Jeff Cain, MD, elected AAFP President-Elect

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**Vision Statement:** Thriving Family Physicians creating a healthier Colorado.

**Mission Statement:** The CAFP’s mission is to serve as the bold champion for Colorado’s family physicians, patients, and communities through education and advocacy.

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<tr>
<td>President</td>
<td>Kajsa Harris, MD</td>
<td>Pueblo</td>
<td><a href="mailto:kajsharris@hotmail.com">kajsharris@hotmail.com</a></td>
</tr>
<tr>
<td>Secretary/ Treasurer</td>
<td>Ryan Flint, DO</td>
<td>Denver</td>
<td><a href="mailto:ryan.flint@accessfamilymed.com">ryan.flint@accessfamilymed.com</a></td>
</tr>
<tr>
<td>President-elect</td>
<td>Robert Brockmann, MD</td>
<td>Englewood</td>
<td><a href="mailto:r.brockmann@yahoo.com">r.brockmann@yahoo.com</a></td>
</tr>
<tr>
<td>Members At Large</td>
<td>Candace Murbach, DO</td>
<td>Pueblo</td>
<td><a href="mailto:candacerm210@aol.com">candacerm210@aol.com</a></td>
</tr>
<tr>
<td>Vice President</td>
<td>Rick Budensiek, DO</td>
<td>Greeley</td>
<td><a href="mailto:rbud5623@hotmail.com">rbud5623@hotmail.com</a></td>
</tr>
<tr>
<td>Chair/ Past President</td>
<td>Luke Casias, MD</td>
<td>Hesperus</td>
<td><a href="mailto:lcasias@hotmail.com">lcasias@hotmail.com</a></td>
</tr>
</tbody>
</table>

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### Board Members

- **Terms expiring 2012**
  - Tracy Hofeditz, MD, Lakewood
  - Monica Morris, DO, Denver
  - Wilson Pace, MD, Aurora
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  - Tamaan Osborne-Roberts, MD, Denver

- **Terms expiring 2013**
  - Larry Kipe, MD, Craig
term expires 2012 (2nd term)
  - E-mail: lkipe@aal.com
  - Kern Low, MD, Pueblo
term expires 2012 (2nd term)
  - E-mail: kln@aal.com
  - Virginia Robertson, Publisher
  - www.pcipublishing.com
  - 14109 Taylor Loop Road
  - Little Rock, AR 72223
  - 501.221.9986

### Affinity Programs Task Force
- Skip Carstensen, MD, Aurora
  - hpractices@qwest.net

### PCMH Committee
- Scott Hammond, MD, Westminster
  - shammond@evcohs.com

### Workforce Task Force
- Tracy Hofeditz, MD, t.hofeditz@smn.com

### Tort Reform Task Force
- Bob Brockmann, MD, r.brockmann@yahoo.com

### Resident Relations Task Force
- Ryan Flint, DO, ryan.flint@accessfamilymed.com

### CAFP Delegate to CMS House of Delegates
- Monica Morris, MD, mccormiga@gonzaga.edu

### Staff
- Raquel Bosen, MA, CAE, Chief Executive Officer
  - E-mail: Raquel@coloradoafp.org

### Annual Scientific Conference Coordinator
- Kristin Bennett
  - E-mail: Kristin@coloradoafp.org

### Wellness Programs Manager
- Cara Coxe
  - E-mail: Cara@coloradoafp.org

### Administrative Assistant
- Eleanor Mills
  - E-mail: Eleanor@coloradoafp.org

### Director of Public Policy
- Jeff Thormodsgaard
  - E-mail: jeff@hendersonconsultinginc.com

### Editor
- Luke Casias, MD
  - E-mail: lcasias@hotmail.com

---

### 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 303-696-7724
- E-mail info@coloradoafp.org
I think it is only fitting to start my year with the Colorado Academy of Family Physicians by saying thank you to all for allowing me the privilege of serving as your president. It is indeed a humbling experience to be allowed to do this. I would like to also thank the CAFP staff and our chief executive officer Raquel Rosen for all the support they have already given and the future support I know I will be receiving from them. Without this very talented group of people we would not be as successful as we are.

We have an exciting year coming up. Yes, we are being faced with some threats but with this I think come some amazing opportunities. We are all very busy in our own practices but I truly believe that the time has come for all of us to pull together and work as the team we are trying to model in the Patient Centered Medical Home. In order to facilitate this we are going to reach out to you in the next few months to find out what you, our members, need. We would like to hear what you are passionate about, what legislative events are important to you and what you need from us as a board. We would like to hear your ideas as well as encouraging all of you to participate in some way. Maybe it will be Tar Wars, Doc-of-the–Day, weighing in on a piece of legislation, running for the board or creating a PCMH in your own practice. No contribution is too small!

On a very positive note, we are receiving a number of grants and planning several educational activities this year. Currently, we have grants related to immunizations, Tar Wars and pediatric obesity, and are working on grant for physician assistant pilot program. For more information on all of this please see the CAFP web site.

In the next few months we are planning webinars to help all of us understand accountable care organizations. As more information becomes available we will work diligently to keep all of you informed on this somewhat complicated topic. There will also be a series of webinars on immunizations coming your way so stay tuned for more information on this. Please, don’t forget in April the scientific assembly. This will be held once again in Colorado Springs at the Cheyenne Mountain Resort and it is not too early to register. Last but not least, the CAFP will continue to provide information and resources on becoming a Patient Centered Medical Home. We have some amazing champions both on and off the board and their experience and knowledge is yours for the asking.

For all who may not know, one of our Colorado Family Physicians and a past president of the CAFP is running for president of the American Academy of Family Physicians. The AAFP congress will be meeting in Orlando in just a few short weeks. Elected or not, Jeff Cain has spent the year traveling, speaking and representing Colorado Family Physicians. Having heard him speak, I am proud to say he has represented us well.

I will close by asking everyone to respond as we begin the process of finding out who we are and what we need as an organization. The time has come for us to stand together and be warriors for our specialty. Together we can be the Bold Champions of Colorado.
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For additional resources and support in adopting certified EHR technology, visit the Office of the National Coordinator for Health Information Technology (ONC):

Highlights Include Obesity Study and Immunization Education

This year, 2011, has been very productive year for the Colorado Academy of Family Physicians. Following are some highlights.

**Pediatric Obesity Study**
With 16 practices participating, we have continued to make progress on the pediatric obesity pilot study. We recently met with The Colorado Health Foundation, which is funding this pilot. We will be submitting a new grant request to expand the study and develop a pediatric obesity training for certification. If you are interested in having your practice participate in the next study please contact cara@coloradoafp.org.

**Systems of Care/Patient Centered Medical Home**
We successfully completed the two-year collaborative grant to raise awareness among all physicians in Colorado regarding the value of the Patient Centered Medical Home (PCMH) and to educate CAFP members on how to transform their practices. We now have a robust library of information on our web site where you can find tools to start your journey to PCMH, http://www.coloradoafp.org/medicalhome.shtml. If you need assistance please contact me and I will help direct you to the right resource.

**Immunization Education**
The CAFP has received a new grant from the Colorado Department of Public Health and Environment to partner with them on a series of webinars on important immunization topics. Please check your email and the CAFP web site for upcoming notices.

**Legislative Activities**
Jeff Thormodsgaard, CAFP director of Public Policy, and Mendez Consulting will be working on strengthening the CAFP’s public policy strategies and activities. What you can do to help is volunteer at least one half-day as the Doctor of the Day at the Capitol and donate up to $50 to the CAFP Small Donor Committee. Your presence at the Capitol as the Doctor of the Day is very important for CAFP and you also provide an important service for the legislators and Capitol staff. Please go to the CAFP web site to sign up at http://www.coloradoafp.org/webcal/month.php?date=20120101.

