

WYOMING Medicine



Turning the Tide of the OPIOID CRISIS

Legislative and
Litigation Responses

- Wyoming's State Prescription Drug Abuse Task Force
- Preparing for the Next Step
- Telehealth in Wyoming: Easier than you think!

Gubernatorial Candidates on
Healthcare Issues

PAGE 8

Advantageous Alliances

PAGE 25

SUMMER 2018 • VOL.9 • NO.1

A PUBLICATION OF THE WYOMING MEDICAL SOCIETY

FEARLESS IS CONFIDENCE

Kids don't let bad things get them down. They trust you to make it all better. Working together, we give Wyoming families the confidence of knowing they have quality healthcare today and for generations to come.

We support you.



800-442-2376 BCBSWY.com/providers

WYOMING Medicine

SUMMER 2018

The Wyoming Medical Society (WMS) is the premier membership organization dedicated to promoting the interests of Wyoming physicians and PAs through advocacy, education and member services. **WYOMING MEDICINE** (ISSN-2154-1681) is published bi-annually by WMS at 122 East 17th Street, Cheyenne, Wyoming 82001. Contact WMS at 307-635-2424 or info@wyomed.org.

WYOMING MEDICAL SOCIETY LEADERSHIP

President	Lisa Finkelstein, DO
Vice President	David Wheeler, MD, PhD
Secretary/Treasurer	Jasper James "JJ" Chen, MD
Past President	Joe McGinley, MD, PhD
Open Trustee	Betsy Spomer, MD
AMA Delegate	Paul Johnson, MD
AMA Alt. Delegate	Rob Monger, MD
WMS Executive Director	Sheila Bush

MAGAZINE EDITORIAL BOARD

Editor in Chief	Robert Monger, MD
Publisher	Sheila Bush
Managing Editor	Kandice Hansen

SUBSCRIPTIONS

To subscribe to **WYOMING MEDICINE**, write to WMS Department of Communications, P.O. Box 4009, Cheyenne, WY 82003. Subscriptions are \$10 per year.

Articles published in **WYOMING MEDICINE** represent the opinions of the authors and do not necessarily reflect the policy or views of the Wyoming Medical Society. The editor reserves the right to review and to accept or reject commentary and advertising deemed inappropriate. Publication of an advertisement is not to be considered an endorsement by the Wyoming Medical Society of the product or service involved.

WYOMING MEDICINE is printed by PBR, Cheyenne, Wyoming.

ON THE COVER

Cover image taken from an opioid abuse campaign created for the Wyoming Prescription Drug Abuse Stakeholders.

POSTMASTER

Send address changes to Wyoming Medical Society, P.O. Box 4009, Cheyenne, WY 82003.

Contents

Gubernatorial Candidates on Healthcare Issues	8
Wyoming's State Prescription Drug Abuse Task Force	16
Preparing for the Next Step	22
Telehealth in Wyoming: Easier than you think!	24
Advantageous Alliances	25
WWAMI Student Profiles	26
Elder Abuse in Wyoming: The Physicians' Role	38
Turning the Tide of the Opioid Crisis: Legislative and Litigation Responses	40
PARTNER MESSAGES	
Palpitations Diagnostic Challenge	44
EHRs Can Advance Good Medicine – If Doctors Are Aware of the Risks	46
When You Need to Say No: Getting Beyond the Fear of a Patient's Dissatisfaction Just Might Save Their Life	47
Eluding Open-Heart Surgery	48
Blue Cross Blue Shield of Wyoming Updating Internal Technology Systems	50
WMS Member List	52



Get Involved with WWAMI

BY ROBERT MONGER, MD



This spring I completed my sixth and final year on the Wyoming WWAMI medical school admissions committee, and in looking back over that time it has been an amazing experience. The Wyoming students who apply to WWAMI each year are impressive both in their academic backgrounds and in their desire to serve our state as physicians. If you have ever considered applying to become a member of the admissions committee, I would strongly encourage you to do so because it is an inspiring process to be a part of.

This spring I also had the opportunity to go to Laramie on a number of occasions to give lectures to the first-year medical students, which is a fun and interesting thing to do. They are excellent students and very interested in any kind of clinical perspective that you can provide to them to supplement the huge amount of basic science that they learn in their first year.

It continues to be very competitive for students to be admitted into the program, and almost all students who are offered a seat in the class accept.

Twenty students per year from Wyoming are admitted each year, and for this year's class that will be starting in the fall of 2018, we've only taken two students from the alternate list. Also, congratulations to three Wyoming WWAMI students who were elected this year to the Alpha Omega Alpha (AOA) national medical honor society: Natalie Eggleston (Jackson), Kayla Morrison (Casper), and Lindsay White (Douglas).

More than 200 Wyoming residents have now earned degrees through the WWAMI program, which started in 1997, and the program continues to have an excellent return rate for WWAMI graduates practicing in Wyoming at nearly 70%. If you are interested in finding out more information about the students who return to Wyoming, I would encourage you to take a look at the University of Wyoming WWAMI website for more details.

They are excellent students and very interested in any kind of clinical perspective that you can provide to them to supplement the huge amount of basic science that they learn in their first year.

There are a number of changes coming to the Wyoming WWAMI program starting this year. Perhaps the biggest change is that the entering 2018 Wyoming WWAMI class will stay in Laramie for their first year and a half of medical school, instead of leaving for Seattle at the end of the first year, and the program is actively recruiting both M.D. and PhD instructors for the extra courses that will now be taught in Laramie.

Following completion of the first year and a half, the students will then have some time to study for the important Step 1 exam and to move to Seattle where they will then begin their clinical rotations.

The other significant change for the program is that they have built a new cadaver lab which will be in operation starting this summer, and instead of the lab being located across the hallway from the student classroom on the fourth floor of the health sciences building, it will be out the door and down the sidewalk in the biological sciences building. The space where the cadaver lab is currently located in health sciences will be remodeled and turned into traditional classroom space.

The Wyoming WWAMI program continues to thrive under the outstanding leadership of the WWAMI Director Dr. Tim Robinson and the Wyoming WWAMI Assistant Clinical Dean Dr. Larry Kirven, and WWAMI continues to promote student clinical opportunities in our state such as the R/UOP program and the TRUST program, in addition to numerous third and fourth year clerkships.

Wyoming WWAMI is an outstanding program and a true asset to our medical community but it doesn't work without the active support of Wyoming physicians. There are many opportunities for you to participate, from having premed college students shadow you in your office to being a preceptor for the third and fourth year clerkships.

I encourage you to get involved and support this outstanding program that we are so fortunate to have here in Wyoming.



WE ARE WHERE YOU ARE

Wyoming kids deserve the best care. That's why, as a regional center and a national leader in pediatric medicine, we staff outpatient clinics with pediatric specialists all over the Cowboy State. We've been doing it for years.

Here, we recognize that a hospital is bigger than its own walls.
Here, we believe the best place for every kid is where the heart is: home.



Children's Hospital Colorado
Here, it's different.™

CLINICS IN:

Casper • Cheyenne • Jackson • Laramie • Lander

childrenscolorado.org/outreach

Children's Hospital Colorado complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. • ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-720-777-1234. • CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-720-777-1234.



We Are Stronger When We Are Together

BY SHEILA BUSH



June in Wyoming reminds each of us of why we love calling this amazing place home. The time of year that blesses us with all the things that make the blowing snow and sub-zero temperatures worth it. The fields sprawl with brilliant shades of green while some of our mountains keep their snow-capped peaks. Families emerge from winter hibernation and neighborhoods come alive.

For more than 30 years WMS members have also known June as the time for coming together as physicians and PAs from all corners of the state for the Annual Meeting at the foot of the Tetons. 2017 and 2018 marked some exciting things at WMS including the launch of the physician leadership academy and the decision to explore new ideas for our Annual Meeting.

While we loved the challenge and adventure that accompanied trying something new and enjoyed the time on the slopes together, we appreciate that our organization isn't quite ready to close the door on decades of tradition.

We are thrilled to announce that WMS will be returning to the Jackson Lake Lodge for the 2019 Annual Meeting on May 31 - June 2. So, mark your calendars, you won't want to miss next year's event!

WMS learned more than just what our members thought about the Annual Meeting location and timing when we surveyed them this spring. In that survey, WMS members underscored again for us the importance and value they place in the mission of WMS.

Advocating for Doctors since 1903 is the mission statement that has guided us the last 115 years, and it was reaffirmed that that continues to be the primary reason physicians support and participate in their professional statewide association today.

Medicine is under attack.

From looming scope of practice battles to reimbursement hits and over-regulation threatening clinical practice, there's

never been a more important time for medicine to come together and fight.

Organized medicine is the vehicle best positioned to help physicians drive this fight, and WMS plays a key role in organized medicine at the state level. At the recent AMA meeting, U.S. Surgeon General Jerome Adams, MD, MPH, gave a rousing speech in which he quoted famous hockey player Wayne Gretzky. He said Gretzky was famous for saying he was great because, "He skated to where the puck was going to be rather than to where it was."

Organized medicine is working to ensure physicians are where the puck will be, preparing to lead the policy discussions most closely impacting medicine. WMS will continue to be the

voice of medicine ensuring physicians guide the future of healthcare in our state.


WMS is only as strong as our membership allows and that strength starts locally. The voice of medicine is a powerful one because policy leaders know that when WMS speaks, we speak for physicians in every community.

WMS will be facilitating and hosting events with every county medical society this year in our continuing effort to strengthen and empower physicians.

We are coming to a town near you not only to share exciting things happening in your WMS, but more importantly to listen and hear what

it is we can be doing to better serve you.

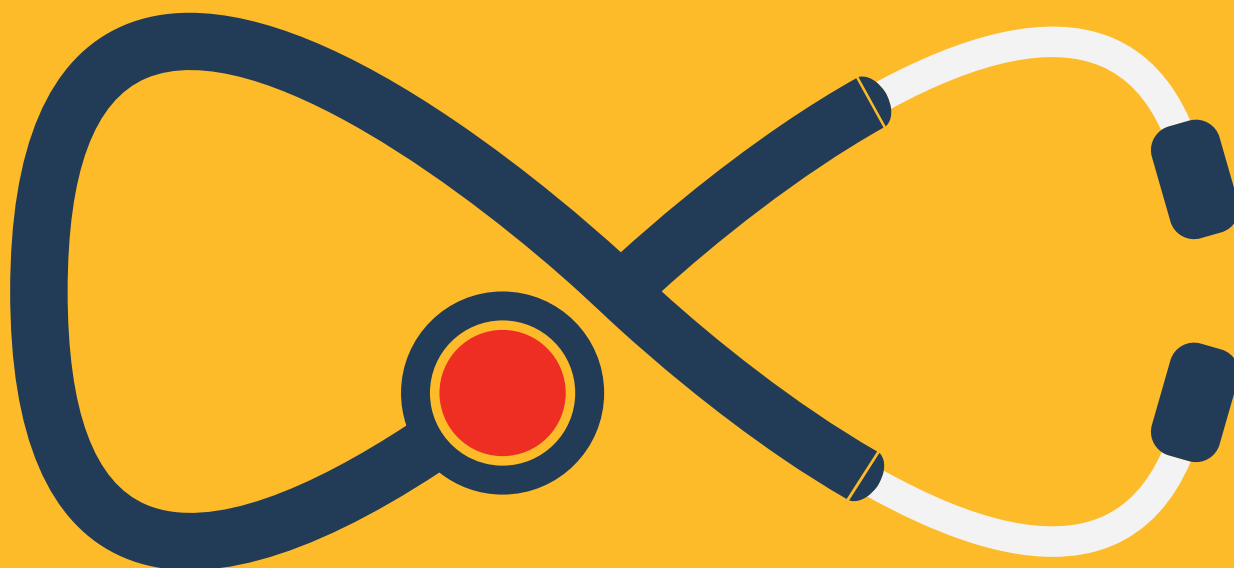
We're proud of all that WMS does well and eager to learn how we can become even better moving forward. Be watching for information about events near you and talk with your friends, whether members or not, about coming and spending some time together.

Thank you for trusting us with carrying the collective voice of physicians in our state's critical health policy discussions. We are stronger when we are together! 

We are thrilled to announce that WMS will be returning to the Jackson Lake Lodge for the 2019 Annual Meeting on May 31 - June 2. So, mark your calendars, you won't want to miss next year's event!

Advancing the practice of good medicine.

NOW AND FOREVER.



ANNOUNCING THE 2018 DIVIDEND FOR WYOMING MEMBERS

The Doctors Company has returned more than \$415 million to our members through our dividend program—and that includes 20% to qualified Wyoming members. We've always been guided by the belief that the practice of good medicine should be advanced, protected, and rewarded. So when our insured physicians keep patients safe and claims low, we all win. That's malpractice without the mal. Contact Susan Miller of The Doctors Agency of Wyoming at 800.451.9829, or smiller@tdawy.com



Exclusively endorsed by

**WYOMING
MEDICAL
SOCIETY**

*Advocating for
doctors since 1903*



THE DOCTORS COMPANY

medical malpractice insurance

Join us at thedoctors.com

Gubernatorial Candidates on Healthcare Issues

BY JULIETTE K. RULE
Wyoming Medical Society



As the 2018 primary approaches Aug. 21, we offer our pre-election survey of gubernatorial candidates' perspectives on healthcare issues facing Wyoming's practitioners and patients. The four-question survey was developed by Wyoming Medical Society leadership, and shared with candidates through Google Forms.

As governor, what will your top three priorities be in the area of healthcare?

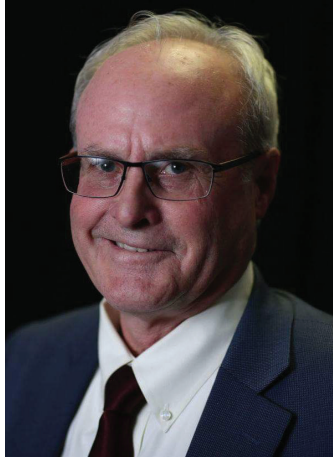
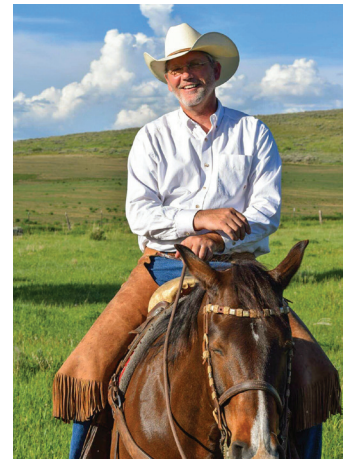
BILL DAHLIN: The economy, patient care and cost.

FOSTER FRIESS: Stabilize our state budget to protect our healthcare system, working with our team in DC to get federal healthcare spending pushed to the states and publishing of self-pay/cash healthcare prices to increase transparency.

SAM GALEOTOS: First and foremost in my mind, and the minds of Wyoming physicians, is ensuring their patients have access to quality, affordable care. However, this vision cannot just be platitudes and rhetoric while our state faces perhaps the most expensive insurance market in the country, while out-of-state hospital systems are carving up Wyoming to feed patients into their home systems. Having served as a trustee for the Cheyenne Regional Medical Center, I have a strong grasp of the challenges our healthcare system faces and know there are few problems that will be solved without the help of Wyoming physicians. While there are serious limits on what a state can do without any change to federal law and rules, as governor I will focus on innovative solutions to health care that bring us closer to affordable, quality care. Central tenants of these solutions include: Advocate for state policies and resources to advance e-

health opportunities across our rural state, using technology to connect patients and their physician-led teams, to drive down cost of delivery and improve system efficiency. Wyoming is the perfect environment to be the laboratory for expanding physician led tele-health services such as tele-stroke. Supporting and expanding our current recruitment and retention models for physicians throughout Wyoming but especially in key critical areas where access to care is struggling. Collaborate with other states to advocate for block grant Medicaid funding to give Wyoming more flexibility in how to run this important program, with meaningful input from physician-led teams and the Wyoming Medical Society.

MARK GORDON: Wyoming faces a number of healthcare challenges. These include addressing our shortage of physicians and other medical providers, medical liability reform, tackling mental health and substance abuse prevention and treatment needs and ensuring adequate Medicaid reimbursement for our providers. Clearly, Wyoming has a lot of work to do to build an effective and responsive healthcare system that meets the needs of our citizens. As governor, three of my top priorities will be: 1) Improving and expanding access to affordable healthcare across the state is essential. This means workforce development, including recruiting and retaining physicians; looking at building innovative business models for health centers and clinics; examining opportunities with tele-medicine and building better networks for care across communities; 2) Costs associated with caring for an aging population are a growing burden in Wyoming. It's a specific challenge for the state budget because so many of our older residents rely on Wyoming Medicaid to pay their bills. We must ensure contin-

**Bill Dahlin****Foster Friess****Sam Galeotos****Mark Gordon****Harriet Hageman****Taylor Haynes****Mary Throne****Rex Rammell**

ued quality care for our older residents. One promising option is boosting creative home care programs and capacity to allow folks to remain in their homes as long as possible, which is a cost-effective solution; 3) Ensuring our residents have access to mental health and substance abuse treatment, as well as supporting effective prevention programs, is absolutely critical to the health and wellbeing of Wyoming citizens. As governor, I'd like to explore bringing in business support to help improve services and reach at our community-based mental health and substance abuse treatment centers. Addiction strikes at the very heart of Wyoming families and communities and we have a responsibility to be proactive in protecting our citizens. Opioid abuse is, of course, a problem in Wyoming that we must work to reduce.

HARRIET HAGEMAN: My top three priorities to improve healthcare in Wyoming would start with reducing the regulatory burden on doctors, hospitals and health insurance companies. Every regulation that we add in order to provide healthcare increases the cost to the consumer. Every requirement we heap upon our medical professionals decreases their

ability to find a less expensive solution for a medical problem. Frequently the best decisions or even the best attempts to solve our healthcare needs are local, not state or federal. As governor I would work to shield our local doctors and hospitals from these restrictions so they could find solutions. We need innovation in healthcare, not more federal control.

Secondly, we are an aging population. Regulations have made the cost of both senior residential facilities and in-home nursing programs too expensive. We must ensure that our regulations and licensing requirements do not hinder our ability to provide our seniors with effective, compassionate, and cost-effective options, while acknowledging the human dignity component of such care. We can ensure quality without making these options too expensive. In Wyoming we already have the experts to advise us on how to better deliver these services without such expense. I will work with them to address these issues.

One solution to providing quality and affordable care is to expand our nursing programs in the State not only to train our new high school graduates but to facilitate midcareer health-

care workers who elected to build their family first and are now ready to advance their skills. Both of these groups would be needed to staff elder care and, when possible, I prefer home grown solutions to meeting our professional needs. Community and family are the two vital ingredients to retain medical professionals like our nurses. The best job interview is to grow up in the community where you elect to stay and work. There is no bond of care more special than when you grow up knowing your patients and their families. This fact applies to everyone working in healthcare. With additional caregivers and the intelligent use of technology, we can provide in-home and state-of-the-art residential care to preserve the dignity of our elders.

Finally, we have families who are struggling with the mental illness of their loved ones, including sons, daughters, parents and siblings. We have communities that are struggling to find beds and facilities to treat their citizens who may be suffering from these afflictions. Currently sixteen percent (16%) of U.S. citizens carry a mental health diagnosis and we are not able to provide the necessary services for our own similarly-affected neighbors. I intend to work with our communities across the State to develop more resources for caring for the people who are suffering. With smaller, more isolated communities, we need a comprehensive solution for Wyoming. This will require careful listening to families, doctors and hospitals across the State coupled with bold, decisive action. I plan to convene a summit on mental health issues in Wyoming in order to bring together a broad spectrum of people to find real-life, workable solutions that we can begin implementing immediately. The participants would include people from the State, our counties, cities, the Tribes, our courts, experts on addiction, educators, and mental health professionals.

TAYLOR HAYNES: My priorities in healthcare will be: 1) ensure adequate access for all citizens; 2) facilitating competition among payors to encourage more affordable premiums; 3) encouraging transparent pricing among physicians and facilities so patients have the information they need to select the most cost-effective, high-quality providers.

MARY THRONE: Healthcare is a necessity and Wyoming's broken healthcare system is harming economic diversity in the state. As governor, my three priorities would be:

Expanding Medicaid: this move will singlehandedly provide access for ~20,000 currently uninsured Wyomingites. It will help reduce uncompensated care, lowering costs for providers, and help to stabilize premiums for those who currently purchase healthcare on the open markets.

Improving access to telehealth: in a state as rural as Wyoming, this is a no-brainer.

Dealing with provider shortages: we need to attract talented professionals to Wyoming and encourage them to stay. That means committing to fixing our healthcare system, to ensuring good reimbursement rates for professionals, and making sure Wyomingites are insured at high rates so they can afford treatment.

REX RAMMELL: Affordable Health Care for all Wyoming

Residents, Quality Medicine and Surgery for patients, and just compensation for medical professionals.

WMS supports physician-led healthcare teams with each licensed provider practicing at the top of their scope. Share your thoughts about licensed healthcare professionals expanding their scope of practice* or expanding the specific tasks they can perform. Would you manage such changes through rule-making or legislation?

**An example of expanded scope might be a psychologist prescribing medications or optometrists performing eye surgery.*

DAHLIN: I feel we need specialized focus and innovative care.

