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INTRODUCING THE
LONE TREE BREAST CENTER

Front row: (from left to right) Colleen Murphy, MD, Dana Knapp, Eamon Berge, MD, James Borgstede, MD
Back Row: Candace Drew, Larissa La Breche, Melissa Klausmeyer, MD, Sara Amateis, Lori Swanson, RN, BSN, Christine Cedilotte, PT, DPT, MS, CLT

University of Colorado Hospital and the CU School of Medicine are proud to announce the opening of the new Lone Tree Breast Center, one of the Colorado’s most comprehensive breast health facilities. The Center offers 3-D mammography for all patients as a standard of care with no additional cost to our patients, and walk-in appointments are always welcome.

Other services include:
» Breast and axillary ultrasound
» Breast biopsies: stereotactic, ultrasound and MRI-guided
» Breast MRI: available in the Lone Tree Health Center across the plaza from Lone Tree Breast Center
» Wire localizations for surgery
» Screening and diagnostic mammography
» Breast Patient Navigator
» Genetic counseling
» Screening and management of patients at high risk for breast cancer
» Breast reconstruction
» Breast cancer nurse navigation
» Medical oncology (Infusion services are provided at the Lone Tree Health Center across the plaza)
» Treatment for and management of benign breast disease
» Multidisciplinary clinic for breast cancer patients
» Breast cancer surgeries including lumpectomies, sentinel lymph node biopsies, axillary dissections and mastectomies (Outpatient surgeries performed at Lone Tree Surgery Center 1/4 mile away)
» Radiation Oncology is available to patients at the UCH TomoTherapy treatment facility, one mile south of Lone Tree Breast Center

Meet Our Comprehensive Breast Health Team:
Colleen Murphy, MD – Breast Surgery, Medical Director, Lone Tree Breast Center
Eamon Berge, MD – Medical Oncology
Melissa Klausmeyer, MD – Plastic and Reconstructive Surgery
Wei-Shin Wang, MD – Breast Imaging
Lara Hardesty, MD – Breast Imaging
James Borgstede, MD – Breast Imaging
Lori Swanson, RN, BSN – Nurse Navigation
Christine Cedilotte, PT, DPT, MS, CLT – Lymphedema Therapy
Candace Drew R.T.(R)(M)CBPN-IC – Mammographer and Breast Imaging Patient Navigator

Hours: 8:00 am-5:00 pm | Scheduling Phone number: 720-553-1200 | Fax: 720-553-1201
Street Address: 9544 Park Meadows Drive, Suite 100, Lone Tree, CO 80124
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Vision Statement:
Thriving Family Physicians creating a healthier Colorado.

Mission Statement:
The CAFP’s mission is to serve as the bold champion for
Colorado’s family physicians, patients, and communities through
education and advocacy.
**Simple or Not**

Each morning I awaken, hug my dog, and enjoy my coffee along with whatever the sunrise has to offer. I go to work; I see patients; I go from room to room; I do paperwork; I wash my hands; I sign my name-a lot, REPEAT! The day unfolds and, invariably, I wonder at how complicated life and medicine have become. I hear it used to be simpler. People paid in chickens. There were only a few antibiotics, a handful of vaccines, and a couple of magic potions.

On the other hand, we were helpless to alter the course of a stroke, restore coronary blood flow, or see many women survive breast cancer. In 1950, childbirth cost $70.00, but 30/1000 infants died. Today, the cost of childbirth is $30,000 and that number has decreased to 6.4/1000. That is nearly 430 times the cost it was. There is nothing simple about that! Nothing simple about the Affordable Care Act. Nothing simple about health care comprising nearly 18% of our gross domestic product (GDP). Nothing simple about the predicted transition from “fee for service” to that somewhat nebulous notion of “managed-care-per-member-per-month” payment reform.

With the unspoken mandate that we, as physicians, must do something to halt the escalation of health care costs and to conserve economic resources, without just giving away our services, I agreed to participate in a leadership seminar focusing on affordability in health care or the promise of such. The Collaborative Health Network, an NRHI (Network for Regional Healthcare Improvement) project, funded by the Robert Wood Johnson Foundation and Stanford University Medical School, hosted a brainstorming event. It was called the “National Physician Leadership Seminar, Total Cost of Care & Resource Use.” Riveting stuff! They brought together a group of about 40 people serving various roles in healthcare across a few select states. These were Maine, Massachusetts, Minnesota, Missouri, Colorado, Oregon, and California. They were chosen because each of these states has invested in and is soon to implement a metric program to provide feedback to physicians on their total cost of care & resource use. This system is an analytical framework designed to identify overuse and inefficiency in health care. Total cost of care measures support multiple levels of analysis, so users can compare cost and utilization by procedure, by condition, or by patient. Physicians have the data and recover from data denial, we predictably start to make changes to avoid being an “outlier.” Initially, most of this data is going to be given on a group basis. The benefit is that it allows us to compare “apples to apples” regarding costs of health care, but there is nothing simple about that either. Collecting and reporting data that is valid and reliable presents multiple challenges.

Here in Colorado, the group, http://www.civhc.org, (Center for Improving Value in Health Care) will be making data available to physicians, insurance companies, and the public later this year. Essentially, each group will have access to a “report card” of their total costs of care. Some information is already available at their website. Ultimately, this transparent data may decrease the cost of health care. We simply cannot sustain having all of our nation’s growth devoured by health care costs.

We spent the entire weekend sharing ideas and brainstorming, engaged and captivated by the enthusiasm created by the seminar leaders and attendees. For at least those few days, the palpable engagement of the participants inspired a bit of optimism. Carrying that optimism home, enlisting participation in our communities and inspiring other physicians to champion these worthy endeavors isn’t simple either.

And still, each morning I awaken, hug my Tillydog, and enjoy my coffee along with whatever the sunrise has to offer. I go to work; I see patients; I go from room to room to room; I do paperwork; I wash my hands; I sign my name-a lot, REPEAT. Simple or not.
Hi CAFP Members,

Fall is the season of change and health care is moving ahead with promising changes for primary care and Family Medicine.

**Medicare’s Coordination Payment**

You might have read about the New York Times article on Aug. 16, 2014 regarding Medicare’s plan to pay doctors to coordinate the care of Medicare beneficiaries who have two or more chronic conditions. The articles states, “Dr. Reid B. Blackwelder, president of the American Academy of Family Physicians, said many family doctors were already coordinating care for Medicare patients, and he predicted that more would do so when the government began paying separately for the service.”

**Medicaid’s Enhanced Payment**

Colorado’s Medicaid program will pay an enhanced Per Member Per Month (PMPM) payment if you meet five of the nine primary care enhanced standards criteria as follows:

1. The PCMP has regularly scheduled appointments (at least one time a month) on a weekend and/or on a weekday outside of typical workday hours.

2. The PCMP provides timely clinical advice by telephone or secure electronic message both during and after office hours. Patients and families are clearly informed about these procedures.

3. The PCMP uses available data (e.g., SDAC, clinical information) to identify special patient populations who may require extra services and support for medical and/or social reasons. The Practice has procedures to proactively address the identified health needs.

4. The PCMP provides on-site access to behavioral health care providers.

5. The PCMP collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents and/or developmental screening for children (newborn to five years of age) using a Medicaid approved tool. In addition, the practice has documented procedures to address positive screens and agreements with behavioral health care providers to accept referred patients.

6. PCMPs providing delegated care coordination services for the ACC and certified patient-centered medical homes are expected to generate lists semi-annually of patients actively receiving care coordination.

7. The PCMP tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information.

8. The PCMP is willing to accept new Medicaid clients and has written an agreement with the RCCO.

9. PCMPs and patient/family/caregiver collaborate to develop and update an individual care plan.

For more information, please visit: http://coloradoafp.org/medicaidenhanced or contact Jeremy Tipton at 303-866-5466

**Colorado’s Cost Commission.**

The Colorado State Legislature passed a bill in 2014 to create a commission tasked with studying health care costs and recommending solutions to lowering them. Family Medicine Physicians will be well represented on the Commission by past CAFP and AAFP president, Jeff Cain, MD. It was largely due to the lobbying efforts of our fabulous lobbyist, Jeff Thormods and that this bill passed. “We have a great opportunity as a state to build upon the Affordable Care Act and really dig deep to find systematic problems that inflate health care costs -- and fix them,” said State Senator Irene Aguilar, MD. “The goal here is to provide Coloradans the highest-quality, most affordable and accessible health care system possible.”

