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Twenty of THE nation’s leading SPECIALISTS from University of Colorado Hospital ARE excited to now be IN your backyard

University of Colorado Hospital is excited to announce the opening of the new Lone Tree Health Center in early December - the newest academic specialty care center in the south metro area.

Combined with our specialty services at our Park Meadows location, we now offer a full complement of services to meet your patients’ needs.

Services and specialties at Lone Tree Health Center:
- Ear, Nose & Throat
- Urologic Gynecology
- Gynecologic Oncology
- Hand Care
- Joint Care
- Foot & Ankle
- Spine
- Gastroenterology, Including Screening Colonoscopy
- Urology
- Radiology
- Medical Oncology
- Cardiology
- Physical Medicine & Rehabilitation

Services and specialties at Park Meadows:
- Obstetrical Care
- Gynecological Care
- Cosmetic Skin Services
- Sports & School Physicals
- Well Baby & Well Child Care
- Hand Surgery
- Rehabilitation Medicine Services
- Sports Medicine
- Physical Therapy
- Phlebotomy

If interested in making a referral, please call 720-848-2200 or visit www.lonetreethealth.org
C AFP Board of Directors
Officers 2012-2013

<table>
<thead>
<tr>
<th>Chair/Past President</th>
<th>Kajs a Harris, MD</th>
<th>Vice President</th>
<th>Candace Murbach, DO, FAAFP</th>
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<td>President-elect</td>
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Vision Statement: Thriving Family Physicians creating a healthier Colorado.

Mission Statement: The C AFP’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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Proclamation

Education & Practice Enhancement
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Demonstration Sets State Standard for Primary Care Colorado Multi-Payer PCMI Pilot, 2008-2012
Primary Care Practices to Participate in Historic Public-Private Partnership
Save the Date! C AFP Annual Scientific Conference
History, Physical Exam, Labs among Keys in Evaluation of Anemia in Children
Self-Assessment Module (SAM) Group Training Dec. 8

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Family Physician of the Year Award Nomination

Contact
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for the C AFP

Fall 2012
Leader Asks for Support through One Action a Week

“I know it’s hard when you’re up to your armpits in alligators to remember you came here to drain the swamp!” – Ronald Reagan

I think of this quote when I imagine one of our Family Physicians sitting at her office computer late at night, indecipherable spreadsheets littering the floor, on hold with a “help desk” located far, far away, as she struggles to get the darn thing to generate some darn report to demonstrate its meaningful usefulness. Up pops an email from the Colorado Academy of Family Physicians asking for help on a project. Her heart sinks, she knows she should do more for the profession but it’s hard to pitch in when you’re struggling just to keep ahead the day-to-day demands. “I feel your pain,” to quote another past president!

The world in which we practice is changing rapidly, from who we work for, to how we are paid, to how our work is evaluated, and by whom, to ever increasing and changing demands for more data to prove we deliver better to happier patients. New recertification requirements from the American Board of Family Medicine ask for more time and money. Throw in a good measure of uncertainty about everything else, stirred by overheated political rhetoric, and it’s no wonder physicians feel overwhelmed. And unlike many of our specialist colleagues, those of us in Family Medicine face additional change as our profession is overhauling the way it delivers services, reshaping primary care practices into Patient Centered Medical Homes. The demands on Family Physicians have never been greater. Being a great doctor is no longer enough. We must be business savvy and politically astute, we must become team leaders and coaches for diverse teams of health care providers, and we must learn to effectively function in medical neighborhoods, sometimes with neighbors we’d rather not have! In the midst of all this, now more than ever, we must advocate for our profession.

Your CAFP is busy forging new alliances, strengthening old friendships and building working relationships with some of our detractors. We know from study after study that “primary care done right” improves quality, lowers costs and improves patient and physician satisfaction. Thus, we are pushing hard at every turn for it’s no wonder physicians feel overwhelmed. And unlike many of our specialist colleagues, those of us in Family Medicine face additional change as our profession is overhauling the way it delivers services, reshaping primary care practices into Patient Centered Medical Homes. The demands on Family Physicians have never been greater. Being a great doctor is no longer enough. We must be business savvy and politically astute, we must become team leaders and coaches for diverse teams of health care providers, and we must learn to effectively function in medical neighborhoods, sometimes with neighbors we’d rather not have! In the midst of all this, now more than ever, we must advocate for our profession.

Your CAFP board and staff are here to do the heavy lifting, but we need your advocacy help. My asks are quick and hopefully not too burdensome. First, every day in every way, promote what you do! If someone says that “health care” provided in a retail store is the same as what you do, politely correct them. If someone represents himself or herself as “the same as a physician,” politely correct him or her. You have an immense amount of training and education -- probably the most in your office. Be proud of that! Do one small action each week that helps your CAFP continue to fight for you and your patients. This week put this magazine in the waiting room for your patients to see. Next week, take 10 minutes and read though the CAFP website. Then the next week contribute to the small donor committee ($50 per year), the following week the political action committee. Another week put CAFP patient materials in your office, the next week make one phone call or send one e-mail to a legislator (we’ll help you), the next week ask one colleague to join CAFP, the next week remind them to join, the next week schedule one day for Doctor of the Day, and the next week sign up for the annual conference! Go to the local chamber of commerce meeting and mention that one Family Physician generates almost $1 million per year in economic activity. Write one letter to the local paper (we’ll help you). You get it, staying engaged and supportive can be simple, and it’s effective. Fifty-two small actions each year by each of us, multiplied by our 2000 members, adds up!

I am confident that by the end of this journey, by working together, our patients will be better cared for, we will have done our part to control costs, there will be better access to care for everyone, and the profession of Family Medicine will be stronger.

“Great acts are made up of small deeds.” Lau Tzu
The Colorado Academy of Family Physicians continues its forward movement in the ever-changing health care world.

**CAFP TV SHOW**

One of the most exciting projects for the CAFP recently was the production of a half-hour TV show on the breadth of care provided by Family Medicine Physicians. I would like to thank the TV team, Bob Brockmann, MD, Joey Castro, MD, Kaja Harris, MD, Tamaan Osbourne-Roberts, MD, and Lisa Rothgery, MD, for all of the time and energy they put into practicing for the show and for the day-long taping of the show. They were fantastic! Thank you to Uli Creative PR consultants Adrienne Thiele and Jeanine Spellman for their terrific guidance through the process. The crew at Comcast were very professional and helpful, especially director and editor Ernie Santella. The show will air during the month of October which was declared Family Health Month. Details are provided in a separate article by the Governor as Family Health Month.

**CAFP ON THE GO**

We have created a new section for the CAFP magazine, CAFP ON THE GO. The CAFP directors of the board do many things on behalf of members, including attending meetings and conferences, and serving as spokespersons to the media and legislature. We would also like to include photos and information from our members who are advocating for Family Medicine in Colorado, so please send those to me, Raquel@coloradoafp.org.

**SMALL DONOR COMMITTEE**

Please make a donation to the CAFP’s Small Donor Committee. Your donation can be up to the maximum per year of $50. We need your help now. Health care reform is building in Colorado and primary care survival is not on everyone’s agenda. We need funds to support legislators who understand the value of primary care and your crucial role in health care reform. Please stand up for your profession for the sake of your patients and your future.

For more information, go to www.coloradoafp.org/smalldonor.shtml or fill out the form in this issue.

**THE COLORADO HEALTH FOUNDATION HEALTH SYMPOSIUM**

In addition to funding the CAFP’s Fit Family Challenge pediatric obesity pilot, the Colorado Health Foundation also puts on a wonderful conference each year with excellent speakers. Thank you to Bob Brockmann, MD, and Rick Budensiek, DO, for speaking on behalf of Colorado’s Family Medicine Physicians during the breakout sessions. Here are some quotes from the Symposium speakers.

“Affordability is a key issue, but we cannot solve the cost problem without improving quality and access.” — Alan Weil, executive director of the National Academy for State Health Policy

“One day the individual mandate will be likened to the seat belt law.” — Marguerite Salazar, regional director, U.S. Department of Health and Human Services

“The fact that it’s easier for a child to get a gun than health care is a fundamental problem.” — Wes Moore, author of “The Other Wes Moore”

**NOMINATIONS FOR ANNUAL AWARDS AND BOARD POSITIONS**

The CAFP recently mailed packets to members containing nomination information for the annual Family Medicine awards for Family Physician, teacher and resident of the year. Please send in your nominations by the Dec. 1 deadline. The mailing also contained the nomination information for the CAFP board of directors. Please send in those nominations as well.

**NEW STAFF**

I would like to welcome the new CAFP staff members. Carrie Wilhelm joined the CAFP staff as the administrative assistant and the Tar Wars Coordinator. She will also be handling the Doctor of the Day scheduling. Her contact information is carrie@coloradoafp.org, 303-696-6655, ext. 17.

Sarah Roth is the new Program Manager for the Fit Family Challenge pediatric obesity pilot. Her contact information is sarah@coloradoafp.org, 303-696-6655, ext. 16.

**NCQA PCMH DISCOUNT**

The CAFP has negotiated a 20 percent discount for CAFP members applying for National Committee for Quality Assurance Patient Centered Medical Home recognition.

The discount can be issued to all sites that have not been approved as “multi-site” practices for PCMH 2011. Multi-site practices of three or more independent sites are eligible for a 50 percent discount off the per-clinician application fees and are not eligible for an additional discount through this sponsorship. Practices that have three or more sites, share the same electronic medical record or practice registry (that tracks patient and billing data the same) and can submit under the same program agreement are eligible for the multi-site discount. Single sites and those with just two locations will not be eligible for the 20 percent sponsor discount through CAFP.

The “discount code” field can be found in the online application and can be added any time prior to submission of the application. It is under the “Practice Site” tab, where you will click on your site name and enter the code in the “discount code” field.

If you would like to receive the code please contact raquel@coloradoafp.org or 303-696-6655, ext. 10.

**2011 FINANCIAL REVIEW**

Auditors with RubinBrown completed the CAFP’s financial review for 2011. “Based on our review, we are not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in conformity with the modified cash basis of accounting.”

continued on next page >>
NEW CAFP STRATEGIC PLAN

The CAFP board of directors has developed a new strategic plan. Thank you to the CAFP members who provided input via the member survey.

CAFP STRATEGIC GOALS & OBJECTIVES

GOAL 1: ADVOCACY - Shape health care policy through interactions with government, the public, business, and the health care industry.