FRIESS: If legislation reaches my desk that provides greater access in the form of increased scope, I would support it. Wyoming's unique rural challenges mean we must support healthcare teams that can be flexible to serve their communities.


GALEOTOS: As advances in technology are deployed in all sectors of our national economy, Wyoming healthcare leaders and policymakers need to give serious thought to what applications benefit our healthcare system, reduce costs, and improve quality of care. We also must protect Wyoming patients from tech applications that remove the human element necessary for quality care.

More than just being consumers of these technologies, we also need to bring Wyoming to the forefront of developing rural health solutions and build quality jobs for our economy.

I believe expanding the scope of practice for non-medical doctors should only happen through legislation and after a thorough vetting by the entire medical community who have their patients' safety and access to care in mind.

HAGEMAN: Parallel to technological advances in healthcare, we can also expect that some providers will push to expand their scope of practice to incorporate these new treatment techniques. They will commonly argue that they are solving a problem of access. While understanding this argument, there is no substitute for clinical training, and holding a paper degree is not the same as having years of residency and fellowship training during which a physician may see 10,000 to 20,000 patients on top of their classroom training, all of which reinforces their expertise in their specialty. Any expansion of scope should be strictly limited to what is safe and commensurate with a healthcare provider's training and expertise. Board-certified specialists should obviously be consulted on these issues. We must also ensure that, even when the argument of access is valid, quality of care should not be sacrificed.

I believe strongly in the legislative process and believe that it is generally superior to rulemaking. Any changes in the scope of practice should be the result of legislative action after a careful and deliberate public hearing where all parties can make their case. By making changes to the scope of practice via leg-



“I take care of
patients the way
I feel they **SHOULD**
be taken care of.”

Cassie Terfehr, NP



Cheyenne Regional
Medical Group

**LEARN MORE ABOUT OUR
PRIMARY CARE PROVIDERS**

cheyenneregional.org/primarycare

MULTIPLE PRIMARY CARE LOCATIONS TO SERVE YOUR NEEDS

Cheyenne Family Medicine
1950 Bluegrass Circle, Ste. 200
Cheyenne, WY
(307) 778-2577

Family First
5416 Education Dr.
Cheyenne, WY
(307) 778-3675

Cheyenne Plaza Primary Care
800 E. 20th St., Ste. 300
Cheyenne, WY
(307) 633-7444

**Cheyenne Health Plaza
Internal Medicine**
800 E. 20th St., Ste. 350
Cheyenne, WY
(307) 996-1560

isolation we have someone to hold accountable, our representatives. Changes like this should not be made by regulators.

In summary, recognizing the expertise and experience of appropriately trained medical professionals such as residency-trained doctors not only improves the quality of care, it attracts other doctors to Wyoming where they know they are recognized for their special skills and value as a care-team member. The free market approach increases access, while promoting competition, which in turn increases the quality of care and lowers costs. This is best accomplished by easing the unnecessary regulatory burden placed on physicians and facilities by moving away from federal mandates that bar alternative access options. This approach will increase competition and innovation, rather than reducing standards with irresponsible scope expansion and potentially unsafe medical practices.

HAYNES: I support expanding the scope of practice only after completing specialized advanced training and certification by specialty boards, such as the American Board of Urology or American Board of Cardiology, to ensure the highest quality practitioners are practicing safely in our state.

THRONE: Every potential change in the scope of practice needs to be vetted through a rigorous statutory or rule-making process. The scope of practice should not be expanded when professionals do not have appropriate training to protect the patient.

Whether to use rule-making or legislation depends on the specific circumstances. The rule-making process usually allows for more in depth study.

RAMMELL: I am running for governor. Governors can influence the law and rules, but they don't make them. I believe the best system is the one that operates according to Free Market principles. In other words, set up the regulatory environment that allows the systems to operate freely. Too many regulations restrict growth and development of the industry and affordable care.

According to the Wyoming Department of Health, 60,121 of Wyoming's 579,315 people don't have access to care - that's about 11 percent. The 2018 WMS membership survey places access to care as the most critical challenge medical professionals face in Wyoming. What is the best means for creating a solution?

DAHLIN: If we do not have a strong economy we have more people that lack coverage. We have fewer professional care givers. The economy touches all of us. As a businessman I pay 100 percent of my employees' insurance. Not all businesses can do this. Wyoming's economy rates among the worst. Also allowing competition to drive insurance costs will help. All of this still hinges on a stronger and more diverse economy.

FRIESS: We have to utilize the amazing technology that's now available in telemedicine. Telemedicine creates the potential for increased access and lower costs. My questions to

the members of the Wyoming Medical Society and doctors and nurses across our state is, "How can I help create an environment where innovations like telemedicine become a reality for the 60,000+ Wyoming residents who lack access to care?"

GALEOTOS: I am a strong supporter of WWAMI (Wyoming's medical school) and the notion that one piece of solving this puzzle is to grow our own talent pool, along with other educational opportunities for members of the physician-led team through our higher education system. This includes support for the recruitment and retention of physicians with loan repayment opportunities to ensure our rural communities can receive the doctors they need.

Again, Wyoming healthcare leaders and policymakers need to give serious thought to which applications benefit our healthcare system, reduce costs and improve quality of care. I will advocate for state policies to advance eHealth opportunities across the state, as these opportunities can greatly increase rural access to healthcare.

An example of technological innovation in our healthcare system could be a public-private partnership pilot to evaluate the efficacy of "medical wearable devices" to aid in the remote monitoring of diabetic or multiple sclerosis patients. Wearables have been proven to provide real-time access to health records and provide quicker diagnosis and treatment of conditions, as well as reducing travel time for patients and providers in a rural setting. Ideally such devices would be simple to use and "connected" with features such as wireless data transmission, real-time feedback and alerting mechanisms. Perhaps the greatest benefit of this technology is that patients are empowered to take control and monitor their own health, freeing up their provider for more pressing care needs. These are also the types of companies we need to be building or recruiting to Wyoming to build good paying jobs that diversify the economy and provide our children great opportunities. I strongly support efforts to bring affordable broadband connectivity to all parts of the state, so such Internet of Things devices can be deployed and play their part to improve cost and access to quality care for Wyoming patients.

HAGEMAN: We must seek alternative ways of finding access to healthcare services, move away from a one-size-fits-all approach, and pursue a waiver from certain mandates passed down by the Affordable Care Act, as other states have successfully done. To do this effectively as Wyoming's next governor, I will work with the medical profession, hospitals, elder-care providers, and mental health professionals to ensure innovation for Wyoming-centered healthcare issues.

The reality is that Wyoming is not California, New York, or Wisconsin, and our healthcare solutions should reflect the unique needs of this State. Remedies and innovations must come from the local level, and therefore solutions should be tailored to the needs of our physicians, healthcare facilities, and Wyoming-specific patient populations.

One small step would be to require that all telemedicine care is reimbursed by all private and government payers. It makes no

sense that we can do everything imaginable using the internet except provide healthcare. We already have the infrastructure and expertise to deliver distance care. I have been informed, however, that we do not consistently reward our doctors who are willing to stretch themselves, leave their comfort zones and explore this means of meeting with patients. It should be a given that distance care or telemedicine is reimbursed.

HAYNES: Truthfully, everyone has access to care through the emergency room, although it's not ideal as a healthcare solution. At one time, physicians shared the care of the indigent and that can be considered on a voluntary basis going forward. The state must institute a friendly environment and low barriers to entry for healthcare payors to encourage them to operate in the state and provide more affordable options for medical insurance.

THRONE: We need to do everything we can to recruit and keep highly skilled professionals, which is difficult in a rural state. Protecting scope of practice will help. We also need to reduce the number of uninsured, and work to make insurance more affordable.

We need to maximize the use of telehealth to ensure that more remote areas have access to care. We could explore telehealth parity, and we need to work to ensure that our rural providers are accessing currently-available federal funding to

support telehealth.

RAMMELL: I think the answer lies in the ability of states to work with each other to provide insurance and care across state lines. I would like cooperative agreements with all the states that surround us for insurance and care for Wyoming residents.

With 26 percent of our state's population being covered by public payers (Medicare, Medicaid, CHIP, dual coverage) and current projected budget shortfalls, explain how you will prioritize reimbursement to physicians.

DAHLIN: It boils down to funding and priorities. With a stronger economy comes more funding. We lost 8,500 people over the last year that left the state. They didn't leave because of low taxes, they left to seek better opportunities. You can't just tax them back to the state. We can be more fiscally responsible allowing for funding priorities to focus more on care. Example, the state owns two jet airplanes, no business person on the planet can justify their expense. We spend 100's of millions of dollars on the Wyoming Business Council and now ENDOW. They have been completely ineffective. We have the opportunity to grow, produce and manufacture industrial hemp prod-

Quality
metabolic &
bariatric
care

Proud to be an accredited
metabolic & bariatric surgical center.
Honored to serve our community.

Learn more at wyomingmedicalcenter.org/weightloss



IMPROVING HEALTH. TRANSFORMING LIVES.



ucts ... look it up, creating a stronger economy. There is more!

FRIESS: This spring I met with Health and Human Services Secretary Alex Azar for over an hour. We discussed publishing prices, specifically over hospitals and doctors that accept Medicare and Medicaid. I emphasized the critical role that providers play in our healthcare system. I believe that stabilizing the state budget, both through diversification and cutting wasteful spending are important steps we can take to protect the safety net we provide to our most vulnerable citizens. Increasing local control, both at the community level and at the state level through “block grants,” allow us to increase efficiency and get physicians and providers reimbursed.

GALEOTOS: Physician involvement in the public payer system is essential, otherwise we will just send all those aged and/or indigent patients to the emergency department, costing the system far more than through preventative care. In the end, this path will only shift the cost of care to insured patients and further exacerbate our expensive market for all patients.

A key piece of physician involvement is providing a physician reimbursement, at the state and federal levels, that will keep physicians involved in the system. I will collaborate with other states to advocate for block grant Medicaid to give Wyoming more flexibility in how to run this important program and bring leadership to the Wyoming Department of Health that can weigh the very best use of resources for Wyoming patients.

GORDON: Like many Wyoming citizens, I remain concerned about the sustainability of public healthcare systems. We must be smart about the choices we make with Wyoming Medicaid. Again, a strong economy offers the best possible support for healthcare in Wyoming. In Wyoming, our participation in Wyoming Medicaid by physicians and other healthcare providers is high compared to almost every other state. One reason for that is our relatively high reimbursement levels.

Wyoming should focus on state-based solutions that incentivize the private sector and encourage competition. While Wyoming has put forth a number of commissions over the years to look at tackling our healthcare challenges, we are now presented with a distinctive point in time to collaboratively develop solutions that meet some of Wyoming’s unique needs. We should bring together key stakeholders and lawmakers who can take into account shifting concerns in the marketplace, the community resources we already have in place, and our low regulatory burden, so we can develop a comprehensive Wyoming solution to help alleviate some of the uncertainty physicians and citizens currently face.

HAGEMAN: Liberating doctors, clinics and hospitals to innovate and create more cost-effective healthcare solutions for patients and employers will make it possible for more people to return to the private healthcare market, thereby leaving Medicaid (they are able to afford healthcare again), and escaping the limitations of government payer programs. Medicare and Medicaid are so deeply discounted that we cannot lessen the reimbursement any further and we cannot damage Wyoming’s healthcare market by expanding the market-share of

government programs which do not cover the cost of such care. Because these programs do not cover the cost of care, and although they are necessary for the elderly and truly needy, they should not be used as a convenient solution for an overregulated private healthcare insurance market.

Government programs resulted in higher healthcare costs by under-paying for services under Medicare and Medicaid. The ACA has stifled innovation and decreased access. The solution to a bull in a china shop (government) is not a second bull. The ACA was that second bull and the catastrophe that it has created was predictable.

Doctors in Wyoming usually see their patients socially every day, in the grocery store, at church, or watching their children play sports together. These doctors understand the pressure to develop less expensive solutions for medical problems and should be trusted to do so. As governor I would work to remove the federal and state regulatory burdens that force physicians to apply for permission to write certain prescriptions or recommend certain treatments for their patients. I would also act as a shield from the onerous restrictions that prevent providers from innovating and finding new ways to treat their patients.


If we create an industry environment that allows doctors to apply their knowledge and expertise, not only to clinical care but also to finding better ways of providing that care, our citizens will benefit and Wyoming will distinguish itself as an attractive environment for medical practice and innovation.

HAYNES: Medicare is a federal program and the governor has no input into physician reimbursement in the program. The Medicaid pool of funds is fixed and must be distributed across all levels of patient care, therefore provider reimbursement is dictated by availability of funding. The true solution is to increase high paying jobs with excellent health care benefits and revitalize the free-enterprise practice of medicine. This will result in a lower number of people dependent on public programs and more funds will be available for those who must rely on those programs, such as the elderly, disabled, and truly indigent population.

THRONE: I’m running to eliminate the boom and bust cycle that keeps us locked into budget shortfalls, which fall heavily on healthcare. By growing our economy, we can reduce the percentage of our state’s population which are covered by public payers. That being said, we have an obligation as a state to ensure that our healthcare providers are adequately compensated for the work they perform.

The state, both as an employer and as public payer, should work with the medical community on innovations such as patient-centered medical homes to reduce inefficiencies, which over time should strengthen reimbursement to physicians.

As a legislator, I supported adequate reimbursement for healthcare.

RAMMELL: Affordable, quality, without interfering regulation, insurance plans so physicians are justly compensated. I am a veterinarian and do appreciate just compensation for all the effort medical doctors have gone through. 

Live your passion



Explore provider opportunities

At UCHealth, our mission is simple: to improve lives. That starts with you. You'll provide personalized care at the highest level, offering some of the most innovative procedures, advanced treatments and medical technologies in the nation—all against the backdrop of the Rocky Mountains. Come live your passion and push the boundaries of medicine.

LEARN MORE
joinuchealth.org

uchealth

Wyoming's State Prescription Drug Abuse Task Force

BY ELIZABETH SAMPSON
Wyoming Medical Society



A back surgery. A herniated disc. A sports injury that just won't heal. A patient is hurting terribly and needs help managing the pain. For some, the injury heals, the pain goes away and so does the need for prescription pain medications. For others, it is the start of a slippery slope that leads to drug addiction and overdose.

Wyoming, despite its small population, is not immune from the results of prescription drug overdose deaths. Aimee Lewis is the current co-chair of the Wyoming Prescription Drug Abuse Stakeholders (RAS) and is the Drug Utilization Review Manager for Wyoming Medicaid for the University of Wyoming. According to Lewis, deaths related to unintentional prescription drug overdose have increased from 19 in 2004-2005 to 96 in 2014-2015. Additionally, information collected on the RAS website indicates the Center for Disease Control said Wyoming ranked 23 in the United States for age adjusted drug overdose deaths with 16.4 deaths per 100,000.

Fortunately, this is not a problem being shouted into the void. The RAS have been working since 2008 toward addressing prescription drug abuse in the state. With the recent passage of Senate File 78, which created a statewide prescription drug abuse task force, the decade-long work of the RAS has been brought to the attention of more people than ever. Whether they are educating medical providers on the keys to preventing prescription drug abuse or promoting a statewide initiative to warn 12 to 25-year-olds about how deadly prescription drugs can be, the RAS is on the frontline of the war

against the opioid crisis.

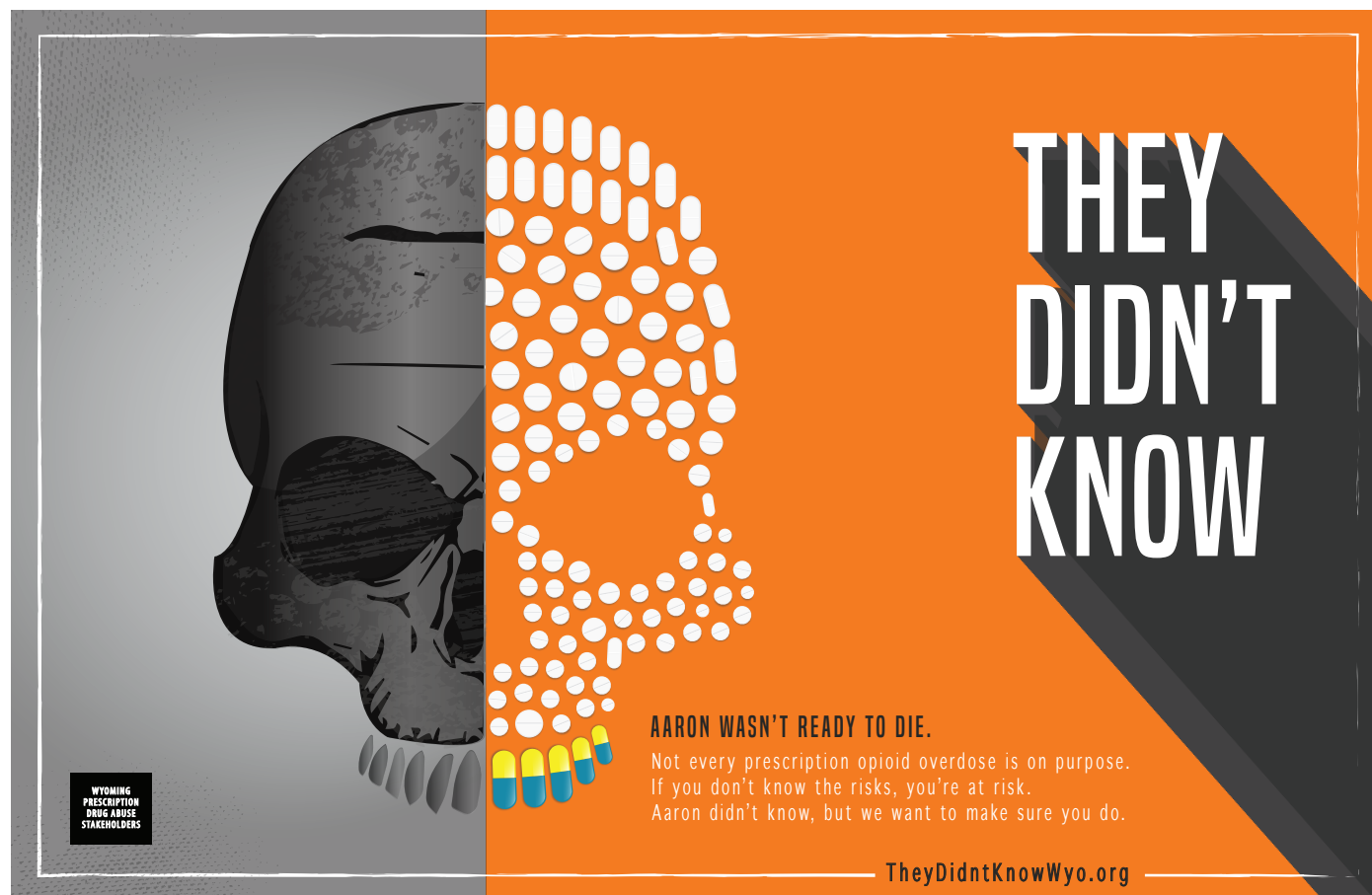
"It is difficult, if not impossible, to identify every patient who will become addicted, and prescription pain relievers are absolutely necessary in some cases," Lewis said. "However, we recommend that prescribers exhaust all forms of non-prescription pain relief, then non-narcotic pain relievers prior to going to a narcotic. When a narcotic is absolutely necessary, limit the quantity that is dispensed in the first few prescriptions—some federal agencies are recommending no more than a seven-day supply for an opiate-naïve patient."

Additionally, Lewis said the RAS suggests medical providers educate their patients on proper disposal of pain medications so they aren't available for others to use, and they recommend urine drug screens in some chronic pain guidelines to ensure that the patient tests positive for the drugs that are prescribed and does not test positive for drugs that are not prescribed.

"Maybe most importantly, prescribers should know the signs of prescription drug misuse and abuse and take immediate action to get these patients appropriate substance abuse treatment," Lewis said.

According to Mary Walker, a founding member of the RAS and the executive director of the Wyoming Board of Pharmacy, a typical prescription drug abuser tends to be in their 30s or older and often starts out with some sort of injury that leads to a prescription to help with the pain.

"Perhaps they started out with a shoulder injury and were given some prescriptions for Tramadol and some other drugs,



and it escalated into where they needed more and more pain relief,” Walker explained. “They have gotten into a desperate situation where their body is addicted to it and they have to find more and more and more. With prescription drug abuse, those people quite frequently started with a legitimate prescription for pain.” However, some patients may not realize how dangerous those prescriptions can be.

“These drugs are so powerful that there are lots of side effects,” Walker said “We are in this crisis because people are dying. There is a significant number of people who either didn’t know, or they think if one is good then two or three must be even better.”

This lack of understanding is where the RAS’s current information push focuses. In February, they released an education campaign called “They Didn’t Know.” This campaign addresses the idea that many people assume prescription narcotics are safe because they are prescribed by a doctor, and patients often don’t know how addicting they can be or that they can be misused. Because young people are often the victims of prescription drug overdose, the campaign focuses on people aged 12 to 25. Lewis said

it is comprised of a video and website (theydidntknowwyo.org) that helps teach the dangers of prescription drug misuse. She noted funding for the campaign came from the Wyoming Department of Health.

