Kent Voorhees, MD, Family Physician of the Year

Dan Fahrenholtz, MD, Family Medicine Teacher of the Year

Zach Wachtl, MD, Family Medicine Resident of the Year

Westminster Medical Clinic Winner of Best PCMH Practice of the Year Award
Rocky Mountain Urgent Care

IV Hydration · Minor Illness
Workers’ Comp · Fracture Care
X-Ray on Site · Stitches
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Sport Injuries

Our patients need follow-up with Primary Care and Specialist Physicians
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303-499-4800

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(Smoky Hill & Himalaya)
303-693-2000

Commerce City at Reunion
(104th & Tower)
303-286-0027

Longmont
(Main & Pike)
720-494-4747

Lakewood - North
(Union & 2nd)
303-986-9583

Englewood
(Clarkson & Hampden)
720-974-7464

Westminster
(92nd & Harlan)
303-429-9311

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The CAFP’s mission is

Mission Statement:

Thriving Family Physicians

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Vision Statement: Thriving Family Physicians
creating a healthier Colorado.
Mission Statement: The CAFP’s mission is
to serve as the bold champion for Colorado’s
family physicians, patients, and communities
through education and advocacy.

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edition 23
As I write this edition’s column, I am staring out the window at 35,000 feet, looking down on the fields of the Midwest. Having just attended a conference on obstetrics (to include obstetric ultrasonography), I find myself reflecting on how lucky I feel to be a Family Physician. Before I elaborate a little more on that, however, I wanted to touch on a few other areas.

It’s obvious to any Family Physician that our specialty is suffering. In Colorado over the past year, many physicians have closed up shop due to financial difficulties. I know several Family Medicine Physicians who are unable to recruit new physicians to join them, despite, by all accounts, having model practices. Those physicians who work in the public “safety net” system are feeling more beaten down than ever and, because of financial cutbacks, are watching their patients experience access issues like never before. As a program director, I watch my brand-new doctors enter residency with $160,000 in debt, joining a specialty in a state where pay has stagnated.

A 2007 article in the *Annals of Internal Medicine* cited income disparities between Family Physicians and other specialties that are not explained by differences in hours worked. In 2004, 15 percent of Family Physicians earned less than $100,000 a year, whereas 20 percent of invasive cardiologists, 25 percent of neurosurgeons and 14 percent of orthopedic surgeons earned more than $600,000 a year. While I don’t begrudge our specialist colleagues for their income, or fail to see the education and training that went into their professional life ... this gap is actually a sinkhole. This income gap becomes really important when our graduating residents (and practicing physicians) find themselves both paying off medical school debt and a mortgage while trying to put food on the table.

Through the CAFP, I believe we are making efforts and real progress addressing some issues of major concern. This year, we have worked both with the Colorado Medical Society and independently on legislative action around patient safety, seeking to address the horrible malpractice climate affecting many of our members. We are working to address limitations on the ability of Family Physicians (and physicians in general) to raise capital through efforts to reform laws governing the “Corporate Practice of Medicine.” We are supporting efforts to expand loan repayment for our new graduates and looking at additional options that might be available to help struggling physicians in other situations. We are supporting efforts around other patient safety initiatives, including the expansion of the Skolnic Act to all health professionals. This action is based on the assumption that transparency in education, among other things, sells our specialty in comparison to other purported “experts” in primary care that claim to practice Family Medicine with only limited clinical experience by comparison. (After all, as board-certified Family Physicians, we have approximately 14,000 hours of clinical education that we bring to the table.)

Through Scott Hammond, MD, and his great efforts around the Patient Centered Medical Home, we are exporting a model of team-based, integrated care that’s serving as a rallying call around health care reform. Mixed in that rallying call are attempts to pressure the American Medical Association and the American Academy of Family Physicians to reform the Relative Value Upscale Committee, also called “the RUC,” and a national call to end insurance monopolies of pricing and aggressive behavior through a call to eliminate their antitrust exemption.

That’s powerful stuff, and it helps motivate me to fight onward. But what else keeps me going? First, the specialty itself: In this two-week period, I will find myself in didactic lectures on gynecology, both learning about and performing obstetric ultrasound, doing minor procedures, delivering babies into this world, caring for elderly patients in the hospital and doing all manner of things in the care of patients. No other specialty can match the breadth or the intellectual challenge of managing such disparate tasks and conditions through care that is so patient centered. Also ... our specialty is portable. Whether in the hospital, where the MRI machine downstairs is at the ready, or at an aid station in Afghanistan, with a stethoscope in hand, I have felt in my element. We’re not dependent on the cath lab, the X-Ray machine, or the Da Vinci machine to keep things interesting and rewarding.