**Focus for the Future**
- Payment Reform: CAFP Leaders will continue to meet with legislators and regulators regarding the need for payment reform for primary care physicians and Patient Centered Medical Home practices.
- PR Branding: The CAFP has hired a public relations company to work with CAFP leaders. The goals of the project are to reframe public opinion regarding:
  - The importance and value of Family Physicians
  - The importance & value of the Patient Centered Medical Home
  - The value of the physician directed team based care
  - Differences in training between Family Physicians & mid-level providers
  - Differences in care provided by Family Physicians & mid-level providers
  - The importance and value of Family Physicians in health care reform
- ACO training: CAFP leaders recognized the need to prepare Family Physicians so they can lead in this new Accountable Care Organization environment. Here is the schedule for upcoming webinars:
  - Webinar #1, Wed. Oct. 19, 12:00 pm - “2012 - A year of Decision: Practical ACO Strategies for Colorado Family Physicians”
  - Webinar #2, Wed. Nov. 2, 12:00 pm - “Forming ACO’s with other specialties - How do the pieces fit?”
- Medical students and residents: You are invited to speak with medical students about your career in Family Medicine and with Family Medicine residents about being involved with the CAFP.
  - Medical Student Dinner
    Friday Jan. 13, 2012, The Summit Event Center
  - Residents Dinner
    Friday May 18, 2012, Maggiano’s Denver
Please RSVP for these events to eleanor@coloradoafp.org.

The staff and I appreciate all you do for the people of Colorado, as well as the opportunity to support you in your efforts.
Congratulations to Jeff Cain, MD, past president of the CAFP, for being elected by the AAFP Congress of Delegates as the next AAFP president. Dr. Cain has served on the AAFP board of directors for the last three years. His leadership, vision, and skill at advocacy were key elements in making him the best candidate.

Here is the campaign speech he delivered to the AAFP Congress of Delegates in Orlando, Florida on Sept. 13.

Family Medicine at the Tipping Point

To author Malcolm Gladwell, the Tipping Point is the moment of critical mass when the curve on the graph shoots upward, when an idea becomes culturally viral. To Gladwell, the tipping point is a book, his theory to family medicine, the tipping point is real and it is right now.

For the first time in our careers Family Medicine is taking Center stage. Why? Because the values we share and the stories of our patient are now aligned with the proven economic benefit of family medicine. Grundy, Starfield, Dobson and others, they've proven that having a family physician translates into better outcomes, healthier patients, improved quality of care, decreased costs. And as Gladwell suggests at a time of crisis, when story and economics align, you reach the tipping point when real change is possible. Our time is now.

Family Medicine is what our patients want because we share the stories of their lives. I met my patient Kristie before she had a name, when all we knew of her was the sound of her heartbeat at her mother's prenatal visit. Kristie's parents Todd and Dianne were scared. Todd was out of work. They were on Medicaid. But Todd's hands were steady as he cut Kristie's cord. Together, we watched Kristie grow and thrive each and every developmental milestone leading up to this point as Kristie heads off to college.

I met Barbara and the other end of life as she faced an incurable disease. Barbara smiled when she told me she and Dave “had to” get married all those years ago. Now that same daughter sat with us at Barbara's end of life conference. That is what family medicine is all about. Relationships. And the stories of people like Barbara and Kristie. Birth to Death and always, patient first.

Family Medicine is changing. From Marcus Welby's black bag to holding a patient’s complete medical information in the palm of your hand. The medical chart, the hospital library, right here. Yet even with the promise of advancing technology the story remains the same. Because it’s relationship that holds the value, both the personal and economic.

Family Medicine and our organization face huge challenges. There are still 50 million Americans without health insurance, without access to a family physician. At the very time that the need for primary care is expanding, medical student interest still remains dim. We need to shine a light on family medicine's proven economic value to make the changes in our health care system and in our practices. And we need to do this for one reason. It's the right thing to do.

I've heard our Academy ask, are we a mission based organization, here for the health of our patients or are we a guild, here only for the economic benefit of our practices. Today the answer is not either/or, mission or guild. The answer is both.

Transforming our health care system requires strong and viable primary care. Patients First means ensuring that every American has access to a family physician. Patients first means transforming our practices into Patient centered medical homes and
During the 2011 legislative session, the legislators worked very hard to pass SB 200, a bill that will reinvent health insurance as we know it in Colorado. Senate Bill 200 took the first steps in creating a Colorado based health care exchange by establishing and implementing the Colorado Healthcare Exchange Board of Directors and in correlation with it, a Legislative Oversight Committee. These two entities will be solely responsible for creating, implementing and maintaining the structure and funding for the exchange. The intent of SB 200 was to increase access, affordability and choice in health insurance with the specific interest of all Coloradans in mind.

The Patient Protection and Affordable Care Act requires exchanges to determine whether people applying for tax credits through the exchange are eligible for Medicaid and the Children’s Health Insurance Program (CHIP, known in Colorado as Child Health Plan Plus). If eligible, applicants are to be enrolled seamlessly into those programs. If not eligible for Medicaid/CHIP, the exchange will determine applicants’ eligibility for federal tax credits for the purchase of private insurance and facilitate their enrollment in an insurance plan. The goal of the federal law is real-time enrollment and a user experience that can be completed in 15 to 20 minutes to find, apply for and enroll in health insurance.

SB 200 was the source of a very contentious and productive debate during this year’s session. A broad coalition from the health care community -- from Family Physicians to small businesses to insurance companies large and small, to consumer advocacy groups -- worked together to compile an agreeable list of requirements for the members of the Exchange Board, and a process for the legislature to oversee their work. The stakeholders worked tirelessly to guarantee the passage of this legislation, and SB 200 was signed into law by Gov. Hickenlooper on June 1, 2011.

The bill included the stipulation each of the nine voting members of the board must provide expertise in at least one of the following areas: individual health insurance coverage, small employer health insurance, health benefits administration, health care finance, administration of a public or private health care delivery system, the provision of health care services, the purchase of health insurance coverage, health care consumer navigation or assistance, health care economics or health care actuarial sciences, information technology, or starting a small business with 50 or fewer employees. The bill also outlines that these members would be appointed by the majority and minority leadership in

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both chambers and the governor to serve four-year terms. The members had to be appointed by July 1 in order to maximize efficiency. The appointments are as follows:

**Governor Appointments:**
- Richard Betts, Telluride, owner of ASAP Accounting and Payroll Inc.
- Eric Grossman, Englewood, vice president of TriZetto
- Gretchen Hammer, Denver, executive director of the Colorado Coalition for the Medically Underserved
- Robert Ruiz-Moss, Lone Tree, executive with Anthem Blue Cross and Blue Shield
- Elizabeth Soberg, Centennial, chief executive of United Healthcare of Colorado

**House Appointments:**
- Arnold Salazar, Alamosa, director of Colorado Health Partnerships LLC – Minority Leader Pace Appointment
- Stephen ErkenBrack, Grand Junction, president of Rocky Mountain Health Plans – Speaker McNulty Appointment

**Senate Appointments:**
- Nathan Wilkes, Arapahoe County, founder and Principal for Headstorms Inc. – President Shaffer Appointment
- Michael Fallon, MD, Denver, emergency room physician – Sen. Kopp Appointment

The board had their first meeting on July 11 and has been meeting on a regular basis. Their goal is to have an exchange researched and funded by the end of 2013 in order to begin implementation in January 2014. At the onset they began to develop the foundations for the board, such as electing a chair, establishing bylaws and subcommittees, writing funding grants, and researching the strategy others states have used.

CAFP will be meeting with the both the Exchange Board of Directors and the Legislative Oversight Committee to ensure that the academy’s guiding principles are known to these very important decision makers. CAFP will continue to advocate for Patient Centered Medical Homes while the discussion continues on how to cover the 800,000 uninsured Colorado residents.

The CAFP director of Public Policy will continue to keep members updated on the board’s progress, but readers who would like more information may reference http://www.coloradohealthinstitute.org/Projects/Health-Care-Reform/cohiex.aspx or call with questions.

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**CAFP Legislative Committee Needs You**

By Inis Jane Bardella, MD, FAAFP

One of my father’s favorite sayings was “no use complaining.” That -- together with a Christian upbringing that emphasized responsibility -- has motivated me professionally to find ways to get involved and engage in creating positive change rather than just “complaining.” So when I saw a request for members on the Colorado Academy of Family Physicians Committee on Legislative Affairs I decided this was an opportunity to become involved in the legislative process rather than just dealing with the results.

