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Includes all templates for acquiring NCQA PPC-PCMH™ Recognition in 6 months or less!

“The patient-centered medical home transformation greatly improves job satisfaction and lessens burnout among primary care providers.”

Robert J. Reid, M.D., Ph.D.
Family Physician, Associate Medical Director for Preventative Care Group Health Research Institute

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Vision Statement: Thriving Family Physicians creating a healthier Colorado.

Mission Statement: The CAFP’s mission is to serve as the bold champion for Colorado’s family physicians, patients, and communities through education and advocacy.
Luke Casias, M.D., a family physician within Valley-Wide Health Systems in Mancos, took over as president of the Colorado Academy of Family Physicians in July 2010. He has practiced in Southwest Colorado since completing his residency at St. Mary’s Family Medicine Residency in Grand Junction in 2004.

Within the CAFP, Dr. Casias has served on the Legislative Committee, the Executive Committee and the Board of Directors. Beyond the CAFP, he is a member of the Department of Regulatory Agencies, the governor appointed him to the Colorado Collaborative Scope Advisory Committee in 2008 and 2009, and he has served Valley-Wide Health Systems in many capacities. From 2005 through 2007, he co-chaired the steering committee of the Community Health Associations of the Mountain Plains States.

Dr. Casias recently discussed what he plans to bring to the presidency and what he hopes to accomplish within the organization during his year in office.

What do you bring to the role of CAFP president that your predecessors may not have?
I bring a strong understanding of community-based health care and an understanding of challenges facing rural family medicine.

What made you decide to practice in Southwest Colorado?
I was drawn to the natural beauty of the location and the need for family medicine, given the socioeconomic challenges of a rural area.

What do you find most rewarding about the work? Most frustrating?
By serving as a safety net clinic, we truly make an impact on the health of this community. We provide care to those who have nowhere else to turn, and this ranges from elderly patients to newborns.

The most challenging aspect of the work is the lack of options for subspecialty referrals for the uninsured, adults on Medicaid and undocumented patients. A perfect example is neurology. If someone has a seizure, I don’t have any place to send that patient unless he or she has $250 upfront to pay. This problem is a direct reflection of the ailments plaguing the health care system.

What would you say might be your/the Academy’s biggest challenge during your year as president?
The securing of funding for the integration and implementation of the Patient Centered Medical Home by third-party and government payers is extremely important and equally challenging.

Before you became a physician, you worked with the Denver Public Schools’ Career Education Center and worked on diversity at the University of Colorado Health Sciences Center. Is inclusiveness still important to you? And, if so, how does it shape your practice, and how does it affect your presidency?
Yes, inclusiveness of people from all socioeconomic and ethnic backgrounds is a life-long interest that affects all areas of my life. I grew up in a lower middle class, if not poor, family in Denver’s Five Points neighborhood, and saw first-hand the impact such an impoverished surrounding can have on families. This background shaped and directed me then and still does to this day.

I strongly believe that encouragement and direction can be found in day-to-day interactions, and I attempt to incorporate this into how I practice medicine, just as I did when I taught students in a DPS vocational magnet school and when I worked with minority students at the university.

I feel that it’s important for me and all doctors to realize that they are role models and they may influence the lives of others without even knowing it. We never know when our actions may be observed. Students and patients are often influenced by nuances and small actions. Because of this, it’s important that we all treat one another in a way that reflects our true sense of humanity.

You’ve been active in other organizations, such as the Department of Regulatory Agencies. What motivates you to participate in the CAFP and other organizations?
My commitment to my patients, my colleagues and my profession compels me to be active in these groups. We as physicians should always strive to ensure the best care for our patients, and this demands us to cross into several arenas to advocate for them and to ensure we are in positions to provide the best care for them.

I think the biggest problem now facing family physicians – the greatest impediment to our being in a position to provide the best care for all patients – is the underfunding of primary care. This is why I want to move forward with finding broad-based financial support for the medical home.

How do you juggle all of your activities and maintain a balanced lifestyle?
I would not be able to do so if not for my wife’s support and her caring for our daughters, who were born in 2007 and 2009.

In addition, I have been amazed by the support in our organization. We are all volunteers and yet, due to member involvement, we accomplish great things. The key is continued involvement on the Board by members. We are constantly in need of new participation by our membership, especially as we broaden into new areas to secure our role in this ever-changing arena.

Lastly, my employer, Valley-Wide Health Systems, has also been very willing to support me in these activities, as the managers and administrators are also committed to strong community-based care.

What is one thing you would like to say to CAFP members about your presidency?
The strength of the CAFP is derived from membership participation, and we have the opportunity to help shape the future of medicine, but only as a collective voice will we be heard and bring about action. I would encourage every member to be an active member.
Learn more–
www.FuelUpToPlay60.com

These health and nutrition organizations support Fuel Up to Play 60, a partnership between the NFL and National Dairy Council impacting an expected 60,000 schools and 36.6 million students.

This program empowers youth to make changes at school that will help them “fuel up” with nutrient-rich foods missing from their diets, such as low-fat and fat-free milk and milk products, fruits, vegetables and whole grains and to “get active and play” for 60 minutes daily.
CAFP Garners Grants and Awards, Offers Opportunities

CAFP SMALL DONOR COMMITTEE – PLEASE CONTRIBUTE & HOST A CANDIDATE

Members are invited to support political candidates by contributing to the CAFP’s Small Donor Committee and by hosting parties for local candidates. Contributions need to be small -- $50 or less during one year. The funds will be used to support legislative candidates and will enhance CAFP’s legislative influence.

In addition to contributing funds, you may also host a party for your local candidate and invite your neighbors and physician colleagues. With limited funds available, the CAFP Small Donor Committee can provide $100 for you to present to your candidate, who will appreciate it. You would need to cover the cost of the food and drink, but you could just serve cookies and coffee. Candidates will need to be approved by the CAFP Legislative Committee.

For more information, please go the CAFP web site, www.coloradoafp.org, click on Members Only, click on Legislative Affairs, and you will see the Small Donor Committee information on that page.

Please mail your checks to CAFP, 2224 S. Fraser St., Unit 1, Aurora, CO 80014.

If you would like to host a candidate party, please go to the CAFP web site and download the request form, http://www.coloradoafp.org/members/legislative.php.

NEW PCMH PRACTICE TRANSFORMATION OPPORTUNITY

The CAFP will be offering a wonderful opportunity through Health TeamWorks for CAFP members to transform their practices to become Patient Centered Medical Homes through a large-group training format. It will involve a one-day learning collaborative on a Saturday followed by five one-hour webinars over a lunch hour, with phone consultations available in between. Only the first 35 practices to sign up will be able to be accommodated. If you are interested, please contact angel@coloradoafp.org.

A Patient Centered Medical Home is:

• A physician-guided team that takes responsibility to provide comprehensive and coordinated care to patients across the complex health care system.
• An approach to patient care that ensures first-contact access and continuous, trusting relationships that provide high quality and safe care based on evidence-based medicine and shared decision-making.
• A medical model that is recognized for the medical, social and economic value brought to the health care system.

A Medical Neighbor is:

• A clinician that collaborates with a PCMH or another medical neighbor to facilitate the efficient, appropriate and effective flow of patient information and participates in the care team that effectively addresses issues of responsibility and accountability in transition of care.

WELCOME NEW BOARD MEMBERS

Thank you to the following CAFP members who were elected to the CAFP Board of Directors and have agreed to serve.

• Candace Murbach, M.D.
• Rick Budensiek, DO
• Monica Morris, DO
• Jessica Tennant, M.D.

And welcome back to the following Board members, who are returning for their new terms.

• Michael Archer, M.D.
• Flora Brewington, M.D.
• Chet Cedars, M.D.
• Victoria Cummings
• Marcus Salmen

BOARD NOMINATIONS NOW BEING ACCEPTED

The deadline for the next round of nominations for the CAFP Board of Directors is Dec. 1, 2010, for the term beginning July 1, 2011. Information on the nomination process is on the CAFP web site, www.coloradoafp.org. Click on About CAFP, click on Board of Directors, then click on Board Nominations (http://www.coloradoafp.org/bodnominations.shtml). The strength of the CAFP lies in its volunteer leaders. We appreciate your contributions and service.

YOU ARE INVITED TO JOIN CAFP COMMITTEES

The following committees need members:

• CAFP Patient Centered Medical Home
• CAFP Education Committee
• CAFP Legislative Committee
• CAFP Tort Reform Task Force
• CAFP Workforce Task Force

Please contact raquel@coloradoafp.org if you would like to volunteer your time. You will find all of these committees and task forces interesting, valuable and worth your time.

NOMINATIONS FOR FAMILY PHYSICIAN, TEACHER AND RESIDENT OF THE YEAR AWARDS

The deadline for your award nominations is Dec. 1, 2010. The awards will be announced at the April Annual Scientific Conference. For complete information and nomination forms, please go to the CAFP web site, www.coloradoafp.org, click on About CAFP, and click on Awards (http://www.coloradoafp.org/awardsapp.shtml).

