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A Feature on the Wyoming State Hospital
PAGE 22

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ABOUT THE COVER

Lillian Heath Nelson (pictured) was Wyoming's first women doctor. Photo courtesy of Carbon County Museum, Rawlins, Wyoming.

Contents

EDITOR'S PAGE

University of Wyoming's Nurse Practitioner Program 4

FROM THE DIRECTOR

Painting the Picture of Health Care Delivery Costs in Wyoming 8

WMS PRESIDENT'S CORNER

Stroke Care in Wyoming 10

Family Practice of a Different Kind 12

Wyoming Opioid Legislation 14

ON THE COVER

Wyoming Women in Medicine 16

A Feature on the Wyoming State Hospital 22

Ceballos Takes Helm for Health 28

Wyoming Physician of the Year 30

UW Residency Profiles 34

PARTNER MESSAGES

Are Your Opioid Pain Management Practices Current? 41

Important Information for Referring Physicians 43

Building Healthy Partnerships 45

WMS Member List 46

University of Wyoming's Nurse Practitioner Program

BY ROBERT MONGER, MD

The Fay Whitney School of Nursing at the University of Wyoming (UW) is helping to address the healthcare provider shortage in our state through their excellent nurse practitioner (NP) program, and we physicians should look for ways to support and collaborate with our nursing colleagues.

UW's NP program originally started in the early 1980s with a master's NP program, which graduated its first student in 1982 and its last students in 2012. In the early 2000s, many health care disciplines started offering more advanced degrees to recognize the highest levels of practice within their discipline, such as pharmacy programs offering PharmD degrees. Similarly, UW's NP program also evolved to offer a more advanced degree, and in 2010, UW's Board of Trustees approved the creation of a three-year nursing doctorate, the Doctor of Nursing Practice (DNP), which started in 2010 and graduated its first students in 2015. UW continues to offer a master's program for nurses who want to teach or move into administrative positions; however, UW's master's program focuses on leadership and teaching and is not a clinical degree.

> We physicians should look for ways to expand interprofessional collaboration with our nursing colleagues as they continue to increase their role in patient care.

UW's DNP program accepts 18 students per year and offers two clinical concentrations: family nurse practioner (FNP), which prepares students for careers in rural primary care, and psychiatric mental health nurse practioner (PMHNP), which prepares students for careers in rural psychiatric mental health care. Each year, the program aims to enroll 12 students into the FNP track and 6 students into the PMHNP track, and the program is considering offering an adult-gerontological acute care nurse practitioner (AGACNP).

In order to be accepted into UW's DNP program students must have a BSN degree. Prior nursing experience is not required; however, many DNP students have years of clinical experience prior to starting the program. Physicians have generally been very supportive of the program, and many DNP students participate in clinical rotations supervised by physicians. UW's DNP program is committed to Wyoming and has a strong rural emphasis, and the FNP program generally focuses on outpatient primary care, not inpatient hospital care or deliveries. Most of UW's DNP students are from Wyoming and following graduation around two-thirds of the graduates stay in the state to practice.

There are several different degrees and certifications in the nursing world which can be confusing to non-nurses. To clarify, the term "advanced practice registered nurse" (APRN) includes four different types of practitioners, including NPs (the largest group), Certified Registered Nurse Anesthetists (CRNAs),


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Clinical Nurse Specialists, and Certified Nurse Midwives. All of Wyoming's APRNs are licensed through the Wyoming State Board of Nursing, and like many other states, Wyoming is what is known as a full independent scope of practice state, meaning that APRNs may provide care in all settings, and supervision or collaboration agreements with any other provider are not required by Wyoming law. Additionally, Wyoming's APRNs are also eligible for full prescriptive authority.

There are number of similarities between UW's DNP program and the Wyoming WWAMI medical school program, including the size of the programs: 20 Wyoming WWAMI students are admitted each year compared to 18 Wyoming DNP students. Both programs are physically located in the same building at the College of Health Sciences in Laramie, and although the two programs have traditionally been siloed without much interaction between them, this is beginning to change. The DNP students, for example, now use the same anatomy lab as the WWAMI medical students (although not at the same time), and several of the WWAMI faculty are teaching DNP classes this year, and at least one DNP faculty member is now teaching WWAMI students. In addition, for the last several years, UW's DNP, WWAMI, and PharmD students have participated in a one-day interprofessional event related to opioid prescribing and they are exploring other interprofessional learning events.

There are also significant differences between UW's DNP and Wyoming's WWAMI programs. For example, following graduation most newly minted DNPs go straight into practice without completing post-graduate training such as a residency. Also, while not trivial, the in-state tuition for the UW DNP program is much less expensive than medical school, with average in-state cost for tuition and fees of around $12,000 each year for three years (compared to many medical students who graduate with more than $200,000 dollars in debt). However, unlike the Wyoming WWAMI medical school program, there is no state loan repayment program available for DNP students.

The 18 members of the class of 2019 graduated in August, and they are the 5th class to graduate with a DNP degree from UW. The program is becoming nationally recognized for its emphasis on rural primary care and will likely continue to grow in the future under the outstanding leadership of the DNP program director Dr. Ann Marie Hart, PhD, FNP-BC, FAANP.

We physicians should look for ways to expand interprofessional collaboration with our nursing colleagues as they continue to increase their role in patient care. For example, Wyoming APRNs have their own state-wide organization, the Wyoming Council for Advance Practice Nurses (WCAPN), which hosts an annual meeting. The WMS works with the Wyoming Association of Physician Assistants to co-host educational opportunities, and we should do the same with the WCAPN. All of us need to work together to improve patient care in Wyoming.

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Painting the Picture of Health Care Delivery Costs in Wyoming

BY SHEILA BUSH

When asking what drives the cost of health care in Wyoming you're bound to get a host of different answers ranging from pharmaceutical pricing and insurance policies to increasing expenses associated with keeping pace with advancing medical technology. Certainly, some will say it's the cost of recruiting physicians to practice in rural Wyoming while others are quick to blame our health care facilities. The legislative committee charged with diving into the details of Wyoming health policy, the Joint Labor, Health and Social Services Committee (JLHSS), continues their quest to solve why health care costs in Wyoming consistently soar above prices in surrounding areas, and they're landing on some interesting ideas and solutions. Not to sound like a broken record, but as I mentioned in my spring column, there's truly no better time for physicians to be engaged in this conversation than right now, and WMS remains committed to making that happen.

During the 2019 Session, the legislature voted to spend $200,000 on facilitating a study of high Wyoming hospital costs and health care services. The state contracted Milliman, Inc. to conduct the study and report to JLHSS on or before October 1, 2019. This report is available on the WMS website. Despite the unavailability of that report that was not released in time for the September JLHSS meeting, the Wyoming Business Coalition on Health (WBCH) offered the committee some interesting health care cost data of their own for the committee to sink their teeth into during their Evanston meeting.

The data presented was drawn only from the claims submitted to the multi-payer claims database (MPCD), roughly about 41% of all state claims, but it painted an eye-opening picture for Wyoming's lawmakers. Throughout the nearly three-hour presentation, we combed through graphs and charts comparing Wyoming to Montana, other like-positioned states and national averages for per member per month costs, inpatient stay lengths, outpatient visits, and so much more. As you might suspect, the data presented didn't necessarily reveal anything we didn't already know, health care in Wyoming is expensive, but it undoubtedly elevated the conversation around health care cost and successfully caught the attention of lawmakers.

If the goal of painting this eye-opening picture was to raise awareness to what appear to be alarming differences in reimbursement between our own Wyoming facilities, or to highlight the number of medical imaging devices in certain WY communities, then the presentation was a wild success. However, if painting the complete picture of health care delivery costs in Wyoming, and the drivers behind those costs, was the goal, I believe medicine would argue the palette was missing a few important colors.

We have our work cut out for us, starting with putting some context around the picture and educating lawmakers to what those key missing colors are on the palette. Conversations around price transparency policy initiatives aimed at identifying high-value/low-cost care are good conversations to have. But, absent some important context, those conversations quickly lead to potentially ill-advised solutions. Without all the right colors, well-intending lawmakers are at risk to believe that the solutions to Wyoming's woes live in policy changes designed to encourage artificially narrowing provider networks, returning to certificate of need practices that expand beyond facility construction to include medical devices and imaging, limiting out-of-network charges, and pursuing bundled payments options.

Rather than being presented a finished painting, lawmakers were given a canvas with some nice starting outlines. It's now the job of medicine and our community facilities to help fill in the details and provide the insights that really bring that painting to life. The best results and solutions will come if we can work together to peel back the layers of this complex problem and embrace that the answers won't be simple ones. WMS will be relentless in our mission to educate around what this cost picture looks like from the perspective of those delivering direct patient care, and there's no question that we will need your help to do it.

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Stroke Care in Wyoming

BY DAVID B. WHEELER, MD, PHD, FAAN, FAES

In the past several years there have been stunning advances in stroke including: expansion of the time window for thrombolytics to at least 4-1/2 hours, development of highly effective mechanical revascularization techniques and the arrival of imaging modalities that reveal how much brain can be saved by intervention regardless of time elapsed since symptom onset. Stroke remains the fifth leading cause of death and a leading cause of long-term disability. We lose nearly 2 million brain cells per minute during a stroke, so the faster normal blood flow is restored the more likely we are to achieve a positive outcome.

As the least populous state in the lower 48, Wyoming faces unique challenges in delivering time-sensitive care. With respect to stroke care, the farther one lives from a hospital the less likely one is to receive thrombolytic therapy, so there is a lower probability of an excellent outcome. In other words, people living in rural settings are more likely to die or be permanently disabled because of stroke than those who live in more densely populated areas. While advances in stroke care have been remarkable, the cost and complexity of delivering this care is such that not every hospital in Wyoming can hope to provide it. It is, therefore, essential that clinicians and hospitals across the state begin working together to develop the organizational infrastructure needed to ensure every Wyomingite has access to the best possible stroke care.

There is abundant data showing that hospitals participating in clinical data registries and using the information for process improvement have better stroke outcomes. Recognizing this, Wyoming enacted a law in 2013 requiring Emergency Medical Services to transport patients with stroke to the nearest appropriate stroke center. In this statute, an appropriate facility is defined as "designated" by the state Department of Health as a stroke center and this requires participation in data submission and process improvement programs. Only one hospital in Wyoming has been designated as a stroke center so far, so the law has not yet helped the state achieve its worthy goal of clinically organizing a system of care for stroke. Participation in clinical registries and process improvement programs is expensive, requires considerable administrative support and clinical effort. Clinicians tend to believe they are delivering excellent care unless and until they are shown data to the contrary, so they rarely push administrators to embark on process improvement missions without some coaxing. The Department of Health has not enforced the rules pertaining to stroke transport and facility designation, so there is no consequence to not participating.

I am confident that we can overcome the financial and administrative barriers to participation by delivering this service on a regional or statewide basis. The American Heart Association's Get With the Guidelines (GWTG) program is the international standard for stroke registries and has provided the basis for our rapidly developing practice parameters in this field. Abstracting charts and entering data into this registry is time consuming and hard to do well if it is done only intermittently. Hospitals with low stroke volume may struggle to provide needed staffing and expertise to do this work properly. Q-Centrix is a company that specializes in supporting hospitals participating in registries like GWTG. They work remotely to abstract charts and enter data into GWTG charging per chart, based on the complexity of the registry, along with a 15% service fee.