From January through June 2011, I learned about the Colorado legislative process, asked many questions, made many comments (I hope a few where useful) and, together with the other members of the committee, guided CAFP’s work to impact the Colorado State Legislature to improve patient care and Family Medicine in Colorado. The learning curve was steep. The time commitment averaged two hours per week and was most heavy from February through mid-April. The value to patients, Family Medicine and me was great and worth the time and effort.

So, I challenge you to get involved in CAFP on a committee since “complaining” without action will not change anything. Members may sign up for the CAFP Legislative Committee by contacting Raquel@coloradoafp.org, 303-696-6655, ext. 10.
On March 29 the state of Colorado signed into law Senate Bill 40: “The Jake Snakenberg Youth Concussion Act.” The bill focuses on concussion safety and education for all youth athletes ages 11 to 18 years through three stipulations. First, coaches are required to complete either free online concussion training or attend a concussion presentation that meets the requirements of the bill. Second, athletes showing any signs or symptoms of a concussion are removed immediately from the playing field by the coach and are not allowed to return to play. Parents should be contacted by the coach to inform them of the head injury. Third, the athlete must be seen by a licensed health care professional and written clearance is required prior to return to activities or sports. Qualified health care professionals as defined in the law include MDs, DOs, physician assistants, nurse practitioners and neuropsychologists. After medical clearance, certified athletic trainers may guide athletes through the return-to-play protocol.

Athletes should be free of all concussion-related symptoms or problems (e.g., headache) before returning to sports. Once the athlete is entirely free of symptoms and is cleared by a doctor as medically safe, returning to play should occur in a gradual, step-wise fashion, as recommended in guidelines based on the Zurich conference:

1. Light aerobic exercise such as walking or stationary cycling; no resistance training.
2. Sport specific exercise such as skating in hockey or running in soccer; progressive addition of resistance training.
3. Non-contact training drills; progressive addition of resistance training.
4. Full contact training after medical clearance.
5. Competitive game play.

It is important to emphasize that the athlete/patient be completely asymptomatic prior to beginning the protocol. Each step requires 24 hours to complete. The athlete should continue to the next level if asymptomatic at the current level both during the activity and for 24 hours at rest after the activity. If uncomplicated, the return-to-play protocol requires approximately one week to complete. If any symptoms occur, the athlete must drop back to the previous step and try to progress again after being symptom-free and a 24-hour period of rest has passed.

Most young people will recover completely from a concussion within a couple of weeks. Typically, athletes can return to school after resting for a few days or less. However, if symptoms continue once the athlete returns to school, he or she should also be allowed academic relief and not be required to take exams during the initial one- to two-week recovery period. If needed, classroom homework assignments should be decreased to ensure the student can adequately manage the workload without becoming overly stressed. If symptoms last longer than one to two weeks after the concussion, a follow-up visit with the primary physician should be scheduled. If problems persist, specialty concussion follow-up could be helpful to develop a plan to support recovery and manage any school-related difficulties.
Federal Budget Debate Holds Potential Harm for Colorado Kids
By Jeffrey J. Cain, MD, FAAFP

In political terms, this summer was a stormy one in Washington, D.C. The debate over raising the federal debt limit roiled our nation’s capital. This fall, the effects of that storm could start to be felt in Colorado. In late July, President Obama and Congressional leaders reached agreement on a deal that would cut the federal deficit by at least $2 trillion over 10 years, in exchange for raising the so-called “debt limit” and allowing the Treasury Department to borrow an additional $2.4 trillion. Under the deal, a little less than half those cuts, or $900 billion, will come from a mix of defense and other discretionary spending — the vast majority of it unrelated to health care — over the next 10 years. The other cuts will be decided in late November, based on the recommendations of the Joint Select Committee on Deficit Reduction, a bipartisan panel of 12 members created under the terms of the deal. The Joint Select Committee, or the Committee, is tasked with making recommendations on at least $1.5 trillion in further deficit reduction, which could include both additional cuts and new revenues.

The Committee, which is made up of six Republicans and six Democrats, with six each from the House and Senate, must vote on its recommendations by Nov. 23, the day before Thanksgiving. The full Congress must vote on the Committee’s deficit reduction bill by Dec. 23, the day before Christmas Eve.

If that timeline makes it seem like Congress has tried to box itself into a corner, it’s because it has. If a majority of the Committee cannot agree on recommendations, or if at least $1.5 trillion in deficit reduction isn’t adopted by the full Congress and signed into law, then a “trigger” of automatic cuts takes effect. Approximately $600 billion of these would come from the Defense Department and $600 billion from Medicare provider rates. Democrats hope the prospect of deep cuts to defense spending will get Republicans to soften their previous opposition to any new revenues. Republicans hope the specter of automatic cuts to doctors and other providers who see Medicare patients will move Democrats to take on entitlement programs. To reach the $1.5 trillion figure, the Committee will have to make some tough choices, including almost certainly taking on health care spending on Medicare and Medicaid. Two potential cuts to Medicaid have me particularly concerned.

The Committee could well look for savings by cutting Medicaid, either by reducing federal matching funds or by continued >>>

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allowing states the flexibility to reduce reimbursement rates, restrict benefits or curtail eligibility. Some have proposed turning Medicaid into a “block grant” program, with the feds chipping in a flat amount and states bearing the risk for increased costs during economic downturns. Colorado, like most states, already has a badly strained budget. In the last few years, the legislature has made hundreds of millions of dollars in cuts to K-12 education to balance the state’s finances. Transforming Medicaid to a block grant program would only make those cuts worse. Another possibility is that the Committee will recommend eliminating states’ provider fees. A provider fee program involves a fee charged to medical providers, which is then pooled, matched by the federal government, and put toward the state’s Medicaid program. Fully 46 states have some type of Medicaid-related provider fee program, but most use provider fees only to increase reimbursement to providers. In Colorado, the provider fee is paid by hospitals and has been used to increase reimbursements but also to expand Medicaid and Child Health Plan Plus (CHP+) eligibility to an estimated 100,000 Coloradans who were previously uninsured. An across the board elimination of federal reimbursement for state provider fees, or a capping of the amount permitted under the programs, could have dire consequences in Colorado.

I hope the Committee will avoid those options. It would be a mistake to cut Medicaid or restrict states’ ability to expand health care coverage in innovative ways through the use of provider fee programs. At a time when families and children in Colorado are still struggling, we should be expanding access to care, not restricting it. There are other potential outcomes, however. The Committee, which has a 6-6 partisan split, may well deadlock. If it does, the automatic defense and Medicare cuts would take effect under the plan agreed to by President Obama and Democrats and Republicans in Congress. These cuts would amount to about $1.2 trillion over 10 years, if left unchanged. There is a possibility that the automatic cuts are changed, in effect deactivating the “trigger” in current law. That would require new legislation to undo the July deal, however, and with divided control of Congress such legislation would face major hurdles in the current political environment. In the short term, something has to give. As the members of the Committee do their difficult work this fall, and as Congress takes up any recommendations they make, I hope they will keep the impact on patients and providers in mind. And I hope that Family Physicians will make their views known to their representatives in Washington. Simply reducing the resources devoted to safety net programs won’t solve the big picture problem of cost in the health care system -- it will simply shift those costs from the public sector onto families, seniors and kids. In the long term, the rate of growth in health care spending is unsustainable. So regardless of what happens this fall and winter, physicians and other providers need to do our part to offer up changes that will make Medicare and Medicaid more efficient, while improving the quality of care we deliver. That change won’t be easy, but it is essential if we are to avoid more draconian and short-sighted measures.
A NEW CONVERSATION ABOUT LACTOSE INTOLEANCE

Help Your Patients Enjoy Dairy Again

Many health authorities agree that low-fat and fat-free milk and milk products are an important and practical source of key nutrients for all people – including those who are lactose intolerant.1,2,3,4,5,6

In fact, the 2010 Dietary Guidelines for Americans (DGA) recognizes dairy foods as an important source of nutrients for those with lactose intolerance.7 Milk is the #1 food source of three of the four nutrients the DGA identified as lacking in the diets of Americans – vitamin D, calcium and potassium – and the DGA recommends increasing intakes of low-fat or fat-free milk and milk products to help fill these nutrient gaps.

