THE 2022 CAFP FAMILY MEDICINE PHYSICIAN OF THE YEAR
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CAFPG 2022 FAMILY MEDICINE TEACHER OF THE YEAR
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THE 2022 CAFP RESIDENT OF THE YEAR
PG...30

HEALTH EQUITY AND COMMUNITY ENGAGEMENT PRACTICE AWARD
PG...32
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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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Ending the HIV Epidemic Starts With Routine HIV Screening.

The Centers for Disease Control and Prevention (CDC) recommends that everyone between the ages of 13 and 64 get tested for HIV at least once and that those with ongoing risk be screened at least annually. Yet 1 out of every 8 people in the United States are unaware of their HIV status.

You can play a critical role in ending the HIV epidemic by offering HIV screening to all your patients. Routine HIV screening helps to:

- Reduce HIV transmission by empowering your patients to know their status.
- Improve your patients’ health outcomes by linking them to prevention or care services.
- Eliminate stigma associated with HIV testing by making it the standard of care.

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Ending the HIV Epidemic Starts With Routine HIV Screening.

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- Eliminate stigma associated with HIV testing by making it the standard of care.

Access new CDC resources on integrating routine HIV screening into your practice at: cdc.gov/ScreenForHIV.
America is in a medical crisis, and I am not talking about a pandemic. Everyone who works in healthcare is aware of this. Our country is stuck in an unsustainable pattern of losing American medicine’s most valuable assets: medical providers.

Hospitals often have entire floors closed while emergency rooms are overflowing with patients waiting for a bed — because there just are not enough doctors and nurses to staff those beds. Patients are forced to wait weeks to see their family medicine doctor and months to see some specialists.

Much has been written about how half a million healthcare workers have left the profession in the past two years. But the truth is, the pandemic only accelerated an already existing problem. Too many medical providers are burned out, thinking about quitting, or even changing professions altogether.

For generations in America, the field of medicine attracted the smartest, most empathetic, hardest working, and resilient people. Physicians have always been rewarded by spending time with their patients, getting to know them, and treating them accordingly. Although a stressful field with long hours, this gratifying style of medicine was sustainable for health care workers. It was never a data entry job, it was a personal interaction career.

Over the past few decades, patient volume has been valued more and more over personal relationships in patient care. And, the rise in patient volume has been driven by a relentless focus on data entry in the clinic. This is further compounded by an increase in administrative burden. There is a dramatic decline in physician wellness as a result: we are overworked and exhausted.

Administrative tasks that do not require a medical degree are increasingly expected of the physician. The value of this work is often measured in reduced costs for healthcare systems. A few examples in a (very) long list include medication prior authorizations, peer to peer discussions for imaging orders, and yearly referral renewals to previously established specialists. These tasks rarely improve patient outcomes and often reduce overall patient care by consuming valuable resources from provider time.

Most physicians accept their long hours, risk to their personal safety, and stressful jobs as worthwhile, as long as it involves improving the health of their patients. But as the administrative busy work increases and the time spent with patients decreases, the rewarding aspect of such a difficult job quickly declines. This is why we are losing health care providers at such an unsustainable rate. I do not believe there is one physician in America that does not know this.

Frustratingly, government, the hospital systems, insurance companies, pharmaceutical companies, health care networks and other healthcare employers are aware of this problem as well. I know they respect their medical staff and they would also like to fix this issue. So why hasn’t it been fixed yet?

Physicians love practicing medicine. They are hard workers and pride themselves on doing what is asked of them. They often put themselves last in line, even at the expense of their own wellness, until it is too late.

But, it is almost too late. We have to turn this pattern around now, while we still have time to prevent even more catastrophic provider loss. I have seen small but encouraging glimpses of action designed to address these issues, like bills to reduce prior authorization paperwork, healthcare employers trying to incentivize advanced payment models, and a general effort to move away from fee-for-service reimbursement. And, most promisingly, the very beginning of movement towards empowering patients to drive change by giving them more options for health care in the form of public options. But if we want meaningful change, family medicine physicians are going to have to direct this change ourselves.

So help us. What are the things that make your job more difficult, the red tape you cut through in order to practice medicine. Ideas you have to improve your job satisfaction and wellness. The ridiculous things you see daily that make you think… why? Email them to me, so I can compile them into a comprehensive plan for which the CAFP can advocate.

I can not promise that we will fix this massive problem immediately. However, we must actively contribute to crafting the solution, because who else has ever better advocated for all medical providers and patients than family medicine physicians.

---

**February, 2022 Board Highlights**

1. The 2022 CAFP Foundation Annual Summit is taking place from May 5-8, 2022, at the Hythe Resort in Vail, Colorado. Our theme this year is **Renewal**. We have three options to participate: in-person at the resort, hybrid from the resort via video (for socializing outside the event space where the COVID risk is lower), and fully virtual. We ask that all attendees follow safety protocols provided by CAFP and that you do not attend any in-person events if you are feeling unwell or showing any symptoms of illness.

2. The AAFP is forming a new Commission on Diversity, Equity, and Inclusion. If any CAFP members are interested in running for a spot on the Commission, please contact EVP/CEO Ryan Biehle: ryan@coloradoafp.org.

3. The CAFP has led an extensive campaign in the Colorado legislature to extend the Rural Preceptor tax credit. As we continue to protect this important support for the development of rural family physicians, we will keep the membership updated.
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MESSAGE FROM THE EXECUTIVE VICE PRESIDENT & CEO

SUSTAINING AND GROWING THE PRIMARY CARE WORKFORCE

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

Renewal is on our minds lately at the Academy. It is the theme of the CAFP Foundation Annual Summit, and we hope you can join us in Vail May 5th-8th to reconnect with colleagues, enjoy the mountain air, and learn the latest in family medicine. At the moment, we appear to be moving into the endemic stage of COVID-19. While the pressure on the healthcare system is easing, the reverberations in the workforce will continue for some time. We have work to do in rejuvenating colleagues and teams while recruiting new physicians and staff to care for patients.

Labor shortages are impacting every sector of the economy, and primary care is no exception. According to the latest Larry A. Green Center COVID-19 Primary Care survey, nearly 50 percent of Colorado practices have open clinician positions they cannot fill, and 65 percent of practices have other staff openings without employees to fill them. Another 66 percent reported we (primary care) are clinically fragile. The pressure from a pandemic on the system may be easing, but we have ground to make up in rejuvenating and making sure family medicine can be the lifelong calling it has always been.

The culprits for these challenges are many: burdensome administrative tasks and insurance hurdles, underfunded primary care amidst rising wages and other inflationary pressures, too few medical students graduating into primary care and too few family medicine residency positions. However, we have reason to be optimistic about our ability to meet and overcome these challenges.