CAFP ANNUAL SCIENTIFIC CONFERENCE

Mark your calendars for the 2011 conference, April 14-17, at the Cheyenne Mountain Resort in Colorado Springs. The CAFP Education Committee has planned an excellent continuing medical education program for you. You will be receiving your registration brochures soon. Check on the CAFP web site www.coloradoafp.org for information.

CONGRATULATIONS TO THE CAFP ON FUNDS RECEIVED

• PEDIATRIC OBESITY PILOT
Thank you to The Colorado Health Foundation for funding this important pilot project. If you have an interest in participating, please contact cara@coloradoafp.org.

IMMUNIZATION INITIATIVE
Thank you to the Colorado Department of Public Health and Environment for their funding of immunization education and research. For more information, please contact leah@coloradoafp.org.

TAR WARS
Thank you to Kaiser for their funding and support of the CAFP’s Tar Wars program. If you are interested in presenting the Tar Wars program to your local fifth-grade classes, please contact cara@coloradoafp.org.

COLLABORATIVE MENTAL HEALTH PROPOSAL
The CAFP and the Colorado Chapter of the American Academy of Pediatrics were invited by Mental Health America of Colorado to partner with them on a grant request to The Colorado Trust with the purpose of integrating mental health care into primary care and to advocate for payment for mental health care in primary care practices. The letter of intent was accepted and a grant proposal was submitted. If you are interested in being trained as a trainer in mental health for primary care, please contact raquel@coloradoafp.org.

PCMH TRAINING IN FOUNDATIONS OF DOCTORING COURSE
Thanks to the wonderful vision and leadership of one of our CAFP student Board members, Marcus Salmen, the Department of Family Medicine is working on incorporating Patient Centered Medical Home training in the Foundations of Doctoring curriculum. And thank you to Wendy Madigosky, M.D., MSPH, director of the Foundation of Doctoring Curriculum, for helping to make this happen.

LARGE PRIMARY CARE GROUP FORUM
A forum for large primary care groups has been created by Roger Shenkel, M.D., and is being supported by the CAFP through a list serve and administration. The new chair of the forum is James Sprowell, M.D.

The following criteria are being used for active membership in the forum, but all practices are welcome to participate.

- Size of practice – The group decided that the forum should be for larger, for-profit, non-hospital owned independent practices, and practices with at least 15 full-time-equivalent physicians of whom a significant portion are Family Physicians.
- Others not fitting the above criteria are welcome to the information but would not be major participants.
- Communication - Getting together by phone is the chosen method of communication, combined with two face-to-face meetings a year.

CONGRATULATIONS TO LEAH KAUFMAN
The CAFP Immunization Champion recently gave birth to a son named Alexander.

COLORADO TAR WARS POSTER WINS FIRST PLACE NATIONALLY
Thank you to all of you who voted on the Colorado Tar Wars posters at the CAFP Annual Scientific Conference in April 2010. You picked the right poster! Jared Gorthy’s (Chipeta Elementary, Colorado Springs) poster won first place in the American Academy of Family Physicians’ national Tar Wars poster contest. Thank you to Cara Coxe for organizing all of the presenters and schools and the contest.

THE STRENGTH TO HEAL and stand by those who stand up for me.

Here’s your chance to be a part of a team that shares your commitment to teamwork and making a difference. Become an Army physician and receive up to $120,000 towards qualifying medical school loans. What’s more, you’ll have access to the most advanced training, treatments and technology.

To learn more about the U.S. Army Health Care Team, call SFC Gregory Kraft at (303) 873-0491, email gregory.kraft@usarec.army.mil, or visit healthcare.goarmy.com/info/mclp1.
CAFP Legislative Wrap-up

By Jeff Thormodsgaard, CAFP Director of Public Policy

Greetings Doctors,

As promised, I wanted to provide information to you all on some of the measures that will be before you in this upcoming ballot. The CAFP Board of Directors has taken a position to oppose the below proposed amendments and propositions. Much of the rationale for opposing these was arrived at because of the devastating effects these measures could have on Colorado and the practice of medicine. The rationale is provided after a brief explanation of the measure. Explanations were formulated with resources from each of the campaigns working on these measures.

Prop 101: Will jeopardize the state and local governments’ ability to provide essential public services by significantly reducing fees that go primarily to K-12 education, transportation, and local governments.
- Will cut the specific ownership tax 98 percent. About half of this money goes directly to the local school district and the rest to the local government.
- Will cut vehicle registration revenue to 1919 levels. This is a primary source of revenue the state uses to build and maintain roads and bridges throughout Colorado.
- Would reduce the state’s income tax revenue by a quarter, forcing further severe reductions in services like K-12, health care, and higher education.

CAFP’s rationale for opposing: About half of the moneys raised by property tax go to fund our public schools. If property taxes are reduced, this drastically affects services such as Medicaid, and the safety net could all but be eliminated. The provider community CAFP represents would be affected by a major reduction in Medicaid Provider Rates.

Amendment 60: Will immediately overturn decisions approved by local voters and will undermine the ability of local voters to invest in their own community.
- Will automatically overturn local decisions made by voters to keep revenue over the constitutional limit. The majority of local governments have approved such a decision (98 percent of school districts, 81 percent of counties, 76 percent of cities).
- Will force local districts to cut the property taxes that go directly to their local school district by half over 10 years. Mandates that the state replace this money annually, creating a new, mandatory obligation on the state budget without providing new revenue.
- Leves a new mandatory property tax on publicly-owned enterprises and authorities, guaranteeing large increases in fees for services such as water, transportation, and higher education.

CAFP’s rationale for opposing: Although this has less impact on the practice of medicine, it will have tremendous effects on the state of Colorado. In so much as CAFP is concerned about its doctors and patients, this amendment could hurt all Coloradans; therefore, a position of oppose was taken.

Amendment 62: Proposes amending the Colorado Constitution to: apply the term “person,” as used in the sections of the Colorado Bill of Rights concerning inalienable rights, equality of justice, and due process of law, to every human being from the beginning of the biological development of that human being.

Amendment 63: This is a constitutional amendment that attempts to opt Colorado out of the national health care reform. It will lead to endless lawsuits and drive up health care costs for Colorado families already struggling with their health care bills. At the end of the day, more uninsured means higher costs for the insured. This complicated amendment will lead to skyrocketing health care costs, as individuals and businesses are forced to absorb the cost of more uninsured, more public health care services, and more emergency room care. Colorado can’t afford rising health care costs that will come from this partisan political statement. It has no place in our constitution and Colorado deserves better.

CAFP’s rationale for opposing: One of CAFP’s major policy objectives is access to health care; CAFP believes that supporting this amendment will only serve to perpetuate the state’s beleaguered system where over 800,000 people remain uninsured.

As always, it is an honor and privilege to represent the Colorado Academy of Family Physicians!

Jeff Thormodsgaard
Mendez Consulting
Small Donor Committee
Support the CAFP SDC and you help support issues in the Colorado General Assembly that matter to Family Physicians.

Do You Care About These Issues?

- Health Care Reform
- Childhood Immunizations
- Tobacco Cessation and Education
- Preventive Health Care
- Patient Safety Tort Reform
- Primary Care Workforce

What is a Small Donor Committee?
Campaign finance reforms enacted by Colorado voters in 2002 authorized “Small Donor Committees” as a new method for ordinary citizens to contribute to political campaigns and better compete with deep pocket special interest groups. Small Donor Committees can only accept contributions from individual persons – no corporate or union contributions are permitted. Individual contributions are limited to $50 per year, per person. Hence the name: Small Donor Committee. Unlike other PAC contributions, Small Donor Committees enjoy much higher limits on what they may give to candidate campaigns. This reform is intended to empower ordinary people to pool their money and compete with big business and special interest. The Colorado Academy of Family Physicians Small Donor Committee was formed to allow the Family Physician community to take advantage of the new campaign finance laws.

How much can a Small Donor Committee give to candidates?
The Colorado Academy of Family Physicians Small Donor Committee can give candidates for Governor, Attorney General or Secretary of State up to $10,600 per election cycle. Candidates for the state legislature may accept up to $4,250 per election cycle from Small Donor Committees.

Which candidates will The Colorado Academy of Family Physicians Small Donor Committee Support?
Each election year, the Legislative Committee of CAFP will determine a slate of candidates to receive financial support. Candidates will be selected based upon their support for family physicians, their viability as a candidate, the competitiveness of their race and the impact that a contribution from CAFP SDC will be expected to have. The number of candidates receiving support depends in large part on the number of small individual donors that have contributed to CAFP SDC.

Why should I contribute to The Colorado Academy of Family Physicians Small Donor Committee?
Supporting CAFP SDC is an easy way to support candidates that support family physicians. Contributions from CAFP SDC will be branded as family physicians’ money. These donations will be a visible means of rewarding elected officials and candidates that support our issues.

Do I have to give $50 each year?
No. That’s the maximum amount that each person is allowed to give per year. Smaller contributions are welcome. Donors will be solicited each year to renew their annual gifts.