**Colorado Primary Care Collaborative (CPCC)**

The CPCC is moving ahead with its mission to build the public will for medical homes and payment reform. Volunteers from the 300 plus supporters have stepped up to work on three action workgroups, Payment Reform (chaired by Cissy Kraft, MD), Delivery Reform (chaired by Brian Hill, MD), and Engaging the Public & Business (chaired by Dan Burke, MD, and Rick Budensiek, DO). These groups along with the CPCC Steering Committee are gathering data and information from experts in health care to determine the best strategies.
and tactics to advocate for medical home and payment reform. The next convening event will be held in June of 2015 and you will be invited to attend and learn about this work.

**PCMH Recognized Physicians in Colorado**

There are now 1,032 NCQA recognized PCMH primary care physicians in Colorado! Specialists can now get a Patient Centered Specialty Practice recognition and there are two in Colorado so far. You can find out more at www.ncqa.org, click on Report Cards and then click on Clinicians.

**Tar Wars Program Improvements**

The AAFP has developed a broader tobacco and nicotine prevention and control program including new office-based tools and community programs. The new curriculum has been posted on the CAFP web site at www.coloradoafp.tarwars.

**Future of Family Medicine 2.0**

In late August 2013, the Family Medicine Working Party launched a follow-up initiative to the Future of Family Medicine Project that began more than a decade ago. The planning phase for Family Medicine for America’s Health: Future of Family Medicine 2.0 project has concluded and the AAFP, in partnership with the seven other organizations, has developed strategic and communications plans. The eight participating organizations have pledged more than $20 million over the next five years to implementing the plan. For more information, please visit: http://www.aafp.org/about/initiatives/future-family-medicine.html.

**Upcoming Events (see web site for details www.coloradoafp.org/events)**

- Oct. 4, 2014, 8 am to 5 pm: DOT Medical Examiner Training at the CAFP office.
- Dec. 6, 2014 12 pm to 5 pm: SAM Pain Management Training at the CAFP office.
- Feb. 2-3, 2015: Fit Family Challenge pediatric obesity training.
- June 2015: Colorado Primary Care Collaborative Convening Event.
CAFP Leader Will Be Physician Representative On Cost Commission

During the 2014 legislative session, one of the big wins for healthcare and the CAFP was a bill that created a Cost Commission to examine health care in Colorado, Senate Bill 187. SB 14-187 creates a 12-member commission to undertake a comprehensive, evidence based analysis of the principal cost drivers in health care in Colorado and the effectiveness of strategies for controlling health care expenditures. The Commission will include representatives from across the state, appointed on a bi-partisan basis by the Governor and Legislative Leadership. The Cost Commission was appointed this summer, including CAFP’s very own Dr. Jeff Cain, and has since had its first meeting. Below is an overview and the appointees. We will continue to update CAFP members about the Cost Commission and the issues that arise.

Why do we need a cost commission?

Colorado will not be able to make meaningful recommendations on controlling health care costs until we understand the principal cost drivers in Colorado as well as effective solutions to address cost-drivers for our state. Several of our Colorado mountain communities now have the highest health insurance premiums in the nation. Health insurance premiums are based on the unit costs of providing care in that region. Insurance premiums will continue to rise and outpace inflation so long as medical costs continue to rise. Consumers need more information to make value based purchasing decisions in health care.

As high health care costs impact everyone, everyone must play a role in addressing Colorado health care cost drivers. The Commission brings together representatives of business, hospitals, health plans and brokers, consumers, and experts and charges them with making evidence based recommendations for action to the General Assembly and the Governor. Colorado is not alone in this. The high cost of health care is a nationwide problem and states as diverse as Massachusetts and Alaska have established commissions to study and make recommendations about costs. Colorado too can begin to impact the high cost of health care.

SB14-187 continues Colorado’s mission to make health care more accessible and more affordable in the best way for OUR STATE. The creation of this Commission is a proactive effort to examine the highest health care cost drivers in our system, and make recommendations about how we can make changes that improve access and quality, while lowering cost.

Appointed Commission members include:

- Elizabeth Arenales of Denver, to serve as a representative from an organization representing consumers and who understands consumers with chronic medical conditions;
- Jeffrey J. Cain, M.D., FAAFP of Denver, to serve as a health care provider who is not employed by a hospital and who is a physician recommended by a statewide society or association whose membership includes at least one-third of the doctors of medicine or osteopathy licensed in the state;
- Rebecca Cordes, of Denver, to serve as a representative of large, self-insured Colorado businesses;
- Greg D’Argonne of Littleton, to serve as a person with expertise in health care payment and delivery;
- Steve ErkenBrack of Grand Junction, to serve as a representative of carriers offering health plans in the state;
- Ira Gorman, PT, Ph.D of Evergreen, to serve as a health care provider who is not employed by a hospital and is not a physician;
- Linda Gorman of Greenwood Village, to serve as a health care economist;
- William Neish Lindsay III, of Centennial, to serve as a representative of licensed health insurance producers;
- Marcy Morrison of Manitou Springs, to serve as a representative from an organization representing consumers;
- Dorothy Ann Perry, PhD of Pueblo, to serve as a person with expertise in public health and the provision of health care to populations with low incomes and significant health care needs;
- Cindy Sovine-Miller of Lakewood, to serve as a representative of small Colorado businesses;
- Christopher Gordon Tholen of Centennial, to serve as a representative of hospitals and recommended by a statewide association of hospitals.

In addition, the Commission will have five ex officio members, as follows:

- Susan Birch, MBA, BSN, RN, Executive Director, Colorado Department of Health Care Policy and Financing;
- Dee Martinez, Deputy Executive Director, Colorado Department of Human Services;
- Marguerite Salazar, Commissioner of Insurance, Colorado Department of Regulatory Agencies;
- Jay Want, M.D., to serve as a representative of the Colorado All Payer Claims Database;
- Larry Wolk, M.D., MPH, Executive Director, Colorado Department of Public Health and Environment.
Earlier this month I had the honor of representing my fellow students at the AAFP National Conference for Students and Residents in Kansas City, MO. My conference began on the morning of Friday August 8, as I accepted my “First Time Student Attendee” scholarship and joined my fellow scholarship recipients for a group photo. The AAFP and individual donors provided $600 scholarships for over 200 student attendees! I spent the rest of the morning in the exhibit hall talking with representatives from residencies from Montana, Idaho, Wyoming, Alaska, Utah and Colorado. Even with a strict focus on programs from the Western/Northwestern region, I found the number of programs represented overwhelming. While in the exhibit hall, I had lunch with three of the students from CU and chatted with a couple of fourth year students from my school (RVU).

The afternoon began with a student congress business session where we heard the annual reports of the student representatives to other organizations, such as the AAFP foundation and the American Medical Association (AMA). Following the student representatives’ reports, candidates were nominated to run for those same offices in the coming year. We were also given an overview of the election process and a review of parliamentary procedure for the following day.

After the business session, I went to “Do’s and Don’ts of Residency Interviewing” which was an information-packed yet lighthearted session presenting advanced interviewing skills. Dr. Joseph Gravel, FA AFP, program director for the Lawrence FMR in Massachusetts, packed the house with a session complete with skits and interactive scenarios. As events in the convention center came to a close for the day, I made my way to the reception hosted by the WWAMI (Washington, Wyoming, Alaska, Montana, Idaho) program network and spent some time talking to representatives from the Family Medicine Residency (FMR) of Idaho and the Providence FMR Spokane whom I had met earlier in the day. To finish off the day, I went to the Colorado FMR reception and talked further with the Grand Junction and Pueblo programs.

Saturday morning the student congress business session started off with final nominations for positions and speeches from candidates. A number of the positions were hotly contested and candidates for those positions sat for a Question & Answer session. The rest of the session was spent alternating between voting for candidates and hearing the reports from the reference committees. Many of the resolutions were adopted with little debate. A few of the more controversial topics included encouraging state chapters to investigate single payer payment models, supporting affordable pricing for the Hepatitis C drug Sovaldi (Sofosbuvir), and advocating for ending the AAFP alliance with Coca-Cola. Much of the debate over the single payer resolution was about wording and whether chapters should be investigating a national or state based system. Ultimately, the decision was to remove the “state based” or “national” descriptors and allow chapters to make their own decisions based on feasibility. Those against the Sovaldi resolution questioned why that drug warranted a specific resolution addressing its affordability while so many other lifesaving therapies are beyond many patients’ means. In response, those defending the resolution cited the short term nature of the therapy and its ability to cure a previously chronic disease. Finally, the discussion over the AAFP’s alliance with Coca-cola revolved around the idea that similar resolutions had been brought to the AAFP congress in past years and never passed.