The 2022 residency match was a banner year for primary care. The AAFP reported that 4,935 positions opened up for family physicians, an increase over 2021. If there was any silver lining in the pandemic’s impact on students applying for medical school, it is that 2021 saw the most applications to medical school of any class. Moreover, a February report from the American Association of Medical Colleges found that in 2021, enrollment by medical students identifying as black or African American rose 21 percent, while 2021 saw the most applications to medical school of any class. Moreover, a February report from the American Association of Medical Colleges found that in 2021, enrollment by medical students identifying as black or African American rose 21 percent, by 8 percent for those identifying as Asian, and by 7 percent among students identifying as Hispanic, Latino or Spanish. We have made gains, and we need only to sustain this momentum.

CAFP recently participated in the Colorado HOSA conference, a student leadership organization that engages underrepresented youth at one hundred Colorado schools in exploring health professions. Building out this partnership and others is part of our commitment to recruiting for the future of family medicine.

In Colorado, there is a legislative effort to establish a new medical school at the University of Northern Colorado. We welcome the opportunity to expand physician training, while also understanding that a new school requires support for additional preceptors and clinical rotations. CAFP will be evaluating the legislative proposal to add this new medical school, while continuing to support students at the University of Colorado School of Medicine and Rocky Vista University College of Osteopathic Medicine in getting a world class medical education. We invite students to come meet Colorado’s family physicians at our Annual Summit and see the excitement of family medicine’s impact on patients.

Beyond medical school, a major pinch in the workforce pipeline is residency availability. We need additional federal funding to expand primary care residencies that have been capped at 1996 levels. We continue to press Congress to expand this funding. The 2021 American Rescue Plan authorized $330 million for Teaching Health Centers, a major investment in primary care residencies and a good start. The Rural Physician Workforce Production Act of 2019 (S. 289) was Colorado-led and provided a template for more robust expansion. While the Act has not yet passed, we continue to raise this imperative for our Congressional Delegation.

CAFP is also participating in a state workforce coalition to bring both immediate relief to the healthcare workforce challenges using American Rescue Plan (ARP) funds, as well as to fund long term planning and development. This coalition is broad, comprised of physician, rural and federally qualified health centers, hospitals, nurses, and public health professionals. We are advocating for the State to use ARP funds for hero/retention pay among those dedicated to a career in health, financial incentives to recruit and educate students in health professions, and scholarships and loan repayment to support those underrepresented in healthcare. In addition, we call on the State of Colorado to engage in comprehensive, ongoing analyses and workforce development efforts to meet our long term workforce needs.

Finally, a study released in March showed the cost of primary care physician turnover at a staggering $1 billion. One-quarter of that cost is due to burnout. Employers and insurers have to take note of the cost and add it to the list of many reasons we should make joy and satisfaction in practice a top priority. On a policy level, we have long advocated to transition from fee-for-service to alternative payment models (APMs) that include prospective payment. These models can ease the pressure for production and give back one of a physician’s most valuable tools in caring for patients - time. Time to listen to the patient, time to take care of the whole person rather than treating one disease or disorder. The Primary Care Payment Reform Collaborative established by CAFP’s legislation to increase primary care investment has outlined a framework to hold Colorado insurers accountable for moving to APMs. CAFP is also working with state legislators who are proposing a bill to create statewide APMs that include prospective payments and aligned quality measures. The work continues to make sure family medicine is leading the way in keeping our communities healthy.

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Partnership in our advancement of policy change

“At rare exceptions, all of your most important achievements on this planet will come from working with others - or, in a word, partnership.”

Paul Farmer, MD

At the end of February, Paul Farmer, an internist, medical anthropologist, and co-founder of Partners in Health, passed away. But, his legacy to the fields of public health, international medicine, and health policy live on. His lessons and achievements are realized in the approach that the Academy takes when advancing system-level change to achieve our vision for thriving family physicians creating a healthier Colorado.

CAFP has spent decades building relationships with our members, partner physician organizations, patient advocates, and elected officials in our state. Mirroring a family physician’s clinic where you work alongside an interdisciplinary team of providers, administrative staff, community-based partners, patients, and their families, the CAFP takes the same approach down at the State Capitol.

This legislative session, the CAFP has deepened existing partnerships with health care alliances to advance our policy agenda:
- We have partnered with over 15 organizations to develop a comprehensive workforce package to bring legislative and budget solutions to address short, medium, and long-term workforce needs to support the existing, growing, and future health care and public health workforce.
- Because of these strong partnerships, the Health Care Preceptors Tax Credit bill we are co-leading with the Rural Health Centers, which will extend the incentive program for another 10 years and expand eligibility to primary care nurses, behavioral health providers and dental hygienists, has had bi-partisan support and is expected to pass both the House and the Senate.

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various coalitions that represent the interests of immunization policy, maternal health, tobacco control, health care payment reform, and substance use prevention. By working across organizations, we distribute the weight of the work and utilize the “power-in-numbers” philosophy to influence or negotiate with elected officials.

- An example of this was with three pieces of legislation that perpetuated vaccine misinformation and undermined public health interventions. Nearly twenty health provider associations, business groups, public health advocates, and disability rights activists came together to defeat these bills. Finally, our members are the foundation to our success in our advocacy efforts. Our members maintain a presence at the state house when volunteering as Doctor of the Day or testifying on a particular piece of legislation. Our members represent the voices of family physicians on state boards and commissions, coalitions, and with their elected leaders. Our members lean into difficult policy negotiations to ensure we are standing strong in our values and achieving the best outcomes possible.

- Member leadership has driven our success at making improvements to a difficult scope of practice bill related to physician assistant supervision. Over two years, members have leaned in to these discussions to maintain a strong relationship with their physician assistant colleagues and to elevate the concerns of the broader physician community. Because of this, we made progress on the bill to ensure there is ongoing coordination and communication with a physician following the initial training hours that a physician assistant has under a physician.

Partnerships help us get through difficult times or challenging policy discussions because we have developed those trusting relationships. We can rely on our colleagues to share the weight of our ambitious agenda because of our shared vision for a healthier, more equitable Colorado. And our colleagues can rely on us to champion the values of family medicine.

“...In a world riven by inequity, medicine could be viewed as social justice work.”
-- Paul Farmer
KEELY BURKE, MD, TESTIFIES IN OPPOSITION TO VACCINE MISINFORMATION BILLS AT THE COLORADO HOUSE BUSINESS AND LABOR AFFAIRS COMMITTEE HEARING.

CAFP COMMUNICATIONS DIRECTOR JOSHUA FOUST (LEFT), RVU MEDICAL STUDENT KATHERINE NICOLICH (CENTER), AND NAINITA MADURAI, MD (RIGHT) PRESENTED A PANEL ABOUT THE LIVES OF FAMILY PHYSICIANS AT HOSA'S 2022 STATE LEADERSHIP CONFERENCE.

MARK DEUTCHMAN, MD, DIRECTOR OF THE CU SCHOOL OF MEDICINE RURAL TRACK PROGRAM AND MEDICAL STUDENT EVAN CORNISH, WHO RECENTLY FINISHED A RURAL ROTATION IN LA JUNTA, TESTIFY IN SUPPORT OF THE RURAL PRECEPTOR TAX CREDIT DURING A HEARING AT THE STATE CAPITOL.