A Solutions-Focused Approach

People who are lactose intolerant should know that when it comes to dairy foods, practical solutions can help them enjoy the recommended three servings of low-fat and fat-free dairy foods every day*, without experiencing discomfort or embarrassment:

• Gradually reintroduce milk back into the diet by drinking smaller amounts of milk at a time, trying small amounts of milk with food, or cooking with milk.
• Drink low-lactose or lactose-free milk products, which are real milk just with lower amounts or zero lactose, taste great and have all the nutrients you’d expect from milk.
• Eat natural cheeses, which are generally low in lactose, and yogurt with live and active cultures, which can help the body digest lactose.

Visit nationaldairycouncil.org for more information, management strategies and patient education materials.

Visit nationaldairycouncil.org for more information, management strategies and patient education materials.

Most people with lactose intolerance say they are open to dairy solutions as long as they can avoid the discomfort associated with consuming them.7 And research shows that people like lactose-free milk more than non-dairy alternatives.8

These health and nutrition organizations support 3-Every-Day™ of Dairy, a science-based education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products, to help improve overall health.

4 USDA, Ph.D. Special Supplemental Nutrition Program for Women, Infants and Children: Revisions in the WIC Food Package, Interim Rule, 7 CFR, Part 246.

* The 2010 Dietary Guidelines for Americans recommends 3 daily servings of low-fat or fat-free milk and milk products for those ages 9 and older, 2.5 cups for children ages 4 to 8 years, and 2 cups for children ages 2 to 3 years.
I love being a Family Medicine Physician with CPMG because...

- We help to decide what is on the formulary and what tests should be ordered using a strong evidence-based approach to practicing medicine. Family Medicine Physicians make the decisions on how we care for our members at every level.
- We are encouraged and supported in using our unique broad-based family oriented skills.
- Our Health Plan Partners are not-for-profit. I am proud to be a part of a group that commits to bettering the health of our members within our communities.
- My career and leadership development are valued, as we are offered medical group-run CMEs and physician-based quality and service committees.
- We have a primary care core with rich support and built-in quality tools and registries to work to prevent illness.
- I have the ability to care for patients through e-mail, telephone visits, group visits, chronic disease care managers and clinical pharmacists.
- I don’t have any call or practice OB. I focus on providing excellent outpatient, preventive, continuity medicine for my patients. And after all, it is the Rocky Mountains, so I find plenty to do with my spare time.
- I can’t see myself making such a difference anywhere else.

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The Colorado Permanente Medical Group recognizes and values Family Physicians as a key cornerstone in our healthcare delivery model. If you are interested in learning more about our full-time and part-time opportunities, we invite you to contact Dr. Donna Baldwin, Family Medicine Physician, at 303-699-3764 or donna.m.baldwin@kp.org. To apply, please contact Chantal Papez, Physician Recruiter at 866-239-1677 or forward your CV to chantal.papez@kp.org. EOE/M/F/V

http://physiciancareers.kp.org/co

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** Members newly recognized
This year’s Tar Wars Poster Contest winner for the 2011-2012 school year was fifth-grader Sophia Hayes from Sopris Elementary in Glenwood Springs. Sophia along with 10 other winning poster contestants attended the 23rd annual Tar Wars poster contest awards ceremony at the Denver Museum of Nature and Science. Sophia and her family won an all-expense-paid trip to Washington, D.C., to participate in the National Tar Wars Poster Contest.

Here is a letter from Sophia’s family after their trip to Washington:

Cara,

Thanks to you and your incredible program we had such a fantastic trip to DC! What an amazing experience from beginning to end! The only sour spot was being stuck in the Denver airport on Friday for 9 hours because so many of their planes got hail damage in the week, yet I think we all needed a little recovery time, so it all worked out for the best!

The conference was extraordinary, and Sophia met some amazing new friends from all over the country … how cool to see her making these new connections! And the meeting with Senator Udall was great as well. Sophia did really well at letting him know why she was there and the importance of the program.

Then on to the Capitol and the White House…we even got to see Michael Bennett making a speech in the Senate session … perfect timing! It was all fantastic from beginning to end!

We learned that we were one of the few who had such amazing funding and support from our state representative so I really want to thank you for making all of this possible!!!!!!

Tar Wars and the American Academy of Family Physicians should be so proud of the efforts they make to keep children tobacco free. This is a great preventative program because I can assure you that the confidence that Sophia gained from this experience will keep her from trying tobacco … she can’t quit telling us about the dangers, counting smokers as we pass by, and looking up statistics….

Kudos to all of you!!!!!!!!!!!!!!!

The Hayes Family
Glenwood Springs, CO

Tar Wars is made possible by a generous donation from the Colorado Academy of Family Physicians Foundation and through grant funding from Kaiser Permanente. The annual Tar Wars poster contest awards ceremony is supported by the Denver Museum of Nature and Science.
Are you ready?

**WEEKLY TO-DO LIST**

**Version 5010**
Deadline: JAN 1st, 2012

**ICD-10 Deadline:**
OCT 1st, 2013

---

**Prepare Now for the Version 5010 and ICD-10 Transitions**

*The change to Version 5010 standards takes effect on January 1, 2012. The change to ICD-10 codes takes effect on October 1, 2013.*

In preparation for ICD-10, starting January 1, 2012, all practice management and other applicable software programs should feature the updated Version 5010 HIPAA transaction standards. Providers will need to use ICD-10 diagnosis and inpatient procedure codes starting on October 1, 2013.

**Make sure your claims continue to get paid.** Talk with your software vendor, clearinghouse, or billing service NOW, and work together to make sure you’ll have what you need to be ready. A successful transition to Version 5010 and ICD-10 will be vital to transforming our nation’s health care system.

Visit [www.cms.gov/ICD10](http://www.cms.gov/ICD10) to find out how CMS can help prepare you for a smooth transition to Version 5010 and ICD-10.
Our health care system has grown overly complex and fragmented. In primary care we interface with hundreds of specialists with whom we need to coordinate care, but often don’t know. Frequently key information gets lost during “hand-offs” between providers, potentially reducing quality of care, increasing costs and jeopardizing patient safety.

The Patient-Centered Medical Home seeks to address this fragmentation by centralizing fundamental services through a primary care team. The team coordinates patients’ care when specialized services, such as cardiology, mental health or hospitalization, are needed.

**Elements to improve care coordination**

Care coordination is fundamental to the concept of whole-person care and rests on four foundations: accountability, better patient support, relationships among members of the “medical neighborhood” and electronic connectivity through such networks as electronic health records and patient registries. (Source: Improving Chronic Illness Care. Care coordination. www.improvingchroniccare.org/index.php?p=Care_Coordination&x=326, accessed June 1, 2011.)

Even under the current payment system, physicians can share responsibilities for care coordination and care management using a team-based approach. Non-physician team members can help patients navigate the health care system and follow up on their customized care plans, which address preventive needs, chronic conditions and acute issues. Once patients and their personal physicians jointly develop the care plan, a practice’s care coordinators/care managers help patients implement it.

**Care coordination vs. care management**

Care coordination intersects with care management, but they are not the same. However, the need for both rises with a patient’s complexity. The more chronic conditions, medications and demographic challenges an individual has, the more support he or she needs to manage conditions, reach personal goals and navigate the health care system.

