IN THIS ISSUE:
2015 Tar Wars Poster Contest Winners Announced!
Page 27

Transgender Medicine: What Role Does Primary Care Play? Page 24

Update from the 2015 AAFP National Conference for Students and Residents Page 30
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carolyn.francavillabrown@healthonecares.com

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bhillwv@gmail.com

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Zach Wacht, MD, Denver
zcwacht@gmail.com

Delegates
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jbender@miramont.us
term expires 2015

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Littletone
kent.voorhees@ucdenver.edu
term expires 2014

Alternate Delegates
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brian.bacak@healthonecares.com
term expires 2015

Rick Budensiek, DO, FAAFP
rubud5623@aol.com
Term Expires 2016

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ChristineHorstmeyer@centura.org

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brianjuan@centura.org

Syed Gillani, DO, Pueblo
dcgillani@gmail.com

Aaron Stupp, MU, Pueblo
aaronstupp@centura.org

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netana.hotimsky@rvu.edu

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

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Grace.Horton@rvu.edu

Lindsey Herrera, CU, grad 2018
lindseyherrera@ucdenver.edu

Joshua Iord, RNV, grad 2017
Joshua.Iord@rvu.edu

Editor
Candace Murbach, DO
candacemurbach@centura.org

Legislative Committee Chair
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chandra.hartman@gmail.com

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

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jcawley@afmfc.com

Monica Morris, DO
mcorrisag@zagmail.gonzaga.edu

Staff
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Chief Executive Officer
raquel@coloradoafp.org

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

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

Jeff Thoroddsen
Lobbyist
jeff@precisionpolicygroup.com

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

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

Contact Information for the CAFP
Colorado Academy of Family Physicians
2224 S. Fraser St., Unit 1
Aurora, CO 80014
phone 303-696-4655 or 1-800-468-8615
fax 303-696-7224
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HEALTH OF THE PUBLIC
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FOOTNOTES
The Merriam-Webster dictionary defines TEAMWORK as “a dynamic process involving two or more healthcare professionals with complimentary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning or evaluating patient care.”

Teamwork is critical to the practice of family medicine and Primary Care in general. We are pulled in multiple directions every day. Morning and evening hospital rounds, patient visits in our offices, phone calls, patient portals, forms to complete, prescription refills, ER calls, nursing home visits and lest I forget practice transformation, payment reform, EHR and meaningful use, among others. Unless you are a recent graduate, you did not likely envision all the changes. As challenging as the practice of family medicine has become, it is also giving us great opportunities.

In my President’s Report in the Summer 2015 Colorado Family Physician, I referred to my practice as a CPCI (Comprehensive Primary Care Initiative) practice. My partners and I were honored to be part of this important project. It allowed us to build a better team. Most physician led teams consist of a mid-level provider and one to two medical assistants. Our practice shares case coordinators, behavior health specialists and a clinical pharmacist. We must also include our front office staff who are at the “front lines” of our practice. As we all know, our administrative staff is an invaluable part of the team as well. Your team may look a bit different, but nonetheless is extremely important to your patient population.

Now back to the definition, “a dynamic process.” The future is clearly a moving target. We must be dynamic in many ways. We are required to adapt to new challenges and evolve our approach to many aspects of patient care. Obviously, we have “complimentary backgrounds and skills.” A very important aspect of all of our complimentary skills is the concept of practicing at the top off our licenses. In other words, delegating responsibilities to your team members commensurate with their training and background, therefore affording the physician the opportunity to be more efficient. It is clearly our responsibility as a physician to lead our teams to “common health goals.” I like to refer to this as the “culture” of the team. We should all take pride in our “concerted physical and mental effort in assessing, planning or evaluating patient care.”

As busy family physicians, we know the team does not end there. The concept of a medical neighborhood extends our team well beyond our office walls. The consultants we choose to be part of our neighborhood play a critical role in patient care and, of course, cost of care. Skilled care facilities and rehabilitation units extend our care further. Another critical team member is a good home health agency to extend our care to the home. Good communication with your home health nurse is vitally important in preventing hospital re-admissions.

Many of you are practicing in a similar environment as I have described. Many of you have limited your practices to outpatient care, others may be hospitalists. Yet other family physicians in Colorado and beyond have focused on nursing home care or even hospice care. In any case, we are all family physicians, the family physician team.

This brings me to the Colorado Academy of Family Physicians. The CAFP’s mission is to serve as the bold champion for Colorado’s family physicians, patients, and communities through education and advocacy. With our ever changing medical landscape, CAFP has become an even more important team member for each of us individually as well as a whole. CAFP represents nearly 2,300 family physicians in the state. We are now considered a “large” academy compared to other academies across the country. It is crucial that CAFP have a staff well equipped to handle this challenge. I wanted to take this opportunity to highlight the terrific “team” at CAFP.

Raquel Rosen, MA, CAE, your CAFP CEO for over 25 years! Not an easy job when there is a new president every year and board members that change every few years. Yet, she has done a fantastic job of creating an academy that has consistently grown in both members and significance. I have had the pleasure and opportunity to see her work. National meetings allow me to see how other academies across the country do business. We are lucky to have such a great CEO. For most of her career as our CEO, she was the only full time employee of CAFP. With the growth of CAFP, hiring a staff was imperative. Currently, we have three staff members who have individual responsibilities.

Erin Watwood is director of Education, Events and Meetings. As her title suggests, she organizes our meetings and other events. Arranging events for medical students and residents are just some of her duties. Of course, our Annual Scientific Conference, which will be now known as the Annual Summit, is one of her biggest responsibilities. Our director of Communications, Marketing and Membership is Lynlee Espeseth. She is busy working on things like the magazine you are reading right now. Like many other organizations, marketing is essential to success. Last but not least is
When I reflect on the vision and mission of our academy, our job can be summed up quite simply. We are here to do everything we can to support family physicians.

This summer we conducted a membership survey, one that will be done each year to see how your needs are changing and how we are doing at meeting those needs. This year we heard very clearly what you need to be the best physicians you can be, and it will be our singular goal to help you over the coming weeks, months, and years.

Almost all of you agreed that payment reform is the most important priority we should have. We agree. The model of fee for service doesn’t work for family physicians, it doesn’t work for patients, and if it continues, our healthcare system isn’t going to get better.

As our new Director of Policy & Government Relations, Ryan Biehle, discusses in his legislative report, there isn’t a universal consensus on what exactly the solution should be. And indeed, there are currently many different initiatives underway in Colorado and across the country to test what will work going forward. I would encourage all of our members to speak up about what initiatives work for you, and what initiatives don’t. You are the most important people policy makers should be hearing from, and it is our hope that decision makers on all levels will continue to believe that too, and enact real change based on your experiences.

The survey was also an excellent reminder that our membership is incredibly diverse, and we must work to make sure we are meeting those diverse needs. That holds especially true for our rural members. You and your practices face a distinct set of challenges, and we must do a better job of helping you with those challenges. Over the next year, look for new educational events delivered to rural members in your community, addressing the specific needs you have related to practice management and patient care. It is our hope that these educational opportunities are more convenient and affordable for you, and will focus on the issues you find most pressing. Additionally, beginning in the next magazine, look for a new feature, “Rural Corner,” where we will share stories from rural physicians making a difference in their communities.

Finally, we realize that a membership survey isn’t going to be able to encompass all of your concerns and ideas. To that end, we encourage you to continue to reach out to us with feedback, for ideas, or to share what you and your practices are experiencing. Every member shapes our organization and makes it what it is, and together we can work to better healthcare for every Colorado patient.
PAYMENT REFORM: A Look at the Present and Future in Colorado

At CAFP, we’ve heard from our members how important payment reform is to family physicians in Colorado. For years, commercial payers, Medicaid and Medicare have paid on a fee for service (FFS) basis. Most have come to agree that this payment model is outdated and inefficient, incentivizes volume over value, and creates significant administrative burdens for physicians. It also presents the largest barrier to achieving the Triple Aim: a better patient experience, with better health outcomes, for a lower per capita cost. While the focus of many policymakers and payers has been on expanding coverage to the uninsured for the past few years, attention is now turning to reforms of our payment and delivery systems. This is an issue CAFP will be continuing to focus on in the coming months and years, but understanding where payment reform currently stands in Colorado is a good place to start. Numerous pilots and initiatives are underway to begin shifting away from FFS.

