

COLORADO FAMILY PHYSICIAN

2nd Quarter
2016 Spring

A Publication from the Colorado Academy of Family Physicians • coloradoafp.org

IN THIS ISSUE:

2016 CAFPA Award Winners- Meet the Family Medicine Innovators and Advocates Recognized this Year

Page 30-34



The CAFPA Annual Summit is Almost Here- What to Look Forward to This Year

Page 18

Protecting Your Online Reputation- How to Manage in the Age of Digital Reviews

Page 16



WE HELP KIDS BREATHE EASIER.

WE NEVER SAY NEVER.®

Whether a child has mild or severe eczema, allergies or asthma, referring a patient to National Jewish Health as early as possible can lead to better outcomes. Our Pediatric Specialists use innovative approaches that address each child's individual needs, helping them (and you) breathe easier.

Front Range pediatrics patients can now get appointments within 48 hours. Physicians can refer patients by calling our physician line at 1.800.652.9555 or visiting njhealth.org/professionals.



National Jewish Health®

Science Transforming Life®



Pediatric conditions we treat include: Allergies (such as anaphylaxis, drugs, foods, rhinitis, urticaria, and venom), asthma, atopic dermatitis, autoimmune/autoinflammatory diseases, eosinophilic esophagitis, gastroesophageal/laryngopharyngeal reflux, immunodeficiency, pulmonary diseases, recurrent infections, sleep disorders, sinusitis, vasculitis, vocal cord dysfunction, wheezing in infants.

Our services include: Comprehensive food allergy testing/challenge, exercise physiology and lung function testing, genetic and immune function testing for immunodeficiency, neuropsychological testing, sleep disturbance evaluations.

ADVOCACY

President's Report 4
 CEO's Report 5
 CAFP Legislative UPDATE 6
 CAFP on the Go 7
 Advocating for Family Medicine in Colorado..... 8

EDUCATION & PRACTICE ENHANCEMENTS

Update on Adolescent Contraception 10
 Instrumental Swallowing Evaluations in the Pediatric Population 12
 Elevate Your Practice..... 16
 Protecting a Physician's Online Reputation 16
 SNOCAP RECAP 17

Colorado's Most Pressing Family Medicine Issues Will Be Highlighted at the 2016 Annual Summit 18
 Low-Dose CT Scanning for Lung Cancer Screening 20
 Bright by Three 24

HEALTH OF THE PUBLIC

The Importance of the Rotavirus Vaccine..... 26
 Vaccine News You Can Use 28

MEMBERS

A Lifetime Dedication to Care 30
 Better Care and Happy Patients:
 The Reward of Practice Transformation... 31
 Making Care Primary Across the Globe.. 31
 Rural Corner: Teaching the Balance of Life and Medicine 34

Edition 47



pcipublishing.com

Created by Publishing Concepts, Inc.
 David Brown, President • dbrown@pcipublishing.com
For Advertising info contact
 Dustin Doddridge • 1-800-561-4686 ext.106
 ddoddridge@pcipublishing.com

Acceptance of ads does not constitute an endorsement by the CAFP of the service or product.

CAFP Board of Directors

Officers 2015-2016

President & Chair	Glenn Madrid, MD Grand Junction gmadrid@pcpgj.com	Member-at-Large	Brian Hill, MD Castle Pines bhillwv@gmail.com
President-elect	Tamaan Osbourne-Roberts, MD Denver tamaan.osbourne.roberts@gmail.com	External Relations/ Awards Committee chair	Rick Budensiek, DO Greeley rbud5623@hotmail.com
Vice President	Monica Morris, DO Denver mcorrigan@zagmail.gonzaga.edu		
Secretary/ Treasurer	John Cawley, MD Ft. Collins jcawley@afmfc.com		

Board Members

Term Expiring 2016
Michael Archer, MD, Westminster
 marcher@completefamilymed.com

Virginia Richey, MD, Denver
 vlrickey@gmail.com

Wendy Richmond, MD, Pueblo
 wendyalalexandra@hotmail.com

Term Expiring 2017

Anneliese Heckert, DO, Pueblo
 annelieseheckert@centura.org

Term Expiring 2018

Craig Anthony, MD, Denver
 craig.anthony.vcu@gmail.com

Monica Morris, DO, Denver
 mcorrigan@zagmail.gonzaga.edu

Laurie Patton, MD, Parker
 lmpatton@miramont.us

Zach Wachtl, MD, Denver
 zcwachtl@gmail.com

Delegates

Brian Bacak, MD, FAAFP
 Highlands Ranch
 brian.bacak@healthonecares.com
 term expires 2017

Kent Voorhees, MD, FAAFP
 Littleton
 kent.voorhees@ucdenver.edu
 term expires 2016

Alternate Delegates

Rick Budensiek, DO, FAAFP
 rbud5623@aol.com
 Term Expires 2016

Glenn Madrid, MD, Grand Junctions
 gmadrid@pcpgj.com
 term expires 2017

Resident Representatives

Kaitlyn Christopher, MD, Denver
 KaitlynChristopher@centura.org

Christine Horstmeyer, MD, Denver
 ChristineHorstmeyer@centura.org

Brian Juan, MD, Pueblo
 brianjuan@centura.org

Syed Gillani, DO, Pueblo
 docgillani@gmail.com

Aaron Shupp, MD, Pueblo
 aaronshupp@centura.org

Student Representatives

Netana Hotimsky, RVU, grad 2016
 netana.hotimsky@rvu.edu

Maggie Reinsvold, CU, grad 2016
 magdalena.reinsvold@ucdenver.edu

Grace Borton, RVU, grad 2017
 Grace.Borton@rvu.edu

Lindsey Herrera, CU, grad 2018
 lindsey.herrera@ucdenver.edu

Joshua Told, RVU, grad 2017
 Joshua.Told@rvu.edu

Editor

Glenn Madrid, MD
 gmadrid@pcpgj.com

Legislative Committee Chair

Monica Morris, DO
 mcorrigan@zagmail.gonzaga.edu

Tamaan Osbourne-Roberts, MD, Denver
 tamaan.osbourne.roberts@gmail.com

Education Committee Chairs

John Cawley, MD
 jcawley@afmc.com

Monica Morris, DO
 mcorrigan@zagmail.gonzaga.edu

Staff

Raquel Rosen, MA, CAE
 Chief Executive Officer
 raquel@coloradoafp.org

Ryan Biehle
 Director of Policy & Government
 Relations
 ryan@coloradoafp.org

Lynlee Espeseth
 Director of Communications, Marketing &
 Membership
 lynlee@coloradoafp.org

Jeff Thormodsgaard
 Lobbyist
 jeff@precisionpolicygroup.com

Erin Watwood
 Director of Education, Events, &
 Meetings
 erin@coloradoafp.org

Vision Statement:

Thriving Family Physicians creating a healthier Colorado.

Mission Statement:

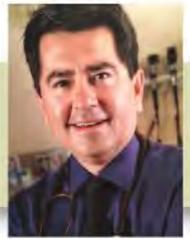
The CAFP's mission is to serve as the bold champion for Colorado's family physicians, patients, and communities through education and advocacy.

Contact Information for the CAFP

Colorado Academy of Family Physicians
 2224 S. Fraser St., Unit 1
 Aurora, CO 80014
 phone 303-696-6655 or 1-800-468-8615
 fax 303-696-7224 e-mail info@coloradoafp.org

PRESIDENT'S REPORT

By: Glenn Madrid, MD



Medicare Access and CHIP Reauthorization Act of 2015, otherwise known as MACRA. The latest acronym that will impact our professional lives. President Obama signed this into law in April of 2015, after the repeal of the Sustainable Growth Rate (SGR) during that same time period. This is new legislation that will transform Medicare physician payment. What is it and why is it important? The standard fee-for-service for our Medicare patients will go away over time. According to AAFP.org, this program establishes the following:

1. Annual positive or flat fee updates for 10 years and a two-tracked fee update afterwards
2. Merit-based Incentive Payment System (MIPS) that consolidates existing Medicare fee-for-service physician incentive programs
3. Pathway for physicians to participate in Alternative Payment Models (APMs), including PCMH
4. Other changes to existing Medicare physician statuses.

I imagine for many if not most of us, this sounds very confusing. Let's compare the two options for physician payment now that SGR is no more.

Alternate Payment Models (APM). A provider (practice) may participate in this model if they meet one of the following criteria:

1. CPCI participating practice
2. Model expanded under CMMI (Center for Medicare and Medicaid Innovation), not including Health Care Innovation Award recipients'
3. Medicare Shared Savings Program ACO
4. Medicare Health Care Quality Demonstration Program or Medicare Acute Care Episode Demonstration Program
5. A demonstration program required by federal law

Those who participate in this model must meet all of the following:

1. Uses quality measures comparable

- to measures under MIPS (see below)
2. Certified EHR user
3. Bear more than "nominal financial risk" or is a PCMH under CMMI
4. Has increasing percentage of payments linked to value through Medicare or all-payer APMs

With this system, the participant receives a lump-sum bonus annually of 5%, beginning in 2019. Thereafter, there will be a transition into payment with more risk but more potential reward.

Merit-Based Incentive Payment System

(MIPS). A professional (physician, PA, APN, clinical nurse specialist, certified registered nurse anesthetist) has this option for 2019 and 2020. After 2020, those who are currently participating in Medicare fee-for-service will be part of this track. The current PQRS (Physician Quality Reporting System), MU (Meaningful Use) and VBPM (Value-Based Payment Modifier) will all be rolled into this system. Each professional

will be assigned a composite score (0-100 scale) based on quality, resource use, clinical practice improvement activities and MU of a certified EHR. This system then allows for baseline payment adjustments depending on the year (see MACRA Physician Payment Timeline table) that can increase, but may decrease depending on the professional's performance. High performers will be eligible for additional payment adjustments.

MACRA started in July of 2015 with a +0.5% baseline update which will be continued in 2017 and 2018. In 2019, as you see in the table, the transformation takes hold. So what will you do? The decision for many of us will be difficult. The APM model, for those that are eligible, may be easier to choose. The Alternative Payment Model may be safer and carry

less risk. However, with the MIPS, greater risk may come with greater reward.

I encourage all Colorado family physicians to educate yourself in more depth. Most of the information above is found in more detail on the AAFP website (AAFP.org).

On a personal note, I want to thank you all for allowing me to serve as your chapter president this year. It has truly been an honor. I have especially been proud to represent the perspective of the full scope family physician (including OB and hospital medicine). My time on the board has allowed me to learn and explore

MACRA | Medicare Access and CHIP Reauthorization Act of 2015
Physician Payment Timeline



2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Anticipated annual baseline payment updates-As provided by MACRA (Note: Updates are cumulative.)									
Jul-Dec +0.5	+0.5%	+0.5%	+0.5%	+0.5%	0%	0%	0%	0%	0%
Current law: PQRS, MU, VBPM									
Penalty up to -0.5%	Penalty up to -5%	Penalty up to -5%	Penalty TBD						
Merit-Based Incentive Payment System (MIPS) Adjustments made on sliding scale based on performance in prior time period TBD									
Baseline payment adjustment*	(-/+) 4%	(-/+) 5%	(-/+) 7%	(-/+) 9%	(-/+) 9%	(-/+) 9%	(-/+) 9%	(-/+) 9%	(-/+) 9%
Maximum payment adjustment for high performers		+12%	+15%	+21%	+27%	+27%	+27%	+27%	+27%
Exceptional performers may be eligible for an additional positive payment adjustment of up to 10%. ⁴									
Alternative Payment Models (APMs) 5% annual bonus – Paid in lump sum Participants are exempt from MIPS.									

Legend
 MU – Meaningful Use
 PQRS – Physician Quality Reporting System
 VBPM – Value-Based Payment Modifier
 RVU – Relative Value Unit

*The projected 0.5% update, established by MACRA, was required due to other legislative provisions. As a result, the 2016 conversion factor will be \$33.89 instead of \$33.53, which is a net reduction of 11 cents per Relative Value Unit (RVU).
¹Lowest quartile performers automatically receive the maximum negative payment adjustment.
²Payment adjustment listed for 2023 through 2024 is an assumption based on currently available information.
³Exceptional performance criteria has not been defined.

the perspectives of all family physicians, regardless of their scope. One of the true beauties of our fine specialty is we have great options to practice. Some of us are office based, others hospitalists, and everything in between. All so very important to our American health system. I encourage you to get involved on the CAFP board. Yes it is work, but with great personal and professional rewards. Lastly, I want to encourage you to attend the Annual Summit at the Cheyenne Mountain resort in April. We will hear more about payment reform and many other important topics relevant to family medicine.

With Gratitude,

CEO's Report

By: Raquel J. Rosen, MA, CAE



Proving the Value of Integrated, High-Quality Care

As you have most likely experienced, getting our larger community on board with integrated, high-quality care can sometimes be an uphill battle. It's always nice, then, where there is proof to back up what we are saying.

The Eugene S. Farley, Jr. Health Policy Center at the University of Colorado Denver recently released an excellent report on the integration of primary care and behavioral health. The report calls on all of us to work towards this integration, as it is a vital piece of giving patients the care they badly need, and reducing the high healthcare costs our country faces. Many recommendations are outlined, including working towards payment systems that support integrated care, engaging our communities around behavioral health issues, and developing educational programs on integrated care for all types of providers.

As the report says, "There should be no 'wrong door' preventing patients from accessing appropriate care. The personal and economic consequences call out for concrete action toward better integration of behavioral health into the health system - beginning with primary care, where patients are likely to seek help first."

I encourage you to read the full report at www.farleyhealthpolicycenter.org/cultureofwholehealth.

A second encouraging report is the Patient-Centered Primary Care Collaborative's (PCPCC) Annual Review of Evidence, 2014-2015. The research found that medical homes are helping to reduce health care costs and/or unnecessary utilizations, like emergency department visits, inpatient hospitalizations and hospital readmissions. Additionally, the more mature a medical home is, the better outcomes they see. The report also details what needs to be done to ensure the PCMH model continues to work not just for patients, but for providers as well. While we know there are benefits to patient care in a PCMH model, questions still exist, particularly when it comes to the best payment strategy.