Care coordination focuses on tactical issues: using patient registries to ensure patients get needed services, tracking

### Roles and skills required for care coordination and care management

<table>
<thead>
<tr>
<th>Care coordination roles and skill sets</th>
<th>Skill Sets</th>
</tr>
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<tbody>
<tr>
<td>Help patients implement individual care plans</td>
<td>LPN, MA</td>
</tr>
<tr>
<td>• Track tests and referrals ordered</td>
<td></td>
</tr>
<tr>
<td>• Implement reliable process for reports getting into medical record</td>
<td></td>
</tr>
<tr>
<td>• Serve as filter for information and reports coming into practice</td>
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<table>
<thead>
<tr>
<th>Registry set-up and maintenance</th>
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<tr>
<td>• Ensure registry functionality and process to maintain it</td>
<td>Data person, front-desk employee, MA, practice manager</td>
</tr>
<tr>
<td>• Manage and present reports on individual patients and overall practice population for team discussion</td>
<td></td>
</tr>
<tr>
<td>• Use outreach reports to identify patients overdue for services</td>
<td></td>
</tr>
<tr>
<td>• Use health plan and hospital reports to prioritize those patients needing intensive case management/care coordination</td>
<td></td>
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<table>
<thead>
<tr>
<th>Coordination of care — medical neighborhood</th>
<th></th>
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<tbody>
<tr>
<td>• Point person for outside entities to facilitate bi-directional communication and follow-up</td>
<td>LPN, MA, health educator</td>
</tr>
<tr>
<td>• Navigator for patients for services outside clinic</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Care management roles and skill sets</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Help patients implement individual care plans</td>
<td>RN, PA, MD, social worker, health educator (limited)</td>
</tr>
<tr>
<td>• Assess barriers for patients struggling with care plan</td>
<td>(Requires higher skills, training, licensure, certification than care coordinator role)</td>
</tr>
<tr>
<td>• Self management support, motivational interviewing to assess patients’ self-efficacy in reaching their goals. Use education materials, tools, counseling, group visits, etc.</td>
<td></td>
</tr>
<tr>
<td>• Discuss medication adherence, reconciliation and management using protocols developed by physicians</td>
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<table>
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<tr>
<th>Increase patient access</th>
<th></th>
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<tbody>
<tr>
<td>• Phone calls, e-mails, extended hours - 24/7 coverage</td>
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Care management focuses on the clinical and behavioral aspects of care: ongoing treatment of chronic conditions, patient activation for self-care, medication adherence, prevention and wellness. Care managers need higher-level skills than care coordinators because they help patients overcome barriers and manage complex needs. The chart (page 18) delineates both roles and skill sets.

Many PCMH practices apply basic care coordination and care management services on site. Very complex patients may need a registered nurse for management of complex cases, a mental health provider or a clinical pharmacist—all of whom may be available to multiple practices through a shared-services model for affordability.

“By developing strong relationships with patients, care teams and medical neighbors, the PCMH engages patients to participate in their care and coordinates care across our complex health care system.”

Preparing the practice for care coordination

To implement care coordination, leaders should assess the roles and skill sets of their current clinical and non-clinical staff. Then, using a team-based approach, the leaders consider new roles and responsibilities, training and retraining and possibly hiring.

Many PCMH practices opt for a dedicated care coordinator. Although this will be easier with approaching payment reforms, some practices are starting to integrate these services now, adopting a 2:1 ratio of medical assistants to providers and doing well even in a fee-for-service market. Other steps include evaluating the organization’s work flow to ensure the best use of care coordination/care management services. How do team members communicate? How well do they integrate their roles? Are patients getting what they need? How could interactions improve to better benefit patients?

When possible, integrating services in one location is advised. Alternatively, collaborating clinicians can establish community networks, defining the information that must be shared for optimal patient care. Technology allows networks to provide secure, efficient, timely exchange of clinical data.

Role of the physician

The physician defines the roles of the care team, working with patients to develop customized care plans and identifying patients who need care coordination and/or care management. After primary diagnosis and treatment, the physician transfers patients to the care coordinator or care manager to track tests and referrals and assist patients as needed for follow-up.

The PCMH has excellent potential to improve patient outcomes, reduce costs and improve satisfaction for patients and their health care teams. By developing strong relationships with patients, care teams and medical neighbors, the PCMH engages patients to participate in their care and coordinates it across our complex health care system.

Marjie Harbrecht, MD, is chief executive officer of HealthTeamWorks in Lakewood, Colo. She can be reached at mharbrecht@healthteamworks.org.

Patients Are Part of the Team

By Angel Perez, PCMH Resource Advisor

Incorporating the patient as a team member has helped health care leaders to realize the importance of this union in health care outcomes. Patients and families who are involved in the planning and goal setting of care plans have been shown to increase both provider and patient satisfaction. This collaboration and partnership increase the mutual respect felt and dignity recognized among patients, families and members of health care team.

In the 2011 standards, the National Committee for Quality Assurance encourages practices to include patients in focus groups and individual input, including participation on quality improvement teams. Standard 1E is the medical home responsibility. Each practice has a process to disseminate information on the role of the Patient Centered Medical Home. Below is a sample of language to be used in a letter to patients for this standard.

The concept of “intention verses perception” has the biggest impact on the relationship between the patient (and families) and the provider. If a patient is part of a team strengthened by trust and rapport, the likelihood of miscommunication is decreased. As I gather stories from my community, the communication gap between intention and perception is the most common theme of distrust in the health care system.

As the health care landscape develops and concern continues about costs, incorporating the partnership of providers, patients and families will increase the quality and safety of care and decrease costs.

For more information on the Patient Centered Medical Home and resources please visit the CAFP website www.coloradoafp.org.
You know that Accountable Care Organizations, or ACOs, are hot topics these days. You have heard that there is great opportunity for the primary care physician. You have also learned that ACOs are going to require complex and expensive-sounding systems, health information technology, metrics, contracts, and legal structures.

But you are a typical hardworking Family Physician in rural Colorado, meaning you have no extra cash and even less spare mental bandwidth. How in the world are you going to get in on the ACO movement? Is your only option hoping that the hospital will employ you?

No. There is actually a straightforward way for a Colorado Family Physician to have lasting success in an ACO and without spending a dime.

This article explains the four-part strategy:

1. **Get Up to Speed Through CAFP.** The Colorado Academy of Family Physicians has extensive resources to arm you for success in the accountable care era, including this article series. Please see the CAFP web site ACO section at http://www.coloradoafp.org/medicalhome.shtml From among those resources, The Family Physician’s ACO Blueprint for Success covers in detail the following:
   - Why unsustainable health care costs are making ACOs, or some version of collaborative care, inevitable;
   - How virtually all successful ACOs will have a Patient Centered Medical Home, or PCMH, core driving care improvement and savings—with corresponding incentive payments;
   - How to recognize and shape the eight essential elements of every successful ACO;
   - Top ACO strategies for Family Physicians; and
   - A step-by-step guide on how to participate in or form an ACO.

The CAFP is offering numerous PCMH and ACO resources, including webinars and programs at the 2012 Annual Scientific Conference. In short, in a surprisingly short period of time (hours, not weeks) you can be the most prepared person in the room the next time there is an ACO meeting.

2. **Conduct an ACO Readiness Assessment for Your Practice.** Perhaps the first item would be to prepare to be a medical home. Of the eight essential elements of a successful ACO, a culture of teamwork is by far the hardest. Cultivate relationships, and get outside your “silo.” Assess your HIT, data capture, and patient self-support tools.

3. **Create or Join a PCMH Network ACO.** This is the most important strategy for the small-town Family Physician. If possible, join one that has, or will have, the eight essential elements for ACO success. This is a rare opportunity, not available to specialist physicians, to not only have such a rich “target field” of high-impact ACO initiatives to choose from, but also to have friendly pre-existing vehicles becoming available.

   No Buy-In – Medicaid and other payers in many states are interested in this model. These payers often do not require a buy-in or require the physician to accept financial risk. Instead, on top of fee-for-service payments, there is often a per member/per month fee and occasionally shared savings bonus payments.

4. **Be a Champion.** You can not only be able to be savvy about which ACO options will make it and in which you will be able to participate with no financial investment, but Family Physicians also have an historic opportunity to lead. With these CAFP tools, you can influence the very success of your ACO and your role in it. A “how-to” on ACO leadership for the Family Physician will be the topic of an upcoming article in our series.

It is not hopeless. In fact, because you happen to be in one of the best specialties to thrive in the accountable care era, opportunity knocks for the small-town Colorado Family Physician. For more on ACOs, contact Raquel J. Rosen at the CAFP, 303-696-6655, ext. 10, or go to http://www.coloradoafp.org/medicalhome.shtml.
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Today more than 80 percent of children and adolescents diagnosed with cancer will be cured of their disease and go on to become long-term survivors (please see Figure 1). Advances in chemotherapy, radiation therapy and surgery have all contributed to this success. With more children being cured of cancer, there will be many more survivors who go on to lead full, productive lives. In fact, it is currently estimated that in the United States there are more than 270,000 survivors of pediatric cancer or about 1 of every 640 adults between the ages of 20 and 39 years. A percentage of these survivors, however, go on develop late effects and chronic illnesses related to the therapy they received. These conditions may be medical, cognitive or emotional. Furthermore, while many tertiary pediatric care centers offer a comprehensive pediatric cancer survivorship program, those individuals that go to become adult survivors of pediatric cancer have far less access to late effects programs. In fact, less than 20 percent of adult survivors of pediatric cancer are followed at a cancer center or by an oncologist. It is therefore important for both Family Physicians and internists to be aware of this population and their unique needs.