Multi-Payer Reform

The Comprehensive Primary Care Initiative (CPC) is one of the largest multi-payer reform efforts, with nine payers, over 70 participating practices, and 497 providers. The initiative runs from 2013-2016 and offers average payments of $20 per member per month (PMPM) for Medicare FFS beneficiaries, in addition to PMPM payments from Medicaid and commercial payers for their members. A recent evaluation of the first year of the program showed all practices met milestones for utilizing patient decision aids, measuring quality improvement and assessing and improving the patient experience. Nearly all practices (99%) provided enhanced patient access through 24/7 availability of practice staff who have real-time access to medical records. Second and third year results are not yet available, but we will be looking to the analysis to see what effect the reforms are having on spending and quality.

Medicaid Payment Reform

The Accountable Care Collaborative (ACC) is Medicaid’s initiative to connect every Medicaid client to a Patient-Centered Medical Home. The nearly 1.2 million Coloradans now on Medicaid need comprehensive and coordinated care to meet their health needs. Medicaid’s ACC offers that opportunity, with nearly 920,000 Coloradans in the program. Patients are attributed to a primary care provider, who receives a standard $3.00 PMPM to cover PCMH services in addition to incentive payments up to $1.50 PMPM for meeting certain criteria and performance measures. The program saved the state $31 million last fiscal year, all while improving well-child visits, hospital readmissions, and imaging and ED utilization.

Paying for Integrated Physical and Behavioral Health

Another major effort is the State Innovation Model (SIM) Grant, recently awarded to the state. The 4-year, $65 million project will assist 400 practices in transformation activities, including integrating physical and behavioral health. Stakeholder workgroups on payment reform, health IT, and practice transformation are currently guiding implementation. Seven payers, including Medicaid, have agreed to additional commitments to pay for integrated care. In addition, practices will receive technical assistance from SIM to support transformation efforts. $5.6 million will be available for direct payments to participating practices. SIM released a Request for Applications from practices; the deadline to apply is October 26. 100 practices will be selected for the first cohort that begins in early 2016.

On the Horizon

Many other payment reform models are being tested as well. Rocky Mountain Health Plans started a Medicaid pilot in six counties on the Western Slope, called RMHP Prime. This comprehensive, full-risk capitation program started in 2013 and preliminary results will be available this fall. Kaiser Permanente is expected to begin a similar program in Denver called Access Kaiser by January of 2016. The Colorado Health Foundation has also formed a 10-year collective impact initiative called Better Care, Better Costs, Better Colorado (BC3) to transform the way health care is paid for and delivered in the state. Beyond these efforts, many of Colorado’s commercial payers are in the midst of their own payment reform initiatives. One emerging payment and delivery model is Direct Primary Care (DPC). Under DPC, a practice collects a monthly fee from or on behalf of its patients. In return, the practice offers patients all their needed primary care services through email, on the phone or in the office, without any additional costs like copays or coinsurance. Private payers, including self-insured employers, are all candidates for coordinating with a DPC practice. This model streamlines administration for primary care physicians and enables patients to receive primary care without having to meet increasingly steep deductibles.

While consensus on the “right” payment model has not been reached, we can anticipate the variety of pilots and initiatives underway will offer useful insight into the path Colorado should take to ensure family physicians can do what they do best – help their patients lead healthy lives.

continued on page 8 >>
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Looking forward to the 2016 Legislative Session

There is rarely much certainty about the issues that will arise in the Colorado General Assembly. There will undoubtedly be some surprises, but we do know some issues that will likely get attention.

Preceptor Tax Credit: Last year CAFP worked to pass HB-1238 to institute a tax credit for preceptors in rural areas. Though the bill did not pass, the credit would have provided physicians who precept up to a $5,000 tax credit. With a shortage of preceptors in rural areas, this credit would be an important incentive for rural physicians to precept, and it would provide needed exposure to rural medicine for medical students – a strategy we know leads to more physicians choosing to practice rural medicine. We are working with the Colorado Rural Health Center and others to introduce a similar bill in 2016.

Medicaid Primary Care Rates: The Affordable Care Act temporarily brought Medicaid primary care service rates into parity with Medicare. While federal funding for this “bump” ended December 2014, Colorado opted to continue funding the bump through the state fiscal year ending June 2016. With a tight budget expected next year, due in large part to downward pressure on state spending from TABOR (the Taxpayer Bill of Rights), continued funding for the primary care bump is uncertain. CAFP will be following this issue very closely and urging the state to continue its investment in primary care.

Direct Primary Care: Direct Primary Care (DPC) is an emerging payment and delivery model for primary care. Under DPC, a practice would collect a monthly membership fee from or on behalf of its patients. In return, the practice would offer patients all their needed primary care services without any additional copays, coinsurance, and so forth. This model is permitted under the Affordable Care Act, but a key need is to ensure patients do not have to double-pay for primary care services through their insurance plan and a DPC practice. Thus, working to include DPC as a part of insurance products in the state, while ensuring practices who offer DPC are not subject to complicated insurance laws, will be a topic of conversation in 2016.

Out of Network Surprise Bills: Last year, the legislature considered SB-259, which was aimed at reignining “surprise bills,” where a patient received services at an in-network facility but had treatment at some point from an out-of-network provider (for instance, a rotating anesthesiologist) and ended up getting billed the out-of-network rate. The bill aimed to prevent these surprise bills, but implementing such a law presented a variety of challenges. It did not make it through the legislative process and is likely to come back in 2016. Providers and insurers are meeting over the interim to seek agreement on how such a law might be crafted.

If you have input on payment reform priorities and opportunities in Colorado, contact Ryan at ryan@coloradoafp.org or 303-696-6655 x 17.
On June 5, 2015 leaders from across the healthcare landscape gathered with the Colorado Primary Care Collaborative to help answer this question. Many exciting initiatives and ideas were shared.

To help capture the spirit of the day, artist Karina Mullen Branson (www.conversketch.com) sketched the conversations as they were happening. In the next few magazines we will feature her artwork and share some of the discussions that took place.

A panel including Perry Dickinson, MD, Judy Zerzan, MD, Gretchen McGinnis, Cissy Kraft, MD, Jack Westfall, MD, and Jeff Cain, MD gathered to discuss efforts in Colorado and across the country to improve primary care, including the Colorado Health Extension System, the Accountable Care Collaborative, actions being taken by payers such as Anthem and the Colorado HealthOP, and the Health is Primary campaign.

Following the panel, Jay Want, MD, owner and principle of Want Healthcare, LLC, discussed common barriers to successful healthcare reform, and what reform efforts have worked across the country.

If you are interested in learning more and getting involved with the Colorado Primary Care Collaborative, contact Raquel Rosen at 303-696-6655 or raquel@coloradoafp.org.
In honor of Family Medicine and the Family Physicians dedicated to advancing high quality health care for all Coloradans, Governor John Hickenlooper proclaimed October Family Health Month. Thank you and congratulations to all of Colorado’s Family Physicians, who are vital to making Colorado the healthiest state in the nation!
Raquel Rosen presented to the residents at St. Mary’s in Grand Junction. Here with Joan Cox, Sherman Straw, MD, and Glenn Madrid, MD.

Raquel Rosen was invited to a State Innovation Model (SIM) reception at the Colorado Governor’s Mansion, and was joined by (from left to right) Kyle Brown, Senior Health Policy Advisor to the Governor, Vatsala Pathy, SIM Director, and Ben Miller, Director of the Eugene S. Farley, Jr. Health Policy Center.

Raquel Rosen at the SIM reception with Sue Birch, Executive Director, Colorado Department of Health Care Policy & Financing, and Mark Laitos, MD, Medical Executive, Rocky Mountain States at CIGNA.

Raquel Rosen at the SIM reception with Perry Dickinson, MD, Professor, Department of Family Medicine at the University of Colorado School of Medicine, and Cissy Kraft, Chief Medical Officer, Anthem.

Raquel Rosen at the SIM reception with Governor John Hickenlooper.

Raquel Rosen joins other stakeholders at an NCQA/PCMH interest group.

CAFP 2015 Resident of the Year, Kari Mader, MD, presents at the AAFP National Conference of Family Medicine Residents and Medical Students alongside AAFP President-Elect Wanda Filer and Primary Care Progress founder Andrew Morris-Singer.