Members of the RAS are also calling on medical providers to join them in the fight against prescription drug abuse. There are some quick and easy things providers can do to help prevent problems for their patients before they start. For starters, providers are required by Wyoming law to register with the Wyoming Online Prescription (WORx) Database, which collects prescription data on controlled substances dispensed in or into the state of Wyoming. This is Wyoming’s portion of the prescription drug monitoring program (PDMP). Once providers are registered, they can get a report on what

a patient has been prescribed within the last year before they prescribe any new medication for them.

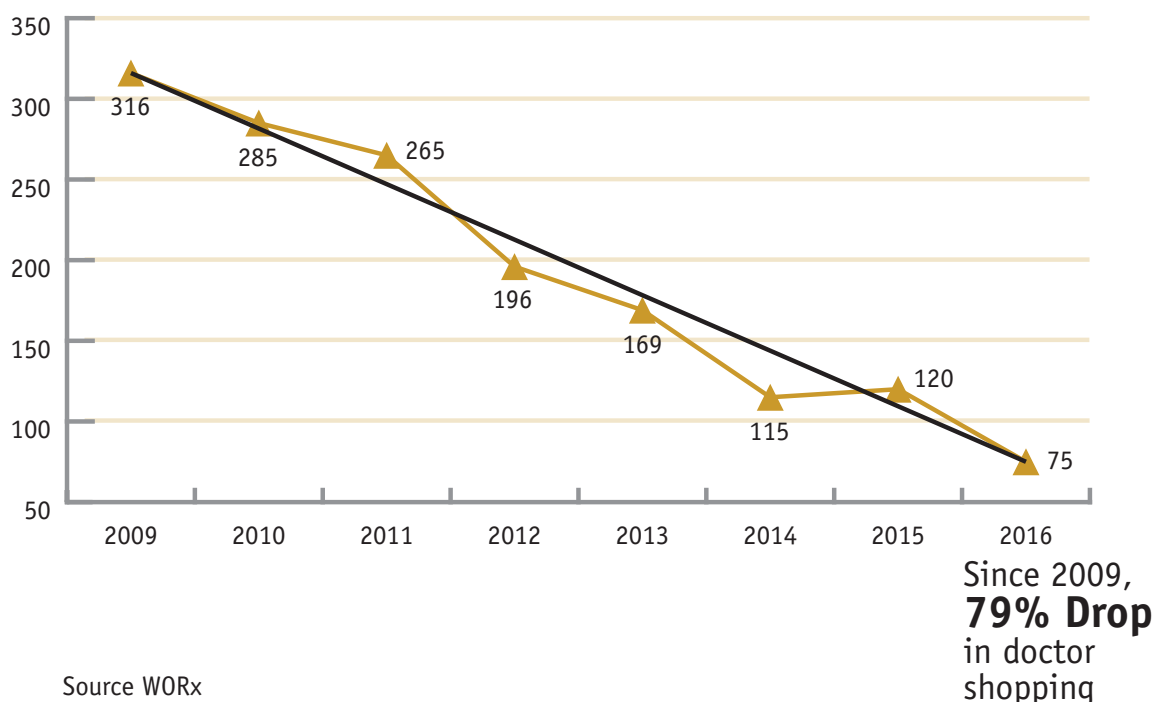
“This is a fantastic resource that is quick and easy to access, available 24/7 and provides a great amount of information regarding the patient’s use of any controlled substance (schedules II – V), gabapentin, cyclobenzaprine and naloxone,” said

“These drugs are so powerful that there are lots of side effects. We are in this crisis because people are dying.”

MARY WALKER

Executive Director of the Wyoming Board of Pharmacy

Total Number of Unsolicited Profiles in Wyoming Since 2009



Lewis. “Prescribers can use this information to assess the risk of misuse and abuse before they prescribe a controlled substance. They can also see if they are on benzodiazepines, carisoprodol or sedative hypnotics, agents that increase the risk of fatal overdose.”

Walker and her co-workers, Lisa Hunt and Matthew Martineau, both inspection/compliance officers for the Board of Pharmacy, hope to assure providers that registering for and using the PDMP is quick and easy.

“We want to dispel the myth and the rumor that the PDMP is difficult to use,” Martineau said. “It is very easy. It is very fast.”

Hunt agreed, saying, “The impression was out there it would take 20 minutes to sign in and get a report on a patient. It’s less than 60 seconds. The program itself is 24/7 online and very easy to use.” Information gathered from the PDMP works best if providers are able to use it as a tool.

“Our prescription drug monitoring program needs to be used more than it is,” Walker said. She noted that prescribers can tell right from the PDMP if the patient has been going from place to place to get more prescriptions—or doctor shopping.

“They can have that conversation with the patient right there,” Walker said. She described a simple conversation providers can have with these patients. They can say they are concerned about their patient’s health and safety, and are worried about their pain after seeing on the PDMP that the person has gone to an emergency room, another doctor and perhaps a dentist in the past month.

The success of WORx is easily visible when it comes to the decline of doctor shopping in Wyoming since 2009. Unsolicited profiles, or reports generated about high risk patients who are prescribed high doses of opioids or appear to be doctor shopping, show a decline in Wyoming. In 2009, there were 316 unsolicited profiles, and by 2016 there were only 75, which was a 75 percent decrease in doctor shopping, said David Wills, data management specialist for the Board of Pharmacy.

The Attorney General’s Office needs providers to help with investigation

Another way providers can help the cause of the RAS is by working with the Wyoming Attorney General’s Office, which is part of the RAS. The Attorney General’s Office is currently participating with 41 others states in an ongoing investigation into the promotion and distribution of opioids by opioid manufacturers—particularly when the information shared by manufacturers may be misleading or otherwise deceptive.

Chief Deputy Attorney General John Knepper said that starting in the early 1990s, opioid manufacturers saw a dramatic rise in the number of prescriptions being written for morphine and morphine equivalents. He said manufacturers promoted these drugs as pain relievers to such an extent that one manufacturer saw sales rising from \$48 million to \$3 billion by the end of the 1990s.

“These are opioids,” Knepper said. “These are drugs that we have known for generations have profoundly addictive



Members of the Wyoming Board of Pharmacy urge all medical providers in the state to use the Wyoming PDMP, WORx, to help ensure their patients are not on the path to prescription drug abuse. Pictured, from left, are Mary Walker, David Wills, Lisa Hunt and Matthew Martineau.

consequences for individuals. As a part of this investigation, the manufacturers have pointed to the physicians as the ones at fault.”

Manufacturers say the drugs were FDA approved, were lawful and were used to relieve chronic pain or end of life pain. Knepper said now these opioid manufacturers are pointing to doctors as the ones who prescribed the medication and are therefore at fault for the prescription drug abuse and opioid crisis that resulted.

“That’s a little simpler than the facts on the ground,” Knepper said. “For many years, the opioid manufacturers promoted both the need for pain relief as a right of patients, and at the same time, they promoted the use of opioids as safe, saying if you were truly in pain you wouldn’t become addicted to these opioids. That was the representation that was made, and we have seen tragically that that is not true—that there’s reason to believe that information is not accurate.”

With published promotional material from the opioid manufacturers from that era in hand, the Attorney General’s Office is now hoping to speak to providers who remember conversations with representatives of the opioid distributors who made these claims. Specific examples of doctors who remember this misleading information being shared will help in the case against the opioid manufacturers.

“If somebody remembers sitting down with a representative of the pharmaceutical manufacturer and having the pharmaceutical manufacturer tell them if you are actually in pain, you

won’t become addicted to opioids—that is tremendously helpful information,” Knepper said. “It puts the emphasis on who should really be subject to our investigation—not physicians who were prescribing drugs, but individuals who were presenting information to these physicians. We have serious concerns about its accuracy.” Knepper went on to say that finding doctors who can help with this case will give providers a chance to respond to the accusations that they are the ones to blame.

“We would like to be able to provide physicians a voice in this process because I think currently, the manufacturers are vilifying doctors without an established ability by those doctors to respond and say, ‘Hey, we relied upon the information you gave us, and that information turned out to be not just wrong, but tragically so.’” If there are providers who remember hearing this claim, they are encouraged to contact the Attorney General’s Office at 307-777-7841.

The current investigation into opioid manufacturers isn’t the first time the State of Wyoming has been involved in a multi-state action against a pharmaceutical company.

In 2017, Wyoming’s attorney general reached a settlement with Boehringer Ingelheim Pharmaceuticals, Inc. (BIPI). This case concerned off-label marketing and deceptive and misleading representations in the promotion of four prescription drugs.

“The heart of the settlement was requiring BIPI to ensure that their marketing practices and promotional practices did not unlawfully promote these prescription drug products,” said

Ben Burningham, assistant attorney general. “Wyoming did receive a payment from the settlement, but the real heart of the settlement was changing the practices and changing the promotion of drugs for uses that had not been approved and for which there wasn’t any scientific evidence.”

Those four drugs were Aggrenox, Micardis, Combivent and Atrovent.

History of the RAS

Walker, who was a charter member of RAS said the group formed in 2008 when Kelly Rankin, who was the US attorney for Wyoming, put together a statewide task force to address prescription drug abuse.

“It was becoming a crisis across the country and his quote was ‘we can’t arrest our way out of this,’” Walker said. When it was founded, the RAS included Rankin and members of the Boards of Pharmacy, Medicine and Nursing as well as representatives of the Drug Enforcement Agency and the Department of Criminal Investigation. Now there are more than 50 people on the task force.

Starting with a goal of educating themselves on the opioid crisis, the RAS members collected articles and went to seminars about the issue. They started meeting monthly at the Attorney General’s Office, and at each meeting they started asking other stakeholders to come, including the Board of Health and the Wyoming Medical Society. Early on, pharmacy students from the University of Wyoming started coming to each meeting and they shared information they had gathered.

“One of our students did an extensive topic presentation about prescription drug abuse in Wyoming,” Walker said. “She got statistics from places we didn’t know existed, and she ended up giving that presentation several times. That was a big wakeup call for all of us and kind of a rallying to do more.”

Since the inception of RAS, the group has hosted several statewide conferences to teach people about prescription drug abuse and how to help prevent it.

“It was hard to have these conferences without being able to pay a speaker,” Walker said. We started looking for other sources of income—particularly for conferences. The Women’s Civic League of Cheyenne stepped up to the plate and provided some of their funding.”

RAS members have no intention of giving up the fight any time soon. They continue to find ways to educate the public and medical providers.

“Goals for the future include continued education and outreach regarding the risks of prescription drug abuse and misuse and disposal methods,” Lewis said. “The group also keeps an eye on legislative and policy issues that may impact our work.”

Sponsoring or supporting legislative changes has always been an important aspect of the work the RAS does. Here is a list of house bills and senate files provided by Walker that RAS has worked on in the Wyoming legislature:

2009 HB0294: Required weekly reporting to the prescription drug monitoring program by pharmacies.

2011 HB0062: Updates to the Controlled Substances Act to add salvinorin A, spice drugs chemicals and bath salts chemicals as Schedule I controlled substances plus several new prescription drugs in Schedule II, Schedule III, Schedule

IV and Schedule V. This bill also added Carisoprodol and Tramadol as controlled substances in Schedule IV—they were not scheduled federally until later. This bill updated the methamphetamine precursor portion of the statute to match federal statutes for purchasing pseudoephedrine and other drugs. Additionally, this bill allowed electronic prescriptions for controlled substances.

2015 SF0016: Added more chemicals to Schedule I that are synthetic cannabinoids (spice drugs) as well as other chemicals that had been ap-

pearing in the state crime lab for testing.

2015 SF0100: Changed the reporting requirements by pharmacies to every 24 hours to the prescription drug monitoring program. Added the ability of practitioners and pharmacists to appoint delegates to get reports from the program.

2017 SF0042: Emergency Administration of Opiate Antagonist Act allowing naloxone to be dispensed and administered to persons at risk of an overdose of opioids, or to persons in a position to assist a person at risk of an overdose. Allows entities to establish a treatment policy and receive training in naloxone administration (such as first responders). Walker said this bill was written by RAS members and many testified at interim committees and legislative meetings.

2018 SF0083: Requires practitioners to register with the prescription drug monitoring program, requires dispensers to report Schedule II, III, IV, and V drugs to the prescription drug monitoring program (not only pharmacies).

2018 SF0078: Creates an Opioid Addiction Task Force until 2019 to seek further changes to prevent opioid addiction and overdoses.

2018 SF0105: Enhancements to the Drug Donation Program.

“Maybe most importantly, prescribers should know the signs of prescription drug misuse and abuse and take immediate action to get these patients appropriate substance abuse treatment.”

AIMEE LEWIS, PharmD, MBA
Co-chair of the Wyoming Prescription Drug Abuse Stakeholders (RAS)

WE UNDERSTAND WHAT MOVES YOU



Shoulder & Elbow | Foot & Ankle | Hip | Interventional Pain
Knee | Neck | Physical Therapy & Rehab | Hand & Wrist
Spine | Sports Medicine | Total Joint Replacement

1-800-446-5684 | www.PREMIERBONEANDJOINT.COM

Casper | Cheyenne | Gillette | Laramie | Rawlins | Riverton | Rock Springs | Torrington | Wheatland

PREMIER 
Bone & Joint Centers
WORTHY OF WYOMING



Turning the Tide of the OPIOID CRISIS: Legislative and Litigation Responses

BY DALLAS LAIN, JD
Wyoming Medical Society

It seems that you can hardly turn on the news without hearing about the “opioid crisis” – the term being used to describe the alarming addiction and overdose rates connected with prescription opioid pain relievers. The Centers for Disease Controls devotes an entire section of its website to Opioid Overdose, and cites statistics which indicate there are as many as 89 total deaths per day involving overdoses of all categories of opioids and 47 of those involve only prescription opioids.

While awareness of this issue has been growing for several years, public health data continues to show that addiction and overdose incidents attributable to prescription opioids is increasing. This article provides an overview of federal and state level legislative and regulatory responses to the opioid crisis, discusses civil lawsuits brought against physicians involving prescription opioid issues, and offers Wyoming providers practical steps to ensure they are minimizing their liability risk when using prescription opioids as part of a patient’s treatment.

Federal Response

In October, 2017, President Trump, along with the Department of Health and Human Services (HHS), declared a public health emergency to address the national opioid crisis. HHS announced a five-point strategy to combat the opioid crisis, including:

- Improving access to treatment and recovery

services

- Promoting the use of overdose-reversing drugs
- Strengthens understanding of the epidemic through better public health surveillance
- Providing support for cutting-edge research on pain and addiction; and
- Advancing better practices for pain management.

The declaration has been criticized as lacking specific funding to implement specific programs to carry out these strategies; however, a number of legislative bills currently are under consideration by the House or Senate. “Jesse’s Law,” which has passed in the Senate and is pending in the House, would require the Secretary of Health and Human Services to develop best practices related to prominently displaying a patient’s history of opioid use disorder in the patient’s medical records. The law’s namesake, Jesse Grub, was a recovering addict who was prescribed opioid painkillers after surgery by a discharging physician who was not informed of her addiction history. Ms. Grub fatally overdosed the day after her discharge.

Other proposed federal legislation includes the Opioid Workforce Act of 2018 (H.R. 5818, S. 2843), which has been introduced in both houses, and would add 1,000 Medicare-funded direct and indirect graduate medical education residency training slots to hospitals with approved residency programs in addiction medicine, addiction psychiatry, or pain management. The Opioid Crisis Response Act of 2018 (S.2680), contains proposals arising from bipartisan hearings on the opioid

crisis and would authorize federal agencies to implement specific public health activities, including supporting research and development of non-addictive painkillers, establishing opioid prescription practices, collecting and monitoring data about prescription of and overdoses related to controlled substances, and providing funding for states to implement targeted interventions.

Wyoming State-Level Response

The Wyoming legislature passed the Emergency Administration of Opiate Antagonist Act during the 2017 legislative session. This legislation allows a pharmacist to prescribe and dispense an opiate antagonist, such as Narcan, to (a) a person who is at risk of an opiate overdose, (b) a person who is in a position to assist a person at risk of an opiate overdose, or (c) a person who in the course of their official duties or business may encounter a person experiencing an opiate related drug overdose. This legisla-

tion makes it possible for family members of a person taking opioid painkillers, as well as first responders and workers in other public-facing environments, to obtain a naloxone auto-injector or nasal spray for use if they encounter an overdose situation.

Wyoming has had a prescription drug monitoring database (PDMP) since 2004, known as the Wyoming Online Prescription Database (WORx). Until recently, only retail pharmacies were required to report prescriptions for controlled substances dispensed to residents of Wyoming. However, during the 2018 session, the Wyoming enacted legislation to require all dispensing practitioners

(including veterinarians, dentists, physicians, and nurse practitioners) to report to the WORx. The 2018 legislature also required all practitioners to register for the WORx, enabling them to review controlled substances their patients may have been prescribed by other practitioners.

The Wyoming legislature did not go as far as a handful of other states which have enacted mandatory PDMP checks, or legislation establishing prescribing guidelines or limits on prescriptions of controlled substances.

Creating lasting partnerships

ONE CLIENT AT A TIME!

Nationwide Expert Services, Revenue Cycle Consulting, E&M, Psychiatric & Surgical Auditing, Provider Documentation Training, Coder Education

To find out how we can help, contact
Amy Hayes, ahayes@USEPHS.com or
Mike Calvetti, mcavetti@USEPHS.com



PARTNERED
HEALTHCARE SOLUTIONS

USEPHS.COM | 1-800-823-2922



Preparing for the Next Step

BY TY STOCKTON
Wyoming Medical Society

Nobody should ever have to decide between buying food or paying for their needed medications. Yet the cost of prescription medications can force many Wyoming residents to have to make that choice on a monthly, weekly or even daily basis.

Insurance can help pay for these medications, as can Medicare and Medicaid. But not all medications are covered by these services, and some patients fall in the “donut hole,” meaning they make too much money to be eligible for state medical assistance, yet don’t make enough money to cover the costs of their expensive medications. Others have circumstances that may require them to work only part-time, meaning they can’t get insurance through their employers, and their individual insurance doesn’t cover the medications they need.

That’s where the Wyoming Medication Donation Program comes in.

The program collects unused medication through donations and dispenses it to people who need those medications but lack the ability to buy them. The collection and distribution of prescription drugs are the chief responsibilities of the program, but there are other advantages that come as beneficial side-effects.

According to the program’s website, when medications are donated, it keeps them from being improperly disposed of, thereby preventing pollution of streams, landfills and ground water; and it also reduces the risk of poisonings by medications that could otherwise be ingested accidentally or by curious children.

In addition, the program’s streamlined services provide a reliable record of the medications they’ve donated. That allows hospitals and the Department of Health to better monitor that people are getting the medications they need.

There’s also the direct benefit of providing needed medications to someone who wouldn’t otherwise be able to afford it.

“Our patients have to be Wyoming residents who have low income (200 percent of poverty level),” said Natasha Gallizzi, the Wyoming Medication Donation Program manager. “We

don’t distribute controlled substances or refrigerated medications, but we are able to provide a lot of the medications many people in Wyoming need. Once a person has completed the application and been approved, we mail the medications directly to them anywhere in Wyoming.”

Gallizzi said the donated medications come from all over the country.

“Most of our donations come from nursing homes,” she said, “but we have 30 donation sites around Wyoming where people can bring unused medications.”

Because most medications are taken by a patient until they are gone, the bulk of the donations come from people who have passed away. Yet through donation, those medicines can help make a difference for another person who needs the same treatment.

“Most of our donations come from nursing homes, but we have 30 donation sites around Wyoming where people can bring unused medications.”

NATASHA GALLIZZI, PharmD
Wyoming Medication Donation Program Manager

“I have a whole file cabinet of people who have been helped by the Medication Donation Program,” said case worker Linda Schulz of Mesa Primary Care in Casper. “I just wish it were more well-known, but it helps so many people, and they’re always so grateful when we give them the medications they need.”

Gallizzi can quantify the help the program has provided since it began as a pilot program in 2008.

“Between when the pilot program was begun and 2017, we’ve collected more than

105,000 pounds of medications,” she said. “That’s more than 15 million dollars’ worth of medications, so it’s definitely helping patients in need.”

Yet despite all the help the program has provided, Gallizzi said the staff still wants to do more. “We get a lot of donations,” Gallizzi said, “and we haven’t been able to keep up.”

The program has grown steadily over the years, and it’s now out of space. Gallizzi said an expansion is underway, and she hopes to be in the new, larger facility in late summer. While the program still won’t be able to provide insulin or other refrigerated medications, the added space will allow the staff to keep a larger inventory, and that in turn will mean the program

can assist more Wyoming residents in need. The expansion also will provide a staff member whose full-time job will be to work directly with pharmaceutical companies to provide free or reduced-cost medications to patients. Creating that direct link between the patient and the drug companies may allow the donation program a way to help patients obtain insulin and other medications that must be kept cold, because the program won't be required to store those medicines.

The program makes it as easy to donate unused medications. Gallizzi said the recipients of the medications are always very grateful to be given the drugs they otherwise wouldn't be able to afford, but the people who donate medications are happy to see that the unused medicines will make a positive difference for another person.

"Donations have to be in a sealed package, and they can't be expired," Gallizzi said. "We have a text line that tells donors where the nearest donation and disposal points are. All

you have to do is text your county name to 307-30-2086, and you'll get a reply telling you the address of the nearest donation point."

Many of the donation sites are public health facilities, but some pharmacies also participate.