Late Medical Complications of Pediatric Cancer Therapy

Virtually every organ system is susceptible to permanent damage from chemotherapy and radiation therapy leading to associated late onset complications and potentially chronic illness. It may in fact take years to decades before the onset of these late effects.

Endocrine and growth complications include growth hormone deficiency and thyroid complications such as hypothyroidism and thyroid cancer. Hormonal deficiencies are secondary to radiation therapy in the head and neck area and are typically seen in survivors of ALL who have received cranial irradiation, Hodgkin’s disease survivors who receive neck and mediastinal irradiation, and irradiated brain tumor patients.

Gonadal dysfunction occurs in both male and female patients. The testes are very sensitive to both chemotherapy and radiation. Exposure to alkylating agents such as cyclophosphamide and ifosfamide can result in long term or permanent azospermia or oligospermia. In addition to interference with spermatogenesis, radiation to the testes, which is done in patients with testicular ALL or as part of the preparative regimen prior to bone marrow transplant (BMT), can also interfere with Leydig cell function with subsequent need for testosterone replacement. It is important therefore to offer semen cryopreservation to adolescents and young adults prior to the initiation of chemotherapy if possible. Exposure of the ovaries to alkylating agents may produce amenorrhea as well as damage to the primordial follicles, which may lead to premature menopause. Ovarian function may be permanently altered with radiation therapy leading to ovarian failure.

Exposure to anthracyclines such as doxorubicin and daunorubicin may lead to permanent destruction of myocytes with subsequent late onset of congestive heart failure. The risk factors of anthracycline-induced cardiotoxicity include total cumulative dose of these agents, age at exposure (age under 4 years), gender (females more susceptible), and concomitant mediastinal/chest irradiation. It is imperative therefore that those patients exposed to anthracyclines undergo periodic echocardiograms as part of the cancer survivorship care. The frequency of the echocardiograms is based on the age at exposure, cumulative dose, and whether concomitant mediastinal/chest irradiation is given. These echocardiograms should continue throughout adulthood.

Additional organ systems that can be adversely affected by chemotherapy long-term include the lungs, which can develop fibrosis secondary to lung irradiation or exposure to the chemotherapeutic agent bleomycin. Dental abnormalities such
as blunted or absent roots, absent teeth and microdontia can occur secondary to chemotherapy or head and neck irradiation; children under 7 years of age are particularly vulnerable to these problems due to ongoing development of secondary dentition. Long-term skin complications are typically seen in the BMT population who develop chronic graft versus host disease of the skin.

Second malignant neoplasms (SMNs) are by far one of the more serious late effects of cancer therapy. Secondary leukemias in the form of acute myeloid leukemia (AML) may occur in patients exposed to alkylating agents or epipodophyllotoxins (etoposide). In the former group of agents, there is a cumulative dose relationship between exposure and development of a secondary AML. In the latter group, dosage schedule appears to be a factor. Secondary AMLs can be very difficult to treat and allogeneic BMT offers the only hope of cure. Radiation therapy can also result in the development of a SMN in field of radiation. There is a dose relationship between exposure to radiation and risk of a SMN. These SMNs typically are sarcomas that do respond to therapy. Female Hodgkin disease patients receiving mediastinal radiation are at risk for secondary breast cancer particularly if they are adolescents at the time of radiation. This population should have mammograms and breast MRIs beginning at age 25. Finally in the central nervous system (CNS), secondary meningiomas, anaplastic astrocytomas, and glioblastoma multiformes can occur following radiation therapy for a primary brain tumor.

Cognitive and Psychosocial Effects of Cancer Therapy in Children

Whole brain radiation, which is given for CNS ALL, as well as radiation for CNS malignancies can lead to impairments in visual motor integration, problem solving and loss of short-term memory. Intrathecal and IV methotrexate can also result in cognitive dysfunction, although this occurs to a lesser extent when compared to radiation. Younger age at diagnosis is a risk factor. Serial neuropsychological evaluation is important in this population so that any cognitive impairment can be diagnosed as early as possible and appropriate interventions put in place.

Survivors of pediatric cancer may experience long-term emotional issues with their siblings as a result of the attention given to them during their therapy. Survivors may also have difficulty relating to their peers due to the whole cancer experience as well as long absences from school during active therapy. During adulthood employment opportunities may be limited due to the late effects of therapy such as amputation and CNS surgery/radiation. While obtaining health insurance may be a problem, a recent report from the Childhood Cancer Survivor Study indicated that more than 80 percent of adult survivors of pediatric cancer had some form of health care insurance.

Childhood Cancer Survivor Study

The Childhood Cancer Survivor Study, continued...
or CCSS, comprises a cohort of adult patients who have survived childhood cancer for at least five years. The CCSS is a collaborative effort among 27 institutions that includes Children's Hospital Colorado. The cohort comprises individuals diagnosed between Jan. 1, 1970, and Dec. 31, 1986, and numbers more than 14,000. The study was initiated in 1993 and has contributed a great deal of knowledge about the long-term effects of pediatric cancer treatment. A second cohort consisting of patients diagnosed between Jan. 1, 1987, and Dec. 31, 1996, is currently being recruited.

Pediatric Cancer Survivorship Programs at Children's Hospital Colorado

Children's Hospital Colorado has been one of the pioneers with the establishment of its pediatric cancer survivorship program in 1987. Known as The HOPE (Helping Oncology Patients Excel) Survivorship Program, the HOPE Clinic has seen more than 1,000 patients since its inception. Patients who come for their first clinic visit participate in a multidisciplinary approach to their long-term care. The HOPE team consists of a pediatric oncologist, physician assistants, radiation oncologist, nurse coordinator/educator, dietitian, social worker, neuropsychologist and endocrinologist. One goal of The HOPE Survivorship Program is to provide patients and their families with information on potential late effects of therapy, as well information on healthy lifestyle living. Following their initial visit, patients return on a yearly basis to The HOPE Follow Up Program. In collaboration with the section of Internal Medicine at University of Colorado Hospital, a transition clinic for adult survivors of pediatric cancer was created in July 2008. Known as the TACTIC (Thriving After Cancer Therapy Is Complete) Clinic, this multidisciplinary clinic, which includes an internist, pediatric oncologists, psychologist and nurse educator, is held each month in the Anschutz Outpatient Pavilion adjacent to University of Colorado Hospital. This clinic, one of the first in the nation, is for patients 21 years of age or older and is designed to help transition care from the pediatric to the adult setting.

A Growing Population

Pediatric cancer survivorship has improved tremendously over the past 20 years. As treatment advances continue to improve outcomes, this population of survivors will continue to increase. Despite having survived their disease, these individuals need to continue with ongoing follow-up care so potential late effects of therapy can be identified and treated and so the patients can understand the importance of living a healthy lifestyle and participating in overall health maintenance.

Brian Greffe, MD, is a board certified pediatric hematologist-oncologist in the Center for Cancer and Blood Disorders at Children's Hospital Colorado. He is a professor of Pediatrics at the University of Colorado Denver School of Medicine and is medical director of The HOPE Survivorship Program.

Kids Corner is a regular feature of the CAFP News brought to you by the The Children's Hospital Department of Family Medicine. For questions about this article or suggestions for future topics, readers may contact Jeffrey Cain, MD, chief of Family Medicine at Children's Hospital Colorado through OneCall: 720-777-3999.

We need to be honest with ourselves and our patients when it comes to immunization. Although both successes and disasters have occurred in the field of vaccination, my belief is that the triumphs of vaccination vastly outdistance the calamities.