WMS is proposing that Wyoming provide a subscription to GWTG, stroke limited, and that we contract with Q-Centrix to provide chart abstraction and data entry for GWTG, stroke limited, to every hospital in the state. We should also provide for a "Superuser" account to be used by a Clinical Coordinator and a Medical Director who would work with participating hospital to develop both site-specific and system wide process improvement plans based on the information collected. The larger hospitals already participating in GWTG will see significant financial savings if GWTG, stroke limited, is provided to them for participating in the statewide system and these net savings could be diverted toward financial support of the Coordinator and Director.

We can dramatically improve access to the best available stroke care in by helping Wyoming's hospitals and clinicians to work together in an organized fashion to deliver the right care at the right time. Together we will lead the way for improved health care delivery in rural environments across the country. Our efforts are being closely monitored and many groups and agencies are looking to us for guidance. If through these efforts even a few people avoid long-term disability from stroke, the financial expenditures on this program will be easily offset by savings to the state for healthcare services for the survivors.

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Family Practice of a Different Kind

BY DAVE SHELLES

Drs. Larry and Greg Seitz enjoyed sharing a dermatology practice in Cheyenne from July 2011 to December 2018 when Larry retired after 42 years in practice. Seitz Dermatology continues under Greg's ownership.

The family that practices medicine together stays together.

Just ask the Winters and Seitzes- practicing families in Wyoming who enjoy working together each day.

Drs. John and Bret Winter have worked as orthopedists at Wyoming Orthopedics and Sports Medicine in Cheyenne since 2013 when Bret joined the practice, while Drs. Larry and Greg Seitz practiced at Seitz Dermatology in Cheyenne from July 2011 until December 2018. Larry retired in 2018 after 42 years in practice, leaving the practice in good hands.

"It's rewarding (to see the business thrive under Greg). I did this for 42 years, so I've got 42 years of energy in developing a dermatology relationship with our community, and it's very nice to have that 42 years continue to blossom."

When John Winters' sons pondered their careers, he stressed the importance of finding bliss at work.

"I have another son (Eric) who's two years older than Bret, and he works as a dentist. When they were both still at home in high school is when, at the dinner table one night, they were talking about careers and both of them did well in school," he said. "I said to them, 'I'm not going tell you what you ought to do in life because you have to decide for yourself, but the most important thing is you're lucky enough to choose a career you like and you want to do it, instead of one you just can't stand.' I think that was important for both of them."

From the beginning, each father let his sons do their own things and never pressured them to follow into the footsteps of medicine- let alone a specific branch of medicine.

A Cheyenne native, Greg earned bachelor's degrees in zoology and psychology from the University of Wyoming before earning his medical degree from Oregon Health Sciences University and rotating through a few specialties during that time. Growing up with a dermatologist father, Greg knew the ins and outs of that field while also experiencing other things.

"It takes time to hone in and focus on a specialty because it's a life choice and you've got to be comfortable with that life choice and understand what that life choice means," he said. "You've got to work out the nuances of the good and the bad of lots of different practices.

"It's fairly easy at the beginning to remove some of the dif-

ferent specialties. Everybody has their own ideas about, 'I don't want to do this for sure, this might be OK,' and it goes back and forth. It was probably midway through my third year of medical school when I started to focus on dermatology and say, 'This is really what I want to do.'"

Also born and raised in Cheyenne, Bret spent time working in his father's orthopedic practice in high school and for a summer in college. After earning a degree in biology from the University of Kansas he went on to KU medical school in Kansas City, going through rotations but keeping orthopedics in mind.

"Part of it was working with my dad while I was in high school and then maybe one summer while I was in college," Bret said. "And then when I decided to go to medical school, orthopedics was the thing that interested me the most. I like the fact that you get to work with your hands and I like the fact that there are mechanical things involved. I felt like there were concrete ways to make people better, but I've learned that's not always the case. I like that problem-solving aspect."

After graduating medical school, Bret had practiced orthopedics in the Salt Lake City area while his wife, Natalie, completed her internship, residency and fellowship in anesthesiology at the University of Utah. Over time the two decided they wanted to move back to Cheyenne, and during a family ski trip in Steamboat Springs, John made Bret a job offer.

"So we were riding the ski lift, and I told him, 'If you decide you want to come [to Cheyenne], there's a place for you, and I'll basically give you whatever surgery I can give you to get you started. But that's your choice, whatever you want to do.' That was the end of the conversation," John said.

"Six months later or so, he called and said, 'We want to come to Cheyenne.' I said, 'That's great.' He knew that I had offered to make a place for him. Growing up here, he knew what it was like… And there was a good practice opportunity for his wife, and I think that was part of it."

Larry made a similar offer to Greg when the youngster finished his medical degree.

"I actually asked him to join the practice when he got out of medical school," Larry said. "But we kept those communication doors open, and there's a lot of unsettled decisions being made throughout that whole time. And I think as he got to the end of his residency we firmed it up. I think that he understood that the door was open for him to come here for a long time."

Greg said he signed the standard three-year contract, understanding that he and his wife might change their minds about Cheyenne. That didn't happen, and he purchased the practice in 2014, before the initial three-year contract was up. Now he said he can't imagine being anywhere else, in any other field.

"Let's be honest, I hope someday that one of my children comes in and takes over for me. I can't think of any easier transition," he said.

"There's something about being able to have an understanding of what happens and how the patients and how the practice runs, and then have someone you know and love take over for you. That's true of all business. I think most parents want their kids to come into their business. It's what I like and what I enjoy doing. It's nice to share a common interest with your kids. I'm here until I retire at this point. Hopefully someday I have somebody who takes over for me."

Dr. Bret Winter, left, joined his father Dr. John Winter in 2012 at the Wyoming Orthopedic and Sports Medicine office in Cheyenne.

While Larry has headed into retirement with the dermatology practice in the worthy hands of his son, John said he tried to retire once but admitted got bored without the work. He continues to practice, heading to work every day alongside Bret. The two said they have a nice back-and-forth, things one doctor might have a greater knowledge of than the other.

And neither one sees an end in sight.

"It's nice to have someone you can bounce ideas off of, and look at things together," Bret said. "We share interests at work and interests outside of work as well. I probably won't be in practice with my son when he gets into a field where he's working. But if I am, it would be nice to share a common interest with him like that."

"I get to see him in ways I wouldn't get to otherwise," John said. "It's been quite a pleasure to see how well he takes care of patients. He's an excellent surgeon and it's fun to operate with him. We've had the last few years, almost always having a good time together, more than what most people get to do. It's been a pleasurable existence."

Opioid Law Changes:

Wyoming Opioid Legislation

BY NATALIE WINTER, MD

Since the opioid epidemic started in 1999, more than 700,000 Americans have died of a drug overdose. On average, 130 Americans die every day from an opioid overdose. As the deaths reached epidemic proportions, lawmakers have been working on legislation to combat the epidemic. Massachusetts was the first state to pass opioid legislation in 2016. Since that time, most states have passed laws restricting opioid prescribing for acute pain. At this time, there is limited data on whether these laws mediate opioid-related morbidity and mortality or whether they are associated with negative unintended outcomes.

In Wyoming, opioid legislation was passed in 2019. The major changes took effect 7/1/19.

The laws state as follows:

- No practitioner shall prescribe nor shall any person dispense any opioid or combination of opioids for acute pain to an opioid naive patient for more than a seven (7) day supply in a seven (7) day period. The board shall by rule establish reasonable exceptions to this section, in consultation with other professional licensing boards that license practitioners, including exceptions for chronic pain, cancer treatment, palliative care and other clinically appropriate exceptions. As used in this subsection:
  - (i) "Opioid" means an opium-like compound that binds to one (1) or more of the major opioid receptors in the body;
  - (ii) "Opioid naive patient" means a patient who has not had an active opioid prescription in the preceding forty five (45) day period.
- Except as otherwise provided in this subsection, when a practitioner, other than a veterinarian, prescribes a schedule II, III, IV or V controlled substance, the practitioner or his delegate shall search the prescription tracking program for prior prescriptions issued to the patient before first issuing the prescription and shall repeat the search every three (3) months thereafter for as long as the controlled substance remains a part of the patient's treatment. A practitioner who prescribes a schedule V controlled substance shall only be required to search the program as otherwise provided in this subsection if the substance is an opioid.
- The board shall require three (3) hours of continuing education related to the responsible prescribing of controlled substances every two (2) years.
- On and after January 1, 2021, except when dispensed directly by a practitioner other than a

> pharmacy to an ultimate user, no controlled substance included in any schedule shall be dispensed without the electronic prescription of a practitioner.

Most states now have laws restricting amounts of opioids prescribed for acute pain. There is data in the literature to support this as we now know that patients can become opioid dependent in just three days. There is also evidence that the greater amount of initial opioid exposure (higher total dose, longer duration prescription) is associated with a higher risk of long-term use, misuse, and overdose. In addition to this, most who abuse opioids obtain them first from diversion—many from a family member or friend for free. There is a lot of evidence in the literature that patients receive more medication than they actually take, such as after surgery, and there is risk then that these excess pills may not be taken as prescribed.

Dr. Winter is a board-certified anesthesiologist specializing in pain management at CRMC.

Wyoming has had a prescription drug monitoring program (PDMP) since 2004. The database provides information on all controlled substances prescribed to a patient in the state of Wyoming. Over the last few months, the database also gives information on other states through Interconnect. This information is helpful in identifying patients who may be doctor shopping as well as patients that are at increased risk for an opioid related complication—those that are on another sedating medication which may interfere with opioid therapy. In 2015, 23% of people that died of an opioid overdose tested positive for benzodiazepines as well. A study in North Carolina showed that a patient prescribed both opioids and benzodiazepines had a tenfold increased risk of overdose related death. Another reason to check the database is to find out exactly how much opioid medication a patient has truly received. It gives information on the dose, amount, and date of fill. Patients who are opioid naïve are at higher risk of complications related to opioids, and even if a patient has been on a high dose in the past, restarting at these doses could result in a fatality if they have not been on opioids recently.

In terms of best practices for opioid prescribing, there are many recommendations. Most notable is the CDC recommendations for managing chronic pain which was released in 2016. These recommendations focused on ways to improve safety and effectiveness of pain management as well as decrease risks associated with long-term opioid therapy. First, opioids should not be first-line treatment for chronic pain. Other treatments are likely to be more effective in long-term management of chronic pain. If, however, these other treatments are not effective or there are limited options, opioid therapy may be considered but only after a thorough discussion takes place between practitioner and patient on the risks with opioid therapy and the goals for treatment efficacy. Immediate-release opioids are safer and should be used first at the lowest dose for the shortest amount of time possible. Providers should caution increasing the dose above 50mg morphine equivalents (MME) and should avoid going above 90 MME without a significant reason. At this dosage, patients have a higher risk of overdose and death. At 50 MME, the risk doubles for overdose death; at 90 MME, the risk increases tenfold. For acute pain, clinicians again should use the lowest dose for the shortest amount of time, and no more than the amount needed should be prescribed. Three days is often enough, and more than 7 days is rarely needed. This is in line with the new legislation limiting initial prescription in the opioid naïve to 7 days.

In addition, there are recommendations for monitoring including evaluating patients within 1-4 weeks of initiation of opioid therapy for chronic pain or with any dose changes. On continued therapy, clinicians should be reevaluating the benefits and harms every 3 months or more frequently. If benefits do not outweigh the risks, then opioid therapy should be tapered. This does not mean forcing patients off of opioids completely. This should be an ongoing evaluation and decision.

The CDC recommendations also include checking the PDMP at least at 3 month intervals, urine drug testing before initiating long-term opioid therapy and then again at least annually, avoiding concomitant benzodiazepine use, recognizing patients with an opioid use disorder so they can receive appropriate treatment (possibly medication assisted treatment such as suboxone in combination with behavioral therapy).