Are contributions tax deductible?
Unfortunately not. Because your contribution will be used to support political candidates, the IRS will not allow us to offer a tax deduction.

Detach here and send contribution to:  CAFP, 2224 S Fraser St. Unit 1, Aurora, CO 80014

Count me in. Enclosed is my contribution to The Colorado Academy of Family Physicians Small Donor Committee.
I understand that only personal checks may be accepted, and my contributions may not exceed $50 per year.

Name

Street Address    City    State    Zip
Early reports of medical home success in the areas of improved patient experience, per capita cost savings, and favorable clinical outcomes point toward focusing coordination strategies on vulnerable patient populations experiencing “transitions in care.” Children in the foster care system make up one of those populations.

If your practice cares for foster children, you will know that often when they and their foster parent or case worker present for an appointment, it is never a simple visit. Typically the social history is complex and not entirely known; medical records are not available, and future availability for follow-up is uncertain. Behavioral health intervention is often warranted as a result of the child’s unfortunate, and frequently tragic, circumstances. Something as simple and straightforward as a school physical or immunization update can challenge even the most efficient provider. From the patient and foster family perspective, lack of continuity and difficulty with accessing and navigating the system can be disheartening. Walk-in clinics and the emergency department are often seen as a reasonable substitute for primary care.

According to most recent federal Adoption and Foster Care Analysis and Reporting System (AFCARS) data, there are 8,754 Coloradan children in foster care. Average length of stay in the foster care system is just over 22 months and often spans two birthdays. Approximately 50 percent of Colorado’s foster children are between the ages of 13 and 21 years of age. Forty percent of our foster care children experience three or more placements, and 30 percent live in group care or institutional settings. The Midwest Study, a landmark prospective study which has been tracking how youth are doing after “aging out” of foster care systems since 1999, suggests that young adults who’ve transitioned out of the system face significant long term challenges (see Table 1).

Beginning in March 2010, children and families in Larimer County’s foster care system have had access to an unprecedented source of comprehensive, coordinated primary care. “Healthy Harbors,” an innovative pilot program funded in part by The Colorado Health Foundation, is targeting approximately 30 percent of Larimer County’s children living in out-of-home placements who lack primary medical, dental and/or mental health care. The success of the model relies heavily upon strong collaborative relationships between community, mental health, dental and primary care partners—and the skillful use of a patient navigator. The navigator coordinates start-up medical and dental data-gathering and evaluations early in the foster child’s placement, assists with collecting health histories to use for future planning, acts as a conduit for communication between families and all partners involved with the child’s care, and when legally possible, aids in the creation of a “Health Passport” which will allow for the child to continue to receive comprehensive services regardless of future placements.

Housed at the Fort Collins Family Medicine Residency Program/PVH Family Medicine Center, “Healthy Harbors” has been able to provide comprehensive, coordinated services for 30 foster- and kinship-care children and families who have not previously had a reliable source for primary care and have shown evidence of needing further medical/dental/mental health care services beyond what their current care situation can adequately provide. The first year goal of this pilot project is to engage 50

### Table 1.
Example Long Term Challenges Faced by Young Adults Who Were “Foster Kids”

*Taken from Courtney et al. 2010*

<table>
<thead>
<tr>
<th></th>
<th>Foster Children</th>
<th>Counterparts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless or couch surfing</td>
<td>37%</td>
<td>--</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No diploma or GED</td>
<td>24%</td>
<td>7%</td>
</tr>
<tr>
<td>Diploma</td>
<td>33%</td>
<td>26%</td>
</tr>
<tr>
<td>4 year college degree</td>
<td>3%</td>
<td>19%</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently employed</td>
<td>48%</td>
<td>75%</td>
</tr>
<tr>
<td>Average income</td>
<td>$12,064.00</td>
<td>$20,349.00</td>
</tr>
<tr>
<td>High food insecurity</td>
<td>58%</td>
<td>--</td>
</tr>
<tr>
<td>Health Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently with health insurance</td>
<td>57%</td>
<td>78%</td>
</tr>
<tr>
<td>ADL limited by health condition/disability</td>
<td>12%</td>
<td>5%</td>
</tr>
<tr>
<td>Mental health counseling</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>Substance abuse counseling</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever pregnant</td>
<td>77%</td>
<td>40%</td>
</tr>
<tr>
<td>3+ pregnancies</td>
<td>42%</td>
<td>21%</td>
</tr>
<tr>
<td>Married at conception</td>
<td>14%</td>
<td>46%</td>
</tr>
<tr>
<td>Interface with Justice System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrests-Female</td>
<td>57%</td>
<td>4%</td>
</tr>
<tr>
<td>Arrests-Male</td>
<td>81%</td>
<td>17%</td>
</tr>
<tr>
<td>Convictions-Female</td>
<td>81%</td>
<td>2%</td>
</tr>
<tr>
<td>Convictions-Male</td>
<td>58%</td>
<td>10%</td>
</tr>
</tbody>
</table>
children, implement a documentation template that is comprehensive—and yet time efficient, coordinate all levels of care in a timely manner, create a regular communication pathway with the county Department of Health Services, and evaluate the general impact of engaging a patient navigator to coordinate care. The goals for the second year of the project will be to engage 75 children and their foster/kinship-care families, streamline the documentation process to maintain comprehensiveness and increase efficiency, facilitate the communication of comprehensive patient health histories to receiving health care providers when patients transfer from the area, document the economic impact of providing comprehensive care to this highly complicated and vulnerable population group, and provide ongoing resources for care when they transition back to families of origin. It is estimated that it annually costs just under $950.00 per child to provide this level of comprehensive, coordinated care, with the goal to avoid episodic, non-emergent care in hospital emergency departments, and receive regular interventional and preventative care.

**The Model**

In the event of suspicion of acute physical or sexual abuse, the child is evaluated within 72 hours by one particular experienced pediatrician, with close follow-up then established with Healthy Harbors or the child’s already-established primary care physician. Children without a regular primary care physician are then offered comprehensive care in the Healthy Harbors program. Within 72 hours of out-of-home placement, an “Initial Screening” takes place at the Family Medicine Center (FMC). In preparation for this, the patient navigator spends approximately eight to 10 hours collecting pertinent medical and social history information from the birth family and Department of Human Services to begin building the “Health Passport” database. Screening visits are bundled to include medical, developmental, mental and dental assessments. The patient navigator prepares the foster family for the visit by helping them to understand the program and what to expect. After gathering and clarifying the information and building the medical record, the navigator discusses the care issues with the faculty physician to review data and highlight critical areas that will require specific attention. Two FMC faculty physicians currently see these patients for their initial visits, taking approximately 40 minutes to review and update the medical history initiated by the navigator and complete the medical evaluation. Within 30 days, a “Comprehensive Foster Care Health Care” assessment is completed by the faculty, with coordinated directives for the navigator to assure timely follow-up for mental health, developmental, dental, and further medical evaluation and intervention; and the patient is assigned to a family medicine resident physician for “Routine Foster Care Follow-Up,” with supervision and review by the faculty family physicians involved with Healthy Harbors. The patient navigator, a contracted employee of the Poudre Valley Health Systems Foundation (for the purposes of the pilot project) who is housed jointly by the Family Medicine Center and Department of Human Services, continues to stay directly involved as long as the child remains a patient in the Healthy Harbors program.

“I have the privilege of acting in a companion role and am able to walk alongside the patients and families through the whole delivery of care,” explains Bob Davidson LCSW, Healthy Harbors patient navigator. “With this role, we are able to bridge with the birth parents in a way that no other resource can … we continue to care and provide care no matter whether the child ‘ages out’ and/or ends up back at home.”

“In these first six months of the pilot project, we have already appreciated a number of remarkable successes,” says Dr Donna Sullivan, FMC faculty physician and foster care coordinator. “To have a complete list of the child’s medical problems, current and past medications, and health care records from other providers—and most especially from the DHS-contracted pediatrician who does the initial abuse evaluation, is unique and incredibly helpful; I can actually define a specific comprehensive health care plan for the child and the foster/kinship parents at the first visit! The navigator has almost always already set up the appointments for the child’s developmental assessments, dental care, and mental health evaluations; and due to his efforts, we now have a direct line of communication with the psychiatrists at Larimer County Mental Health. We also now have regular dialogues with the directors and case-workers at DHS and have begun the same process with the Larimer County Department of Public Health and Environment, which is unprecedented; the improvement in communication and understanding of our respective concerns for the patients has been outstanding.”

Healthy Harbors is collaboratively sponsored by Poudre Valley Health System (PVHS), the Fort Collins Family Medicine Residency Program/Family Medicine Center, and the Larimer County Department of Human Services. The pilot program partners with Colorado State University (CSU), the Larimer Center for Mental Health and the Larimer County Department of Health and Environment. Its advisory board holds representation from local pediatricians, pediatric dentists, family physicians, PVHS Community Health, CSU Department of Social Work, and the Healthier Communities Coalition of Larimer County.