OBJECTIVES:
- Advance health care for all.
- Advance the Patient Centered Medical Home.
- Support payment reform to achieve practice viability, improved quality and decreased costs.
- Increase Family Physician workforce.
- Enhance Doctor of the Day program.
- Support legislative issues that are important to Family Medicine Physicians including but not limited to patient safety, tort reform, peer review and workforce.

GOAL 2: EDUCATION & PRACTICE ENHANCEMENT - Promote high-quality, innovative education for physicians, residents and medical students that encompasses the art, science, evidence and socioeconomics of Family Medicine; enhance members’ abilities to fulfill their practice and career goals.

OBJECTIVES:
- Assist members to become designated Patient Centered Medical Homes.
- Promote the ongoing imperative for practice redesign through education and communication.
- Assist our members to achieve financial success and fulfill career goals.
- Promote viable models of Family Medicine.

GOAL 3: HEALTH OF THE PUBLIC - Assume a leadership role in health promotion, disease prevention and chronic disease management.

OBJECTIVES:
- Involve Family Physicians in targeted public health activities to include but not be limited to tobacco, obesity, exercise and immunizations.
- Increase member and patient awareness of resources on www.familydoctor.org.

Auditors from RubinBrown presented the Financial Review of CAFP’s 2011 finances to the board.

UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

Department of Family Medicine • Assistant Professor Faculty - Rose Family Medicine Residency

JOB POSTING #818722 – POSITION #657616

The Department of Family Medicine at the University of Colorado Anschutz Medical Campus is seeking a full-time ABFM-Certified or eligible family physician for our community based program. The Rose Residency is located at Rose Medical Center, ranked nationally as a top 100 hospital, and is supported by the Colorado Health Foundation, a non-profit organization dedicated to making Colorado the Healthiest state in the nation. Applicants must possess or be eligible for medical licensure in the State of Colorado. Applicants must demonstrate experience and competence in teaching and patient care. This is a full-time position with obstetric skills and hospital call required. Women and minorities encouraged to apply. Detailed job descriptions and qualifications required can be found at jobsatcu.com and the Department’s website http://www.ucdenver.edu/academics/colleges/medicalschool/departments/familymed/pages/FamilyMedicine.aspx.

JOB RESPONSIBILITIES: Applicant will be a core member of the Residency Teaching Faculty: Teaches residents, supervises residents and students in the provision of patient care, provides direct patient care in the inpatient and outpatient setting, participates in scholarly activity, serves as a leader and role model for residents.

REQUIRED QUALIFICATIONS: MD/DO degree, Colorado Medical License, DEA Certificate, Board Certified/Board eligible in Family Medicine. Practices full spectrum of Family Medicine, including Obstetrics and inpatient medicine. Must obtain Medical Staff privileges within the HealthONE LLC d/b/a Rose Medical Center and obtain Medical Staff Privileges at University of Colorado Hospital.

PREFERRED QUALIFICATIONS: Experiences in family medicine teaching/practice preferred. Salary is commensurate with skills and experience. The University of Colorado offers a full benefits package. Information on University benefits programs, including eligibility, is located at http://www.cu.edu/pbs/.

Applications are accepted electronically at www.jobsatcu.com. Review of applications will begin September 1, 2012 and continue until position is filled. When applying at www.jobsatcu.com, applicants must include:
1) A letter of application which specifically addresses the job requirements and outlines qualifications.
2) A current Curriculum Vitae.

Questions should be directed to regina.garrison@ucdenver.edu.

The University of Colorado Denver and Health Sciences Center requires background investigations for employment. The University of Colorado is committed to diversity and equality in education and employment.
This section will present news of activities of the CAFP board and staff members and how they are representing and promoting Family Medicine Physicians around the state on your behalf.

John Bender, MD, CAFP past president and current delegate to the AAFP congress of delegates, spoke in Washington, D.C., at the White House and the Office of the National Coordinator for Health Information Technology Event. Feedback from e-MDs community members in attendance included the below report from the Austin, Texas PRWEB dated June 29, 2012.

“On June 19th, the White House and the Office of the National Coordinator (ONC) for Health Information Technology (HIT) held an invitation-only Town Hall meeting in the Executive Office Building of the White House Complex to discuss the status of HIT. White House members in attendance included Cecilia Munoz, the director of the White House Domestic Policy Council and Liz Fowler, special assistant to the president for health care and economic policy. The session was moderated by ONC director Farzad Mostashari, MD, who announced that 110,000 providers had attained incentive payments from CMS thus far for the Meaningful Use of certified electronic health records (EHRs). A total of 88 HIT stakeholders from diverse backgrounds (hospitals, clinics, the payer community, universities and others) accepted invitations to attend, including seven members of the e-MDs community (six e-MDs users and the e-MDs president and CEO).

“A panel made up of five health care professionals, including e-MDs user Dr. James D. Johns, shared their experiences with HIT. Dr. Johns noted that the support and funding made available through The Health Information Technology for Economic and Clinical Health (HITECH) Act and the Ohio Regional Center (REC) had been very helpful to his practice as they recently implemented their EHR. The floor was then opened to questions, and e-MDs user John Bender, MD, described in detail the challenges associated with interoperability, in particular the costs of implementing these systems. Several members of the audience concurred, and others offered that the implementation of candidate standards would reduce the cost of interfaces. Other participants described challenges with sharing data in communities and difficulties with getting some organizations to share data due to business related concerns. Some offered that the Direct Model was working well for them in their communities.

“Success stories related to the patient care advantages of EHRs emerged as a persistent theme. Overall, participants demonstrated a high level of sophistication with EHR technology and many were seeking guidance as to how to best participate in health data exchange.”
Election season is officially upon us, evident to many by the onslaught of political ads on television. Thus, the attention of Coloradans has switched from under the dome to the voting booth for the rest of 2012. The good news is that Colorado is shaping up to be a very important demographic in the national elections; which gives Coloradans the opportunity to highlight all the attributes our state has to offer, especially in the light of health care reform. Colorado has the potential to experience the biggest shift in the state legislature that we have ever seen.

Many of you are familiar with the process of redistricting that occurs every 10 years, following the U.S. census. However, what many people are less familiar with is the “state level” version of redistricting, which happens simultaneously. This separate and distinct process for redistricting Colorado’s 35 State Senate and 65 State House of Representative districts in the state legislature is referred to as reapportionment. The outcome of the reapportionment committee is what has led us to this monumental shift in the General Assembly for 2013. Potentially, this election could bring as many as 40 new freshman legislators to the 100-member General Assembly.

The potentially large number of new legislators has placed a new emphasis on the importance of the 2012 elections. Elections are won and lost based on actual votes, however that is only half the battle. Organizational support and input are essential to a campaign’s success, not only because of financial contributions, but also because organizational endorsements also lend their established credibility to the candidate.

In order to stay vital this November, the CAFP formed a political committee earlier this year, Colorado Academy of Family Physicians Political Committee or CAFFPC. Similar to the small donor committee CAFP established a few years ago, CAFFPC will be used as a resource for Family Physicians to have direct conversations about CAFP legislative priorities with candidates for office in Colorado. In order to initiate these conversations, CAFFPC sent out a survey to each candidate, with questions based on membership input. Once the surveys were returned, the CAFFPC, which is currently composed of CAFP’s Executive Committee members, met and established criteria for eligibility. If a candidate was deemed eligible based on satisfactory survey answers, he or she was then discussed at length by the committee, which decided on the level of support to give. Please go to www.coloradoafp.org for the list of candidates that the CAFP supported.

If you would like to view the legislative candidate survey in its entirety, please email info@mendezconsultinginc.com.

A note from your President:

This is an exciting year for CAFP! In keeping with our mission of being “Bold Champions for Colorado Physicians,” starting this year our Small Donor Committee and Political Committee are endorsing select candidates who support the Academy’s mission and goals. For many years we have weighed in on hundreds of proposed health care bills. We have asked for and received crucial support from legislators. We now have the ability to directly support the candidacies of those who share our views. This process also serves as another great means for communicating CAFP’s positions on key health care issues to present and future decision makers at the Capitol.

Robert Brockmann, MD, MS, FAAFP
NUMBER ONE
15 YEARS AND RUNNING.

WE NEVER SAY NEVER.*

At National Jewish Health, we never say never. It’s one of the reasons we’ve been the nation’s number one respiratory hospital since 1998. Our innovative approaches to treating respiratory and heart disorders can help you breathe easier. So don’t let severe or even mild breathing problems hold you back. Call 1.800.621.0505 to make an appointment or visit njhealth.org.

National Jewish Health®
Science Transforming Life®
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 accept contributions only 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 Political Action Committee 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 interests. 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 candidates, 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: ________

Email Address __________________________________________
Phone: __________________________
Dear Colleagues:

The Colorado Academy of Family Physicians (CAFP) is conducting its nomination process for the 2013-2014 Board of Directors. This is your opportunity to have more involvement in the election process. You may nominate yourself. For all nominees, please ask if they are willing to be nominated. All nominees are asked to submit a paragraph on themselves explaining who they are and why they want to be on the CAFP board of directors. The deadline for the paragraph is Dec. 1, 2012.

You are invited to send in your nominations for the CAFP board of directors by Dec. 1, 2012. Afterwards we will send you a mail-in ballot with the slate of nominees compiled by the CAFP nominating committee. The new voted-in board would be installed at the April 18-21, 2013, annual scientific conference at the Cheyenne Mountain Resort in Colorado Springs. Their terms would start July 1, 2013.

We strive to be representative of the constituency and we would particularly ask that rural physicians consider running for office.

Your speedy cooperation would be greatly appreciated.

Sincerely,

Kajsa Harris, MD
Chair

MEMBER BALLOT CAFP BOARD NOMINATIONS

Deadline Dec. 1, 2012

Your Name: ______________________________________________________________

I nominate the following Family Physicians for a position on the CAFP board of directors: (Include name & city)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

You may nominate yourself. For all nominees, please ask the person if they are willing to be nominated. All nominees must submit a paragraph on themselves explaining who they are and why they want to be on the CAFP board of directors. The deadline for nominations and paragraphs is Dec. 1, 2012.

Please mail to CAFP, 2224 S. Fraser St., Unit 1, Aurora, CO 80014 or Fax to CAFP at 303-696-7224.

You may also send in your nominations by email to raquel@coloradoafp.org
Pulitzer Prize winning author Jared Diamond describes the consequences of societies that lost focus on priorities. Settlers on Easter Island, Europeans in Greenland, Anasazi Indians in southwest Colorado, the Mayans of central America. These societies no longer exist because of a lack of focus on priorities.