CAFP was represented at a meeting of the SB 222 Task Force, regarding immunization availability.
Preparing for Surgery: ANESTHETIC CONSIDERATIONS OF UPPER RESPIRATORY INFECTIONS

Case study:

Johnny is an 8-year-old male. A family medicine physician saw him recently in clinic for a well child examination. On review of systems, she noted mild discomfort when jumping up and down. On exam, a suspected inguinal hernia was evident and she referred the patient to a pediatric surgeon. An inguinal hernia repair was scheduled. The day before the procedure his physician received a message from her nurse that Johnny’s mother called reporting cold symptoms which were concerning given the surgery planned for the next day. The nurse made arrangements for Johnny to be seen by his primary care provider. His mother is very concerned about how this will impact his procedure and anesthesia…

Twenty years ago the answer to this clinical question was relatively straightforward, children who developed upper respiratory infections (URIs) prior to anesthesia were rescheduled whenever possible, preferably four weeks after symptoms resolved. However, this is not always possible, subjects the patient and family to inconvenience, and delays the care that many patients need.

Postoperative Respiratory Complications

Traditionally, procedures requiring anesthesia were cancelled in the presence of a URI due to multiple studies in the 1980s showing a link between respiratory complications and upper respiratory tract infections. This work was expanded upon in the 1990s by Cohen and Cameron, who reviewed 20,000 cases as part of a longitudinal study and found that patients with an active or recent URI were two to seven times more likely to suffer a respiratory complication from their anesthetic, and this increased to 11 times if the patient was intubated.

The risk factors for perioperative respiratory complications were defined by Parnis who reviewed 2,051 pediatric patients undergoing surgical procedures and found five clinical predictors: parental disclosure of a “cold,” presence of sputum, nasal congestion, secondhand smoke exposure, history of snoring, and three anesthesia technique predictors: induction drug (the drug administered to begin anesthesia), airway management technique (intubation was more problematic than mask or laryngeal mask airway (LMA)), and use of muscle relaxant without reversal.

Tait et al. largely confirmed this work in his review of 1,078 children with active and recent URIs and found seven independent risk factors for respiratory adverse events in children undergoing anesthesia: presence of secretions, nasal congestion, secondhand smoke exposure, surgery involving the airway, history of reactive airway disease, history of prematurity, and intubation for the procedure.

Another complicating issue is after a URI, there is a window of airway hyperactivity extending from two to as long as six weeks in which there may be a higher risk of bronchospasm, especially in cases where the trachea is instrumented.

Results of Complications

While there are significant increases in respiratory complications for children undergoing an anesthetic with a URI, the good news is it appears to result in very little morbidity. In the studies mentioned above, the most serious complication was hospitalization for pneumonia at a rate of approximately 3/1,000. Furthermore, the anesthesia closed claims database (a systematic review of closed legal claims involving anesthesiologists) shows no cases where a URI was causative of significant harm.

While this is reassuring, for elective cases, any additional risk is significant and treatment, which might be avoided, or delays in hospital discharge, should be reduced when possible.

Preoperative Decision Making

All patients undergoing a planned anesthetic should be optimized whenever possible. This includes, for example, stabilizing patients with asthma on a treatment plan prior to surgery. However, with a viral URI there is little that can be done to reduce the risk of complications, therefore
the approach becomes one of risk stratification, taking into account the urgency of the procedure, anesthesia technique, and severity of symptoms. Social factors, such as long distance travel, are also a consideration. Additionally, many patients will live in a constant state of URI symptoms throughout the winter months and postponing surgery does little as a new URI may be present on the rescheduled date of the procedure.

When a patient arrives for an elective procedure an anesthesiologist will conduct a preoperative assessment including a thorough history and examination. In the presence of URI symptoms, particular attention is directed at respiratory examination by auscultation, and rarely supplemented by radiograph. Signs such as shortness of breath, secretions, presence of fever, and the general appearance of the child will inform the assessment.

Decisions on the two extremes are relatively straightforward. Patients with mild URI symptoms, undergoing straightforward procedures not requiring tracheal intubation, are generally well tolerated and safe. A patient who appears toxic for a long, complex operation, such as a scoliosis repair, should be rescheduled.

Patients and families in between these extremes benefit from a thorough discussion of the risks and benefits of delaying the surgery versus proceeding. A typical approach taken by an anesthesiologist will be to first determine if the procedure is urgent or emergent. In these cases, the anesthesiologist will try to modify their anesthetic technique to account for the URI and complete the procedure as safely as possible. The parents will be prepared for the possibility of an extended stay in the post anesthesia care unit (PACU) or admission and the need for postoperative oxygen.

If the planned surgery is elective, the first question is if the causative agent is an infection. Upper airway symptoms caused by other etiologies typically do not increase the risk of the procedure or are not helped by waiting. If the infection is severe or bacterial the patient would most likely benefit from a delay of four weeks and appropriate treatment. Symptoms such as copious secretions, high fever, ill appearance, lethargy, and lower airway involvement typically result in the anesthesiologist requesting that the procedure be rescheduled.

However, in cases with one or two risk factors where the child appears well and the anesthesiologist and family are comfortable proceeding, the anesthetic is typically uncomplicated and the patient benefits from proceeding.

The key to the decision is a thorough risk benefit analysis and good communication between the patient, family, surgeon, anesthesiologist, and primary care provider.

**Preventing day of surgery cancellation**

Cancelling procedures immediately prior to the scheduled time is sometimes necessary but creates inconveniences and increases costs for the family and sometimes an institution. Family medicine physicians can play a key role in helping to reduce day of surgery cancellations and the resulting frustration to families.

If a child presents a few days before the procedure or lives far away from where the procedure is performed, seeing the patient in clinic may allow for a better understanding of the disease process and if necessary, ease rescheduling challenges. Some anesthesia departments have a process by which the patient, family, or primary care provider can speak with an anesthesiologist and determine if the procedure will likely proceed or be cancelled. Also, many practices maintain an anesthesia pre-operative clinic in which the patient can be seen quickly and evaluated.

While anesthesia with an upper respiratory infection may carry risk, in most cases a child with an uncomplicated URI can be safely anesthetized with no long-term sequelae.

**Case Resolution:** Johnny was seen in clinic and diagnosed with a viral URI. The family medicine physician explained to his mother that while it would be up to the anesthesiologist the day of surgery, in most cases he should be able to have the procedure. He received his hernia repair, was discharged the same day, and is doing well.

Dr. Guffey welcomes questions or comments to patrick.guffey@childrenscolorado.org. References available upon request.

Patients, families or primary care physicians of patients scheduled for anesthesia at Children’s Hospital Colorado can reach an anesthesiologist 24/7 at 720-77-SLEEP or toll free through One Call at (800) 525-4871.

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Andrea (Anne) Nederveld, MD

I am a med-peds trained physician and have been in practice for 10 years. I recently started a two year fellowship in primary care research at the University of Colorado. I was first introduced to health services research in residency and strongly considered applying for a fellowship following residency. For a few different reasons, at the end of residency, that didn’t seem like the right path and my husband and I moved to Western Colorado. Since moving to Grand Junction, I have had great clinical experiences including some teaching at a family medicine residency program, working at a safety net clinic and starting a private practice with a few friends. These experiences exposed me to practice-based research and rekindled my interest in pursuing a fellowship. I have also become more passionate about prevention and health promotion after 10 years of seeing the effects of the lack of such on my patients and our health care system. I am very excited to start my research training and plan to focus on obesity prevention and intervention, primarily from a community perspective. I believe that the solution to our obesity crisis has to extend out of the exam room and am eager to conduct a community engagement intervention on pediatric obesity. I am also interested in practice transformation and in developing processes that will return the joy to clinical medicine for my primary care colleagues!

Contact Anne at ANederveld@fmgj.com

Matthew Simpson, MD, MPH

I am originally from Columbia, Missouri and after completing my undergraduate education I ventured north to the University of Michigan for medical school. Because of my quantitative background (major in physics, minor in mathematics), I took a one-year detour to obtain my MPH in general epidemiology to satisfy my need for numbers. I then headed out west for residency training with the Rose Family Medicine Residency, which I completed in June, and I am now a research fellow within the department of family medicine.

With my fellowship, I am seeking to gain additional expertise in various aspects of primary care research. I am currently participating in ongoing research projects within the department, taking advantage of excellent educational opportunities within the University of Colorado, and working on several manuscripts and presentations. My goal with my fellowship is to gain the skills needed to transition into the role of an independent investigator. I will continue my clinical practice with the residency at Rose Medical Center, serving as an attending physician with our full spectrum inpatient service, precepting in clinic, as well as seeing my own patients in my continuity clinic.