CAFP BOARD MEMBER AT LARGE ABBIE URISH, MD, TESTIFIES IN SUPPORT OF THE CONTINUATION AND EXPANSION OF THE RURAL PRECEPTOR TAX CREDIT DURING A HEARING AT THE STATE CAPITOL.
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Greetings again from SNOCAP-

We hope you’ve been coming into this Spring with good health and a positive outlook!

We have a short SNOCAP update for everyone this go-round!

Over the past year, we have worked with eight practices across the state to survey patients and practice providers and staff on their levels of burnout, and if patients are perceiving any change in their regular care that could be a sign of burnout.

We are in the middle of data analysis currently and look forward to sharing our findings, hopefully in the next issue!

In November/December 2021, SNOCAP launched its 11th COVID-19 Response Survey for practices state-wide. If you have been tracking along with SNOCAP for some time, you may know that we spent a great deal of time since March 2020 surveying practices and reporting on how COVID-19 was affecting practices, patients, and the wonderful work done in partnership. If this is sounding new and interesting to you, you can learn about the November/December results, and all others, by visiting: https://bit.ly/SNOCAPCovidwebsite.

Lastly, and in our minds most excitingly, SNOCAP created an Annual Report to showcase all of the wonderful work done by our practices, patient and community partners, and researchers throughout 2021. We are excited to share that with you on our website home page! Thank you to every person, practice, project, and community showcased in this work; and to those who have engaged in many other ways with us over the past year. It means so much to us: https://medschool.cuanschutz.edu/family-medicine/community/practice-based-research-networks/snocap

We’re sure you have a lot in the works as well. Please reach out and let us know what’s going on in your community! Until then, that’s all for this quarter. Thank you again for all of your work and please stay safe.

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

Follow along on Twitter: @SNOCAPpbrn

Email Don Nease: Donald.nease@cuanschutz.edu

Best wishes!
Don Nease, Mary Fisher & the entire SNOCAP Team
MANAGING PATIENT CONCERNS ABOUT WEARABLE DEVICE DATA

BY ERIC ZACHARIAS, M.D.
COPIC DEPARTMENT OF PATIENT SAFETY AND RISK MANAGEMENT

An active 53-year-old patient saw her physician because she was worried about the rapid heart rates data she downloaded from her fitness monitor. She told her physician that she had a strong family history of heart disease and an internet search revealed that a high heart rate can be the first sign of an impending heart attack. Her data downloads had never shown such high heart rates before. She brought in a year’s worth of heart rate data printouts to the appointment and asked to put these in her medical record. What should this physician do?

There has been a significant increase in the use of consumer-marketed, wearable technologies that measure and report physiological data. As a consequence, physicians have noticed patients are starting to bring this information to appointments expecting something to be done with it. Understanding a few basic principles will help when seeing such patients.

First, it is useful to make it clear to patients who bring in data from consumer-grade monitoring devices that the information is designed for consumer use and not for medical care. For example, you may choose to tell patients that although you see and agree that the information from their wearable device is indeed abnormal/outside what may be expected, this information is not from a medical-grade, FDA-approved device. Thus, you know neither its reliability nor necessarily how to interpret it. Furthermore, it may be useful to explain that any abnormal information from such a device is not a medical diagnosis, but perhaps may be a reason for a careful medical assessment.

Additionally, set expectations with patients who bring physiological data from wearable devices as to how this information may be documented and used. For example, you could tell them that, given its limitations, the information may be documented in a subjective way in your note and may help contribute to their care, but it will not be stored as part of the medical record as data from a physician-prescribed, medical-grade device would.

Although data from wearable devices is not medical grade, it probably should not be completely dismissed without at least looking at it. This may involve a follow-up office visit. In an established physician-patient relationship, it is reasonable for physicians to assume they have some responsibility to consider the data that a patient presents them from wearable devices in their overall decision-making process. However, as noted above, the actual data brought by the patient can be considered indeterminate due to the unclear reliability of the source. Some physicians report that they treat data from wearable devices in a fashion analogous to how they would treat a sheet of paper brought in by the patient with a list of questions or self-checked pulses on it: it informs the care during the visit, but is not put directly into the medical record.

Lastly, it should also be made clear and documented that any patient who believes they are having a medical emergency, no matter what information a wearable device is reporting, should immediately dial 911.

So, for the case presented, here is a reasonable approach the physician might take once the presence of an emergency situation has been excluded:

1. Perform a thorough history and physical examination and let the patient know this is informed by her concerns as well as the information she brought from her wearable device. Determine appropriate near- and long-term testing, referrals, and follow-ups as for any evaluation.
2. Alert the patient as to the plan for further evaluation and management as well as signs and symptoms that would warrant re-evaluation or calling 911.
3. Tell the patient that although you appreciate the data, it is not appropriate for the medical record. Also, communicate that the device used is not medical-grade and the information may not be accurate or reliable.
When parents are concerned about their child’s mental health, the first professional they will likely discuss these concerns with is their child’s primary care provider, according to research on the PCPs role in addressing behavioral disorders. This supports the ever-increasing awareness of the importance of establishing “medical homes” for pediatric patients. Medical home refers to a comprehensive approach to primary care that focuses on partnerships between caregivers and patients and their families. One of the many benefits of establishing these medical homes is the increased emphasis on the integration of mental health into routine pediatric practice. As such, primary care providers are uniquely positioned to identify patients who are experiencing psychological difficulties.

Unfortunately, primary care practices often under-detect mental health issues in children, particularly when medical providers rely on clinical judgment or poorly constructed screening measures. For example, providers who rely solely on clinical judgment to identify patients with mental health concerns will only positively identify approximately 30% of clinical patients, whereas 70% of these patients are accurately identified when using a validated screening measure.

Recognizing the importance of mental health as a key determinant of overall well-being has markedly increased over the past decade. In fact, the Surgeon General’s national health goals recommend that primary care providers should routinely screen for mental health concerns in their patients. Below you will find practical suggestions to support primary care providers in implementing behavioral health screenings in their practice.

### Universal behavioral health screening

Prevalence data suggest that approximately 1 in 5 children and adolescents will experience a diagnosable mental health disorder at some point during their childhood. Given the high prevalence of childhood mental health concerns, providers should consider having all patients complete a brief behavioral health screening at their well-child visits.

The Pediatric Symptom Checklist (PSC-17) is an excellent universal screener that is widely used in primary care practices and has been endorsed for use as a national standard of care by the National Quality Forum. A positive score on the PSC (15 or greater) indicates the presence of possible mental health issues and the need for further evaluation by a qualified medical or mental health provider.

### Narrow band screening

If a provider suspects the presence of a specific disorder (e.g., ADHD, depression), consider administering a narrow band screening. Information obtained from these screeners can help confirm a diagnosis and can be re-administered over time to track changes in response to treatment.