Take for instance the incredible triumphs of Louis Pasteur more than 125 years ago. Pasteur, knowing that a smallpox vaccine had been developed and that viruses could be attenuated, developed both a rabies (viral) and anthrax (bacterial) vaccine. What an incredible feat it was at that time to keep a person alive who had been bitten by a rabid dog!

Polio is a disease that has had both soaring triumphs and terrible tragedies. Thousands were paralyzed before the 1950s when Salk and many others developed a polio vaccine. But almost immediately thereafter, the Cutter incident of inadequate inactivation resulted in 204 people actually getting paralytic disease from the vaccine. And within a few decades it was realized that SV40, a simian virus was found in both polio vaccine and in specific types of tumors. The SV40 disaster led to the thesis that the passenger virus in the polio vaccine may have been responsible for hundreds or even thousands of cases of cancer. (SV40 was removed from all polio vaccines by 1969). But these calamities are miniscule when placed against the health benefits of preventing 1.12 million cases of paralytic polio that have now been prevented by the vaccine. And the polio vaccine has a long track record of safety now.

There are many more stories of the triumphs of vaccination. Rubella, measles, tetanus, pertussis. The scales of good decisions clearly lean toward the health benefits of vaccination. In my opinion, clinicians are clearly thinking when they choose the vaccines that will protect their patients from vaccine-preventable diseases.
Dear Colorado Academy of Family Physicians,

We would like to thank you for the opportunity to attend the American Academy of Family Physicians National Conference in Kansas City, Mo. It was truly an invaluable experience. We both learned a great deal about the operations of the AAFP and about Family Medicine at large. The main stage lectures allowed us to learn about directions Family Medicine is taking and about important issues affecting the specialty. We attended a lecture by Stephen Woolf, MD, MPH, that addressed advocating for policy changes that emphasize the importance of a patient’s socioeconomic status in patient outcomes. We also had the opportunity to attend several clinical skill presentations on topics such as acute headache management and mindful eating. These presentations provided valuable insight into topics that we have had little exposure to in our coursework thus far.

The conference had an exposition hall with booths set up for Family Medicine residency programs throughout the country. Our experience at the exposition hall offered both of us an opportunity to learn about how residency programs can vary and what to look for in a residency program when the time comes to apply. Furthermore, we were able to explore options for fourth-year sub-internships in some of the residency programs we are interested in.

Most of our time at the conference was spent in the National Congress of Student Members (NCSM). We both attended the joint business session during which we were introduced to the structure of student congress, parliamentary procedure and resolution writing. The following day we observed how new congress members were nominated and elected. We also had the opportunity to attend the reference committee hearings. The hearings allowed us to hear about the resolutions that our fellow students had put forth as well as the opinions of other student members that were both for and against the resolutions at hand. On our final day at the conference we attended the student congress’ final business session. At this session we heard from the candidates for each of the elected positions and subsequently voted for each position. Afterwards, we discussed the reference committee’s report of their recommendations for adoption of this year’s resolutions. We were able to observe and participate as the congress voted for extractions of certain resolutions, amended others and ultimately voted for adopting or not adopting each of the resolutions.

There were a few resolutions brought forth in both the reference committee hearings and the final business session that led to a great deal of discussion and debate. Some of the more heavily debated resolutions from the student congress included:

- A recommendation that the AAFP endorse preventive services offered by organizations such as Planned Parenthood
- A recommendation that the AAFP advocate for the elimination of fast food advertisements targeted toward children
- A request that the AAFP support changing the typical screening question of, “Do you use any illegal drugs?” to include an additional question that asks patients, “Do you do anything to get high?”
- A recommendation urging the AAFP to not renew its contract with Coca-Cola

All of the above resolutions were adopted by a majority vote in the student congress for further discussion by the Commission on Education. It was great to hear the opposing arguments on each of these topics as it taught us a great deal about the issues and demonstrated how a diverse group of students can work together to compromise for the greater good of the academy.

Other resolutions that were met with little opposition and were adopted by the student congress included a resolution to incorporate business education into medical school curriculum and a resolution that requires pharmacies to track the immunizations they administer in a state vaccine database. These were both great ideas and we are excited to see the outcome of their adoption in the future.

Overall, this was an incredible experience. Again, we would like to thank you for the opportunity to learn more about the academy, Family Medicine and the current issues facing Family Medicine. It was a privilege to represent our chapter’s voice at the conference and we look forward to attending in years to come.

Sincerely,

Nicole Struthers and Kristen Young

University of Colorado School of Medicine Class of 2014
ABCD Helps Connect Kids with Services

Tips offered on identifying developmental delays

By Mindy Craig, MS, PA-C and Laura Pickler, MD, MPH

What is ABCD and how can it help my practice?
ABCD, Colorado’s Assuring Better Child Health and Development, or ABCD, project works with pediatric health care providers to help them identify children who may have potential developmental delays as early as possible. ABCD also focuses on ensuring that once children with potential delays are identified, they are successfully connected with the services and resources they need.

ABCD knows that at 24 months of age, 14 percent of children have developmental delays that are likely to make them eligible for early intervention services as specified in the Individuals with Disabilities Education Improvement Act. ABCD also knows that current detection rates are below the actual prevalence, which leads the organization to believe children in Colorado who could benefit from early intervention services are being missed.

Isn't it easy to detect children with developmental delay in the Well Child Check?
ABCD knows physicians cannot rely on history, physical and informally asking about developmental milestones to detect developmental delays, which are not always obvious. Incorporating a developmental measurement, such as the Ages and Stages Questionnaire, also called ASQ, or PEDS, is essential to quality well child care. When implementing the ASQ, one practice saw an increase in referrals of 224 percent, illustrating the power of standardized developmental screening tools at detecting potential delays.

I know I should do this, but I get so busy and don’t know where to start?
ABCD knows that the typical Family Medicine physician is very busy and finding time to research tools, train staff and navigate the referral system can be daunting. ABCD can offer free technical assistance to practices to assist in implementing standardized development screening. ABCD has helped many practices with selecting the best tool, determining the work flow, and understanding the referral process. ABCD can even be in the office when practices start using a tool to help trouble shoot any problems that may arise.

What do I do with a child who has a concerning screening result?
ABCD finds that most Family Medicine physicians are not fully aware of the community resources available in Colorado.

* Did you know that within 45 days of referral to Early Intervention Colorado or Child Find, your patient will have had a comprehensive evaluation and should have a plan specifically designed to meet his or her needs?
  * Did you know that if children are found eligible, Early Intervention Colorado provides services for those children in their homes at no cost to their families?
  * Did you know that a child over age 3 with developmental delay may be eligible for free pre-school through Child Find in the school district he or she lives in?

It can be a bit complicated, but all children Family Physicians identify with potential delays should be referred to these systems and some will also need an evaluation by a Developmental Pediatrician. ABCD can help Family Physicians navigate the Early Intervention Colorado and Child Find systems so families receive the care they deserve.

How can I find ABCD?
The ABCD website, www.coloradoabcd.org, has all the information needed to support physicians in this process. ABCD is also available to come in person to your practices. ABCD finds that the most successful practices have ongoing relationships with the organization.

Whether in person, over the phone or by email communication, ABCD is available to physicians throughout the process. Additional information is available by contacting Mindy Craig at: Mindy Craig, MS, PA-C, 720-203-0444, mindycraig@comcast.net

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### Developmental Screening Tools

<table>
<thead>
<tr>
<th>TOOL</th>
<th>SENSITIVITY/SPECIFICITY</th>
<th>TIME TO COMPLETE</th>
<th>PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASQ-3</td>
<td>86.1% 85.6%</td>
<td>10-15 min Parent</td>
<td>$200-$250* Unlimited number of copies</td>
</tr>
<tr>
<td>Peds</td>
<td>74-79% 70-80%</td>
<td>5-10 min Parent</td>
<td>$275 kit w/ 100 forms, re-order S32/100</td>
</tr>
<tr>
<td>Denver II</td>
<td>56-83% 43-80%</td>
<td>10-20 min Provider</td>
<td>$128 kit w/100 forms, re-order S36/100</td>
</tr>
<tr>
<td>Milestone Checklist</td>
<td>Not standardized, no normative sample</td>
<td>5-10 min Provider</td>
<td>Free, included with many EMR forms</td>
</tr>
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*Practices working with ABCD can receive a 12% discount and free shipping on new ASQ orders.