Contact Matt at matthew.simpson@ucdenver.edu

Just Published

Advancing Care Together by Integrating Primary Care and Behavioral Health in a special issue of the Journal of the American Board of Family Medicine. This issue contains eight original research articles and four commentaries about ACT, a five-year program in 11 Colorado practices administered by the CU Department of Family Medicine and funded by the Colorado Health Foundation. If you are interested in HOW to integrate behavioral health and primary care in real-world practices of various types, this supplement is for you. Knowledge from practice for practices.

Join us at a SNOCAP meeting!

SNOCAP is the network of practices throughout Colorado who participate in research. Learn what is happening by attending one of our monthly meetings in person or via webinar. The meetings are held the first Tuesday of each month from 12-1:30 PM in Academic Office 1 room 3101 on the Anschutz Campus. Conference line number: 415-762-9988 (US Toll) or 646-568-7788 (US Toll), Meeting ID: 205 686 178, or online using Zoom: https://ucdenver.zoom.us/j/205686178. Questions about participating? Contact Stephanie.L.diaz@ucdenver.edu.

Questions about SNOCAP?

Donald Nease, MD, Director, Donald.nease@ucdenver.edu
Jodi Holtrop, PhD, Co-Director, Jodi.holtrop@ucdenver.edu
Mary Wold, MPH, Coordinator, Mary.wold@ucdenver.edu
Winner of the 2015 Quest for Quality Prize

We are the proud recipient of the 2015 American Hospital Association-McKesson Quest for Quality Prize — chosen from both adult and pediatric hospitals.

“Full-scale partnerships between our board, community physicians, leadership team, medical school and faculty, patients and families, and frontline staff are key in our quest to continuously improve the care we provide.”
- Dan Hyman, MD, MMM, chief quality and patient safety officer at Children’s Colorado

For more information, please visit childrenscolorado.org
Feeding: It’s Not as Easy as it Looks

Feeding, eating and swallowing are complex processes, with multiple underlying physiological, sensory, motor, behavioral and environmental influences. Studies suggest that feeding difficulties are evident in 25% of all children and in 70-80% of children with developmental disabilities or chronic medical challenges. Aside from consuming adequate nutrition for growth and development, normal feeding and eating are also part of social, emotional and cultural maturation.

Feeding, eating and swallowing difficulties are common and patients often first come to their family physician with concerns. Teasing out the underlying cause can be challenging. It helps to first understand how normal feeding develops in infancy and early childhood, which is the focus of this article. Feeding involves more than just eating and includes coordination of the following six physiological and developmental systems:

<table>
<thead>
<tr>
<th>CHART:</th>
<th>Feeding is More Than Just Eating:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiologic Stability: Neurological development, Cardiopulmonary, GI System</td>
<td>Appropriate nutrition: Oral, tube, modified diet</td>
</tr>
<tr>
<td>Communication: Expression, understanding and social language skills</td>
<td>Sensory Processing development: Tolerance of a variety of sensory experiences (tactile, auditory, visual, olfactory, vestibular and proprioceptive)</td>
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</table>

Children are able to learn to eat successfully when they have normal anatomy, well-coordinated muscle activity, appropriate sensory processing development, a supportive and predictable eating environment, and positive early feeding experiences. Differences in one or more of these areas can lead to feeding difficulties.

As with other developmental skills, feeding is a process learned over time. The following chart outlines the expected skills necessary for successful eating as a child grows. Feeding skills outside of these parameters may be an indication that a child’s feeding is not progressing as expected.

If the underlying cause of a patient’s feeding problem can be identified, subsequent intervention is more likely to be successful. Many times a problem is multifactorial and would benefit from a team approach within the context of a child’s medical home. Some patients can be successfully evaluated and managed in primary care but others will require consultation. When would it be time to consider referring a child in your practice for a feeding evaluation versus other intervention? It is important to note that feeding and swallowing evaluations are not the same. Referrals for these evaluations assess different concerns.

The following list provides some indicators to where feeding evaluation and/or intervention may be of benefit:

- Chronic poor growth compromised nutritional status based on World Health Organization (WHO) or Centers for Disease Control (CDC) growth charts
- Food refusal: This can include a variety of behaviors such as verbal refusals, throwing foods, and distraction and/or avoidance behaviors during the meal time
- Decreased variety of oral intake: This can include refusal
of particular food groups and/or age-appropriate food textures

- Decreased volume of oral intake: A child may not be taking enough food by mouth to meet their nutritional and hydration needs
- Transition from tube feeding to oral feeding
- Prolonged feeding time
- Difficulty transitioning to developmentally appropriate solid foods: From liquids to purees, or from purees to table foods
- Persistent gagging, vomiting, or choking while eating
- Sensory processing difficulties
- Oral-motor delays or impairments: This can be caused by structural compromise to the oral-facial anatomy or skills may be delayed for other reasons
- A history of gastroesophageal reflux, constipation, or other gastrointestinal problems leading to discomfort with feeding

- Medical conditions including, but not limited to: allergies, respiratory health, neurological factors, sensory factors, premature birth, genetic/metabolic conditions

If a child in your care is demonstrating concerns listed below, then an evaluation for an upright modified barium swallow study may be indicated:

- Coughing and or choking while drinking liquids
- Concerns about a child's overall pulmonary health (chronic oxygen requirement or frequent lower respiratory illnesses)
- Neurological or medical condition which may suggest swallowing dysfunction
- Resistance to drinking liquids
- Persistent concerns about growth and weight gain in light of above concerns

Brackett, Arvedson and Manno suggest that, “Feeding disorders are rarely the result of a single etiology treatable by a single professional. They typically represent a complex interaction among multiple factors that require treatment by an interdisciplinary team.” Children's Colorado Feeding and Swallowing Program is available to partner with your practice. For additional information or questions call 720-777-6827 or toll free through One Call at 800-525-4871 or e-mail Dr. Laura Pickler at Laura.Pickler@childrenscolorado.org.

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. Laura Pickler, the Chief of Family Medicine at Children's Colorado, through One Call at (720) 777-3999 or (800) 525-4871.

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**CHART: Ages and Stages of Feeding Development**

<table>
<thead>
<tr>
<th>Age</th>
<th>Motor Skills</th>
<th>Oral Motor Skills</th>
<th>Sensory Processing Development</th>
<th>Communication</th>
<th>Feeding Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal</td>
<td>Association between suck/swallow at 32 weeks</td>
<td>Mature suck, swallow, breathe sequence by 37 weeks</td>
<td></td>
<td></td>
<td>Food textures include liquids and smooth, thin purees introduced between 4-6 months</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Holding bottle</td>
</tr>
<tr>
<td>0-6 months</td>
<td>Hands to midline and mouth Development of sitting patterns</td>
<td>Latch to breast and/or bottle Suckle pattern with introduction of spoon feeding</td>
<td></td>
<td>Cry to have a need met, bonding, predictable pattern of feedings</td>
<td>Child/caregiver dynamic</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Food textures: liquids, purees, melttable solids, some soft solids</td>
</tr>
<tr>
<td>6-12 months</td>
<td>Sitting independently Emerging self-feeding with fingers using pincer grasp Crawling, pulling to stand, cruising</td>
<td>Improved coordination of spoon feeding Vertical (up and down) chewing with emerging rotary (circular) chewing by 12 months</td>
<td></td>
<td>Social aspects of feeding with caregivers, nonverbal communication</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Food textures: liquids, purees, melttable solids, soft solids,回避 solid foods, avoid foods which pose a high risk for choking</td>
</tr>
<tr>
<td>12-24 months</td>
<td>Independent ambulation is learned May transition to booster seat at table Using fingers and learning to use utensil to feed self Learne independent cup drinking</td>
<td>Improved biting and chewing through more challenging food textures Improved cup drinking with less spilling</td>
<td></td>
<td>Using single words: Able to request and refuse food items based on preference</td>
<td>Food textures: Liquids, purees, melttable solids, soft solids,回避 solid foods, avoid foods which pose a high risk for choking</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Food textures: A variety of types and textures of foods</td>
</tr>
<tr>
<td>24 months and beyond</td>
<td>Can sit at the table independently More refined utensil and cup use</td>
<td>Able to chew and swallow a wide range of foods and textures Typically fully weaned from breast/bottle</td>
<td>Oral exploration of objects begins to decline</td>
<td>Using two word combinations and beginning to use sentences Responds to simple sentences Can see an increase in verbal refusal</td>
<td>Avoid foods which pose risk for choking until age 3</td>
</tr>
</tbody>
</table>
Healthcare Reform:  
Changing How Care is Delivered and Paid For

By Allyson Gottsman, Colorado Health Extension System

The Time is NOW!