Common narrow band screening measures used in primary care settings include:

- ADHD screener: Vanderbilt ADHD Rating Scales
- Anxiety screener: Screen for Child Anxiety Related Disorders (SCARED)
- Autism spectrum disorder screener: Modified Checklist of Autism in Toddlers (M-CHAT) for ages 16-30 months; Childhood Autism Spectrum Test for ages 4-11 years; Autism Quotient for ages 12-15 years
- Behavior screener: Strengths and Difficulties Questionnaire (SDQ)
- Depression screener: Patient Health Questionnaire-9 (PHQ-9)
- Eating disorder screener: Eating Attitudes Test (EAT-26)

### Clinical tips when performing behavioral health screenings

It is critical that medical providers discuss mental health in a destigmatizing manner. Emphasize that mental health concerns are common and that seeking support for these concerns is a positive step towards promoting overall health and well-being. When discussing mental health concerns with a patient, provide empathic statements such as, “I can see that you’re really hurting right now,” or “It sounds like you’re worried a lot these days.” Show genuine interest and concern for the patient. Start by talking with the patient about a low-threat topic, such as their hobbies. Children are more likely to open up
to adults if they feel comfortable and understood.

During the screening, pay attention to signs of possible mental health concerns. These behaviors could include:

- Irritability
- Minimal eye contact
- Appearing withdrawn
- Complaining of unexplained medical symptoms (e.g., stomachaches, headaches)

In addition to the screening and discussion with your patients, be sure to obtain additional information from parents, school personnel and other medical providers.

**Behavioral health referrals**

If screening reveals mental health issues, healthcare professionals can support the family in accessing high-quality mental health services within the community. Children's Hospital Colorado's Pediatric Mental Health Institute provides evidence-based comprehensive mental health services.

For more information, providers can call 720-777-6200. Additional Colorado mental health services can be found through the Colorado Department of Human Services.

**Additional behavioral health resources**

Peer reviewed care guidelines from a professional association:

- American Academy of Pediatrics Clinical Practice Guidelines
- American Academy of Child and Adolescent Psychiatry Practice Parameters
- Partnership Access Line (PAL) in Washington

Free access screening measures:

- PSC-17 – Pediatric Symptom Checklist
- SCARED – Screen for Child Anxiety Related Disorders
- NICHQ Vanderbilt Assessment Scales
- M-CHAT - Modified Checklist of Autism in Toddlers
- SDQ – Strengths and Difficulties Questionnaire
- PHQ-9 – Patient Health Questionnaire
2022 CAFP Foundation Annual Summit
Renew Your Passion - Together!

May 5-8, 2022
The Hythe Resort
Vail, CO

Conference Agenda

Thursday, May 5, 2022

10:15 a.m.  Registration Opens

Life Support Courses presented by:
Health Education Network
Instructor: Kristin Paston, RN

10:30 - 11:30 a.m.  Basic Life Support (Register)
11:45 a.m. - 1:00 p.m.  Advanced Cardiac Life Support (Register)
1:15 - 2:30 p.m.  Pediatric Advanced Life Support (Register)

5:30 - 6:00 p.m.  Welcome Reception

6:00 - 7:00 p.m.  *COPIC Presents:  Minors & Risk:  Immunizations, Pregnancy, STI, Addiction, Mental Health, Custody Battles, & More!
Alan Lembitz, MD (1 CME Credit)

7:00 p.m.  Adjourn - Dinner on your own
Friday, May 6, 2022

7:30 - 8:30 a.m.  Grab & Go Breakfast
8:30 - 8:55 a.m. *CAFP Board Installation
8:55 a.m.         *Conference Welcome & Announcements
9:00 - 10:00 a.m. *The “Fourth Trimester”: Guidelines for Comprehensive Postpartum Care
                  Charity Lehn, MD (1 CME Credit)
10:00 -10:45 a.m. Exhibit Hall Break (open until 6:25 p.m.)
10:45 - 11:45 a.m. *Awards Ceremony, Fellows Convocation, & CAFP President Speech
11:45 a.m. - 12:45 p.m. Grab & Go Lunch
12:55 - 1:55 p.m.  *Gender Variance & Healthcare
                   Ruth K. Weinberg, MD (1 CME Credit)
                   Judy Shlay, MD (1 CME Credit)
2:55 - 3:55 p.m.   Exhibit Hall Break
3:55 - 4:55 p.m.   *Dermatology Showcase
                   Whitney High, MD (1 CME Credit)
                   Lauren Hughes, MD (.5 CME Credit)
5:25 - 6:25 p.m.   Exhibit Hall Happy Hour
6:25 - 8:00 p.m.   Dine-Out Groups
Saturday, May 7, 2022 - Morning Agenda

7:05 - 7:55 a.m.  |  Grab & Go Breakfast
7:05 - 7:50 a.m.  |  *Non CME Presentation Slot
7:55 a.m.         |  Conference Welcome
8:00 - 9:00 a.m.  |  Pediatrics Potpourri
                  |  Paul Berman, MD, MBA (1 CME Credit)
9:00 - 10:30 a.m. |  *Vaccine Panel: Pneumococcal Disease Prevention in At-Risk Adults
                  |  Rachel Caskey, MD
                  |  9:00 - 9:40 a.m.
                  |  Vaccine Hesitancy & Building Vaccine Trust In Your Patients & Community
                  |  Kim Yu, MD
                  |  9:40 - 10:20 a.m.
10:20 - 10:30     |  Q & A
                  |  10:20 - 10:30
                  |  (1.5 CME Credits)
10:30 - 10:45 a.m.|  Break
10:45 - 11:45 a.m.|  *Educating the Next Generation of Family Physicians Suzanne Minor, MD (1 CME Credit)
11:45 a.m. - 12:45 p.m. |  Grab & Go Lunch
<table>
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<tr>
<th>Time</th>
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| 12:45 p.m. | **Legislative Update**  
*Erica Pike, MS*  
12:45 - 1:15 p.m.  
(.5 CME Credit)   |
| 1:15 p.m.  | **Town Hall**  
*Craig Anthony, MD, Ryan Biehle, MPH, MPA, CAE,*  
*Erica Pike, MS*  
1:15 - 1:45 p.m.  
(.5 CME Credit)   |
| 1:45 p.m.  | **AAFP Update**  
*Tochi Iroku-Malize, MD,*  
*MPH, MBA, FAAA*  
1:45 - 2:15 p.m.  
(.5 CME Credit)   |
| Break     | 2:15 - 3:00 pm                                                                                                                           |
| 3:00 - 5:00 p.m. | **Social Determinants of Health Cluster Session:**  
*Addressing Health Disparities in Your Office*  
*Oswaldo Grenardo, MD,*  
*MBA, MSHA*  
3:00 - 3:35 p.m.                               |
|            | Race in Medicine  
*Charity Lehn, MD,*  
*Harriet Huang, MD*  
3:35 - 4:10 p.m.                               |
|            | Gardening for Health  
*Emily Troutman, DO,*  
*Travis Simmons, MD*  
4:10 - 4:45 p.m.                                |
|            | Q & A  
4:45 - 5:00 p.m.  
(2 CME Credits)   |
| 5:00 - 5:15 p.m. | Attendee Sip & See | Drinks & Light Snacks before the CME |
| 5:15 - 6:15 p.m. | **Better Chronic Pain Management Approaches**  
*Kyle Knierim, MD & Team* (1 CME Credit) |
| 6:30 - 8:30 p.m. | **Dine-Out Groups** |
| 8:30 p.m.   | Student & Resident Meet Up                                                     |
|            | **KSA**  
*Heart Disease*  
*Nida Awadallah, MD*  
2:00 - 5:30 p.m.  
(8 CME Credits)   |
|            | **Nutrition Panel:**  
*How to Talk About Health Without Talking About Weight*  
*Lauren Rhoades, MD,*  
*Molly Swanton, MS, RDN,*  
*CDCES*  
12:45 - 1:35 p.m.                               |
|            | Pros & Cons of Various Nutrition Plans  
*Carolynn Francavilla Brown, MD*  
1:35 - 2:25 p.m.                                |
|            | Q & A  
2:25 - 2:45 p.m.  
(2 CME Credits)   |
|            | **Ultrasound Procedural Workshop**  
*Leslie Dempsey, MD*  
3:00 - 5:00 p.m.  
(2 CME Credits)   |
|            | **Nutrition Panel:**  
*How to Talk About Health Without Talking About Weight*  
*Lauren Rhoades, MD,*  
*Molly Swanton, MS, RDN,*  
*CDCES*  
12:45 - 1:35 p.m.                               |
|            | Pros & Cons of Various Nutrition Plans  
*Carolynn Francavilla Brown, MD*  
1:35 - 2:25 p.m.                                |
|            | Q & A  
2:25 - 2:45 p.m.  
(2 CME Credits)   |
|            | **Ultrasound Procedural Workshop**  
*Leslie Dempsey, MD*  
3:00 - 5:00 p.m.  
(2 CME Credits)   |
Sunday, May 8, 2022