You can read the full report at www.pcpc.org, under Resources.

Finally, there is proof in the value of high-quality care among our own Colorado members. That is demonstrated very clearly in the winners of the 2016 CAFP Awards.

UCHealth Primary Care- Family Medicine at Lone Tree is our Patient Centered Medical Home Best Practice. They are seeing very positive results after moving to the PCMH model, and have encouraging words for other practices thinking about making the change. Our physician of the year, Dr. Mary Fairbanks, is providing integrated care at InnovAge, giving new opportunities to older patients in-need. Teacher of the Year Dr. Kurt Dallow is helping residents in Greeley explore the full spectrum of family medicine practiced in rural

communities, and Resident of the Year Dr. Michael Matergia is bringing quality care across the globe through his India-based nonprofit.

For those of you working every day to provide better patient care, it's nice to be reminded we are on the right path. I am excited to continue to walk that path with all of you.

On another note, we have noticed a few of you have been missing email messages from us, as they have been filtered into your junk mail. If you wish to stay up-to-date with what we have going on in real-time, be sure to check your junk mail and add our address to your address book!

InnovAge congratulates

DR. MARY FAIRBANKS

2016 CAFP Family Physician of the Year

Dr. Fairbanks is one of the healthcare experts with InnovAge PACE—Program of All-inclusive Care for the Elderly—who provides interdisciplinary and coordinated medical care. InnovAge PACE can be an excellent option for individuals with limited financial resources or declining ability to perform activities of daily living.

Learn more at
MyInnovAge.org or 888.992.4464

innovAge
Life on Your Terms



CAFP Legislative UPDATE

By Ryan Biehle, Director of Policy and Government Relations



From supporting rural medicine, to steering away from a primary care cliff, to ensuring we are moving toward an integrated health care system rather than a fragmented one, this 2016 legislative session has no shortage of proposals impacting Family Medicine.

Fighting for Primary Care

Averting a 23% cut to Medicaid primary care rates continues to be CAFP's number one priority. With 450,000 Coloradans newly signed up on Medicaid, fair reimbursement for primary care is essential to sustaining family practices and ensuring quality care and access for all patients. I liken this proposed cut to something Family Physicians are all too familiar with: The Sustainable Growth Rate (SGR) that plagued Medicare for far too long. With the recently passed MACRA legislation at the federal level (Medicare Access and CHIP Reauthorization Act), the failed SGR is in our rearview mirror. But we are continuing our work to avoid similarly harmful cuts to Medicaid right here in Colorado.

CAFP members have played a large roll in elevating the importance of this issue at the legislature. From hundreds of providers responding to Action Alerts to contact their legislators, to CAFP leaders meeting with their Representatives and Senators at Family Medicine Lobby Day in February, Family physicians have been at the forefront of the fight to preserve primary care.

Of the 6 Joint Budget Committee members, a majority have stated their commitment to finding funds to preserve primary care rates and ensure Family Physicians have the resources needed to provide the best patient care. The budget will not be finalized until mid-April, but we are optimistic

that this issue will be a funding priority and we will be able to avoid such a severe cut.

Supporting Preceptors & Rural Health Care

One of CAFP's priority bills is HB16-1142, which would provide a \$1,000 tax credit for rural preceptors who train our future physicians – Colorado medical students. One of CAFP's own physicians, who trained in Grand Junction and practices in a rural community today, shared her testimony with the Health Committee members: "I spent 6 weeks at the clinic in Telluride, CO and was quickly compelled that being a primary care provider in a remote area of Colorado was what I wanted to do with my career." As you know, students who train in a rural area are much more likely to practice there as well. The bill cleared its first hurdle and passed the House Health Committee by a vote of 10-2. With our state facing a tight budget situation, it is unclear whether the bill will clear the Appropriations committee to get the funding it needs. CAFP continues to collaborate with the Colorado Rural Health Center and Area Health Education Centers to grow support for the bill among legislators.

Pharmacy Collaborative Agreements

What was cause for great concern when drafted, is now a bill that could improve access to treatment for patients. SB16-135 as originally drafted could have removed the physician from the picture of a patient's treatment, jeopardized quality, and fragmented care. Instead, through extensive negotiations by CAFP's President, Legislative Committee and advocacy team, CAFP shaped a measure that preserves the physician-patient relationship while allowing for better continuity in appropriate cases. SB 135 enables experienced pharmacists to enter into a collaborative agreement with a physician to help manage their patients' care. Under a delegated agreement, the pharmacist would now be able to deliver services such as smoking cessation help and travel health services so long as they are able to communicate with the primary care provider and document changes to the patient's medical record.

Funding Proven Contraceptives

CAFP is again part of a broad coalition supporting state funding for family planning services this year. The approximately \$2.5 million proposal is part of the Public Health Department budget, which would go toward funding Long-Acting Reversible Contraception for young women in Colorado. A privately funded pilot has showed a 50% reduction in unwanted pregnancies as well as abortions. This program is a clear-cut way to ensure robust family planning



services that have a profound impact on public health. Thus far, it is included in the budget package and will be funded, barring any amendments when the budget is debated by the full House and Senate.

A Novel Idea: Tax Credit for Unreimbursed Medicaid Expenses

Unlike any idea we've heard elsewhere, Representative Kit Roupe has introduced a

bill that would take a unique approach to supporting physicians who take Medicaid. HB16-1212 would offer a business tax incentive to providers who take Medicaid. Practices could get a tax write-off equal to 50% of the difference between total Medicare and Medicaid payments. CAFPP consulted with Rep. Roupe to craft the language. While the bill's prospects of passage are slim, the state's fiscal analysis will give us a much better understanding

of the total amount of unreimbursed care being provided in Colorado. It will also help bolster our argument that we need adequate provider reimbursements across the board.

In this Spring edition of the legislative update, we cover just some of the hot issues down at the State Capitol. You can always find an up-to-date list of all the bills we're following under the *Current Legislation* page at www.coloradoafp.org.

CAFP ON THE GO



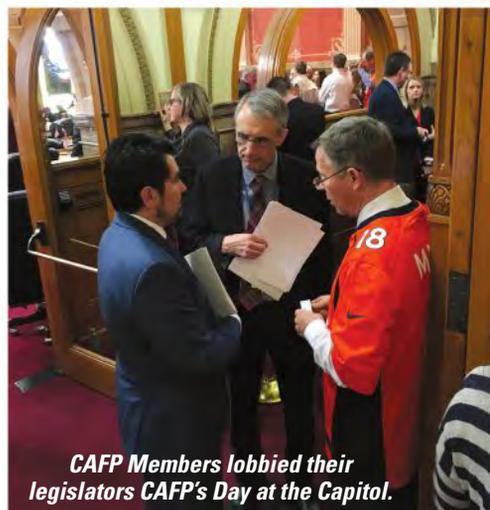
The Aurora Health Access "Access to Specialty Care Taskforce" met at the CAFPP offices in January, with Raquel Rosen and Ryan Biehle in attendance.



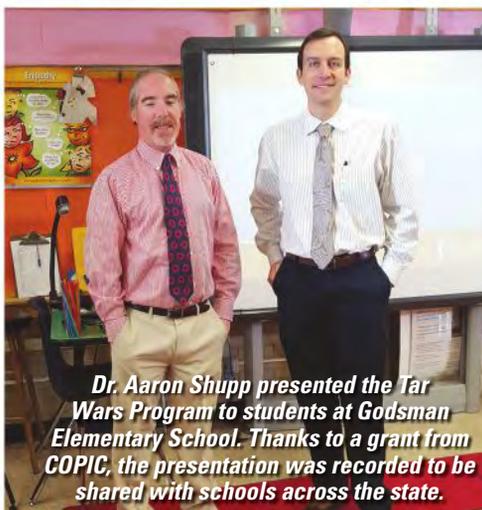
CAFP and Red Rocks Community College are collaborating on a grant that will bring education about the Patient Centered Medical Home to physicians and physician assistant students.



CAFP President-elect Tamaan Osbourne-Roberts sharing best practices at the AAFP Multistate conference in Dallas, Texas.



CAFP Members lobbied their legislators CAFPP's Day at the Capitol.



Dr. Aaron Shupp presented the Tar Wars Program to students at Godsman Elementary School. Thanks to a grant from COPIC, the presentation was recorded to be shared with schools across the state.



Dr. Zach Wachtl testified in front of a Senate committee in favor of Senate bill 27 that would allow Medicaid patients to get prescriptions through the mail.

ADVOCATING FOR FAMILY MEDICINE IN COLORADO

By Alex Sable-Smith, MD, MPH and Stephanie Gold, MD

Only nine percent of University of Colorado medical students chose to go into family medicine in the 2015 match, despite coming from an institution and state with deep historical roots in the field. This statistic led our residency program to form a task force to advocate for family medicine on the CU campus. To figure out why we produce so few medical school graduates going into family medicine, we invited a panel of medical students who have expressed interest in primary care to bring us their feedback.

The students told us that they have inadequate exposure to family doctors in the early, formative years of their medical career. A fourth year student explained she ultimately chose internal medicine in part because she felt she had gotten to know people in the field better. We were informed that there are more students interested in additional family medicine experiences than there are preceptors to mentor them. Medical students considering family medicine also often encounter a “hidden curriculum”: the unspoken, or sometimes explicit, putting-down of primary care.

The good news is that we can have a tremendous impact on future physicians. Positive discourse around family medicine does lead to more graduating students choosing to go into the field (1). A review of studies examining what influences specialty choice amongst medical students supports what we have all experienced; continuity relationships with preceptors who are regarded high-quality teachers have an impact on specialty choice (2). Inspiring role models can counteract the “hidden curriculum” that frequently disparages primary care.

There is a multitude of opportunities where medical students could be exposed to family doctors and we can increase our presence. For example, CU has a longitudinal “Foundations of Doctoring” mentorship program where first year students are paired with a preceptor and spend about 15 clinic sessions with them per year for the first 3 years of medical school. There is a new, student-run free clinic in Aurora, Dedicated to Aurora’s Wellness and Needs (DAWN), that relies on volunteer preceptors, and would be thrilled to welcome new preceptors from the University

Opportunity	Time commitment	Contact
Foundations of Doctoring MS1-MS3	2-3 afternoons per month for the school year (~15 clinic sessions per year)	Foundations.doctoring@ucdenver.edu
DAWN Student-Run Free Clinic	Any number of Tuesday evenings	Dr. Joe Johnson joseph.johnson@dawnclinic.org
Ambulatory Care MS3 Clerkship	Any number of 4-week blocks	Dr. Caroline LeClair caroline.leclair@ucdenver.edu

and community practices. Finally, there is the requisite ambulatory medicine rotation for third year medical students, who work with either family medicine or internal medicine preceptors. These students, with USMLE Step 1 behind them, are looking ahead at their careers and being paired with a passionate, thriving family medicine doctor could make all the difference in their choice to specialize in family medicine.

We were influenced to choose family medicine by the compassion and intelligence of a mentor, the ethos of community engagement, and the relationships we form with our patients. We call on you to engage with Colorado’s medical students to model the traits that make this the best specialty in medicine. Here are some ways you can get involved:

1. Rodríguez, C., López-Roig, S., Pawlikowska, T., et al. (2015). The Influence of Academic Discourses on Medical Students’ Identification With the Discipline of Family Medicine. *Academic Medicine*, 90(5), 660-670.
2. Senf, J. H., Campos-Outcalt, D., & Kutob, R. (2003). Factors Related to the Choice of Family Medicine: A Reassessment and Literature Review. *The Journal of the American Board of Family Medicine*, 16(6), 502-512.

Alex Sable-Smith, MD, MPH is a second-year resident at the University of Colorado Family Medicine Residency. Stephanie Gold, MD is a health policy fellow at the University of Colorado Department of Family Medicine and an incoming member of the CAFP Board.

Leading the future of health care.



FAMILY MEDICINE PHYSICIAN OPPORTUNITIES Northern & Central California

Many organizations have a mission statement; we have a calling: to lead the way to a better future for health care. Through our leadership in the use of advanced technology, our creation of innovative solutions and our influence on health policy and reform efforts, we are shaping the future of health care in the nation. Currently, we have opportunities available for Family Medicine Physicians in Northern and Central California.

FORGIVABLE LOAN PROGRAM - \$150,000-\$200,000 *(based on experience)*

To demonstrate how much we value the role our Primary Care Physicians play, we've created a special incentive just for you. Available exclusively to Internal Medicine and Family Medicine Physicians, the Forgivable Loan Program is just one of many incentives we offer in exchange for your dedication and expertise.

LA SALUD PERMANENTE

At The Permanente Medical Group, Inc. (TPMG), we practice a multi-lingual, culturally inclusive approach to care that celebrates the diversity of our patients and physicians. By developing medical programs that are in tune with every aspect of our patients' lives—from the language they speak to the heritage they embrace—we are actively investing in initiatives and services that reflect the diversity of our member community. Here, our bilingual physicians can act as true advocates for their patients, delivering care that's as medically advanced as it is culturally sensitive. Si su vocación y avocación son una y la misma, please join us today.

TPMG is the largest multi-specialty group practice in the nation with over 9,000 physicians and an over 65-year tradition of providing quality medical care. We offer competitive salaries and a generous benefits package. For further details, please contact Gretchen Miles at Gretchen.H.Miles@kp.org or Aileen Ludlow at Aileen.M.Ludlow@kp.org. You may also call (800) 777-4912. Please visit our website at: <http://physiciancareers-ncal.kp.org>. We are an EOE/AA/M/F/D/V Employer. VEVRAA Federal Contractor.