We have been talking about “healthcare reform” for years, and it seems the time for action on a large scale is finally presenting itself, and Colorado is ready!

It has been a long time coming, and many of us have been preparing for this in various capacities for years. Perhaps you remember the CMS Physicians’ Congress for Health Care Reform, the group of committed physician leaders that began meeting on Saturdays starting way back in 2008? You are also probably well aware of some of our pioneers that have been working on medical homes, systems of care, transitions of care, meaningful use, and behavioral health integration into primary care, starting way before these terms became part of everyday conversation. Well, now it’s time to go mainstream! It’s time for an “all in” approach to improving the health of Coloradans, balancing a focus of reducing the cost of care, while also improving the experience of care for patients, families and healthcare teams. Practices that are prepared should do well in the changing system; those that do not pay attention now risk falling by the wayside.

Payers are now ready to take what started out as pilots to scale in a major way. By 2019, the Center for Medicare and Medicaid (CMS) has committed to a goal that 90% of Medicare payments will be directly tied to value. The commercial carriers and Colorado Medicaid are on a similar trajectory. However, being paid for value, not activity, means new models of care delivery must be implemented that can demonstrate value with comprehensive data, including clinical as well as claims data. The new models involve challenging changes in care delivery and the use of data. Practices benefit greatly from support in making these changes, which take time and certainly do not happen overnight.

Two opportunities in particular are available statewide for primary care participation. The Colorado State Innovation Model (SIM) is open to primary care practices, with a focus on assisting practices in moving to advanced primary care that includes behavioral health integration and alternative payment models. Through SIM, along with other collaborative projects, the payers are building an aligned framework for a new system of care and payment. While the details of the payment reforms for SIM are not yet fully known, payers have committed to supporting practices in this effort. For more details visit www.coloradosim.org/payers-sim

The other opportunity is the AHRQ -funded EvidenceNOW Southwest, with a focus on cardiovascular risk mitigation and the new CVD guidelines for managing heart health for adults. EvidenceNOW is a great initial preparation for practices not quite ready for SIM, but wanting to engage with SIM in 2017 or 2018, or that otherwise want to begin to prepare for the new payment models.

Applications are being accepted now for both programs, and we welcome your interest and participation. For additional SIM information and to access the application please go to ucdenver.edu/practicetransformation. For additional information on the EvidenceNOW Southwest program, visit: http://www.evidencenowsw.org

These opportunities and more are offered through the Colorado Health Extension System, a collaborative of more than 20 organizations in Colorado that provide support for practices in various quality improvement and practice transformation projects. CHES provides a mechanism for coordinating practice transformation support across Colorado, aligned with the emerging payment models.

EvidenceNOW Southwest

WHO: Primary care practices with adult patients
10 or fewer providers
WHAT: 9 months of in-office practice facilitation
2 collaborative learning sessions
Focus on cardiovascular risk management
Aspirin, Blood Pressure, Cholesterol, Smoking Cessation
Prepare for future cohorts of SIM in 2017 and 2018
HOW: For information and to apply: www.evidencenowsw.org
WHEN: Apply now – first cohort begins November 2015

SIM

WHO: Primary care practices
EHR required
Experience with elements of medical home
Commitment to improving behavioral health
WHAT: Advanced primary care with behavioral health integration and alternative payment models
2 years of practice facilitation
6 core measures in year one
2 collaborative learning sessions per year
Up to $5000 stipend, plus small grants
Potential compensation from payers
HOW: For information and the application go to: www.ucdenv/PracticeTransformation
WHEN: Apply now – first cohort begins February 2016
Earlier this year, the Department of Health and Human Services (HHS) released its “annual reports” concerning HIPAA breaches, security and breach notification compliance, and breaches of unsecured protected health information. HHS will use the report findings to determine where to focus its enforcement and education efforts, and consequently, health care providers should be focusing on these areas as well.

**PRIVACY RULE CONCERNS**

Improper notice of privacy practices—HHS found that patients were either not receiving a Notice of Privacy Practices (as required) or the notice was deficient. This can be easily addressed by using model notices (in English and Spanish) available on the HHS website at www.hhs.gov/ocr/privacy/hipaa/modelnotices.html

Timeliness and cost of providing medical records—Under HIPAA, a provider must provide access to fee to a patient, typical when paper records were copied, may no longer be considered reasonable or cost-based with EMRs. Charges to entities other than patients are subject to the Colorado Statute (C.R.S. 25-1-801).

Provide only the relevant medical record information—The Minimum Necessary Standard requires that you only produce those portions of medical records that are needed for the purpose in which the disclosure is permitted. For example, you are permitted to disclose some HIPAA protected health information (PHI) when sending a patient to collections for not paying a bill. However, the billing information will usually suffice in this situation, and you should not disclose medical treatment notes unless required.

Authorization issues—These include failing to obtain a necessary HIPAA compliant authorization when required or using an authorization form that does not contain all of the required information.

When providing records to a patient, a provider may only charge a “reasonable, cost-based” amount for copies. Charging a per-page copy fee to a patient, typical when paper records were copied, may no longer be considered reasonable or cost-based with EMRs.

**SECURITY RULE CONCERNS**

Maintain a current risk analysis—A risk analysis helps your organization ensure it is compliant with HIPAA’s administrative, physical, and technical safeguards. It also reveals areas where PHI could be at risk. If a HIPAA complaint is filed, the first thing the government will ask for is the most recent risk analysis. Failing to have the risk analysis, or failing to update it, has been prominently cited as the justification for sanctioning large fine amounts when a substantial data breach occurs.

- To assist in compliance, the Office of Civil Rights, in conjunction with the Office of the National Coordinator, created an online tool that walks you through the risk analysis process. It is available at www.healthit.gov/providers-professionals/security-risk-assessment

Lost or stolen data—“Media Movement and Disposal” refers to PHI lost or stolen when being moved or when being improperly disposed. Loss or theft of PHI was the cause of 65 percent of breaches involving more than 500 patients. Most of these were lost or stolen laptops, thumb drives, DVDs, cellphones and other forms of portable media, but they also include stolen or left behind briefcases and paper patient files.

- Be cautious in situations where laptops, thumb drives, or cellphones that are not encrypted could be stolen. Encryption capabilities may be an upfront cost now, but it could save you in fines and reputation damage.

- In terms of disposal, make sure that any copies of medical records are securely destroyed. Never throw billing information or copies of medical records out with the normal trash. And don’t forget to wipe the hard drive on your leased digital copier before returning it.

Audit and monitoring—HIPAA requires that covered entities regularly audit their systems for intrusions and have policies and procedures for how and when this occurs. If providers rely on outside information technology contractors, they should discuss these issues with them.
Physicians and Family Practices – Developing an Exit/Succession Strategy

By Michael Dambeck, President/CEO, Summit Wealth Advisors, LLC

Your exit strategy may be one of the most important, yet least thought-out, elements of your practice plan. Among the important decisions: who will take over the practice, will you continue to practice once you leave the practice, will your current employees stay, including any family members, and how will the sale proceeds be deployed. The development of an exit strategy also opens the door for a wide range of tax management, philanthropic, and estate planning activities and opportunities. However, since effective strategies balance complex legal, financial, tax planning, and contractual issues, professional advice is virtually required.

If you are like many of your peers, the career path into your practice was more clearly laid out than your exit strategy. However, a well-drawn roadmap for a succession plan can be the difference between achieving success and missing the target on important life goals. As a result, preparing an effective exit plan should be a central part of your overall practice plan.

Laying the Groundwork

A viable practice exit strategy must take account of where you are today or where you would like to be in the future and provide for contingencies in the event of unforeseen circumstances. As a result, your exit planning should start with a comprehensive appraisal of your practice, your staff and personal finances. Many physicians have found it valuable to start by developing a comprehensive net-worth assessment with their financial advisor.