6:45 - 7:45 a.m.  Breakfast Presentation
Don't Forget to Breathe: Bringing Mind Body Skills Into Clinical Practice
Kristin van Konynenburg, MD (1 CME Credit)

7:55 a.m.  Conference Announcements

8:00 - 10:00 a.m.  *Behavioral Health & Pain Management Cluster Sessions
Utilizing Practice Facilitators to Assist in the Integration of Behavioral Health & Pain Management
Kathy Cebuhar, MA, Taylor Miranda Thompson, MPH, Andrew Bienstock, MHA
8:00 - 8:55 a.m.

Creating a More Inclusive Work Environment: Microaggressions & Upstander Training
Harriet Huang, MD, Charity Lehn, MD
8:00 - 10:00 a.m.
(2 CME Credits)

It Takes a Team - Integrating Behavioral Health into Chronic Pain Management Workflows
Kyle Knierim, MD
8:55 - 9:50 a.m.

Q & A
9:50 - 10:00 a.m.
(2 CME Credits)

10:00 - 10:15 a.m.  BREAK

10:15 - 10:45 a.m.  *Hearing Loss & Dementia - Now Hear This!
David C. Kelsall, MD (.5 CME Credit)

10:45 a.m. - 11:45 a.m.  *Changing Seasons: Health Impacts of Climate Change in Colorado
Bhargavi Chekuri, MD (1 CME Credit)

11:45 a.m. - 12:45 p.m.  *Updates in Osteoporosis Management
Liza Claus, PharmD, BCACP (1 CME Credit)

12:45 p.m.  Annual Summit Closes
“It’s important as a healthcare provider to help people understand that our patients are in control of their healthcare.”

Dr. Lesley Brooks
Greeley, CO

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November 2021 ACIP Meeting Features Several Important Changes in Vaccine Recommendations

After spending the first day of the November 2-3 virtual meeting on COVID-19 vaccine issues, CDC’s Advisory Committee on Immunization Practices turned its attention to several other pressing items involving other vaccines. Among these was hepatitis B.

Heretofore – as detailed in recommendations most recently published in 2018 – the ACIP has recommended universal vaccination for hepatitis B for persons under 19 years of age. Mostly, because of the length of time that vaccination of infants has been routine, persons under 19 would have had the vaccine at or shortly after birth. For adults, the recommendation has applied to individuals with any of a long list of risk factors: behavioral (mostly sexual), or medical (existence of HIV, HCV, or any of several other conditions that either are markers for increased risk of infection, or which would predispose the individual to severe complications if hepatitis B infection were to ensue.) Additionally, those at occupational risk of blood exposure were included. Taken together, those with any circumstance on this list would comprise a large fraction of the population.

However, classification of individuals by self-acknowledged or clinician-diagnosed risk has never been ideal. People interpret definitions differently; some simply read past descriptive language and assume that “special circumstances” just do not apply to them. So, not surprisingly, the ACIP has now changed its approach and is recommending HBV vaccine for all persons under 60 years, except of course, if one has a medical contraindication, which for a subunit vaccine such as HB is quite unusual. Above the age of 60, epidemiologic data indicate that the risks are low enough in this country that universal vaccination would not be cost-effective or indicated.

This makes it simpler for clinicians. Routine offer of HB vaccine can now be worked into the rhythm of daily clinical practice, as is done with many other vaccines and screening modalities. Hopefully, a further decline in HB infection nationally will result.

In addition, the ACIP took on two vaccines which are intended for very special circumstances – namely for individuals who are at special risk of exposure to Ebola virus or to orthopoxviruses. A live-attenuated Ebola vaccine known as Ervebo® has been recommended for individuals responding to Ebola outbreaks, health care personnel stationed at federally designated Ebola treatment centers, and laboratory workers at level 4 biosafety facilities. Now, ACIP has added two other categories: 1) health care personnel involved in the transport and treatment of patients with suspected or confirmed Ebola virus infection at special pathogen treatment centers, and 2) laboratory or support staff at Laboratory Research Network facilities who work with or may handle Ebola virus specimens.

An orthopoxvirus (this is the virus class that includes smallpox and monkeypox viruses) vaccine that is “replication deficient” – called Jynneos® is now available. This vaccine is safer than the preparation made from replicating vaccinia virus that was used previously. It is for those with potential occupational exposures.

In addition, the ACIP approved the routine vaccination schedules for 2022. These should be available at www.cdc.gov/vaccines/acip shortly.

Survey: Family physicians can impact vaccine confidence

A survey by AAFP’s 2020-2021 Vaccine Science Fellows indicates that public trust in vaccination has increased in some ways. However, many respondents also stated they have less confidence in vaccination than they did when the COVID-19 pandemic began. Survey results also showed that many people’s confidence increased following advice from their usual source of care, such as a family physician. A more complete account published by American Academy of Family Physicians is available here (tinyurl.com/2p8vvk4x).

Many authors from around the world, prior to the COVID pandemic, have explored the factors involved with vaccine hesitancy. A group of authors from India opined “The behaviours responsible for vaccine hesitancy can be related to confidence, convenience, and complacency. The causes of vaccine hesitancy can be described by the epidemiological triad i.e. the complex interaction of environmental- (i.e. external), agent- (i.e. vaccine) and host (or parent)- specific factors. Vaccine hesitancy is a complex and dynamic issue; future vaccination programs need to reflect and address these context-specific factors in both their design and evaluation.” (tinyurl.com/2p963j36).