Health is an important societal priority. We need health care to assure a healthy population and have a decent quality of life. Access to health care is a value most other “first-world” countries prioritize. The U.S. hasn’t prioritized health care for some 50 million uninsured, yet the U.S. pays more for our health care, and gets less value for the dollars we spend compared with those other first-world countries.

As doctors, and as a society as a whole, we should talk about health care access because it is a problem too big for our present political and economic system to solve alone. It is going to take all of us listening, talking and thinking to solve it. For too long, health care has been on the back burner of political debate and public will. For too long our medical schools have turned out too few primary care doctors -- the backbone of any successful health care system. For too long duplicative service lines and investment in brick and mortar have driven up health care costs, making health care too expensive for many, even those with insurance. For too long, the habits of defensive medicine have been the financial burden of our dysfunctional medical tort system. For too long the medical loss ratio of the insurance industry has quadrupled those of the more efficient systems of the world, even those systems with multiple private payers.

How is it that the U.S. is paying more, covering fewer lives, and getting poorer scores in terms of population health than so many other countries? How can the country that took such pride in putting the first men on the moon have let other countries overtake it in much more important priorities? Will future societies look back and say, “there was another society that had its priorities all wrong?”

We need serious conversations about health care at all levels. From the local coffee shops to the backrooms of our largest corporations, our country needs to build the public will to deal with a broken, inequitable, expensive, and disjointed (non) system. We need to stop the slogans and rhetoric that confuse and distort the debate about health care. We need to push health care to the tipping point. We need our elected officials to know how important this issue is to us. Our lives and very existence as a society, the greatest society in the world, depend on it.
In October CAFP's Family Medicine Physicians On Call for Colorado will premier on Comcast Entertainment Television (CET), which is in one million households throughout Colorado. The program features four CAFP member physicians and CAFP President Robert Brockmann, MD, MS, FAAFP, who hosts the thirty-minute television program. Myths and facts around safe pregnancies, young adults and health risks, fevers and obesity are covered by Joseph Castro, DO, Kajsa Harris MD, Tamaan Osbourne-Roberts, MD, and Lisa Rothgery, MD.

The concept for the television program was developed as part of CAFP's branding strategy. The program supports CAFP's strategic initiatives, which include outreach to communities to strengthen public awareness of disease prevention and chronic disease management, increase awareness of the value of Family Medicine physicians, and advance the Patient Centered Medical Home model of health care delivery.

"Utilizing a television format to communicate the value of having a family medicine physician and to promote the benefits of physician-led Patient Centered Medical Homes is unique and a first ever for our organization. As an extended value, after the program's initial exclusive run on Comcast, our PR consultants will distribute the program to local access channels statewide, which allows us to further our reach into communities throughout Colorado," says Raquel Rosen, CAFP chief executive officer.

It took nearly six months to develop the program’s content under the strategic leadership of Rosen and the program’s physicians. It

continued on next page >>
was important to deliver information where viewers would not only learn something new, but also gain insight into the vast experience of Family Medicine physicians and their expertise in caring for people of all ages.

Dr. Castro focuses on fever phobias and provides important information about dosing and proper use of medications for children. Dr. Harris discounts age-old myths regarding pregnancies and offers important tips for before, during, and after pregnancies. Dr. Rothgery provides in-depth information about obesity and lays out specific examples related to nutrition, eating behaviors and healthy living tips. Dr. Osborne-Roberts provides a delightful perspective on young adults and the benefits of developing a relationship with a Family Medicine physician early in life.

The program concludes with Dr. Brockmann describing CAFP’s vision of future care delivery – the physician-led Patient Centered Medical Home – and explains the concept through an example that is easily understood. This portion of the program demonstrates how Family Medicine physicians are leading the way to improve quality of care, lower costs, and improve patient satisfaction by adopting this common sense idea that is sweeping the country.

The program is engaging, friendly and is packed with information that viewers can benefit from today and well into the future.

The program ends with a viewer tip to visit CAFP’s website where a new consumer area will be launched in conjunction with the program’s premier and Family Health Month. By clicking on a new Family Health icon located under the home page navigation bar, the public will find information on Family Medicine physicians, Patient Centered Medical Home, health care myths and facts, tips on living healthy in Colorado and resources, such as a BMI calculator and a link to FamilyDoctor.org. The consumer area also features a newly developed CAFP Know Card that can be downloaded for families to document important health information about every member of the family. The Know Card was developed as a public service of CAFP.

To promote the program, CAFP will have links to a tune-in commercial on its website. Press releases will be distributed and story pitches will be made to media outlets by our PR consultants as a part of October Family Health Month promotions. The program will also be featured on the CET homepage at comcastentertainmenttv.org where a photo of the program physicians and a description will be a featured program.

“We look forward to the community’s response to this effort. It’s a creative way to provide valuable information to residents of Colorado and showcase the value of the specialty of Family Medicine. Additionally, we will advise legislators of this program to continue to share the important role of Family Medicine physicians within the Patient Center Medical Home model of health care delivery,” said Rosen.

CAFP has also produced a new public service announcement (PSA), which will be distributed to broadcast stations statewide in September. The PSA promotes the Know Card public service, which features the campaign theme “Knowledge, the new physician-recommended apple of the day.”

CAFP welcomes content for the consumer page of the website from CAFP members interested in sharing myths and facts regarding a health topic or tips to living healthy in Colorado. Contact Raquel Rosen at 303-696-6655 for more information.
THE STRENGTH TO HEAL and get back to what I love about family medicine.

Do you remember why you became a family physician? When you practice in the Army or Army Reserve, you can focus on caring for our Soldiers and their Families. You’ll practice in an environment without concerns about your patients’ ability to pay or overhead expenses. Moreover, you’ll see your efforts making a difference.

To learn more, visit us at www.healthcare.goarmy.com/colorado
WHEREAS, Colorado’s Family Physicians have historically demonstrated their dedication to the health and well being of this state’s citizens by emphasizing the family and providing care to all patients; and

WHEREAS, Family Physicians have studied for seven years from medical school through residency and have received specialized training to provide primary care and medical treatment for the families of this state; and

WHEREAS, this care is based on knowledge of the whole person in the context of the family and the community, and is not limited by age, sex, race, religion, or type of health problem; and

WHEREAS, Colorado’s Family Medicine practices provide high quality care, and reduce costs through the Patient Centered Medical Home (PCMH); and

WHEREAS, Family Physicians play a crucial role in ensuring the health of families across the state;

Therefore, I, John W. Hickenlooper, Governor of the State of Colorado, do hereby proclaim October 2012,

FAMILY HEALTH MONTH

in the State of Colorado.

GIVEN under my hand and the Executive Seal of the State of Colorado, this twenty-ninth day of May, 2012

John Hickenlooper
Governor
Demonstration Sets State Standard for PRIMARY CARE

Colorado Multi-Payer PCMH Pilot, 2008-2012

By Lisa Schneck, MSJ, HealthTeamWorks

The Colorado Multi-Payer Patient-Centered Medical Home pilot was one of the earliest and most complex PCMH demonstrations in the country. When it launched in 2008, it was the only PCMH project with voluntary participation by seven health plans, both public and private. They, along with 16 primary care practices, agreed to test whether more resources given to primary care practices to deliver an enhanced model of care resulted in better health at less cost.

The PCMH is an approach to providing continuous, comprehensive, coordinated care for patients of all ages. It incorporates a health care setting that facilitates partnerships between each individual patient and his or her health care team and, when appropriate, the patient’s family. The PCMH, in turn, is joined to an integrated medical “neighborhood” of specialists, hospitals, pharmacies and other health care resources.

The three-year Colorado PCMH pilot concluded in April 2012. Quality and patient experience data are resoundingly positive; while only preliminary results for the first two years are available at this time, indications of cost savings are optimistic.

PILOT LEADERSHIP AND FUNDING

HealthTeamWorks, a nonprofit dedicated to health care improvement, convened and managed the pilot. Its leaders (see list) established a physician advisory committee, a patient advisory committee, a health plan payment subgroup, a hospital subgroup and a behavioral health integration subgroup to guide the project. Each was led by a HealthTeamWorks’ staff member.

Support for the pilot came from the Colorado Trust and the Commonwealth Fund. A grant from Abbott Pharmaceuticals in early 2012 allowed HealthTeamWorks to extend coaching in the practices through August 2012.

Goals and objectives

Pilot leaders aimed to prove the medical home as a scalable solution to achieve the goals of the Triple Aim put forth by the Institute for Healthcare Improvement: optimize health outcomes, reduce cost trends and improve satisfaction for patients and their health care teams. They agreed to:

1. Common measures and targets.
2. PCMH definitions and key elements.
3. Data reporting – Plans agreed to provide consistent data elements to the evaluator (Meredith Rosenthal, PhD, of the Harvard School of Public Health) for quality, cost, utilization and patient surveys; give practices ongoing utilization data; and identify high-risk patients for them to manage.
4. Patient attribution – Using a retrospective review of patients with prescriptions or medical claims to determine which patients were covered under which of the participating insurers.
5. Payment model, payment schedules and administrative procedures. Per-member per-month, or(PMPM) fees were based on practices’ National Committee for Quality Assurance PCMH recognition levels, practices’ cost estimates for delivering enhanced care, plans’ assessments of their ability to recoup up front investments and comparison to PMPMs for other pilots. Each plan set a PMPM fee of $4 to $8.

PARTICIPANTS

The Colorado Multi-Payer PCMH Pilot drew national interest because the health plans — UnitedHealthcare, Anthem-WellPoint, Aetna, Cigna, Humana, Colorado Medicaid and CoverColorado (the state’s high-risk-pool carrier) — joined voluntarily. As no single insurer dominated Colorado’s health care market, it was vital to engage as many payers as possible to reduce fragmentation and achieve enough market share to incentivize and enable practices to evolve into medical homes.

The seven insurers agreed to provide enhanced compensation to the 16 chosen Front Range family medicine and internal medicine practices, (which are listed separately). The plans agreed to a payment model that blended fee-for-service; a PMPM care management fee to help practices build PCMH infrastructure, including care coordination and care management services; and a pay-for-performance bonus for achieving cost and quality targets.

The participating practices, comprising of about 84 providers and 258 staff members, agreed to:

• Operate consistently with the concepts of the Joint Principles of the Patient-Centered Medical Home.
• Participate for the span of the pilot.
• Work with a HealthTeamWorks (quality improvement) coach to improve quality measures, redesign practice

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systems for efficiency and improve satisfaction for patients and the health care team.