Update on Adolescent Contraception

Update on Contraception for Teens

By Eliza Buyers, MD, FACOG, Pediatric and Adolescent Gynecology, Children's Hospital Colorado



Family physicians play a pivotal role in counseling adolescent patients about reproductive life planning. An overwhelming 82% of all teen pregnancies are unintended and the majority could be prevented with highly effective contraception. This is one of the many reasons that long-acting, reversible contraception (LARC) is now recommended as the first-line option for teens and young women who want birth control. Available long-acting, reversible methods include the contraceptive implant and various IUD's (Table 1).

Table 1: Overview of Long-Acting Reversible Contraception (LARC)

	Sub-dermal Implant	Intrauterine Devices (IUDs)
Name(s)	Nexplanon®, formerly Implanon®	Levonorgestrel IUDs: Mirena®, Liletta®, Skyla®; Copper T: ParaGard®
Description	Toothpick-sized rod inserted into sub-dermis of upper, inner arm.	T-shaped device inserted into the uterus.
Duration of Use	3 years. Remove anytime.	3, 5 and 10 years. Remove anytime.
Mechanism of Action	Release of etonorgestrel (a progestin) which prevents ovulation.	IUD blocks sperm from reaching fallopian tubes where fertilization occurs.
Non-Contraceptive Benefits	Relief of dysmenorrhea and endometriosis symptoms.	Levonorgestrel IUDs: treatment for menorrhagia, dysmenorrhea, and endometriosis symptoms.
Provider Training	Manufacturer (Merck) provides FDA-required training.	From experienced provider, or contact manufacturer for training information.

The implant is a highly-effective form of reversible contraception and is easy to insert and remove. Potential users should be counseled that there will be a change in their menstrual bleeding. About one-third of users will have amenorrhea, whereas most users will have a more unpredictable bleeding pattern. Teens who do have persistent bleeding with the implant should be reassured that this is an expected side effect and can be offered medical treatment (for example, NSAID's or OCP's). Pre-insertion counseling about the possibility of unpredictable bleeding, and reassurance after the implant is inserted, increase continuation and satisfaction with this method.

There are several IUD's available, all of which are safe for women of any age, including teens and women who have never been pregnant. Dispelling common myths and misperceptions about IUD's is a necessary aspect of contraceptive counseling and results in higher rates of use. (Table 2)

Table 2: Common Topics of Misperceptions about IUD's

Infection	IUD's do not increase the risk of acquiring a sexually transmitted infection (STI) or pelvic inflammatory disease (PID). If STI or PID does occur with an IUD in place, the infection can be treated with the IUD left in situ. Screening for STD's can be at the same time as insertion.
Outdated Restrictions	Women with the following conditions can safely use an IUD: previous ectopic pregnancy, multiple partners, previous STD's, women of any age, women who have never been pregnant.
Outdated Protocols	IUD can be inserted at any time during the menstrual cycle as long as pregnancy can be reasonably excluded (i.e., negative pregnancy test and no unprotected sex in previous 2 weeks, or woman is currently using another effective form of contraception).
Fertility	Previous IUD use has no effect on future fertility. Once removed, immediate return to fertility.
Cost	All insurers, including Medicaid, must cover the cost for contraceptive visits, devices, and surveillance. Uninsured teens, or those who need strict confidentiality, can be referred to Title X family planning clinics that provide free or reduced cost services.
Postpartum insertion	An IUD can be inserted immediately after the delivery of the placenta. An Implant can be placed before discharge home. Both methods are safe for breastfeeding.

Many teens use the implant and the levonorgestrel IUD for their non-contraceptive benefits including reduced bleeding and pain. LARC methods do not contain estrogen and are therefore a safe option for teens that have migraine with aura, or other contraindications to estrogen-containing methods. A landmark study of more than 9,000 women (The CHOICE project, Washington University) showed that when women are counseled on all options for contraception and barriers such as access and cost are removed, 75% will choose a LARC method. Furthermore, implants and IUD's have the highest user satisfaction rates of any method, and continuation rates over double that of pills or Depo-Provera. Table 3 summarizes the major advantages and disadvantages of effective contraceptive methods.

Contraceptive counseling in teens is facilitated by the use of medically, accurate, teen-friendly resources. *How Well Does Birth Control Work?* is an example that can be used for one-on-one counseling and/or hung in the exam room to start a discussion about contraception.

Reproduced with permission from www.bedsider.org.

Finally, many teens and young adults will want to do their own research and have additional questions about contraceptive methods. Table 4 lists two excellent websites for medically accurate information on contraception, STD's, sex and relationships.

HOW WELL DOES BIRTH CONTROL WORK?

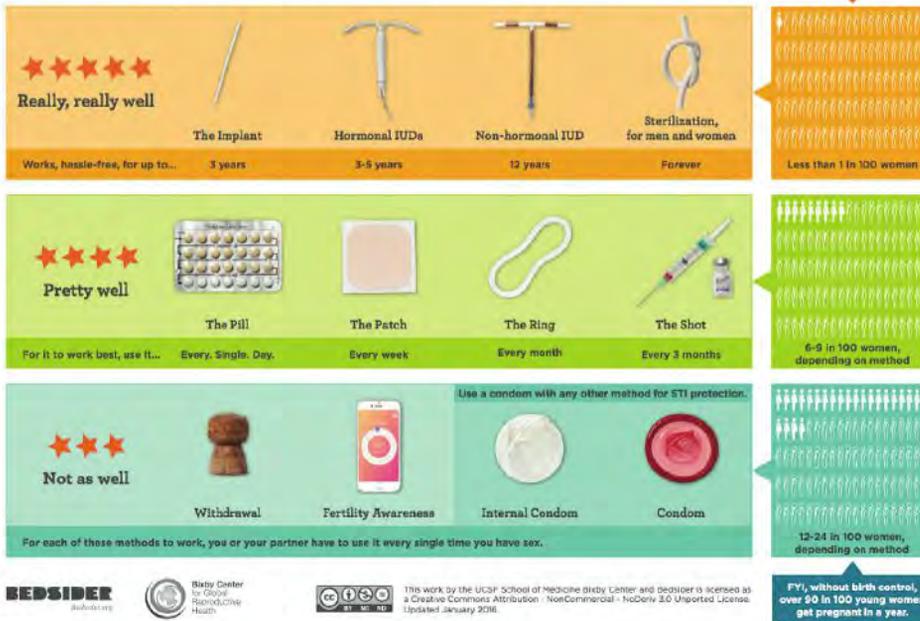


Table 4: Teen-friendly, Medically Accurate Websites on Sexual Health

<p>www.bedsider.org</p> <p>The National Campaign to Prevent Teen Pregnancy's online birth control support network. No funding from pharmaceutical companies.</p> <ul style="list-style-type: none"> • Information and comparison of all contraceptive methods. • Health clinic finder (enter zip code). • Can set up daily, weekly, monthly text message reminders (for short-acting methods).
<p>www.itsyoursexlife.org or www.GYTNOW.org</p> <p>MTV's public health campaign to support young people to make responsible decisions about their sexual health. Also supported by the Kaiser Family Foundation.</p> <ul style="list-style-type: none"> • STI information and prevention. • Talking to partner about STI's. • Links to other trusted sexual health resources including live chat feature.

For questions about “Who to consult” visit our website at www.childrenscolorado.org/departments/adolescent-medicine or call the Adolescent Medicine team at (720) 777-6131 or toll free via One Call at (800) 525-4871.

This article was written by Eliza Buyers, MD, FACOG, Pediatric and Adolescent Gynecology at Children's Hospital Colorado. She can be reached by e-mail at eliza.buyers@childrenscolorado.org.

Table 3: Contraceptive Methods: Advantages and Disadvantages

Advantages	Disadvantages
Sub-dermal Implant (contains no estrogen)	
<p>Highest Efficacy. High satisfaction and continuation. Simple and quick insertion. Discreet. Immediate reversibility. Relief of dysmenorrhea and endometriosis symptoms. No effect on bone density. No adverse affect on acne.</p>	<p>Uterine bleeding, although not dangerous, may be frequent and prolonged. Small percent of users (6-12%) report weight gain, but unclear if due to implant use.</p>
IUD's (contain no estrogen)	
<p>Very high efficacy. Highest satisfaction and continuation of any method. Discreet. Immediate reversibility. (Levonorgestrel IUDs) Treatment for bleeding, dysmenorrhea, anemia due to menorrhagia, and relief of endometriosis symptoms. Safe for almost all teens, including those with complex medical conditions. No medication interactions.</p>	<p>Pelvic exam required for insertion.</p>
Depo Medroxyprogesterone Acetate (contains no estrogen)	
<p>Good Efficacy. Simple and quick injection. Discreet. Relief of dysmenorrhea and endometriosis symptoms. No medication interactions.</p>	<p>Irregular bleeding common in first 3-9 months. Possible increased appetite and associated weight gain Theoretic concerns about bone health with prolonged use. Visit every 11-13 weeks.</p>
Combined Hormonal Contraception: OCP's, Patch, Ring (contain estrogen + progestin)	
<p>Good efficacy when used correctly and consistently. Widespread familiarity. Many non-contraceptive benefits. Easy for user to start (and stop)</p>	<p>Remember each day (pills), week (patch), month (ring) Requires visit to pharmacy for refills Need to store for use</p>



Jennifer Maybee, OTR MA CCC-SLP, Speech-Language Pathologist, Children's Hospital Colorado

Arwen Jackson, MA CCC-SLP, Swallowing Disorders Clinic Team Lead, Children's Hospital Colorado



Instrumental Swallowing Evaluations in the Pediatric Population

Dysphagia, or difficulty swallowing, may be seen in children across the age-span and with a variety of medical conditions, including but not limited to prematurity, Down syndrome, neurological involvement (seizures, cerebral palsy), genetic syndromes involving midline defects, upper airway anomalies (vocal fold paralysis, laryngomalacia), and progressive/degenerative disorders. Dysphagia may also be seen in typically developing children for reasons that are not always easy to identify. In some cases, presenting symptoms of dysphagia are recognizable and children may present with coughing, choking, or red/watering eyes during mealtimes or history of multiple episodes of aspiration pneumonia. In other cases, presenting symptoms are subtle and involve chronic pulmonary problems such as recurrent upper respiratory infections, persistent oxygen requirement, and chronic cough that do not resolve with typical medical treatments. In contrast to the evaluation of oral feeding problems such as difficulty chewing or picky eating, evaluation of swallowing function requires instrumental imaging assessments. Direct imaging of the swallow is necessary because clinical observations of swallowing alone do not reliably predict the presence of swallowing problems such as aspiration of food and liquid.

There are two options for instrumental evaluations of swallowing in the pediatric population, the upright modified barium swallow study (UMBSS), which is known in some facilities as the videofluoroscopic evaluation of swallowing (VFSS), and the fiberoptic endoscopic evaluation of swallowing (FEES). Each exam offers advantages and disadvantages (see Tables 1 and 2) based on patient characteristics, and in some cases both exams

may be beneficial with the same patient to more thoroughly evaluate a complex swallowing problem. The FEES and UMBSS are both functional, real time evaluations with two primary goals. The first is to evaluate the child's baseline swallowing function, including the timeliness of initiation of the swallowing reflex, ability to protect the airway (achieve adequate laryngeal closure and elevation) and ability to completely clear the mouth and pharynx of swallowed food and liquid. The second goal of the FEES and UMBSS is for an appropriate feeding plan to be recommended for the child based on the findings of the exam. A feeding plan may include recommendations for consistency of food/liquid, patient positioning during feeding, and appropriate feeding modalities (cups, nipples, utensils, etc.). In many cases of pediatric dysphagia, the child's family physician is involved in recommending a feeding plan. This is because the evaluation of the risks and benefits of ongoing oral feeding with known potential for aspiration requires in-depth knowledge of the child's medical status and falls beyond the scope of pediatric therapists.

The UMBSS is conducted in radiology under fluoroscopy with a sagittal view of the head and neck (Figure 1). The child is positioned upright, semi-reclined, or in side lying and is offered various liquid and food consistencies mixed with barium contrast. Swallowing is evaluated as the child consumes a barium meal. Adaptations to the consistencies presented (e.g. thickened liquids) and the method of presentation (e.g. slower flowing bottle nipple) are made based on the child's swallowing. For example, thickened liquids may be presented to a child who aspirates on thin liquids during the swallow because

Table 1: Basic Comparison of FEES versus UMBSS/VFSS

	FEES	UMBSS/VFSS
View	View is "top down" (camera generally hovers just above the tip of the epiglottis, can be moved)	View is sideways (sagittal) of head and neck, swallow can be seen from mouth to esophagus
Anatomy	A clear image of the structures of the hypopharynx and larynx can be seen	A broader range of structures can be seen, but with less detail
Contrast	Green/blue dye; Barium may also be used due to its coating properties	Barium
Swallow	View disappears briefly during moment of swallow "white out" - can't detect events during swallow	Comprehensive view of all swallowing phases - oral, pharyngeal, cervical esophageal

thickened liquids move more slowly through the pharynx and allow increased time for airway protection. Team members present may include a speech-language pathologist (interprets the fluoroscopic view or the oral and pharyngeal swallow), an occupational therapist (evaluates oral motor skills and oral sensory processing, supports appropriate positioning, and use functional bottles/cups and utensils), a dietitian (evaluates nutritional status), a radiologist (evaluates oral and pharyngeal anatomy and function radiographically) and a radiology technician (supports radiologist).

Children of all ages are appropriate candidates for the UMBSS and it is typically the preferred exam for initial swallowing evaluations as a view of the oral, pharyngeal, and upper esophageal phases of the swallow can be obtained. In rare cases, children who are obese or children who have large wheelchairs may be difficult to position in the radiology suite. In these cases, adaptive positioning outside of the wheelchair or consideration of an alternate exam (FEES) would be considered. Children who have had multiple UMBSS may also be referred for a FEES evaluation to reduce their radiation exposure risk. Because a child is exposed to radiation during the exam, the UMBSS is time limited and clinicians will often choose to view swallows at the beginning, middle, and end of a feeding with fluoroscopy turned off in between these time periods in order to obtain a representative sample of the child's swallowing over the course of a meal. To optimize participation in the pediatric population, the barium is mixed with preferred liquids and foods and is presented in familiar bottles, cups, or dishes that the parent brings from home. Caregivers may be present during the study and are allowed to feed their child. Typically, a child should be able to consume an ounce of food or liquid by mouth before being referred for an UMBSS.

continued on page 14 >>



University of Colorado
Anschutz Medical Campus
School of Medicine – Department of Family Medicine
University of Colorado Family Medicine Clinics
Senior Instructor/Assistant Professor – Physician

The Department of Family Medicine at the University of Colorado is hiring family physicians!

