said, “The world was a better, funnier, kinder place with Bill Fosmire in it.” Krista Richardson, RN, of Laradon Hall noted that he was “genuine, patient and caring.” She remarked that he always taught, providing interdisciplinary learning for residents, pharmacy students, and staff. Holly Church, Director of Medical Staff Services for St. Joseph Hospital, said “He was so open about his life and experiences, advocating for each person to be their better self.” “As a staff leader, his guiding principle was to benefit patients. When she told him she had received the Covid vaccine, Bill said, “I didn’t see you share that on FaceBook! You have to post it; you need to be an advocate.” He struggled with alcoholism with courage and forthrightness, and had been in recovery for many years. He used his experience to reach out a helping hand to others in their struggles.

We could trust Fozzy with our true selves -- as patients, as students, and as colleagues, knowing that he trusted us with his true self. He shared enthusiasm about his interests and the interests of others. He was the go to person for information or assistance; he never turned down a task or complained about one. He shared music, medical knowledge, and workflow improvements with equally positive energy. And those FaceBook posts...they always lifted our spirits with their humor, reframing, and expressed gratitude for life and love.

So, this was it: He lived and loved life, he taught and loved learning, flew and loved flight, cured and loved curing, struggled and sanctified struggle, suffered and transmuted suffering into connection. And he elevated us all in the process of living his life.

Bill said that the messages he found and posted on FaceBook were ones he needed to have in his own life. Here are some from his FaceBook page in his last weeks of life:

“I’m the person who sees the sun set every day and is still amazed by it, every time.”

“Go as far as you can see. When you get there you’ll be able to see farther.”

“I had my own version of grief I thought it was the sad time that followed the death of someone you love,

And you had to push through it To get to the other side.

But I’m learning there is no other side.

There is no pushing through. But rather there is absorption. Adjustment. Acceptance. And grief is not something you complete. But rather, you endure. Grief is not a task to finish And move on, But an element of yourself— An alternative of your being. A new way of seeing. A new definition of self.”

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Meet Colorado’s Candidate for AAFP Board of Directors:
Megan Adamson, MD, FAAAAFP

For Dr. Megan Adamson, MD, MHS, FAAAAFP, taking care of family physicians is a crucial part of being a family physician. The Lafayette, CO resident, wife, and mother of three has pursued a career of service to her fellow clinicians as well as her patients. As Medical Director at Clinica Family Health in Lafayette, Megan works hard to optimize the daily operations of the clinic, as well as seeing her own patients. She grew up in Colorado, and even shadowed at Clinica during her college years, already seeking to work in primary care.

Though her career has taken her around the nation, the Boston University Medical School graduate returned to Colorado in 2018 and serves on the board of the CAFP. Now a candidate for AAFP Board member, Dr. Adamson seeks to continue her fight against physician burnout and mile-high stacks of paperwork at the national level.

Dr. Adamson’s candidacy for AAFP Board is the latest in a series of career decisions centered around easing burnout and unnecessary complication, which she often likens to a hamster wheel. “We need to address the toxic stressors that cause burnout for too many,” she says. “And especially to work on reducing the excessive burdens that threaten small, independent practices.” Impractical productivity metrics, failures of EHR interoperability, and the demands on PCPs as gatekeepers place a huge burden on family physicians, who also have their own lives. Pay for performance, long work hours, and enormous student loan debt all impinge on family doctors’ personal lives, which can strain a family. Depersonalized decision-making in large hospitals and health organizations only exacerbates these burnout factors, making AAFP advocacy essential.

“Family doctors end up feeling like they’re not doing what they got into medicine to do,” Dr. Adamson says. With some studies reporting more than half of all family physicians are experiencing symptoms of burnout, addressing inciting factors is crucial to physicians’ own health, as well as the quality of patient care. Dr. Adamson sees her primary mission as freeing up family physicians to focus on patient care.

The day-to-day of family physicians is a far cry from the ideals of pre-meds studying for the MCAT. In addition to lowering their own standards, family physicians are too familiar with the comparatively low pay they receive for time with patients, if they get enough time with those patients. “I got into medicine to help people,” she says. “Naturally, I want to help my fellow physicians to help their patients.”