Schulz said even the recipients sometimes become donors.

"The people who have been given medications are always so thankful," she said. "They want to help make the program successful. We've had patients bring back unused medications they've had allergic reactions to, or for some other reason can't take the medications. So even those who have been recipients of the free medications will,

from time to time, become donors themselves."

Information about how to apply for the Wyoming Medication Donation Program, as well as information about how to donate unused medications, can be found on the program's website at <https://health.wyo.gov/healthcarefin/medicationdonation/>.

“The people who have been given medications are always so thankful, they want to help make the program successful.”

NATASHA GALLIZZI
Wyoming Medication Donation Program Manager

Go-getters. Strong leaders. High achievers.

We recognize the Wyoming Medical Society for their commitment to affordable, quality health care. Their dedication is an inspiration to us all.

Telehealth in Wyoming:

Easier Than You Think!

BY JAMES BUSH, MD
Wyoming Medical Society

For years, doctors have been hearing about telehealth and the promise it held, but the perceived barriers were too much to entice many providers into trying telehealth.

"It's too complicated, it doesn't pay, the patients won't like it," are just a few of the most common myths. The reality is it has never been easier to provide telehealth, it is occurring today in Wyoming, and your patients can benefit from it as well.

MYTH #1 - It's too complicated! When telehealth first came out the equipment was expensive and daunting! There were new remotes, the monitor looked like the viewscreen on Star Trek, and you needed Scotty at the controls to connect you and keep a clear signal. No wonder many Tandbergs and Polycom units shortly became the medical equipment equivalent of an exercise bicycle in March- an expensive coat hanger. Now with the Wyoming state contract with Zoom, anyone with internet access can send a HIPAA compliant invitation to a patient through their phone, tablet or computer at NO cost. All you need to do is contact the Wyoming Telehealth Network at the website shown at the bottom of this article to receive a free Zoom license.

MYTH #2 - It doesn't pay. Not true! Wyoming is one of the most telehealth-friendly states in the union. It is covered by Medicaid, Medicare, Cigna, and by all reports of all the other payers in Wyoming. Medicaid pays the same as in-person visits and even allows the patient to be seen in their home! To code it, you just add the modifier GT to the code. As in a 99213GT. If the patient is seeing a specialist from your office, you can also bill an originating site code, Q3014. And if there is a code that can reasonably be done by telehealth, WDH can open it for you. For example an ENT doc in Denver is adjusting cochlear implants via telehealth, and WDH opened those codes. Just review all the requirements in your provider man-

ual on pages 111-116.

MYTH #3 - The patients won't like it! A patient satisfaction study was performed here in Wyoming and 97.4% reported being comfortable with telehealth. 84% preferred using telehealth to only 16% preferring in-person psychiatric visits. And no wonder, 54% had to travel over 20 miles with 28% having to travel over 100 miles to see a psychiatrist! Once patients know they can see specialists without hours of windshield time, they become fast adopters.

Telehealth can be used for primary care visits, consultations and even education via ECHO clinics that are provided through the University of Wyoming. All the resources can be found on the WDH webpage. Just Google Wyoming Telehealth, and the webpage for the Telehealth Consortium is right there. There is also a directory of providers with their specialties and contact information. Make sure your name gets added to the list! There is a toolkit, training and technical support all available from the site. Visit <https://www.uwyo.edu/wind/wytn/about.html>.

The reality is it has never been easier to provide telehealth, it is occurring today in Wyoming, and your patients can benefit from it as well.

WE'VE GOT MORE THAN JUST YOUR BACK.

As a nationally recognized leader in patient safety and risk management, COPIC offers a better option for medical professional liability insurance. We keep you covered from front to back.

- Educational Resources that Address Emerging Issues
- On-Site, No-Cost Reviews to Identify High-Risk Areas
- Access to Medical and Legal Experts
- 20+ Years of Communication and Resolution Expertise

COPIC
Better Medicine • Better Lives

callcopic.com | 800.421.1834

COPIC is proud to be endorsed by:

Colorado Hospital Association • Colorado Medical Society • Iowa Medical Society • Nebraska Medical Association

Advantageous Alliances

BY TY STOCKTON

Wyoming Medical Society

Small towns in Wyoming face huge challenges when it comes to providing medical care for their residents. When those residents need specialized care from an oncologist, a surgeon or an obstetrician, it usually requires a trip to a larger city – and quite often, that city is on the other side of the Wyoming line.

That leaves the state's smaller communities in a difficult position. In the past, it meant either giving up control of their community-owned hospitals to large healthcare systems or watching their residents leave town to find medical care.

Even the former wasn't always a viable solution. While large corporations can offset the cost of healthcare in small communities with profits made in metropolitan hospitals, they still have to monitor their bottom lines. Very few corporations will allow a small hospital to operate for long at a loss, even if the services it provides are vital to a community.

In an effort to offer the healthcare needed, several hospitals in the state have begun forging various alliances with larger systems. In some cases, those alliances come in the form of a bigger organization – like a multi-state hospital system or a medical school – sending medical staff to the smaller hospital on a regular basis or providing telehealth services.

Or they can be more structured partnerships, in which the smaller hospital's administrators are employees of the larger hospital, while the smaller hospital retains its community ownership. While the methods of the partnerships may differ greatly, one characteristic remains constant; everyone benefits from the alliance.

"The types of agreements are all over the board," said Eric Boley, president of the Wyoming Hospital Association. "Each facility has to figure out what works best for them. ... A big concern is that without a way to keep people in their communities, (medical) care will go out of state. For the most part, these agreements are working well, and they're keeping people close to home for medical treatment."

Boley said affiliate agreements are a solution several hospitals in Wyoming have found successful. For instance, Coram Health has affiliate agreements with the Rawlins and Cody hospitals, as does UCHealth with Iverson Memorial Hospital in Laramie.

The administrators of these hospitals are employees of Coram Health or UCHealth, but the hospitals themselves are still community facilities.

This allows more options to the doctors and patients when specialized care is necessary. In the past, a patient who needed care the smaller hospital couldn't provide would have had to

travel to receive that care. Under these agreements, the hospital may bring a specialist to the smaller hospital to treat that patient.

In situations where the patient still has to travel to a larger facility, the doctors are better able to communicate when they're working within the same system, and the patient often can get continuing care back in his or her home community.

Under these affiliate agreements, specialists often travel to the smaller communities on a regular schedule, or they may be sent to the Wyoming hospital immediately in the case of an emergency. A surgeon may travel to Rock Springs, for instance, so a patient no longer has to travel to Salt Lake City to undergo a procedure.

"There are still some areas where the providing hospitals can't do everything," Boley said. "Small communities can't hire specialists, but the larger systems can provide them. It creates continuity of care, keeping patients close to home."

There are even partnerships between hospitals within the state. Boley said the Riverton and Lander hospitals are both owned by SageWest, and they share one management team between the two hospitals. Torrington and Wheatland operate with a similar arrangement under Banner Health.

"It creates continuity," Boley said. "The staffs of both hospitals collaborate better than they would if they were run independently."

Another example is telehealth. Advances in technology now make it possible for a doctor in Casper to examine a patient who is in a telehealth-equipped exam room in a different hospital hundreds of miles away. Boley said the doctor can use cameras and other medical equipment to treat the patient, even though they are physically in separate locations.

"Health care is pivotal," Boley said. He explained that communities can't exist without access to medical care. Yet facilities that provide that care are expensive, especially when they employ specialists.

"These agreements are a way to provide that care to people in their own communities," he said. The patients benefit by being able to get medical care close to home; the smaller hospitals benefit by remaining viable in their communities; and the larger systems benefit from the referrals that come through the partnerships.

"Affiliate agreements keep care from leaving our state, and through these agreements, smaller hospitals are able to bring more resources to bear," Boley said. "There are some real innovative, smart things going on around the state when it comes to partnerships between hospitals."

WWAMI Student Profiles

In the summer edition of Wyoming Medicine Magazine, we take the time to profile Wyoming students who are in their first year of the WWAMI program. This year we asked them the following questions:

1. What is the name of your undergraduate institution, and what was your major?
2. What has been the highlight of med school thus far?
3. What areas of practice are you considering and why?
4. What areas of the country would you like to practice in and why?
5. What do you like about the WWAMI program?
6. What brought you into the field of medicine?

Lingga Adidharma

Laramie, Wyoming

1. Johns Hopkins University - Biomedical Engineering.
2. My clinical experiences with my preceptor and hospitalist have been my favorite part. Not only do these experiences ground the material we are learning in class, but they also remind me of why I wanted to go into medicine in the first place.
3. I am interested in combining engineering with medicine and could see myself doing this in many areas of practice. Currently, I see the most potential for overlap with surgical fields.
4. I do not have a specific town in mind, but I would like to practice in an area close to my family that has easy access to the outdoors.
5. Similar to my highlight, I have enjoyed how the WWAMI program exposes us early on to clinical experiences. I am excited to continue these experiences learning from preceptors and working with diverse patient populations around the WWAMI region during clinical rotations.
6. Through my research and engineering experiences I found enjoyment in the innovation inherent to engineering, but I felt a disconnect between my work and the people it impacted. Experiences in volunteering and shadowing exposed me to how physicians had the privilege of working on challenges in a more direct, personal level and developed my desire to become a physician.



Ethan Slight

Cody, Wyoming

1. Boise State University. Health Science Major, Biology Minor.
2. Really getting to understand the human body. Very amazing to me! Along with all the great experiences working with my preceptors and getting some great patient time.
3. That is a great question. I really have no idea. I like IM and EM but haven't ruled anything out at this point.
4. Wyoming. Beautiful country, great people and been my home since I was a kiddo.
5. The small class class size, ability to travel and the TRUST program.
6. The desire to serve other people. I watched my father do this in his practice when I was a kid. He has been a constant inspiration for me to always do better and work hard to help those around me.





Austin Lever

Rock Springs, Wyoming

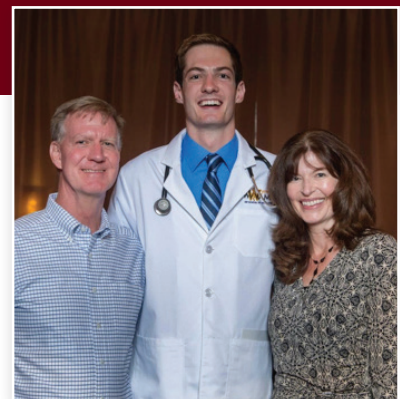
1. Boston College, Biology.
2. The highlight of medical school so far has been being able to spend so much time with preceptors and physicians in the area during the first year. It has been amazing having the opportunity to spend time in clinic with patients while learning from great mentors.
3. I am currently interested in internal medicine because of the broad focus and ability to work and interact with patients from a diverse population with a wide range of pathologies. However, I am open to many specialties and excited to explore them as my education continues.
4. Having grown up in Wyoming, I have a huge love for this state and its people. For this reason I would really like to return to Wyoming to practice medicine.
5. One of the aspects about the WWAMI program that is invaluable is the ability to gain so much clinical experience outside of the classroom during the first year. Along with this, every person involved with the WWAMI program is so invested and supportive which creates a great environment.
6. I wanted to study medicine because I have always had a passion for science and public health. What really appealed to me was that the integration of the scientific and personal aspects of medicine make it a dynamic field that allow you to make huge impacts on people's lives.



Cody Hansen

Rock Springs, Wyoming

1. I earned a Bachelor of Science Degree in Neuroscience from Brigham Young University.
2. The highlight of my medical school education thus far has been working with my clinical preceptors and in the hospital. I really enjoy working with patients and collaborating with other physicians to find ways to better their health and care. It's been great to see how what we are learning in class applies directly to improving our patients' lives.
3. Right now, I am considering ophthalmology, radiology, and anesthesiology. I have always enjoyed health professions that allow you to perform procedures and have loved working with doctors in these fields. I also enjoy the work-life balance that comes with these areas of practice.
4. I want to practice in an area of the country where I can raise a family and be close to the outdoors. I'm planning on coming back to Wyoming after my medical school training and practicing somewhere in the state. I want to live somewhere that will allow me to be a strong member of the community I live in.
5. The WWAMI program has been an amazing opportunity. I'm grateful to be a part of this program and to get to learn from instructors and physicians throughout the WWAMI region. I also have enjoyed serving in a smaller community and getting to know the other Wyoming and WWAMI students as we work towards our individual career goals.
6. I was drawn to the field of medicine during high school because of amazing high school science teachers. I loved being able to serve and help others, throughout my undergraduate time, and felt like an education in the field of medicine would best help me to apply the knowledge I was learning to others' care. The field of medicine allows me to care for others, raise a family, and be a strong citizen in my local community.



WWAMI Student Profiles

Dillon Brown

Cheyenne, Wyoming

1. Brigham Young University- Russian Major
2. The highlight of medical school so far has been learning how to suture. I love using my hands so getting to suture was such a tangible realization that I am really here and on the path to becoming a physician. Clinical experiences and little breaks from book work like this that help inspire me to reach for mastery of the material in order to help my future patients.
3. I am keeping my mind open so that I don't miss learning about specialties and discovering new things that I like. In the past I have been interested in surgery, but recently discovered that it was doing procedures and being in the OR that I really love. Through this realization, I also have seen the other areas of medicine that allow me to do what I love. My top interests now include, interventional radiology, anesthesiology, and orthopedics.
4. I laugh when people ask me where I want to live because it's still about 9 years before I'm even done with residency if all goes as planned. However, I love the West. I can't imagine a life without the mountains. Wyoming and surrounding states are at the top of my list of places to practice someday.
5. I love that in the WWAMI get early clinical experience and that we have connections to our home state and at the same time have all the resources of the University of Washington at our disposal. In our class size of 20 we have good friends and lots of individual attention from teachers. Couple that with the great reputation of UWSOM that we carry to residency applications and you have a winning program.
6. I first became interested in medicine through the surgical repair of a high school knee injury. The medical team and the way they helped me to gain such great knee function through surgery and rehabilitation really touched me. I want to do the same for others.



Heidi Hanekamp

Laramie, WY

1. University of Wyoming; Majors in Molecular Biology and Physiology; Minor in Music
2. I have really enjoyed being able to see the direct relationship between the manifestation of a disease and findings on a physical exam. I am amazed by how many different systems can be impacted by one disease!
3. I am still exploring my options for different specialties, but I have an interest in OB/GYN because I enjoy the combination of both surgery and primary care medicine.
4. I am open to living where my specialty of interest takes me, but I will likely end up in some sort of primary care medicine, which will hopefully bring me back to beautiful Wyoming!
5. I have enjoyed interacting with other Medical Student Association (MSA) members and faculty from all of the WWAMI regions. Being in MSA has showed me how many resources are available to us through connections with four other states.
6. There are many reasons why I decided to pursue medicine, including an interest in the details of how the body works, a love for lifelong learning, and a passion for helping others. What I enjoy most about medicine though are the complexities and challenges that come with functioning at the crossroads of physiology, psychology, and sociology.





Madeleine Birch

Cody, Wyoming

1. The University of Utah. Major in biology.
2. The course at NOLS was a highlight. Working with my preceptors, Dr. Schiel and Dr. Ewell has been great.
3. Emergency medicine, or a specialty off internal medicine.
4. Wyoming.
5. The small class size the first year and getting to attend such a high esteemed medical school.
6. Exposure to the profession from a very young age. I discovered my own fascination of the sciences in undergrad and love how it is integrated into medicine.



Michael Robison

Green River, Wyoming

1. I attended the University of Wyoming and earned a B.S. in Physiology. I graduated in 2013.
2. I have enjoyed our hospital mornings. Five of us students met biweekly with a hospitalist and discussed clinical medicine, read ECGs, and saw hospital patients. We also practiced bedside case presentations. I liked that the patient presentations were more complex, and that we had the time to do more in-depth analysis. I also enjoyed observing my colleagues as their clinical skills developed over the year.
3. I really like Internal Medicine and the associated subspecialties—especially Cardiology, Pulmonology, and Critical Care. I'm interested in a balance between procedural medicine and clinical medicine. I enjoy complex cases, and I'd really like to become an expert of a smaller field of medicine. While our program puts an emphasis on primary care, I believe that Wyoming needs more specialists who are motivated to be based in Wyoming. With Internal Medicine, I could choose to either stay in primary care or to further specialize. I like that flexibility.
4. I'd like to come back to Wyoming. I'd like to honor my WWAMI contract, plus it's close to family.
5. I love the small class sizes. It's been a great chance to get to know my colleagues and the faculty. I've enjoyed the early exposure to clinical medicine. We are doing things in our first year that many students don't experience until their third year. That puts us at a huge advantage for becoming competent clinicians. The value of the WWAMI program simply cannot be beat. The connection to University of Washington really gives us a lot of educational and career opportunities that we otherwise wouldn't have. For example, I'm part of an elective LGBTQ Health Pathway. This pathway is training me to provide culturally responsive care for the LGBTQ population in Wyoming. I'm excited to see where this training takes me in extending better care to more of Wyoming's underserved populations.
6. I will be the first physician in my family. My career exploration began with a love for science. As I learned more about medicine, I realized that becoming a physician is something I simply needed to do. Physicians interact with patients at some of the most significant moments of their lives—from birth to death, and in illness and in health. I find that relationship inspiring. Also, doctors get to be trained to do some amazing procedures that few people are able to do. Getting a medical degree from the WWAMI program is going to open a world of opportunities for me, and my hope is to pay back the investment when I'm through with my training.



WWAMI Student Profiles

Sarah Maze

Ranchester, Wyoming

1. University of Wyoming, B.S. Physiology, minor in neuroscience, B.A. Spanish
2. I loved wilderness medicine training with NOLS in Lander, and have greatly enjoyed my preceptorship experiences. It is such an incredible opportunity to learn in a variety of clinical settings and apply our knowledge hands-on so early in our education.
3. Right now, every aspect of medicine is fascinating, I'm really looking forward to continuing to explore a variety of specialties.
4. My upbringing in Wyoming instilled a desire to work toward increasing access to health care in rural areas as a physician. I would like to incorporate global medicine into my future career, ideally practicing in a rural community similar to the one that shaped me in Wyoming and also spend time serving abroad.
5. The WWAMI program is such a supportive learning environment—it's great to have our faculty, staff, and really the whole state of Wyoming behind us, advocating for our education and the future of health care in Wyoming! I also love the importance placed on early clinical exposure, and the "learn by doing" approach.
6. Combined with my interest in human physiology, my passion for serving others fueled my interest in medicine. Medicine is an opportunity to have a meaningful impact on the lives of others while learning something new every day. I look forward to working with patients to optimize their individual health and ensure they are able to live a rewarding life.



Jordan Reed

Gillette, Wyoming

1. University of Wyoming, Bachelors in Microbiology and Minor in Chemistry
Colorado State University, Masters in Biomedical Sciences
2. The highlight of medical school so far has been getting to know the other students in my class and establishing friendships. I have also enjoyed the clinical experiences. We are able to interact with patients early in our education and we are provided with a plethora of shadowing opportunities, both of which are quite unique and extremely beneficial as first year medical students.
3. I am currently keeping an open mind as I gain more experience and exposure to different specialties. However, I have always enjoyed working with children, and the pediatric age group is the population in which I would like to work with.
4. I would like to come back to Wyoming and practice. Wyoming has always been my home as I was born, raised, and received the bulk of my education here. I would thoroughly enjoy giving back to the state and citizens that have helped me get to where I am today.
5. The WWAMI program does an excellent job providing engaging preceptors and hospitalists. Their contributions undoubtedly help solidify the knowledge gained in the classroom by applying it to a clinical context.
6. Medicine provides an avenue that combines my passion for learning, science, and my desire to work with people. Through my prior experiences in the medical field, I discovered the teamwork involved in medicine along with the gratification of helping others in need, which confirmed my decision to pursue a career as a physician.

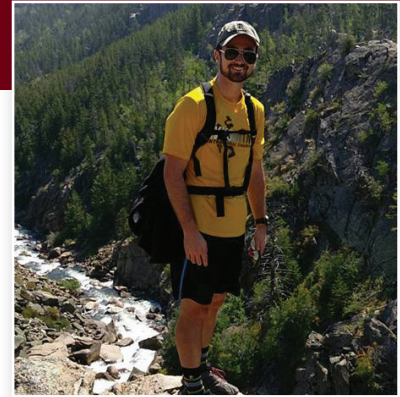




Joshua Henry

Laramie, Wyoming

1. University of Wyoming, Major in Chemistry with Honors
2. NOLS was the most exciting part of medical school so far. Getting to know my classmates in the setting of Wilderness Medicine was an amazing experience. I also love emergency medicine and spending time outside so this experience was the perfect way to get excited for our future as physicians.
3. As I said before I am interested in Emergency Medicine as well as Radiology. I love fast paced acute medicine where making decisions quickly is necessary. I also enjoy using images and tests to reach a diagnosis. That being said I have yet to spend time in a clinic that I have not enjoyed. Any specialty is still on the table.
4. Most any rural location in the Rocky Mountains would be fine for me. I am partial to south-eastern Wyoming and the Douglas area is one of my favorite places to spend time. The outdoor community and down to earth people make me feel at home.
5. I most enjoy the faculty to student ratio. We have many faculty who dedicate so much of their time to our training as physicians and with only 20 students they are readily available for any question you may have. Being able to get more one on one teaching in with teachers has been extremely helpful in understanding challenging concepts and feeling at home.
6. I am the eldest of 5 boys which placed me in a sort of caretaker and provider role from a young age. This combined with my fascination in the capabilities and strengths of the human body made medicine appear as the only possible career choice once I hit High School. I love the conversations and the change you get to see in the lives of those you are fortunate enough to interact with.