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Michelle F. Jimerson, MD, and Lisa Young, DO, Honored Nationally

Two winners of AAFP/Bristol-Myers Squibb Award are from Colorado

By Buffy Gilfoil

Two recipients of the 2011 AAFP/Bristol-Myers Squibb Award for Excellence in Graduate Medical Education are from Colorado. They are Michelle F. Jimerson, MD, of Grand Junction, and Lisa A. Young, DO, of Evans.

Sponsored by the AAFP, the award is presented each year to second-year Family Practice residents demonstrating leadership, community involvement and exemplary patient care.

**Dr. Jimerson seeks to improve health care delivery**

Dr. Jimerson earned her bachelor’s degree in Human Biology at Stanford University and her medical degree at New York Medical College. She then received a Master of Public Health degree in International Health at the University of Sydney in Sydney, Australia. She is a resident at St. Mary’s Family Practice Residency in Grand Junction.

Caroline Dorman, MD, who is on the faculty of St. Mary’s Family Medicine Residency, wrote in support of Dr. Jimerson’s nomination for the award. Dr. Dorman (formerly Dr. Reilly) stated, “The Family Medicine clinic here at St. Mary’s is undergoing a transformation into the Patient Centered Medical Home model and Michelle has been instrumental in its planning and implementation. We also recently converted all of our records and documentation to an electronic medical record. Michelle was quick to learn and adopt the EMR and a champion for its use among other providers.”

In a personal statement, Dr. Jimerson wrote of her experience with the underserved. “During medical school I worked with several marginalized populations in New York City, including immigrants, homosexuals, HIV infected patients and homeless people,” she wrote.

She also stated, “In my clinical experiences thus far, I have seen a wide variety of health care delivery systems and huge discrepancies in health care and related health outcomes. I aim to dedicate my career to the improvement of personal and public health by means of improving health care delivery.”

continued >>>

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**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.

To see how you can become involved contact: Karen Savoie, RDH
Education Director
Cavity Free at Three Program
karen.savoie@ucdenver.edu
303-724-4750
In pursuit of her goals, Dr. Jimerson has worked to build personal connections through a variety of channels. As a board member of the Colorado Academy of Family Physicians, she has committed to traveling to Denver for regular board meetings. Having been involved with anti-tobacco activities during medical school, she has since 2009 served as resident coordinator of Tar Wars for the American Academy of Family Physicians.

Other groups in which she is active include the western Colorado business association known as Club 20, and Mesa County, Colorado and American medical societies.

Dr. Jimerson speaks Spanish fluently and her international work includes services provided in Ecuador and Nepal.

As a nurse, Dr. Young supported needle exchange

Dr. Young began her health care career as a nurse, having earned her bachelor's degree in Biology in 1992 at the University of Puget Sound and her master's in Public Health Nursing in 1998 from San Francisco State University. She received her Doctor of Osteopathy degree at Midwestern University, Arizona College of Osteopathic Medicine, in Glendale.

She is on the Advanced Maternal Path at North Colorado Family Medicine Residency in Greeley, where she also serves as chief administrative resident and as the resident representative for the pain protocol for the Patient Centered Medical Home at the residency program.

Throughout her career, Dr. Young has shown her commitment to serving the underserved, including those in the inner city and foreign countries.

As a mobile nurse from 1999 until 2002, she worked in San Francisco’s Tenderloin neighborhood, providing nursing services on the street, in single-room-occupancy hotels and in a clinic. Her patients were HIV-positive, injection drug users, homeless and mentally ill. Between 1997 and 2005, she volunteered and developed the health care services at all of the needle exchange sites in San Francisco.

In January and February 2011, Dr. Young restructured and ran a newly formed drug rehabilitation center in Kenya and she has also provided care in Ecuador, Haiti, Mexico, and Tibet.

After she completes her residency, Dr. Young is under contract to work for at least three years in an underserved or rural area in Arizona. “Although I am committed to working with underserved communities wherever I go, I am very interested in working on an Indian reservation,” she stated.

Beyond that, her list of career goals includes continuing to care for the underserved, teaching, supporting and creating preventive care and programs for healthier lifestyles, and working internationally.

Dr. Young’s extracurricular activities include more than 14 years as a drummer, playing in rhythm and blues, funk, acid jazz, folk, rock and pop bands.

Dr. Young wants to stay “happily balanced.” She stated, “I will continue to make time to run, play sports and play music. These hobbies always make me happy, give me the opportunity to meet new friends and keep me energized.”
Juan is a 47-year-old Latino male whose occupation is roofing. Six weeks prior to presenting, he had lost 12 pounds and had to urinate four times a night.

His initial exam revealed a blood pressure of 160/100 and a random blood sugar was 460. Both his parents have type 2 diabetes. His diagnosis was new onset type 2 diabetes and hypertension. He was given a free glucometer, signed up for free diabetes classes, and was given a $4 prescription for Metformin and a $4 prescription for Lisinopril. When he returned in 10 days, his sugar was 240 and his blood pressure was 145/95.

Now his diabetes and hypertension are both controlled and he is feeling “muy bueno.” His wife, at each appointment, brings in fresh homemade tortillas for the staff.

Juan is a typical patient at Clinica Colorado, a new nonprofit medical clinic for uninsured people. It opened June 1 in Westminster, just west of St. Anthony North Hospital. The need for primary care medical services is huge, and Clinica Colorado is already busy. Currently, Jim Williams, MD, is the only provider. Clinica Colorado is actively seeking volunteer providers to increase the number of patients served. It is a very rewarding place to work; the patients are so grateful to find affordable health care. An office visit costs $20 and the labs are discounted. Approximately 80 percent of the patients are Spanish speaking, so it is a great classroom for Español.

Additional information about volunteer opportunities is available by calling Dr. Williams at 303-915-4617.

**Why is this clinic needed?**

Colorado has 1.3 million people without adequate health insurance. This is a large problem and there is no solution in sight. Even the Affordable Health Care Act will not reach many of these people. People without insurance delay seeking health care until their problems become severe and then they visit the emergency room. Preventive care isn’t fully addressed and medications are often discontinued after the medical crisis. These factors lead to very expensive, short-term care.

**Who directs the clinic?**

Clinica Colorado is an independent nonprofit medical clinic for people without insurance. The organization has a board of directors with Dr. Vernon Naake, MD, as the president. The medical director is Dr. Williams, who has been practicing Family Medicine for 34 years. All patients are welcome without discrimination.

**What services are offered?**

Services include preventive care, well child care with vaccinations, and well woman examinations with Pap smears. Acute illness is treated, as well as minor trauma with lacerations and fractures. Serious problems are managed and referrals to specialists who have agreed to a discounted fee occur when necessary. Several hospitals have agreed to discounts for the patients.

Clinica Colorado is located in the town of Westminster in Adams County, which has a population that is 35 percent Latino. It is just west of St. Anthony North Hospital where 20 percent of emergency room visits are not emergencies, but are due to patients not having a primary care physician.

**How are the services covered financially?**

At Clinica Colorado, office visits cost $20 and the patients are asked to pay, if possible. It has been shown that when patients participate financially in their care, they are more motivated to assist in their health. Approximately 85 percent of patients pay their bills and this generates 25 percent of the revenue needed to cover the overhead. The remainder of the costs of Clinica Colorado needs to be covered by grants from foundations, donations from corporations, and individual giving. Clinica Colorado is an approved 501c3 nonprofit organization, so all donations are tax deductible and greatly appreciated. Expenses at Clinica Colorado are monitored closely and controlled by receiving discounted laboratory charges and lease adjustments and by utilizing volunteers in many different capacities, such as physician and midlevel care, bookkeeping, grant writing, graphic design, and statistical analysis.

**How many patient visits are expected annually?**

Clinica Colorado will make a positive impact on the health care crisis in Colorado. In the first year the organization will provide 4,500 patient visits. This volume will increase as finances allow and third-year projections are for 14,000 patient visits. This is a nonprofit model that will work and is sustainable for helping people in difficult economic circumstances.
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- Guaranteed 400% R.O.I.
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