Our clinical faculty members are recognized for providing innovative, patient-centered care at our Metro Denver clinics, and enjoy flexible scheduling, work-life balance and a dynamic team environment focused on an integrated patient experience. We're currently hiring for our Boulder and Westminster clinics.

ABOUT US:

- Consistently ranked in the Top 10 programs by U.S. World & New Report.
- All practices are certified Patient Centered Medical Homes.
- Innovative research and teaching projects to advance your career.
- Stipends for inpatient call/hospitalist shifts.
- Professional development (CME) allocations and outstanding benefits!

THE JOB:

- Provide full scope family medicine ambulatory care at one of our Metro Denver clinics, seeing patients 32 hours per week, exemplifying the highest standards in patient care as a faculty member of the University of Colorado.
- Take home call ~5 weeks per year.
- Participate in quality improvement and practice transformation projects to enhance patient care and provider/staff satisfaction.
- Educate medical students and residents.

WHAT WE'RE LOOKING FOR:

- Successful candidates will be Board Certified in Family Medicine, with experience practicing the full spectrum of Family Medicine in an ambulatory setting.
- You'll need to be able to obtain a Colorado Medical License and possess a current DEA Certificate, and successfully complete medical staff credentialing at University of Colorado Hospital.
- Additional know-how required includes a demonstrated ability to establish and maintain effective working relationships at all levels of the organization, the ability to work effectively as part of a team, and experience with teaching students and residents.

Interested?
See a full job description and apply online at www.cu.edu/cu-careers or email your CV to brian.bacak@ucdenver.edu

"The University of Colorado Denver and Health Sciences Center requires background investigations for employment."
"The University of Colorado is committed to diversity and equality in education and employment."

<< continued from page 13

Figure 1: View of pharyngeal and laryngeal anatomy using UMBSS/VFSS

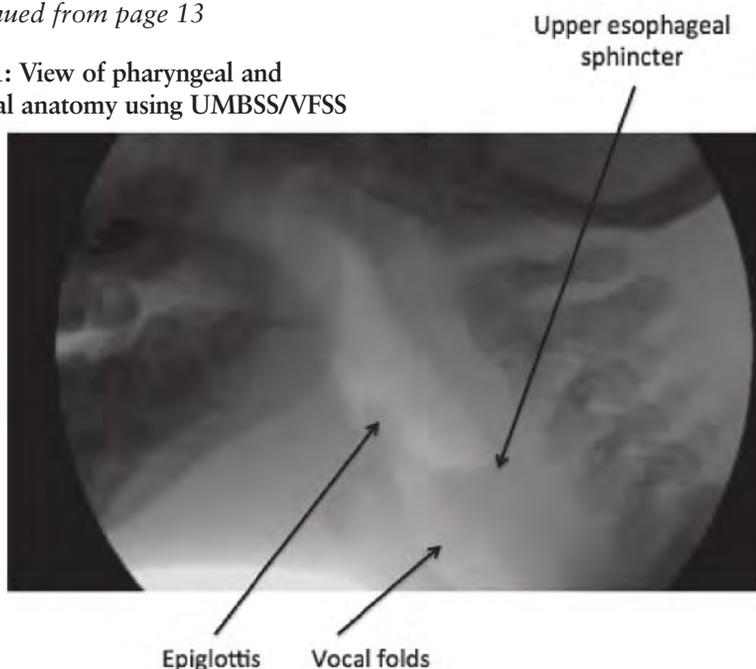
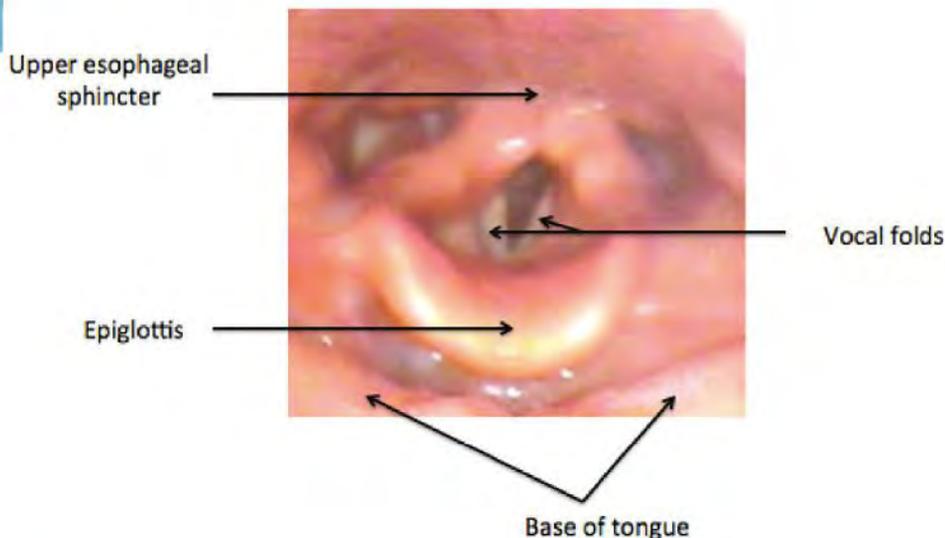


Figure 2: View of pharyngeal and laryngeal anatomy using FEES



The FEES exam is conducted in the otolaryngologist’s office or at the bedside for some inpatients. The child is positioned in an otolaryngology exam chair or in a supportive feeding position in their caregivers lap. A pediatric-sized endoscope is passed through the patient’s nasal passages to the level of pharynx, and the structures of the larynx and pharynx are viewed from above at rest and during swallowing (Figure 2). A small amount of topical nasal anesthetic may be offered for older children. Similar to the UMBSS, adaptations are made to the liquid and food consistencies and methods of presentation throughout the study. Caregivers may be present and are allowed to feed their child. In the FEES, blue or green food coloring is typically used as the contrast agent to enhance visualization of swallowing. Because the endoscopic view using FEES is “top down” and is not a radiographic image, it is possible to evaluate the symmetry, structural integrity, and mobility of the structures of the hypopharynx. Additionally, FEES allows for the assessment of a patient’s ability to swallow secretions. Team members present may include a speech-language pathologist, an occupational therapist, a dietitian, and an otolaryngologist (evaluates oral and pharyngeal anatomy and function endoscopically).

FEES is most often appropriate for children age 12 months and younger and children age 4 years and older

Table 2: Advantages and Disadvantages of FEES and UMBSS/VFSS

FEES Advantages	UMBS Advantages
<ul style="list-style-type: none"> • No radiation exposure • Can evaluate a longer meal if patient tolerates • Ability to examine nasal and pharyngeal structures (e.g. edema) and function (e.g. vocal fold paralysis) • Ability to evaluate small volumes and swallowing of secretions • Ability to easily position in parent/caregiver lap, wheelchair, sidelying 	<ul style="list-style-type: none"> • View of oral, pharyngeal and upper esophageal phases of the swallow • Ability to view depth of laryngeal penetration (predictive of aspiration risk) • Ability to observe nasopharyngeal regurgitation
FEES Disadvantages	UMBS Disadvantages
<ul style="list-style-type: none"> • Comfort/compliance with nasopharyngoscopy • White out during moment of swallow • Inability to view oral phase of swallow • Potential compromise of pharyngeal swallow function with use of topical anesthetic (conflicting findings in literature) 	<ul style="list-style-type: none"> • Radiation exposure • Time constraints due to radiation • Taste of barium • Positioning challenges in radiology suite (e.g. large wheelchairs)

developmentally. In some cases, children in the toddler age-range undergo FEES despite the possibility for poor cooperation due to the potential for valuable insight into their swallowing dysfunction. For toddlers and other children who may have difficulty tolerating the nasopharyngoscopy, supports are put in place to encourage their participation such as involvement of therapeutic recreation professionals, use of one to one behavioral reinforcement, and having comfort items from home at hand. Children who have particular difficulties with participation may benefit from having “practice” sessions before the date of their swallow study. FEES can be used across a range of patient populations, but can be a particularly useful exam for patients with upper airway anomalies such as laryngeal cleft or vocal fold paralysis. It can also be useful for patients with brainstem or cranial nerve involvement due to their potential to have asymmetric pharyngeal function, which can be difficult to appreciate on the sagittal view via UMBSS. Patients who have upper airway anomalies that prevent passage of the endoscope or limit endoscopic view (i.e. choanal atresia, tongue base collapse) are not candidates for FEES. Additionally, patients with significant sensory processing or behavioral challenges may not be able to cooperate adequately to participate and would be most appropriate for a UMBSS. The image quality of FEES makes it possible to evaluate smaller volumes of food and liquid than is possible during UMBSS and a patient does not need to be able to consume a specific amount of food or liquid prior to participating in FEES.

In summary, direct imaging is needed to accurately evaluate swallow function. The UMBSS and FEES are both useful instrumental evaluations of swallowing and each exam

offers benefits to specific patient populations and categories of swallowing dysfunction.

For questions about “Who to consult” visit our website at <http://www.childrenscolorado.org/departments/ears-nose-and-throat/clinics/fees> or call the Feeding and Swallowing team at (720) 777-6168 or toll free via One Call at (800) 525-4871.

This article was written by Jennifer Maybee, OTR MA CCC-SLP, Speech-Language Pathologist, Children’s Hospital Colorado

Arwen Jackson, MA CCC-SLP, Swallowing Disorders Clinic Team Lead, Children’s Hospital Colorado

*The Colorado Department of Public Health and Environment
Retail Marijuana Education Program introduces:*

Marijuana Pediatric

Exposure Prevention and

Pregnancy and Breastfeeding

Clinical Guidance

Evidence-based guidance for Colorado health care providers to talk with patients about marijuana exposure.

Visit Colorado.gov/CDPHE/marijuana-clinical-guidelines for

- Marijuana Pregnancy and Breastfeeding and Pediatric Exposure Prevention Clinical Guidance
- Marijuana Factsheets for Patients
- Marijuana Clinical Guidelines Educational Webcast
- Additional resources for health care professionals



COLORADO
Department of Public
Health & Environment

ELEVATE YOUR PRACTICE:

Multiple Opportunities Available for Grant-Funded Practice Support!

By Kyle Knierim, MD and Allyson Gottsman

As a Colorado family physician, you have the opportunity to participate in two excellent programs that offer grant funded support to help your practice thrive in the evolving world of health care.

EvidenceNOW Southwest (ENSW) is an onsite practice support program that focuses on cardiovascular disease risk mitigation and is available to practices with fewer than 10 providers per practice site. In this program, practices work with a practice facilitator and a Clinical HIT Advisor to develop the infrastructure, roles, and work flow to improve team based care and clinical outcomes around this condition. Practices also build competencies needed for patient centered medical home certification, value based payment, and participation in other program opportunities. The program provides nine months of onsite support addressing workflow analysis, office efficiency, EHR optimization and measures reporting, patient engagement, care management, and coordination. In addition, practices have the opportunity to join their peers in two peer-to-peer collaborative learning sessions to share and learn best practices with other small, independent primary care practices. Maintenance of Certification (MOC) part IV and CMEs are available for participating providers.

TCPi (Transforming Clinical Practice Initiative) is a mostly virtual support program that requires less hours of participation per month but offers support over a longer period of time: up to three years. TCPi specifically addresses the building of infrastructure skills and competencies to prepare for value based compensation including high functioning care teams, efficient workflows, efficient and effective referral processes, and demonstrating the value of care. Over the period of three years, practices will work with a facilitated peer learning community, led by practice facilitators with access to expert faculty. Expert

faculty will provide training in specific content areas including leadership development and effective business processes needed for value based payment. Because TCPi also includes specialists, this program lends itself well to developing well-coordinated medical neighborhoods, which will be essential in new models of compensation where compensation will correlate to quality and total cost of care. The program offers preparation for understanding and succeeding in the sweeping changes in Medicare compensation models of MACRA: Medicare Access and CHIP Reauthorization Act. Maintenance of Certification (MOC) part IV and CMEs are available for participating providers.

The American Board of Family Medicine is funded to support family physicians engaged in TCPi and have made the outstanding offer of 3 years use of PRIME Registry at no cost to the first 6,000 participating board-certified family physicians. PRIME Registry enables users to easily extract data from their EHRs to execute population management, identify gaps in care, facilitate measures reporting, report PQRS measures, and earn maintenance of certification part IV credit. For more information, visit <https://www.theabfm.org/primeregistry/>.

Applications are now being accepted for EvidenceNOW SW and TCPi. Interested practices may enroll in one or both of these programs. Both programs are an excellent opportunity to prepare for participation in SIM (State Innovation Model, www.practiceinnovationco.org/sim/) which focuses on behavioral health integration into primary care and requires practices have experience with practice transformation such as in ENSW and TCPi.

To apply or learn more about either program, contact Allyson Gottsman at Allyson.Gottsman@UCDenver.edu or 303-724-8968, or visit www.practiceinnovationsco.org.

Protecting a Physician's Online Reputation

Protect Your Online Reputation

By Dean McConnell, JD, Senior Legal Counsel
COPIC Legal Department

Patient complaints often share one common denominator: a breakdown in the physician-patient relationship. When the breakdown is more business oriented, a negative online comment can occur. The best options, therefore, for protecting your online reputation should be directed at repairing and preserving relationships with your patients.

Ignoring a negative comment looks like you do not care or agree the comment is valid. Hiding or removing negative reviews may result in a re-post of the comment on multiple sites, pointing out your efforts to "hide the truth." Attacking the commenter is dangerous and often

results in more malicious or derisive comments.