Addressing these problems has been a focus of Dr. Adamson’s career since reaching her own low point. Dr. Adamson finished residency at Duke University’s newly-revamped family medicine program, and stayed on for a fourth year completing a Master’s degree in clinical leadership. She then moved into a practice in Duke’s network of primary care in Durham, NC. “It was just too much,” she recalls of the short patient visits and the daily patient totals. “I was relying on my husband, himself a stressed-out Ph.D. student, to take care of our boys, who were all under five.” No one was getting much sleep.

“It was time to make a change.” Dr. Adamson became the lead physician at a new kind of occupational health practice at the Dartmouth-Hitchcock Medical Center in Lebanon, NH, called LiveWell/WorkWell. This was her first chance to take care of other physicians in a setting that allowed her to really get to know her patients. A startling discovery revealed itself: she wasn’t alone. From the hospital’s environmental technicians, to its residents and more experienced physicians, everyone was dealing with the same stressors. In addition to her clinical role, Dr. Adamson served as faculty at the Geisel Medical School, advisor to the Family Medicine Interest Group, and mentor to Dartmouth students for underrepresented groups through the Pathways to Medicine Program.

She recognized it was time to help at another level, and found the opportunity in the most pedestrian of places: a mass email from the state AFP chapter. Megan attended the National Conference of Constituency Leaders (NCCL) for the first time in 2015, and began attending national and state-level AFP meetings. Megan ran for and was elected as New Physician Co-Convener, and represented new physicians at the Congress of Delegates. She has since served three times as New Physician Delegate and once as
Recovering from 2020

BY SARAH MCAFEE, DIRECTOR OF COMMUNICATIONS, CENTER FOR HEALTH PROGRESS

2020 was the longest decade of my life. Time lost all meaning as the days, weeks, and months ran together into a distressing, depressing sludge of death counts, crises, never-ending elections, and isolation. We held our breath, literally and figuratively, waiting for a new year to bring us something, anything that was better than what we were living through. And now here halfway into 2021--is it safe to exhale yet?

It’s not, of course, because turning the calendar page didn’t end the pandemic. In the same way, a new president didn’t undo the last four years of intensifying racism and xenophobia in our policies and communities, and now that we want everyone to get a COVID-19 vaccine, we can’t just erase centuries of neglect and abuse of Black, Indigenous, and other people of color by the health care system.

How we will recover and heal from COVID-19 as a society and country has been top of mind for many of us. Individuals and organizations have written impassioned calls to action and detailed policy maps that can guide our hearts and minds. Across Colorado, much has been written about our collective vision and path for an equitable recovery in Colorado. At Center for Health Progress, we’ve been planning alongside patients and community members, because they unfairly shoulder the burden of our crises and know better than any of us what it will take to solve them.

Many people and organizations talk about health equity as ensuring equal outcomes—that there is nothing about a person’s race, class, gender, citizenship status or otherwise that should limit their health or health care access. After a year like 2020 though, is that even enough? Would it be enough to solve maternal mortality disparities, close life expectancy gaps, provide health insurance and paid family leave to all regardless of documentation status—would it be enough to achieve equal health outcomes for future generations? Would the families of the 600,000 people—disproportionately people of color and immigrants—who have died of COVID-19 in the US feel better if they knew we’d do better in the next pandemic? True justice rightfully demands more of us than that.

Recovering from the last year—and centuries further back, if we’re being honest with ourselves—is going to require recognizing and repairing the full extent of the harm white people have caused communities of color. This must happen across all systems and institutions, including in health care. The history of racism in the US health care system is long and well-documented, and the impact has been generational trauma and untold damage to communities. It will also require white people like myself to recognize our own roles in upholding white supremacy, wrestle with our own sins and those of our ancestors, and be actively anti-racist in our daily actions. We owe it to each other, to ourselves, and to our ancestors before us to restore and repair the harm.

If there is one positive outcome from the past sixteen months, it is the knowledge that we can do extraordinary things together. We can mobilize trillions of dollars. We can develop a vaccine for a novel virus in record time. We can make bold policy changes—at the Capitol, in our states, in our workplaces, in our schools, in our communities, and everywhere else—quickly, to suit the needs of the people and the demands of the time. And even when our leaders and government fail us, we can come together to take care of each other. More of all that is how we’ll recover and rebuild.
WELCOME NEW MEMBERS

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

ACTIVE:
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BAABA BABSON, MD
J RUSSELL BOWMAN, DO, MS, MHA, CPE, FAAFP
JOHN BRECK, DO
HEATHER BROUGHTHAM, DO
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