All in all, it was a busy and productive weekend. I would like to thank the CAFP for their support and the opportunity to represent my peers.
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WE NEVER SAY NEVER.

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

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

Our services include: Comprehensive food allergy testing/challenge, exercise physiology and lung function testing, genetic and immune function testing for immunodeficiency, neuropsychological testing, sleep disturbance evaluations.
This year’s AAFP Resident and Medical Student Congress held in Kansas City August 7th-9th, 2014 showcased many important issues affecting not only the next generation of Family Physicians, but also the current state of our profession. A strong student and resident voice brought forth numerous resolutions on a variety of topics ranging from AAFP policy on ethics and public health to science, economics, and medical education. I personally worked with the committee on medical education and helped to author and review resolutions aimed at addressing specific financial threats to Family Medicine and medical education.

Of particular interest to me, medical students have cited indebtedness as a barrier to choosing family medicine as a career path over other higher-paying specialties [1]. This issue weighed heavily on me over the past few years when choosing to enter a primary care residency program. While the mean cost to attend four years of medical school has soared to $207,868-$278,455 for public and private medical schools, respectively [2], little has been done on a large scale to incentivize a financially feasible pathway to a primary care career. Furthermore, Federal Direct educational loans charge an interest rate close to 8% [3] even though medical school loans have a default rate less than 1% compared to the 10% default rate on non-medical school federal education loans [3,4].

Family Medicine residents, like me, fear entering a workforce under the burden of high interest loans and cut-throat practices of large employed physician groups that often impose unfavorable working conditions in an increasingly low-margin market.

References:


Jeffrey Cain, MD, FAAFP, Chair of the American Academy of Family Physicians, was named as the Physician Representative on the Colorado Commission on Affordable Health Care.

State Senators, Representatives and Candidates from across our state met with the CAFP leadership at the 2014 CAFP Political Endorsement Reception.

Anna Wegleitner, MD, secretary and treasurer of the Colorado Academy of Family Physicians speaks with Mark Parker, a candidate for State House.

Jeffrey Cain, MD, FAAFP, Chair of the American Academy of Family Physicians, stands with Senator Mark Udall (second from the left) and Senator Michael Bennet (first from the right) at a Physicians for Udall event.

Dr. Cain spoke about the importance of finding a Colorado-centric solution to the growing cost of health care.


Health Care Leaders and Family Physicians met at the Western Patient Centered Primary Care Collaborative to discuss the practice transformation and issues around primary care.

The Colorado Health Foundation was attended by CAFP leaders including both the Chair, Richard Budensiek, DO, FAAFP and Vice-President, Glenn Madrid, MD, of the Academy.

John Bender, MD, FAAFP, Past CAFP President, Glenn Madrid, MD, Vice President of the CAFP and Seth Alkire, MD, Resident, attended the Family Medicine Congressional Conference to speak with legislators and legislative aides about the issues they face in their practices.

Raquel Rosen, CEO of the Colorado Academy of Family Physicians, calls for action in demanding payment reform and delivery reform.

The Colorado Academy of Family Physicians held a successful DOT training course in August 2014.

4. Jeff Cain, MD, FAAFP, Chair of the American Academy of Family Physicians, stands with Senator Mark Udall (second from the left) and Senator Michael Bennet (first from the right) at a Physicians for Udall event.
Greetings again from the
SNOCAP TEAM!

In past newsletters you’ve heard from us about why we think participating in SNOCAP projects is a good thing for you and your practice. This time, we wanted to let clinicians from a participating practice tell you.

Juniper Family Medicine is a private primary care practice in Grand Junction serving patients of all ages. The clinicians there include Andrea Nederveld, MD, Laura Campbell, MD and Kate Pierce, MD. Juniper has been very involved in practice-based research through our BIGHORN practice-based research network, (part of the consortium of networks called SNOCAP). Dr. Jodi Holtrop from the University of Colorado Department of Family Medicine spoke with two of the providers recently about their experience involving their practice in research.

Current Projects

Juniper is involved in two studies through BIGHORN and SNOCAP. These are the Fit Family Challenge, a family group-based weight loss program for kids, and Connection to Health, a technology-based assessment providing information and motivation regarding patients risks for diabetes and other chronic conditions.

Benefits versus Drawbacks of involvement in Research

Both Drs. Nederveld and Campbell overwhelmingly endorsed participation in research primarily for the benefit it brings to patients. Dr. Campbell shared because of involvement in research “we are able to offer a number of different things to our patients.” For example, with Fit Family Challenge, obese children can be offered support and education, rather than just advice to lose weight. “Patient care is more than just checking boxes; its making sure the goals are legitimate and asking the patient ‘how can we help you with that?” Research projects promote the staff being involved and part of the team, keeps them interested, and encourages their engagement with patients. Also the physicians feel that it helps them deliver quality care. Dr. Nederveld describes it: “It helps to stay in touch with changes in medicine...it is more invigorating than just a day full of patients. It keeps you intellectually stimulated.” Also connection with other physicians and researchers provides a sense of team. Dr. Nederveld: “Practice can feel like a silo. Meeting people keeps me excited.” Although participation in research does take extra time, sometimes paperwork, and a willingness to try new approaches, it is worth it for what it brings to everyone in and served by the practice.

Getting started

Dr. Campbell expressed that involvement in research fit in well with establishing the practice and aligned with quality improvement efforts such as involvement in a Beacon project and working towards PCMH designation. This quality improvement, serving patients orientation is just “part of our fabric.” Also, having Dr. Nederveld as a practice champion -- who becomes aware of research opportunities, brings them to the group for decision-making and then shepherds the projects along, has been key.

For more information about participation in practice-based research or to be added to our online newsletter, please contact SNOCAP coordinator Tabria Winer (tabria.winer@ucdenver.edu) or one of the directors, Donald Nease, MD (Donald.nease@ucdenver.edu) or Jodi Holtrop, PhD (Jodi.holtrop@ucdenver.edu).

“Practice can feel like a silo. Meeting people keeps me excited.”

– Andrea Nederveld, MD
Do you want to save lives?

Did you know...

- Primary care providers diagnose more skin cancers that dermatologists
- Nearly 5 million people are treated for skin cancer each year
- The annual skin cancer management cost is $8.1 billion
- 1 in 5 Americans will be diagnosed with skin cancer in their lifetime
- Skin cancer is the most common and fastest growing cancer in the US

Become certified in skin cancer to not miss an obvious melanoma and minimize unnecessary referrals.

The Venetian Resort Hotel Casino
Las Vegas: 13-14 December

Certificate in Primary Care
Skin Cancer MEDICINE

GOAL: Learn how to diagnose and manage skin cancer in the primary care setting
- Head-to-toe Skin Checks
- Dermatoscopy
- Punch and Shave Biopsy
- Surgical Treatments
- Non-Surgical Treatments
- Hands-on Practical Sessions

The Venetian Resort Hotel Casino
Las Vegas: 13-14 December

Certificate in Primary Care
Skin Cancer SURGERY

GOAL: Develop surgical skills beyond basic elliptical excisions in small learning groups
- Elliptical Excisions
- Rotational and Advancement Flaps
- Effective Wound Closure
- Skin Grafting
- Local Anaesthesia
- Hands-on Practical Sessions

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For more information or to register workshop attendance:
Visit www.skincancercourses.com or call (800) 867-1390
The Department of Family Medicine at the University of Colorado Denver School of Medicine is seeking an outstanding Family Physician and Clinician Educator to serve as Medical Director for our residency practice located at Rose Medical Center.

Rose Family Medicine Residency exists today as a unique collaboration between three entities: the University of Colorado, Rose Medical Center and The Colorado Health Foundation. The residency is administered by the University of Colorado as one of three residency programs falling under the Department of Family Medicine, which provides access to a full array of educational, clinical, research and academic resources to faculty and residents alike. The residency is located at Rose Medical Center, a 250 bed community hospital in central Denver. Rose is a national leader in patient safety and patient satisfaction, with consistently excellent quality and safety scores. The residency is also supported by the Colorado Health Foundation, a non-profit organization dedicated to making Colorado the healthiest state in the nation.