“We chose to focus our efforts on children who are living with some of the greatest physical and mental health risks in our county. We already know that these kids also have not had the ability to receive the benefit of coordinated care. With frequent changes in foster homes, the fragmentation had the potential to be more harmful than helpful. This navigator model has provided a way to coordinate care that helps the child, foster family and medical providers more than anything else we have tried,” states Ruth Lytle-Barnaby, executive director for the PVHS Foundation.

There is momentum in Larimer County supporting primary care’s adoption of the medical home approach to care. Three of 16 practices participating in Colorado’s Multi-Payer, Multi-State PCMH Demonstration

continued on next page
Pilot are local to Fort Collins. The Fort Collins Family Medicine Residency Program is one of nine family medicine residency programs statewide participating in a PCMH redesign project. Finally, Larimer County, under the leadership of the Healthier Communities Coalition of Larimer County, was selected by the Colorado Department of Public Health and Environment Colorado Medical Home Initiative as one of four pilot counties to receive two-year grant funding to build local systems which support coordinated, comprehensive, continuous family-centered care, particularly for members of the pediatric population that have exceptional challenges. The processes initiated by the Larimer County Medical Home Coalition are already being cited as examples for other counties to follow, according to representatives of the CDPHE Colorado Medical Home Initiative.

Healthy Harbors is an example of using innovation and collaboration within the medical home and the medical neighborhood approach to care to make a difference on many different levels—one family at a time. For more information about the program or details about the “Health Passport” design, contact Dr. Donna Sullivan (sull@pvhs.org) or Bob Davidson, LCSW, Healthy Harbors navigator (bd8@pvhs.org). If you and your practice are interested in working toward starting on the PCMH journey, contact Allyson Gottsman, Health TeamWorks executive vice president (720-297-1681 or agottsman@healthteamworks.org), to learn more about coaching resources available to you.

Endnotes

High Country Health Care, in beautiful Summit County Colorado, is seeking one board certified family physician to join our physician-owned multi-specialty group. The position offered is located in Summit County. We offer a generous guaranteed base salary and comprehensive benefits package, and are located in an idyllic recreational paradise.

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8 Denver- Area Locations

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<td>Commerce City at Reunion</td>
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JOHN K. DAVIS III, M.D.
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STEVEN M. ATKINS, D.P.M.
CAFP NEWS

Dr. Scott Hammond hosted a Parade of Medical Homes at his practice.

The Systems of Care (SOC) Patient Centered Medical Home (PCMH) grant has been hopping. We are now in the second phase or “Implementation phase” where the “tires hit the road,” literally. During this phase, the CAFP Resource Advisor (Angel Perez) will be coming out to individual offices and providing basic presentations. She will help get you started on the journey to PCMH in addition to answering all your questions, whether it is through e-mail or by phone.

CAFP has several programs through the SOC/PCMH grant. The first program is the Parade of Medical Homes. This is a “tour” of NCQA PCMH level 3 recognized practices in Colorado. This is geared mostly for doctors, but staff is welcome as well. It is an interactive tour that will go through all the standards and elements of the NCQA application. You would also have the opportunity to ask the staff questions on different areas of the NCQA PCMH process.

The Mentoring Program for the PCMH will pair you up with an NCQA PCMH level 3 recognized physician for a one-on-one consultation. This is all in addition to the Annual Scientific Conference workshop.

The Speaker’s Bureau program is an assembly of doctors in Colorado who are trailblazers in the PCMH movement. They are available to give talks to physician and community groups.

On Oct. 23, we will also start the “Journey to PCMH Recognition,” a group training on NCQA PCMH recognition.

The Colorado Academy of Family Physicians greatly appreciates Copic’s generous acknowledgement of the value of the NCQ Patient Centered Medical Home Recognition (PCMH). Copic has agreed to award two ERS points for NCQA PCMH Level 1, four ERS points for NCQA PCMH Level 2, and six ERS Points for NCQA PCMH Level 3, certification and recertification, effective Jan. 1, 2010.

CAFP has a “toolbox” of resources for members. If you are interested in a PCMH presentation in your office, have questions, or would like to obtain resources or additional information, please contact Angel Perez at angel@coloradoafp.org or 303-696-6655 ext. 16.

Colorado Academy of Family Physicians
Medical Home Core Messages

Team Approach (Benefit)

A medical home benefits all of us, because it uses a team approach to health care that is centered on a patient and family’s needs.

- CAFP encourages primary care physicians and other health professionals to join in a medical neighborhood that coordinates efforts to ensure access to high quality, timely, safe, appropriate and cost-effective medical care.

August 2010
Cavity Free at Three

Cavity Free at Three is a Colorado based educational program aimed at preventing oral disease in young children. We aim to engage physicians, dentists, nurses, dental hygienists, public health practitioners and early childhood educators in the prevention and early detection of oral disease in pregnant women and children.

Dental decay is the most chronic childhood disease, yet it is preventable. Oral health is an integral part of overall health.

As a health professional, you can play an important role in the prevention of early childhood caries in children.

We offer comprehensive training opportunities to address the prevention of oral health disparities of children under the age of three.

For additional information on our program visit our website at: [www.cavityfreeatthree.org](http://www.cavityfreeatthree.org).

To see how you can become involved contact:

Karen Savoie, Director of Education, Cavity Free at Three Program
karen.savoie@ucdenver.edu
303-724-4750

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Colorado Academy of Family Physicians Undertakes Childhood Obesity in the Primary Care Setting

by Cara Coxe & Lena Cazeaux

Primary care physicians have lately observed an increase in overweight and obese pediatric patients. Rates of childhood obesity in the United States have more than doubled in less than 30 years, with no signs of slowing down. The rates of co-morbidities, such as type 2 diabetes, are also increasing. And yet, there is still a disconnect between this knowledge and delivery of care. The lack of set protocols and clinical strategies has left primary care physicians without the tools for diagnosing and treating obese children in their practices.

There are growing numbers of programs designed to provide physical and nutritional activities for youth; however, many youth simply lack the funds and encouragement to engage in wellness and fitness programs and many are embarrassed to participate because of their weight. Considering all the social implications -- the loss of self-esteem, the ridiculing and the stigma associated with being obese -- it is very sad that many of these children live quiet lives of very intense suffering. Clearly, efforts to address the upward trend in childhood obesity must go beyond developing yet another program for youth. Efforts must include changes at a systemic level that impact policy and that provide overarching guidance for physician practices seeking to address growing obesity rates among youth. These efforts must also include support for the family in making lasting changes in the home environment.

The American Medical Association recommends expanding the role of the physician, as previously detailed by Barlow and Dietz in 1998. Since the 1998 recommendations were released, multiple publications outlining nutrition and physical fitness guidelines have been written. Despite these guidelines, only 39 percent of pediatricians believe they could effectively manage obesity in their patients, and worse, only 12 percent report high self-efficacy in this skill set. To help boost their confidence in managing childhood obesity and, in turn, to assist in the interpretation and adoption of the AMA recommendations, physicians need access to educational programs, clinical tools, and weight-management and community-based physical activity programs.

In response to this crisis, the Colorado Academy of Family Physicians recently received funding from The Colorado Health Foundation for a program that aims to decrease the upward trend of childhood obesity in Colorado. The goal of this project is to reduce childhood obesity by integrating new childhood obesity guidelines and evidence-based tools into clinical and community settings across Colorado, with a focus on rural and underserved populations. This will afford primary care physicians the tools they need to diagnose and treat children struggling with obesity and to engage their families in the process. The loose frameworks provided to primary care physicians to date are still heavily theoretical, leaving primary care physicians without a truly relevant methodology for applying these ideas to clinical practice for young patients and their families. Although physicians recognize the growing problem of childhood obesity, the absence of a set protocol means that most physicians do not know what to include in screening, nor do they have the tools to “confirm” diagnosis or screen for other risk factors. As a result, they do not document the cases and causes; and consequently, the issue is glossed over during the office visit with no plan for the home or follow-up.

In addition to this disconnect between theory and practice, studies show that there is little success for interventions that target the individual child specifically. However, family-administered and home-based therapeutic lifestyle changes, or TLC, may be more effective for the prevention and treatment of childhood overweight, obesity, borderline high blood pressure and high blood pressure. The benefits of a family-based approach are based on the ideas that: (1) health problems, including obesity, tend to cluster in families; (2) families share living environments and habits; and (3) parents have a significant impact on their children’s lifestyle patterns and food choices. Therefore, a focused effort must be made to involve the entire family in the healing process to truly affect long-lasting results. In fact, a recent clinical trial examining the effectiveness of family-based behavioral counseling to manage childhood obesity found that when parents followed the program and lost weight, their children were significantly more likely to do so as well.

Also addressing these insufficiencies, Health TeamWorks, formerly Colorado Clinical Guidelines Collaborative, recently finished creating childhood obesity guidelines that help inform approaches to educating children and families about this issue, while providing physicians with a consistent template for evidence-based guidelines for treating childhood obesity. The Childhood Obesity Guideline was distributed to nearly 5,000 practicing providers in the state of Colorado upon its completion. The Health TeamWorks guidelines are evidence-based and easy to read, and they provide user-friendly educational resources for busy providers.