What should a doctor do, then? Recognize that you have an unhappy patient. Respond to the complaint in a positive manner. React based on a full and objective assessment of the situation.

Recognizing that the patient is unhappy is difficult when you are feeling attacked. Negative comments invoke defensive reactions and fears that the physician's reputation and practice may be seriously harmed. Despite these normal reactions, the patient's concerns must be addressed in a professional and appropriate manner. Whether the patient's complaints are justified or not, the patient is unhappy

enough to make his or her complaints known to the world at large. Remember that this is only one of many patients in the practice, most of whom are very happy. While action is often prudent, it needs to be measured and appropriate to the context.

Acknowledge that the patient is not satisfied, that patient satisfaction is important, and ask to take the conversation offline to address the issue. The written response should be tailored to the specific complaint. If a patient is unhappy about waiting too long for an appointment, an appropriate response might be: "Thank you for taking the time to comment. While we try to respect each patient's time, sometimes the number of people who need our help causes unexpected delays, especially when emergencies arise. If there is anything we can do, please give us a call at the office. Your satisfaction is important to us." If the patient does not call, contact him or her. People will often say things online that they would never say face-to-face. A phone call provides a better chance of connecting with the patient and solving the problem. Before responding, cool off. Let it sit overnight and ask a trusted colleague to review it before posting. Also, be careful about HIPAA. Do not include treatment or payment information or provide patient names or identifying information in your response.

Sometimes patients are right. Maybe the physician was just having a bad day. An explanation and an apology is usually all that it takes to resolve this situation. Maybe the payment policy

for "no shows" should not be absolute and it can be waived for the mom who missed her appointment because she had to pick up her sick kid from school. Maybe the problem really is a rude front desk person and corrective action should be taken. Take this opportunity to evaluate the practice and improve it.

Sometimes patients are wrong. Nevertheless, they are still patients. Maybe they were having a bad day. Maybe this patient is just not the right fit for your practice and you can provide them with a referral to a colleague that might be a better fit. In resolving these issues, communication with the patient is critical. Try to understand the situation from their perspective and consider whether there is some concession you can live with. Perhaps an explanation of how "no shows" affect the practice, a one-time waiver of the fee, and a clear explanation that future "no shows" will be charged. A good, long-term patient might be saved for the price of an office visit. Patients who have been heard will sometimes remove their own negative comment or, better yet, post a positive one extolling how the doctor cares about patients and was willing to listen and address the problem.

Build a following of good patients online. Post a short blog on a health topic of interest. Ask patients to post reviews. These activities build a positive presence online. A negative comment will look like an outlier and provoke positive responses from your followers. For the most serious violations, and as the last resort, consult an attorney about bringing a defamation claim.

By Don Nease, Jodi Holtrop, and Mary Wold
SNOCAP Director, Co-Director and Project Coordinator

SNOCAP RECAP

Greetings from your SNOCAP practice-based research team!

NAPCRG Conference

NAPCRG is coming to Colorado this November! What's a NAPCRG and should we be stocking up on supplies you may be asking? NAPCRG stands for the North American Primary Care Research Group, and their annual meeting is the place where primary care research from not just North America, but increasingly all over the world, gets presented and discussed. Much of this research involves work done in practices like yours. In fact, you can count on the fact that a good deal of Colorado research will be presented. Last year our CU team had over 50 presentations, posters and workshops. Most importantly, NAPCRG isn't just for lofty academic discussions, there is a very strong group of folks in full time primary care who attend and keep the rest of us grounded. In fact, even patients are attending these days. In recognition of that, NAPCRG now includes a patient/community member on its Board, and the first person to hold that honor is our own Maret Felzien from Sterling, Colorado!

We'd really like to have a strong showing from our Colorado practices and patients. The conference will be held November 12-16, 2016 at the Broadmoor in Colorado Springs. We are planning to offer some support for folks from our practices to attend. If you think you might be interested, please let us know by emailing Mary Wold, MPH, our coordinator, at mary.wold@ucdenver.edu. You can find out more at: <http://napcr.org>.

Chronic Pain and Opioid Use Disorder

Chronic pain and Opioid Use Disorder are hot topics on the

national scene, and our Colorado practices have been telling us for several years that these are hot topics here as well. We've heard you and are involved in multiple projects and proposals on these topics. First, with support from the Patient Centered Outcomes Research Institute, we've been interviewing and learning from patients who are successfully managing their chronic pain. The interview data is being analyzed by our team and also being examined by our CaReNet Patient Advisory Council using the Boot Camp Translation process. We hope to create messages and materials that can be used in your practices with patients struggling with chronic pain. Second, Jack Westfall is leading a grant proposal to make available two innovative strategies for implementing Medication Assisted Treatment in rural Colorado. The project, if funded, will start in the Fall in the High Plains Research Network and the San Luis Valley region of CaReNet. Next, we are participating in a large, multistate proposal to test clinician and patient education around non-cancer chronic pain. This will involve a combination of web-based and on-site training for practices and patients. This project, if funded, will involve practices in two of our practice-based research networks: BIGHORN and CaReNet. We will continue to keep you posted on these efforts!

ECER Conference

The Engaging Communities in Education and Research (ECER) Conference will be held October 14-16, 2016 in Breckenridge. While still in the planning phases, we are excited to be part of this multidisciplinary event! We will provide details in the next newsletter.

Refresh, Recharge, Reboot

Colorado's Most Pressing Family Medicine Issues Will Be Highlighted at the 2016 Annual Summit

Family physicians in Colorado have no shortage of important issues affecting their practices. At this year's Annual Summit (formerly Annual Scientific Conference), running from Thursday, April 14 to Sunday, April 17 at the Cheyenne Mountain Conference Center in Colorado Springs, attendees can expect highlights on all those issues and more.

Thursday, April 14

Looking for extra CME, or need to take DOT Medical Examiner Training or American Heart Association Classes? Join us on Thursday for a full day of preconference sessions. Of special note, we are offering Fit Family Challenge training from 8:00 a.m. to 4:30 p.m. This excellent training will build the skills you need to discuss childhood obesity with patients, and help entire families get fit.

We will finish out the day with a welcome reception from 5 p.m. to 6 p.m. followed by a unique CME offering that will explore the social determinants of health, presented by Kaiser Permanente Colorado and the Colorado Coalition for the Medically Underserved.

Friday, April 15

Friday kicks off the first day of the regular conference, and is filled with CME. In the morning learn more about the ongoing opioid problem, as well as an introduction to Suboxone and Suboxone licensure. Colorado physician Dr. Steven Wright will join us for a discussion on marijuana, and a medical marijuana patient and business owner will be available for a Q & A session. In the afternoon the first of two half-days of infoPOEMs will be presented, and the day will wrap up with the popular seafood dinner. Don't forget, Friday is also your day to visit exhibitors!

Saturday, April 16

The final half-day of infoPOEMs will finish up in the morning, followed by three concurrent sessions to choose from: Nexplanon Training, Transgender Medicine for the Primary Care Provider, and Hepatitis C in Colorado. More CME is available in the late afternoon, and everyone is welcome to join us for the family friendly dinner with entertainment by CAFP's own resident member Dr. Brian Juan.

Sunday, April 17

The final day of the summit includes many exciting sessions, including "The MAGIC of Family Medicine" presented by Walt Larimore, MD and a debate on Amendment #69, the proposed single payer health plan for Colorado, also known as ColoradoCare. Speaking in favor of the amendment will be Senator Dr. Irene Aguilar, one of the main advocates behind the amendment. Speaking in opposition will be CAFP member Dr. Tom Jeffers.

Extras

There is plenty of extra fun to be had at the summit for both you and your guests and family members. If you are bringing children with you, take advantage of free passes to the Cheyenne Mountain Zoo. Relax in the newly completed spa at the conference center (attendees receive 15% off services) or take advantage of nearby hiking and biking. Meals on Friday and Saturday, as well as the Thursday welcome reception and Sunday breakfast are included in your registration.

Register Now!

There is still time to take advantage of early registration rates. Prefer to plan last minute? No problem! You can register on-site for the full conference, a single day, or a single class. Visit www.coloradoafp.org/summit to learn more.



BACK IN MOTION.

Everyday mobility and function is critical to quality of life. At University of Colorado Hospital's Orthopedics Department, your patients can expect timely appointments and access to our fellowship-trained physicians whose highly specialized knowledge allows more accurate diagnosis and treatment. From head to toe, we help hundreds of patients each year by reducing pain and regaining function while delivering award-winning care.

For a consult, transfer or direct admit, please call DocLine toll-free at **1.844.285.4555**. To refer a patient to one of our clinics, please contact the preferred clinic directly.



**University of
Colorado Hospital**
UNIVERSITY OF COLORADO HEALTH



Orthopedics
UNIVERSITY OF COLORADO

Aurora/Anschutz Medical Campus • Boulder • Denver/Cherry Creek
Denver/Lowry • Lone Tree



Brought to you by the Orthopedics Department
at University of Colorado Hospital—

RANKED #1 IN COLORADO.

Proud to be ranked among 5280's Top Docs.

Low-Dose CT Scanning for Lung Cancer Screening: A Primer for Primary Care Practitioners

The Importance of Lung Cancer Screening in High-Risk Individuals

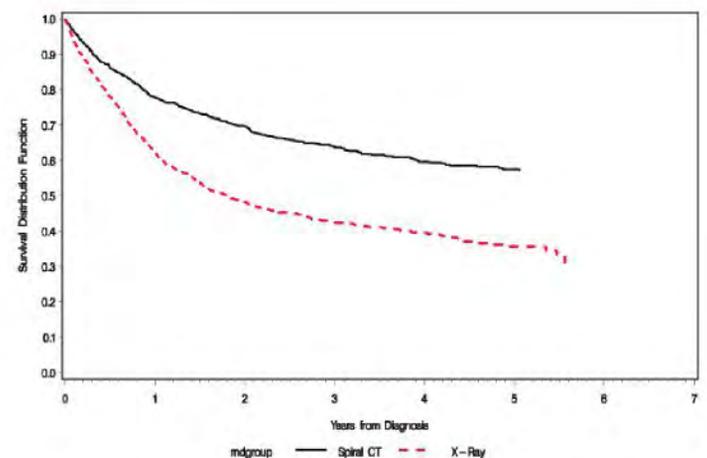
By Timothy C. Kennedy, M.D., F.A.C.C.P.
James Fenton, M.D., F.A.C.C.P.
Members of the Colorado Lung Cancer Task Force

In 2016, 158,080 Americans are expected to die from lung cancer. Lung cancer is responsible for more cancer deaths than breast, prostate and colon cancer *combined*. It represents the number one cause of cancer death in both men and woman, surpassing breast cancer 20 years ago. In Colorado, 2,540 new cases of lung cancer are expected this year with 1,690 expected to die of the disease. Clinical outcomes for non-small cell lung cancer is variable and directly related to the stage at the time of diagnosis as well as variable biologic aggressiveness. If lung cancer is found at an early stage, the 5 year survival rate is 50-80%, but if found at an advanced stage, the 5 year survival rate is only 5-15%. Early detection is clearly important to help decrease mortality.

Previous efforts to develop effective lung cancer screening methods were ineffective. In the 1970s and 1980s 3 major studies showed no benefit to chest x-rays and sputum cytology. By the early 1990s, however, it became clear that CT scans were much more sensitive than plain chest films in discovering small tumors in the lungs, detecting 3x the number of lesions compared to CXR. This realization led to a large NCI sponsored study (National Lung Cancer Screening Trial-NLST), which used annual chest CT, scans to detect nodules. The study published in the *New England Journal of Medicine* in 2011 showed a 20% reduction in disease specific mortality for high-risk individuals defined as adults ages 55-77 who have smoked at least 30 pack-years, and are current smokers or stopped smoking within the last 15 years. This is the largest reduction of mortality in the history of treatment of solid tumors and it takes only 320 screenings to save one life from lung cancer. This compares to 900-1900 mammograms needed to save one life from breast cancer or 500 colonoscopies to save a life from colon cancer.

The results of the National Lung Screening Trial triggered great excitement, substantially resolving a 50-year debate over whether early detection of lung cancer was even possible. It showed that it was useful to improve the care of patients at high-risk for lung cancer due to smoking and age. The robust design by the study planners sought to address criticisms of past studies because it was a randomized, prospective, controlled study of 55,000 patients performed in multiple sites around the country. It also had a six-year follow-up period, and used three serial annual low-dose CT screenings at centers structurally organized to provide comprehensive lung cancer care. The control patients were offered 3 annual chest x-rays, which had been previously shown to be of no benefit. This was done to reduce “control contamination” which could occur if controls were motivated to get CT scans on their own. A LDCT scan is reimbursed by Medicare at the approximate price of a mammogram. Below are the comparative survival curves in the NLST.

It is estimated that 18 million Americans, about 30% of the US population 50 to 64 years of age, with at least 30 pack-years of smoking history, fall into the high-risk



Why CT is better than plain films



group targeted for CT screening. An analysis by Bruce S. Pyenson and colleagues at the New York office of Milliman, an actuarial and consulting firm in Seattle, predicted that annual screening for the 18 million high-risk Americans could prevent 130,000 deaths during the first 15 years of its application.

As a result, the US Preventive Services Task Force now recommends annual screening of patients with a 30 pack-year smoking history who are either current smokers or who have stopped within the last 15 years, and who are 55-80 years old. This mandates screening without co-pay for all patients including those going through exchanges under

Low Dose Chest CT comparative doses

Exam Type	Dose
PACXR	.02mSv
Screening mammogram	4 mSv
L spine xray 5 view	1.2mSv
Low Dose Chest CT	1.5mSv
1 yr Background radiation in Denver	3mSv
Routine Chest CT	8mSv

the Affordable Care Act. CMS has now authorized screening without a co-pay for Medicare and Medicaid recipients with the same criteria but only age 55-77 years. Estimates of cost effectiveness vary but range between \$19,000 and \$81,000 per year. With the escalating costs of treatment of advanced disease in unscreened patients, the cost benefit for lung cancer screening is likely to improve over time.