The residency is comprised of 18 residents, 7 physician faculty members, a PhD psychologist, two social workers, and two pharmacists. The residency practice clinic is currently an NCQA Level-II Patient Centered Medical Home (PCMH) and a winner of the STFM/Family Practice Management Practice Improvement Award. The residency has a strong emphasis on patient safety and quality improvement, utilizes an electronic medical record for patient care and data collection, and will be implementing a patient portal and additional population management tools in 2014.

**JOB RESPONSIBILITIES:** The Medical Director will lead the residency practice in its continued PCMH transformation to include Level-III NCQA certification, care integration, service expansion and continuous quality improvement. The Director will oversee the practice’s involvement in Colorado’s Medicaid Accountable Care Collaborative. The Director will work closely with hospital leadership in developing additional clinic services, in planning for clinic expansion, achieving quality and productivity benchmarks, and in meeting goals for superior patient care and satisfaction. As a member of the residency faculty leadership, the Director will teach and supervise residents and students in the provision of patient care, provide direct patient care in the inpatient and outpatient setting, participate in scholarly activity, and serve as a leader and role model for residents and faculty.

**QUALIFICATIONS:** Must possess or be eligible for medical licensure in the State of Colorado; Board Certified in Family Medicine by the ABFM, with a minimum of 5 years practice experience; Prior clinic administrative/leadership experience; Outstanding communication and leadership skills; Demonstrated experience and competence in teaching and patient care; Prior experience in GME preferred; Ability to balance a visionary and strategic approach with an orientation to details.

This position is full-time and reports to the Residency Director. Obstetrics and hospital call required. Women and minorities encouraged to apply. Detailed job descriptions and qualifications required can be found on jobsatcu.com and the Department’s website, http://fammed.ucdenver.edu/home/careers.aspx. 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.

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 December 15, 2013 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.**
The Colorado Center for Celiac Disease (CCCD) is the first of its kind in the Rocky Mountain region and one of only a handful of programs focusing solely on pediatric celiac disease and gluten sensitivity across the nation. As such, the CCCD is setting the standard for multidisciplinary care of children with celiac disease and gluten-related disorders by focusing on the unique needs of the pediatric population. Our clinical team provides comprehensive services including a variety of screening methods, genetic testing, diagnostic procedures, and long-term health management.

The CCCD is dedicated to the long-term care of children with celiac disease and gluten-related disorders. Whether an individual needs assistance in managing their diet or is seeking consultation for possible celiac disease, the Colorado Center for Celiac Disease team will work to formulate a personalized care plan specific to each patient and their individual and family needs.

For more information about the Colorado Center for Celiac Disease, please visit childrenscolorado.org/celiac. For patient referrals, please call 720-777-3825.

Many hands, one heart.
There is no more terrifying situation than being an expectant parent and finding out your fetus has something wrong. It is imperative that physicians provide an accurate diagnosis or prognostic information to these families to provide for their ongoing care needs. In addition, this process may take several weeks to navigate, requiring referral to multiple specialists, if available. In many cases, pregnant women carrying a fetus with a serious congenital anomaly are also required to deliver at an obstetrical hospital, and the newborn ends up being transferred to a free standing children’s hospital to receive the care they need, thus separating mother and baby. This separation can add to the stress the family is already dealing with as a result of the baby’s condition.

Early referral to a center with an experienced multi-disciplinary team can aid these families by providing an accurate diagnosis and prognosis for their particular malformation in a rapid fashion, possible prenatal treatment, and prevention of the separation of mother and baby after delivery. Cases that will benefit from early referral include conditions that are life-threatening in utero, such as Twin-Twin-Transfusion Syndrome or large tumors that may cause in utero hydrops. Other cases that would benefit are specific anomalies that impact delivery and resuscitation, such as neck masses that distort the airway, severe congenital diaphragmatic hernias that have high risk of ECMO, or cases that have significant congenital heart disease. Additionally, referral of patients with spina bifida for evaluation for in utero repair has the potential benefit, if eligible, of reducing the need for ventriculoperitoneal shunting and improved ambulation at 30 months, as demonstrated in the recent NIH Management of Myelomeningocele Study (MOMs). Finally, the referral of patients where the identity or anatomical relationship of an anomaly is in question would benefit from referral to such a center. The concentration of patients with congenital anomalies in a center in one location where there is a vast experience in the diagnosis and pre- and post-natal management improves the outcome for these babies and also helps to alleviate parental anxiety about their baby receiving the best care possible.

To address these issues in Colorado and the Intermountain West, Children’s Hospital Colorado, the University of Colorado Hospital and the University of Colorado School of Medicine partnered to create a joint venture, putting all Obstetric Services, including General OB, Maternal Fetal Medicine, Colorado Fetal Care Center, the Fetal Heart Program, all of Neonatology and the Cardiac Intensive Care Unit in a single business unit. Thus was born the Colorado Institute of Maternal and Fetal Health. As part of this new Institute, a 12-bed labor and delivery suite was built in Children’s Hospital Colorado, immediately adjacent to both the NICU and the CICU with a specially...
Since opening the MFCU in February 2013, it has transitioned from planned C-Section or EXIT procedures only, to scheduled inductions of labor. Since October 2013 the MFCU has provided 24/7 full service obstetrical cases with in-house Obstetrics Hospitalists and obstetric anesthesia coverage. The MFCU, while still a boutique obstetrical service limited to healthy mothers with anomalous fetuses, has grown continuously to the point where we are now delivering approximately 15 babies a month. The babies delivered at Children’s Colorado have had a range of anomalies from gastrochisis to congenital diaphragmatic hernia, to hypoplastic left heart syndrome and everything in between. In partnership with referring family practice physicians and obstetricians, privileges in the CIMFH at Children’s Hospital Colorado can be arranged to allow them to deliver their patients in the MFCU assisted by our Maternal Fetal Medicine specialists.

In addition to delivering babies with congenital anomalies the MFCU is the preoperative and postoperative unit supporting the care of fetal surgical patients treated in the Colorado Fetal Care Center (CFCC). The CFCC evaluates and treats mothers from all over the country with the full range of conditions amendable to fetal surgical intervention. The Fetal Surgical Suite on the MFCU was specifically designed to treat maternal-fetal patients whether by fetoscopic surgery, open fetal surgery, ultrasound guided procedures or with EXIT procedures. Since its opening in 2012 the CFCC has performed more than 280 fetal surgeries and is on track to perform more than 150 fetal surgical procedures this year, making it one of the busiest fetal surgical centers in the world.

Among the most common conditions treated is Twin-Twin-Transfusion Syndrome (TTTS). Fetoscopic laser photocoagulation for TTTS uses a 3.3 mm fetoscope and a 600 micron laser endostat to photocoagulate the communicating vessels between identical twins which are responsible for TTTS. Over 95% of pregnancies with TTTS treated in the CFCC have one or both twins survive and in 85% of pregnancies both twins survive which are the best survival rates ever reported for TTTS. In addition, we offer open fetal surgery for congenital pulmonary airway malformations (CPAM), Sacrococcygeal Teratoma, Bladder Outlet Obstruction and Myelomeningocele. In the last year we have performed 19 open fetal surgeries for prenatal Myelomeningocele repair. We have performed Ex-Utero Intrapartum Treatment procedures for airway obstruction, resections of intra-thoracic masses, EXIT-to-ECMO for severe CDH, EXIT-to-Cardiac Bypass for treatment of hypoplastic heart with intact atrial septum. We have performed release of amniotic bands to prevent limb amputation, interstitial laser photocoagulation for bronchopulmonary sequestration associated with tension hydrothorax. In addition, we have used fetoscopic guidance for thoracoamniotic and vesicoamniotic shunt and radiofrequency ablation to treat Twin Reversed Arterial Perfusion (TRAP) sequence. Most recently, with the recruitment of Neil Wilson, MD as the head of our Cardiac Catheterization Laboratory, we now have the capability to perform fetal balloon valvuloplasty for aortic stenosis to prevent progression to hypoplastic left heart syndrome.

The expertise and experience in the CFCC makes it one of the few centers in the world capable of offering every form of fetal surgical intervention currently available and through its research effects is developing the future of fetal intervention. The CFCC however, is much more than its fetal surgical capabilities. Patients come from all over the country for comprehensive integrated fetal imaging and consultation. Over 35% of patients evaluated are found to have either a different diagnosis than originally thought or additional diagnoses changing the prognosis or changing treatment options. This integrated fetal imaging takes advantage of the complimentary nature of ultra-fast fetal MRI, ultrasound and echocardiography as leveraged by collaborating interactions between Maternal Fetal Medicine Specialists, Radiologists and Cardiologists to enhance the accuracy of prenatal diagnosis. In addition, the availability of every pediatric subspecialty for consultation provides comprehensive consultative services for the full spectrum of fetal conditions.