Kelsey Tuttle

Rock Springs, WY

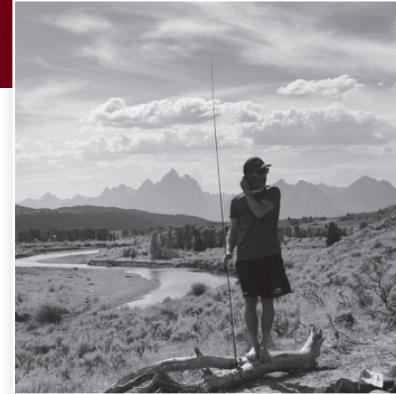
1. University of Rochester; Majors in Chemistry and Business, Minor in Movement Studies
2. I have especially enjoyed the time I spend in the community with local practitioners. We have so many generous physicians in our community volunteering their time to educate us as well as community members that are eager to be a part of our learning process. It makes for a wonderful environment to learn in!
3. I am undecided about what area of medicine I would like to practice in. I have found things I like about many of the specialties I explore, so I am keeping my mind open and continuing to investigate my interests.
4. I would love to come back to Wyoming! All of my family is in Wyoming and I look forward to being close to them.
5. I love that we have a small class size! It allows me the opportunity to know all of my classmates and it creates comradery among us. It has also made it easy to connect with professors and build relationships with those teaching and supporting us on this journey. I also enjoy the many clinical experiences we have been given, from family medicine, to the emergency medicine, to the operating room, we are able to explore many interests.
6. I grew up watching family members navigate the health system, so I originally became interested from a policy standpoint. Originally, I thought about going into policy or benchtop research in the basic sciences to do my part in improving health care, but the more I learned about medicine and health policy the more I realized I wanted to be a physician. I want to be a physician so that I can help people navigate the system we currently have while supporting and having a deep appreciation for those advocating for improvements in policy and those doing research to change medicine in the future.



WWAMI Student Profiles

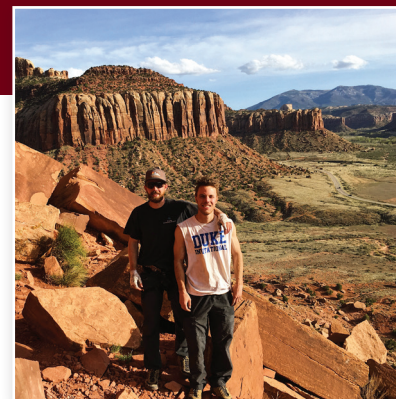
Aaron Robertson Douglas, Wyoming

1. Middlebury College, Music
2. Working with my preceptors, Dr. Amy Jo Harnish, Dr. Patrick Tufts and Dr. Paul Johnson. I have been able to see the specifics of their respective medical practices. This has given me the opportunity to refine my history taking and physical exam skills. Additionally, I have been able to participate in multiple procedures.
3. I am open to a lot of areas of practice at this point, I am keeping my options available. Four fields of medicine I am most interested in are internal medicine, emergency medicine, otolaryngology and orthopedics.
4. I will practice in Wyoming. I need access to the things I enjoy. Mountain biking, fly fishing, hunting, skiing, camping, etc. Wyoming is filled with hard working, good people. There is no better place than Wyoming for my future career.
5. The WWAMI program provides tangible hands on experiences from day one. This allows me to take complicated topics from my didactic learning and connect them to real life experiences. There is no better way to ingrain what you learn in the classroom than to see it in practice.
6. My initial interest in medicine is related to personal experiences as a patient. Since then, I have discovered that medicine is an engaging and fulfilling career path. It will allow me to live a life of continual learning while making a difference in the lives of Wyomingites.



Spencer Pecha Gillette, Wyoming

1. Undergraduate institution: Duke University, Major: Environmental chemistry with a minor in Earth and Oceans Science
2. So far, the highlight of medical school for me has been really diving into the curriculum. I find the pathophysiology of the conditions we study, as well as the related anatomy of the organ systems, fascinating and enjoyable to study. Additionally, spending time outside of the classroom learning through preceptorships with Dr. David Kasarda in the Laramie ED and Dr. Carol Schiel of Cheyenne Regional Pediatrics has been amazing. I have really enjoyed getting more comfortable around the pediatric population of patients via working with Dr. Schiel.
3. At this point I find nearly everything interesting and am very open to all possibilities. I hope to hone in on an area of medicine that I am passionate about, and one that allows for a good work-life balance. I am looking for a specialty that incorporates both procedures and patient care and am strongly considering anesthesiology, emergency medicine, internal medicine, and ENT/facial & neck surgery.
4. Really the only places I see myself practicing are in Wyoming or the Rocky Mountain Region. I am really interested in rural healthcare delivery and see myself practicing in a rural area. But, I also really enjoy teaching, so teaching medical students and residents at a teaching hospital would not be out of the question in the future.
5. I really like how the School of Medicine is so open to student feedback, especially concerning curriculum improvement. They are always asking for student feedback and are willing to improve things based off that feedback.
6. Medicine represents and incorporates what I want out of a career: critical thinking and life-long learning, team-work, interpersonal relationships, service, and teaching to name a few.





Mason Stillman

Gillette, Wyoming

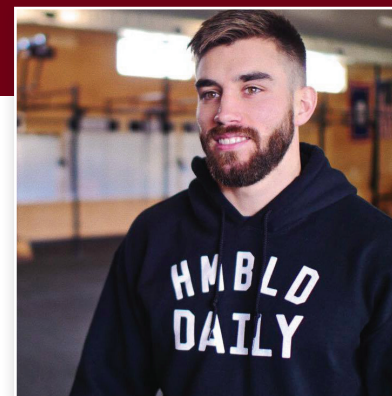
1. University of South Dakota – Biology Major
2. The best part of medical school so far has been the ability to apply information I've learned to patients in my clinical experiences.
3. I'm currently exploring a lot of options, but my biggest areas of interest are psychiatry, neurology, emergency medicine, and internal medicine. I really enjoy anything concerning thought processes and brain function, but I'm interested in the others because of the variety they offer.
4. Wyoming, because it would mean a lot to be able to help the communities that raised me. I also enjoy hiking, biking, and fishing, so Wyoming has a lot to offer.
5. I really like the community feel that the program offers. Every staff member is very helpful and concerned about the success of the students, and that makes for a very inclusive learning environment.
6. My brother was born 3 months prematurely, so I've always been around healthcare. I just really liked what I saw in the medical field during that exposure. The difference that healthcare professionals were able to make for my family and countless others had a large impact on me.



Quinn Rivera

Cody, Wyoming

1. University of Wyoming, Physiology.
2. The highlight of medical school thus far been the ample patient interaction that we receive so early on as a part of the WWAMI program. That experience holds so much value in building our confidence and professionalism early. I've also thoroughly enjoyed getting to know my classmates and all of those who make the WWAMI program possible. It is a devoted crew that helps make our goals a reality, and I am very thankful for that.
3. I am currently interested in Ophthalmology and Radiology. My time spent with both of those specialties has proved fruitful, and they both align with many of my interests. After my training I hope to pursue mission work alongside my practice, and Ophthalmology has a ripe mission field due to the high prevalence of preventable blindness caused by cataracts. I plan to remain open minded during my future rotations and look forwards to learning about each area of medicine.
4. I would love to come back and practice in Wyoming. The people in Wyoming are unparalleled and throughout my life here I have been molded and shaped by the communities I have been blessed to be a part of. I see no better way to give back than to come back to the state to practice.
5. The early clinical experience has been a great advantage of the WWAMI program. I also enjoy the small class size and the comradery that has been built between classmates because of it. The doctors in Wyoming seem to be very fond of the WWAMI program and that allows doors to be opened for us students to gain additional experience which is also a great aspect.
6. I pursued medicine because I have deep rooted passions to serve, learn, and teach, which are all encompassed by the medical profession. Physicians have a unique opportunity to serve patients and build bridges when they are often in a very vulnerable state. I greatly look forward to the relationships that will be built throughout my career through the pursuit of health and the highest quality of life.



WWAMI Student Profiles

Jackson Schmidt

Cody, Wyoming

1. University of Colorado - Degree in Psychology
2. Learning about so many disease processes involving various organ systems, and then using this knowledge while seeing patients in order to categorize problems and explain them to patients.
3. I am interested in surgery because it is such a fascinating and challenging skill but also equally intrigued by family and internal medicine because of the broad spectrum of knowledge necessary to practice in these fields.
4. Wyoming, Colorado, or Montana, as I have always loved these states above all the others I have visited.
5. It is very personal and the faculty are genuinely invested in our progression toward becoming physicians. It truly is an amazing program.
6. Mostly the desire to gain knowledge that would allow me to help other people with their health problems in a variety of settings. It's the universal utility of medicine that exists regardless of culture or region that drew me to the field.



The intersection of health care and law is a puzzling place. We can help put those pieces together.

Health care is a constantly and quickly changing field, and health care law is no exception. Over 30 years, we have developed significant experience advising physicians on the impact of the myriad laws affecting their practices, and we spend a great deal of time and energy staying on top of current developments in health care law to better serve Wyoming's physicians.

DDR&H

DRAY | DYKMAN | REED | HEALEY PC
ATTORNEYS AT LAW

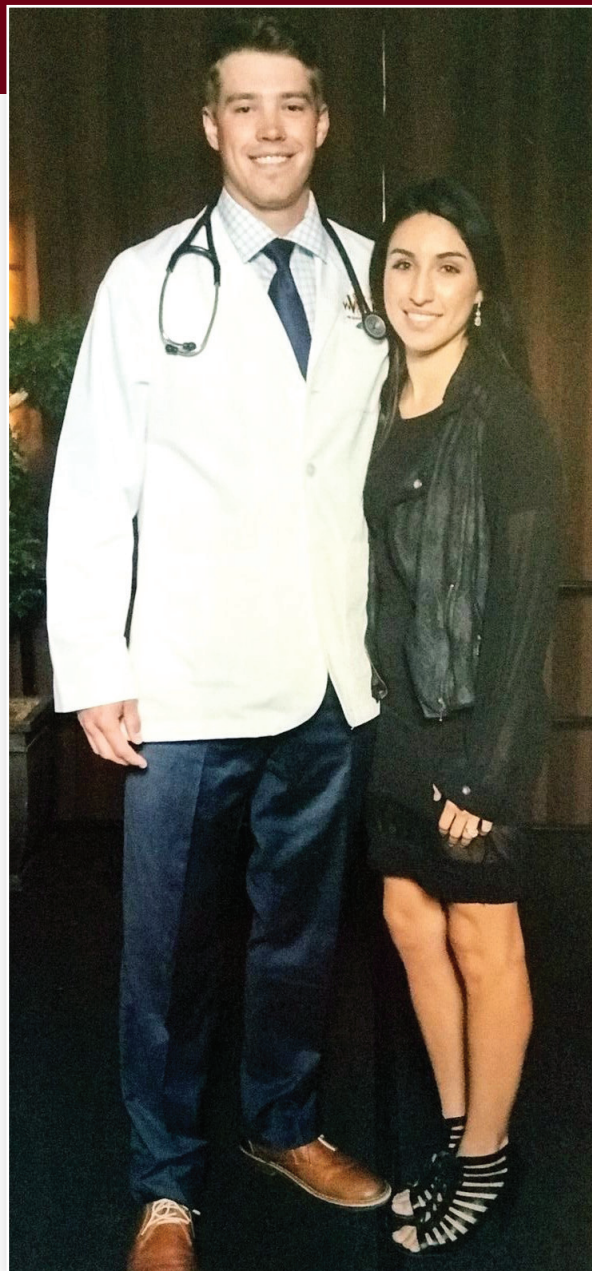
The Wyoming State Bar does not certify any lawyer as a specialist or expert. Anyone considering a lawyer should independently investigate the lawyer's credentials and ability, and not rely upon advertisements or self-proclaimed expertise.



Trevor Mordhorst

Cheyenne, Wyoming

1. I attended the University of Wyoming with a Physiology Major and Neuroscience minor. After the University of Wyoming I attended Tulane University for a Pharmacology masters program.
2. I have really enjoyed getting to know the fellow students in the WWAMI program and the time I have spent with my preceptors. The program helps to develop valuable relationships and promotes mentorship through early clinical experience.
3. At this point I am confident I would like something to do with sports medicine. I am unsure of which path I should take to get to this goal. Currently Physical Medicine and Rehabilitation is my top choice, however the more I learn over the next year or so will refine my decision. I will spend time this summer with Physiatrists to learn more about my interests. I like that PM&R uses aspects of Internal Medicine, Orthopedics and Neurology to treat a patient's quality of life and the wide range of practice from sports medicine on a field or in a clinic to spinal cord injury in critical care.
4. I love Wyoming and plan on coming back to Cheyenne. I am not able to stray far from the front range area and all that it has to offer. Both my wife and I grew up in Cheyenne, where we still call home. We enjoy being close to friends and family and an outdoorsy lifestyle.
5. WWAMI has been absolutely spectacular for me. The staff and students have all been great. We get an early exposure to clinical skills that is not common in many medical schools. Things that we learn in class are further cemented in the clinic, as we see patients that bring a face and a story to a pathology. As I mentioned earlier the program also puts students in a position to develop relationships with mentors. I have found this valuable. As students we are experiencing most of medicine for the first time. These mentors help to provide a real-life guide to medicine on both an academic and personal level.
6. Firstly, I have had a lifetime of love for biology and the magic that is nature. I grew up on a small ranch between Cheyenne and Laramie and was always surrounded by animals and wilderness. In school I experienced a natural transition to studying physiology and the innerworkings of biology. I excelled in this area and was continuously fascinated with learning all that I could. Medicine was a perfect way to continue my passion for science and a lifetime of learning. Secondly, growing up my mother was diagnosed with an autoimmune kidney disease. She was on dialysis at home and our home was full of the medical equipment necessary to replace her malfunctioning kidneys. Over twenty years she has had many complications with her disease, including two kidney transplants. I witnessed the vast improvement medicine had on her life, and the lives of all of us in her family. I saw the potential I had in medicine to make drastic improvements in people's lives and this was too enticing not to take part in.



WWAMI Student Profiles

Sabrina Westover Cheyenne, Wyoming

1. I studied Molecular Biology and Physiology with a minor in the Honors Program at the University of Wyoming. I graduated with my Bachelors of Science in the fall of 2016.
2. I've really enjoyed my experience in my primary care practicum. The physicians and patients I met have been inspiring.
3. Pediatric Oncology has always been an interest of mine. I developed a passion for working with children and cancer when I completed an undergraduate research fellowship at the University of Colorado.
4. Wyoming because I enjoy the culture, the people, the outdoors, and have family nearby.
5. Early exposure to patients in our pre-clinical curriculum has been really beneficial. It's been a great break from classroom material and is a nice reminder of the reasons I wanted to enter the field of medicine.
6. A culmination of many experiences over time has lead me to pursue a career in medicine. I think what ultimately drew me to the field was knowing that the possibilities to help people are endless.



Giandor Saltz Powell, Wyoming

1. I attended the University of Wyoming for my undergraduate studies and studied Physiology and Spanish.
2. The highlight for my first year of medical school is my spring preceptorships in geriatrics and ob/gyn specialties. I was lucky to be able to work with two different physicians.
3. I am interested in internal medicine. I like that this specialty has a broad spectrum and a lot of possibilities for sub-specialization. I am also interested in anesthesiology, as I really like the physiology and pharmacology involved.
4. I would like to stay in the west.
5. I like spending some of the pre-clinical phase in a rural area. This gives you a lot more hands-on experience with patients.
6. I have always loved working with patients. I was a CNA before I started medical school and patient interaction was the highlight of my job. I wanted to be able to do more for my patients and have so far loved my time in medical school.



Professional Services Offered Nationwide
Billers Education
Outpatient Billing
Revenue Cycle Evaluations



Contact: Amy Hayes, ahayes@oabilling.com
 OR Mike Calvetti, mcalvetti@oabilling.com
 1-800-823-2922 | oabilling.com

We understand the art
of healing and the
science of avoiding risk.



Medical liability and more.

At UMIA, medical liability is just the beginning. For more than 38 years, we've worked directly with physicians and developed a deep understanding of the risks involved with practicing medicine. We're there for those who are always there, drawing on a wide range of clinical data, insights and best practices from medical experts to help care teams deliver better care. To learn more visit **UMIA.com**.



UMIA

Elder Abuse in Wyoming: The Physicians' Role

BY JAMES BUSH, MD
Wyoming Medical Society

Case Studies from Wyoming Medicaid

CASE STUDY #1 - A 64-year-old woman s/p recent CVA was receiving home care from an adult daughter. She was bed-ridden and incontinent. She was on a Medicaid waiver, so a case manager conducted monthly home visits. Over a period of 4 months, the case manager noted progressive decubitus ulcers developing and enlarging, while the bed was constantly wet with urine. The daughter appeared to the case worker to be burnt out. The case manager kept referring this to the nurse, but there were no interventions and no requests for extra nursing assistance or wound care were made to the physician. The patient finally died at home, in pain and septic from bleeding decubiti.

CASE STUDY #2 - A 77-year-old woman on a Medicaid waiver was taken to the ER 26 times by a "family member" with complaints of falls and pain, and requests for pain medications. Upon further inquiry, the home nurse had not been notified of these ER visits and had, in fact, documented that the patient was stable on her feet. It was discovered that the "family member" wasn't related at all. He was found to be verbally abusive to the patient, and had moved her into his home without her belongings. A referral to the Department of Family Services - Adult Protective Services (APS) was made for opiate diversion. The woman was admitted to an assisted living facility and has since stabilized.

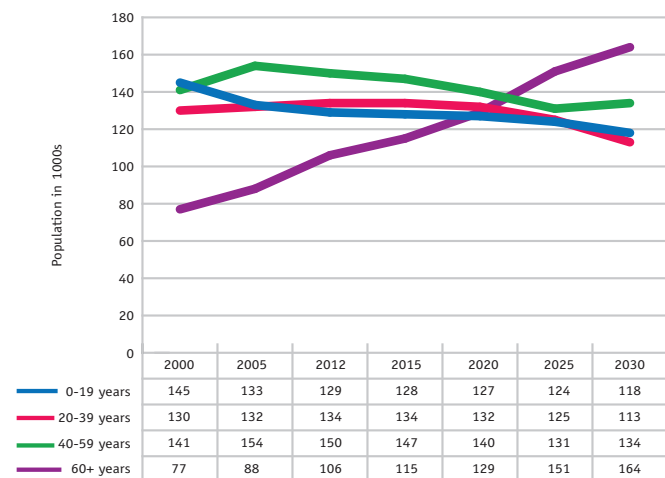
CASE STUDY #3 - A couple in their mid-70's had been stable at home with waiver support, skilled nursing, and personal care support despite diabetes and neuropathy. However, their services were stopped by the adult son, who then began calling the primary care physician's (PCP) office saying his parents were in pain and needed more medication. He also moved them into his house. When the mother died, the son still phoned in for a refill of her opiates the day after her death and was able to pick them up. He also requested medication increases for his father. Upon questioning, the PCP had been unaware of these facts. The PCP is now aware, APS is involved, the father is living with another child, and the drug diversion has stopped. Proper officials were notified of the drug diversion.

Background Statistics for Wyoming

According to the American Community Survey (ACS), approximately 20% of Wyoming's population was aged 60 or older in 2014, including the 2% who are aged 85 and older. By

all accounts the older population is expected to grow beyond 2030 as the generation of baby boomers (individuals born between 1946 and 1964) age and retire. Furthermore, it is projected that the fastest growing age group will be individuals aged 85 and older—a group most likely to experience disabilities and impairments that often require specialized programs and services.

Projected Wyoming Population Trends



- 20.4% of Wyoming's population was over 60 in 2012.
- 31% of Wyoming's population will be over age 60 by the year 2030.
- By 2030, Wyoming will be the 4th oldest state in the country.

With the population of older adults growing, there will inevitably be an accompanying increase in abuse, neglect and exploitation of vulnerable adults in Wyoming. Elder abuse, neglect and exploitation have been subjected to decades of data collection, research, and studies. Those studies reveal some alarming statistics.

- It is estimated that approximately 1 in 10 seniors over the age of 60 is abused (not including financial abuse) each year. <http://www.justice.gov/elderjustice/research/>
- Elder abuse is grossly underreported with

between 1 in 14 and 1 in 25 cases of elder abuse coming to the attention of authorities. <http://www.ncea.aoa.gov/Library/Data/index.aspx#abuser>

- In 90% of abuse cases the perpetrator was a family member, typically an adult child or spouse. <http://www.ncea.aoa.gov/Library/Data/index.aspx#abuser>
- The majority of elder abuse victims are women living in the community, rather than nursing homes or other senior living facilities. <http://www.justice.gov/elderjustice/research/>

Who is considered a vulnerable adult? People 18 years of age or older who are vulnerable to abuse because they are unable to perform or obtain services needed to maintain their health, safety, or welfare due to a physical or mental limitation, or advanced age (60 years of age or more). Adults who lack sufficient understanding or capacity to communicate their needs are also considered vulnerable.