A successful exit process should be based on a sound understanding of existing practice management, staff relationships and provisions for succession. You should identify the key personnel and care management in your practice and then formulate appropriate reward and retention strategies for them. A primary consideration of many practice owners is finding another physician with similar skills that will take care of their patients in a similar fashion.

Potential Deal Forms to Consider

Buy-Sell agreement -- This arrangement is designed to permit multiple physician owners to terminate their business relationship by setting the parameters for some physicians to buy out others. It enables one or more physician associates to maintain involvement in the practice when one physician wants to retire or go in another direction. It can also provide funding for a buyout in the event of the disability or death of a physician-owner. A buy-sell agreement requires careful design to ensure that its execution does not work at cross-purposes with other estate and succession planning tools.

Cash sale to a third party -- A pure cash transaction may create the greatest immediate liquidity for the selling physician, but other financing structures may have the potential to generate greater net yield over time. Keep in mind that one of the challenges of seeking a third-party buyer is that quite often there is no ready market to sell a medical practice. Simply put, it can take time and money to find the most suitable succession strategy for the physician’s exit.

Buyout or recapitalization -- In leveraged transactions partners sometimes borrow the funds to purchase the retiring physician’s stock or share of the practice’s appraised value. These deals may be especially useful for dissolving a multiple physician ownership arrangement while otherwise maintaining the practice as a going concern. Recapitalizations can also be used to finance an annuity for a physician owner who might wish to combine financial independence with limited practice involvement.

Employee Stock Ownership Plan -- An ESOP is a form of leveraged buyout designed specifically to give control of the practice to a broad base of its current staff. ESOPs may have higher transaction costs than ordinary cash sales, but in many cases these costs are not out of line with the costs of other more complex deals. There are also specific tax benefits for ESOP transactions that may improve their net value significantly.

Managing the Proceeds

A key part of any exit strategy is the financial plan for managing the proceeds of the exit transaction in a manner consistent with the physician’s financial goals. Such plans typically include a blueprint for investing sale proceeds in a diversified portfolio. They also typically include an estate plan crafted to take advantage of the trust structures and tax-code features that allow you to preserve wealth, minimize taxation and protect the future interests of their heirs. Among the favored devices may be family limited partnerships and grantor retained annuity trusts, which can reduce the estate value of shares passed on to heirs. In addition, many physicians are interested in charitable remainder trusts. These may be used to fund philanthropic programs that realize specific charitable goals while maximizing tax benefits, minimizing costs, and creating an income stream.

Professional Guidance a Must
Just as you likely rely on key advisors when making significant practice decisions, you’ll need to assemble a team of legal, tax and finance professionals to help you analyze your current and future objectives and planning needs.

Points to Remember

1. The sale of a physician practice is only one transaction at the center of a larger plan often referred to as an exit or succession strategy.

2. The most successful exit strategies are those that give the physicians the greatest probability of comfort with the results as seen in their financial security, practice dynamics and long-range goals.

3. There are many options for structuring the sale of a physician practice, and each has different implications for the other elements of the broader strategy. Buy-sell agreements can help maintain continuity for remaining physicians and staff in a practice. Pure cash transactions typically yield the greatest immediate liquidity but can be the most difficult for the ongoing practice. Leveraged transactions may enable other physicians to take over and maintain continuity for the business. ESOPs can provide tax benefits and empower other staff members.

4. Trusts can be valuable tools for managing the income tax and estate planning implications of the wealth derived from a practice sale.

This information is not intended to be a substitute for specific individualized tax or legal advice. We suggest that you discuss your specific situation with a qualified tax or legal advisor. Please note that the LPL Financial Advisor providing this article does not provide business valuation services. LPL Financial Representatives offer access to Trust Services through The Private Trust Company N.A., an affiliate of LPL Financial.

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Transgender Medicine for the Primary Care Physician

By Ben Kirkley, MD

As primary care physicians, we often extend our scope of practice and find niches to meet the needs of our patients that are hard to find elsewhere. Over the past three years I have developed a passion for the care of transgender individuals; a community that has and continues to face barriers to basic healthcare. From beauty pageants to Olympic athletes, transgender folks are garnering media attention nationally and globally, and the word ‘transgender’ is starting to find its way into popular discussion more than ever before. With changes under the Affordable Care Act including the Medicaid expansion and minimum essential coverage requirement, many of us have experienced a surge of patients establishing care for the first time, and a lot of these are patients in the twenty-to-forty year old demographic. Most transgender individuals transition between the ages of 18 and 44.1 With these societal and healthcare climate changes, the transgender community is seeking care now more than ever.

Estimates of numbers of transgender individuals are hard to come by and are usually underestimates because the U.S. Census Bureau does not ask questions about gender identity, and, as one national survey from 2011 cites, 71% of transgender people have hidden their gender or gender transition to avoid discrimination1. Many organizations reference the Williams Institute estimates of 0.3% of Americans being transgender,2 or close to one million transgender individuals nationwide, and about 12,000 transgender people in Colorado.3

As mentioned above, the climate is recently becoming more favorable for transgender people to enter into healthcare and start transitioning. In March 2013, the Colorado Division of Insurance released Bulletin B-4.49 which prevents discrimination based on sexual orientation or transgender status in health care plans in the private sector. In May 2014, the U.S. Department of Health and Human Services overturned the exclusion of transition-related care under Medicare, including some gender confirming surgeries.4 I recently sat down with Leo Kattari, the health policy manager at One Colorado, Colorado’s leading LGBT advocacy organization. One Colorado has done substantial work to elucidate the demographic and health statistics of our transgender community. Mr. Kattari and One Colorado are working on various policy initiatives including extending Medicaid benefits for transgender care and allowing physicians and other health professionals to have the authority to change the sex on birth certificates.

To briefly review some vocabulary, a transgender person is any individual whose gender identity or expression (the gender they know themselves to be) is different from those typically associated with the sex assigned to them at birth.5 A cisgender person is anybody whose gender identity or expression matches that of their birth sex. Gender identity comprises a wide spectrum. There are transgender individuals who have no desire to change their physical appearance but firmly identify as a gender opposite that of their birth sex, those who take hormones and/or have had gender confirming surgeries and every variation in between, including those who are gender non-conforming altogether. A transman is a female-to-male transgender person and a transwoman is a male-to-female transgender person.

As a primary care physician, you already provide most of the care needed for transgender patients, including basic preventive medicine and attending to any acute concerns that arise. Physical exams and preventive screenings should be structured based on actual organs present rather than the perceived gender. For example, a 55 year old transwoman needs a discussion about prostate cancer screening and a 50 year old transman who has not had a mastectomy or hysterectomy needs a mammogram and pap smear. As practitioners, we should also be aware that certain health conditions have been shown to disproportionately affect the transgender community, namely depression and anxiety. Survey results

Helping a patient through the transitioning process is incredibly rewarding and easily done in the primary care office with a little additional training.
demonstrate that transgender Coloradans are nine times as likely as the general Colorado population to have contemplated suicide in the past year.\(^4\)

Transgender specific care mostly revolves around the transitioning process. In children, this is primarily done by delaying puberty with gonadotropin releasing hormone antagonists. In general, female-to-male transition utilizes mainly testosterone and male-to-female transition is accomplished primarily with estrogen and anti-androgens. There are many different gender confirming surgeries, also known as sex reassignment surgeries (SRS), generally referred to as ‘top’ or ‘bottom’ surgery. An example of a top and bottom surgery respectively is a mastectomy in a transman and an orchietomy in a transwoman. There are many other modalities and nuances in the transitioning process which I am not able to cover in detail here, but two great references are the World Professional Association for Transgender Health’s Standards of Care document\(^5\) which can be found on their website and the ‘Primary Care Protocols’ from the UCSF Center of Excellence for Transgender Health website.\(^7\)

Helping a patient through the transitioning process is incredibly rewarding and easily done in the primary care office with a little additional training. Regardless of whether you are prescribing hormones, there are things we can all do to help meet the health needs of our transgender community. The first step to having a welcoming office is to educate ourselves and our staff. Local organizations which can provide transgender specific and/or comprehensive LGBT 101 trainings include the Gender Identity Center, Denver’s LGBT Center and the Colorado Anti-Violence Program. Ask your transgender patients what pronouns they prefer to be called and encourage colleagues and staff to use the preferred pronouns. Changing intake forms to provide multiple options for sexual orientation and gender identity is also helpful; there are good examples on the UCSF Transgender website referenced above. Having diverse patient education literature, magazines and wall pictures/art is important since that is what patients typically encounter first when they walk into an office. But more than anything, bring an open mind and don’t be afraid to ask questions.