The CAFP childhood obesity project brings obesity-related clinical guidelines, such as Health TeamWorks, from “theory into practice,” first in the primary care setting and, second, in the home and community, by creating diagnostic tools for physicians to utilize in clinical practice. This user-friendly, relevant template can be readily implemented at the clinical level and will result in an integrated, easily replicable obesity prevention and intervention model for Colorado youth and families.

The project will include a pilot that will test the model and lead to program modifications that will pave the way for a larger-scale rollout to more primary care offices. The pilot will facilitate the adoption of intervention programming that is developmentally appropriate and scalable and that builds on the evidence-based approaches. Physicians and practices that would like to participate in the pilot study or would like additional information about the CAFP childhood obesity project may contact Cara Coxe, CAFP Wellness Programs manager at 303-696-6655 ext. 14 or cara@coloradoafp.org.

References

1. Larimore et al, An Eight-Week Pilot Trial of a Family-Based Intervention for Childhood Obesity and Hypertension;
2. Lau et al, Canadian clinical practice guidelines on the management and prevention of obesity in adults and children; CMAJ, 2007(April 10); 176 (8): 1103-1106
PCMH was Focus of First Workshop

**Report from AAFP Resident/Medical Student National Conference**

By Lawrence (LP) Wegryn, MS4

**Thursday, July 29** – After arriving in Kansas City, Mo., early to register, I attended the conference orientation led by the student and resident organizers (Tanya Anim and Shannon Brodersen, respectively). Next was the opening main-stage lecture by Darrel Kirch, M.D., which was a motivational launching point for the conference. The first workshop I attended was “Determining the ‘Homeness’ of a Residency or Practice.” In this session, the presenters discussed methods and questions that we could use to evaluate how programs that we are considering committing to have integrated the concept of the Patient Centered Medical Home into their practice. After lunch, I attended the joint resident and student congress, where we heard annual reports from resident and student leaders and learned about the parliamentary resolution system. Later that afternoon, I attended a dermatology workshop titled “Common Skin Problems.” That evening, I returned with my wife for the residency fair in the exposition hall, where we met representatives of a number of residency programs to gather information for my ongoing application process.

**Friday, July 30** – The morning started with a speech from the keynote speaker Denis Rodgers, M.D., who lectured about health disparities and how we can individually make a difference. Following this lecture, I attended an informative session, “Applying to Residency: From Application to Interview,” where I learned of some new resources and was reminded of deadlines. After lunch, I attended the student congress, where we heard from associated organizations American Family Medicine Residency Directors and the Society of Teachers of Family Medicine. We also obtained copies of the proposed resolutions and heard an overview of the remaining steps in the resolution process. After this session, I returned to the exposition hall, where I talked with more residency programs. Before leaving for the evening, I attended a workshop titled “How Do I Stay Current?” where we learned about some of the different resources available for keeping up with medical literature in residency and in practice.

**Saturday, July 31** – Again, the morning started with a keynote speaker. This morning, we heard from Norman Kahn, M.D., about the economic and political environment that faces us as family physicians. The rest of the day was spent in the student congress business session, where we heard the recommendations for the reference committees before voting on the individual resolutions and consent calendars.

Resident Recruitment was on the Agenda

**Report from 2010 AAFP Resident/Medical Student National Conference**

By Jessica Tennant, M.D.

The American Academy of Family Physicians Resident/Medical Student National Conference filled an exciting weekend that brought together the nation’s family medicine residencies, including faculty and residents, along with medical students interested in pursuing family medicine as a career. In addition, the medical student and resident congresses met in session to discuss resolutions that state chapters and individual residents and students in medicine have written and believe are important for the AAFP to hear, consider, and perhaps implement at the national level. I had a great time and want to share a few highlights.

Part of my time at national conference was spent at the booth for the Exempla Saint Joseph Residency, where I am a resident. By staffing the booth, I was able to meet medical students and help the Colorado Association of Family Medicine Residencies recruit potential candidates for future residency positions in Colorado. There were resident and faculty representatives from all nine Colorado residencies, and our state’s booth was one of the busiest all weekend long! CAFMR does a great job of collectively recruiting for the entire state, and the booth set-up, details, and information given to medical students were organized very effectively by the CAFMR staff. Overall, I think Colorado Family Medicine residencies were well represented this year!

The other half of my time was spent attending the resident congress business sessions with Colorado Resident Delegate Kyle Knierim, M.D. There were three sessions, and both resident elections and resolutions were on the agenda each day. I was quite impressed with the number and breadth of resolutions brought to the conference by residents and their state delegations. Topics ranged from urging the AAFP to advocate for healthy eating in schools to continuing to work on residents’ behalf for better loan repayment options after residency. The sessions were very educational, and I am confident that the newly-elected resident congress will represent our voice well at the national level this coming year.

I truly appreciated the opportunity to attend this year’s conference as the alternate resident delegate.
Variety of Lectures Provided Glimpse of Family Practice

Report from 2010 AAFP Resident/Medical Student National Conference

By Carolynn Francavilla

This year, I had the opportunity to attend my first AAFP National Conference of Family Medicine Residents and Medical Students. When I walked into the exposition hall for the first time, I was shocked at its size. It felt like I had at least two football fields of exhibits to walk through. Getting the chance to talk to residents from programs all around the country was invaluable. I was able to start thinking about what is really important in a resident program and getting a good feel for what different programs are like. I also learned about programs I had never heard of – like integrated medicine curriculums and leadership curriculums. I enjoyed the variety of lectures I was able to attend, with topics ranging from dermatology to family planning. These lectures provided a great example of the variety I expect to enjoy in family medicine. What really struck me the most were my encounters with other students from around the country. Everyone was so excited and passionate about going into family medicine – so enthusiastic for the huge range of opportunities that awaited them. Already excited myself to enter family medicine, I left proud and eager to be joining the field of family medicine.

Rural Track Turned Residents Toward Family Medicine

Jena Valdez, M.D., and Andrea Wismann, MSPH, M.D., were in first class

The following is part of a series of articles about the Rural Track at the University of Colorado Denver School of Medicine. For more information, see previous articles in the CAFP Magazine or at http://www.uchsc.edu/som/rural. Family physicians interested in hosting a Rural Track student can contact Program Director Mark Deutchman, M.D., at mark.deutchman@ucdenver.edu or 303-724-9725.

Having begun the Rural Track at the University of Colorado Denver School of Medicine in 2006, Jena Valdez, M.D., and Andrea Wismann, MSPH, M.D., were in the first class of graduates in 2009 and completed their first year as University of Colorado family medicine residents in 2010. Both reported multiple benefits from the program, including the realization or confirmation that they wanted to become family physicians.

“I did not know I wanted to be a family medicine doctor until I did my summer experience in Walsenberg for the Rural Track between first and second years of medical school,” Dr. Valdez wrote. “It was that month that really opened my eyes to what family medicine means.”

Dr. Valdez continued, “I feel like that experience has helped me during residency because I got to see what it means to be a great family doctor in a small town. I got the benefit of seeing what it was like to work both in an inpatient and outpatient setting, which is something I would like to continue when I start my career.”

She saw value in the Rural Track experience even in the process of getting into a residency program. “Being a member of the Rural Track gave me a great support system, especially when it came time to doing residency applications and interviews. Dr. D (Mark Deutchman, M.D., Rural Track director) was always willing to answer questions and give helpful advice. Even though I have graduated from medical school, I feel that I can still go to him with any questions I might have about my future career. Furthermore, doing rural rotations in medical school helped me to get more exposure to both operating room and office procedures, which has been an advantage during residency.”

Dr. Wismann reported that, on reflection, she feels the Rural Track “was the most influential experience in medical school. Overall, it helped expose me and prepare me for life as a primary care doctor.”

She continued, “The faculty and staff that facilitate the Rural Track program were incredibly supportive of my interests and actively helped me learn more about career opportunities in primary care. The procedural workshops we did were excellent skills training, such as ultrasound, suturing, casting and splinting, or examination of scratches and removal of foreign bodies in cow eyeballs.”

As a result, she wrote, “I felt much more confident going into residency having much more experience in these areas compared to my peers. Also, the opportunity to do an internship with a rural family physician during the summer of our first year of medical school solidified that family practice was what I wanted to do and provided a model that I can envision practicing within.”

Finally, Dr. Wismann wrote, “As part of the initial Rural Track class, we were a close group, with a camaraderie that carried over into the rest of our medical school activities. We still keep in touch with e-mails and newsletters.”
Roger Neil Chisholm, MD, Dies at Age 88

Son was among a galaxy of Family Physicians praising former CAFP pres.