What is abuse? It often manifests as financial exploitation by an adult child or caregiver. Neglect or self-neglect, and physical or sexual abuse are other common forms of abuse. Intimidation, most often through threats that the victim or their family, friends, or pets may be deprived of food, shelter, or support unless conditions are met, is also considered abuse. An abuser can be a trusted family member, caregiver, or friend. Caregiver stress, substance abuse, financial problems, and personal problems can all cause a well-meaning person to become abusive.

Abuse can be difficult to detect in the typical office encounter, and co-morbidities need to be considered, such as depression or early dementia that may be developing. While there are screening questionnaires, such as the 15-question Hwalek-Sengstock Elder Abuse Screening test (H-S/EAST), the US Preventive Service Task force gives routine screening an “I” as the data is inconclusive for routine screening. Situations in which the patients’ appearance is declining, the caregiver is refusing to bring the patient in, or a caregiver is answering all the questions for the patient, would be good situations in which the H-S/EAST could be administered.

If you have reasonable suspicions of abuse, remember that you are a mandatory reporter. If you think a crime has been committed you should report to your local law enforcement. In most situations, it won’t be so clear-cut, and a referral to APS will be appropriate. There are offices in every county with your local Dept of Family Services office, or you can call 1-800-

457-3659. An on-call caseworker is available 24 hours/day. The information you as the physician provide is invaluable to help APS determine what to do. There is no legal risk to anyone who reports in good faith. If possible, be present when the local office holds the Adult Protective Team meeting at which they discuss your patient. You might be able to join by phone.

APS has many resources, including a Financial Abuse Specialist Team (FAST), which may be available to help handle cases of financial abuse. The Wyoming Dept. of Health Aging Division has useful information on its website, and an Elder Ombudsman is also available.

In summary, elder abuse and exploitation is more common than we would like to think, and with the growth in this population, you will see cases in your practice. Remember to be alert for warning signs; you are often the only person who has the ability to save your patient from abuse!

I would like to acknowledge the Governor’s Task force for elderly, vulnerable adults for collecting the statistics used in the population trends section of this, and the Adult Protective Services unit for the language around abuse. The case studies came from Medicaid Quality reviews.



This free app helps patients manage their health, personalized for each family member.

- Keep track of appointments and milestones
- Locate providers and free community resources
- Includes a pregnancy tracker with tips and tools



Free from the Wyoming Department of Health. Text the word “Family” to 307-317-0819 for a link to the free download. **Visit wyhealth.net to learn more.**



This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this program is for your information only and is not a substitute for your doctor’s care. Program representatives cannot diagnose problems or suggest treatment. This program is covered by your health plan. It is not an insurance program and may be discontinued at any time. Your health information is kept confidential in accordance with the law.
© 2018, WYhealth. All right reserved. WF691192 05/18

The Wyoming legislature did not go as far as a handful of other states which have enacted mandatory PDMP checks, or legislation establishing prescribing guidelines or limits on prescriptions of controlled substances. However, these legislative directives are not entirely off the table, as the 2018 legislature did create an Opioid Addiction Task Force, and charged the task force with considering a laundry list of issues, including both mandatory PDMP checks and prescribing limits. The full scope of the legislature's direction to the task force includes the following issues:

- Prescription drug monitoring programs and electronic prescribing systems, including [the WORx], and patient prescription history verification requirements;
- Grants relating to substance abuse education, prevention, treatment and recovery made available by the federal government, the State of Wyoming and other organizations;
- The availability and use of naloxone and other prescription drugs to counteract opioid overdoses;
- The quality and availability of treatment for opioid addiction and overdoses in Wyoming;
- Strategies to reduce the administration of opioids

including promotion of alternative treatments, methods and possible limits on the quantity of opioids that a health care provider is authorized to prescribe;

- Authorized uses of opioids and any needed legal exceptions for authorized uses;
- Strategies for community engagement, including outreach to stakeholders and support for families of persons who have been impacted by opioids;
- Strategies for the state of Wyoming to undertake a focused, unified and cross agency approach relating to opioid education, prevention and treatment;
- Prescriber and dispenser education relating to opioids;
- Necessary law enforcement strategies and tools;
- Any relevant findings developed by the advisory council on palliative care; and
- Any other matter relating to opioids determined to be relevant by the task force

Civil Litigation

In addition to the legislative responses discussed above, the

opioid crisis has prompted a variety of lawsuits. Several states and other governmental entities have sued pharmaceutical companies directly. Most of the suits revolve around allegations that the pharmaceutical companies knew about the addictive qualities of opioid pain killers, but concealed the potential effects from consumers in order to benefit financially; including allegations that pharmaceutical companies represented their products could be used safely for chronic pain management. In Wyoming, the Northern Arapaho Tribe and Carbon County have filed suits of this kind in federal court, and the Wyoming Attorney General has said his office is investigating filing such a suit on behalf of the State .

Litigation is not limited to proceedings against the pharmaceutical companies however. A surge of recent lawsuits shows that courts are

Do you have diabetes or pre-diabetes (high blood sugar)?



Take steps toward a healthier you and learn how to better manage your diabetes!

• • • • •

JOIN US FOR SIX FREE DIABETES CLASSES!

Community Hall
426 Fourth Street
Mills, WY 82644

Classes meet on Wednesdays:
April 25 and May 2, 9, 16, 23 & 30
1:00 to 3:00 PM

To register or for more info, call Genee Miller at
(307) 439-2371.

These fun, interactive classes are meant to support, not replace, professional diabetes education. They are designed for people with Medicare, but anyone who has diabetes or pre-diabetes is welcome to attend!



Developed by Mountain-Pacific Quality Health, the Medicare QIN-QIO for Montana, Wyoming, Hawaii and Alaska, under contract with the Centers for Medicare & Medicaid Services (CMS). Contents do not necessarily reflect CMS policy. 115OW-MPQH-WY-B2-18-42

willing to impose liability on physician prescribers for over-prescription of opioid painkillers. In one notable case, a Missouri appellate court upheld a verdict against a physician and his employer awarding a plaintiff and his wife \$1.7 million in compensatory damages and \$15,000,000 in punitive damages where the physician's prescription of opioid painkillers resulted in severe opioid use disorder. The appellate court found that evidence admitted during the trial that repeatedly referred to a nationwide "opioid epidemic" was not irrelevant or prejudicial because such evidence had logical relevance to the case and established how the defendant physician's conduct compared to what others in the profession were doing under similar circumstances.

Best Practices

So what are Wyoming prescribers to do in the face of this opioid crisis and resulting legislative and litigation responses? There are many resources with best practices for prescribing controlled substances. These include the CDC's 2016 checklist for prescribing opioids for chronic pain, as well as the Wyoming Board of Medicine's 2009 Pain Management Policy and the Chronic Pain Management Toolkit also adopted by the Board of Medicine. With help from these resources, Wyoming providers can navigate the existing and emerging risks of the opioid crisis by undertaking the following activities within their practice:

- Become familiar with professional guidelines related to using controlled substances to treat pain, including long-term use to treat chronic pain.
- Ensure that all prescribers have adequate education and training about the risks and opioid addiction, abuse, and overdose.
- Consider providing patient education about the symptoms of overdose and the availability and use of opiate antagonists such as NarCan to respond to accidental overdose.
- Set policies within their practices related to prescribing opioids, including policies about checking the WORx before prescribing controlled substances, particularly for new patients.

1 CDC, NAT'L CTR. FOR INJURY PREVENTION AND CONTROL, DIV. OF UNINTENTIONAL INJURY PREVENTION, Opioid Data Analysis, available at <https://www.cdc.gov/drugoverdose/data/analysis.html> (last visited June 10, 2018).

2 Huffington Post, The Young Woman Whose Addiction Story Touched Obama's Heart Just Died, (March 28, 2016) available at https://www.huffingtonpost.com/entry/jessica-grubb-obama_us_56f99db9e4b014d3fe23de54 (last accessed June 1, 2018).

3 SEA 60, <http://www.wyoleg.gov/Legislation/2018/SF0078>

4 Wyoming Public Media, Wyoming Attorney General Investigating Potential Opioid Lawsuit, (May 23, 2018), available at <http://wyomingpublicmedia.org/post/wyoming-attorney-general-investigating-potential-opioid-lawsuit#stream/o> (last visited June 1, 2018).

5 Koon v. Walden, 539 S.W.3d 752 (Mo.App.2017).

6 CDC Stacks Public Health Publications, Checklist for prescribing opioids for chronic pain (March 2016), available at <https://stacks.cdc.gov/view/cdc/38025> (last visited June 1, 2018).

7 Wyoming Board of Medicine Policy 40-01, Pain Management, (February 13, 2009), available at <http://wyomedboard.wyo.gov/resources/board-of-medicine-policies-and-procedures>, (last visited June 1, 2018).

8 Wyoming Rx Abuse Stakeholders, Chronic Pain Management Toolkit, available at <http://wyomedboard.wyo.gov/resources/chronic-pain-management-toolkit> (last visited June 1, 2018).

In 2017, WBCI's funds granted into Wyoming supported:

40 

Breast Prosthetic & Bra Fittings

1,575 

Clinical Breast Exams, Screening or Diagnostic Mammograms, or Ultrasounds

5 

Awareness & Celebration Events

7 

Diagnosed with Breast Cancer Through the Screens



Wyoming BREAST CANCER INITIATIVE

We are firm believers that **early detection** is our greatest weapon against breast cancer, and are committed to ensuring every man and woman in the state has a fair shot at beating it.

Will you join us?

We are seeking **100** Wyoming doctors to donate **\$100!** Your sponsorship will provide survivors' registration fees at the Wyoming Pink Ribbon Run, which will be held on August 11th, and will fund WBCI grant programs. In return, you will be recognized at WBCI events and in media as a **Doc for Pink!**

Check out the WBCI Voucher program that provides your patients much needed early detection screening. This program funds breast health services for uninsured and underinsured Wyoming residents, available in every county. Visit our website-wyomingbreastcancer.org for specific details.

All Proceeds Stay in Wyoming, for Wyoming

Will you be 1 out of 100? Join Docs for Pink by:

- Emailing info@wyomingbreastcancer.org
- Visiting the sponsor section on our website wyomingbreastcancer.org
- Texting DocsForPink to 50155
- Calling **307-840-WBCI**
- Sending a check to WBCI, P.O. Box 2541, Cheyenne, WY 82003





Palpitations Diagnostic Challenge

BY JOHANNES VON ALVENSLEBEN, MD

Pediatric Cardiology and Electrophysiologist at Children's Hospital Colorado
Assistant Professor of Pediatrics at the University of Colorado School of Medicine

The complaint of palpitations or development of syncope is a common presenting concern for patients to their primary care provider. While the vast majority of patients will thankfully have no life-threatening cause for their symptoms, it can present a diagnostic challenge to providers and frequently results in a referral to other specialists. Understanding the most common causes for palpitations or syncope, as well as the “red flags” that should prompt a more intensive work-up or referral, can make the evaluation of these complaints more manageable.

Palpitations

Palpitations are the perceived abnormality of the heartbeat characterized by awareness of cardiac muscle contractions in the chest: hard, fast and/or irregular beats. Though they are both a symptom reported by the patient and a medical diagnosis, they do not necessarily imply that a structural or functional abnormality of the heart is present. In general, the provider is attempting to determine whether the palpitations are secondary to an arrhythmia, with the most common diagnoses being supraventricular tachycardia (SVT), premature atrial contractions (PACs), and premature ventricular contractions (PVCs).

Diagnosis: History of Present Illness

When determining whether palpitations are likely to secondary to an arrhythmia, the history can be quite helpful. Several important aspects include:

- Onset and termination: is it abrupt or gradual?
- Rate: can the rate be counted or is it “too fast to count”?
- Association with rest or exercise
- Association with chest pain, shortness of breath, dizziness, or syncope
- Duration: do palpitations last for seconds or hours?
- Frequency: occurring daily (or several times per day) or less often?

For many providers, the overarching question when faced with palpitations is, “What is the likelihood that this is secondary to SVT?”. Supraventricular tachycardia typically has an abrupt onset and termination and may be described by younger patients as “heart beeping”. The rate is usually too fast to count and has the sensation of “buzzing” under the fingertips. It is

commonly associated with chest discomfort, shortness of breath, and occasionally dizziness. Syncope is quite rare. Younger patients will frequently experience SVT while at rest while adolescent patients develop SVT during exercise. This is secondary to the differing SVT mechanisms that are more common in these age groups. Daily symptoms that last for only a few seconds are much less likely to be SVT.



Johannes von Alvensleben, MD

Diagnosis: Other History and Physical Exam

In general, the family history is less helpful to determine whether an arrhythmia is to blame for palpitations. Though PVCs tend to run in families, their overall prevalence is so high that a positive family history is rarely predictive.

Like family history, the physical examination is also unlikely to assist in the diagnosis. While extrasystoles or an irregular rhythm may suggest atrial or ventricular ectopy, sinus arrhythmia would present similarly and is a normal finding. A murmur can point to specific structural heart abnormalities which may or may not be related.

Diagnosis: Testing

Determining whether an arrhythmia is occurring is most often accomplished with an EKG, Holter monitor, and/or transient event monitor. Knowing the clinical utility of each can assist the provider in selecting the correct test for each situation.

- EKG: Best used to assess the presence of an ongoing arrhythmia (PACs or PVCs) or potential risk of arrhythmia (ventricular pre-excitation suggesting Wolff-Parkinson-White Syndrome).
- Holter monitor: Used to determine the overall frequency of ectopy or to assess heart variability in the setting of baseline bradycardia or tachycardia. Typically, not useful in the evaluation of episodic palpitations.

- Transient event monitor: Usually the most useful in assessing episodic palpitations, particularly for the documentation of SVT.

When to Refer and Management

A referral to Cardiology for palpitations is typically made for either diagnosis or ongoing management of a particular rhythm disturbance. By utilizing the above described testing strategies, the majority of patients can be referred with an existing diagnosis already made. Ongoing management can range from observation to advanced cardiologic testing and medications.

Premature Atrial Contractions:

In the vast majority of patients, the diagnosis of isolated PACs is an incidental finding and not specifically related to palpitations. In these circumstances, PACs do not contribute to symptoms, will not cause cardiac pathology (myopathy), and do not require ongoing follow-up.

Referral is indicated in the setting an ectopic atrial tachycardia which is most commonly detected on a Holter monitor or transient event monitor. In this case, a baseline echocardiogram is obtained to rule out structural heart disease or the development of a tachycardia induced cardiomyopathy. Medications, most frequently a beta blocker, can be used to control the ectopic focus though many patients eventually undergo an electrophysiologic study and ablation. Exercise restrictions are typically not necessary unless a known structural abnormality or cardiomyopathy is present.

Premature Ventricular Contractions:

As with premature atrial contractions, PVCs are most commonly an incidental finding during routine evaluations. Unlike PACs, however, even isolated or asymptomatic PVCs should prompt a referral to Cardiology as there is a risk of ectopy induced cardiomyopathies.

PVCs may arise from almost any location in the ventricles though a right or left ventricular outflow tract origin accounts for the vast majority, particularly in otherwise healthy individuals. A 12-lead EKG can be utilized to predict this and locations other than the outflow tracts typically prompt a more intensive evaluation. All patients will have an echocardiogram and a baseline 24hr Holter monitor. In those cases where the PVC origin is outflow tract, the echocardiogram is normal, and the 24hr ectopic burden is <10%, no additional follow-up is typically necessary. Patients are not restricted from athletic participation from a cardiac perspective. When the ectopic burden is >10%, some degree of follow-up is typically recommended with the most common being annual evaluations with a repeat echocardiogram. As before, athletic participation is not restricted.

Exercise stress tests are typically reserved for patients with atypical PVC morphologies (non-outflow tract origin) or if there is a potential association with symptoms and/or syncope. Outflow tract mediated PVCs may increase with or be suppressed by exercise and so this response is less often helpful in management. A history of exertional symptoms, particularly syncope, necessitates a stress test to evaluate for catecholaminergic polymorphic ventricular tachycardia (CPVT). Additional evaluation

tools include a cardiac MRI to assess for cardiac fibrosis or morphologic predictors or arrhythmogenic right ventricular cardiomyopathy (ARVC), and a signal averaged EKG.

As with PACs, the majority of patients with PVCs do not require intervention though beta blockade can be utilized for symptomatic ectopy. Ablation procedures are reserved for symptomatic patients not controlled with medications or those with the development of cardiomyopathies.

Supraventricular Tachycardia:

Supraventricular tachycardia is the most common tachyarrhythmia in pediatrics (excluding sinus tachycardia) with an incidence of roughly 1:1000. Many will present in the first year of life and 90% of pediatric SVT will involve a reentrant circuit between the atria and ventricles. As described previously, the mechanism of SVT can vary in the younger versus older pediatric patients with accessory pathways (either concealed or Wolff-Parkinson-White Syndrome) being more common in younger patients. Atrioventricular nodal reentrant tachycardia (AVNRT) is the overall most likely cause of SVT in adolescents and young adults.

The diagnosis of SVT relies on documentation of the arrhythmia; either on a transient event monitor or a 12-lead EKG during active palpitations. A Holter monitor is much less useful in this case because of the transient and episodic nature of SVT. Prior to diagnosis, vagal maneuvers can be reviewed with patients for whom a strong suspicion of SVT is suggested by the history. All patients with documented SVT should be referred to Cardiology for additional evaluation.

A screening echocardiogram will be performed to assess for structural abnormalities. While most patients with SVT will have structurally normal hearts, the presence of congenital heart disease, in particular Ebstein's Anomaly, predisposes to accessory pathways. The overall management depends on patient/family presence and the presence of ventricular pre-excitation.

In the absence of Wolff-Parkinson-White Syndrome, SVT is rarely a life-threatening condition and management options include observation with vagal maneuvers, anti-arrhythmics for rhythm control, and electrophysiologic study/ablation. All pediatric patients with ventricular pre-excitation are recommended to undergo invasive testing given the risk of pre-excited atrial fibrillation and sudden death. In the current age of pediatric ablations the risk is quite low, typically quoted with a <1% chance of any significant complications. In particular, most pediatric centers will utilize cryotherapy as part of their lesion placement which reduces the risk of permanent heart block to essentially zero.

To hear further education about heart arrhythmia's from Dr. von Alvensleben, download his August 29, 2017 podcast episode on Charting Pediatrics, found on iTunes and Google Play or at www.childrenscolorado.org/chartingpediatrics. The pediatric cardiology team at Children's Hospital Colorado can be reached for consultations and referrals through One Call, 720-777-3999 or 719-305-3999 in Colorado Springs.



EHRs Can Advance Good Medicine — If Doctors Are Aware of the Risks

BY DAVID B. TROXEL, MD
Medical Director, The Doctors Company

The EHR has introduced patient safety risks and unanticipated medical liability risks. According to a new study from The Doctors Company, the nation's largest physician-owned medical malpractice insurer, the number of EHR-related medical malpractice claims has risen over the past 10 years.

Factors Behind EHR Errors

For the most part, the EHR is a contributing factor in an EHR-related claim and not the primary cause. This and their low frequency (0.9 percent of all claims) suggest that EHRs infrequently result in adverse events of sufficient severity to develop into a malpractice claim.

When EHRs are a factor in a claim, the study showed that user factors (such as data entry errors, copy-and-paste issues, alert fatigue, and EHR conversion issues) contributed to nearly 60 percent of claims. As computer users, we all copy and paste. Therefore, it's no surprise that time-pressured physicians embrace the same habits when using EHRs.

System factors (such as data routing problems, EHR fragmentation, and inappropriate drop-down menu responses) contributed to 50 percent of claims. EHR fragmentation was among the most prominent system factors, contributing to 12 percent of errors. This factor means that different components of a single patient encounter might not be located together in the EHR. Consequently, doctors must check in different places to find laboratory and x-ray results, histories and physicals, etc.—resulting in important information being overlooked or unidentified.

I'm optimistic that the EHR will evolve over the next 5 to 10 years and improve both the quality of medical care and patient safety.



Re-Claiming the Doctor-Patient Relationship

One overwhelming response to adjust to burdens introduced by EHRs has been the rapid growth of medical scribes. Nearly 20 percent of medical practices are using scribes to help untether physicians from the EHR. Yet, according to a survey of hundreds of physicians from The Doctors Company, the lack of standardized training and variability in experience among scribes poses risks to data accuracy and delivery of care—which could increase liability for the patient and physician alike.

With or without scribes, lowering risk begins with each patient visit. At the beginning of each new session, doctors should inform patients of the purpose of the EHR and emphasize they are listening closely even though they might be typing during the appointment. Practices can set up treatment rooms so the patient can watch the screen and see what is being typed. It is also helpful to summarize or read the note to the patient to demonstrate that you have listened, and ask, “Do I have it right?”

What the Future Holds

As with any challenge of major proportions, progress will take time. But I'm optimistic that the EHR will evolve over the next 5 to 10 years and improve both the quality of medical care and patient safety.

Today, what I hear from The Doctors Company's 80,000 member physicians is encouraging. Doctors are eager to “re-claim” their profession and refocus patient relationships amidst the new demands of today's digital age. Into the future, new protocols, policies, and training programs must take these small successes to a large scale.