The CIMFH is a unique model allowing the care of both mother and baby to occur in the best setting possible for each. For mothers with significant medical complications of pregnancy but healthy babies, delivery can occur in the best possible environment for the mother at Labor and Delivery at the University of Colorado Hospital. Conversely, in healthy mothers with a baby with a congenital anomaly delivery can occur in the best possible environment for the baby in which mother and baby are not separated.

Kids Corner is a regular feature of the CAFP News brought to you by the Children’s Hospital Colorado Department of Family Medicine. For questions about this article or suggestions for future topics please contact Dr. Jeffrey Cain, the Chief of Family Medicine at Children’s Colorado, through One Call at (720) 777-3999 or (800) 525-4871.
For many business owners in the medical community, the 401(k) plans they offer their staff may have become a headache in recent years. The reason? In August 2012, new ERISA regulations went into effect. The key words that summarize these new rules are “transparency” and “fiduciary.” Last year, nearly 75% of retirement plans audited by the Department of Labor (DOL) were fined, penalized, or had to make reimbursements for errors in administering the plans.

As general practitioners, doctors find themselves in the place of both business owner & doctor. We often hear our doctor clients mention that they love the “doctor” part of their job, but that the business part is a headache. For many, these new regulations increase those headaches as they have increased their vulnerability and legal liability.

The silver lining is that the laws also provided flexibility for doctors to increase how much they (as business owners) can contribute on a tax deferred basis. In classic IRS fashion, there is a complicated equation that dictates the maximum amount business owners can contribute, so long as the plan is designed properly.

However, let us not minimize the darker aspect of this. As a business owner offering a 401(k) plan the DOL labels you as a “fiduciary” (fɪˈduːʃərɪ): 1. a person bound to act for another’s benefit, as a trustee in relation to his beneficiary —adj. This means that as the fiduciary you are charged to act in the best interest of the plan participants including plan design (including cost), implementation and investment choices. You are also liable, not just as a business, but personally liable. We live in a rapidly changing world where laws can change right out from under us without notice. It’s crucial to seek out advice on this key part of your business and life.

The three steps we recommend to make sure you are in compliance with the new laws:

1. First talk to an accountant or third party administrator who specializes in 401(k) plan design. They can help you sort through the myriad of plan requirements.

2. The second step to reducing liability looks at the 401(k) plan itself to make sure the fees and funds are in alignment and the plan is administered according with the Department of Labor’s guidelines. If 401(k) plans become “orphaned” (stopped or abandoned) or the plan has fees that are not (in the words of ERISA) “usual and customary,” the plan may be out of compliance attracting lawsuits. As fiduciaries, our concern is that these lawsuits could be directed back to the doctors themselves even though the fees aren’t going in their pockets.

3. Step three is to try to kill off as many of these thorns as possible at one review without too much pain. It’s always easier to do nothing, until doing nothing becomes very hard and painful. Technology continues to make 401(k) plan management more and more convenient.

While these new regulations may seem innocuous at first glance, the DOL has brought on an army of 1,000 new hires, specifically tasked with enforcing ERISA laws. As reported by the DOL, the average fine was $600,000 per plan. As they say, a little action now can save lots of pain later, especially when the steps to making sure your plan is in compliance is easier than ever with some of the free resources available today.
Advanced Medical Imaging exists to provide excellence in radiological services from image generation to interpretations for our referring physicians, patients, and health care delivery partners in the greater Denver Metro area. We hold dear our values of integrity, compassion, professionalism, and quality of care. Let us help you see the future in radiological services.
Let Recreation Work its “Magic” in the Health of Children and Youth with Disabilities

Wendy D. Larsen, MHS
Manager, Hospital Adaptive Sports Program
Children’s Hospital Colorado

Much research exists today that supports the correlation between recreation participation and healthy lifestyles for children. This connection is vitally important when it comes to children and youth who live with disabilities. In fact, universities now have established degree programs built on this premise. Temple University in Philadelphia, PA, states that Therapeutic Recreation is “an established health related profession committed to promoting the connection between health and recreation involvement. It has a unique role in the health and human service system to promote play, recreation and leisure as a means to psychological and physical recovery, health and well-being among individuals with disabilities.”

Therapeutic Recreation intervention often starts in the hospital, prescribed for patients dealing with ongoing limitations associated with congenital conditions, as well as those confronted with significant lifestyle changes due to traumatic injury or illness. The focus for treatment is on the child’s residual abilities, as opposed to the pathology or deficits accompanying the diagnosis. Comprehensive programs of therapeutic recreation in institutions pave the way for on-going connections to adaptive recreation programs in the patient’s home community.

Community recreation for children and youth with disabilities (often called adaptive recreation) runs the gamut in terms of activity provision. Wide-ranging programming can include fine arts (drama, music and artistic expression), social opportunities (clubs, dances, camps), fitness and sports (exercise classes, bicycling, winter and summer sports), as well as community education experiences (field trips using local transportation, attending community events and utilizing community resources).

Recreational activities seem to have an inherent “magic” that promotes socialization, camaraderie and friendship through sheer involvement. Consequently, children and youth with disabilities can experience a sense of community and inclusion through participation in various activities which focus on common interests. Often, the therapeutic or adaptive recreation professional just has to bring the right ingredients together for a positive outcome to result. That person acts as a catalyst, or “magician” if you will, and the recreational experience itself directly impacts the participant. In an article titled “Using Recreation to Support the Social Well-Being of Children and Youth” Hoffer, McKeown, and Heyne state: “One of the primary reasons people participate in recreational activities is to socialize with others, which can result in tremendous benefits for overall well-being. Through recreation, people discover who they are as individuals and who they are as members of a group. They learn the give-and-take of relationships, appropriate manners and customs, and the skills necessary to make and keep friends.” In light of the social isolation experienced by many individuals with disabilities, recreational experience can be key for social development and emotional health.
Sometimes simple modifications are all that may be needed for disabled children to gain mastery and achievement in a variety of recreational pastimes. Modifications can range from reducing the number of participants in a group to specialized equipment designed for a particular sport. Alpine skiing is a good example of an activity that can be adapted across disabilities through equipment modification. Outriggers and sit-skis are just a few examples of equipment used to balance ability levels in this sport. Programs that are appropriately adapted promote success, equalize participation and promote self-esteem and competence, fostering motivation in on-going involvement.

Children and youth with disabilities frequently face secondary health challenges like deconditioning and obesity. This population in particular has unique needs that make on-going physical activity central to enhancing and maintaining health. Obesity rates for children with disabilities are approximately 38% higher than for children without disabilities. (From the 2003-2008 National Health and Nutrition Examination Survey - NHANES, CDC). Children with conditions affecting motor function and mobility often enter adolescence with a greater tendency toward weight gain associated with puberty. These teens can then require more extensive aides for mobility and acquire additional health-related problems, such as high blood pressure and cholesterol, osteopenia, and elevated insulin. In “Promoting the Participation of Children with Disabilities in Sports, Recreation and Physical Activities” Pediatrics, 2008:121;1057, Murphy and Carbone state that, “overall, the participation of children with disabilities in sports and physical activities can decrease complications of immobility.” Clearly, active involvement in recreation contributes to increased levels of health and wellness, and can help to decrease the incidence of secondary conditions resulting from sedentary lifestyles in this population.

In Colorado there are many state and community recreation resources for children and youth with physical disabilities that can readily be found on the internet. Larger metro areas typically will offer adaptive activities within their local Parks and Recreation programming. Many non-profit agencies across Colorado offer extensive opportunities for this population as well. There are program formats which mainstream individuals with disabilities in with the general population and others that are distinctly designed for those who have special needs.

It goes without saying that the earlier children are exposed to consistent activity the better, as the benefits to body, mind, and spirit can affect a lifetime. Recreation allows for the focus to be on ability and promotes the well-being of the young person as a whole, rather than on the parts of him or her that may be labeled as disabled. The life skills and healthy habits that result from participation can greatly enhance the overall well-being of children and youth with physical disabilities. A sense of community, competence and accomplishment are components of a rich life that can all be found through the “magic” of recreation and leisure pursuits.
Minimizing imaging radiation risk for children

It is well known that medical imaging procedures can be lifesaving for children who are sick or injured. However, it is important to consider if the diagnostic benefit that a study can provide in the short-term outweighs the long-term risks associated with exposure to ionizing radiation inherent in many of these exams. In most cases the answer to this question is yes.