“Who could ask for a better role model? As a child, I remember sitting in the back of our station wagon with my mother and siblings after church on Sunday while my father would go on a house call or stop at Swedish Hospital to see a patient. As a teen, I remember his constant travel and meetings as he and his contemporaries -- Jim Price from Brush; Tom Nicholas from Buffalo, Wyo.; Jerry Wildgen from Kalispell, Mont.; and countless others -- labored to get Family Medicine established as a board certified medical specialty. As a medical student and resident I saw him draw on his wealth of experience to teach and inspire a new generation of Family Doctors. … I care for the next generation of many families that were patients of my father. Every few months a new patient will come in and say, ‘Your father delivered me.’”

Thomas Chisholm, MD
June 2010


Richard Krugman, MD, was among those who signed the online guestbook in his memory. He wrote, “On behalf of the faculty, students, residents and staff of the C.U. School of Medicine, I want to express our sadness in Neil’s passing and our pride in his career here and what he meant for generations of Family Medicine physicians in training and practice. He really was a gentleman and a scholar and we will miss him.”

Others who wrote tributes included Robert A. Fried, MD, of the University of Colorado Family Medicine Residency Program class of 1979; Bill Marine, MD, professor Emeritus at the Colorado School of Public Health; and Frank Barry, MD, of Colorado Springs, as well as Family Physicians from around Colorado and as far away as Montana and Virginia.

Dr. Chisholm interned at Saint Joseph Hospital in Denver with emphasis on General Practice and surgery, then established a General Practice in southeast Denver in 1952. His practice thrived as he delivered hundreds of baby boomers to young parents, many of whom would remain loyal patients for decades.

He served as chief of staff at Saint Joseph Hospital in the 1960s and of Swedish Hospital in the 1970s. Then, after 25 years in private practice, he left to become a full-time faculty member at the University of Colorado School of Medicine. He eventually became chairman of the Department of Family Medicine and director of the Family Practice Residency Program.

Dr. Chisholm served as the president of the Colorado Academy of Family Physicians in 1959 and 1960 and on the board of directors of the American Academy of Family Physicians in the late 1960s. He was instrumental in the establishment of Family Medicine as a recognized specialty.

While on the faculty at the University of Colorado, Dr. Chisholm traveled as an ambassador of Family Medicine to Great Britain and Taiwan. He learned about the practice of Family Medicine in those countries and taught physicians there about how Family Medicine was established in the United States.

When he retired from the university in 1989, Dr. Chisholm signed on as a ship’s physician for Semester at Sea and, along with his wife, and traveled around the world with a group of college students and faculty.

In retirement, Dr. Chisholm pursued his passions for fly-fishing, golf and travel. He was a member of Emmanuel United Methodist Church for more than 50 years.

Throughout his life, Dr. Chisholm put family above career and self. He was married to Jeanne for 62 years before she preceded him in death in 2008. He was survived by two brothers, five children, eight grandchildren and one great-grandchild born just weeks before his death.

Shawn Dehne wrote in Dr. Chisholm’s guest book, “To all the Chisholm kids – your dad was absolutely the best Family Doc ever – brought me into this world, and helped keep me here on more than one occasion. He was a role model, and someone I feel honored to have known. If there is a ‘fishing heaven,” I’m pretty sure he and dad are hipboot-deep in a good hole!”
Syncope in Children: A Treatable Dilemma in Primary Care

By Kathryn K. Collins, M.D., and Jeffrey J. Cain, M.D.

Fainting and syncope are common complaints for children in primary care. Although most of these children with syncope may be managed in primary care, syncope may also be the first symptom in serious cardiac disease that requires consultation with a pediatric cardiologist. What are the keys in the history and physical that can help us best manage these children in our offices and to refer those children with more serious disease?

Syncope is defined as an abrupt loss of consciousness and postural tone followed by relatively prompt recovery over a period of minutes. It is a common occurrence in children, with the highest incidence seen in teenage girls. As many as 10 percent to 40 percent of adolescents report either fainting or having significant presyncopal symptoms. At The Children’s Heart Institute at The Children’s Hospital, Aurora, Colo., syncope is the referring complaint in 5 percent of all patients seen in cardiac consultations in the outpatient setting.

The syncopal conundrum is that simple fainting, also referred to as vasovagal or neurocardiogenic syncope, is a benign finding, and most patients can be appropriately managed in the primary care setting with minimal evaluation or intervention. But on the other hand, there is a concern that syncope may be the first or presenting symptom for one of the more malignant diseases which can cause sudden cardiac death. Table 1.

Although sudden cardiac death in the pediatric population is extremely low, it is always a terrible tragedy for the family and the community when a young individual who was thought to be healthy dies suddenly and unexpectedly from a previously undiagnosed cardiac cause. How can we differentiate between benign syncope and the potential for sudden cardiac death?

Patient history for vasovagal syncope

The classic story for vasovagal syncope would be for a pre-teen or teenager who reports prolonged standing on a hot day, such as at choir or band practice. Alternatively, the patient may also report prolonged sitting and then an abrupt position change to standing. Commonly there is often a report of not having eaten or drank much on that specific day. Usually children with vasovagal syncope will complain of prodromal symptoms of feeling warm, slight dizziness, seeing spots, tunnel vision or a general sense of unease. During the syncopal episode, the patient will pass out for a brief period of time and then recover without intervention. When the patient recovers from the loss of consciousness, he or she may continue to be pale, somewhat dizzy and typically quite exhausted.

Other classic stories for vasovagal syncope include specific triggers such as the sight of blood, having blood drawn or noxious stimuli like hitting an elbow. Hair grooming syncope or micturation syncope have been reported.

Patient history for cardiac syncope

In contrast to vasovagal syncope stories, patient histories for sudden or aborted cardiac death involve abrupt collapse with few or no prodromal symptoms. A typical story would be a previously healthy young athlete who

Table 1. Potential Causes of Cardiac Sudden Death in Patients Without a Murmur

- Hypertrophic Cardiomyopathy
- Long Qt syndrome
- Wolff-Parkinson-White Syndrome
- Catecholamine polymorphic ventricular tachycardia
- Brugada Syndrome
- Arrhythmogenic Right Ventricular Dysplasia
- Congenital Coronary Artery Anomalies
Table 2. ‘Red Flags’ for syncope which could prompt referral to a cardiologist

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<td>Family history of sudden or unexplained death</td>
<td>Syncope with no prodromal symptoms</td>
</tr>
<tr>
<td>Abnormal physical examination (murmur)</td>
<td></td>
</tr>
</tbody>
</table>

was running down the basketball court and then drops to the floor in mid-stride. These patients are not even able to try to catch themselves as they fall and may sustain injuries secondary to the fall. Several cardiac conditions with no previous symptoms can present with exercise-associated syncope, including hypertrophic, dilated and electrical myopathies. While symptoms of palpitations, urinary incontinence, onset with exercise, or onset while sitting or supine could raise the suspicion of serious arrhythmia, none is diagnostic. Thus, all patients with syncope during or around exercise deserve prompt cardiac referral and additional testing.

Other important factors that may indicate cardiac sources could be syncope associated with loud noises or with extreme emotion or prolonged QT syndrome.

Because many cardiac diseases in children have a genetic background, it is important to gather any pertinent family history relating to early, sudden or unexplained deaths. And, in reverse, a sudden or unexplained death in one family member should prompt consideration for screening other family members.

Cardiac evaluation

The diagnosis of neurocardiogenic syncope can be confidently made in most children with a detailed history, physical examination and electrocardiogram. In one study of patients referred to a pediatric cardiology practice for evaluation of syncope, 5 percent were found to have cardiac syncope. Of those, almost all could be identified by syncope with exercise, an abnormal electrocardiogram, a family history of arrhythmia or an abnormal physical examination. Family history should focus on sudden or unexplained death prior to age 40 years, congenital deafness or cardiomyopathy. Physical examination should focus on orthostatic vital signs, a detailed cardiac examination for murmurs and a neurologic examination. Examination should also explore for any signs of systemic disease, such as connective tissue disease like Marfan syndrome.

The electrocardiogram is a good screening tool that can show signs of left ventricular hypertrophy (suggestive of hypertrophic cardiomyopathy), Wolff-Parkinson-White syndrome, conduction defects, and electrical myopathies, such as long QT syndrome, but does not screen for coronary abnormalities. Further evaluation with 24-hour Holter monitoring, event recorders or loop recorders can be used as a means to correlate symptoms with any cardiac rhythm abnormality.

Routine echocardiographic screening for syncope has very low yield. In most instances, the reason to do an echocardiogram is to demonstrate absence of serious disease. If the history or electrocardiogram demonstrates some abnormality, then an echocardiogram would be the next step for determining such diagnoses as hypertrophic cardiomyopathy or abnormal coronary artery origins.

**Treatment and clinical course for vasovagal syncope**

Initial treatment for vasovagal syncope is volume expansion through increasing salt and water consumption. Patients can also learn to be more aware of prodromal symptoms and can choose to sit or lie down in order to avoid a frank syncopal episode. Behavioral therapy has been supported in the literature. Pharmacologic management is also available, albeit very imperfect, through medications such as fludrocortisones, betablockers, midodrine or serotonin reuptake inhibitors. Neurolly mediated syncope is not associated with any increased risk for mortality. Most adolescents appear to outgrow their episodes over several years.