When You Need to Say No: Getting Beyond the Fear of a Patient's Dissatisfaction Just Might Save Their Life.

BY EMILY CLEGG, JD, MBA, CPHRM

Director, Risk Management and Client Services, UMIA Insurance, Inc.

Conversations about opioid prescriptions are sometimes about more than symptoms and treatment. There can be unspoken fears and motivations swirling beneath the surface if the patient feels entitled to opioids, or feels frightened by the prospect of coping without them. The patient may be dishonest, overly-emotional or even aggressive. The provider may fear backlash from the patient if the answer is no, but also knows that saying no could save a life.

Dan O'Connell, PhD, is a clinical psychologist who trains, coaches and consults with health care professionals on improving communication and patient relationships. He uses his psychology background to help clinicians through tough conversations about pain management and opioids.

Dr. O'Connell promotes a simple mantra: Patients are not the problem. The provider is not the problem. The problem is the problem. "Namely," he says, "the problem that opioids may be causing more harm than good." It's not the patient's fault they're struggling with psychological cravings, but the provider saying "no" isn't the bad guy either. The problem is the problem.

Talking Points for Saying No

Sometimes the answer needs to be "no." Algorithms and assessment tools are available to help screen for risks, alcohol and substance abuse, or depression.

A conversation, however, is the place to start. Dr. O'Connell promotes three key talking points for those conversations: drug safety, drug effectiveness, and (balancing those two), is the drug doing more harm than good?

These talking points will help to open the dialogue.

SAFETY

Probe about tolerance, addiction, or diversion, drawing out the patient's own understanding of the safety. Then educate to fill in gaps.

Questions to ask:

- Do you find yourself needing more and more?
- How would you know if you were becoming addicted?
- Can you account for every pill?

EFFECTIVENESS

Reflect the patient's own complaints back to them.

Questions to ask:

- If opioids were really the most effective way to help, I would expect them to be making more of a difference. Instead, I'm hearing...
- It sounds like you're struggling with stress and lack of sleep. Opioids are not the most effective treatments for those. Let me propose a more effective approach.

BALANCING SAFETY AND EFFECTIVENESS

Reframe the conversation as balancing necessity vs. risk:

- I'm open to considering any plan we both agree is the safest and most effective way to help your pain, and which we are both certain could not do more harm than good.

Concluding the Conversation

After following this format, clinicians need to present a clear conclusion. Some examples:

- I've come to the conclusion that the way you're using opioids is causing more harm than good and we need to agree to a different plan.
- I'm willing to prescribe opioids if we can agree to a contract that includes the elements we need to watch for safety and effectiveness, and to be sure they are not causing more harm than good. Let me describe those, and you decide if you can commit to each one.

If a patient grows angry or disagrees, Dr. O'Connell suggests using a defusing technique such as getting a second opinion or the input of a specialist.

It's important for clinicians to remember the mantra that the patient is not the problem, but neither are you. The problem is the problem. Dr. O'Connell advises, "Be soft on the people, but be hard on the problem."

This article originally appeared in the Summer 2017 issue of Brink® magazine, published by Constellation. UMIA is a member of Constellation, a growing collective of MPL insurance and partner companies offering solutions that are good for care teams and good for business. To learn about the services UMIA provides to physicians, hospitals and health systems, visit UMIA.com.



Eluding Open-Heart Surgery

UCHealth trial now gives more patients a chance to have a less invasive procedure to fix their heart valves

BY KATI BLOCKER
UCHEALTH

For people with certain heart valve problems, years can pass before the problem needs to be addressed. But once the heart's ability to work is affected, the valve must be fixed, and that usually means open-heart surgery.

That is, until recently.

UCHealth can give patients who would otherwise need open-heart surgery the chance to have their heart valves repaired with a less-invasive procedure.

Lee Steele, an interior trim carpenter from Cheyenne, Wyoming, got that chance.

Steele and his UCHealth cardiologist, Dr. Todd Whitt, had been monitoring Steele's condition, called aortic stenosis, for more than four years.

As one ages, basic wear and tear can cause the flaps of a valve to thicken. As a result, the heart has to work harder to pump blood through the valve, and the body can suffer from a reduced supply of oxygen.

"A lot of times the issue is found because a doctor will identify a heart murmur," said Dr. Brad Oldemeyer, a UCHealth interventional cardiologist.

It's usually not until blood flow is significantly restricted that people experience symptoms such as breathlessness, chest pains or pressure, noticeable heartbeats, decline in physical ability or fainting.

After close monitoring and a failed stress test, doctors decided it was time for Steele, who was 79, to have his valve fixed.

And they had another option for Steele other than open-heart surgery: the less-invasive transcatheter aortic valve replacement, or TAVR.

During open-heart surgery, the damaged valve is removed and replaced with an artificial valve while the patient is under anesthesia. Typical recovery is eight to 12 weeks and requires months of cardiac rehabilitation to help the patient regain

energy and overall health. What's more, a person with a mechanical valve will most likely take medication the rest of his or her life to help prevent blood clots.

TAVR repairs a damaged valve without removing it. A team of heart surgeons and interventional cardiologists works together to place a collapsible artificial valve into the heart by way of a catheter in the vein. When in position, the artificial valve expands and pushes the old valve leaflets out of the way, and the tissue in the replacement valve takes over the job of regulating blood flow.

The procedure was approved by the FDA in 2011 but only for patients who were too

high risk for open-heart surgery. The FDA later approved the procedure for moderate-risk patients, and Steele was part of a trial at UCHealth Heart and Vascular Center – Medical Center of the Rockies to determine if the procedure also could benefit low-risk patients.

"Before, we've had to tell people that they were too healthy for TAVR," Oldemeyer said. "But the data is showing that it's

"I feel very good. Since the surgery, I've met a number of people in rehab that have had the different procedures, and those who have had TAVR don't seem to have any hesitation recommending it. Their quality of life afterwards is excellent."

LEE STEELE
Cheyenne, Wyoming



Lee Steele, of Cheyenne, Wyoming, was back doing what he loves just days after his TAVR procedure at UCHealth. Photo by Kati Blocker, UCHealth.

equivalent, if not superior, to surgery with the outcomes we want, and therefore it's being offered to a broader range of patients."

Just a few days after his August 2016 heart surgery, Steele began to do minimal work in his small workshop. As a trusted partner of UCHealth, Cheyenne Regional Medical Center provided Steele with cardiac rehab, allowing him to stay close to home for his recovery.

"I feel very good," he said. "Since the surgery, I've met a number of people in rehab that have had the different procedures, and those who have had TAVR don't seem to have any hesitation recommending it. Their quality of life afterwards is excellent. And I know the program for which I've been exposed has been an A-plus program."



Help Me Grow Wyoming serves children birth to eight years old through a comprehensive integrated approach that promotes developmental monitoring and early detection through a supportive referral process and linkage to resources.

For more information or to contact us, choose from the following options:
DIAL 2-1-1 and ASK for Help Me Grow Wyoming OR
DIAL (307) 433-3079 and ASK for Corey Villeneuve, Care Coordinator OR
DIAL (307) 223-3555 and ASK for Dr. Jane Brutsman, System Coordinator



Blue Cross Blue Shield of Wyoming Updating Internal Technology Systems

BCBSWY REMAINS COMMITTED TO OUR PARTNERSHIP WITH WYOMING PROVIDERS TO PROVIDE THE HIGHEST QUALITY HEALTH CARE SERVICES TO OUR MEMBERS. OUR GOAL IS TO REDUCE ADMINISTRATIVE PROCESSES AND OFFER AN EASY-TO-USE ELECTRONIC PORTAL TO MAKE WORKING WITH US EASIER AND QUICKER.

Blue Cross Blue Shield of Wyoming (BCBSWY) is updating our internal technology systems, including our customer communication and claims processing, to bring innovative business solutions to our members, employer groups and providers. We are collaborating with HM Health Solutions (HMHS), a part of the Highmark Blue Cross Blue

Shield plan. HMHS is providing an industry-proven platform that has been successfully implemented by several other Blue companies.

Local ownership is important to us, and this arrangement allows us to gain the capabilities of a 10 million-member health plan while remaining an independent, not-for-profit Wyoming business serving Wyoming people.

To Our Wyoming Physician Partners

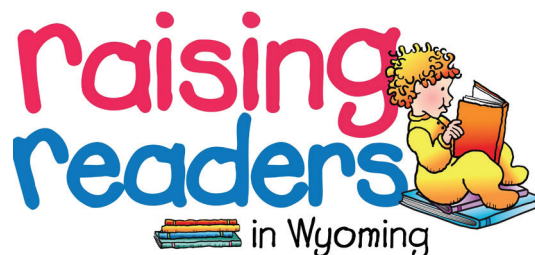
We want to make it easier for you to manage the care of your patients with less paperwork and fewer hassles with forms and faxes. To reduce the wait and on-hold time when you call us, we'll have more of the things you need online at your fingertips, and quicker more accurate claims processing and payment.

As with any system upgrade, some things will be different and may result in changes to the procedures we ask you to use today. We'll try our best to keep any disruptions and changes to a minimum, and work with you to resolve any issues. For instance, we know that prior authorization requests may initially be slower to process as we implement the new electronic system. As we identify other major changes or disruptions, we'll let you know what is changing and why.

A New Portal

The new Availity Portal is a multi-payer site where a single user ID and password lets you work with BCBSWY and other participating payers. There's no cost to register or use any of the online tools. Availity offers similar core functionality

"Give \$5" to
Raise a Reader in
Your Community!



Raising Readers in Wyoming provides beautiful new books to children during their well health and immunization appointments through local medical providers!

To learn more about how to become a provider, visit us at
www.raisingreadersinwyoming.org,
call 307-673-1885 or email execdirector@raisingreadersinwyoming.org

"Give 5" today to change the life of a child through reading by donating
online at <http://raisingreadersinwyoming.org/donate-1/>

Or by mailing a donation to
PO Box 21856
Cheyenne, WY 82003

of THOR but in an easier-to-navigate format. Eventually the Availity Portal will replace our existing THOR provider portal for doing things like:

- Making eligibility and benefits inquiries
- Submitting claims and reviewing claim statuses
- Viewing your electronic remittance advice

New Electronic Data Interchange (EDI)

We will also be using Availity to offer a full suite of EDI health information exchange services through a connection to the Availity Intelligent Gateway. BCBSWY will offer the Availity Intelligent Gateway to serve as your new method to submit claim transactions, member eligibility, and claim status – 24 hours a day, seven days a week.

Training


Training resources, videos and other information on Portal and EDI services can be found in the Availity Learning Center after logging into www.Availity.com.

Member Transition Schedule

While these new systems will be available to providers, we will not move any of our current members to the

new system until later this year. A small number of BlueCard members (those with coverage through out-of-state Blue Cross Blue Shields plans) will transition on July 1. Another small group will move to the new system on September 1, 2018, but most of our members will not transition until January 1, 2019.


We value our partnership with Wyoming providers and appreciate your understanding during this transition. For more information on the transformation visit www.bcbswy.com/NewWay. If you have questions, please feel free to call 888-666-5188 or provider.support@bcbswy.com.



MEDICINE KNOWS NO BORDERS

**Your medical needs aren't determined
by your location and neither should your
ability to access cutting edge medical care.**

U of U Health Regional Network allows
for the seamless transfer of knowledge,
expertise, and care between systems, all
for the good of the patient. After all, every
patient matters, no matter where they live.



HEALTH

UNIVERSITY OF UTAH

University of Utah Health Affiliate Network is a system of 20 first-rate health care systems, four of which are located in Wyoming:

- St. John's Medical Center, Jackson
- Sublette County Rural Health District, Pinedale & Marbleton
- Memorial Hospital of Sweetwater County, Rock Springs
- Evanston Regional Hospital, Evanston

Advertise in Wyoming Medicine

PREMIUM POSITION	1X	2X
Back Cover Full Page	\$1,500 . . .	\$2,700
Inside Cover Full Page.	\$1,300 . . .	\$2,200

INTERIOR POSITION	1X	2X
Full Page	\$900 . . .	\$1,600
1/2 Page	\$650 . . .	\$1,100
1/4 Page	\$400 . . .	\$700

SPONSORED CONTENT

Cover feature (per page)	\$1,250
Internal page (per page)	\$900

CONTACT

Sheila Bush, WMS Executive Director
307-635-2424 • Sheila@wyomed.org

Artwork Specifications available upon request.

WYOMING Medicine

Ask about our Friends of WMS Program

Wyoming Medicine is published bi-annually. Your message will reach more than 70 percent of Wyoming physicians as well as healthcare policy leaders and citizens from across the state. The circulation of over 1,500 includes Wyoming Medical Society member physicians, as well as legislators, medical-related organizations, media outlets, and other regular subscribers.

Afton, WY

Clayton Brown, MD
Michael Pieper, MD

Big Horn, WY

Jonathan Herschler, MD
Edward Hobart, MD
Gregory G. Marino, DO
D. Scott Nickerson, MD

Big Piney, WY

William David Burnett, MD
Brendan Fitzsimmons, MD

Billings, MT

Alan Dacre, MD

Boulder, CO

Michael Wasser, MD

Bozeman, MT

William Bennett, MD

Buffalo, WY

Brian Darnell, DO
Hermilio Gonzalez, MD
Grace Gosar, MD
Tracy Jons, PA-C
Lawrence Kirven, MD
Fred A. Matthews, MD
Patrick D. Nolan, MD
Mark Schueler, MD
Alyse Williams, MD

Casper, WY

Brock Anderson, MD
James Anderson, MD
John Bailey, MD
David Barahal, MD
John Barrasso, MD
David Baxter, MD
Todd Beckstead, MD
Jerome Behrens, MD
Scott Bennion, MD
Peter Bergquist, DO
Joseph Bicek, MD
John Billings, MD
Jonathan Binder, MD
Darren Bowe, MD
Charles Bowkley III, MD
Gregory Brondos, MD
Stephen Brown, MD
Michael Bruno, MD
Nyasha Bullock, MD
Mary Burke, MD
Thomas Burke, MD
Jeffery Christensen, DO
Lydia Christiansen, MD
Eric (Frederick) Cubin, MD
Jonna Cubin, MD
Alexandru David, MD
Frederick Deiss, MD
Zachory Deiss, MD

Frank Del Real, MD
Nino Dobrovic, MD
Matthew Dodds, MD
Mark Dowell, MD
David Driggers, MD
Mesha Dunn, MD
Eugene P. Duquette, DO
P. Bruce Ebrahimpour, MD
Diane R. Edwards, MD
Martin Ellbogen Sr., MD
Rita Emch, MD
David J. Erk, MD
Elie Fahed, MD
Shawn Ficken, PA-C
Michael Flaherty, MD
Adrian Fluture, MD
Sherrill Fox, MD
Timothy N. Frary, PA-C
Frederick Freeman, MD, FACS
Ghazi Ghanem, MD
Ronald Gibson, MD
Valerie K. Goen, PA-C
Henry P. Gottsch, MD
Jared Hall, DO
Todd Hammond, MD
Todd Hansen, MD
Kevin Helling, MD
Diane C. Henshaw, MD
Wesley W. Hiser, MD
Douglas Holmes, MD
Dana Ideen, MD
Oleg Ivanov, MD
Ronald D. Iverson, MD
Seth Iverson, MD
Oliver Jeffery, MB ChB
Jungsook Johnson, MD
Ray B. Johnson, PA-C
John Paul Jones III, MD
Raoul Joubran, MD
Mahesh Karandikar, MD
Sharon Karnes, MD
Anje Kim, MD
Caroline Kirsch-Russell, DO
Thomas A. Kopitnik, MD
Phillip Krmpotich, MD
Tom Landon, MD
Eric Lawrence, DO
Carl S. Lundberg, DO
Mary MacGuire, MD
James A. Maddy, MD
Paul Malsom, PA-C
Allan Mattern, MD
Joseph McGinley, MD, PhD
Megan McKay, MD
Lynnette McLagan, PA-C
Joseph Mickelson, MD
Meredith H. Miller, MD

Michael V. Miller, DO
Matthew Mitchell, MD
Michele Mohr, MD
Joseph Monfre, MD
Rene Mosada, MD
Eric Munoz, MD
Robert Narotzky, MD
John L. Noffsinger, PA-C
David Norcross, MD
Robert Novick, MD
Steven Orcutt, MD
John W. Pickrell, MD
Eugene Podrazik, MD
Lida Prypchan, MD
John Purviance, MD
Tyler Quest, MD
Michael Quinn, MD
Thomas Radosevich, MD
Jo Ann Ramsey, PA-C
Jerry Realing, MD
Karri Reliford, PA-C
Beth C. Robitaille, MD
Joseph Rosen, MD
John Roussalis, MD
Louis Roussalis, MD
Stuart J. Ruben, MD
Cora Salvino, MD
Angelo Santiago, MD
Sam Scaling, MD
Robert Schlidt, MD
Eric Schubert, MD
Kamlesh S. Shah, MD
Benjamin Sheppard, MD
Susan Sheridan, MD
Michael Sloan, MD
Craig Smith, MD
Geoffrey Smith, MD
Lane Smothers, MD
Laura Smothers, MD
Carol Solie, MD
Shelley Springer, MD
Albert Steplock, Jr., MD
Cory Stirling, MD
Renee Stirling, MD
Werner Studer, MD
Daniel Sullivan, MD
Daniel Sulser, MD
Matthew Swan, MD
Jay Swedberg, MD
Rowan Tichenor, MD
Robert Tobin, MD
Berton Toews, MD
John M. Tooke, MD
Brandon Trojan, MD
Kati Tuma, PA-C
Ashley Ullrich, MD
Brooke Umphlett, PA-C
Brian Veauthier, MD

Joseph Vigneri, MD
Robert A. Vigneri, MD
Samuel Vigneri, MD
Mark Vuolo, MD
Debra L. Walker, PA-C
Lee Warren, MD
David Wheeler, MD, PhD
Daniel White, MD
Allan Wicks, MD
Caleb Wilson, MD
Todd Witzeling, MD
Cynthia Works, MD
Demian Yakel, DO
Linda Yost, MD
Jerry L. Youmans, MD

Cheyenne, WY

Ahmad Alqaqa'a, MD
Rodney Anderson, MD
Janet Anderson-Ray, MD
David Armstrong, DO
Ashley Aylward, PA-C
Samina Ayub, MD
John Babson, MD
Jean Denise Basta, MD
Carol Wright Becker, MD
Steven Beer, MD
Kristina Behringer, MD
Casey Berry, MD
Jacques Beveridge, MD
Phillip Brenchley, MD
Kimberly Broomfield, MD
John Bryant, MD
Kenneth Buran, MD
Marian Bursten, MD
James Bush, MD
Jerry Calkins, MD
Tracie Caller, MD
Jeffrey Carlton, MD
Jasper Chen, MD
Mary Cole, MD
Harmon Davis II, MD
Robert Davis II, MD
Don Dickerson, MD
Dustin Durham, MD
Douglas Edgren, MD
Sarvin Emami, MD
Sharon Eskam, MD
Arthur (Joe) Farrell, PA-C
Claudio Feler, MD
Carol A. Fischer, MD
Carlotto Fisher, MD
Mary-Ellen Foley, MD
Jeremy Gates, MD
William P. Gibbens, MD
Lakhman Gondalia, MD
Rayna Gravatt, MD
Phillip Haberman, MD
J. Sloan Hales, MD

Thor M. Hallingbye, MD
Jean Halpern, MD
Amy Jo Harnish, MD
James Harper, MD
William Harrison, MD
Joanne Hassell, MD
Scott Hayden, MD
Taylor H. Haynes, MD
John P. Healey, MD
Michael C. Herber, MD
J. Richard Hillman, MD
Rene Hinkle, MD
Basu Hiregoudar, MD
W. Joesph Horam, MD
Brian Horner, MD
Brian Horst, MD
Mark Howshar, MD
Eric Hoyer, MD
James Hubbard, MD
Donald G. Iverson, MD
Alireza Izadara, MD
Paul Johnson, MD
Randolph Johnston, MD
Robert Kahn, MD
Robert R. Kanard, MD
Matthew Kassel, DO
D. Michael Kellam, MD
Mary Louise Kerber, MD
William Ketcham, MD
Afzal Khan, MD
David Kilpatrick, MD
Kenneth Kranz, MD
Charles Kuckel, MD
Michael Kuhn, MD
Oussama Lawand, MD
Donald J. Lawler, MD
Ronald LeBeaumont, MD
Robert W. Leland, MD
David M. Lind, MD
Daniel J. Long, MD
Megan Looby, DO
Pat Lucas, PA-C
James Lugg, MD
Charles Mackey, MD
Julie Maggiolo, MD
Ronald L. Malm, DO
Michael Martin, MD
Mohammed Mazhar, MD
Theodore N. McCoy, MD
Ronald McKee, MD
Shauna McKusker, MD
Scott McRae, MD
A. John Meares, MD
Jonathon Medina, MD
Arthur Merrell, MD
R. Larry Meuli, MD
Samantha Michelena, MD
Anne Miller, MD