When it comes to radiation dose, all imaging procedures are not the same. Some procedures, like ultrasound and magnetic resonance imaging (MRI), use no x-rays or ionizing radiation. Procedures that use x-rays (like standard x-ray or computed tomography) or radioactive materials (nuclear medicine) vary widely in dose. Dose depends on the type of procedure and the part of the body being examined.

Individuals are always exposed to background radiation. It comes from the air, sky, ground and the foods we eat. It is natural to our environment. To put dose from medical imaging in perspective, we compare imaging dose to the time it takes to reach the same dose from natural background radiation. Over one year’s time, our dose from natural background radiation is approximately 3 mSv at or near sea level or approximately 5 mSv in the state of Colorado. Examples of approximate dose in medical imaging include: Chest x-ray 0.1mSv; CT Chest 0.8mSv; CT Head 1.5 mSv; CT abdomen/pelvis 2.0 mSv; and Dental x-ray 0.005 mSv.

The potential for radiation-induced cancer depends on the amount of radiation exposure and accumulation of exposure over a long time. Lower exposure levels such as background radiation or diagnostic imaging studies carry low risks. Nevertheless, a large volume of circumstantial evidence suggests that diagnostic levels of radiation probably are associated with a low level of risk for inducing disease many years after exposure, though such an event would be very infrequent. Consequently, it is important to use diagnostic exams only when necessary. Appropriate imaging considers the potential risk of radiation against the benefit of the diagnostic study.

Radiation risk is greater for children and adolescents than it is for adults. Children grow quickly, and their cells are more sensitive to radiation. Since effects of radiation take years to develop, their youth extends the time for any potential effects from ionizing radiation to occur. The risk can be offset by reducing dose for pediatric imaging. Therefore, the risk associated with a diagnostic medical examination for a child need not be greater than that for an adult.

The radiology community has adopted a multi-faceted approach to appropriately manage radiation exposure to patients during imaging exams. This includes adopting the principle of ALARA (which represents a practice mandate adhering to the principle of keeping radiation doses of patients and personnel As Low As Reasonably Achievable); accrediting facilities that have established their imaging competence (www.acr.org/Quality-Safety/Accreditation); utilizing appropriateness Criteria®; and the establishment of a CT dose Index Registry (https://nrdr.acr.org/Portal/DIR/Main/page.aspx).

In addition, two international campaigns aimed at dose reduction have been initiated within the past ten years. These include Image Gently®, a collaborative initiative of radiology professional organizations with the goal to change radiology practice by increasing the awareness of opportunities for lowering radiation dose when imaging children. Image Wisely® is a similar program directed at adults.

How can we as a referring physician advocate for our patient? First, image only when appropriate and consider radiation dose when choosing the exam to request. Confer with your Pediatric Radiologist if you are uncertain as to the best test. Refer to facilities with equipment and protocols optimized for pediatric patients. Limit the scan to the area of concern. If the issue is in the mandible one does not need to image the head. Realize that multiphase imaging is rarely necessary in children. Pre- and post-contrast, and delayed CT scans rarely add additional information in children.

It is the responsibility of all members of the healthcare team to ensure that every imaging study in pediatric patients is thoughtful, appropriate and indicated for each and every child. A diagnostic examination should not be refused because of the fear of radiation exposure. The risk associated with these tests is very small compared to the help provided by the imaging test.

REFERENCES:
www.RadiologyInfo.org
Image Gently® (pedrad.org/associations/5364/ig/)
Image Wisely® (imagewisely.org)
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The Advisory Committee on Immunization Practices has recommended the FluMist nasal spray vaccine over influenza vaccine injections for children aged two through eight. The recommendation follows the publication of manufacturer-sponsored studies concluding that the spray vaccine leaves children only half as likely to acquire the virus. Currently, AstraZeneca’s FluMist is the only available spray of this kind.

Experts say the spray prompts a better immune response in children who may have never been infected with flu before, but there is no clear difference in adults.

Family physician Dr. Michael Brady of Ohio State University is reported to have said the vote hinged on “studies that were done before flu vaccine was encouraged for most children and vaccination rates were much lower. It’s possible fresher data might not show such a difference.”

Dr. Brady added, “We really feel you shouldn’t place (doctors) and families in a situation where if they don’t receive the live vaccine, they feel they’re getting an inferior product. Because it may not be an inferior product.”

The American Academy of Pediatrics, in contrast to the ACIP, objected to giving preference to the spray for children by noting that FluMist is more expensive and cannot be used for everyone. In addition, the AAP noted, most physicians have already ordered their vaccine doses for the 2014-2015 flu season.

Health officials are stressing that if you do not have FluMist in stock, influenza vaccine shots are perfectly fine – both work. FluMist costs about $23; shots range from about $8 to $22.

**A record number of measles cases are due primarily to vaccine refusal**

The number of measles cases to date in 2014 is the highest year-to-date total since 1994 and has the Centers for Disease Control and Prevention (CDC) worried that the virus may become endemic again on US soil as it spreads from overseas travelers to pockets of vaccine refusers. The only good news is that no fatalities have yet been reported.

The CDC declared in 2000 that the United States had eliminated measles as an indigenous disease, meaning there was no longer any year-round endemic transmission of the virus. Although this country’s status has not changed, other countries such as the Philippines are rife with the disease.

Anne Schuchat, MD, director of the CDC’s National Center for Immunization and Respiratory Diseases, warned at a press conference that the findings are a “wake-up call” as “measles anywhere in the world can reach our country, and unvaccinated Americans are at risk.” Furthermore, she added, “Measles can really get out of control quite quickly. You can get indigenous spread if you can’t break the chain of transmission.”

As of May 2014, in sixty-nine percent of the cases, the infected person was unvaccinated. In another twenty percent, the vaccination status was unknown. In addition, fifteen scattered US outbreaks accounted for seventy-nine percent of all cases. The largest outbreak, involving 138 cases, hit unvaccinated Amish communities in Ohio that had dispatched aid workers to the Philippines, which is still recovering from last year’s Typhoon Haiyan.

NPR reported that the Amish communities in Ohio are reconsidering their position on vaccines in light of the measles outbreak. NPR reports that while the Amish “are not against vaccines in principle,” many “have never had shots.”

One key to lowering the measles case count, said Dr. Schuchat, is for Americans with international travel plans to get 2 doses of the measles, mumps, and rubella (MMR) vaccine if they have not been vaccinated or do not know their immunization status. The 2-dose regimen also applies to healthcare workers and childcare attendants who are catching up on measles protection. As always, pregnant women and individuals with suppressed immune systems should not receive the vaccine.

Dr. Schuchat noted that individuals born before 1957 probably had measles at some point, which relieves them from getting the shot. The vaccine debuted in 1963. She described it as “very safe and effective.”

As a reminder, routine vaccination for children consists of a first dose at 12 to 15 months of age and a second dose at 4 to 6 years of age. However, if someone is traveling internationally with a child aged under 12 months, the CDC recommends a single dose before departure. Such a child should receive a second dose at 12 to 15 months and a third at least 28 days later. Children aged 12 months or older should have 2 doses separated by at least 28 days.

Not only can the unvaccinated become ill, but also, no vaccine is 100 percent effective and, in some, immunity fades over time. So, a second reason for this year’s measles epidemic is “vaccine failure.” As a result, about ten percent of the measles cases have occurred in vaccinated individuals.

Even worse, a case study was published in February about a woman dubbed “Measles Mary,” which described a scenario that researchers had not known was possible: In 2011, the 22-year-old New York theater worker, who
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had been vaccinated, not only contracted measles, but also passed it along to four others, two of whom had also been vaccinated.

This was the first documented case of a vaccinated person passing measles along to others; however, the case illustrates another way measles can pose a threat even to those who have had their measles vaccine. The first MMR vaccine will fail to immunize the recipient about five percent of the time. That is the reason for the second shot in the MMR series. After the second shot, only one to two percent are left unprotected.

Parents who decline to vaccinate their children may ask, “Why does it matter to you that my kids aren’t vaccinated if yours are?” The reason is that an unvaccinated child is more likely to catch a disease and then pass it on to others, including to someone who has been vaccinated but — because of a failed vaccine — is not fully protected.

Your patients may be reading that “The flu vaccine is the most dangerous vaccine in the U.S.”