In that context and in light of constant news updates regarding COVID and COVID vaccines, the results of a recent survey conducted by the AAFP’s 2020-2021 Vaccine Science Fellows are somewhat expected (see tinyurl.com/yc2tbucs). The survey found that while confidence in vaccines has increased for many people, a surprising number of people have less confidence in vaccines now compared with the start of the pandemic. On a more positive note, the survey also found that having a usual source of care such as a family physician had a significant impact on an individual’s confidence in vaccines and their willingness to get vaccinated — a finding that demonstrates the role FPs can play in explaining the benefits of vaccines and alleviating patient concerns.
Survey examines pre-pandemic parental vaccine hesitancy

A survey of 7,645 U.S. parents, conducted before the COVID-19 pandemic, indicated that 23.6% felt hesitant about getting vaccinations for their children, 24.3% had concerns about the number of vaccines administered simultaneously, and 23.2% were worried about long-term effects of vaccination. The survey also showed that mothers were more likely to feel vaccine hesitancy than fathers were. Prior data indicate that only 44% of children aged 24 months are fully vaccinated according to CDC and AAPF recommendations. The researchers provided several CDC-endorsed strategies for increasing vaccine uptake and vaccine confidence, including determining which populations have low vaccination rates; providing data during office visits to back up physician-made claims; and discussing and dispelling myths and misinformation with patients who are vaccine hesitant. The best news was that the vast majority of the parents (over 80%) believed their child’s doctor was the most trusted source of information about childhood vaccines. The study was published in the American Journal of Preventive Medicine (tinyurl.com/3prvp3en).

CDC updates recommendations for recombinant zoster vaccine in immunocompromised adults

In the Morbidity and Mortality Weekly Report dated January 21, 2022 (tinyurl.com/2p9525z4), CDC published updated recommendations for the use of recombinant zoster vaccine (RZV, Shingrix®). Over the last few years, this vaccine has essentially replaced the previously available live zoster vaccine (Zostavax®), because of better safety and efficacy. This updated recommendation is for those “who are or will be immunodeficient or immunosuppressed due to disease or therapy”. Now, persons in that category are recommended to receive two doses of RZV, with the second dose usually two to six months following the first.

CDC data: Majority of ADULTS missed routine vaccines in 2018

Often, a review of CDC’s Surveillance Summaries, published in the MMWR, brings to light information not seen in the regular weekly bulletin. Such is the case with a report on the surveillance of vaccination coverage among U.S. adults, published in May 2021 (see tinyurl.com/45kbs442). The source of the information is the National Health Interview Survey which is a long-standing, continuous, cross-sectional national household survey of noninstitutionalized U.S. civilians. In this report, investigators found that “a majority of adults in the U.S. went unvaccinated for one or more vaccine-preventable diseases during the 2017-2018 season.” Specifically, coverage among adults for influenza vaccination was 46.1%, for pneumococcal vaccine in adults aged ≥65 years was 69.0%, for herpes zoster for adults aged ≥60 years was 34.5%, for tetanus for adults aged ≥19 years was 62.9%, and for HPV for females aged 19–26 years was 52.8%. As in the two items below, these results call for increased vigilance in the clinical practices where many adults who seek care for unrelated reasons might be quite willing to catch up on their vaccines if the issue is raised with them by their family physician.

Routine CHILDHOOD immunizations down due to pandemic

Studies performed at a Philadelphia pediatric network (tinyurl.com/2p8jeepu) and at three academic community-based clinics in Washington, DC (tinyurl.com/2p9eab8n) documented a variety of disruptive consequences to routine care, including immunizations, during the early (spring/summer 2020) phase of the COVID pandemic. In Philadelphia, not surprisingly, up-to-date rates for childhood vaccines decreased sharply when lockdown took effect in March, then rebounded in the late summer and fall when the clinic implemented an aggressive catch-up campaign. The Washington DC study was conducted to assess reasons for missed visits. Concern about catching COVID, and confusion as to whether non-emergency outpatient care was considered “essential business” and allowed to remain open (it was), were frequently cited. As with the items above and below, these results remind family physicians to consider offering catch-up vaccines with children not only in preventive care visits, but also during acute visits when possible.

Survey explores factors tied to incomplete vaccinations among INFANTS during COVID-19 pandemic

According to a Research Letter published in JAMA Pediatrics (tinyurl.com/2p9ex7xw), a 2020 study of 1107 infants revealed that incomplete immunization was associated with some of the factors one might predict (parity, education, health insurance, for instance) but also with COVID-19– and non–COVID-19–related stress factors such as income loss, discrimination, receiving telehealth prenatal care, and briefer postpartum hospitalization. Other factors found to be associated with missing immunizations included perinatal care limitations (telehealth prenatal care and brief postpartum hospitalization), COVID-19–related income loss, and experiencing discrimination owing to one’s race, gender, sexuality, or body size. Infants whose mothers who had greater concern about perinatal infection and greater birth satisfaction were more likely to be fully vaccinated. As with the two items above, as family physicians who care for folks of all age groups, this year let us be increasingly vigilant to help our patients and their families use 2022 to become fully vaccinated.
Humility, Service, Dedication:
AIMEE ENGLISH, MD - FAMILY MEDICINE PHYSICIAN OF THE YEAR

Aimee English, MD, who is the CAFP’s 2022 Family Physician of the Year, had an early interest in doing science. “I majored in biochemistry,” she says, “because it seemed like there were some big equity questions in genomics I wanted to be a part of.” However, the classes were impersonal and very dry. “The human side of science really interested me,” she says, and added management to her biochemistry major. “I learned a lot of skills studying management,” she says. “I think that led me on a path to clinical leadership.”

After graduating, Dr. English did not see much appeal in joining the corporate world. “I wanted to be more hands on,” she says. “And, being a doctor seemed like a good way to put my interests in science and helping people to work.”

She was interested in family medicine early. “Growing up, family medicine was my entire experience of medicine,” she says. When she arrived at University of Massachusetts School of Medicine, she spent much of her first and second years being exposed to family medicine, since part of the school’s mission is to meet the primary care needs of the state. “Approaching patients and connecting with them as people, on a human level, is something I instantly connected to,” she says. “After seeing how family medicine works, and how it helps patients, it clicked as the right path for me.”

Early on, she found an inspirational mentor: Michele Pugnaire, MD, then the dean of the school and now a Professor Emeritus. “She was a mom, and a family doctor, but also had this incredible record of education and scholarship, too,” Dr. English says. “I learned so much from her.” At UMass, Dr. Pugnaire encouraged Dr. English to get involved with a Patient-Centered Medical Home (PCMH) project. The pilot project, funded through the school, opened her eyes to how primary care can be a transformative practice. “That is kind of how I ended up in Colorado,” she says. “I saw the chance to go to a residency program with a practice transformation curriculum.”

While completing her residency at CU Anschutz, Dr. English saw the need to understand the whole patient as central to her practice philosophy. “If I only see
a person once,” she says, “and I don’t understand all of the other life factors that affect how they make decisions about their health, then that’s a missed opportunity. That was the tipping point for getting me into family medicine.”