Kathleen Mondanaro, DO
Robert Monger, MD
Michael Nelson, DO
Julie Neville, MD
Evan Norby, DO
Jennifer Nottage, MD
Lawrence O'Holleran, MD
Dimiter Orahovats, MD
Douglas S. Parks, MD
Ambrish Patel, PA-C
John Paulus, DO
Peter Perakos, MD
Kyle Piwonka, DO
Gergana Popova-Orahovats, MD
Robert Prentice, MD
Matthew Ptaszkiwicz, MD
Take Pullos, MD
Mark R. Rangitsch, MD
Steven Reeb, MD
Harlan R. Ribnik, MD
Margaret L. "Peggy" Roberts, MD
D. Jane Robinett, DO
Kevin Robinett, DO
Earl W. Robison, MD
John Romano, MD
Andrew Rose, MD
Stanley Sandick, MD
Carol J. Schiel, MD
Philip Schiel, MD
G. Douglas Schmitz, MD
Greg Seitz, MD
Larry Seitz, MD
Reed Shafer, MD
Kirk Shamley, MD
Michael Shannon, MD
Philip Sharp, MD
Amy Shaw, PA-C
Brent D. Sherard, MD
Paul V. Slater, MD
Bruce Smith, MD
G. L. Smith, MD
Reuben Smits, MD
Danae Stampfli, MD
Greg Stampfli, MD
Jakub Stefka, MD
Ronald Stevens, MD
Jeffrey Storey, MD
Rex Stout, MD
Robert Stuart Jr., MD
Sandra Surbrugg, MD
Daniel Surdam, MD
Donald B. Tardif, PA-C
Kathleen Thomas, MD
Thomas V. Toft, MD
Richard E. Torkelson, MD
Melissa Tuck-White, MD
Lindsay Tully, PA-C

Kristine Van Kirk, MD
 Ronald W. Waeckerlin, MD
 Philip L. (Bert) Wagner, MD
James Wantuck, MD
 Russell Williams Jr., MD
 John E. Winter, MD
 Natalie Winter, MD
 John Wright, MD
 Georgia Young, DO
 Katarzyna Zarzycki, MD

Chula Vista, CA
 David Silver, MD

Cody, WY
 Tom Anderson, MD
 Jeffrey Balison, MD
 Jimmie Biles, Jr., MD
 Adair Bowbly-Joskow, MD
 Ross Collie, MD
 Gregory Cross Jr., MD
 Kathleen DiVincenzo, MD
 Stephen Emery, MD
 Rand E. Flory, MD
 Randy Folker, MD
Allen Gee, MD
 Travis Graham, MD
 Lee K. Hermann, MD
 Charles E. Jamieson, MD
 James L. (Bo) Johnson II, MD
 Donald R. Koehler, MD
 Bradley L. Low, DO
 Gregory McCue, MD
 Clint Merritt, PA-C
 David Mills, MD
 Dale Myers, MD
 Mark Ryzewicz, MD
 Catherine Schmidt, MD
 Frank Schmidt, MD
 Robert Treece, MD
 Barry Welch, MD
 Charles Welch, MD
 Derek Wille, MD
 Lisa Williams, MD
 Jay Winzenried, MD

Dallas, TX
 James Randolph, MD

Denver, CO
 James E. Stotzel, MD

Douglas, WY
Deeanne Engle, MD
Roberto Fars, MD
 Terri Marso, PA-C
 Mark Murphy, MD
 Tristyn Richendifer, PA-C
 Patrick Yost, MD
 Dennis Yutani, MD

Elk Mountain, WY
 Elizabeth Hills, DO

Eureka, MT
 Ronald Gardner, MD

Evanston, WY
 Michael Adams, MD
 Jared Barton, MD
 Jason Haack, MD
 Eric Hansen, MD
 Ardella Kemmler, MD
 Thomas Simon, MD
 Eric N. Swensen, DO
Spencer Weston, MD

Evansville, WY
 Jack V. Richard, MD
Fort Collins, CO
Laryssa Dragan, MD
 Jason Merritt, MD

Gillette, WY
 Gerald Baker, MD
 David Beck, MD
 Garry Becker, MD
 Angela Biggs, MD
 Rodney Biggs, MD
 Kris Canfield, MD
 Amber Cohn, MD
 Thomas Davis, MD
 John P. Dunn, MD
 David Fall, MD
 Jennifer L. Frary, PA-C
 Timothy Hallinan, MD
Suzanne Harris, MD
 Sara Hartsaw, MD
 Jonathan M. Hayden, MD
 Katie Houmes, MD
 Michael Jones, MD
 Mindy Keil, PA-C
 James LaManna, MD
 Joseph Lawrence, DO
 Landi Lowell, MD
John Mansell, MD
 Margaret McCreery, MD
 Philip McMahill, MD
 Kelly McMillin, MD
 James J. Naramore, MD
 Kirtikumar L. Patel, MD
 Paul Rigsby, DO
 Erica Rinker, MD
 Jacob Rinker, MD
 Nicholas Stamato, MD
 Hollie Stewart, MD
 Michael Stolpe, DO
 Ian Swift, MD
 William Thompson, PA-C
 Linda Walby, MD
 Grace Wang, MD
 Doug Watt, MD

Billie Fitch Wilkerson, MD
 William Boyd Woodward Jr., MD

Glenrock, WY
 Charles L. Lyford, MD

Greeley, CO
 Dennis Lower, MD

Green River, WY
 Charles J. Amy, PA-C
 Gordon Lee Balka, MD
 Lynn Eskelson, MD
 Connie Fauntleroy, MD
 Michael Holland, MD
 Jacob Johnson, DO
 Joel Robertson, PA-C
 Kristine F. Sherwin, PA-C

Hulett, WY
Robert C. Cummings, PA-C

Jackson, WY
Berit Amundson, MD
 Giovannina Anthony, MD
 Joshua Beck, MD
 Robert Berlin, MD
 Brent Blue, MD
 Andrew Bullington, MD
 Dennis Butcher, MD
 Lars Conway, MD
Christian Dean, DO
 Marc Domskey, DO
Jonathan Figg, MD
Lisa Jo Finkelstein, DO
 Roland Fleck, MD
Jennifer Fritch, PA-C
 Shirl George, MD
 Miles Gilbreath, PA-S
 Angus Goetz, DO
 Christopher Haling, MD
 Jacquelin Hardenbrook, MD
 Bruce Hayse, MD
 Gary W. Heath, MD
 Christopher Hills, DO
Robert Jones, MD
 David Khoury, MD
 Randy Kjorstad, MD
 Ludwig Kroner, III, MD
 Maura Jean Lofaro, MD
 Phillip Lowe, MD
Marcia Lux, MD
 Thomas McCallum, MD
 Heidi Michelsen-Jost, MD
 Tiffany Milner, MD
William Mullen, MD
 Mary Neal, MD
 William Neal, MD
 Kathryn Noyes, MD
 Richard Ofstein, MD
 Holly Payne, DO

John Payne, DO
 Thomas Pockat, MD
 Travis Riddell, MD
 Shannon Roberts, MD
 Michael Rosenberg, MD
 Paul Ruttle, MD
 Geoffrey Skene, DO
 William Smith, MD
 Martha Stearn, MD
 Simon Stertz, MD
 David Tomlinson, MD
 Martin Trott, MD
 Christine Turner, MD
 Larry Van Genderen, MD
 Laura Vignaroli, MD
 Keri Wheeler, MD
Eric Wieman, MD
 Rafael Williams, MD

Kelly, WY
 David Shlim, MD

Lander, WY
 Charles Allen, MD
 Mary Barnes, DO
 Richard Barnes, MD
 Lawrence Blinn, MD
 Nancy Brewster, PA-C
 Edwin Butler, MD
 Perry Cook, MD
 Peter Crane, MD
 David Doll, MD
 Thomas Dunaway, MD
 Brian Gee, MD
 Phillip Gilbertson, MD
 Donald Gullickson, MD
 Hart Jacobsen, MD
 Troy Jones, MD
 Cori Lamblin, MD
 Charles McMahon, MD
 W. Davis Merritt, MD
 Robert Nagy, MD
 Susan Pearson, MD
 Douglas Phipps, MD
 Steven Platz, PA-C
 Heather Sanders, PA-C
 Jan Siebersma, MD
 Cynthia Stevens, MD
 John Whipp, MD
 Mark Woodard, MD, PC

Laramie, WY
 Nicole Alexander, PA-C
 Debra Anderson, MD
 Ryan Aukerman, MD
 Calvin Bell, DO
 Thomas Bienz, MD
 John Bragg, MD
 Dave Brumbaugh, PA-C
 Marten Carlson, MD

Jay G. Carson, MD
 Charles Coffey, MD
 J. David Crecca, MD
 Nathan Eliason, MD
 Derek Ewell, DO
Sameera Fareed-Farrukh, MD
 William Flock, MD
Kelly Follett, MD
 Marie Gempis, DO
 Andrew Georgi, MD
 Timothy Gueramy, MD
 John Haeblerle, MD
 Eric Harris, MD
 Angele Howdeshell, MD
Farrukh Javaid, MD
 Lawrence Jenkins, MD
Elizabeth Judy, PA-C
 Michael Kaplan, MD
 Travis Klingler, MD
 Daniel Levene, MD
 James Martinchick, MD
 Randall Martin, MD
 Robert Martino, MD
 Mark McKenna, MD
 Darren Mikesell, DO
 Hermann A. Moreno, MD
 Tom Nachtigal, MD
 Dalva Olipra, MD
 Harold Pierce, MD
 Kenneth Robertson, MD, FACP
 Shawn Rockey, PA-C
 Shaun Shafer, MD
 Galyn M. Stahl, MD
 Gregory Wallace, MD
 Mark Wefel, MD
Kim Westbrook, MD

Lead, SD
 William Forman, MD

Lovell, WY
 Deborah Brackett, MD
 David Hoffman, MD

Lusk, WY
 Jake Behringer, MD
 Lynn Horton, MD

Maricopa, AZ
 Hein H. Kalke, MD

Moran, WY
 Dale A. Lavalley, MD

Mountain View, WY
 Steven Babcock, DO

Newcastle, WY
 Michael L. Carpenter, PA-C
 D. Charles Franklin, MD
 Willis Franz, MD
 Aaron Jagelski, MD

Michael Jording, MD
 Tonu ("Tony") Kiesel, MD
 Peter Larsen, MD
 Jan E. Mason-Manzer, PA-C
 Lanny Reimer, MD

Pinedale, WY
Renae Dorrity, MD
 J. Thomas Johnston, MD
 David Kappenman, MD

Powell, WY
Dean Bartholomew, MD
 Robert Chandler, MD
 Nicole Comer, MD
 Sarah Durney, MD
 Robert Ellis, MD
 Lyle Haberland, MD
 Valerie Lengfelder, MD
 Jacob Merrell, MD
 Bradley North, DO
 Juanita Sapp, MD
Elizabeth Spomer, MD
 Michael Tracy, MD
 John Wurzel, Sr., MD
 Mark Wurzel, MD

Rawlins, WY
 David Cesko, MD
 Marvin W. Couch II, MD
Gregory Johnson, MD

Riverton, WY
 Brooks Allison, MD
 Jason Brown, MD
 Robert L. Darr, PA-C
 Michael Fisher, MD
 Michael J. Ford, MD
 Roger L. Gose, MD
 Richard M. Harris, PA-C
 Jack Hildner, PA-C
 James Taylor, MD
 Richard C. Wecker, MD
 James White, DO

Rock Springs, WY
 Peter Allyn, MD
 Michael Bowers, DO
Cody Christensen, DO
 Gerard Cournoyer, MD
 Steven Croft, MD
 Brianne Crofts, MD
 Wallace Curry, MD
 David Dansie, DO
Jacques Denker, DO
 Sigsbee Duck, MD
 Bird Gilmartin, MD
 Preetpal Grewal, DO
 Brian A. Holtan, MD, FACC
 John Iliya, MD
 Augusto Jamias, MD

Peter M. Jensen, DO
 Samer Kattan, MD
 Charles Knight, MD
Lawrence Lauridsen, DO
 David Liu, MD
 Brytton Long, DO
 Brandon Mack, MD
 Pritam Neupane, MD
Zachory Nicholas, MD
 Joseph Oliver, MD
 Rahul Pawar, MD
Kishore Rasamallu, MD
 William Sarette, MD
Bikram Sharma, MD
 Jed Shay, MD
Israel Stewart, DO
 Michael Sutphin, MD
 Wagner Veronese, MD
 Jeffery Wheeler, MD
 Chandra Yeshlur, MD

Saratoga, WY

William Ward, MD

Scottsbluff, NE

Kay Buchanan, MD

Seattle, WA

Robert Hilt, MD

Sheridan, WY

Fred J. Araas, MD
 Thomas Bennett, MD
 Mary Bowers, MD
 Christopher Brown, MD
 Lindsay Capron, MD
 James Ferries, MD
 Lawrence Gill, MD
 Luke Goddard, MD
Sierra Gross, MD
 Hannah Hall (Tenney) MD
Bradley Hanebrink, DO
 Amy Herring, PA-C
 Marilyn K. Horsley, PA-C
 Karl Hunt, MD
 Ian Hunter, MD
 Corey Jost, MD
 Brian Laman, MD
 Robert Marshall, MD
 Thomas Mayer, MD
 Brenton Milner, MD
 Howard L. Mussell, MD
 Suzanne Oss, MD
 Jason Otto, PA-C
 Anthony Quinn, MD
 Jamie Alex Ramsay, MD
 Amber Robbins, MD
 Walter Saunders, MD
Kristopher Schamber, MD
 Timothy Scott, MD
 Dennis Schreffler, MD

Chris T. Smith, MD
 Erin Strahan, PA-C
 Michael Strahan, MD
 William Taylor, MD
 Seymour Thickman, MD
 James Ulibarri, MD
 Charles F. Walter, MD
 Barry Wohl, MD
 Jeremy Zebroski, MD

Steamboat, CO

Donald Cantway, MD
 Jeanne Hennemann, MD

Teton Village, WY

John Feagin, MD
 Jack A. Larimer, MD
 Stanley E. Siegel, MD
 Kenneth J. Wegner, MD

Thermopolis, WY

William Bolton, MD
 W. Travis Bomengen, MD
 Mattson Mathey, MD
 Vernon Miller, MD
 Kurt Pettipiece, MD
 Debbie Roper, PA-C
 Jason Weyer, DO
 Howard Willson, MD

Timnath, CO

Dale Brentlinger, MD

Torrington, WY

Norma Cantu, MD
 Ezdan Fluckiger, MD
 Jose Lopez, MD
 Bonnie Randolph, MD
 Kayo Smith, MD
Marion Smith, MD
 Sheila Sterkel, PA-C

Tucson, AZ

William F. Flick, MD
 Thomas J. Gasser, MD

Vancouver, WA

John Glode, MD

Wheatland, WY

Ty Battershell, MD
 Jeffrey Cecil, MD
 James Hawley, MD
 James Kahre, MD
 Lauri A. Palmer, MD
 Steve Peasley, MD
 Willard Woods Jr, MD

Wilson, WY

Robert Curnow, MD
 Annie Fenn, MD
 James Little, MD
Michael Menolascino, MD
 Elizabeth Ridgway, MD

Jacques Roux, MD
 Anna Tryka, MD
 Richard Whalen, MD

Worland, WY

Diane Noton, MD
 Richard Rush, MD
 John Thurston, MD

Wright, WY

Scott Johnston, MD

WWAMI Students

Lingga Adidharma
 Widya Adidharma
 Michael Alley
 Makenzie Bartsch
 Madeleine Birch
 Dillon Brown
 Brittany Christensen
 Glen Clinton
 Allison Dawson
 Lindsay Dodds
 Christopher Ellbogen
 Bryan Feinstein
 Rage Geringer
 Tappy Gish
 Alexandra Gobble
 Brittney Goeken
 Laurel Green
 Weston Hampton
 Heidi Hanekamp
 Cody Hansen
 Isaac Hayward
 Joshua Henry
 Teal Jenkins
 Amanda Johnson
 Amanda Kinley
 Claire Korpela
 Shay Lanoutee
 Austin Lever
 Sarah Maze
 Mathias McCormick
 Daniel McKearney
 Natalie Meadows
 JayCee Mikesell
 Trevor Mordhorst
 Dana Morin
 Kayla Morrison
 Kevin Muller
 Dan Nicholls
 Megan Olson
 Spencer Pecha
 Rachael Piver
 Jordan Reed
 Caleb Rivera
 Quinn Rivera
 Aaron Robertson
 Michael Robison
 Olivia Rogers

Kymberly Ross
 Glandor Saltz
 Brian Schlidt
 Jackson Schmidt
 Casey Slattery
 Ethan Slight
 Mason Stillman
 Aaron Spurlock
 Janelle Strampe
 William Trebelcock
 Kelsey Tuttle
 Jaryd Unangst
 Isaac Wentz
Sabrina Westover
 Lindsay White
 Stephanie White
 Peter Wilcox
 David Wilson

WWAMI Residents

Ryan Abbaszadeh, MD
 Marcus Bailey, MD
 Tyler Baldwin, MD
 Jeff Bank, MD
 John Barnes, MD
 Kelly Baxter, MD
 Sean Bell, MD
 Landon Bluemel, MD
 Danielle Borin, MD
 Millie Boyd, MD
 Hannah Chapman, MD
 Lydia Clark, MD
 Tanner Clark, MD
 Alexander Colgan, MD
 Kimberly Cranford, MD
 Tobin Dennis, MD
 Brandon Douglass, MD
 Melissa Dozier, MD
 Bryan Dugas, MD
 Roberta Enes, MD
 Andrew Fluckiger, MD
 Steven Flynn, MD
 Matthew Fournier, MD
 Aaron Freeman, MD
 Sandra Gebhart (Smylie), MD
 Alicia Gray, MD
 Sarah Gregory, MD
 Ryan Griesbach, MD
 Daniel Grissom, MD
 Andrea Habel, MD
 Levi Hamilton, MD
 Kyle Hancock, MD
 Eli Harris, MD
 Dane Hill, MD
 Daniel Holst, MD
 Eric Howell, MD
 Christopher Ideen, MD
 Erik Jacobson, MD
 Kyle James, MD

Tricia Jensen, MD
 Lauren Johnson, MD
 Morgan Johnson, MD
 Krystal Jones, MD
 Matthew Kapeles, MD
 Sarah Koch, MD
 Max Kopitnik, MD
 Aislinn Lewis, MD
 Karren Lewis, MD
 Elise Lowe, MD
 Krista Lukos, MD
 Craig Luplow, MD
 Stephanie Lyden, MD
 Andrew Maertens, MD
 Katelyn Miller, MD
 Lauren Millett, MD
 Galen Mills, MD
 Arla Mayne Mistica, MD
 Trenton Morton, MD
 Mary Mrdutt, MD
 Brittany Myers, MD
 Coulter Neves, MD
 Ross Orpet, MD
 Rishi Patel, MD
 Travis Pecha, MD
 Tony Pedri, MD
 Hannah Phillips, MD
 Jason Reynolds, MD
 Hope Richards, MD
 Justin Romano, MD
 Anna Rork, MD
 Benjamin Ross, MD
 Michael Sanderson, MD
 Griffen Sharpe, MD
 Sarah Sowerwine, MD
 Elise Sylar, MD
 Ellen Thompson, MD
 Jason Vergnani, MD
 Jory Wasserburger, MD
 Sawley Wilde, MD

University of Wyoming Residents – Casper

Sarah Abdellatif, DO
 Matthew Balls, DO

David Busick, MD
 James Calamia, DO
 Samuel Christensen, DO
 Katrina Clumer, DO
 Hannah Dupea, MD
 Jonathan Fausett, DO
 Kyle Jordan, MD
 Jared Lambert, MD
 Damian Lara, MD
 Nicholas Loughlin, DO
 James McLennan, MD
 Jesse Miller, DO
 Kody Nilsson, MD
 Timothy Nostrum, MD
 Jordan Palmer, DO
 Taylor Pedersen, DO
 David Pratt, DO
 Sarah Richardson, MD
 Boyd Tamanaha, MD
 Timothy Tetzlaff, MD
 Patricia Tu, DO
 Benjamin Willford, DO

University of Wyoming Residents – Cheyenne

Jacob Bailey, MD
 A. Carsen Bahn, MD
 Jason Caswell, MD
 Gregory Christian, MD
 Courtney Dahl, DO
 Jonathan Egbert, MD
 Hope Ferguson, MD
 Elisabeth Gehringer, DO
 Olivia Klinkhammer, DO
 Annie Le, DO
 Benjamin Leishman, DO
 Kathleen Mondanaro, DO
 Lincoln Mosier, DO
 Amber Moss, DO
 Anh Phan Nguyen, MD
 Baier Rakowski, DO
 William Ratliff, MD
 Bernard Roscoe, DO
 Michael Snarr, DO
 Matthew Strang, MD

Italicized Names denotes New Members in 2018

Red names denote Wyoming Medical Society Board Members



WYOMING
 MEDICAL
 SOCIETY

*Advocating for
 doctors since 1903*

WORKING TOGETHER WORKS FOR EVERYONE

Cigna salutes the Wyoming Medical Society for being a staunch advocate for physicians. We also support their commitment to improving the health of Wyoming's citizens. Together, we're making Wyoming a healthier place.



Together, all the way.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

918268 05/18 © 2018 Cigna.

One number accesses
our pediatric surgical specialists.
Any problem, anytime.



We know children.

1.855.850.KIDS (5437)

The Physicians' Priority Line is your 24-hour link to pediatric specialists for physician-to-physician consults, referrals, admissions and transport