Here is a typical report seen on the Internet:

The last report issued ... by the Department of Justice (Vaccine Court) ... for people injured or killed by vaccines (revealed) there were 139 claims settled during this time period, with 70 of them being compensated. ... Of the 70 cases compensated, 42 of them were for the flu vaccine, or 60% of the cases settled where compensation was awarded for injury (69 cases) or death (1 case) due to the (flu) vaccine. ... and most of those were for Guillain-Barré Syndrome (GBS). Yet these facts ... are never reported in the mainstream media. So we will report them here.

What those opposed to vaccines fail to mention is that to win a compensation case, the attorneys only had to show that it was more likely than not that the symptoms were related to the vaccine received. They did NOT have to prove it beyond a shadow of a doubt, which is the usual standard in court cases.

In addition, here are some additional facts our patients might not know:

• In the 2013 flu season, the CDC reported there were over 135 million influenza vaccinations administered. That means the risk of a possible adverse event related to the flu vaccine that results in compensation is 70 out of 135 million—a risk of about 0.00005%.

• Meanwhile, according to CDC, during the same flu season, flu vaccination prevented an estimated:
  • 6.6 million influenza-associated illnesses (roughly equivalent to the population of the State of Arizona),
  • 3.2 million medically attended illnesses (roughly equivalent to the number of passengers on 1,067 mega-cruise ships or 7,200 Boeing 747 airplanes), and
  • 79,000 hospitalizations (roughly the equivalent of the number of fans at an average NFL football game).

• There were at least 169 deaths among children from the flu illness itself that were reported to CDC, meaning a child was about 4 times more likely to die from the flu itself than to suffer a possible (not proven) adverse effect that will result in compensation.

• Furthermore, according to CDC, “We could prevent even more illness by increasing use of flu vaccines among people of all ages. If 70% of the population had been vaccinated (instead of the only 40% who took the vaccine) last season, another 4.4 million flu illnesses, 1.8 million medically attended illnesses, and 30,000 flu hospitalizations could have been prevented.”

• Of course, the opposition would likely point out that that would have meant another 30 adverse events (while not pointing out that this would have been 30 out of another 100+ million vaccinations).

So, the bottom line is quite clear ... the benefits of the flu vaccine outweigh the extremely small risk by ... oh ... three-quarters of a million to one.

As pediatrician Paul Offit, MD, chief of infectious disease at Children’s Hospital of Philadelphia, says, “The most dangerous aspect of giving your child vaccines is driving to the office to get them.”

Delivering vaccines may increase risk of seizures

A new analysis published in Pediatrics in June (tinyurl.com/n6p6o3j) showed that delaying the measles-mumps-rubella vaccine beyond fifteen months of age more than doubled the risk of a post-vaccine seizure, while delaying the measles-mumps-rubella-varicella vaccine almost doubled the risk of a seizure. Furthermore, the greater the delay, the greater the risk.

Delayed vaccine schedules leave children unprotected during their most vulnerable years. This study identifies yet another risk associated with delaying MMR or MMRV administration — the increased risk for seizures, which should be incorporated into discussions of vaccination with parents along with the fact that vaccine administration according to CDC schedules should be encouraged.
Commentary from Dr. Finger

I did not think I would live to see another measles resurgence in the United States. Yet, as documented above, it is occurring. Measles cases have reached a 14-year high, the highest since CDC declared that indigenous transmission of the infection no longer existed in this country. We have, of course, been battling importations ever since, because measles remains endemic in most places in the world except the Americas.

In 1989-1991, as a state epidemiologist, I lived and worked through the nation’s first measles resurgence since the introduction of the vaccine. At that time, we faced a combination of three factors: an unacceptably high vaccine failure rate, because we used a one-dose strategy; a failure to reach many children in the inner cities with vaccine; and a gradual receding of the immunity of the adult population that had resulted from near-universal natural infection in the pre-vaccine era. We redoubled our efforts to reach children in the inner cities, one of which was located in my state. We introduced a two-dose vaccine schedule, not a trivial investment for our health departments by the standards of the time. We also benefited from dramatically improved measles control—and eventual elimination—in the other countries of our hemisphere.

I was at CDC for many meetings about immunization in the 1990s and 2000s, and remember being told that whenever incidence of vaccine-preventable diseases quiets down, the voices of those opposed to immunization become more widely heard. MMR vaccine was accused of contributing to autism, in an oft-read and quoted publication that has now been completely discredited.

For some time, we continued to see very low measles numbers in the U.S., the results of importations which did not spread very extensively. Now, however, when we are dealing with a disease that is this good at finding every possible susceptible person, the price will be paid. For a variety of reasons, the vaccine opposition movement has now resulted in enough exemptions and unimmunized people to give measles a renewed foothold in this country. A generation of clinicians who have never seen measles will see their first cases. Much effort will be required to recapture lost ground.

With a workable two-dose schedule in place and a very effective vaccine, there is, in my opinion, not much more to be done by way of policy. The resourceful, well-meaning American people must decide that they want no more of this disease. And, to assist them, family physicians can and should be at the front line in providing sound information that sorts out truth from the fiction to which they are constantly exposed on the Internet.

Reginald Finger, MD, MPH
Indiana Wesleyan University School of Health Sciences
One of the biggest complaints we hear from physicians, as well as nurses and other practice staff, is how difficult and time-consuming it can be to collect complete clinical histories for new patients, or manage the needs of complex and chronic disease patients who are seen by multiple physicians. Often there are many phone calls back and forth between offices and stacks of paper faxes for which the relevant patient information is hard to find. Even worse, the information you need today may not arrive until weeks after a referral appointment or hospital discharge. The process of gathering and managing patient records is frustrating and most health care professionals have just learned to accept it.

As a physician, you may not spend countless hours gathering and organizing patient information yourself, but your medical assistants or support staff are likely tied up with it. Or perhaps you’ve become adept at filling in large gaps of missing information with rapid fire questions during patient appointments?

Information Gathering Made Simple

Although you and your team have developed into expert information gatherers, there is a way to cut back on this tedious and inefficient work. In Colorado we have one of the nation’s most advanced health information exchange (HIE) networks managed by the Colorado Regional Health Information Organization (CORHIO). More than 2,500 office-based providers, 49 hospitals, 133 long-term and post-acute care facilities, 27 behavioral health centers and five medical laboratories have joined the network. CORHIO, a nonprofit organization governed by an impressive board of health care leaders, including three practicing physicians, has installed a highly secure, high-speed electronic network that allows providers to share clinical information for care coordination. And while the ultimate aim is to improve the quality of patient care, it also provides many efficiencies to a busy primary care practice.

Using an encrypted Web portal, in just a few mouse clicks (or a few taps on your handheld tablet computer) you can view a new patient’s consolidated record with up-to-the-minute lab results and hospitalization records. Additionally, hospital or outpatient labs, radiology reports and other information can be seamlessly and automatically routed into the electronic health record (EHR) you use every day. Very soon, as ambulatory EHRs capabilities catch up to interoperability standards, the CORHIO network will support office-based physicians’ ability to electronically share clinical summary documents (also known as CCDs).

Many of your peers have already joined the network, including Dr. Clark Zimmerman from Hilltop Family Physicians in Parker, Colo. Dr. Clark recently commented, “CORHIO has allowed me to treat my patients in real time. In the past, I felt like I was always trying to recover the information I needed after it was required. Now it’s at my fingertips and has improved the accuracy and timeliness of patient care.”

When Efficiencies Go Up, Costs Go Down

With automated and streamlined information exchange, practices become more efficient and are able to reduce some costs related to paper, printer ink and fax lines. Many physician offices participating in the CORHIO network report that with access to HIE data, they are able to repurpose one-half of a full-time employee toward other more strategic office responsibilities.

One such practice is Alpine Urology, which receives lab results from CORHIO seamlessly into their EHR. Since staff no longer wastes time tracking down patient information or scanning documents, the amount of personnel time has been greatly reduced. Practice administrator Bill Carlton estimates they have saved the cost of a part-time office staff member. “Being able to retrieve lab results electronically has also reduced what we spend on paper and toner cartridges,” he said. “All of that adds up after a while.”
HIE Options Based on Your Needs

CORHIO offers four different ways in which practices can connect to the HIE network, depending on whether you use an EHR or if you are participating in the Medicare or Medicaid EHR Incentive Programs:

1. Results Delivery – Your patients’ lab results and other data, including radiology and newborn screening reports, are automatically routed into your EHR (or Web portal inbox). Having lab results available in your EHR can help you meet Meaningful Use Stage 2.