The new state legislation and the CDC guidelines both require a lot of time and consideration, but as we have seen since 1999, this is necessary to avoid more unnecessary deaths. Opioid related death is preventable, and with responsible prescribing, more deaths may be avoided.

Women Physicians in Wyoming Join Together

Wyoming Women in Medicine is a group for currently practicing female physicians in Wyoming. The group recently formed and is accepting new members. More information can be found on their Facebook page.

Wyoming Women in Medicine

WMS CONTRACTED CONTENT

When Lillian Heath Nelson packed her .32 caliber revolver and rode horseback 40 miles to see her patients—stitching up bullet holes and delivering babies—she blazed a trail across Wyoming history that has left a remarkable path for all other female physicians in Wyoming to follow.

Now, 126 years after she graduated from medical school and became the first woman doctor in Wyoming, women are still pioneering firsts as physicians. Though only 25 percent of the state's doctors are women even now, Wyoming has had its share of women leading the way.

Whether they are like Dr. Marion Smith of Torrington who served as the first female president of the Wyoming Medical Society or Dr. Betsy Spomer of Powell who is pioneering ways for doctors to find a work-life balance that is successful for them, Wyoming's women physicians are doing great things for the state.

A new organization called Wyoming Women in Medicine (WWM) now seeks to offer an opportunity for women doctors to network with each other, advocate for female physicians and promote the medical field to young women.

Alexis Anderson, a medical student in her second year of training with WWAMI at the University of Wyoming is spearheading the group. When she first entered medical school she started investigating whether a group just for women doctors was available. She asked women who were already practicing medicine and they told her nothing like it currently existed. That prompted her to work toward organizing WWM.

"I thought it would be a really great way to give female providers a platform to talk to each other around the state and create a coalition of female physicians," Anderson said.

During her research, Anderson discovered that not only was the state low on providers, Wyoming is also especially low on female providers.

"We found that Wyoming has the lowest percentage of female providers to male providers in the United States," Anderson said. "The group could be a way to bring a little bit of light to that fact and to see why that is happening."

Wyoming Women in Medicine held their first meeting at the Wyoming Medical Society conference in Jackson, with both medical students and current providers in attendance.

"At this point, we're really just discovering what everybody wants from a group like this," Anderson said. "Our goal is to start reaching out more and contacting more female providers."

With the group still in its nascence, WWM members are working to decide what role the organization will play in Wyoming. Anderson said it could become a legislative advocacy group that works on behalf of women doctors. Alternatively, it could serve as a support group where female providers can get information and advice from one another, discussing things that affect their career.

Though she is early into her medical career herself, Anderson has anticipated factors that affect women physicians more than their male counterparts, and these are things that could be discussed if WWM leans toward becoming that kind of group.

"I think women just have a few different things we need to think about when we become a physician," Anderson said. "How can you have a family or children one day? What does that look like when you go through residency? Men are parents as well, obviously, but women are the ones who physiologically carry the baby."

Another direction Anderson would like to see the group go is becoming an advocate for education and teaching young people about the medical field. She envisions WWM taking time to go into schools to tell young people—especially girls—about the possibility of becoming physicians and trying to get more Wyomingites excited about the prospect of going into medicine.

"Educating young people about what it is to be a physician in Wyoming, what the perks are and how it's achievable—it could be really cool for this organization to move into that kind of realm in the future," Anderson said. "I do think sometimes it can seem daunting to become a provider because you haven't seen someone do it before or you don't know how you can."

Dr. Yvette Haeberle, who is the clinical curriculum coordinator for first and second year medical students in WWAMI, is helping Anderson get the group up and running. She said WWAMI students have an annual ladies night out where practicing physicians come and speak to the female medical students to discuss the challenges women doctors face.

"This is something more formal for all the women across the state," Dr. Haeberle said of WWM. "As small of a state as we're

Wyoming Women in Medicine held their first meeting during the Wyoming Medical Society Conference in Jackson.

Women Physicians in Wyoming Join Together

in, it's nice to have networking."

She said those WWM members who met in Jackson came to the consensus that membership would be for practicing physicians and they would try to have quarterly meetings.

Anyone who identifies as female and would like to join WWM can do so by contacting the group through their Facebook page or by emailing them at wyowomeninmedicine@gmail.com.

Before Dr. Haeberle became the clinical curriculum coordinator, she worked as a family medicine doctor. She completed her residency in 1997 and then went on to work in private practice, as a hospitalist and then in emergency room care—so she knows the challenges her female students are facing as they enter the medical field.

"I feel like I can advocate more for the female students," Dr. Haeberle said. "This isn't a sprint—it's a marathon. Pace yourself and sign up for the long haul, but don't forget to live your life outside of medical school and residency."

She can also advise about what it means to be a doctor who is a woman.

"Women have more household responsibilities and are maybe more torn between career and families," she said.

But that's not to say it's all negative, she noted. Dr. Haeberle brought up a study published online in December 2016 that reported on research done at Harvard's T.H. Chan School of Public Health. The report said elderly hospital patients treated by female physicians rather than males were less likely to die within 30 days of admission or to be readmitted within 30 days of discharge.

"On the positive side, there have been studies that show female physicians connect better with their patients or have more empathy," she said.

Dr. Haeberle said if she made an educated guess about why there are still fewer women than men doctors in Wyoming, she thinks it could be based partly on the difficulty of being a sole provider in a small community and trying to also have a family.

"Most of the Wyoming communities are fairly small," she said. "To go hang a shingle and be a self-employed physician in a small community in Wyoming as a primary care provider would be kind of a daunting task. It's probably not conducive to a family lifestyle. I'm guessing that may be a barrier."

She said that a factor for women doctors who are in a group practice is that they are likely to see more of the female patients.

"Practicing in a group you tend to get more of the complex patients—a lot more maternal medicine and women's medicine—which tends to be a little bit more challenging and time consuming," Dr. Haeberle said.

Many women physicians in Wyoming have experienced just what Dr. Haeberle is talking about. While they were earning their spot on the list of firsts for female physicians, they were also facing the challenges that go along with being female in what is a male dominated career in this state.

Dr. Betsy Spomer's path leads to coaching

Like many doctors in rural communities, Dr. Betsy Spomer soon found herself with a booming practice when she arrived in town. She was the first female physician in Powell to deliver babies, and she was also the only female physician covering obstetrics for several years. The women of Powell were happy to have a female doctor care for them during childbirth and beyond.

"It really helped my practice because my practice was ultimately largely female," she said. "I think it gives you some credibility—especially once you've been pregnant and had kids. They know you get them and can relate. That seemed to be a real advantage."

She said being female can give a doctor an edge that is helpful in patient care, no matter whether the patient is a man or a woman.

"I'm of course biased, but I think women have a special way of connecting with patients—male or female," Dr. Spomer said. "I suspect it is the way we connect with people and our ability

Dr. Betsy Spomer is a Powell family practitioner who now works with physicians seeking to gain a better work-life balance.

to empathize with people. It really matters how we show up—it matters on a physiological level. People just do better when they are cared for in a compassionate way— and women have the edge."

Needless to say, with a patient population that was mostly female, she soon found herself delivering babies on nights and weekends even when she wasn't on call.

"If I was in town, I would do the delivery," she said. "That took its toll. You can predict it's going to happen when you're not on call and in the middle of the night."

Though she was pioneering as a female doctor in Powell, she never felt that she was treated differently from her male peers. There were some things she had to navigate through that her colleagues didn't though.

She became the first physician in the practice who ever needed to take maternity leave.

"In fact, I had to write the maternity leave policy myself because they never had dealt with that," she laughed. "It was great because I made it like I wanted it."

Other situations, mostly dealing with household and child-drearing issues, looked different for her.

"I think being a working mom I had different needs and requests than my male counterparts—everything from working through pregnancies to child care issues and breastfeeding," Dr. Spomer said. "Plus my husband worked full-time as well. Many of my male counterparts' wives weren't working or were working part-time."

Over the course of her practice, she eventually stopped seeing male patients or going on nursing home rounds. The obstetrics work was what she loved, but also very time consuming and intensive.

"I basically was carving out my practice just to accommodate more OB," she said. "There was a point when I stopped doing OB, and I was left with a skeleton of a practice I could have filled up."

Instead, she took a hard look at what kind of life she wanted to be leading. She knew she wanted to have time to do things outside of her medical career.

"I decided to just give myself a breather," she said. "I never went back on a regular basis."

After she made her slow exit from practicing medicine full-time, she was able to take a clear look at the factors that led to her wanting to take a break.

"Now I'm on the outside, I can actually see clearly now what was going on," Dr. Spomer said. "I was exhausted. I couldn't even access my brain half the time if I wanted to." It was then that she made a turn in her career path that helped her to trail-blaze in a different direction as a physician.

She became a life coach, using her own experiences as a doctor to help other physicians who are facing burn-out or exhaustion.

"I feel like now I am in a place rather than healing patients, I'm in the business of hopefully healing health care providers—one provider at a time," she said.

Dr. Spomer was familiar with life coaching after having used one herself, so she knew the value of the work. Coaching had helped her to look at her own experience and ask herself some important questions.

"How could I have trained to do this and love it so much and feel like I needed to leave it?" she wondered. "It's been a really interesting journey, and I'm at a place now where I am really recognizing how we physicians seem to be trained to think in such a way that doesn't serve us well. We have this way of just putting it all on the line, thinking if we do it really, really well, everything will be great, but not recognizing the significance of self-care."

She points to eating right, getting enough sleep, exercising, having a spiritual life and focusing on mental well-being as things that are important aspects of self care.

"All of those things are so important, and we're not trained well at all in the importance of that," Dr. Spomer said. "Now I am almost obsessed about the need for physicians to have that kind of training and wellness. It's not just about being happy. It translates to quality patient care and correlates with fulfillment and joy in the work."

After noting that more than half of physicians report feeling burned out, she said she believes the health-care field is currently broken in many ways. Her goal is to get physicians to a place where they can find fulfillment in their work, by helping them figure out what works for them and knowing how to be a bigger and better voice for themselves.

"I really feel strongly that providers are key to figuring it out," Dr. Spomer said. "I don't believe we are at an impasse in health care—we just need to learn to be different as providers."

For female providers in particular, especially those who are navigating some of the same issues she faced, Dr. Spomer has suggestions for ways to increase the percentage of women providers in the state. She believes women physicians might find more job satisfaction if they had a better opportunity to embrace or accommodate their unique female needs.

Everything from medical facilities offering child care on site for providers to letting a doctor practice-share their panel of patients with another physician are ways Dr. Spomer thinks the industry can attract more women.

"I want to encourage female physicians to use their voice and trust it," she said. "It's new territory. We have to be a little bit

Women Physicians in Wyoming Join Together

brave too. It's not an easy conversation to have in a room full of nearing-retirement male physicians."

Now Dr. Spomer is living life more on her own terms and is happier for it. In addition to her life coaching business, which is called Soul Honey Coaching, she also fills in periodically as a physician in Powell and also does consulting with the hospital where she is offering a physician resilience program.

"I am no longer practicing on a regular basis, but people still call me Dr. Spomer," she said. "My kids see me modeling this life where I am able to achieve and be who I was designed to be—their mom, a wife, a community member and a physician—and I do it my way."

Dr. Marion Smith first female president of WMS

If Dr. Marion Smith had let naysayers stand in her way or deter her on her way to becoming a doctor, she might not have gone on to become the first female president of the Wyoming Medical Society.

She remembers a discouraging conversation she had with an older male doctor when she learned she had been accepted to Creighton Medical School in Omaha. Prior to the conversation, she grew up in Buffalo, always knowing she wanted to do something in science.