Summary

Neurocardiogenic syncope, or vasovagal syncope, is a common occurrence in childhood. A thorough patient history, family history and physical examination are the main means of diagnosing this condition, which can be managed in primary care. A referral to a pediatric cardiology clinic should be made if there is syncope with exercise, a family history of sudden or unexplained death or abnormal physical examination findings.

Kathryn K. Collins, M.D., is an associate professor of pediatrics at The Children’s Hospital and the University of Colorado, where she is the director of the Pediatric Arrhythmia Center and Adult Congenital Electrophysiology.

Jeffrey J. Cain, M.D., is an associate professor of family medicine at the University of Colorado and the chief of family medicine at The Children’s Hospital.

Kids Corner is a regular feature of the CAFP News. You may reach the authors for questions or suggestions for future topics thru OneCall (720-777-3999.)
The New Colorado Child Restraint Law and Anticipatory Guidance

Children up to age 8 need age-appropriate restraints

Effective Aug. 1, 2010, Colorado’s child passenger safety law was expanded to require that all child passengers under age 8 be protected using a child safety seat. Colorado joins 27 other states requiring children up until the age of 8 to ride in a child restraint or a booster seat.

“Congratulations Colorado. It’s clear that enforcement makes a difference. We have seen a dramatic decrease in injury in our own state as a result of implementation of similar legislation,” stated Dr. Marilyn Bull, medical director for the National Automotive Safety Program at Riley Hospital for Children, Indiana University School of Medicine.

This change in legislation means thousands of 6- and 7-year-olds across the state will now begin riding in booster seats or with five-point harness restraints. Previously, the law required only 4- and 5-year-olds to be in boosters. Experts recommend that children remain in a forward-facing car seat longer if the upper weight limit of the seat allows it (usually 40-50 pounds). A five-point harness allows for better distribution of crash force and prevents “submarining,” which occurs when a passenger slides under a lap belt. However, most kids ages 4, 5, 6 and 7 prefer a booster seat to a five-point restraint.

Why is a booster seat so important? Studies show booster seats increase your child’s odds of avoiding personal injury in the event of an auto accident (Winston et al, Pediatrics 2009).

It is well known that children ages 5 to 8 are the least likely to be appropriately restrained (Durbin et al, Pediatrics 2001). Many parents and caregivers mistakenly believe that a seatbelt is enough to protect their children. Unfortunately, seatbelts are made for adults and do not fit children properly. “In a car crash, a child in a booster seat is half as likely to suffer an injury, compared to a child wearing only an adult seat belt. Improperly restrained children can suffer a range of injuries, such as abrasions and abdominal injuries, or more devastating injuries such as paralysis or head injury. Booster seats save lives and help prevent lifelong disabilities. We have yet to see evidence that booster seat effectiveness declines with age,” stated Steve Moulton, M.D., trauma director, The Children’s Hospital, and professor of surgery, University of Colorado School of Medicine. In Colorado from 2004 through 2008, 28 children ages 4 to 7 were killed in traffic crashes. Twenty of them were improperly restrained, totally unrestrained or using the vehicle lap and shoulder belts alone.

When children turn 8, the law allows them to use seatbelts. But for the best protection, it is recommended that kids continue to use a booster seat until they are big enough to ride safely using a lap and shoulder belt. This can be determined by answering the following five questions:

1) Is the child able to sit with his or her back against the vehicle seat?
2) Are knees bent?
3) Does the shoulder belt fit in the center of the shoulder and across the child’s chest?
4) Is the lap belt touching the thighs?

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2) Are knees bent?
3) Does the shoulder belt fit in the center of the shoulder and across the child’s chest?
4) Is the lap belt touching the thighs?
5) Can the child stay seated like this for the duration of the ride?

These criteria are typically met when a child is 4’9” tall. Few 8-year-olds meet these criteria as a 9-year-old that is 4’9” is in the 95th percentile.

There are additional changes to the law that give parents more flexibility in choosing appropriate safety seats for their children. Children younger than 1 year must ride restrained in the rear seat. Once babies turn 1 year old and weigh 20 pounds, the law gives drivers the option of using a front-facing car seat. Rear-facing car seats are still allowed by the new Colorado law, and it is recommended that parents continue using them until the upper weight limit allowed by the car seat manufacturer is reached. Rear facing is simply the safest way to ride in a vehicle -- it provides the maximum protection of the head, neck and spine. For the best protection, all children should ride in the back seat until they are at least 13. It’s twice as safe as the front seat. (Insurance Institute for Highway Safety).

September is National Child Passenger Safety Month. In honor of National Child Passenger Safety Week, Sept. 12-17, the Colorado Department of Transportation, in collaboration with The Children’s Hospital, is distributing a “Physician Resource Tool Kit.” This tool kit includes a poster, brochure and a one-page flyer on the new law. Complimentary tool kits are available through silva.selena@tchden.org.

Resources are available online at www.thechildrenshospital.org/carseats.

The Role of Health-Care Providers in Preventing Pertussis

Leah R. Kaufman

Pertussis has shown a dramatic increase in the number of confirmed cases in 2009. An unusually high number of cases continue to be reported in 2010. Over the last 5 years, 8,000-25,000 cases of pertussis were reported per year in the United States. Pertussis is an endemic disease in the United States. As such, there are generally outbreaks every 3 to 4 years. During 2008, Colorado had 158 confirmed cases of pertussis. In 2009, the number of confirmed cases of pertussis rose to 233. The age group with the highest rate of pertussis in 2009 was infants <1 year of age (43.6/100,000). The majority of cases in the <1 year-old age group (74%) were under 7 months of age and, therefore, too young to receive the minimum of three doses of pertussis vaccine needed for protection. The majority of children, especially infants, contract pertussis from a parent or other adult they are in contact with, rather than from other children.

Health care providers can help alleviate the increase in pertussis with these important measures:

1. Test patients suspected of having pertussis in a timely manner with the rapid and sensitive PCR test for nasal wash specimens.
2. Provide antibiotic prescriptions for patients with pertussis and their close contacts, regardless of age or immunization history, to prevent further spread of this disease.
3. Instruct patients with pertussis to avoid public contact because they are contagious until they have completed 5 days of antibiotic treatment or 3 weeks of coughing if untreated.
4. Review vaccine coverage for pediatric patients and encourage parents to make sure that their children’s immunizations are up-to-date. Parents should also ensure that their immunizations are up to date.

Please visit the CDC website at: http://www.cdc.gov/vaccines/pdp-vac/pertussis/ for further information on pertussis outbreaks 2010. There are also some excellent resources for healthcare providers, including Guidelines for the Control of Pertussis Outbreaks and information on Surveillance of VPDs.

Information for this article was obtained from the Colorado Department of Public Health and Environment, The American Academy of Family Physicians and the Centers for Disease Control and Prevention. For a list of references please visit: www.coloradoafp.org – Immunization Initiative.
Genetic Screenings Help Identify Patients at Increased Risk for Cancer

By Alan Lembitz, M.D., Vice President, Patient Safety and Risk Management

Although claims related to a failure to address genetic issues in adults are not yet frequent, COPIC predicts they will increase. For this reason, and for optimal care of your patients, we share the following.

It seems obvious that an individual’s health is influenced by family history and genetics. It’s also fair to note that adverse environmental factors (e.g., asbestos, exposure to UV rays, smoking) do not result in disease in all individuals. Advances in the identification of genetic variations in individuals help explain some of these differences.

A woman’s lifetime risk for the development of breast cancer is reported to be between one in eight and one in 10. However, approximately 10 percent of breast and/or ovarian cancer may have a hereditary predisposition. Most of these hereditary (or familial) cases are due to mutations in genes BRCA1 (on chromosome 17) or BRCA2 (on chromosome 13). Currently, Myriad Genetics Laboratories has the patent to perform the analysis to identify these mutations. This mutational analysis can be performed using tissue and/or blood.

Some factors increase the likelihood that a particular patient may have inherited the predisposition to hereditary breast and ovarian cancer, or HBOC. These include:

1. Multiple relatives with breast and/or ovarian cancer
2. Personal or family history of ovarian cancer at any age
3. Early age of diagnosis of breast cancer (before 50 years of age)
4. Personal or family history of male breast cancer
5. Bilateral breast cancer
6. Breast and ovarian cancer in the same individual
7. Ashkenazi Jewish (Central or Eastern European) individuals with a family history of breast and/or ovarian cancer

Mutational analysis results are reported as:

1. Negative for a deleterious mutation
2. Positive for a deleterious mutation
3. Suspected deleterious mutation
4. Probable polymorphism (thought to be a normal variant)

It is recommended that the mutational analysis test is performed on a relative who has been diagnosed with the disease before performing the test on a relative who may be at risk for developing the disease. If testing a relative with the cancer is not possible, then testing an at-risk relative may be in order.