- Provide team-based care, including a practice improvement team represented by providers, clinical staff, front-office staff, the practice administrator and potentially a patient to meet no less than twice a month.
- Attend, along with key practice personnel, one-and-a half-day learning sessions three times a year and participate in monthly learning collaborative calls.
- Enter data into a patient registry or electronic health record with registry and reporting capability.
- Collect data on specified measures and submit them to HealthTeamWorks each month.
- Provide data as requested and share them with the Colorado PCMH Pilot evaluator.
- Implement a patient registry that is compliant with the Health Insurance Portability and Accountability Act for communication with patients and other providers.
- Achieve at least NCQA PCMH Medical Home Level One by the pilot's start in Spring 2009.
- Continue working toward higher levels of NCQA PCMH throughout the pilot. One practice dropped out in the pilot's first year, citing competing priorities. Several practices merged during the pilot, and two separated from one another, but the remaining 16 clinics stayed essentially intact for the duration of the initiative.

MEASURES OF QUALITY
Pilot leaders developed detailed clinical measures for patients’ progress and outcomes, based on national benchmarks. In consultation with the health plans, they focused on four areas with the potential for significant cost savings, health care quality and patients’ experience of care: diabetes, heart/stroke, coronary artery disease and prevention. Pilot leaders also decided to measure patient experience, a fundamental principle of the PCMH.

JOURNEY TO PCMH TRANSFORMATION
Each practice benefited from the support of a HealthTeamWorks quality improvement coach who met with physicians and staff on site approximately every other week. Coaches assessed practices’ capabilities, assisted with culture change, encouraged team-based care, facilitated implementation of guidelines and clinical measures, and promoted care coordination and care management functions. Practice members were encouraged to attend the learning collaboratives and scheduled webinars to network, exchange experiences and hear from PCMH experts.

Pilot leaders set goals for the practices:

Year 1: Establish PCMH infrastructure and collect quality measures monthly.

Year 2: Improve quality measures and begin establishing processes to reduce emergency room visits and hospitalizations. Increase use of generic pharmaceuticals.

Year 3: Continue to improve on cost and utilization issues while sustaining other PCMH changes.

Each month the practices submitted data to HealthTeamWorks showing the requested measures. The practices, guided by their coaches, used these data to inform quality improvement efforts.

LEARNING COLLABORATIVES
Three times a year, HealthTeamWorks convened learning collaboratives for the pilot practices. The events used a model in which “all teach, all learn.” Practices were encouraged to bring as many members as possible to maximize shared learning.

Learning collaboratives featured speakers who addressed patient-centered care, health care quality or health care reform. Practices also heard from peers who described challenges and successes in the evolution to a new way of delivering health care. Breakout sessions focused on components of the PCMH, such as planned care, open-access scheduling, process mapping and care coordination.

RESULTS
Data from the Colorado PCMH Pilot are still being compiled, but figures from the first two years are extremely positive. For example:

98 % of patients said they get care when they need it.

Practices in the Colorado Multi-Payer PCMH Pilot

Belmar Family Medicine, Lakewood
Broomfield Family Practice
Clinix Health Services of Colorado, Centennial
DeYoung Family Medicine, Ft. Collins (later merged with Miramont Family Medicine)
Family Care Southwest, Littleton
Family Practice Associates, Louisville
Ideal Family Healthcare, Woodland Park
Internal Medicine Clinic of Ft. Collins
Lakewood Family Medicine
Lone Tree Family Practice
Michael Mignoli, MD, Lone Tree
Miramont Family Medicine, Ft. Collins
Mountaintop Family Medicine, Parker
Provident Adult and Senior Health, Denver and Westminster
SouthPark Internal Medicine, Highlands Ranch
Westminster Medical Clinic
97% stated they would recommend their practice to family or friends.
95% said they find their clinics dwell organized, efficient and respectful of their
time.
90% of patients said they found it easy to speak to a physician when they call.
More than 85% of diabetics in the pilot practices were screened for tobacco use.
More than 75% of diabetics who smoke were assisted in quitting.
Approximately 59% of diabetic patients kept their LDL cholesterol number below
100 (national target is 36 percent).
Approximately 52% of diabetic patients maintained blood pressure below 130/80
(national target is 25 percent).
Results from Anthem, the only health plan to date reporting pilot data, showed that
pilot practices:
• Reduced total medical and prescription medication cost for PCMH members by
  14.5% compared with non-PCMH practices
• Decreased acute inpatient admissions by 18%, compared with an 18% increase
  in a control group
• Decreased emergency room visits by 15% compared with a 4% increase in a
  control group
• Increased the number of prescriptions written per 1,000 patients compared with
  a control group
• Generated a return on investment estimated at 2.5:1 and 4.5:1
• Improved nearly all clinical quality measures for diabetes patients
• Reduced hospital admissions 12 to 23% compared with other providers
• Reduced patients’ emergency room use 11 to 17% compared with other
  providers.
The pilot evaluator will publish final data in the coming months. Until then, David
Nuhfer, MD, of Family Practice Associates in Louisville, Colo., says it well: “[The
PCMH] is answering the call that I felt a long time ago to become a family physician.
I feel I am now part of a team that provides that care that I’ve always wanted to
provide as a family physician ... The model of the patient centered medical home
provides a way to do that. As a patient, this is how I’d want to be cared for.”

**Colorado Multi-Payer PCMH Pilot Leadership**

**Health plans**
- Aetna
- Anthem-Wellpoint
- CIGNA
- CoverColorado
- Colorado Medicaid
- Humana
- United Healthcare

**Employers**
- Centura
- State of Colorado IBM
- Patient-Centered Primary Care Collaborative
- McKesson Corp.
- Colorado Business Group on Health

**Hospitals**
- Colorado Hospital Association
- Centura Health

**Physician societies**
- American Academy of Family Physicians
- American College of Physicians
- Colorado Academy of Family Physicians
- Colorado Medical Society
- Pilot Partner Region
- Health Improvement
- Collaborative of Greater Cincinnati

**Pilot evaluator**
- Harvard School of Public Health

**Others**
- Colorado Department of Public Health & Environment
- University of Denver Health Science Center
- HealthTeamWorks
- Family Voices

**Independent practice associations**
- Integrated Physician Network
- Northern Colorado IPA
- Physician Health Partners
  (Primary Physician Partners
  and South Metro Physicians)
- MedSouth

**Funders**
- The Colorado Trust
- The Commonwealth Fund

- **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
  medicine 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.**

**OPPORTUNITIES IN DENVER/BOULDER & LOVELAND**

and our new office opening in 2014 in GREELEY

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. You may also
contact Andrea Hughes-Proxmire at 303-344-
7833 or Andrea.C.Hughes-Proxmire@kp.org.
EOE/M/F/V

http://co.kpphysiciancareers.org
Primary Care Practices to Participate in Historic Public-Private Partnership

Colorado is among participants testing unique investment in coordinated care

In support of more effective, more affordable, higher quality health care, 500 primary care practices in seven regions, including the state of Colorado, have been selected to participate in a new partnership between the practices and payers from the Centers for Medicare & Medicaid Services, or CMS; state Medicaid agencies; commercial health plans and self-insured businesses. This partnership is designed to provide improved access to quality health care at lower costs.

Under the Comprehensive Primary Care initiative, the centers will pay primary care practices a care management fee, initially set at an average of $20 per beneficiary per month, to support enhanced, coordinated services on behalf of Medicare fee-for-service beneficiaries. Simultaneously, participating commercial and state plans, as well as other federal insurance plans, are also offering enhanced payment to primary care practices to support the practices in providing high-quality primary care on behalf of plan members.

For patients, this means these physicians may offer longer and more flexible hours, use electronic health records, coordinate care with patients’ other health care providers, better engage patients and caregivers in managing their own care, and provide individualized, enhanced care for patients living with multiple chronic diseases and higher needs.

“The Comprehensive Primary Care initiative is the kind of common-sense investment in health care we need,” said Health and Human Services Secretary Kathleen Sebelius. “Businesses, families, and taxpayers all benefit from a stronger primary care system that helps to improve our health and lower costs.”

The initiative started in the fall of 2011 with CMS soliciting a diverse pool of commercial health plans, state Medicaid agencies and self-insured businesses to work alongside Medicare to support comprehensive primary care. Public and private health plans in Arkansas, Colorado, New Jersey, Oregon, New York’s Capital District-Hudson Valley region, Ohio and Kentucky’s Cincinnati-Dayton region, and the Greater Tulsa region of Oklahoma signed letters of intent with the centers to participate in the initiative. The markets were selected in April, 2012, based on the percentage of the total population covered by payers who expressed interest in joining this partnership.

Eligible primary care practices in each market were invited to apply to participate and start delivering enhanced health care services in the fall of 2012. Through a competitive application process, primary care practices within the selected markets were chosen to participate in the Comprehensive Primary Care initiative. Practices were chosen based on their use of health information technology, ability to demonstrate recognition of advanced primary care delivery by leading clinical societies, service to patients covered by participating payers, participation in practice transformation and improvement activities, and diversity of geography, practice size, and ownership structure. According to estimates by the centers, more than 300,000 Medicare beneficiaries will be served by more than 2,000 providers through this initiative.

“Primary care practices play a vital role in our health care system and we are looking at ways to better support them in their efforts to coordinate care for their patients” said
The Comprehensive Primary Care initiative is the kind of common-sense investment in health care we need.

–Kathleen Sebelius
Health and Human Services Secretary

Marilyn Tavenner, acting administrator of the centers.

The Comprehensive Primary Care initiative is a four-year project administered by the Center for Medicare and Medicaid Innovation, which was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care.

Additional information is available online at http://www.innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative

Number of primary care practices 73
Number of providers 335
Estimated number of Medicare beneficiaries 41,000

Market Payers
Anthem Blue Cross Blue Shield of Colorado
Cigna
Colorado Access
Colorado Choice Health Plans
Colorado Medicaid
Humana
Rocky Mountain Health Plans
Teamsters Multi-Employer Taft Hartley Funds
UnitedHealthcare

COLORADO PRACTICES SELECTED FOR COMPREHENSIVE PRIMARY CARE INITIATIVE

<table>
<thead>
<tr>
<th>Participating Practice</th>
<th>City</th>
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<tr>
<td>San Luis Valley Regional Medical Center</td>
<td>Alamosa</td>
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<td>Medical Center</td>
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<td>First Street Family Health</td>
<td>Salida</td>
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<td>High Country Healthcare</td>
<td>Silverthorne</td>
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<td>Yampa Valley Medical Associates, PC</td>
<td>Steamboat Springs</td>
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<td>NE Colorado Family Medicine Associates PC</td>
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<td>Sterling Primary Care</td>
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<td>Telluride Medical Center - Primary Care</td>
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<td>Miramont Family Medicine</td>
<td>Wellington</td>
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<td>Partners in Health Family Medicine, PC</td>
<td>Westminster</td>
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<td>Byers Peak Family Medicine</td>
<td>Winter Park</td>
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Anemia in children becomes problematic when reduced hemoglobin (Hgb)/hematocrit (Hct) levels decrease oxygen-carrying capacity below a body’s metabolic demands. Levels more than two standard deviations below the mean for the age- and sex-adjusted reference population (Table 1) are considered anemic. Most reference ranges for children are composed of multiple racial/ethnic groups, but note that healthy African-American children have average Hgb values 0.5 g/dL below that of their Caucasian or Asian counterparts.