"The human body's workings were just fascinating to me," Dr. Smith said. She had earned a zoology degree from the University of Wyoming and started thinking about medical school at the end of her time in Laramie. She was excited to learn she had been accepted into Creighton.

Back home in Buffalo, she was telling a visiting specialist her exciting news.

"I had known him forever," Dr. Smith said. "When I told him that I had been accepted to medical school he said, 'Well, that's too bad because you will be taking a spot from a man, and you're just going to have babies and not practice.'" Dr. Smith remembers feeling shocked by his statement.

"It certainly wasn't called for," she said.

Well, she did go on to become a doctor, and she did indeed have babies—four sons, in fact—and she didn't give up her practice. After she finished her family practice residency at St. Joseph's in Omaha, she began practicing in Torrington in 1985 and is still going strong.

"Of course it's challenging," Dr. Smith said. "My husband and family are very supportive. Everybody helped me. I couldn't have done it without help of course."

Being a doctor was challenging in itself, but being a woman added some challenges as well.

"I think the home-work balance is more challenging as a woman," Dr. Smith said. "We are just more concerned about birthday cards and things have to be right, and the laundry has to be done. The home things weigh more."

Dr. Marion Smith was the first female president of the Wyoming Medical Society, and she encourages other women doctors to take an active role in the society.

But Dr. Smith says that is a positive thing.

"I think the fact that we are more sensitive to those kinds of feelings make our performance better as well," she said. "It makes us sensitive to what other people are feeling."

Early on in her career, Dr. Smith was very active in the Wyoming Medical Society. She became the first female president the society ever had.

"That was a very male dominated field and I feel it still is," she said. "I would encourage women to be more active in the medical society. We need more numbers there to have political influence. I think that's where decisions are made and influences are exerted."

Dr. Smith said she is absolutely glad when she sees young women coming up through the ranks to become physicians, and she only has one piece of advice for them.

"Just make sure you're doing what makes you happy," Dr. Smith said.

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A Feature on the Wyoming State Hospital

Psychiatrist Profile:

A View from Inside the Safety Net

BY DAVID W. CARRINGTON, M.D.
Medical Director, Wyoming State Hospital

Human societies have always had to cope with the numerous challenging issues related to serious mental illness (SMI). I can imagine a tribe of early hunter gatherers having to insist, perhaps at the tip of a spear, that a member whose behavior had become too disruptive to tolerate leave the safety of the community after the usual rituals had proved ineffective. After a variety of not so successful treatment modalities – including exorcism, imprisonment and exile –what is thought to be the world's first psychiatric hospital was established in London in 1247. Bethlam Royal Hospital (commonly referred to as Bedlam) was an early example of government's acknowledgement of SMI as an important issue requiring its attention and resources. In the United States, the early 1800s saw the rise of the asylum system of care for persons affected by SMI. This movement was spearheaded by Dorthea Dix and Dr. Thomas Story Kirkbride and was centered on providing a relatively pleasant and humane environment for persons affected by SMI to reside and recover.

Despite having a population of only around 30,000, in 1886 the Wyoming Territorial Legislature recognized the need for a publicly supported system of care for SMI persons and appropriated $30,000 for the construction of what was originally named the Wyoming Insane Asylum (later named the Wyoming

Statue from the gates of Bethlem Royal Hospital c. 1676.

State Hospital (WSH)). Like most asylum systems at the time, the Wyoming Insane Asylum followed the Kirkbride Model of Care in which SMI was believed to be curable as long as "moral principles" were followed. These principals included the provision of pleasant surroundings, fresh air, and decent food as well as physical and intellectual engagement. This model also emphasized a professional staff trained to provide care with gentleness and compassion. Despite the progressive and hopeful mission of the hospital, many patients spent the remainder of their lives there as the numerous graves at the hospital cemetery will attest.

Throughout the early 1900s various psychiatric treatments came and went including such now discredited and distasteful practices as hydrotherapy, insulin shock and lobotomy. Though the goal of care at WSH was "cure" or at least stabilization to the point that discharge was appropriate, the increase in the hospital census over the years attest to the challenges of treating persons with SMI. When the hospital was established in 1887 the census was twenty. In 1955 it grew to 655, reaching its peak of 750 in 1968. With the advent of psychotropic medications in the 1950s and the implementation of Medicaid and Medicare in the 1960s, the process of deinstitutionalization of State Hospitals began. The idea was that a small number of hospital beds should be available for the acute stabilization of SMI persons in crisis but that the vast majority of care should be provided by outpatient clinics. This continues to be the model we aspire to today but the reality is not quite that simple.

The Present State of Affairs

The Substance Abuse and Mental Health Services Administration (SAMSA) defines SMI as "someone over 18 having (within the past year) a diagnosable mental, behavioral or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities". The Center for Behavioral Health Statistics and Quality (CBHSQ) estimates that in 2018 there were 23,758 such individuals in the State of Wyoming. Virtually everyone is in agreement that persons with SMI are ideally served by outpatient services in the community where they reside. Psychiatric hospitals should only be used in cases where less restrictive alternatives do not exist. Just this month a federal judge found the State of Mississippi has violated the Americans with Disabilities Act by failing to provide adequate levels of community based care for their mentally ill citizens, thereby unnecessarily confining them in state mental institutions.

In Wyoming the civil commitment of mentally ill persons is governed by Title 25 of the civil code. This statute sets forth the procedures as to when and how someone is to be involuntarily hospitalized. Involuntary hospitalization is an issue largely unique to psychiatric medicine. People are not involuntarily hospitalized for other medical conditions with the rare exception of communicable diseases posing a risk to the public. The practice of involuntary hospitalization remains a necessary but reluctantly utilized option of last resort in psychiatric medicine. On occasion, the very nature of some psychiatric illnesses impairs or precludes SMI individuals from having insight into their illness and their need for treatment. Other factors such as the societal stigma of mental illness and an understandable aversion to the loss of liberty and autotomy make people reluctant to seek or accept psychiatric hospitalization. To be sure, the majority of persons with SMI either alone or with the assistance of their support systems, seek treatment voluntarily when their symptoms increase to a level of discomfort or disability. These individuals are more readily treated by means of outpatient care or short stay voluntarily hospitalization in their communities and they are typically more willing and able to adhere to the course of treatment recommended by their providers. It is for the minority of SMI persons who lack the insight or ability to seek help when needed that the civil commitment laws are intended.

> "The practice of involuntary hospitalization remains a necessary but reluctantly utilized option of last resort in psychiatric medicine."
>
> DAVID W. CARRINGTON, MD
> WYOMING STATE HOSPITAL

In order to be involuntary hospitalized in Wyoming, a person must be found by a court to be both mentally ill and a danger to themselves or others as a result of that mental illness. In Wyoming the statutory definition of mental illness includes the presence of dangerousness:

> **Title 25-10-101:** "Mental Illness" and "Mentally Ill" means a physically, emotional, mental or behavioral disorder to cause a person to be dangerous to self or others in which requires treatment, but do not include addiction to drugs or alcohol, drug or alcohol intoxication or

A Feature on the Wyoming State Hospital

developmental disabilities except when one or more of those condition co-occurs as a secondary diagnosis with mental illness.

The Wyoming statutory definition of mental illness differs from a more clinical definition which does not require a finding of dangerousness. If an examiner (defined as a licensed psychiatrist, physician, advanced practice registered nurse, physician assistant, psychologist, professional counselor, addictions therapist, clinical social worker or marriage and family therapist) finds a person to be mentally ill under the statute (if the examiner is not a physician or psychologist the court must appoint one to review the findings) and the court finds by clear and convincing evidence that the individual is mentally ill, the court is obliged to consider the least restrictive and most therapeutic alternative available. This may include directed outpatient commitment or more typically, involuntary hospitalization at the WSH. If the committed person is found to be incompetent to make medical decisions, the Court can authorize the involuntary administration of medication subject to the medical judgement of licensed practitioner.

Directed outpatient commitment is a relatively new and underutilized alternative available to the Courts. This option essentially orders an individual to comply with the terms and conditions of a treatment plan as established by an examiner in consultation with any gatekeeper designated by the Department of Health and approved by the court. If the person does not comply with the treatment plan, i.e. take medicine, show up to appointments and refrain from using drugs and alcohol; the court may revoke the outpatient commitment order and schedule an involuntary commitment hearing which could result in the person's being ordered to the WSH. The reason why directed outpatient commitment is used so infrequently likely stems from unfamiliarity with this option (it was enacted in 2016) on the part of the Courts and county attorneys as well as a lack of community resources and expertise available to treat difficult and brittle SMI individuals on an outpatient basis.

Once a court has found by clear and convincing evidence that an individual is mentally ill (and thereby a danger to themselves and others under the statutory definition) and has been ordered to the State Hospital as the least restrictive and most therapeutic option, the committed individual typically doesn't go there right away. There is usually a waiting list to get into the WSH due to the volume of civil commitments that occur throughout the state. As of late the wait list has been in the teens but a few years ago it reached as high as forty or more. The WSH currently has 103 beds available for occupancy. The census of the hospital is typically in the low to mid 70s for a few reasons. The patient rooms in the civil part of the hospital are double occupancy and particularly ill patients with violent or disruptive behaviors may require their own rooms – a challenge we hope to resolve with the construction of the new facility which I will touch upon later. Also of late, patient rooms and treatment areas have had to be closed in order to effect required physical plant renovations including ligature point abatement and the installation of door top alarms to reduce the risk of suicide by hanging.

Natrona Hall currently serves as the administration building of the Wyoming State Hospital.

Due to the waiting list, people who have been ordered to the State Hospital for treatment are usually first diverted to a designated hospital until they are admitted to the WSH or have recovered to the point that admission is no longer required and the Tile-25 order can be dismissed. Most people waiting for admission are diverted to Wyoming Behavioral Institute in Casper, but Cheyenne Regional Medical Center, Ivinson Memorial Hospital and a few others also admit those waiting to get into the State Hospital. The State pays these designated hospitals a per diem while the patient awaits admission. In some cases a committed individual with violent or difficult behaviors will be denied admission by a designated hospital. In such instances, committed persons are sometimes held in local emergency rooms or detention centers while they wait for admission. These individuals are given priority on the State Hospital waiting list and are brought in as soon as possible.

Once admitted to the WSH, an individual treatment plan is developed and a variety of treatment modalities including psychotropic medication, medical care, and individual and group therapy are employed in order to reduce the person's symptoms of illness to the point that they are no longer a danger to themselves or others. When this point is reached, the court is notified by the treating provider that conditions necessitating hospitalization no longer exist and three days later (a statutory requirement) the individual is released to the community for outpatient follow up. The rate limiting step in this process is frequently obtaining housing and funding. People that are committed to the State Hospital frequently do not have others who are willing to help provide shelter and care. Group homes, assisted living centers and nursing home beds are in short supply. These limitations make it difficult and time consuming to place hospitalized patients with SMI back into the community. Other challenges that significantly delay discharge include the lack of available guardians to authorize care and placement for patients who are not competent to direct their care; skilled nursing home beds willing and able to cope with challenging behaviors and supported living facilities able to accept persons with intellectual disabilities and the challenging behaviors that sometimes co-occur.