2. Gates, Gary J. How many people are lesbian, gay, bisexual, and transgender? The Williams Institute, April 2011.


4. Transparent: The State of Transgender Health in Colorado. One Colorado Education Fund,

5. HRC Transgender FAQ. http://www.hrc.org/resources/entry/transgender-faq#1


7. http://transhealth.ucsf.edu/trans?page=protocol-00-00

Dr. Kirkley recently finished his family medicine residency at Rose Medical Center where he created a transgender transitioning protocol for the residency clinic. He is now working at Salud Family Health in Commerce City, Colorado. He will be presenting on transgender healthcare at the CAFP’s 2016 Annual Summit on April 16, 2016. You can contact him with questions or feedback at bgkirkley@gmail.com.
The Why, When, and How of Hepatitis C Screening

New anti-retroviral therapies are increasing the value of early hepatitis C detection. Here are three reasons that you should make hepatitis C screening a routine part of primary care for people born between 1945 and 1965, and for those who have specific risks including a history of injecting illicit drugs.

1. Early screening detects hepatitis C before the development of liver disease.

Liver-related cirrhosis, cancer and death are increasing in the U.S. and expected to peak by 2030. Recent advances in medications mean that a patient with hepatitis C can be treated and obtain a sustained viral response within 12 weeks. People born between 1945 and 1965 should be screened for hepatitis C in addition to risk-based screening. Birth cohort screening linked with effective hepatitis C treatment is predicted to markedly reduce cases of decompensated cirrhosis, hepatocellular carcinoma, liver transplantation, and HCV-related deaths.

The Chronic Hepatitis Cohort Study (CHeCS) is a large multicenter observational study of patients who received care in four integrated health systems in the U.S. Moorman et al. examined the temporal relationships of initial HCV infection diagnosis with cirrhosis and found that many CHeCS patients had advanced liver disease at the time of their initial HCV diagnosis (Hepatology. 2015 May;61(5):1479-84). The study demonstrated that multiple missed opportunities to screen patients for hepatitis C led to high rates of hospitalization and mortality related to liver disease.

2. Hepatitis C screening is the first step in protecting communities.

Hepatitis C is an infectious disease. In the last two years, Colorado identified clusters of new hepatitis C infections in southern and western counties involving injection drug use. Currently a small rural county in Indiana is in the midst of co-occurring outbreaks involving hepatitis C, HIV, and addiction to the prescription drug Opana. Ninety percent of 181 HIV cases are co-infected with hepatitis C in a community of just under 5,000 people. The lessons learned so far indicate that better screening and public health monitoring of hepatitis C could lead to earlier detection and response to future outbreaks. Are your patients at risk?

3. Screening is cost effective

Multiple studies have shown that risk factor-based screening alone misses the majority (49%-75%) of hepatitis C infections. This can lead to more serious and costly health effects. Not screening for hepatitis C also has a cost to community members that are still at risk of acquiring hepatitis C. Birth cohort screening in addition to risk screening for hepatitis C is cost effective. It has a similar cost to other standard screening measures for other common diseases.

Hepatitis C screening is simple. It starts with a hepatitis C antibody test. Based on a Grade B recommendation from the U.S. Preventive Services Taskforce, the cost of this test should be covered by insurance. If the hepatitis C antibody test is reactive, an HCV RNA test should be done to detect ongoing infection. Anyone with a positive HCV RNA should also get a genotype test. This will help inform which treatment regimen is most appropriate.
Winners Named in Colorado Tar Wars Poster Contest

For 27 years, students have been turning what they learn about tobacco use into positive messages

Saints Peter and Paul’s 5th grader, Joshua Jeffers, won first place in the Colorado Academy of Family Physicians statewide Tar Wars poster contest. His poster was submitted to the state contest after winning first place in his school’s poster contest.

Depicting a map of the globe inside a pair of lungs, the poster proclaims “Help the World Breathe a Little Easier.” Jeffers drew his inspiration from a family vacation to California where he saw a pair of lungs during a trip to a nearby museum. Second Place Winner, Molly Merrill from Aspen Creek Pre K-8, is beyond thrilled, as an aspiring young artist and an increasingly health conscious youth, to be recognized for her efforts. Merrill lost her Grandpa, a long-time smoker, to lung cancer just a few short years ago.

Last year, the AAFP announced a significant shift in their Tar Wars program strategy. In place of the Annual Tar Wars Conference and National Poster Contest, the AAFP now offers annual, customizable mini-grants for innovative ideas in the prevention and control of tobacco use efforts at the state and local level. Grants are awarded for the implementation of action plans in one of three key focus areas: Office Tools, Community Engagement, or Advocacy.

Other winners in this year’s poster contest:

Honorable Mentions:
Sophie Christopher – Aspen Creek PreK-8
Keira Peterson – Aspen Creek PreK-8
Porscha Jacobs – Idalia Elementary School

Tar Wars is a tobacco-free education program that discourages tobacco use among the country’s youth. The program, which was established in 1988 by Past AAFP Board Chair and Colorado physician Jeffrey Cain, MD, is supported by the American Academy of Family Physicians and managed locally by the Colorado Academy of Family Physicians.

Thousands of Family Physicians and healthcare professionals across the country present ‘Tar Wars programs to fourth- and fifth-graders in their local schools every year. They discuss not only the long-term effects of smoking on the body, but also focus on the short-term, image-based effects of tobacco use.

To find out how you can become involved in this fun, informative and innovative program to help the kids in your area stay tobacco free visit http://www.coloradoafp.org/tarwars.
The movement toward no non-medical vaccine exemptions. Should Colorado join?

In May of this year, to virtually no fanfare, Vermont became the first state to remove philosophical exemptions from its vaccination law. As an article in The New Yorker opined, “If parents want their children to remain unprotected from vaccinations, perhaps they should have that right. But should those children then be allowed near other students, in public places like playgrounds, or anywhere else where they could infect people with weakened immune systems? By removing the philosophical objection, at least one state has begun to say no.”

And Vermont is not alone. In July, the American Medical Association adopted a policy opposing religious and personal belief exemptions for childhood vaccines. As a result the organization will now lobby policymakers to remove such exemptions from state laws.

One of the reasons for the new policy was a concern by the AMA that over the last two decades “the number of non-medical exemptions for school immunization requirements have almost doubled due to philosophical or religious reasons,” and as such “access to these philosophical exemptions has gotten progressively easier to obtain and is more widely available.”

A former president of the American Academy of Pediatrics, David T. Taylor, MD, commented during debate about the new policy that AAP policy calls for no non-medical exemptions whatsoever.

In debating personal versus public rights, one physician testified and compared public safety in traffic laws to public health in vaccinations. “It’s like a speed-limit. I’m not sure any of us want to have deeply held beliefs about speeding.” Or, as I like to tell the anti-vaccine zealots, “Your right to swing your fist ends at my nose.”

Then, in July, a bill banning exemptions from school vaccinations for personal and religious beliefs (but allowing medical exemptions considered appropriate by the California Department of Public Health) was signed into law in California.

In a July editorial, USA Today commended the laws passed by California and Vermont, saying that the states “are finally doing what’s needed to stop the leading edge of a public health hazard,” and that states with relaxed laws “should follow suit.” While the editorial acknowledged that some exemptions are acceptable “for very narrowly defined medical or religious reasons,” it says that states with opt-outs “should look to Vermont and California for a better way.”

Is it time for the CAFP to push for similar legislation here in Colorado?

ACIP Issues New Recommendation for MenB Vaccination and Pneumococcal Vaccine

During its June meeting the CDC’s Advisory Committee on Immunization Practices (ACIP) voted to issue a Category B recommendation for the use of two serogroup B meningococcal (MenB) vaccines in patients ages 16-23 for short-term protection against the disease, with a preference for administration between ages 16 and 18.

Previously, the ACIP had recommended the two MenB vaccines, Pfizer’s Trumenba, which is given as a three-dose series, and Novartis’ Bexsero, which is given as a two-dose series, only for people ages 10 and older who are at increased risk for serogroup B meningococcal disease.

High-risk groups include those with persistent complement component deficiencies, anatomic or functional asplenia, microbiologists working with serogroup B meningitis, and populations at risk because of outbreaks.