2. Community Health Record – Using our PatientCare 360® Web-based application, you can search for a patient and retrieve up-to-date, comprehensive and consolidated information (i.e. longitudinal health record).

3. Direct Messaging and HISP Services (point-to-point communication) – This is a simplified version of HIE, which works like secure email. You can Direct message another specified provider for referrals or transitions of care, or even a patient directly (recipient must have a valid Direct address). Direct messaging can help you meet Meaningful Use Stage 2.

4. Public Health Immunization Reporting – For providers planning to attest to Stage 2 of Meaningful Use, CORHIO can automatically route your patients’ immunization information directly to the state health department, CDPHE. Cancer reporting and other health department data exchange is coming soon.

Register now for the

Fit Family Challenge
Dissemination Training

What: The award-winning Fit Family Challenge is a proven pediatric obesity intervention that takes place in the primary care clinic. This hands-on training will give you the tools you need to implement this program at your practice.

Cost: $295

When: 02/02/2015—02/03/2015

Where: Marriott Denver Airport at Gateway 16455 E. 40th Circle, Aurora, CO 80011

Register now at https://www.regonline.com/ffcdisseminationtraining

Additional Questions? Please contact Sarah Roth by email: Sarah@coloradoafp.org or by phone: (303) 696-6655X16
On the Passing of
Dr. John A. VanBuskirk

John A. VanBuskirk, M.D. died on August 30, 2014. John practiced family medicine in the Englewood, Colorado area for 40 years. He was on the staff of Porter Adventist Hospital and Swedish Medical Center, retiring at the end of December 1996. He is survived by his wife of 61 years, Loretta; 4 children, David, James, Alan and Linda. He also had 10 grandchildren. Dr. VanBuskirk was a past president of the Colorado Academy of Family Physicians from 1979-1980. The CAFP sends condolences to his family. In lieu of flowers, donations may be made to The Wild Animal Sanctuary - 1946 County Rd. 53, Keenesburg, CO 80643 or to the Salvation Army.

CAFP Lunch Time Webinars

Early intervention for unhealthy alcohol use to improve health in Colorado- October 29 at 12:15PM

Colorado has one of the highest levels of unhealthy alcohol use in the U.S. which contributes to early mortality and many of the common diseases, injuries, family and social problems encountered in primary care. Most adults who drink too much do not have an alcohol use disorder. Screening and brief motivational counseling for unhealthy alcohol use is one of the most effective preventive services, yet only one in six adults ever talks with a health professional about alcohol. This webinar will provide an overview of the essential steps to address alcohol in primary care using one validated screening question and a brief conversation to help motivate patients to change a pattern of unhealthy use.

Effective conversations about marijuana in healthcare – November 19 at 12:15PM

Most patients are receptive to discussing drug and alcohol use with their physician. Feedback from health professionals in Colorado suggests that marijuana can be a difficult topic to address in healthcare. This webinar will provide a brief overview of key health concerns associated with marijuana use in adolescents, pregnant women and adults; suggestions for addressing common beliefs and misperceptions about marijuana; and key points for educating parents to help prevent marijuana use in adolescents.

To Register: visit coloradoafp.org/cafpwebinar

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2015 Annual Scientific Conference
Cheyenne Mountain Conference Center, Colorado Springs
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• 60+ Hours of CME Available
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Come join your fellow Family Physicians of Colorado at this year's ASC!

Registration Opens October 1. Visit coloradoafp.org/asc2015 for full conference details and registration.
What is the Accountable Care Collaborative?

The Accountable Care Collaborative (ACC) is a Medicaid program to improve clients’ health and reduce costs. Medicaid clients in the ACC receive the regular Medicaid benefit package, and belong to a Regional Care Collaborative Organization (RCCO). Medicaid clients also choose a Primary Care Medical Provider (PCMP).

The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes.

- Current Enrollment: 662,000
- Expansion Enrollment: 250,900 (new members, since January 1, 2014)
- Approximately 2/3 of all Colorado Medicaid clients are now in the ACC
- 65% of all ACC members are attributed to a PCMP
- Around 430 practices are contracted as PCMPs within the ACC, representing about 2,100 rendering physicians

Primary Care Medical Providers are affiliated with a RCCO, and act as “medical homes” for clients. As a medical home, the PCMP will coordinate and manage a client’s health needs across specialties and along the continuum of care. PCMPs receive care coordination practice support services from their RCCO, along with other incentives:

- Per member per month (PMPM) payments for acting as a medical home
- Increased PMPM payments for meeting enhanced PCMP standards
- Incentive payments for meeting regional Key Performance Indicator (KPI) targets
  - Well-child visits, age 3-9
  - Postpartum visits
  - Emergency room utilization
- Potential to share in savings that accrued due to the ACC program.

The ACC is not traditional managed care. It is a unique program that blends aspects of managed care with fee-for-service Medicaid—with the goal of transforming our delivery system from one focused primarily on episodic, medical delivery to one focused on health outcomes. The ACC is helping Colorado Medicaid move toward a person-centered health model that integrates and coordinates medical and non-medical supports and services to provide better quality care at lower costs, to more people.

The ACC is community driven, as each RCCO is responsible for program accountability within their region of the state. This allows for greater local understanding of and control over the unique resources and barriers to access found in communities across Colorado and underscores the value of Medical Neighborhoods in the health care delivery system.

For further information, contact: Marty Janssen
(303) 866-4095
Marty.Janssen@state.co.us

Improving health care access and outcomes for the people we serve
while demonstrating sound stewardship of financial resources

August, 2014
mj
What are the benefits of being a PRIMARY CARE MEDICAL PROVIDER (PCMP) in the Accountable Care Collaborative (ACC)?

The Accountable Care Collaborative (ACC) program is Colorado Medicaid’s premier reform effort and the predominant services delivery system for physical health care services. Regional Care Collaborative Organizations (RCCOs) are responsible for provider support, care coordination, and accountability of care in each region.

Per Member per Month Payment
PCMPs receive $3 per member per month reimbursement for providing medical home level services.

FFS Reimbursement
PCMPs receive FFS reimbursement for medical services.
- In July 2013, provider rates increase by 2%.
- Beginning January 1, 2013, physician reimbursement for Medicaid services increased to 100% of Medicare reimbursement for evaluation & management codes.

Incentive Payment
The Department has paid out over $1 million to providers for two quarters of performance. Every participating ACC provider has received an incentive payment.

$1 per member per month Incentive Payment may be paid based on four regional key performance indicators:
- Hospital All Cause Thirty (30) Day Readmissions
- Emergency Room (ER) Visits
- High Cost Imaging Services
- Well Child Visits

Shared Savings
All ACC providers will be eligible to receive a percentage share of medical cost savings generated by the program.

Patient Panel Limits
Providers can set limits on their patient panels.

Data Analytics and Reporting Capabilities
Through the Statewide Data and Analytics Contractor (SDAC), PCMPs will receive client level utilization and risk data on the clients in their panel. The SDAC provides a web-portal dashboard for each practice that physicians can use to manage, coordinate and integrate care.

Care Coordination and Medical Management
Regional Care Collaborative Organizations (RCCOs) coordinate the services provided to clients, which may include behavioral health, long term services and supports, and government social services. Care coordinators may also link clients to non-medical community services, such as adoption and advocacy services, youth programs, housing programs, and emergency financial assistance.

Practice Support
RCCOs supply providers with practical tools and resources to fulfill the basic elements of a Medical Home. Practice support may include clinical tools, client materials, operational practice support, data, reports and other resources.

Technical Support
The RCCOs assist providers in navigating Medicaid administrative systems.

*Contact your RCCO today to get signed up.*
Visit [www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675](http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675) to find out what RCCO Region you are in

| Region 1: | Rocky Mountain Health Plans | Jenny Nate | 303.967.2082 | Jenny.nate@rmhp.org |
| Region 2: | Colorado Access | Dave Rastatter | 970.350.4665 | Dave.rastatter@coaccess.com |
| Region 3: | Colorado Access | Molly Markert | 720.744.5415 | Molly.markert@coaccess.com |
| Region 4: | Integrated Community Health Partners | Donna Mills | 719.543.1344 | Donna.mills@ichpcolorado.com |
| Region 5: | Colorado Access | Julie Holtz | 720.744.5427 | Julie.holtz@coaccess.com |
| Region 6: | Colorado Community Health Alliance | Adam Bean | 720.315.6626 | Adam.bean@phpmcs.com |
| Region 7: | Community Care of Central Colorado | Kelley Vivian | 719.632.5094 | Kelley@ppchp.org |
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