In addition to treating civilly committed persons, the WSH provides forensic services to the state criminal courts under the jurisdiction of the Title 7 Criminal Code. Forensic services are provided to the entire State on both an inpatient and outpatient basis. A criminal court may order an assessment of a defendant's competency to stand trial or criminal responsibility on either an in or outpatient basis. In FY 2018, 177 outpatient evaluations and 51 inpatient evaluations were ordered. These evaluations are typically conducted by a psychologist with forensic specialization, usually in county detention centers on an outpatient basis or at the WSH when defendants are ordered to be evaluated as inpatients. The inpatient evaluations are conducted on the Criminal Justice Services unit at the WSH. This is a 28-bed unit that is designed to provide greater security than the civil unit. This unit also serves as the treatment unit for the several civil patients with aggressive behaviors that require a greater level of structure and security than can be provided on the civil adult psychiatric services unit of the hospital. If a defendant is found incompetent to stand trial, they are generally ordered to the State Hospital for the purpose of competency restoration. This involves treatment of the symptoms of mental illness that pose a barrier to the defendant's competency to stand trial but also includes group and individual education regarding the legal system and its processes. If a criminal defendant is found not criminally responsible for their actions (not guilty by reasons of mental illness or NGMI) they may be ordered to the State Hospital for an indeterminate period of time. Individuals adjudicated NGMI, particularly those who have committed violent or notorious acts, may remain at the hospital for a long time. When NGMI aquittees are deemed to be treated to a point that they no longer pose a substantial risk of danger to society, the hospital may petition the court for conditional release to the community.

The entry way to the Criminal Justice services unit of the Wyoming State Hospital

The Future

The goal of the WSH is to provide acute stabilization of acutely ill persons with SMI and to transition them back to the communities in as short period of time as possible. A major challenge to the State Hospital's ability to accomplish this goal is its role as the safety net provider for persons with a variety of psychiatric, intellectual, cognitive, neurological or medical

A Feature on the Wyoming State Hospital

Construction of the new State Hospital is ongoing and slated for completion sometime in the Summer of 2020.

Architect's rendering of the new State Hospital.

conditions for whom no alternative treatment facility can be found. The hospital is frequently placed in the position of providing custodial care for patients with dementia, intellectual disabilities and personality disorders who exhibit challenging behaviors that other treatment facilities are unable or unwilling to address.

Recognizing these challenges, in 2014 the Wyoming State Legislature established a Joint Executive and Legislative Task Force on Wyoming Department of Health Facilities. This task force presented options for the Legislature to consider governing populations served and the services offered by facilities operated by the Department of Health – primarily at the WSH in Evanston and the Wyoming Life Resource Center (WLRC) in Lander. The Task Force Report advised that the proper role of the State is that of a safety net provider, i.e. the State should not compete with services provided by the private sector. The safety net concept refers to the State's obligation to ensure access as a provider of last resort of facility level services for those individuals that would otherwise be critically endangered or a threat to public health and safety. With this role in mind, a strategic plan defining the roles of the WSH and the WLRC was adopted. Under the plan that has been adopted, the WSH's role is to provide acute short term psychiatric services to Title 25 involuntary hospitalization for civil patients and to continue to provide a variety of forensic services to the criminal courts throughout the State under Title 7. The role of the WLRC is envisioned to expand beyond providing care to the intellectually disabled and traumatic / acquired brain injured persons that they currently serve. The new role of the WLRC will also include providing intermediate level care for SMI persons; long term care for individuals that are hard to place in the private sector, have high medical needs, or require geriatric psychiatric care and manifest challenging behaviors.

To support this strategic vision, the Wyoming Legislature has appropriated $182 million for the construction of new facilities at the WSH and the WLRC. Construction at the WSH is expected to be completed by the summer of 2020 with the facilities at the WLRC anticipated to be completed the following year. A primary benefit of the clearly articulated roles for these "sister facilities" is expected to be shorter wait times for civilly committed patients awaiting admission to the State Hospital and thus a reduced civil commitment waiting list, thereby reducing costs to the State as longer term patients are transferred to the WLRC. The total number of beds at the new State Hospital facility will remain essentially the same (104 vs. 103) but with the shorter length of stay resulting from a focus on acute stabilization, more people will be able to be served.

Wyoming, like all other societal or governmental entities in the history of civilization grapples with difficult decisions related to the care of those of their citizens who struggle with severe mental illness. The care of the mentally ill involves a complex interplay of clinical, legal, financial and moral issues. I am optimistic and encouraged by the attention and concern demonstrated by the Wyoming State Legislature and the Wyoming Department of Health to these universal challenges. No society has ever developed a perfect system to address the difficult issues posed by the effects of severe mental illness. The pendulum of society's willingness to allocate thought, time and treasure to the effects of serious mental illness on both people and institutions has always swung back and forth. From where I'm standing, at least in Wyoming, it appears to me that the pendulum is swinging forward.

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Director of the Wyoming Department of Health

Ceballos Takes Helm for Health

IN JANUARY, GOV. MARK GORDON APPOINTED MIKE CEBALLOS TO LEAD THE DEPARTMENT OF HEALTH. CEBALLOS BRINGS DECADES OF BUSINESS AND STATE BOARD EXPERIENCE TO THE ROLE.

BY JULIETTE K. RULE
Wyoming Medical Society

Ask Mike Ceballos what he knows about health and he'll tell you he doesn't have to know everything, that he's in a position of learning and listening, and it's a role for which he's well suited.

"This is where my generalist background pays off," Ceballos said in a September phone interview. "You can't be the subject matter expert in all areas."

In January, the Democrat was tapped by Republican Governor Mark Gordon to replace a retiring Tom Forslund, to lead one of the state's largest agencies. Ceballos and Gordon connected in their work on the Wyoming Retirement System Board, on which Ceballos continues to serve as a member at-large.

Since retiring from Qwest, now known as CenturyLink, in 2011, Ceballos has kept busy. In 2014, he ran (and lost) a bid for Superintendent of Public Instruction. He began his work on a PhD in educational leadership at the University of Wyoming and has just one class remaining. A clear nod, he says, to his generalist approach in his career.

For 30 years at Qwest, Ceballos was in "learning mode," he says, citing the 14 different roles he filled before retiring as the telecommunications carrier's Wyoming state president.

"When you've held many positions, you set up a different way for making decisions," he explains.

As Director of the Wyoming Department of Health, Ceballos is heading out on a listening tour, visiting communities around the state to hear from patients, local leaders, and providers. When it comes to the latter, he wants to learn what they do and how they do it. (The Department of Health issues press releases in advance of the listening tour events, and those releases also are shared on the department's website.)

He sees a lot of commonality in his capacity as a business leader and now a leader in the public sector. His approach at Qwest was to "get close to the customers," and that's an opportunity he believes dovetails with his current role.

"I'd like for us (the Department of Health) to be innovative, take risks, and I don't see that as being much different from where I came from (professionally)," he explains. "State employees do have ownership over their work... I think maybe it's an assumption that the state doesn't do things effectively and efficiently with best practices."

Cultivating a culture of curiosity and continuous improvement leads to his encouragement of innovation and new ideas. When things don't go as planned, his approach will be to regroup, debrief and learn.

"That's important in today's world with a such a quick change of pace," he notes. "The challenge in our work is that we're going to do this, then you can't tell me all the good things. What's working? What's not? Where are the struggles?"

Early in his conversations with Gordon, Ceballos says he recognized the critical importance of healthcare policy and leadership.

"I wanted to take this opportunity to apply what I've learned in business to help the department meet its challenges," he explains. "Plus, when your governor asks you to take a role, that's a request that's hard to ignore."

The key to his success in this role will be engaging with customers, he says, noting it's a similar approach to his work with

Qwest customers in Wyoming.

"We should explore best practices from business for ideas we can employ in government to improve our effectiveness (in communities)," he explains. "It's trying to get as close to the customer as you can. One of the direct deliverables is community visits."

Ceballos' interest is in having community members come forward before there's a problem, so he's being prospective in going to the providers, and setting up meetings at community-minded facilities, and visiting with public health nurses and other key stakeholders.

Those relationships include legislators he says, but he's also come to recognize the critical nature of the work county commissioners do in partnership with providers in Wyoming. Health is one of the state's biggest spenders with a nearly $2 billion budget ($900 million of which comes from federal coffers).

As such, Ceballos is well-aware money can't be the only issue raised by his department, providers and other stakeholders. Instead, his attention will turn on efficiently spending what has been appropriated. If the community meetings lead people to tell him they simply need more money, he says, then he doesn't really need to visit.

"Tell me what's working," he says. "Tell me what's not and tell me why and what you would do."

Hard decisions will have to be made, that's the job of a department director.

"I understand we can't be everything for everyone," Ceballos says. "I want to work with my staff, stakeholders and state leadership to develop and understand our priorities for state and private efforts."

Ceballos is no stranger to the question of managing an aging population in a rural state.

"That will affect us all," he explains. "We expect heavy budget pressures in Medicaid as a result and there will be increased demand for care. What can be done to help keep people in their homes as long as possible?"

Mental health emerges an issue, too. Can people in crisis get the help they need?

And that circles around to attracting and retaining talent. Prioritizing mental health care practitioner recruitment and retention is key. That means attracting younger people to the profession and figuring out how to retain the people with the knowledge and experience.

While expertise in Wyoming is remarkable, there's also the reality that small, rural states don't always have the resources or customers. Salaries are high. Physicians are in demand.

"It's not that we don't have money in mental health," he continues. "Those docs are just hard to come by. Those docs are in high demand. The salaries are harder for small communities to come up with, if they can even afford it."

All of that creates frustration at the community and family levels.

"If (practitioners) have more expense than revenue, they're not going to stay," he explains. "We have at tremendous workforce of credentialed professionals with great backgrounds. They are disciplined professionals with a process-mentality."

While Wyoming might have less money, there's never enough money to "do it all," he says.

He is a supporter of telehealth but notes that ensuring access to the availability of high speed internet at the municipal level isn't a Department of Health challenge even as improving access to healthcare remains an open question. It's a promising approach and allows Wyoming communities to bring highly-specialized services and care that are otherwise harder to maintain in a rural state.

"We need to examine any existing barriers to growth in the telemedicine's adoptions so that we make the most of this opportunity," he explains.

It's not lost on him that the questions facing Wyoming health care today are pretty much the same as they were 20 years ago. That drives his interest in his on-the-ground learning through his community visits.

"We can't do what we did in the past, and we're not sure what to stop doing," he explains. "How do we really talk together about what our priorities can be and how do we do that with the right amount of resource? And how we do that without scaring people?"

Have a concern or an idea about healthcare in Wyoming?

Wyoming Department of Health Director Mike Ceballos wants to hear from you.

Michael.Ceballos@wyo.gov | 777-7656

**Ceballos asks that email communications and voicemails be succinct so he can absorb and respond to the inquiries and ideas.*

Stephen Brown is WY's Physician of the Year

Dr. Brown's friends know him as someone who puts his family first. "He is the epitome of the family man," Dr. Sigsbee Duck said. "He loves his family—his children and his lovely wife. Medicine is great, and his devotion to pediatric psychiatry and the Medical Society—they're all great. But they are secondary to how much he loves and cares for and is so proud of his family."

Meet Stephen Brown, MD:

Wyoming Physician of the Year

BY ELIZABETH SAMPSON
Wyoming Medical Society

Trying to hold back the tide in the middle of a landlocked state may seem impossible to some, but that is just what one Wyoming doctor has been doing since he arrived here.

Casper's Dr. Stephen Brown, a child and adolescent psychiatrist, has at times been the only one standing between trauma and Wyoming children in need of mental health care. He started his practice in Wyoming in 1990, and since then there have been times when he was alone as the only child and adolescent psychiatrist practicing in the state.

Now, 30 years into his practice, Dr. Brown has not only held back the tide for those children—he has worked to turn the tide of mental health care throughout Wyoming for the better.