Individuals who are found to have a deleterious or suspected deleterious mutation may have an increased risk of at least 53 percent to 75 percent for the development of breast cancer by age 70 and at least 35 percent to 40 percent risk for the development of ovarian cancer. Individuals who have had breast cancer may have a 20 percent increased risk for developing breast cancer again.

Carriers of these mutations may also be at increased risk for:

- Leukemia
- Lymphoma
- Stomach cancer
- Colorectal cancer
- Pancreatic cancer

Males with a deleterious mutation would be at an increased risk for the above cancers and prostate cancer.

Use of tamoxifen and possibly Evista® in females at risk will reduce the risk for the development of breast cancer. Birth control pills may lower the risk for ovarian cancer. Bilateral mastectomy with or without reconstruction and bilateral oophorectomy with or without hysterectomy may lower the risk of cancers of these organs by 90 percent to 95 percent. Individuals with a deleterious mutation should begin breast surveillance and have annual or semi-annual pelvic ultrasound with color Doppler flow studies and CA-125 at 25 to 35 years of age. Blood studies for HE4 for monitoring patients with ovarian cancer in combination with CA-125 have recently become available, and new studies are looking at the role of blood HE4 and urine Bcl-2 in ovarian cancer detection and surveillance.

Thanks to Paul Wexler, M.D., for his contributions to this article.
What’s Reading Aloud Got to Do with It?

Promoting healthy child development lies at the heart of providing pediatric health care, but applying evidence-based standards to the promotion of childhood development is a major challenge. In one area of this effort, however, the evidence is clear: Reading aloud to young children, particularly in an engaging, supportive manner, promotes emergent literacy and language development. It also supports the relationship between child and parents.

Although shared book reading is often considered a common activity among parents and young children, fewer than 60 percent of parents in Colorado reported reading daily to their children ages 0-5. The problem is not limited to low-income families; in fact, approximately 30 percent of middle- and upper-income parents reported that they did not read to their children daily. It is therefore critical that health providers encourage all parents, regardless of income status, to read aloud to their young children.

So what does parents’ reading with their children have to do with family medicine?

- More than 50 percent of the well-child exams done in Colorado are conducted by family physicians.
- More than 50 percent (94,000) of the low-income children under age 5 in Colorado benefit from the Reach Out and Read program; many of these children are in rural and underserved communities.

By incorporating the Reach Out and Read program into your practice, you are simply rethinking how you provide pediatric care, and it doesn’t add time to your well-child exams. The evidence-based program consists of a simple, three step model:

1. Provide literature-rich waiting rooms (reading corners).
2. Give a new book to children ages 6 months to 5 years at the start of their well-child exam.
3. The primary care provider is the one to give the book and encourage the parent(s) to take it home and share it with their child.

In Colorado, more than 850 primary care providers, most of these family physicians, provide the Reach Out and Read program through more than 145 primary care clinics. Program expansion occurs via providers requesting the program in their offices, speaking to the ease and efficiency of implementing this evidence-based program in the clinic setting.

The cost of the program is fully covered by Reach Out and Read Colorado. Additionally, Reach Out and Read Colorado provides training, best practices and program implementation support -- all for free. There is no better way to support the language and literacy development of your patients than Reach Out and Read, and all at no cost to your clinic!

Ninety percent of Colorado’s children receive preventative health care, while only 30 percent are in childcare settings. Providers have unprecedented access to young children and families, and parents listen to the anticipatory guidance given by their children’s providers. As a provider of pediatric health care, you are in a unique and critical position to support children’s love of books.

During shared book reading, children uncover the basic steps that precede reading: They learn to recognize letters and understand that print represents the spoken word. They learn how to hold a book, turn the page and start at the beginning (Bus, van Ijzendoorn, & Pellegrini, 1995a; Snow & Ninio, 1986; Vellas, 1996). Shared bookreading is also associated with learning print concepts (Snow & Ninio, 1986), exposing children to the written language register, which is different from spoken language (Mason & Allen, 1986), as well as story structures (e.g., stories have a beginning, middle, and end) and literary conventions such as syntax and grammar, which are essential for understanding texts (Cochran-Smith, 1984). All these skills are important for later success in reading (e.g., Lonigan, Burgess, & Anthony, 2000; Sénéchal & LeFevre, 2002). Finally, shared bookreading can also promote children’s phonological awareness and the ability to manipulate the sounds of spoken language (e.g., Adams, 1990; Lonigan, 2006; Stanovich, 1992; Vellutino & Scanlon, 1987), other important prerequisites of learning to read. Children’s knowledge of nursery rhymes at age 3-4 is related to detecting alliteration and rhyme at ages 4-7 (MacLean, Bryant, & Bradley, 1987).

Parents can help promote children’s phonological knowledge by reading books with rhymes and alliteration and by drawing the child’s attention to the rhyming sounds.

The types of conversations adults and children have while reading aloud also matter. The emotional quality of their interactions and the discussions related to print are important (Snow, 1994). It is not sufficient to simply read a text aloud in order to encourage children to learn from being read to. When parents are supportive, this affects how children engage with books (Bus, 2003).

To learn more about, or start, Reach Out and Read for your practice, visit www.reachoutandreadco.org or call at (303) 623-3800. For the hundreds of providers currently providing this important program, we thank you!
With the recent attention the Grand Junction, Colo., health care community has garnered, there has been some curiosity as to how it all started. The success of the community is actually a great testimony to the impact a group of concerned physicians can have.

The setting in Grand Junction in 1971 was an economically depressed community with about 60 physicians and three hospitals located 250 miles from two major medical centers. Medicaid paid $3.80 for an office visit, so most physicians did not bill Medicaid, but saw the patients for no reimbursement rather than waste resources on the billing process. Most physicians had a “Free Day” each month when they saw patients who could not afford care and did not charge these patients. The physicians were frustrated with the lack of preventive services for those without money and with their presentation in the late stages of disease, when little could be done to help them.

The catalyst for change was a small group of physicians who met for lunch once a week at the local country club to discuss the Clinical Pathology Conference from the New England Journal of Medicine.

The group was referred to as the “Friday Noon Chowder and Marching Society” and was attended by a dermatologist, two general practitioners, a general internist, an orthopedist, a psychiatrist, a radiologist and a general surgeon.

Ward Studt, M.D., the orthopedist, had recently completed a MBA program in Medical Administration at the University of Colorado. He returned from one session with news of a new concept, a Health Maintenance Organization (HMO) that the federal government was proposing. He and Ed Ellinwood, M.D., a family physician who had a neighboring parking place, happened to be leaving their offices at the same time, and Dr. Studt ran the concept of the HMO by Dr. Ellinwood. They decided to discuss it further at the Friday noon meeting. They felt that an HMO would offer several significant benefits, including the following:

1) A low-cost health plan that included preventive services;
2) A solution to the Medicaid reimbursement dilemma;
3) A potential option to the increasing regulatory conundrum of the new Medicare program; and
4) A local HMO option rather than an outside entity coming to town, since the federal program included a proposal to require all employers to offer an available HMO to their employees.

The “Chowder and Marching Society” discussed the possibilities
and decided to proceed. The first step was to garner support from local physicians, so the members first approached the local general practitioners and internists. These physicians would need to become gatekeepers and accept a 20 percent withholding from their fees that would be “at risk” depending upon the success of the venture. The general practitioners and internists were supportive, so the group approached the various specialty groups with general acceptance. Within a year, nearly 80 percent of the physicians had signed up with the newly formed “Western Colorado Physicians Services, P.C. (WCPS, P.C.), which was to be the legal entity to apply for the HMO license with the federal government.

The group applied for and received a $9,000 federal grant that helped with the costs of organizing and incorporating.

Rocky Mountain Health Maintenance Organization was subsequently established by WCPS, P.C. Dr. Ellinwood was elected president of the new HMO board. He then had the “privilege” of signing on the $325,000 federal loan to fund the startup of Rocky Mountain Health Maintenance Organization (RMHMO) in 1973, the same year the federal HMO act was finalized. RMHMO was the seventh federally qualified HMO in the nation.

RMHMO offered a commercial plan initially, then contracted with Colorado State Medicaid for Medicaid services, and shortly thereafter received a cost contract with Medicare.

The early physician participants recognized the critical issue of access and devised the plan to share funds between lines of business and pay physicians equally for Medicaid, Medicare and commercial business. As a result, Mesa County has had universal access for Medicaid patients for the past 37 years. This represents a unique occurrence in large communities.

Dr. Studt met John Harrison, a fellow student in the MBA program, and Harrison was hired as the first administrator to help set up the HMO. Together with Charles Wilson, M.D., they developed the structure of the HMO and signed the original incorporation documents.

Harrison hired Mike Weber as a financial officer. Shortly thereafter, Weber became the chief executive officer and the administrative driving force of RMHMO for 27 years.

Once formed by the physicians, RMHMO was turned over to a community board. RMHMO would later become Rocky Mountain Health Plans. The WCPS, P.C. would later become the “Mesa County Physicians’ Independent Practice Association.” Those two entities drive the innovative, collaborative, high quality and cost-effective program that is the “Grand Junction Model of Health care Delivery” and continues to this day.

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