Physiologic responses to anemia include increased cardiac output, central blood shunting blood, increased erythropoietin (EPO) stimulating red blood cell (RBC) production, increased 2,3-DPG reducing oxygen affinity and enhancing tissue oxygen release by right-shifting the oxygen dissociation curve. Acute uncompensated anemia can cause severe clinical symptoms. Despite compensatory mechanisms, chronic anemia in children may result in failure to thrive, hypoxemia and hypovolemia leading to brain damage or organ failure. Prolonged iron deficiency anemia, or IDA, leads to neurocognitive/behavioral problems.

Increased tissue oxygen levels after delivery decrease renal erythropoietin production, resulting in a physiologic anemia of infancy. Preterm infants have more pronounced anemia because their RBCs have a shorter half-life (~17 days) than those of term infants (~23 days). Anemias such as this are common and temporary, and don’t require significant workup.

Anemia in children requiring workup is progressive, symptomatic, persistent, and/or severe (well below the reference ranges in Table 1, or Hgb<10/Hct<30 in any age group). The typical starting point for laboratory evaluation in the primary care office is a complete blood count, or CBC, and the reticulocyte count. The whole CBC should be reviewed, but the most helpful parameters are mean cell volume, or MCV, and red blood cell distribution width, or RDW. The former index allows differentiation into micro/macro/normocytic categories, each with different secondary evaluations (Figures 1-3), while the latter reveals RBC size consistency. The reticulocyte count can suggest an etiology related to either decreased marrow

Table 1: Age-Specific Normative Red Blood Cell Values

<table>
<thead>
<tr>
<th>Age</th>
<th>Hemoglobin (g per dL)</th>
<th>Hematocrit (%)</th>
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<tbody>
<tr>
<td></td>
<td>Mean 2 SDs below mean</td>
<td>Mean 2 SDs below mean</td>
</tr>
<tr>
<td>26 to 30 weeks’ gestation</td>
<td>13.4 11.0</td>
<td>41.5 34.9</td>
</tr>
<tr>
<td>28 weeks’ gestation</td>
<td>14.5 NA</td>
<td>45 NA</td>
</tr>
<tr>
<td>32 weeks’ gestation</td>
<td>15.0 NA</td>
<td>47 NA</td>
</tr>
<tr>
<td>Full term (cord sample)</td>
<td>16.5 13.5</td>
<td>51 42</td>
</tr>
<tr>
<td>1 to 3 days</td>
<td>18.5 14.5</td>
<td>56 45</td>
</tr>
<tr>
<td>2 weeks</td>
<td>16.6 13.4</td>
<td>53 41</td>
</tr>
<tr>
<td>1 month 13.9</td>
<td>10.7 44</td>
<td>33 101</td>
</tr>
<tr>
<td>2 months</td>
<td>11.2 9.4</td>
<td>35 28</td>
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<tr>
<td>6 months</td>
<td>12.6 11.1</td>
<td>36 31</td>
</tr>
<tr>
<td>6 months to 2 years</td>
<td>12.0 10.5</td>
<td>36 33</td>
</tr>
<tr>
<td>2 to 6 years</td>
<td>12.5 11.5</td>
<td>37 34</td>
</tr>
<tr>
<td>6 to 12 years</td>
<td>13.5 11.5</td>
<td>40 35</td>
</tr>
<tr>
<td>12 to 18 years (male)</td>
<td>14.5 13.0</td>
<td>43 36</td>
</tr>
<tr>
<td>12 to 18 years (female)</td>
<td>14.0 12.0</td>
<td>41 37</td>
</tr>
<tr>
<td>Adult (male)</td>
<td>15.5 13.5</td>
<td>47 41</td>
</tr>
<tr>
<td>Adult (female)</td>
<td>14.0 12.0</td>
<td>41 36</td>
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<table>
<thead>
<tr>
<th>Mean corpuscular volume (fL)</th>
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<tr>
<td>Mean 2 SDs below mean</td>
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<td>Adult (male)</td>
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production or increased RBC turnover/loss.
A third group of initial tests can be ordered based on specific elements of the history and physical exam, such as dietary deficiencies and suspected hemolysis, for example. If further evaluation/management is required after these initial tests, consideration of referral to a pediatric hematologist should be made.

Understanding the various causes of anemia can guide history-taking, physical exam and further laboratory test selection. Figure 1 shows a suggested workup algorithm with the three general groups of anemia etiology: blood loss, decreased RBC production, and increased RBC destruction.

Blood loss may be readily identified through symptoms such as nosebleeds and penetrating wounds or not easily discovered. The latter may be the case when blood loss is due to a slow gastrointestinal bleed or to intra-abdominal/retroperitoneal, pulmonary, intracranial, or occult traumatic bleeding, such as that caused by a femur fracture. A careful history and physical lead to appropriate imaging studies. Reticulocyte response, discussed below, can suggest the chronicity of the bleed.

The decreased RBC production category, associated with decreased reticulocytosis, includes bone marrow failure syndromes, marrow replacement, impaired erythropoietin production, and ineffective erythropoiesis. Bone marrow failure refers to both temporary situations such as transient erythroblastopenia of childhood or parvovirus B19-related aplastic crisis, or rarer pediatric scenarios such as those seen with Diamond-Blackfan Anemia, Fanconi Anemia, or paroxysmal nocturnal hematuria, or PNH. Marrow replacement syndromes can be malignant, as is the case with leukemia, neuroblastoma, medulloblastoma, retinoblastoma, Ewing sarcoma, soft tissue sarcoma; or it may be non-malignant, as is the case with myelofibrosis and osteopetrosis. Impaired erythropoietin production may result from renal failure, chronic inflammation, hypothyroidism, or severe protein malnutrition. Finally, ineffective erythropoiesis may result from deficiencies of essential RBC nutrients, such as iron, folate or vitamin B-12, or from hemoglobin disorders, such as sickle cell anemia, thalassemia or unstable hemoglobins. Other examples of ineffective erythropoiesis include sideroblastic anemia, congenital dyserythropoietic anemia, erythropoietic protoporphyria, and myelodysplasias.

RBC destruction, usually identifiable by a robust reticulocytosis following the acute stage, may be extracellular or intracellular in nature. The extracellular causes include mechanical injury such as hemolytic-uremic syndrome, turbulent cardiac valve defects and Kasabach-Merritt phenomenon; antibody-mediated destruction, such as autoimmune hemolytic anemia; thermal RBC injury such as severe burns; various infections; drugs, potentially including antibiotics, acetaminophen, ibuprofen, antimalarials or Rho immune globulin); and toxins varying from arsenic and intravenous water to heavy metals and nitrates. The intracellular causes include RBC membrane defects such as hereditary spherocytosis elliptocytosis.

continued on next page >>

We’re not just a hospital for children. We make parents feel a whole lot better too.

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Questions about anemia may begin with family history, including race/ethnicity, to identify familial anemias. Next, birth history, past medical history, and developmental history should be evaluated for significant underlying conditions and can identify both the severity and timing of the anemia symptoms. Review of previous blood tests (if available), or history of transfusions/other therapy, can help determine chronicity. Careful review of medications, including over-the-counter drugs and herbal supplements, is critical, along with a discussion of potential toxin exposures, including well-water nitrates, lead-glazed cooking pots and similar substances. Reported changes in skin or urine color may suggest hemolysis, while altered stool color or neurologic status may lead to an occult source of bleeding, such as GI or intracranial, respectively. Finally, dietary interrogation is important to determine whether deficiency of a nutrient such as iron, folate or B12 is causing the anemia.

The physical exam can also provide information regarding the severity of the anemia. Close attention should be paid to the vital signs, looking specifically for tachycardia and hypotension, as the former can suggest attempted early cardiac compensation to maintain adequate cardiac output, and the latter may indicate congestive cardiac failure. A new murmur is another concerning cardiac sign, suggesting compensation-related strain. Hepato- and/or splenomegaly can be consistent with congestive cardiac failure, malignant diseases, or increased RBC destruction. Scleral icterus and jaundice suggest hemolysis. Finally, pallor is predictive of severe anemia when noted in sites of visible capillary beds – for example, conjunctiva, palms, nail beds and sublingual area – but not for mild anemia.

Laboratory test selection is guided by information gained during the history and physical. For proper context, evaluate the entire CBC, not just Hgb/Hct. For example, anemia and low platelet and/or white blood cell counts may indicate marrow failure or infiltration, and elevation of these parameters suggests infection or other inflammation. One essential CBC parameter is the MCV, which describes the average volume of individual RBCs in the sample. Like the Hgb and Hct, normal
MCV values vary based upon age (see Table 1). Microcytosis and macrocytosis refer to values two standard deviations below or above the mean, respectively. Microcytosis can be seen with iron deficiency, lead intoxication, chronic inflammation, and thalassemias or other non-sickle hemoglobinopathies. Mild microcytic anemia may be treated presumptively with oral iron therapy in children of the appropriate age (6-36 months) who have risk factors for iron deficiency anemia such as prematurity, poor diet, increased cow’s milk consumption, or chronic blood loss, but if no improvement is seen, the child should be evaluated for gastrointestinal blood loss or thalassemia. Macrocytosis can be caused by medications including anti-convulsants and immunosuppressive agents; liver disease; vitamin B12 or folate deficiency; aplastic anemia; or reticulocytosis. Workup of normocytic anemia is based on bone marrow function as determined by the reticulocyte count: elevated in chronic blood loss or hemolysis and decreased in aplasia or bone marrow failure or replacement.

RDW describes the spectrum of RBC sizes in the sample. The Metzner index is a good way to differentiate microcytic anemias and can be calculated by dividing MCV by RBC (in millions); values greater than 13 suggest iron deficiency, while values less than 11 suggest thalassemia. The RDW is also helpful to differentiate iron deficiency anemia, wherein the value is elevated, usually greater than 20, from thalassemia, where the value is normal.