"He has been a champion for increasing access to mental health services for children and adolescents in Wyoming," said Cheyenne's Dr. Robert Monger who has known Dr. Brown for about 20 years. "That's something he is well known for, and he has done a great job."

To honor his tireless efforts and commitment to his field, Dr. Brown has been named the Wyoming Medical Society's Physician of the Year for 2019. His friend, Dr. Sigsbee Duck of Rock Springs, himself a former Physician of the Year, nominated

Dr. Stephen Brown has been named as the Wyoming Medical Society's 2019 Physician of the year. He is a child and adolescent psychiatrist based in Casper.

Dr. Brown.

"I can't think of a more gracious, caring and intellectual person and physician to represent our state as Physician of the Year," Dr. Duck said. "Dr. Brown has been an invaluable asset and resource for pediatric psychiatry. He essentially established pediatric psychiatry in the state of Wyoming. He's a very caring man and goes the extra mile to try to help kids with psychiatric issues."

There is no shortage of practitioners in Wyoming who agree with Dr. Duck's assessment.

"Steve is a clear choice for Physician of the Year," said longtime friend Dr. Paul Johnson of Cheyenne. "He has a long history of advocating not only for his patients in the exam room but for patients in the entire state and country."

Throughout his career, Dr. Brown has worked to not only increase access to mental health care, he has also been an advocate for a better understanding of the field of mental health itself.

"I've always been trying to make sure that mental health is recognized and appreciated," he said.

Doing so has meant volunteering with various medical boards and societies, working to improve the mental health education for medical students in the state and challenging those who would try to cut funding for mental health care.

Dr. Brown grew up on a farm and ranch near Brush, Colo. where he earned the title of 4-H Eastern Slope Livestock Judging Champion. He attended Colorado College in Colorado Springs where he received his undergraduate degree in physics. While there he played small college football as a defensive end. His team was nationally ranked every year and even went to the national playoffs.

Following his junior year of college, he and some friends prospected for gold in the backcountry of Alaska.

"We found enough gold that it would have paid for our trip and then some," he said. Dr. Johnson joked he was glad Dr. Brown didn't take to prospecting full-time.

"We are all lucky Steve wasn't a very good prospector or Wyoming would have lost an amazing physician," he said.

Dr. Brown went on to earn a Bachelor of Science in electrical engineering and an MBA at Washington University in St. Louis before graduating from Keck School of Medicine at the University of Southern California. He completed his residency in general psychiatry at Barnes Hospital at Washington University in St. Louis where he received the first Award for Clinical Excellence. From there he completed a child and adolescent psychiatry fellowship at St. Louis Children's Hospital and Washington University.

After he completed his training he knew he wanted to reside in the west. He and his wife Helen had intended to move back to Colorado for his practice, but nothing seemed to fit, prompting them to look north to Casper instead.

"It was actually the only place we looked in Wyoming, and we

Dr. Brown and his wife Helen enjoy spending time in Jackson Hole. Dr. Brown said he relies on his wife Helen for support and advice.

Stephen Brown is WY's Physician of the Year

fell in love with it," Dr. Brown said.

Upon his arrival in Wyoming, he quickly got to work improving the state's mental health care, and he hasn't stopped since. Dr. Brown is a Distinguished Fellow of the American Psychiatric Association (APA), and he has a private practice in Casper with both outpatients and inpatients. He is the Chief Medical Officer for Wyoming Behavioral Institute (WBI). He helped the facility go from 50 beds to 120 beds and become even more of a full-service psychiatric hospital after he arrived in the state, which is one of the things he is most proud of in his career.

Since his arrival, he has seen some changes for the better in the way mental health is viewed by people of Wyoming.

"There's a much higher recognition of the importance of mental health treatment," he said. "There's more recognition that society has a really significant problem in this state. I think there's been a lot of work in trying to get people to recognize it, but it is just affecting so many people. Wyoming is usually the number two or three state in the nation for suicide rates."

Other changes he has seen include mental health treatment itself.

"The art of treating kids has improved some," he said, and he noted that there are now more child psychiatrists in the state—though there is still room for more.

"We actually have extremely competent physicians in this state that everybody should be thankful for," Dr. Brown said. "But there is a shortage, and an even bigger shortage of child and adolescent psychiatrists. I was often one of one, two or three child psychiatrists in the state. When there was one it was just me. Now I think we are up to eight or so."

The sheer size of Wyoming makes the shortage of psychiatrists even more of a burden. Some patients have been known to have to drive a couple of hundred miles to find psychiatric care. Knowing this, Dr. Brown took to the air to reach his patients. For about 15 years he flew to clinics in Gillette, Cody, Jackson and Rock Springs. He still keeps up with his clinic in Jackson.

Helping so many children and adolescents made the extra effort to see them worth it.

"My favorite memories are when a light bulb goes on in a child's brain over a therapeutic issue and they suddenly do better," Dr. Brown said. "Sometimes you don't think an adolescent has really got it. They leave and you're not sure they are doing well, and then a few years down the line you get a thank you note saying 'I finally understood what everyone was trying to get me to do,' and then they'll tell you how much better they are."

Dr. Brown remembers an adolescent patient he had who was bi-polar, but her parents were against using medication to treat her. When she reached adulthood, she arrived in his office without her parents and told him she was old enough now to be in charge of her own health and medical choices.

Dr. Brown pictured with his wife and granddaughter Addyli.

Dr. Brown enjoys traveling to spend time with his children.

"She showed up in my office, and I said, 'Why are you here?'" He remembered. "She said, 'I'm 18 and I can now choose to have my own medicine, and I know I need it.'"

Advocating for patients like this adolescent whose parents didn't want to get her treatment has been a big part of Dr. Brown's career. He has pushed to make people understand the importance of physician care for mental health patients.

"The reliability of diagnoses in psychiatry is one of the highest in any field of medicine," Dr. Brown said. "People don't recognize it because we don't do blood tests and lab tests as much, but the diagnoses criteria is pretty clear and pretty reliable."

Over the 30 years he has been practicing, there have been some consistent challenges to face.

"There continues to be prejudice against providing resources in the mental health field," he said. He added that even though there are mental health parity laws in place ensuring that mental is covered equally, health insurance companies seem to have ways to get around those laws.

"They do it in subtle ways, but they really do it," Dr. Brown

said. “Insurance companies fail to recognize that rural mental health doesn’t have some of the resources of big cities, so it complicates it.”

Other hurdles go beyond problems with insurance companies to the political arena.

“There’s always struggles with the Department of Health finances and providing adequate treatment,” he noted. “In this state one of the biggest expenditures is on mental health, and that’s one of the ones that often gets targeted when cuts come.”

Despite these struggles with outside forces, Dr. Brown said he has been pleased with the support the mental health field has received.

“I’ve been pleasantly surprised with how other medical doctors are quite supportive of mental health,” he said.

As part of his advocacy work, Dr. Brown has been a long-time member and leader of the Wyoming Medical Society. He has served two terms as president and has been a long-term member of the executive committee.

Dr. Duck served with Dr. Brown on the WMS board for many years and counts him as a great leader.

“Steve’s very level-headed,” Dr. Duck said. “He has the ability to tell the truth in a way that other people respect his opinion, and most of the time that opinion is followed. He’s honest. He’s caring. He’s smart. He says what he thinks, but he’s very gracious and tactful.”

Beyond the Wyoming Medical Society, Dr. Brown has served as the Wyoming delegate to the the American Medical Association and the representative to APA Assembly. He represented the western area of the APA, was chairman of the council for the western area and served on the APA Assembly executive committee.

“I’ve always been advocating for mental health, and psychiatry in particular,” he said.

His efforts to establish a third-year clerkship in psychiatry in Wyoming for the state’s medical students were successful, which helps to ensure future psychiatrists will be available here.

Dr. Brown has also volunteered his time for the community of Casper. He was again the president of the Natrona County Medical Society several years ago to help revive the organization, and this year he received their Physician Service Award. He was a long-time member of the Rotary Club in Casper and served on the board of directors and acted as president for the Casper Development Center. He also served in those same roles for Mountain Pacific Quality Health, which is a four-state not-for-profit quality improvement organization.

Outside of his practice and volunteer work, Dr. Brown makes time to travel extensively with his wife and their family. In addition to visiting with their three children, including 28-year-old twin daughters and a 27-year-old son who live in Denver and Los Angeles, Dr. Brown and his wife like to go boating, utilizing their boat slip at Jackson Lake in the Tetons. They also like to enjoy other Wyoming pastimes like skiing, hunting and fishing. In addition, Dr. Brown enjoys backpacking into the Wind River Mountains.

Dr. Stephen Brown and his wife Helen have three children. His twin daughters are named Julie and Danielle, and his son is named Matt.

“He is the epitome of the family man,” Dr. Duck said. “He loves his family—his children and his lovely wife. Medicine is great, and his devotion to pediatric psychiatry and the Medical Society—they’re all great. But they are secondary to how much he loves and cares for and is so proud of his family.”

Dr. Brown said that his wife is someone he can look to when he needs help.

“I rely on my wife for support and advice,” he said. “She has a lot of wisdom.” Undoubtedly it will be her advice that he looks to when he decides it’s time to transition to retirement. For now though, he doesn’t see that in his immediate future.

“I don’t have any present plans to retire,” he said. “Probably what I will do is try to figure out how to slowly limit what I am doing, but I still enjoy seeing patients get better.”

Perhaps young doctors just entering their field could benefit by heeding Dr. Brown’s description of what makes a good psychiatrist.

“As with most physicians, having compassion, using the science of medicine to help people and being flexible are key,” he said. “Use your intuition. Then you pick up on things much quicker, and you use science to confirm things, but science doesn’t have the solution to everything. That’s true of every field of medicine.”

UW Residency Program Profiles

In the fall edition of the Wyoming Medicine Magazine, we take the time to profile the third-year University of Wyoming family medicine residents in the Casper and Cheyenne programs. This year we asked them the following questions:

1. Where are you from originally and where did you attend medical school?
2. What made you consider Wyoming for your residency?
3. What makes Wyoming a unique place to practice?
4. If you were recruiting medical students to UW Family Medicine Residency Program, what would you tell them?
5. Please share a great experience that you have had while practicing in Wyoming.

Courtney Dahl, DO
Cheyenne, Wyoming

1. I'm originally from central Iowa. I went to medical school in the heart of Appalachia at the University of Pikeville Kentucky College of Osteopathic Medicine.
2. Cheyenne family medicine residency program was my top choice program primarily because it offered traditional full scope training including procedures and obstetrics that I want to include in my future practice.
3. I enjoy farming and ranching communities and the lifestyle that goes along with it.
4. I would tell medical students interested in the Program that if they want training in every aspect of family medicine then they should consider Cheyenne.
5. There have been a lot of good experiences for me here. For example as residents here we might work at a rodeo one day and deliver a baby the next morning. That kind of variety is what I really enjoy.

Jesse Miller, DO
Casper, Wyoming

1. I was born and raised in Casper, WY. I attended medical school at A.T. Still University – SOMA in Mesa, AZ .
2. The UW Family Medicine Residency offered excellent, comprehensive training within my hometown community.
3. Wyoming is host to beautiful mountain lakes, wonderful people, and rural communities who need comprehensive primary care services.
4. The UWFMR will provide everything you want in a comprehensive, full-spectrum training and personalized education tailored toward your professional goals. Wyoming will provide beautiful open landscapes (with torrential winds), beautiful mountain ranges (with unrelenting blizzards), and excellent educational opportunities for your children.
5. The indescribable feeling the first time a patient says, "I play bridge with your grandmother.