In screening studies, 55-85% of cancers are diagnosed at Stage I on a baseline study and 60-100% are Stage I if detected on a follow up screening study. This compares to only 16% when diagnosed by routine clinical care because many patients are not symptomatic until later stages. Lung cancer screenings by low dose CT scans impact mortality by shifting detection to an earlier stage.

Finally, we have a simple, effective tool to screen for lung cancer early and truly make a preventative impact for our high-risk patients. This good news, however, comes with important concerns and regulatory restrictions. 24% of patients screened were found to have imaged lesions that were possibly malignant, yet 95% of those lesions were benign. In the NLST study, 24% of the patients going to surgery were found to have benign disease. Other published studies of screening ranged from 18-30% incidence of benign resection. A more recent community based study was found to have a 35% incidence of benign resection. Even in an age of more sophisticated, more limited resection, surgical mortality is still about 1%, so limiting futile resections is important.

Concerns have also been raised

continued on page 22 >>

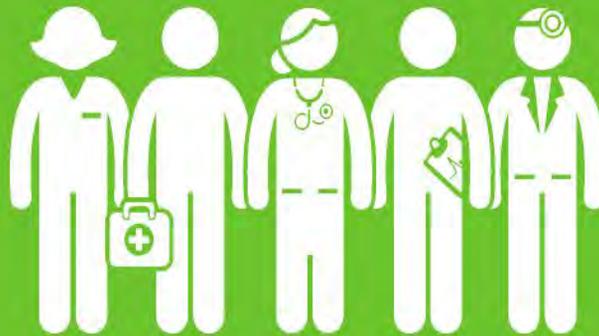
Colorado Physician Health Program

...because

Healthy Doctors Give Better Care

The Colorado Physician Health Program (CPHP) has been serving Colorado physicians and physicians assistants with all health conditions, from medical problems to situational issues, including stress and burn-out, since 1986. If you, or a colleague should need assistance visit our website at www.cphp.org or call us at (303) 860-0122 to get assistance today.

TEAMS WORK



WHERE HEALTH IS PRIMARY.



In primary care, teams of health professionals provide patients what they need when they need it in a coordinated setting.

Family doctors work closely with team members to keep their patients healthy.

Let's make health primary in America.

Learn more at healthisprimary.org.

Brought to you by
America's Family Physicians



#MakeHealthPrimary

about the risks of annual radiation exposure. These are more concerning in younger patients (<age 40) and those who have already had a lot of radiation in the past. Nevertheless, the net benefit (based on NLST results) is that the survival benefit substantially outweighs the radiation risk in this defined group of high-risk patients. Comparative radiation exposure doses are shown on previous page.

All these concerns led to the USPSTF to give LDCT screening a B recommendation, mandating that screening only be performed by medical centers organized into a multi-disciplined, structured program for screening, as opposed to having a caregiver order a LDCT from their nearest imaging center. NCCN guidelines in 2012 state: “Lung cancer screening with CT should be part of a program of care and should not be performed in isolation as a free standing test or series of tests.”

CMS also mandated that all participating programs enter their screening patients into a qualified national registry and that the caregiver document a face to face discussion with each enrolling patient spelling out the risks as well as benefits of screening called “shared decision making,” similar to “informed consent.” This is considered a 15 minute discussion and is given the CPT Code G0296. It can be added to a same visit E&M code with (-25). The CPT code for the test itself is G0297, and ICD code is Z87.891.

The order should include the word “screening” and no symptoms for lung cancer (e.g. hemoptysis, weight loss) should be on the order. If a diagnosis is required, use disease diagnosis codes such as COPD or chronic bronchitis rather than symptoms. If the patients have symptoms or suspicions of lung cancer, then a diagnostic CT scan should be ordered, not a screening CT scan. The order for screening should include the age and the smoking history in pack-years and the statement that patient is either a current smoker or stopped less than 15 years ago.

Screening may not be appropriate for patients with substantial comorbid conditions (severe COPD, CHF, peripheral vascular disease, renal insufficiency etc.), particularly if the patient is in the upper end of the screening age range. Persons with serious comorbid conditions may

Category Descriptor	Category Descriptor	Primary Category	Management
Incomplete	-	0	Additional lung cancer screening CT images and/or comparison to prior chest CT examinations is needed
Negative	No nodules & definitely benign nodules	1	Continue annual screening with LDCT in 12 months
Benign Appearance or Behavior	Nodules with a very low likelihood of becoming a clinically active cancer due to size or lack of growth	2	
Probably benign	Probably benign finding(s) - short term follow up suggested; includes nodules with a low likelihood of becoming a clinically active cancer	3	6 month LDCT
Suspicious	Findings for which additional diagnostic testing and/or tissue sampling is recommended	4A	3 month LDCT; PET/CT may be used when there is a ≥ 8 mm solid component
		4B	chest CT with or without contrast, PET/CT and/or tissue sampling depending on the probability of malignancy and comorbidities. PET/CT may be used when there is a ≥ 8 mm solid component.

<http://www.acr.org/Quality-Safety/Resources/LungRADS>

experience net harm, no net benefit, or at least substantially less net benefit. Persons who are unwilling to have curative lung surgery are also unlikely to benefit from a screening program. Mild COPD would not undermine the benefit of screening and in fact, doubles the risk of lung cancer.

The main method for reducing unnecessary invasive procedures or surgery is use of algorithms to determine sequential LDCT follow-up intervals in order to determine growth of suspicious lesions. Radiologists in qualified programs use standardized language to describe lesions and determine the appropriate next step. The most commonly used format is the American College of Radiology LungRADS system which is similar to Bi-RADS used in mammograms. Above are the LungRADS Category descriptors and associated management recommendations.

Comprehensive screening programs are usually associated with a nodule clinic or a multidisciplinary conference to help evaluate management options in accordance with various guidelines. Also, most programs have a nurse navigator to guide the patient through the process and provide support to the imaging centers and treating physicians.

Medicare has mandated that smoking cessation efforts be included with a screening program. In 1965, 46% of adults smoked. Now only 18% of people smoke.

55% of people who ever smoked have now stopped smoking. It is important that caregivers do not ask “Do you smoke?” but rather, “Have you ever smoked?” If “Yes,” then determine pack-years, “current” or “stopped” and “when stopped.” Recent studies have shown that an additional 20% drop in mortality can be seen in screening programs in patients who have recently quit or quit at the start of the program. This results in a total 40% drop in mortality.

Caregivers should familiarize themselves with qualified screening programs available in their area. Some free-standing imaging centers may create a relationship with a qualified center in order to provide patients with this service. Referring patients to a lung cancer screening program is a 3-way partnership between the primary care provider, the patient, and the institution, so the methods of communication between all partners should be clear and effective. Nurse navigators may facilitate the communication of results and future ordering but a reliable tickler file is crucial so that nodule follow up is done as recommended.

Chest CT screening should be a part of a preventative health maintenance discussion in appropriate high-risk individuals. It is a proven way to decrease mortality and begin to make an impact on this deadliest of cancers.



Peer Assistance Services

Substance use is part of overall health. If you don't ask, you won't know.



**Treat
substance
use like the
healthcare
issue it is.**

Unhealthy alcohol use is a major contributor to the global burden of disease and injury. The U.S. Preventive Services Task Force has recommended alcohol screening and intervention in general medical settings since 2004. Despite this, only 1 in 6 adults has ever talked with a health professional about alcohol. Having a conversation about substance use only takes a few minutes, but can make a lasting difference in a patient's life.

Call 303.369.0039 x245 or email SBIRTinfo@PeerAssist.org to learn more about substance use screening, brief intervention, and referral to treatment (SBIRT) training opportunities for physicians and clinical staff.



COLORADO
Office of Behavioral Health
Department of Human Services



Working with Colorado Physicians to Engage Millennial Parents and Caregivers to Support Early Cognitive and Social-Emotional Development

By Jennifer Cajina Grigsby

Bright by Three (formerly Bright Beginnings) is an education and resource-awareness program offered free of charge to every Colorado parent and caregiver of children aged prenatal to three years. Our network of over one hundred partners across the state help introduce patients and communities to our program; either by sharing a kit of materials and activities or by simply encouraging patients to sign up for Bright by Text messages by texting “Bright” to 444999. Many of our partner organizations, including Nurse Family Partnership, WIC, Baby Bear Hugs, and others have integrated our kit of materials into biweekly or monthly programming.

Founded in 1995 by a public and private partnership between Brad Butler, former Chairman of the Board of Procter & Gamble, and then-Governor Roy Romer, Bright by Three’s core program was created by Steve Berman, MD and Bonnie Camp, MD, and influenced by the work of Hart and Risley, the Perry Preschool Project, the Carolina Abecedarian Project, and others.

Dr. Berman is a Professor of Pediatrics at the

the University of Colorado School of Medicine. Both doctors continue to advise and research the Bright by Three program.

Bright by Three was originally intended to welcome newborns into the community via a one-time visit now known as Part A (prenatal-12 months). As Parts B (12-24 months) and C (24-36 months) were developed, the program evolved into a three-year series of annual home and clinic visits. Today, the program helps parents and caregivers provide the best possible start for children with the addition of text messages, emails, and phone follow-up to share age-appropriate tips and other information, significantly increasing the dosage and scalability of Bright by Three.

Our programming is both complimentary to other early childhood programs and easy to integrate into busy clinical environments. Bright by Three has a number of resources for clinicians, including posters for waiting rooms, postcard handouts, bookmarks, and informational brochures to help healthcare partners introduce their patients to the fun and

Our programming is both complimentary to other early childhood programs and easy to integrate into busy clinical environments. Bright by Three has a number of resources for clinicians, including posters for waiting rooms, postcard handouts, bookmarks, and informational brochures to help healthcare partners introduce their patients to the fun and informative program materials that will correspond to their children’s stage of development for years to come.

University of Colorado School of Medicine, head of Primary Care Pediatrics at the Children’s Hospital in Denver, Director of the Children’s Outcomes Research Center, and a former President of the American Academy of Pediatrics. Dr. Camp is best known for her development of the Think Aloud Program, a cognitive behavior modification program designed to improve social and cognitive problem-solving skills in young children. She is currently professor emeritus of pediatrics and psychiatry at

informative program materials that will correspond to their children’s stage of development for years to come.

To discuss how Bright by Three can help you support the cognitive and social emotional development of your patients and families at no cost, contact Jennifer Cajina Grigsby, Program Coordinator, at jennifer@bb3.org or (719) 695-8552.

WE'RE CHANGING THE GAME in heart care



UCHealth is the only system in the state to offer the WATCHMAN™ Device

Reduce the risk of stroke without anticoagulants

Now your non-valvular atrial fibrillation patients have an alternative to long-term warfarin therapy for stroke risk reduction with the WATCHMAN Device, only offered at UCHealth.

Call to refer

Medical Center of the Rockies
Loveland

970.460.2255

University of Colorado Hospital
Aurora

720.709.2996



uhealth.org/watchman-implant

The Importance of the Rotavirus Vaccine

Reginald Finger, MD, MPH

In the last several years, vaccines targeting measles, pertussis, influenza, meningococcal meningitis, polio and human papillomavirus (HPV) have gotten most of the attention in the world of immunizations and vaccine preventable disease control, and rightly so. Meanwhile, another vaccine, a relative newcomer to the immunization schedule, has quietly been busy preventing millions of illnesses, thousands of hospitalizations, and dozens of deaths.

Colorado Children's Immunization Coalition. We had our work cut out for us to reassure the public of the safety of any vaccine.

Before I move on to the subsequent history of rotavirus vaccines, it is worth pausing to note that both these events, the suspension of rotavirus vaccine in particular, testify to the diligence in assuring vaccine safety exercised by the public health agencies in this country. Vaccine manufacturers, the FDA, the CDC, and the broader public health

I was on the Advisory Committee for Immunization Practices (ACIP) and had the opportunity to review vaccine safety concerns from a much closer vantage point.

Our committee diligently checked out the new rotavirus vaccine to be well assured that the previous problems would not recur. (tinyurl.com/ygcxm4u) Experience since then with RotaTeq® and with Rotarix® (licensed in 2008) has confirmed the validity of our judgment. As vaccine uptake has increased over the past ten years, rotavirus vaccines have reduced hospitalizations from rotavirus-associated diarrhea among infants by about two thirds. (tinyurl.com/zflr5wv)

The vaccine is given as a series of two oral doses (Rotarix®) or three oral doses (RotaTeq®) at two and four, or two, four, and six months. (tinyurl.com/ygcxm4u) Because this vaccine is designed to make an impact in infancy and not many years later, the doses must be started and finished within a narrow window. After four months of age, it is too late to start the series, and after eight months, it is too late to finish.

Fortunately, almost all young infants are seen at least this frequently by physicians and public health clinics. Rotavirus vaccine, an oral preparation, does not add an additional needle stick to the schedule. For these reasons, I see no legitimate reason why rotavirus vaccine coverages should have lagged behind other vaccines and currently sit at 72 percent in the latest available national report. (tinyurl.com/z3jyr89)

I urge any medical professional who cares for infants to consistently administer the recommended rotavirus vaccine. Hopefully we can dent the remaining one-third of this serious disease among our littlest ones.

Rotavirus vaccine, an oral preparation, does not add an additional needle stick to the schedule. For these reasons, I see no legitimate reason why rotavirus vaccine coverages should have lagged behind other vaccines and currently sit at 72 percent in the latest available national report.