Mean corpuscular hemoglobin concentration, or MCHC, is a calculated index (MCHC=Hgb/Hct) that indicates normochromia, hypochromia (iron deficiency), or hyperchromia (spherocytosis). Reticulocytes are immature RBCs, identifiable by a blue tint caused by residual nuclear RNA on standard Wright-Giemsa staining and are reported as a percentage of the RBC population. After the first few months of life, the mean reticulocyte percentage reaches adult levels, approximately 1.5 percent. In the case of anemia, it is essential to interpret the reticulocyte count in the context of the reduced RBC number. Often, this absolute reticulocyte count, or ARC, is calculated as the product of the RBCs/L x % reticulocytes, with a value less than 100 multiplied by 109/L indicating an inappropriately low erythropoietic response. Thus, the absolute reticulocyte count indicates bone marrow activity with elevation in the setting of active erythropoiesis in response to RBC loss or destruction, or recovery from erythroblast suppression or replacement of essential nutrients. On the other hand, anemia with normal or low absolute reticulocyte count indicates suboptimal bone marrow response such as that seen in marrow aplasia, infiltration by malignant cells, decreased erythropoietin production, or the effect of infection or toxic agents.

The peripheral blood smear will also show important causes of anemia. Specific causes can be suggested by structural hallmarks, such as spherocytes in extravascular hemolysis or schistocytes and...
Come work in a group to enhance your learning and finish the Self-Assessment Module (SAM) for Hypertension! You will have fun, interact with colleagues, and check off one module for your maintenance of certification for the American Board of Family Medicine. Please come prepared to be online on your computer prior to the start of the workshop. You pay the ABFM for your module and get American Academy of Family Physicians credit directly after finishing the 60-question knowledge test and the clinical simulation (up to 12 hours). And you pay the Colorado Academy of Family Physicians for the room space, internet access, IT help, teachers and snacks! See you in December.

Martha Illige, MD, and Kern Low, MD

The SAM course WILL TAKE PLACE AT THE CAFP OFFICE AT 2224 S. FRASER ST., UNIT#1, IN AURORA.

**YOU MUST BRING LAPTOP COMPUTER WITH INTERNET CAPABILITY. THERE WILL BE WIRELESS INTERNET AVAILABLE AT THE OFFICE.**

**TIME OF PROGRAM**
The class is being held 12:30 to 5:00 p.m. on Dec. 8.

**PROGRAM BENEFITS**
- Earn 15.00 continuing medical education credits in just four hours time.
- Complete your SAM requirement.
- Enjoy effective and efficient group learning approach.
- Class will be taught by Family Physicians.

**CME ACCREDITATION**
This program has been reviewed and is acceptable for 15.00 prescribed credits by the AAFP. Upon completion of the SAM, participants will receive 15.00 credits that will be submitted to the AAFP by the ABFM.

**CAFP & ABFM REGISTRATION**
The fees are $125 for CAFP members and $250 for non-members. Prior to the session, you must also register with the ABFM. Instructions on how to register with the ABFM are below.

**SHOULD I ATTEND?**
The answer is YES if you are an ABFM board certified physician and you certified or recertified in July 2003 or after. For more information on specific recertification requirements from the ABFM, please call 888-995-5700 or visit http://mcfp.theabfm.org and enter the year that you certified/recertified.

**SESSION OVERVIEW**
The CAFP is offering group learning sessions to assist members with the completion of the Self-Assessment Modules that are required by the ABFM for completion of the maintenance of certification process.

It is the academy’s experience through previous SAM workshops that for many physicians, this group learning approach is an effective (and efficient!) way to both satisfy the ABFM SAM requirement for maintenance of certification and to learn practical applications of the material.

The SAM is a 60-question internet-based exam and online patient management module. The faculty team will present each of the 60 questions on the test and discuss the important teaching points for each, which will facilitate the participants’ completion of each item. They will also guide the participants through the patient management simulation module. Internet access will be provided to allow completion of the entire SAM such that when participants leave this session, they will have completed their yearly ABFM requirement and will have received a total of 15 CME credits!

**HOW TO REGISTER WITH THE ABFM**
It is imperative that you make the following preparations PRIOR to the session on Sat. Dec. 8, 2012. If you do not have your user name and password you will not be able to complete the SAM. If you need assistance, please call the CAFP at 1-800-468-8615, ext. 10.

1) Call the ABFM at 888-995-5700 and obtain a user name and password. Please tell them you are interested in signing up for a Self-Assessment Module. You may already have this as a result of previous use of the board’s website, but please confirm this.

2) Go to the ABFM web site (www.theabfm.org) and log in with your user name and password and you will be taken to the Physician Portfolio page. In the Physician Portfolio on the left hand side, there is a link titled Track Your Progress. Click this link. On the Track Your Progress page at the very top, there are links to Begin a Part II Module and Begin a Part IV Module. Click the Begin a Part II Module. You will be taken to a page with a selection of modules. Please choose Hypertension. This will take you to the payment screen for the assessment module. Please bring your user name, password and payment confirmation to the CAFP SAM session. You must pay the ABFM recertification fees in addition to the fee you pay the CAFP.

**LOGGING ON TO THE ABFM WEBSITE**
Please complete the following steps on your computer to access the SAM questions for the session.

Go to www.theabfm.org.

Enter your user name and password on the right-hand side of the page.

Click Track Your Progress on the left-hand side of the page.

Click Begin a Part II Module.

Click Resume under the Module you will take.

Scroll down to the bottom of the page and click Continue.

Click Start – this should take you to question #1.

**BRING YOUR LAPTOP!**
Helping Parents Be on the Lookout for **BULLYING**

*A conversation with Natalie Abramson, pediatric psychologist*

As kids head back to school, it is not uncommon for parents to have questions about their children’s safety and wellbeing at school. According to the 2009 Colorado Healthy Kids Survey, 19 percent of students in Colorado reported being bullied in school. And while school districts across the state are taking the issue of bullying seriously, many parents are looking to health care providers to help identify ways that they as parents can know if their children are being bullied, and what they can do to try to prevent it from happening in the first place.

Natalie Abramson, PhD, pediatric psychologist at Children’s Hospital Colorado, provides useful tips for talking with parents about the signs of bullying and what they might do to help prevent it.

**Q:** Not all bullying has physical signs. What other signs should parents look for if they suspect their child is being bullied?

**A:** Kids may avoid school at one time or another for any reason but parents should look for ongoing signs of reluctance to go to school or overt refusal to go school such as consistent headaches, stomachaches or other reasons why they should not go to school. If this is happening with your child it is time to investigate and start asking questions.

**Q:** What can parents do to help prevent bullying?

**A:** I’d like to share three tips for parents to help prevent bullying:

1. Make sure your children know they can talk to you about any issue whether significant or insignificant and that you will hear them out, listen and not necessarily talk back.
2. Have a network of relationships not only among your children's peers but the friends' parents so that there are lines of communication among parents within the peer group to keep tabs on what might be going on in that circle of friends.
3. Conduct regular communication with school personnel. Ask your children's teachers, coaches, guidance counselors and other involved adults questions beyond academics to find out how your children are doing socially and emotionally at school and within their peer groups.

To watch the video of Dr. Abramson's interview on signs of bullying and tips for parents visit [http://www.youtube.com/watch?v=Ui0o06knrnc](http://www.youtube.com/watch?v=Ui0o06knrnc).

Dr. Abramson also provides tips for parents in a second video: *Is Your Child a Bully? How Parents Can Pay Attention.*

Watch at: [http://www.youtube.com/watch?v=Ja23jOJ8noY](http://www.youtube.com/watch?v=Ja23jOJ8noY)

Additional resources on how to stop bullying: [http://www.childrenscolorado.org/wellness/info/parents/58079.aspx#Resources](http://www.childrenscolorado.org/wellness/info/parents/58079.aspx#Resources)

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Fit Family Challenge Update: **Shared Successes!**

We are pleased to share a number of updates from the Fit Family Challenge pilot project. This innovative initiative aims to reduce childhood obesity in Colorado by integrating pediatric obesity guidelines and implementation of a primary care office-based intervention into clinical settings across Colorado. Based on the 5-2-1-0 message, this program brings together children and their families to identify lifestyle habits that may put the child at risk for obesity. Excitingly, our preliminary data indicates success! Detailed in the last edition of the CAFP News both behavior change data and Body Mass Index data are trending in the right direction.

These preliminary results garnered interest for further study from the project team and The Colorado Health Foundation (TCHF). Encouraged, we applied for a second three-year grant. Again, the FFC project team met success. On June 1st TCHF renewed funding for the FFC project through May 2015. During this grant cycle we hope to quantitatively confirm that the FFC intervention effectively treats pediatric obesity in clinical settings.

To maximize the project’s reach we hope to expand our reach to twenty practices in this new grant period. Last year eleven practices participated in the FFC pilot. We are delighted that seven of these original practices will continue to participate in the FFC in the coming years. This summer we recruited practices from across the state of Colorado to participate in the FFC pilot project. We targeted practices that serve rural and underserved communities, as these populations tend to have a higher risk of obesity. Due to a high interest in the program, we are currently in the process of reviewing applications and meeting with each prospective practice. On October 4th & 5th we will host new and continuing practices at our Bi-Annual Learning Collaborative.

Finally, I am thrilled and excited to join the FFC project team. At the beginning of July, I began as the Program Manager for the Fit Family Challenge. A recent graduate from the University of Denver’s Josef Korbel School of International Studies, I am excited to share my passion for health access as well as my program coordination experience to the project.

Find out more about the Fit Family Challenge!

Information available online at our website [http://coloradoafp.org/poobesity](http://coloradoafp.org/poobesity) and our Facebook page [www.facebook.com/Colorado5210](http://www.facebook.com/Colorado5210)

Additional information available by contacting Sarah Roth, Program Manager Fit Family Challenge, 2224 S. Fraser St., Unit 1; Aurora, CO 80014; by phone at 303-696-6655x16; or by email sarah@coloradoafp.org

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**Tar Wars**

IT’S THAT TIME OF YEAR AGAIN!

admin@coloradoafp.org
www.tarwars.org

The mission and goal of Tar Wars is to educate fourth and fifth grade students about being tobacco free, provide them with the tools to make positive decisions regarding their health, and promote personal responsibility for their well-being. By utilizing a community-based approach to mobilize family physicians, educators, and other health care professionals, Tar Wars can accomplish its mission. Goals of the program are to:

- Educate and motivate students to be tobacco free
- Mobilize health care professionals to become proactive in their community’s health education
- Encourage community involvement in support of the Tar Wars program

Together, Tar Wars presenters and the Colorado Academy of Family Physicians (CAFP) have been able to reach thousands of fourth and fifth graders with the Tar Wars message, helping children live healthier, tobacco-free lives. In order to duplicate last year’s success, Tar Wars needs your support. Volunteering for this program is one way you can combat the epidemic use of tobacco by youth through prevention. We would like to extend an invitation to all of you to join us. This program will only take a small amount of your time.