Dr. English’s passion for making human connections, centering patient wellbeing, and diligent work to improve their health is at the heart of why her peers nominated her for the award. As an Assistant Professor at the Department of Family Medicine, and Attending Physician at the University of Colorado Hospital, she has earned the respect of the staff, clinicians, and residents for her relentless focus on patients.

“Dr. English has been breaking ground to discover and build the most advanced primary care clinic which serves four communities and over 19,000 patients,” one colleague said of her accomplishments. “During the darkest days of the pandemic, her expertise has enabled us to maintain a high functioning clinic against the odds.”

Family medicine provides a unique opportunity to work for people’s overall health, a perspective she eagerly embraces. “I think people gravitate to Family Medicine for all kinds of different reasons,” she says. “Most of us want continuity of care for our patients, but a lot of us also care about championing healthy equity or public health. Being part of the solution for getting and keeping people healthy really animates my work.”

A key innovation Dr. English has spearheaded is around how her clinic addresses high-risk patients. At regular meetings, care managers, social workers, behavioral health specialists, and nurses meet to review patients with high complexity scores and help develop individualized care plans to support patients. She has also developed a system to help patients at risk with resource navigation and access to supportive services as they navigate the healthcare system.

“I don’t come from a family of physicians,” she says. “I think that helps me remember what it feels like to be an outsider navigating our healthcare system, and that helps me relate to patients when they are facing it for the first time.” She believes in creating a judgment free zone for patients to make risk-benefit assessments about their care. “It helps patients really open up,” she says.

“At the end of the day it’s their body,” she says. “It’s my job to give them the information to make an informed decision, but all I can really do is support them and treat them the best I can.”

The humility with which she approaches her practice is one of the reasons so many of her colleagues nominated her for this award. They said, “Her patients, her clinic, and her staff are all better because of her leadership.”

Dr. English will accept her award at the 2022 CAFP Foundation Annual Summit. For more information and registration details, please visit https://www.coloradoafp.org/2022-cafp-foundation-summit/.

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A Lifetime of Service to Family Medicine:
KENT VOORHEES, MD - FAMILY MEDICINE TEACHER OF THE YEAR

When Kent Voorhees, MD was about 12 years old, he realized he wanted to help people. He and his friends put on yearly backyard carnivals and solicited businesses in his neighborhood in St. Louis to donate prizes, food and drinks. After three years of putting on the carnivals and raising money through ticket sales and soliciting donations, they raised enough money to purchase new wall-to-wall carpeting for a local orphanage. “It sunk in,” he says, “that I could help more people on a bigger scale by going into medicine.”

Choosing medicine was a big decision for a 15-17-year-old. “I was pretty good at math and science,” he says. “It sounds crazy in hindsight, but I called the deans of nearby medical schools, to ask what university would be the best to come from to get into medical school. The consensus was Vanderbilt, so that is where I applied and was accepted.”

Vanderbilt turned out to be the right choice, as Dr. Voorhees was accepted to the medical schools he applied to – including Vanderbilt. But he wanted to focus more on directly helping patients and less on research, so he chose the University of Missouri Columbia, in part because it was near his home in St. Louis, and in part because they produced more clinicians.

“I had never heard of Family Medicine when I began medical school in 1976,” he says. “But I did a couple of Family Medicine rotations and it clicked. That’s what I wanted to do, and I specialized in it.” He got back to St. Louis for his Family Medicine residency at St. John’s but did not stay in Missouri. A friend of his had just opened a new practice in Denver promising to engage patients in new ways, and so once his residency ended in 1983 Dr. Voorhees packed up for Colorado.

Dr. Voorhees approached Swedish Medical Center to propose their support in starting a multi-specialty group practice. By 1992 it had grown into a multi-office, multi-specialty largely primary care network that grew to 75 doctors. His practice was so busy that the University of Colorado Anschutz approached him about opening a new family medicine residency in the city. Dr. Voorhees helped to found the Swedish Family Medicine Residency using his practice. He started working on this in 1992, and first residents began in 1994, now with over 150 graduates.

It was at Swedish that his accolades as a teacher grew, including recognitions as Faculty of the Year or Preceptor of the Year, and his reputation for being devoted to both his patients and his residents grew beyond the clinic. By 2001, he had become the Program Director of the Swedish Family Medicine Program and served in that role until 2006 when Frank deGruy, MD asked him to be the Vice Chair (VC) of Education for the University of Colorado Department of Family Medicine, where he has served ever since.

As a teacher and preceptor, Dr. Voorhees has trained hundreds of Family Physicians, creating a lasting legacy of dedicated doctors who branch out to improve the health in their own practices and communities. As a Professor of Clinical Medicine at the University of Colorado Anschutz Medical Campus, he continues to inspire and mentor the next generation of family physicians.
Dr. Voorhees leads by example, showing a dedication to improving the practice of Family Medicine at the national level through leading committees and advocating for legislation. He has been the Chair of the AAFP’s Commission on Education and Chair of Residency Program Solutions Executive Committee with the AAFP. This has helped to shape and develop educational programs nationally. He was one of the original members of the Graduate Medical Education Initiative, which seeks to reform the national GME funding system. He has helped to develop numerous new family medicine residency programs across the country. He helped to write legislation for Senator Corey Gardner – the “Rural Physician Workforce Production Act” to fund rural training differently across the country. This bill has since been picked up by Senator Jon Tester. He also helped Senator Irene Aguilar write two bills for increasing the number of primary care physicians in Colorado. These provide funding for 3 new Rural Training Tracks in Colorado, as well as funding to expand the number of residents in 5 of our family medicine residency programs in the state. These bills also provide needed loan repayment for faculty and also for graduates in the 5 expansion programs who go on to practice in Rural Colorado. He has represented the CAFP on the Commission on Family Medicine and he lends his leadership to the Colorado Association of Family Medicine Residencies. He chairs the Appointments and Promotions Committee for the DFM, and mentors numerous faculty for promotion in the regular, research or clinician educator series. He has shared his national expertise in GME funding with the School of Medicine and hospitals and committees within UCHealth, including for University of Colorado Hospital, the Graduate Medical Education Committee in the CU SOM, and hospitals in Longmont, Brighton and Highlands Ranch. He has worked to help to improve Gender Equity in the promotion process as well as drawing attention to Diversity, Equity, Inclusion and Anti-racism in all of what we do.

His former students are voluminous in their praise. “His depth of knowledge and seemingly unending wisdom infuse through every conversation you have with him,” says Ryan Flint, DO, who learned from Dr. Voorhees at Rose Family Medicine in 2005. “I’m actually quite shocked he hasn’t already received this award in the past!”

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A Passion for Rural Medicine:  
SHAWNECCA BURKE, MD - CAFP RESIDENT OF THE YEAR

Being able to connect with colleagues and patients is a super power Family Physicians have, and it’s one that Shawnecca Burke, MD, demonstrated early in her career. At the University of Colorado Family Medicine Residency Fort Morgan Rural Training Track, Dr. Burke was working on the labor and delivery team, historically very challenging for new residents, and within a day nurses were seeking out her care for their patients.