Michael Snarr, DO
Cheyenne, Wyoming

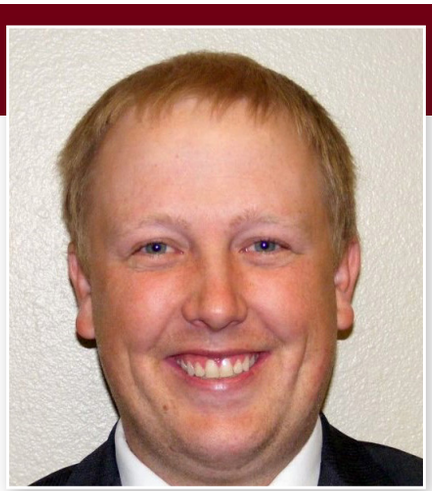
1. I am from Salt Lake City, Utah. I attended Midwestern University in Arizona.
2. The major pull to this program was the opportunities to learn and practice full scope family medicine in an unopposed residency. I also like that my commute time is around 10 minutes.
3. Practicing in Wyoming is especially unique for Family Physicians in the ability to more easily practice full spectrum medicine.
4. Most, if not all residencies, will allow you plenty of experience in the clinic, but one of the major benefits of this residency is the ample amount of procedures and skills you get outside of clinic that can broaden your scope of medicine, which allows you to define exactly how you want to practice medicine the way you want to after residency.
5. One of my favorite days in residency was when I delivered a few babies in the morning, helped in the ED by performing a lumbar puncture and then rounded on a few patients before I finished my day at clinic in the afternoon. The variety of my experiences throughout the day was gratifying.

Jacob Bailey, MD
Cheyenne, Wyoming

1. I am originally from Nephi, Utah. I attended Trinity School of Medicine.
2. What drew me to Wyoming for residency is the fact that this program is unopposed. After interviewing here, I found I like Cheyenne and the fact that it is not a huge city but still has everything I need.
3. I enjoy the fact that in practicing in Wyoming I can do full spectrum medicine. I enjoy the small town feel of Cheyenne and how friendly people are.
4. This is a great place especially if you would like to learn many procedures and want to do full spectrum medicine.
5. During my time here I have enjoyed all the hands on learning we get. Not only that but the continuity of care that we get to enjoy. I have had the wonderful pleasure of seeing a patient in clinic, following them through for a procedure and see them after for follow up.

UW Residency Program Profiles

Sam Christensen, DO
Casper, Wyoming



1. I'm from St. George, Utah and attended Midwestern University / Arizona College of Osteopathic Medicine
2. Family was the primary reason I considered Wyoming for my residency as my brother is a practicing physician in Casper. I also liked that it is close to home.
3. Wyoming-specifically Casper- is a great place to practice and train because it is a small, tight knit medical community but also is a referral center so there is a lot of patients and experiences.
4. When I recruit medical students to our program, I talk about the great rural medicine training that makes you feel comfortable doing a little bit of everything as a family physician.
5. A great experience that I have had while in Wyoming is when my patients refer their family and friends to me.

Adrian Durham, DO
Cheyenne, Wyoming

1. I am originally from Hartford, CT. I went to Med school in Spartanburg, SC at Edward Via College of Osteopathic Medicine.
2. I was in Emergency Medicine initially but after 2 yrs, even though I learned a lot, I was great at doing emergency procedures, but I didn't feel like I was truly helping anyone. I thought traditional family medicine was going to be a waste of my skills, but found that the rural tracks of FM were places that I could use all of my skills. From the time I got to Cheyenne, I felt like I was home!
3. The altitude, the outdoors, the unpredictability of the environment, and you are exposed to everything!
4. I would say that this is a unique environment where you can find a way to learn whatever you want to. Everyone encourages you to learn. It's a safe environment to learn, but you are treated like a grown physician. When you start here, you aren't an intern. You are a Physician (with no experience, but that comes with time). When you leave, you are more than ready to tackle life on your own.
5. There are so many daily. But, one of my patients were referred to me, since no one could explain her strange leg pain. After a complete medical workup, to include Rheumatology, and neurology. Nothing serious could be found, but no answers. I figured that maybe it was structural and recommended Osteopathic assessment and found her hips were shifted causing a short leg. I fixed it and she saw me weeks later stating that she thought this was just going to be an old age thing and was never going to get better. Now she feels like she has a new lease on life. This can happen anywhere, but my point is, that no one in this community feels like they can't ask anyone for help. In residency, everyone knows they have limitations and when they can't figure it out, they get help.

Greg Christian, MD
Cheyenne, Wyoming

1. I grew up in Mamaroneck, NY and attended New York Medical College.
2. The lifestyle, environment and people. It has small town charm even in its biggest city.
3. Working in a rural area offers so many different practice options. These range from full spectrum to a more focused practice. Working with small rural populations also lets us get to know our patients better on a personal level.
4. I tell them it is a great place to practice and learn. We are unopposed and get to work with great attending physicians both in our program and with other local physicians in various specialties. We are a very "hands-on" program and encourage our residents to be proficient in all types of procedures.
5. During my intern year I met a man in the hospital whom I spent a lot of time with and got to know pretty well. I followed him in the hospital, a rehab facility and then the clinic. Through my encounters I also got to know his daughter and her family very well. They are a very nice and caring family and they invited me out to their beautiful ranch for my first branding. It was one of the few special times as a resident where you truly connect with a patient and their family.

Hannah Dupea, MD
Casper, Wyoming

1. I'm from Bigfork, Montana and attended University of North Dakota School of Medicine.
2. I came to Wyoming for the full spectrum training and I liked that Wyoming was not just close to home, but a lot like my home.
3. Wyoming provides a great rural training but with a big hospital experience that provides a good volume and broad view of patients.
4. When I recruit medical students to our program, I tell them that I have really enjoyed being here and wouldn't have changed anything. The program provides a supportive environment and a good team approach. Hard work pays off and prepares you well for broad scope of practice.
5. My best experiences have been the patient relationships, especially with my continuity prenatal patients. I enjoy taking care of them all through pregnancy, labor, and delivery as well as then taking care of them and their babies after delivery. We get to share these incredible and sometimes scary life experiences with these patients, but hopefully can provide support and education as they become new parents.

UW Residency Program Profiles

Taylor Pederson, DO

Casper, Wyoming

1. I'm from Missouri and attended Kansas City University of Medicine and Biosciences.
2. I came to Wyoming for my residency because it provided unopposed training with a strong OB experience, especially with the OB track.
3. Wyoming is a unique place to train and practice because even though Casper is a bigger city, it still provides a rural practice experience.
4. When I recruit medical students to our program, I tell them that we have a great culture throughout: the clinic, faculty, residents, and hospital. The core faculty love to teach and the community physicians respect our program and also enjoy teaching us. The program and faculty work hard to find a way to meet our educational goals.
5. I love my OB patients. I love that I take care of them from the beginning of their pregnancy, through labor and delivery and then afterwards when they are new moms. I like being a part of them growing a family.

Jordan Palmer, DO

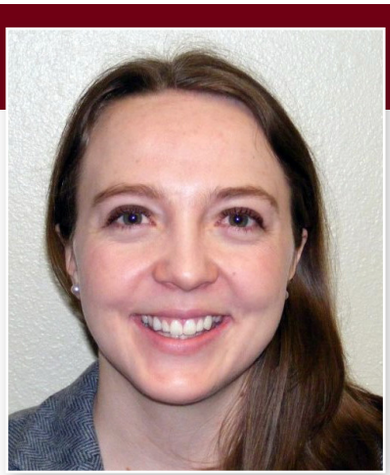
Casper, Wyoming

1. I'm from Missouri and attended AT Stills-Kirksville College of Osteopathic Medicine.
2. I came to Wyoming for my residency because it is an unopposed program that provides a strong rural training emphasis.
3. Wyoming is a unique place to practice because of its culture of self-reliance and independence, which creates a challenging and rewarding practice experience.
4. When I recruit medical students to our program, I tell that that it is a second-to-none program that provides unopposed and full-scope training. It is a unique opportunity to train in a large hospital and yet have so much direct patient access as family medicine residents.
5. A good experience I had was just recently when I took care of a sameday/walk-in patient who was very ill but resistant to go to the hospital because he did not have insurance. We did our best to follow his wishes and attempted to work him up and stabilize him in our clinic, but he was too ill and so I had to convince him that he needed to go to the hospital and not worry about the cost. The patient was grateful for our efforts.

Baier Rakowski, DO
Cheyenne, Wyoming

1. Originally from Long Island, New York I attended medical school at Western University of Health Sciences College of Osteopathic Medicine of the Pacific, Northwest Campus.
2. I was looking for unopposed residency programs west of the Mississippi. The breath of training and opportunities do develop a wide range of skills were an enticing part of the opportunities available here.
3. The opportunity to practice in an area of such stark beauty, the close knit community, and the opportunity to work at some of the best training institutions in the country as electives made practicing in Wyoming very appealing.
4. Our program in Cheyenne provides unfettered access to some of the best specialists I have ever had the opportunity to work with. The people we have the opportunity to work with here are bright, committed professionals who take great pride in their work. I always encourage medical students to observe the people they are interviewing with and to compare the residents and professionals here to those anywhere else and ask, “could I be happy here?” I most certainly have been.
5. Working with several specialists at CRMC, our hospital team, as well as a number of consulting physicians in Colorado, we were able to successfully transition a long-term diabetic with a hereditary renal deficit back to a full working life as a productive member of society. I was so impressed during that process with the willingness to collaborate seen between the primary team and our consulting care providers. Everyone, from the nursing staff to the residents and attending physicians and social workers pushed to establish a plan to ensure a positive outcome for this person. That hospital stay and the patient’s subsequent success is by far one of my proudest moments as a resident.

Sarah Richardson, MD
Casper, Wyoming



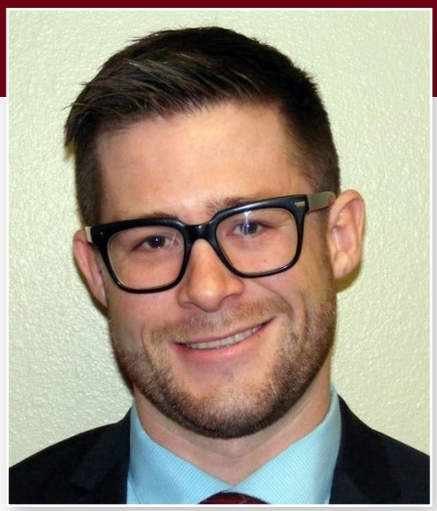
1. I’m from Colorado and attended St. George’s University School of Medicine.
2. I came to Wyoming to do my residency because I wanted rural training and it was close to home.
3. Wyoming is a unique place to practice because of the people, who are kind and easy to work with.
4. When I recruit medical students to our program, I tell them that it is a great residency with excellent teaching. Everyone gets along. Wyoming is a great place to live.
5. A great experience that I have had during my training was with a challenging continuity patient who has multiple medical and mental health issues that have resulted in recurrent admissions to the hospital. We were able to do a home visit with her, and that really helped us to connect and she now trusts me more and has opened up to me.