Please join us in participating to help bring this life-saving program to the kids of Colorado. In order to get to the Tar Wars website, please go to [www.coloradoafp.org](http://www.coloradoafp.org) and click on CAFP Programs, then Tobacco Education/Cessation, and finally Tar Wars. You may then fill out the Presenter Participation form and submit or request a form by email and I will send it directly to you. Join us, for the health of it!
Physicians may weigh several variables in determining the best course of action when faced with patients who may be unsafe drivers.

**Colorado Reporting Law**

Several states currently require physicians to report patients who may be impaired drivers. Colorado, however, has a permissive rather than a mandatory reporting law. If the Department of Motor Vehicles, or DMV, has evidence indicating that a licensed driver is incompetent or otherwise not qualified to be licensed, it can require the driver to submit to a re-exam, which may be in the form of a written exam, eye exam, and road test.

Physicians may request a re-exam and send information to the DMV regarding a patient’s physical ability to drive a motor vehicle. A person’s spouse, parent or child may also send a written request for a re-exam stating the reason for the request. The driver has a right to know who requested the re-exam and can obtain a copy of the request for a small fee. The DMV is authorized to seek and receive a written medical opinion from any licensed physician to determine whether a driver is physically or mentally able to operate a motor vehicle safely. It may also consider an unsolicited medical opinion from the patient’s personal physician submitted at the driver’s request.

No civil or criminal action can be brought against a physician who provides a written medical opinion as long as the physician acts in “good faith” (i.e., with an honest belief or purpose) and “without malice” (i.e., the physician has an objective basis for the opinion). A written medical opinion relating to a driver is considered confidential for the DMV’s use in determining the person’s qualifications as a driver. It can’t be used as evidence in any trial or proceeding except in matters concerning the person’s qualifications to receive or retain a driver’s license.

**Duty to Inform Patients—Driving Risks Associated with Treatment**

A physician has a duty to inform patients of the risks of treatment as part of the informed consent process. This may include warning a patient of the risks of driving while using a medication or undergoing a particular treatment. While it’s unrealistic to require that a physician advise a patient of all conceivable risks of a particular treatment, “substantial” risks should be disclosed. These are risks the physician knows or should know would be significant to a patient’s decision whether to undergo a particular treatment. A patient employed as a bus driver, for example, would want to know whether a drug causes daytime drowsiness and whether there are better alternatives.

The manufacturer’s warnings included in a prescription drug insert don’t relieve a physician of the duty to inform a patient of the risks of treatment. These warnings are aimed at physicians who are in the best position to understand the significance of the risks involved and weigh the advantages and disadvantages for a particular patient.

**Patient Confidentiality**

Physicians have both an ethical and legal duty to maintain patient confidentiality. There is an ethical duty because the physician-patient relationship is based on trust. A patient will be reluctant to share medical information if the physician uses it to limit the patient’s freedom to drive. A patient’s health information is also protected under state and federal law. A physician may disclose a patient’s protected health information, however, if the physician believes that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

**What is a Reasonable Approach?**

The approach for a patient who may be impaired but wants to drive varies depending on the circumstances. If a patient is acutely impaired in a treatment setting, it’s appropriate to try to prevent the patient from driving. If the patient refuses to stay for treatment, is unable to give an informed refusal for treatment, and poses an imminent threat to himself/herself or the public, security and/or law enforcement should be notified.


Although written to address driving impairments in older drivers, the approach is valid for patients of any age. The guide lists red flags for medically impaired driving; explains how to formally assess a patient’s functional ability (including applicable CPT codes); addresses driving with certain medical conditions (such as seizure disorder and cardiac conditions); suggests specific interventions for any deficiencies; and provides detailed guidance in counseling a patient about driving. It also provides educational material and other resources for patients and their families.

It’s a judgment call as to when a patient is better protected by continuing to counsel him or her about driving limitations vs. filing a report with the DMV. If you determine that a patient’s driving poses a strong threat to the patient or public safety, and the patient continues to drive despite your best efforts, it’s ethically appropriate to report this to the DMV. (See American Medical Association Ethical Opinion 2.24-Impaired Drivers and Their Physicians, available at [http://www.ama-assn.org/ama1/pub/physician-resources/medical-ethics/code-medical-ethics/opinion224.page](http://www.ama-assn.org/ama1/pub/physician-resources/medical-ethics/code-medical-ethics/opinion224.page).) Because the patient will be notified that a report was filed and has a right to know who filed the report, it’s best to discuss reporting with the patient first. The Physician’s Guide has sample language to use in a follow-up letter to the patient. In all cases, document your decision making process as well as your communications with patients who may be driving-impaired.

Missing from the Label, Salt Was on the Table at Special Constituencies Conference

New physician rep worked on advocacy, policy, leadership skills

By John C. Cawley, MD

Organized medicine has always been an interest of mine. This year I was able to represent the new physicians from the Colorado Academy of Family Physicians at the National Conference of Special Constituencies held May 3-5 in Kansas City, Mo. I was taken aback by many things, including the Missouri humidity, but even more by the teamwork of partnership by Family Physicians working to improve health care for their patients. This conference was held in conjunction with the Annual Leadership Forum, also hosted by the American Academy of Family Physicians, which allowed new physicians, as well as many other traditionally underrepresented groups -- such as women, international medical graduates, minorities, and lesbian, gay, bisexual and transgendered physicians -- to work and learn from the senior leadership teams that included leaders from Colorado and the rest of the country.

I have not had previous experience in politics, however, over the course of the conference I co-authored and drafted a resolution advocating for the Federal Drug Administration to work on clearer labeling of food, specifically in an attempt to help bring clarity to already confusing food labels. We asked the AAFP to advocate to the FDA that on food labels “salt” should be listed either instead of or along with the word “sodium.” Something so simple could potentially have a huge impact on patients’ dietary consumption of sodium. Oops I meant “salt.”

In addition to brainstorming, resolution writing, and advocacy and policy work, I had the opportunity to work on improving my leadership skills through the many leadership-focused seminars that were available. Thank you, CAFP, for sending me as your “new physician” representative. The benefits of networking and learning from one another while working to better Family Medicine and patient care were well worth the time spent in the humidity!

John C. Cawley, MD, practices at Associates in Family Medicine in Fort Collins.

**DBS**

Colorado Disability Benefits Support Program (DBS)

Mission: DBS assists individuals with disabilities, including those with chronic conditions/illnesses, to acquire income, health insurance and other basic needs to stabilize their lives, health and living situations.

**Direct Services**

**DBS:**

- Assists individuals with disabilities, including those with chronic conditions/illnesses to develop and file a Social Security Administration Disability benefits’ application and monitor the status of submitted applications.
- Provides basic needs (housing, food, medical care) referrals for individuals with disabilities who have these unmet needs.
- Offers application assistance on available and relevant Medicaid-related services.
- Provides post-enrollment services to individuals approved for SSA disability benefits programs and Medicaid-related services.
- Delivers services in compliance with the Americans with Disabilities Act rules and regulations.
- Serves ages 17 and half up to 65 years.

DBS conducts capacity building activities to train individuals and organizations on assisting these individuals to acquire income, health insurance and other basic needs.

**Capacity Building Activities**

**DBS:**

- Delivers capacity building training activities and educational materials focused on SSA disability benefits acquisition and maintenance to individuals and organizations.
- Delivers capacity building training activities and educational materials focused on application assistance on available and relevant Medicaid-related services.
- Delivers training and technical assistance activities via teleconferences, webinars, face-to-face workshops and individual sessions.
- Ensures that information is accessible and available in alternate formats to ensure universal accessibility.

DBS can currently provide direct services for those living in the Denver Metro area. Outside of this area, DBS can provide phone consultation and answer questions.

**DBS Phone Number:** 1.888.396.9838
**DBS Office:** 3532 Franklin Street, Suite S, Denver, CO 80205

For more information on DBS and sending referrals please contact:

Peter Pike, Executive Director
Peter.pike@coloradodbs.org or 720.234.5907
**Coloradans Co-authored Popular Measure at National Conference**

*Inspiring stories, multiple programs highlighted student and resident gathering*

By Daniel G. Bates, MS

Sitting here in the Kansas City airport, waiting to get back to my wife and daughter, I find it the perfect venue to reflect on my experience over the past few days. This was my first visit to the American Academy of Family Physicians National Student and Resident Conference, and I was proud to have the honor of attending as the Colorado Academy of Family Physicians chapter delegate.

This year was a busy one for the student congress. A record number of resolutions—42 in total—were brought to vote. One was co-authored by Melissa Noble, the CAFP alternate delegate, and me, along with three other chapter delegates from around the U.S. The resolution was to encourage the AAFP to make a statement of continued support for same-sex couples and families, and bring the AAFP’s stance on same-sex unions in line with our colleague organizations, the American Academy of Pediatrics and American College of Gynecology. Having received input from our fellow Colorado chapter students, we decided to support the resolution that was initially discussed on our student email listerv. Melissa and I had the opportunity to become co-authors on the resolution and help guide it through the various facets of the student legislature. In the end though, the resolution didn’t need much guiding as it turned out to be popular among this year’s delegates and passed the student congress without objection.

Of course the main attraction of the national conference is the residency expo, and this year was no exception. Immediately, I was blown away by the vast number of programs in attendance at the expo hall. It was great to have so many programs from around the country in one place, and to be able to meet residents and faculty from all of the institutions. Though most of the meetings were little more than a few minutes long, and ended in an exchange of contact information for various items of swag, I feel that the expo really made it possible to get a good feeling for each program. The biggest surprise was how many great programs I encountered that I had no idea even existed. As well, I was impressed by programs I had no interest in before the conference. The Colorado programs made a fantastic showing, and their combined expo booths were, in my opinion, some of the best of the expo, and gave out great swag this year! (I love my monkey stethoscope cover!) All of the Colorado programs were wonderful to speak with, and our state definitely came across as having a strong presence of Family Physicians.