Those of us involved with health care (especially public health or health care for children) in the 1990s remember July 1999 as an especially unfortunate month. The thimerosal (ethyl mercury) controversy came to a head at that time, prompting the U.S. Public Health Service and the American Academy of Pediatrics to recommend removal of thimerosal from vaccines. (tinyurl.com/6qy7je3)

That same month, the newly introduced rotavirus vaccine came under fire because careful surveillance of vaccine adverse events revealed an excess of intestinal intussusception cases in infants who had received the vaccine. This vaccine (Rotashield®) was taken off the immunization schedule and removed from the market. (tinyurl.com/zlpb29v)

I was in charge of immunizations at the El Paso County Health Department at the time, and on the

and medical care systems take a lot of heat as we administer and advocate for vaccines. Many in the general public and in the anti-vaccine community in particular, suspicious both of the scientific imperative and of profit motives in the industry, believe that the system cannot be trusted to protect people from harms caused by vaccines. The swift action on rotavirus in 1999 was one major development that assured me otherwise. I knew that we had built a diligent vaccine safety monitoring system by then, as the 1955 Cutter incident and the 1976 swine flu crisis were still within the memory of many. However, until a system is tested, you cannot have complete confidence that it works.

The vaccine manufacturers went back to work on a safer rotavirus vaccine. By the time RotaTeq® was released in 2006,

PAIN?

GO WITH
THE BEST in
interventional
care

COLORADO PAIN
MANAGEMENT, P.C.
Peter Reusswig, M.D.
Paul Leo, M.D.
303-286-5067

- Level II Accredited
- Over 35 years of experience
- All diagnostic and therapeutic injections, neurolytic, implantable devices
- Safe, cost-efficient, and goal-oriented
- Dedicated to the pain care of your patient
- Board Certified in Anesthesiology and Pain Medicine

WE GOT YOUR BACK

www.coloradopainmanagement.com

The Colorado Department of Public Health and Environment
Retail Marijuana Education Program introduces:

Marijuana Pediatric

Exposure Prevention and

Pregnancy and Breastfeeding

Clinical Guidance

Evidence-based guidance for Colorado health care providers to talk with patients about marijuana exposure.

Visit Colorado.gov/CDPHE/marijuana-clinical-guidelines for:

- Marijuana Pregnancy and Breastfeeding and Pediatric Exposure Prevention Clinical Guidance
- Marijuana Factsheets for Patients
- Marijuana Clinical Guidelines Educational Webcast
- Additional resources for health care professionals



Medical Director at Clinica Colorado



Clinica Colorado is a nonprofit Primary Care Clinic. Its mission is to provide low cost healthcare for those who are indigent, without health insurance or unable to obtain primary care services. Our vision is to have affordable healthcare available to all residents of Colorado.

Our Values:

- Show compassion for all patients and family members.
- Make services available within a reasonable time frame.
- Provide high quality health care.
- Provide healthcare for the whole person, not just an illness.
- Provide healthcare services to as many persons as possible.

A majority of our patients are uninsured, and many are monolingual Spanish speakers. Dedication to caring for underserved populations is a key requirement for this position.

Qualifications:

- Current Colorado license to practice medicine
- Current DEA certification

Primary Duties:

- Provide patient care services 40 hours per week.
- Supervise physician assistants.
- Coordinate care with volunteer physicians.
- Collaborate care with mental health providers.
- Establish and maintain good relationships, as well as referral paths, with specialty colleagues and hospital institutions.
- Oversee and facilitate smooth clinic operations.
- Enhance the public image of Clinica Colorado.
- Collaborate with the executive director for the overall benefit of the organization.
- Attend Clinica Colorado Board of Directors meetings, usually scheduled bi-monthly.

Compensation and benefits are competitive and commensurate with experience.
Start date is negotiable.

Please forward a cover letter and resume to Jill Schneider, Executive Director, at jschneider@clinicacolorado.org.



For Advertising

CONTACT

Dustin Doddridge
ddoddridge@pcipublishing.com

1-800-561-4686
ext. 106

By Walt Larimore, MD, DABFP, FAAFP and Reginald Finger, MD, MPH

Study Shows Value in Healthcare Workers Receiving Influenza Vaccine Early

So, when the influenza vaccine is released later this year, should you and your colleagues get your shots when the vaccine is released, or should you wait a while? A Mexican study published in the *American Journal of Infection Control* may have provided an answer by reporting that health care workers who receive the influenza vaccine earlier in the season take less time off from work and experience fewer flu-like symptoms.

Mary Lou Manning, president of the Association for Professionals in Infection Control and Epidemiology, who was not involved in the study, told Reuters News that beyond the lost work from delayed or skipped vaccinations, health care professionals who aren't protected against influenza can unknowingly spread the virus to patients. She added, "The scientific evidence is clear that the routine annual influenza vaccination of health care providers can reduce influenza-related illness and its potentially serious consequences among the providers and their patients." As a result, "There is also evidence to suggest that when hospital workers get vaccinated, community flu rates decline." Adrian Camacho-Ortiz, senior author on the study, said it takes three weeks after vaccination for flu antibodies to develop. (Reuters: tinyurl.com/j9c9ljs; Original Article: tinyurl.com/jaksxv9.)

AAFP Promotes Second Dose of Meningococcal Vaccine

The AAFP has signed a "Dear Colleague" letter that promotes the Immunization Action Coalition's campaign to encourage physicians to administer the second dose of the meningococcal ACWY vaccine at age 16. In 2011, the CDC's Advisory Committee on Immunization Practices recommended a booster dose of the vaccine at age 16 to bolster protection, but only 28.5% of 17-year-olds have received the two doses.

According to the AAFP: Teens, in particular, are at increased risk of meningococcal meningitis from engaging in common activities such as sharing utensils and water bottles, as well as from coughing or kissing. The disease has a 10 percent to 15 percent fatality rate and can rapidly infect and overcome an otherwise healthy young patient, causing severe illness and even death in as little as 24 hours after the first symptoms appear. (AAFP News: tinyurl.com/h9lxogu)

Many Americans Believe Flu Vaccine is Unnecessary

The latest NPR-Truven Health Analytics Health Poll conducted at the end of last year surveyed over

3,000 American adults regarding how they feel about flu vaccination. The poll revealed that "62 percent ... said they had been vaccinated or intended to get vaccinated against flu," while those who had not been vaccinated "cited a variety of reasons." The poll found that "the top factors" for avoiding the flu vaccine included a belief that it "is unnecessary for them (48 percent of the group), concerns about side effects or risks (16 percent) and worries that the vaccine could infect them with the flu (14 percent)." Another 8 percent said they would "skip vaccination ... because they believe it's ineffective." Cost didn't seem to be a significant barrier. More than three-quarters of those who had received the flu vaccine said it cost them nothing out of pocket.

Previous research has shown that family physicians can significantly increase the percentage of their patients receiving the influenza vaccine by utilizing interventions such as standing orders, patient and clinician reminders, and patient education. (NPR: tinyurl.com/na55vvs; Poll Results: tinyurl.com/zbb8peu)

Survey: 75% of First-Time Mothers Plan to Follow Recommended Vaccine Schedule

A survey of 200 first-time expectant mothers in the U.S. revealed 75 percent planned to follow the recommended vaccination schedule for their children, while 10.5% planned to spread out administration of the recommended vaccines, and 4% planned to give their child some but not all of the recommended vaccines. The study was conducted by the U.S. Centers for Disease Control and Prevention and published in the *American Journal of Preventive Medicine*.

Of no surprise, the moms who weren't planning on following the recommended vaccination schedule said they got most of their information about childhood vaccines from online sources or family and friends, as opposed to their family physician. Study co-author Glen Nowak, PhD, of the University of Georgia told HealthDay News, "This shows the need to find ways to provide these women with information from pediatricians and family doctors." Nowak added, "The findings indicate pediatricians and family physicians should be careful when it comes to assuming how familiar new parents are about childhood vaccines." (HealthDay: tinyurl.com/oobfeyc; Original Article: tinyurl.com/jfzurzsc)

Healthy Seniors Need to Wait Longer Between Doses of Different Pneumococcal Vaccines

Prescriber's Letter, in a recent news brief, reminds us of new CDC recommendations that suggest we continue to give our patients who are 65 years of age or older both *Prevnar 13* and *Pneumovax 23*. However, we should

now space them at least one year apart, instead of waiting 6 months to a year per previous guidelines. Both pneumonia vaccines are encouraged because *Prevnar 13* covers one serotype that isn't in *Pneumovax 23*, while *Pneumovax 23* covers eleven serotypes that aren't in *Prevnar 13*. Remind your patients that Medicare Part B will now pay for both vaccines.

Remember to give *Prevnar 13* first, as the immune response to it is better if it's given before *Pneumovax 23*. If the patient has already had *Pneumovax 23*, then wait at least one year before giving *Prevnar 13*, keeping in mind that immunocompromised patients (chronic renal failure, etc.) should get *Pneumovax 23* just 8 weeks after *Prevnar 13*.

For those under age 65 who have had an early pneumococcal vaccine, a repeat dose is not needed. However, if a patient cannot remember whether they've had one or the other or both of the pneumococcal vaccines, it's safe to vaccinate. In addition,

either of pneumococcal vaccines can be administered on the same day as other immunizations (influenza, shingles, Tdap, etc.). The CDC says that even though *Prevnar 13* labeling suggests antibody response may be lower if it's given with the flu vaccine, this does not reduce vaccine efficacy, and the CDC advocates giving both on the same day. (CDC: tinyurl.com/onhn2xo)

Many Family Physicians are Delaying HPV Discussion and Vaccination for Preteens

More than one-third of doctors surveyed don't strongly recommend giving children ages 11 or 12 a human papillomavirus vaccine, but would most likely recommend it to older children, according to a study published in *Pediatrics*. However, research shows that the vaccine works best if children receive it before they become sexually active.

Researchers surveyed nearly six hundred family physicians and

pediatricians and found that a belief that the preteen patients hadn't had sex and that parents would object were the most common reasons doctors reported for delaying HPV discussions and vaccinations. Noting that about one-third of all youth have had sex by age 16, the researchers, led by University of Colorado researcher Dr. Allison Kempe, told the *Denver Post* that doctors need a clearer understanding of reasons to vaccinate preteens.

The HPV vaccine has been available for girls since 2006 and for boys since 2011. A national survey last year found that 60 percent of adolescent girls and only 42 percent of boys had gotten at least one dose. Three doses are recommended, although a single dose can provide significant protection. Infections caused by the virus can cause genital cancers including cancer of the cervix and penis, as well as cancers in the mouth and throat. (*Denver Post*: <http://tinyurl.com/jzdqcys>; Original Article: tinyurl.com/zqx8hxxg)

Make sure your family has a plan in case of an emergency.

Fill out these cards, and give one to each member of your family to make sure they know who to call and where to meet in case of an emergency. For more information on how to make a family emergency plan, or for additional cards, go to ready.gov



Family Emergency Plan

EMERGENCY CONTACT NAME: _____
TELEPHONE: _____

OUT-OF-TOWN CONTACT NAME: _____
TELEPHONE: _____

NEIGHBORHOOD MEETING PLACE: _____
TELEPHONE: _____

OTHER IMPORTANT INFORMATION: _____

DIAL 911 FOR EMERGENCIES

Ready ✓

Family Emergency Plan

EMERGENCY CONTACT NAME: _____
TELEPHONE: _____

OUT-OF-TOWN CONTACT NAME: _____
TELEPHONE: _____

NEIGHBORHOOD MEETING PLACE: _____
TELEPHONE: _____

OTHER IMPORTANT INFORMATION: _____

DIAL 911 FOR EMERGENCIES

Ready ✓

A Lifetime Dedication to Care

Dr. Mary Fairbanks is CAFP's 2016 Family Physician of the Year

By Lynlee Espeseth

Dr. Mary Fairbanks has been a longtime advocate of primary care, and delivering quality care to some of the most in-need patients. That dedication comes from the realization that any of us could find ourselves in need, and often our healthcare system isn't equipped to be able to help everyone.

I ended up in primary care because it is such a marvelous breadth of puzzles you get to solve. You get to know people in such a unique and individual way. You can learn amazing stories from your patients.

"The problem with the safety net is that it's a net. There are more holes than string. People can still fall through the gaps," says Dr. Fairbanks. "I'm very grateful for the opportunities I've had in life. I've learned luck has a lot to do with it, you see how close any of us could be to disaster."

Dr. Fairbanks' career reflects her interest in working with those who sometimes fall through the gaps. She has worked at the Stout Street Clinic, run by the Colorado Coalition for the Homeless, as well as for Denver Hospice. She served as a faculty member at St. Anthony Family Medicine Residency, and is currently a physician with InnovAge Greater Colorado PACE-Cody Center in Lakewood.

"PACE is the best kept secret on the planet," says Dr. Fairbanks. "PACE programs are really the first true working models of a PCMH."

The framework for PACE (Programs of All-Inclusive Care for the Elderly) began in San Francisco in the early 1970's. At that time, elderly in the Chinatown neighborhood

were having to move to nursing homes far away from their communities, where those caring for them didn't speak their language, and weren't able to provide the kind of care that the patients truly wanted. A group of providers came together to determine what could be done, and from that On Lok was born. The On Lok facility allowed seniors to stay in their communities and receive highly integrated care. Medicare noticed that the program was costing much less than others, and eventually the idea was replicated to other systems around the country. In 1994, with the support of On Lok, the National PACE Association was formed, and 11 PACE organizations were operational in nine states.

Today, there are 116 PACE programs in 32 states. InnovAge began its first Colorado PACE program in 1990 as Total Longterm Care. Today there are InnovAge locations across Colorado, as well as in California and New Mexico. InnovAge provides healthcare, home care and day centers, primarily to seniors who qualify for both Medicare and Medicaid, allowing them to "age in place." Healthcare services, including primary care, occupational therapy, optometrists and more, are located directly at the day centers. Additional services, such as social workers, are also available. Seniors who are part of PACE programs can take part in activities like dances and outings to museums. The program allows seniors to stay in their homes, yet receive quality, patient-centered care throughout the day.

For Dr. Fairbanks, it is a culmination of the all-inclusive care, delivered to all patients, that she has been passionate about since beginning her career. It encourages her to "think outside of the box" to determine what patients need to make them happy, and lets her work with patients in a deeply personal way.