UW Residency Program Profiles

Ben Willford, DO
Casper, Wyoming

1. I'm from San Diego, CA and attended Lincoln Memorial University, DeBusk College of Osteopathic Medicine.
2. I came to Wyoming because as a high school student, I went to Boys Scout camp outside of Evanston and I thought it was beautiful. Then, I met Dr. Miller at the AAFP National Conference in medical school, who recommended that I do a sub-internship rotation in Casper. That experience was great and so I sold on coming here for residency too.
3. Wyoming is a unique place to practice because Casper has a community hospital, but also takes patients from across the state, so there is a lot of patients with diverse pathology-yet the experience is not impersonal like an academic health center.
4. I tell medical students that there is good quality and value of patient experiences, including procedures, clinic, and hospital. The program has a supportive environment. There is lots to do on your days off.
5. A great experience I had was with a patient that I delivered my intern year. She went to the emergency room with abdominal pain and found out that she was pregnant. She established care for her pregnancy with me, which was challenging at first because she smoked tobacco and meth. I was able to help her quit these when she found out that she was pregnant and she was able to get her life together. She and the baby are still my patients and they are doing great.

Nick Loughlin, DO
Casper, Wyoming



1. I'm from Cherokee, Iowa and attended Kirksville College of Osteopathic Medicine.
2. I came to Wyoming for my residency because I wanted to receive rural medicine training. I also like that Wyoming has great outdoor activities and a down to earth culture.
3. Wyoming is a unique place to practice and train because it allows a lot of autonomy as well as the ability to individualize my residency training experiences.
4. When I recruit medical students to our program, I tell that that our faculty are very engaged in teaching us and that I have learned a lot. Residency has been a good time.
5. A great experience that I have had while in Wyoming is that I was able to purchase land on Casper Mountain and build a cabin. I also had a really great experience on my rural rotation in Thermopolis.

WYOMING

Community Impact Update

Building Healthy Partnerships

Since 1945, Blue Cross Blue Shield of Wyoming has provided health care coverage to people in Wyoming letting them live free of worry. We've also had the privilege through corporate giving, employee volunteerism and the BCBSWY Caring Foundation to support programs and partnerships that have a positive effect on the health and well-being of all Wyoming communities. Our deep local roots help BCBSWY understand the importance of prioritizing the needs of our local communities.

Nearly 5 years ago, we started a partnership with the Boys and Girls Club Alliance of Wyoming to implement Healthy Habits—a healthy lifestyles program that is designed to help Wyoming's youth live healthier lives. The program teaches Club members goal setting, selecting healthy food and better eating habits, and provides healthy meals and snacks.

The program teaches Club members goal setting, selecting healthy food and better eating habits, and provides healthy meals and snacks.

Expanding our partnership with the Boys and Girls Club Alliance of Wyoming, the BCBSWY Caring Foundation funded a new statewide program to support suicide prevention through training for Club staff and teen members, provided by Grace for 2 Brothers. With Wyoming's high suicide rate, we think it's important to help young adults deal with potential suicide situations among each other, their friends and their families.

We also continue to address health care workforce development through scholarship opportunities. Renewing our multi-year commitment in 2019, the BCBSWY Caring Foundation increased the number of scholarships it supports for students accepted in the Doctor of Nurse Practice (DNP) program at UW Fay W. Whitney School of Nursing, with an emphasis on DNP students who specialize in psychiatric mental health (PMHNP). In response to a match challenge by the BCBSWY Caring Foundation, hospital partners St. John's Medical Center in Jackson and Wyoming Medical Center in Casper, also pledged to fund a scholarship for a DNP student to complete the program.

Wyoming faces significant challenges in meeting the health needs of its population and addressing the capacity of the workforce is a critical part of the solution. Our scholarship gift also provides scholarships to each community college through the ReNew BSN program and our Health Professions Scholarship program. Ben Mortiz, Chief Academic and Student Services Officer with the Wyoming Community College Commission shared, "The Wyoming Community College Commission is deeply thankful to Blue Cross Blue Shield of Wyoming for its expanded commitment to training the next generation of nurses and health professionals. Wyoming is experiencing a growing need for health care workers, and programs like this allow the Wyoming Community Colleges to train more students to work in the health care industry."

BCBSWY has been a trusted community partner for nearly 75 years by working with physicians and health care professionals to ensure the best health care system possible. Though there's more work to be done, these investments and important partnerships aim to improve the overall health and well-being of people throughout the state. Our commitment to Wyoming is unwavering and local community investment will always be important to us.

UMIA | Constellation Together for the common good.

Technology and a team-based approach can increase patient safety and reduce risk.

Are Your Opioid Pain Management Practices Current?

BY LORI ATKINSON
RN, BSN, CPHRM, CPPS

The opioid addiction crisis continues to dominate headline news. According to the Centers for Disease Control and Prevention (CDC), in 2016, 40 percent of opioid overdoses involved prescription opioids, with more than 46 people dying every day.1 The most common drugs involved in prescription opioid overdose deaths are methadone, oxycodone and hydrocodone.

While the overall prescribing rate of opioids has been declining since 2012, the amount of opioids prescribed in 2015 remained approximately three times as high as in 1999 and varied substantially across the country.2 There is continuing evidence of problematic prescribing patterns. In 2017:

- There were still almost 58 opioid prescriptions written for every 100 Americans3
- 17 percent of Americans had at least one opioid prescription filled, with an average of 3.4 prescriptions dispensed per patient
- The average number of days per prescription continues to increase, with an average of 18 days in 2017.3

A review of Constellation medical professional liability (MPL) claims asserted from 2010 to 2015 found that opioids were involved in 19 percent of claims where medication was a factor, and 24 percent involved more than one medication. The opioids most involved were hydromorphone, methadone and oxycodone. The combination with the highest indemnity and severity was fentanyl and oxycodone. Death was the outcome in 22 percent of all cases.

Clinicians continue to face scrutiny of their opioid prescribing practices through DEA investigations, state medical board sanctions and medical professional liability claims—and for good reason. Some clinicians and organizations still are not using best practices outlined by the CDC, state boards, and other organizations.

> A team-based approach to workflows ensures that clinicians have time to spend with complex chronic pain patients.

Following current best practices can prevent harm and protect organizations from allegations of negligent prescribing, overprescribing and failure to recognize and treat opioid use disorder (OUD).

Keep current on best practices

Reducing injuries in patients being treated with opioids and the resulting malpractice claims can be accomplished by implementing the following:

1. Use a team-based approach, which redistributes roles and accountabilities across the team and empowers team members to work up to the scope of their license and education. A team-based approach to workflows ensures that clinicians have time to spend with complex chronic pain patients. Redesign workflows to assure tasks are appropriately and efficiently delegated to team members in these areas:

- History intakes and updates
- Medication reconciliation

- Review of the prescription drug monitoring program in your state
- EHR documentation during and after exams
- Follow-up system that track exams, refills, tests, test results and referrals
- Patient education, goal setting and coaching
- Monitoring of pain patient dashboards

2. Employ technology to automate processes:

- Embed documentation templates and risk assessment tools into the EHR to capture and document pertinent medical history, family history, risk factors for OUD and mental health status.
- Create a patient dashboard view of pain status, functional and goal status, risk level, opioid prescriptions, morphine milligram equivalents (MME) dosages, refills and requests, test results, monitoring status and referral status
- Run reports from the EHR to identify outstanding lab test reports, referral reports and patients due for exams and testing.
- Create a clinician opioid-prescribing dashboard, and include a feedback loop for individual clinicians on their opioid prescribing practices.

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Cheyenne Regional Medical Center

Bariatric Surgery Success Rates:

Important Information for Referring Physicians

BY NAPOLEON E. CIEZA, MD
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Bariatric surgery has been shown to be a safe and effective weight-loss treatment for the morbidly obese, but some primary care physicians (PCPs) remain hesitant about postoperative treatment and managing patients who have undergone the surgery and recommend it to their obese patients infrequently.

Definition of Obesity

The disease of obesity is no longer considered a cosmetic issue that is caused by overeating and a lack of self-control. The World Health Organization, along with national and international medical and scientific societies, now recognize obesity as a chronic progressive disease resulting from multiple environmental and genetic factors.

Obesity is specifically defined as a body mass index (BMI) of 30 kg/m2 or more. It is linked to more than 40 diseases, including type 2 diabetes, heart disease, stroke, osteoarthritis and cancer.

Results from the 2015–2016 National Health and Nutrition Examination Survey indicate that 39.8% of adults are affected by obesity, and no state had an obesity rate under 20%.

In Wyoming 65% of individuals are either overweight or obese. Our state is ranked 32nd for its overall obesity rate; however, it is ranked second to last for the number of bariatric surgeries performed each year.

Over the next decade, the obesity epidemic is projected to increase both in number and severity.

- The Centers for Disease Control and Prevention projects that 42% of the United States population will suffer from obesity by 2030.
- It is also estimated that 11% of the population will suffer from severe obesity (BMI of 40 or more).

Various studies show that the general attitude of PCPs toward bariatric surgery is supportive. Yet, fewer patients are being informed that they are obese or overweight by their health care professional.

Studies also show that physicians are largely aware of the indications and benefits of bariatric surgery; however, many express concerns about surgical and medical complications following bariatric surgery. This, in part, might be the reason why there is such a low rate of referral for bariatric surgery.

> Individuals with morbid obesity have a 50-100% increased risk of premature death compared to individuals with a healthy weight.

Bariatric Surgery Overview

Qualifications for bariatric surgery include:

- BMI ≥ 40, or more than 100 pounds overweight
- BMI ≥ 35 with at least one or more obesity-related co-morbidities such as type 2 diabetes, hypertension, sleep apnea and other respiratory disorders, non-alcoholic fatty liver disease, osteoarthritis, lipid abnormalities, gastrointestinal disorders or heart disease
- Inability to achieve a healthy weight loss sustained for a period of time with prior weight-loss efforts

Safety of bariatric surgery

When compared to the risks of living with obesity — including complications related to diabetes, sleep apnea, hypertension and the increased likelihood of premature death — the risks of bariatric surgery are minimal.

Clinical studies report significant improvements in metabolic and bariatric surgery safety. The primary reasons for improved

safety include the increased use of laparoscopy, advancements in surgical techniques and the American Society for Metabolic and Bariatric Surgery and American College of Surgeons accreditation program.

The overall mortality rate for bariatric surgery is about 0.1% — less than gallbladder (0.7%) and hip replacement (0.93%) surgery — and the overall likelihood of major complications is about 4.3%

Clinical evidence shows that the risks of morbid obesity outweigh the risks of metabolic and bariatric surgery.

Effectiveness of bariatric surgery

Studies show patients typically lose the most weight one to two years after surgery and maintain substantial weight loss with improvements in obesity-related conditions.

Patients may lose as much as 60% of excess weight six months after surgery and 77% of excess weight as early as 12 months after surgery. On average, five years after surgery, patients maintain 50% of their excess weight loss.

Impact of bariatric surgery on mortality

Bariatric surgery helps to improve or resolve more than 40 obesity-related diseases and conditions, including type 2 diabetes, heart disease, certain cancers, sleep apnea, GERD, high blood pressure, high cholesterol, sleep apnea and joint problems.

Individuals with morbid obesity have a 50-100% increased risk of premature death compared to individuals with a healthy weight. Successful bariatric surgery reduces that risk by 30% to 40%, including the following specific risk reductions:

- 60% reduction in mortality from cancer, with the largest reductions seen in breast and colon cancers
- 56% reduction in mortality from coronary artery disease
- 92% reduction in mortality from type 2 diabetes

In 2017, 228,000 bariatric procedures were performed in the United

States. Despite being the most successful long-lasting treatment for morbid obesity, metabolic and bariatric surgery remains underused, as approximately 1% of all patients who qualify for bariatric surgery actually have the surgery. Studies have also shown that the mean preoperative BMI for the patients who underwent a primary bariatric surgery was 48.1 kg/m2.

As a whole this information shows that we could do a better job of providing patients with the best tools to treat obesity and that we could also provide these tools in a more timely manner.

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