For students like me who are interested in the more specialized family residencies, or ones that are scattered geographically (I’m aiming for a combined Family Medicine/Psych program come Match Day), it was wonderful to meet with programs from around the country without having to break the bank traveling from state to state. I feel like I have had the opportunity to experience the flavor of each of the programs and it has really helped to flesh out my list of applications come October.

Richard Roberts, MD, JD, former AAFP president and president of the World Association of Family Doctors, rounded out the conference with a rousing talk about the experience and the value of primary care physicians around the world. One story struck me in particular, that of an Uzbekistani physician caring for a poor, rural community. In a country of extreme poverty and even more striking inequity, this physician lives in a simple shack 20 feet from his clinic. He walks the streets of his village, shaking hands, high fiving local teens, and drinking tea in the shade with his neighbors, not once feeling resentful of government officials a few hundred miles away living in elaborate palaces. He feels proud and happy to care for his community. For me this story shined a bright light on the highest paid specialty, we are uniquely rewarded with the ability to care for entire families and entire communities and earn their love and respect. This truth (along with a bunch of swag) is coming back with me from the national conference and I hope to take it into residency next July and into the community after that.

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RBC fragments in intravascular hemolysis, target cells in thalassemias, teardrop cells in marrow infiltrative disorders, or blister/bite cells in G6-PD disease; prototypical shape, such as hereditary spherocytosis and elliptocytosis; or unique structures.

Adjunctive studies include evaluation of bilirubin—total and fractionated—and lactate dehydrogenase to evaluate for elevated values consistent with hemolysis if suspected. Additionally, levels of iron, folate, and B12 can be studied to detect deficiencies of these RBC building blocks.

Full evaluation of iron deficiency anemia should also include ferritin (iron storage) and total iron binding capacity, an indirect measure of total iron.

The evaluation of pediatric anemia, therefore, begins with an understanding of erythropoiesis and major etiologic categories to guide history and physical exam, which lead to choice of appropriate laboratory tests to reveal the correct diagnosis that will, in turn, guide management decisions.

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Brian R. Branchford, MD, is a clinical and research fellow with the department of Pediatric Hematology, Oncology, and Bone Marrow Transplant at the Center for Cancer and Blood Disorders at Children’s Hospital Colorado.

Kids Corner is a regular feature of the CAFP News provided by the Department of Family Medicine at Children’s Hospital Colorado. Questions about this article or suggestions for future topics you may be directed to the author or to Chief of Family Medicine Jeff Cain, MD, through OneCall: 720-777-3999.
John L. Bender, MD, FAAFP, a leader in both the Colorado Academy of Family Physicians and in the medical home movement, was elected president-elect of the Colorado Medical Society.

His chief goal will be to lead initiatives that support both medical homes and medical neighborhoods.

“The Patient Centered Medical Home doesn’t work without a medical neighborhood,” Dr. Bender said. “The new model is dependent on strong, integrated relationships.”

Two specific areas in which Dr. Bender plans to press for change are tort reform and accountable care organizations, or ACOs.

He champions legal reforms that would end “out-of-control” malpractice awards and institute practices that could “actually help people,” he said. He would work toward a no-fault approach to cerebral palsy that would include a fund to help families with children who suffer from the illness.

He would take steps to assure more physicians participate in hospitals’ ACOs, which are panels that tie provider reimbursements to quality metrics and reductions in total cost of care.

The practice Dr. Bender and his wife, Teresa, bought in 2002 in Fort Collins demonstrates the power and effectiveness of the medical home model. When they purchased Miramont Family Medicine in 2002, the practice included one physician, one employee and one computer in a single location.

Over the course of a decade, as other Larimer Care primary physicians abandoned their practices, Miramont Family Medicine grew to become a network of four Patient Centered Medical Homes delivering full-spectrum primary care services in suburban and rural communities. With Dr. Bender serving as president and chief executive officer, Miramont comprises 14 providers, 50 employees and 80 computer workstations networked through an integrated data center to serve more than 27,000 patients.

Miramont Family Medicine in 2008 received recognition as a Level 3 medical home from the National Committee for Quality Assurance. In 2010, Miramont won a national HiMSS Nicholas E. Davies Award of Excellence for outstanding achievement in implementation of and value from health information technology. In 2011, the practice was honored as the CAFP Patient Centered Medical Home of the Year.

Dr. Bender was CAFP president in 2007 and 2008 and he currently serves as a CAFP delegate to the American Academy of Family Physicians Congress of Delegates and as a member of the AAFP Commission on Finance and Insurance. He has served as president of the Larimer County Medical Society and Northern Colorado Independent Physicians Association. He currently serves on the board of the Colorado Medical Society and is a member of the society’s Finance Committee.

In February 2012, Dr. Bender testified before the Health Subcommittee of the U.S. House of Representatives Ways and Means Committee on programs that reward physicians who deliver high quality and efficient care.

The president-elect of the Colorado Medical Society was selected by approximately 300 delegates representing constituent organizations.
COLORADO FAMILY PHYSICIAN OF THE YEAR

AWARD NOMINATION

OVERVIEW & CRITERIA
Please go to the CAFP web site, www.coloradoafp.org, click on About CAFP, then click on Awards and fill out the application form.

The Colorado Academy of Family Physicians announces the annual call for nominees for the Colorado Family Physician of the Year award. All CAFP members are urged to consider their colleagues and submit nominations. The criteria set forth for the Colorado Family Physician of the Year award are as follows:

1. Provides his/her patients with compassionate, comprehensive and caring Family Medicine on a continuing basis;
2. Is directly and effectively involved in community affairs and activities that enhance the quality of his or her community;
3. Is a credible role model professionally and personally to his or her community, to other health professionals, and residents and medical students;
4. Can effectively represent the specialty of Family Medicine and the American Academy of Family Physicians in public speaking; and
5. Stands out among his or her colleagues.

Please address these criteria in your nomination information.

Past nominees may be resubmitted.

NOMINATIONS SHOULD INCLUDE:
- Curriculum vitae
- Current black and white photograph
- Letters of support

Please submit nominations to: CAFP, 2224 S. Fraser St., Unit 1, Aurora, CO 80014

NOMINATIONS MUST BE SUBMITTED NO LATER THAN DECEMBER 1

Winner will receive award at the CAFP Annual Scientific Conference at the Cheyenne Mt. Resort, Colorado Springs, April 20, 2013; an engraved plaque, free registration and lodging at the Annual Conference in 2013; and will be publicized in CAFP News and on the CAFP website: www.coloradoafp.org, with state and local news releases sent to newspapers.
Atlantic Health Partners! The CAFP is pleased to announce a partnership with Atlantic Health Partners! Atlantic, the nation’s leading physician vaccine program, provides your practice: • Best Pricing for Sanofi Pasteur and Merck Vaccines • Enhanced Ordering and Payment Terms • Medical Supply Discounts and Reimbursement Support and Advocacy. Join your many colleagues in Colorado that have lowered their vaccine costs. Call Atlantic Health Partners at 800.741.2044 or email info@atlantichealthpartners.com. www.atlantichealthpartners.com

BEST CARD: Discounted Credit Card Processing - Serving more than 1,000 medical offices, these practices are saving an average $350 annually (23%) since switching to Best Card. Members receive great rates including swiped rates of 1.74% debit, 1.94% credit, and 2.44% rewards, with no rate higher than 2.74%. No hidden fees ($5 monthly fee and $0.05-.12 per transaction based on average ticket) and unparalleled customer service. Call 877-739-3952 or fax your recent credit card statement to 866-717-7247 and receive a complimentary cost comparison.

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

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Law Consulting by Michele Law: Michele offers consulting services for physician clients with regard to their contractual arrangements with insurance carriers, health maintenance organizations and/or networks. We advise, analyze and make recommendations regarding contracts and their reimbursement schedules, and, upon request, we directly negotiate the terms of those agreements. Law Consulting operates a messenger model consulting service where the physician client retains the final and ultimate business decision regarding his or her contract. Law Consulting offers a discount to CAFP members. Please contact Michele Law 719-687-5465, lawconsult@qwestoffice.net.

National Procedures Institute: NPI offers you an exciting opportunity to bring new procedures to your practice and generate revenue for your state academy at the same time. When you attend an NPI course, NPI will send $50 to the Colorado Academy of Family Physicians. All you have to do is enter “Colorado” in the Referral Code field when you register online at the NPI Web site so that our chapter receives credit for your attendance. Visit NPI online at www.npinstitute.com to view course descriptions, learn about NPI’s outstanding faculty, find a course in our area and register. Don’t forget to enter the name of our state in the Referral Code field during the registration process and start getting more out of your practice with NPI.

NCSP: NCSP Incorporated, the nation’s leading accounts receivable management firm. As opposed to collection companies that charge a percentage of the patient bill, or a flat fee and a percentage, NCSP charges CAFP members only a low flat fee. Because of their customer focus, NCSPPlus reports a recovery rate that is more than twice the national average. CAFP members who enroll in this program receive a free Bonus Upgrade Package that includes: • Guaranteed 400% R.O.I. • Complimentary computer maintenance fee • Free debtor reporting to the major credit bureaus

Sharkey, Howes & Javer is a nationally recognized financial planning and investment services firm that offers complimentary consultations to doctors for their personal needs and their company retirement plans. The firm has been recognized by Medical Economics as a top advisor for doctors and is the preferred provider of financial services for members of the Colorado Medical Society. Located in Denver. Visit www.shwj.com or call 303-639-5100 for more information.

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NCSPPlus: NCSPPlus Incorporated, the nation’s leading accounts receivable management firm. As opposed to collection companies that charge a percentage of the patient bill, or a flat fee and a percentage, NCSPPlus charges CAFP members only a low flat fee. Because of their customer focus, NCSPPlus reports a recovery rate that is more than twice the national average. CAFP members who enroll in this program receive a free Bonus Upgrade Package that includes: • Guaranteed 400% R.O.I. • Complimentary computer maintenance fee • Free debtor reporting to the major credit bureaus

A strong focus on service and competitive rates translate into a valuable benefit for our members. To get started in this low-cost and effective collections system, please contact NCSPPlus Representative, Polly Kildaras, at 303-704-8896, or send email to pkildaras@ncspplus.com.

Northwestern Mutual Financial Network: James O’Hara offers a broad range of financial planning services and products. Consultations are complimentary. Some of the areas of practice are non-qualified executive benefits, retirement planning, and education funding. Visit www.nmfn.com/jamesohara for more information on James O’Hara, his team and the products available from Northwestern Mutual as well as informative articles and calculators.

CAFP members receive a $500 lender credit to be used towards closing cost.
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