“I really love what Family Medicine lets you do for patients,” she says. “You can build this long-term relationship, really get to help them in an exciting and holistic way. It’s what gets me so excited about my practice.”

Residency is about refining and improving your clinical skills, translating academic knowledge into the physician-patient relationship. It is here where Dr. Burke truly shines. Of particular interest for Dr. Burke is rural medicine, which is why she is training in the rural track at the University of Colorado Residency. “There is a lot of need,” she says. “And I feel like going where the need is the greatest makes sense for me.” She has also trained extensively in pregnancy and delivery, and created an elective rotation so she could learn from Midwives about mother-centered care.

“Dr. Burke is so proactive in building her skills,” Claire Bovet, MD, the director of the Fort Morgan Rural Training Track, says. “She puts in extra time outside work to be on call for deliveries. She has had more deliveries than any other resident in our program to date, all while balancing the normal workload of residency.”

As Chief Resident this year, Dr. Burke has set a strong example for patient advocacy. “In family medicine, you get the time to really get to know the nitty-gritty details a patient wants you to know,” she says. “That relationship makes a personal connection with the patient, and I want to honor that trust.”

Since the start of her residency, Dr. Burke was focused on making her patients’ lives better. Shortly after arriving at Fort Morgan she encountered several patients with alcohol use disorder and successfully advocated for the clinic to begin injectable naloxone training so the staff would know exactly what to do in an emergency.

Dr. Burke is strongly oriented toward her community. “I grew up in a really community-oriented household,” she says. “My grandparents immigrated to Maryland, and grew up there, and that taught me how important it is to connect with your neighbors and town. Especially in such a migrant-heavy community, we really looked out for each other and took care of each other.”

When she goes out shopping, she sees her patients at the local Walmart. “I love running into patients when I do chores,” she says. “It’s like, ‘I go here too! We’re all in the same community!’”

Hundreds of thousands of people, physicians and patients alike, have been personally impacted by the COVID-19 pandemic, but Dr. Burke experienced an especially harrowing time when her entire family became ill with COVID, and she became the de facto care coordinator for her critically ill grandparents. She faced the challenge of long-distance advocacy for a family member, conveying medical information to her relatives, and addressing racism in the institutions that were treating her grandmother. Her grandparents ultimately passed away due to COVID, and she was able to reflect on her experiences during a custom palliative care/end-of-life rotation that she helped design during this time.

Her time at Ft. Morgan is coming to an end, however – not because of anything that happened in the community, but for personal reasons and to be closer to her sister and niece, “I love the community I have here,” she says. “I think this community has given me so much more than I think I could have given them. I am sad to go.”

But, she is transitioning further south to Denver Health to further her work serving the marginalized in her community. “I’m sure I’ll have to build another community there, but it’s exciting to stretch my skills and continue to find new ways to help people.

It is this focus on serving her patients, and improving their lives, even during periods of tremendous personal stress and loss, that makes Dr. Burke the Resident of the Year. “Shawnecca’s uniquely warm, caring approach to patients and families is what truly sets her apart,” one of her colleagues in Ft. Morgan says.

“Primary care is the most important part of our healthcare system,” she says. “But it just isn’t valued enough. I get to specialize in the patient, I get to treat everything, I get to support everyone in my clinic and become their champion.”

Dr. Burke will be honored at the 2022 CAFP Foundation Annual Summit.
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When the pandemic was first beginning in 2020, Raeanna Simcoe, MD, noticed that access to health care had become difficult at her clinic – especially when it came to low income patients. Her clinic, the Lowry Family Health Center, was seeing an influx of patients who were hesitant to get treatment, not only for COVID-related issues, but for health screenings in general. “We have a lot of non-English, non-Spanish speakers,” she says. “A lot of them are refugees, too. We try to meet with them, walk them through their options, and nudge them into getting immunized.”

Denver Health is the primary safety net healthcare system in Colorado, serving thousands of patients from lower socioeconomic status. Lowry Family Health Center (LFHC), on the eastern side of the city, is one of the Denver Health primary care clinics and it serves a population of about 17,400, many of whom either speak Spanish or are non-Spanish, non-English speakers. The majority of the patients are served by Medicaid.

Community-based health centers like LFHC are vital outposts of care for people who otherwise struggle to access it. “One way to help more people realize the care options available to them is to tell them about it,” Dr. Simcoe says. “So, I created a patient outreach strategy, basically a calendar throughout the year, to help them begin navigating the healthcare system.”

In addition to helping low income Coloradans, LFHC works in coordination with Colorado Refugee Services Program and the Colorado Department of Human Services to provide health screenings for newly arriving refugees and asylees. Dr. Simcoe is the lead of only one of these outreach programs. Another program, called Quality Suggestions, recruited Daniel Kortsch, the Denver Health Chief Information Officer and an expert in electronic health records, to create an integrated clinical decision aid that automatically runs on each visit and makes suggestions for screening and management of over 60 conditions. The program improves screening for at-risk populations by considering many factors of the patient’s background, such as country of origin. In their pilot of the system, the initial data shows a dramatic improvement in screening for latent tuberculosis, HIV, hepatitis B, and hepatitis C. As one might guess, this increase in screening also helped doctors plan out treatment for these conditions. As one example, during the last year the increase in screening doubled the rate of tuberculosis referrals for specialized treatment.

In 2022, CAFP is launching an annual Health Equity and Community Engagement Award, which highlights and recognizes clinics that do extraordinary work to serve their community and close the gaps of care that exist for the most vulnerable members of Colorado society. Our inaugural award winner, Lowry Family Health Center, is being recognized for this extraordinary work to serve a population that is often excluded from considerations in health care policy and delivery, both because of their complex challenges and the difficulties of operating during the stressors of the pandemic.

In the past year, Lowry Family Health Center has implemented a multi-faceted approach to improve health equity for their patients and community. Through targeted efforts within individual patient encounters, reaching out to high risk patients, plus expanded hours to accommodate global refugees, and added curriculum to train the next generation of physicians to break down barriers to care for marginalized groups, LFHC has demonstrated how a commitment to health equity can have dramatic benefits for a community.

When a trickle of refugees from Afghanistan became a flood after the national government fell in 2021, LFHC set up a Saturday clinic to help the parolees get basic screening and care navigation. Led by Janine Young, MD, the success of the program led Denver Health to adopt their program system-wide, showing how local pilot programs to build equity can have lasting impacts in the community. Finally, Daniel White, MD, works with these three programs to manage the medication-assisted treatment pathway for patients.

The way LFHC has spearheaded new treatment approaches, a novel outreach program, and a systemic approach to helping patients at the bottom of the socio-economic ladder is a model for how a health equity focus, built around culturally sensitive processes, can transform a community and expand access to care.

We always want to highlight clinics like LFHC, who are performing vital work to transform health care and make it more equitable for our communities. If you know of a clinic or physician who is working to improve the equity of care in their community, please reach out to Joshua Foust, Director of Communications, Marketing, and Membership, at joshua@coloradoafp.org.
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