"I ended up in primary care because it is such a marvelous breadth of puzzles you get to solve. You get to know people in such a unique and individual way. You can learn amazing stories from your patients."

Dr. Fairbanks was CAFP's F. William Barrow's Outstanding Family Medicine Resident in 1990.



Better Care and Happy Patients: The Reward of Practice Transformation

Lone Tree Primary Care is the Colorado Patient Centered Medical Home of the Year

By Lynlee Espeseth

Lone Tree Primary Care has many complex patients. With both family medicine and internal medicine services, and an older patient population, the clinic needed a way to successfully manage their patients and provide the best healthcare possible. For the clinic, transforming into a Patient Centered Medical Home (they received NCQA Level 3 Certification in December, 2013) was a way to accomplish this.

The clinic has a number of quality improvement initiatives in place focused around three clinically important conditions: diabetes, hypertension and depression. Lone Tree Primary Care also has a diabetes educator in the office once a week, a clinical pharmacist, and other team members including a social

worker and care coordinators. The clinic has seen vaccination rates and screenings for depression, smoking cessation and mammograms go up. Across their patient population A1c levels are improved, and fewer patients are being hospitalized. Additionally, patient satisfaction has gone up, as patients feel more engaged in care. The clinic provides worksheets that help patients explore and set health goals, and providers talk through the worksheets with patients when they are in for visits.

As one of UHealth's primary care practices, Lone Tree at Primary Care is part of a network of Patient Centered Medical Homes across the region. All of the primary care clinics in UHealth's system are or are becoming NCQA Certified Patient Centered Medical Homes.

This system wide transformation is proving to have a big impact. According to David Linger, Practice Manager at the clinic, across UHealth's primary care clinics hospital admissions rates have dropped from 57% to 13%.

For the clinic, a key factor in the success of transformation has been getting all team members involved. Admittedly, that isn't always an easy or fast process. Physicians estimate that it took about 18 months before they had full buy in from the staff. Open and continuous communication was essential to making their practice work.

As for the advice the physicians at the clinic would pass on to others working through or thinking about transformation?

"Have patience, and go with the flow," says Dr. Debra Bislip, one of the family physicians at Lone Tree Primary Care. "It's a slow process but it really pays off. Put things into place step by step, and keep your eye on the final place you want to be, and once you are there it will get easier."

Making Care Primary Across the Globe

By Lynlee Espeseth

Dr. Michael Matergia is CAFF's 2016 F. William Barrows Outstanding Family Medicine Resident

Dr. Michael Matergia didn't have the most conventional early path to medical school. While at the University of Pennsylvania he took all of the necessary prerequisites, but the history major admits he wasn't always sure he would attend. That unique start shaped Dr. Matergia into the physician he is today, and is a large part of why he is passionate about healthcare not just in the US, but across the globe.

After taking a Southeast Asian history class, Dr. Matergia knew he wanted to travel to the area and volunteer. After completing his undergraduate education, he found an opportunity on a tea plantation in rural India, and along with his wife Denna (who volunteered in a nearby school), wound up staying for over a year. While there, Dr. Matergia and Denna witnessed the realities of living in a rural community with limited access to health resources. In the school Denna worked at there were no toilets or electricity, and children often missed school because of water-borne illnesses. Children died from conditions that, in other parts of the globe, are fully preventable or treatable. Unfortunately, in the remote part of the country they were in, help from healthcare workers was very limited. Dr. Matergia and Denna began teaching some basic healthcare

classes, which would become the start of a major mission in their life.

Dr. Matergia returned to the United States and began medical school at Harvard. While there, he experienced the drain and exhaustion that many medical students feel, and wanted to find something beyond his studies that would energize him again. He attended AAFP's National Conference of Family Medicine Residents and Medical Students and felt very inspired by the stories of leadership. Dr. Matergia, along with Denna, decided to just "go for it," and with the help of grant and fellowship funding from Harvard, started Broadleaf Health Education Alliance in the same rural Indian community the couple fell in love with during their first volunteer experience.

Broadleaf is unique in that all of the "on the ground" work is done by members of the community. Individuals serve as school health activists where they deliver weekly health education lessons. They are also able to deliver primary care services like screenings and well-child checks, as well as identify children who should travel to see a specialist for any number of reasons, ranging



from needing eyeglasses to mental health concerns.

The community-based model has proven to be very successful, as it is community members who are motivated to be the biggest advocates for children. Often the community will come together to pay for the care a child

needs if their family can't otherwise afford it. Broadleaf Health Education Alliance is in 11 schools this year, and they are looking to double that over the next two years.

Now in residency, Dr. Matergia realizes what an incredible impact being a family physician can have on a community, no matter where you are or what area you are most interested in. That's the message he hopes medical students hear.

"You can change the course of a patient's life in primary care. That's a good enough reason to work in it for the next 40 or 50 years. It saves lives, it saves money, and you're a significant part of people's lives," says Dr. Matergia. "If you want the opportunity to do really cool stuff, then family medicine is for you. You can work in a private clinic, go teach, go work in Africa. If you can dream it I've met a family doctor who has done it."



Relationships are still the heart of medicine.



The bond you build with a patient makes practicing family medicine special.

The partnerships Children's Hospital Colorado builds with family physicians bring world-class pediatric specialty care to more kids.

In addition to our hospital on the Anschutz Medical Campus in Aurora, we have 16 locations in Colorado with pediatric services including emergency care, urgent care, pediatric specialty clinics, therapy care, diagnostics and observation. Visit [Childrenscolorado.org/locations](https://www.childrenscolorado.org/locations) for a full list.

For a list of our outreach clinics, which allow children to remain in their local communities while receiving the same specialty care, visit [Childrenscolorado.org/outreach](https://www.childrenscolorado.org/outreach).

Children's Colorado recognizes the important role family practice providers play in a child's healthcare team. **ONE CALL** is the primary care physician's link to pediatric and adolescent services and information.

Use **ONE CALL** to help you with:

- 24-hour consultations and diagnostic dilemmas
- Arranging patient transport
- Outpatient referrals
- Professional support/continuing education
- Inpatient admissions
- Identification of pediatric subspecialties
- Any other questions

800-525-4871



Children's Hospital Colorado



THE **STRENGTH** TO HEAL

and stand by those who stand up for me.

Learn the latest treatments and play an important role in the care of Soldiers and their families. As a physician on the U.S. Army Reserve health care team, you'll continue to practice in your community and serve when needed. You'll work with the most advanced technology and distinguish yourself while working with dedicated professionals. You'll make a difference.

To learn more about the U.S. Army health care team, call 303-873-0491 or visit healthcare.goarmy.com/eb19.



RURAL CORNER

Teaching the Balance of Life and Medicine

Dr. Kurt Dallow is CAFPs 2016 Teacher of the Year

By Lynlee Espeseth

Dr. Kurt Dallow is a passionate educator, and is passionate about living life well. Most days you can find him bicycling to work, meditating or working out, in addition to teaching and practicing at North Colorado Family Medicine Residency in Greeley. For him, both are important lessons to pass on.

“Medicine is a demanding job, you should always strive for balance,” says Dr. Dallow. “I see residents who are sleep deprived and stressed, they have family commitments. Your health can take a backseat, but I want them to realize what a difference it can make. The residents see me bicycling to work or running, I want to practice what I preach.”

That message has not been lost on the residents who have studied under Dr. Dallow.

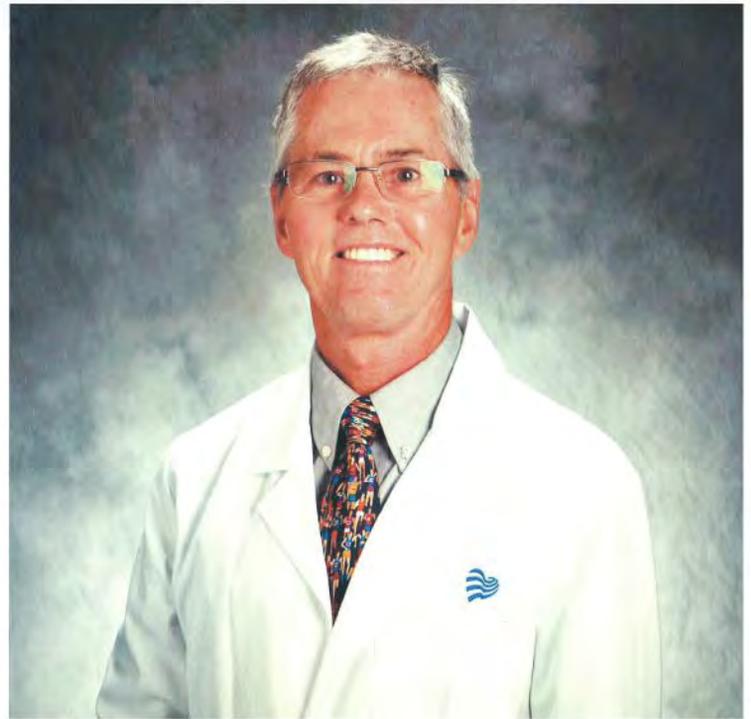
“Dr. Dallow stresses the importance of work-life balance,” says Dr. Meghan Curry O’Connell, a former resident at North Colorado Family Medicine Residency. “He practices healthy living and is a wonderful example of how to be a well-rounded physician in practice and in life. While teaching us medicine he teaches us the important (and often overlooked) skill of taking care of ourselves.”

Dr. Dallow’s love for health has also translated into practice. He received a certificate of added qualification in sports medicine in 2000, and serves as a team physician for the University of Northern Colorado, as well as many of the community high school teams. Dr. Dallow holds sports medicine clinics, and conducts casting/splinting and suturing classes throughout the year. He also successfully lobbied for the residency to receive a new ultrasound machine, so residents would be able to learn musculoskeletal ultrasound.

Living, practicing and teaching in a rural community also adds to Dr. Dallow’s enjoyment of a balanced life.

“It’s easier to live a good lifestyle here,” he says. “I believe in living where you work. It makes sense to be a part of the community you are in, to be involved with the local teams and local activities.”

Residents at North Colorado Family Medicine Residency are often well suited for practice in a rural setting, and are strongly



encouraged to continue on in such as community after their time in residency is completed. They see and participate in the true full spectrum of family medicine, and learn to be independent and manage the many things that are handed to them. For Dr. Dallow, and for many of the residents he teaches, practice in a rural community truly embodies what family medicine is all about.

“It allows you to look at all aspects of care. You can do so many things as a family physician. It embodies the life-long learning you have to do when you are a physician,” says Dr. Dallow. “In communities when you see whole families, generations, and are a part of their lives, that’s really special.”

The Core Content Review of Family Medicine

Why Choose Core Content Review?

- CD and Online Versions available for under \$250!
- Cost Effective CME
- For Family Physicians by Family Physicians
- Print Subscription also available



The Core Content Review of Family Medicine

Educating Family Physicians Since 1968

PO Box 30, Bloomfield, CT 06002

North America's most widely-recognized program for Family Medicine CME and ABFM Board Preparation.

- Visit www.CoreContent.com
- Call 888-343-CORE (2673)
- Email mail@CoreContent.com



CAFP DISCOUNT PROGRAM



As part of the CAFP Discount Program, the following companies are offering special pricing and opportunities to CAFP members.

Atlantic Health Partners – Atlantic, the nation's leading physician vaccine program, provides your practice: • Best Pricing for Sanofi Pasteur and Merck Vaccines • Enhanced Ordering and Payment Terms • Medical Supply Discounts and Reimbursement Support and Advocacy. Join your many colleagues in Colorado that have lowered their vaccine costs. Call Atlantic Health Partners at 800.741.2044 or email info@atlantichhealthpartners.com. www.atlantichhealthpartners.com

BEST CARD: Discounted Credit Card Processing – Serving more than 2,000 medical offices, these practices are saving an average \$1,277 annually (23%) since switching to Best Card. Members receive great rates including swiped rates of 0.51% debit, 1.94% credit, and 2.44% rewards, with no rate higher than 2.74%. No hidden fees (\$5 monthly fee and \$.0-.12 per transaction based on average ticket) and unparalleled customer service. You get PEOPLE not PROMPTS. Call 877-739-3952 or fax your recent credit card statement to 866-717-7247 and receive a complimentary cost comparison.

Health E-careers Network. FPJobsOnline is the official online job bank of the Colorado Academy of Family Physicians and provides the most targeted source for Family Physician placement and recruitment. Accessible 24 hours a day, seven days a week, FPJobsOnline taps into one of the fastest growing professions in the U.S. Please visit www.FPjobsonline.com or call 1-888-884-8242! Mention you are a CAFP member to receive discount.



**EHR &
Practice Management
Consultants**

Care Management & Technology Services

Industry Leading Care Management & Technology Services Firm

We provide best pricing to CAFP members, we provide expertise in Meaningful Use, ICD-10, PQRS, Privacy/ Security, Optimization and Care Management Services, we have experience working on over 150 EHR Systems. We help healthcare providers develop a seamless Chronic Care Management/Transitional Care Management program(s) to improve patient outcomes and drive recurring revenue without the need to increase staff. We assist providers in creating a better work-life balance, alleviating much of the burden chronically ill patients place on your staff by utilizing our patient-centered clinical care team. Our Healthcare Technology and Care Management Services help improve the health of your patients and the wealth of your practice. To learn more about EHR & Practice Management Consultants, Inc., service offerings, please visit www.ehrpmc.com or call 1-800-376-0212

**Colorado Academy of
Family Physicians, Inc.**

2224 S. Fraser St., Unit I
Aurora, Colorado 80014

Presorted Standard
U.S. Postage Paid
Little Rock, AR
Permit No. 2437



**WE'VE GOT
MORE THAN
JUST YOUR
BACK.**

100+

education courses
and seminars offered
each year.

Nationally recognized patient safety and risk management programs provide knowledge and guidance to help you navigate current challenges in health care. COPIC has you covered from front to back.



Better Medicine • Better Lives

callcopic.com | 800.421.1834

COPIC is endorsed by