The FDA-approved indication for MenB vaccine is limited to those ages 10-25, but the ACIP saw no theoretical difference in calling for its use in older individuals and so broadened the recommendation.

Our AAFP liaison to the ACIP Jamie Loehr, M.D., of Ithaca, New York, said the group decided to expand the recommendation beyond just those at high risk to individuals ages 16-23 via a B recommendation because the committee concluded that “this is a very deadly disease that’s devastating for families, and if we didn’t have a B recommendation (and, consequently, mandatory insurance coverage), there would be inequity as to who could afford it.” On the other hand, Loehr
added, the vaccine wasn’t sufficiently cost-effective to warrant an A recommendation.

In other business, the ACIP voted to recommend that for patients 65 and older, the interval between administration of 13-valent pneumococcal conjugate vaccine and pneumococcal polysaccharide vaccine be one year regardless of which vaccine was given first.

The ACIP also voted to recommend that for patients 65 and older, the interval between administration of 13-valent pneumococcal conjugate vaccine (PCV13; Prevnar) and pneumococcal polysaccharide vaccine (PPSV23; Pneumovax) be one year regardless of which vaccine was given first.

Previously, the interval protocol was to administer the second dose at one year or more if PPSV23 was given first but only six months later if PCV13 was given initially. This led to confusion.

“There wasn’t data to show that the six to 12 months was necessary, and (the CDC) was getting so many questions about why is it six months one way but one year if given in reverse, the ACIP decided to make things uniform,” Loehr said.

Colorado Regional Immunization Summit

This meeting will be held in Grand Junction on October 23, 2015, and is hosted by the Colorado Children’s Immunization Coalition and St. Mary’s Hospital. It will be a one-day conference which aims to provide an opportunity for Coloradans involved in immunization delivery, education, and advocacy to learn about current issues and best practices to promote vaccination from world-renowned experts in the field.

Walt Larimore is an award-winning family physician, medical journalist, and best-selling author who lives in Monument.

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**Closer Than We Have Ever Been**

Reg Finger, MD, MPH

Throughout my professional lifetime, public health officials worldwide have labored valiantly to rid the world of polio. In this effort the World Health Organization, CDC, and health agencies of other nations have had invaluable assistance from some very influential partners, most notably Rotary International and the International Foundation of Red Cross and Red Crescent Societies.

I was a first year medical student in 1977 when the world saw its last case of smallpox. Ever since then we have been working at number two. Polio eradication has proved much more difficult than that of smallpox for several reasons: the large preponderance of clinically invisible cases, the existence of three different subtypes of wild virus, and the reality of vaccine-derived cases of disease, to name a few.

Twice in the last decade, polio has been pushed to the brink of eradication, only to rebound and spread to previously polio-free countries. Now, so far as we know, wild poliovirus has once again been contained to just two nations, Afghanistan and Pakistan, whose geography and political situations pose particular challenges to control efforts. As of this writing, just 34 cases have been reported, 28 from Pakistan and 6 from Afghanistan, since January 1, 2015.

Hope runs high, especially because two other countries, long thought to pose the most difficult challenges to polio eradication, have succeeded in stopping the disease.

Densely populated India saw its last case in January, 2011. Nigeria, after several logistical setbacks, has now not seen polio since July, 2014, although epidemiologists quickly point out that only after three years with excellent surveillance since the last known case can any world area be certified as polio-free.

The hope now is that if Afghanistan and Pakistan can get through this “high risk” transmission season (summer and fall) without a major setback and with aggressive implementation of vaccine campaigns, perhaps in the next “low” season (January through April, 2016) transmission can be stopped once and for all and the world can start its three-year countdown toward certification as polio-free.

All that said, we remember that in today’s busy world of air travel, infectious diseases can circle the globe in a few hours. Polio vaccine will still be on our childhood immunization schedules for several years to come. It would be supremely foolish for any of us to take chances with a virus that still survives anywhere on earth. Let us protect ourselves, while giving our global partners all the support we can.

Reg Finger is a public health physician, a former member of CDC’s ACIP, and an assistant professor at Indiana Wesleyan University in Indiana.

References available upon request.
Every year, Kansas City, Missouri hosts the AAFP National Conference for Students and Residents, which is an excellent opportunity for students interested in Family Medicine to find out more about our specialty, develop our skills and knowledge base, and get involved in leadership at the national level. It’s all packed into three days in early August and I would strongly recommend that any student interested in pursuing a career in Family Medicine attend by their third year. If you are a physician mentor or preceptor, please make sure your students are aware of the opportunity and encourage them to attend. Hundreds of students attend every year, yet many more don’t know about it at all or find out too late. Fewer yet understand the leadership opportunities available or may think that they are inaccessible to the average student.

There are a number of ways to get involved in leadership at National Conference without taking too much away from the other activities going on. Although the residency fair, seminars and workshops are the main attractions for most students, there are options for leadership development for any level of interest. Any medical student can attend the business sessions of the student congress to get a taste of how the congress works, without any commitment or time obligations. At first glance the structure may seem intimidating, but go ahead and find the “Colorado” section and meet your delegate(s). If you want to be somewhat more involved, become a member of the election committee. The election committee is obligated to be present for congress proceedings on Saturday morning but there are no other time commitments or prior experience required.

For the student willing to invest some time and energy, there are a number of opportunities available that take a bit more forethought. One of the most prominent leadership positions at the student congress is the state delegate. Contact the CAFP prior to the conference if you are interested in representing our state as a delegate or alternate. Another option is to become a member of a reference committee. Reference committees are formed prior to the conference, so get in touch with the folks at the AAFP prior to the conference to sign up. Finally, you can run for an elected national position or apply for an appointed national position. Elected positions are decided during the national conference and it is best to prepare your CV and letter of intent prior to attending. Appointed positions are somewhat separate from national conference, yet still a great opportunity to get involved. These positions are year-long commitments and you can find more information on the AAFP website.

So what exactly happens during the student congress business sessions? I’ll use this year’s session as an example. This year I served as the Colorado delegate, a reference committee member and an election committee member. Over the course of 3 days we debated and passed numerous resolutions and elected next years’ student leaders. Resolutions of interest to the general membership this year included standardizing the use of the LGBT acronym throughout the AAFP, support of expanded naloxone training and access, AAFP endorsement of the proposed FDA nutrition label modification to include percent daily value of sugar, and updating evidence based information about the efficacy of fertility awareness based methods of family planning. Resolutions of interest to student and resident members of the AAFP included addressing burnout in medical training, support for miscarriage management training in FM residencies, transparency in medical school tuition and investigating the impact of medical school student wellness programs. Two resolutions were particularly contentious, one regarding transparency in training settings affiliated with religious health care organizations and another regarding access to medical student loans for non-US citizens. Both of these were passed following amendment. All of the resolutions passed by the student congress are forwarded to the appropriate committee at the AAFP for further action.

The AAFP National Conference for Students and Residents offers unparalleled opportunities for students to explore Family Medicine. The residency fair is one of the largest in the country and allows students to talk face-to-face with residents, program faculty and staff. The seminars cover everything from excelling in clerkships to advanced interviewing techniques. However, some of the hidden gems of the National Conference are the leadership possibilities.
Congratulations to the Following CAFP Members On Their Accomplishments!

• Haftu Gebrehiwot, MD, FAAFP, received his Degree of Fellow from the AAFP
• David M. Gordon, MD, FAAFP, received his Degree of Fellow from the AAFP
• Elizabeth Grace, MD, FAAFP, received her Degree of Fellow from the AAFP
• Julian T. Hsu, MD, FAAFP, received his Degree of Fellow from the AAFP
• Philip J. Rosenblum, MD, FAAFP, received his Degree of Fellow from the AAFP
• Zachary Wachtel, MD, FAAFP, received his Degree of Fellow from the AAFP
• Kyle Waugh, MD, FAAFP, received his Degree of Fellow from the AAFP
• Pamela Webber, MD, FAAFP, received her Degree of Fellow from the AAFP

Do you have exciting news about yourself or a colleague that should be recognized? Email Lynlee Espeseth at lynlee@coloradoafp.org

The CAFP would like to wish Dr. Tracy Hofeditz the best in his retirement. Clearly, he won’t be slowing down at all!

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

Marijuana Pediatric Exposure Prevention and Pregnancy and Breastfeeding Clinical Guidance

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

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