Second, my patients keep me going. That bond is tough to define but underlies everything we do.

Third, new physicians keep me going. I am lucky to work with medical students and residents who have bucked the odds and ended up in Family Medicine through a continuing desire to take care of patients. They have chosen Family Medicine despite going to a medical school that lacks a department of Family Medicine. They have ignored the “advice” that they are smart and should go into a subspecialty. They have embraced the knowledge of a mountain of debt and still soldier on. They most often tell me that they just can’t imagine spending their life any other way.

On behalf of your academy, I thank you for your service to our profession and to your patients. We’ll continue to work diligently on your behalf. See you in Colorado Springs!

Sincerely,

Brian Bacak, MD, FAAFP
President, Colorado Academy of Family Physicians
The Colorado Academy of Family Physicians has much to celebrate, thanks in large part to members who are active in steering Family Medicine into the future. In addition to several successes in support of the Patient Centered Medical Home, members and staff are leading advances in areas ranging from childhood obesity to tort reform. Active membership is at an all-time high.

CAFP WARRIORS
CAFP Board leaders are working with admirable altruism and enviable influence on behalf of all Colorado Family Physicians. They have become like CAFP warriors, tirelessly meeting, talking, arguing, presenting, and fighting for all that’s best for Colorado patients.

• Brian Bacak, MD: Work force Collaborative
  Dr. Bacak, CAFP Board president, has represented the CAFP on issues involving the primary care work force in Colorado. He has argued for additional funding for residency training, payment reform, loan repayment programs, and the physician-led integrated team model of the PCMH.

• John Bender, MD: Financing for Family Physicians
  Because of the strong efforts of Dr. Bender, CAFP Board chair, the CAFP introduced legislation (HB 1244) regarding the corporate practice of medicine and transfer of practice ownership.

• Scott Hammond, MD: Patient Centered Medical Home
  As a CAFP Board member, chair of the CAFP PCMH task force and medical director of the Systems of Care PCMH Grant, Dr. Hammond has continued to educate primary and specialty care physicians on how to set up medical homes and medical neighborhoods. His practice, recognized by the National Committee for Quality Assurance as a PCMH Level 3 practice, serves as an example in the delivery of patient care.

• Bob Brockmann, MD: Patient Safety and Tort Reform
  Dr. Brockmann, CAFP Board member-at-large and member of the CAFP legislative committee, met with attorneys and legislators to ensure that the wording of the Patient Safety Bill (HB 1283) was good for Family Physicians and patients. The bill is one step toward reforming the medical malpractice environment in Colorado.

• Luke Casias, MD: Childhood Obesity
  Two years ago, Luke Casias, MD, currently the CAFP Board president-elect, set the CAFP in the direction of working on pediatric obesity. The CAFP submitted a grant to The Colorado Health Foundation to help Family Physicians implement systems of care and protocols in their offices so that they can help families with pediatric obesity issues. Stay tuned for more on this pilot program.

CAFP Has Many Reasons to Celebrate
CEO encourages more members to join ranks of CAFP warriors

CAFP CEO REPORT
by Raquel Alexander, MA, CAE

PCMH GRANT PHASE II APPROVED
Through its collaboration with the Colorado Medical Society, Colorado Chapter of the American Academy of Pediatrics, Colorado Clinical Guidelines Collaborative and Colorado Society of Osteopathic Medicine, the CAFP received funding from The Colorado Health Foundation to continue its work educating CAFP members on the PCMH. CAFP Resource Advisor Angel Perez is available now to make presentations to practices on the basics of setting up a PCMH.
PARADE OF MEDICAL HOMES
The CAFP initiated its Parade of Medical Homes by offering a guided tour of the Westminster Medical Clinic, an NCQA PCMH recognized practice. Members who would like to see a medical home in action may sign up with Angel Perez.

CAFP BEST PCMH PRACTICE AWARD
The Westminster Medical Clinic received the first CAFP Best PCMH Practice Award. Congratulations to Scott Hammond, MD, and the staff.

COPIC RECOGNIZES VALUE OF PCMH
The insurer Copic has begun providing experience rating system points for practices that achieve PCMH recognition by the NCQA. The points are allocated according to the recognition level.
• 2 ERS Points for NCQA PCMH Level 1
• 4 ERS Points for NCQA PCMH Level 2
• 6 ERS Points for NCQA PCMH Level 3
Twenty-five physicians have applied for the points, and I can provide form for others interested in applying.

SAM TRAINING
CAFP held the first self-assessment module training in our conference room. Twenty-six Family Physicians attended and were able to complete their asthma SAMs. Thank you to Kern Low, MD, and Martha Illige, MD, for teaching the course.

MEDICAID REFORM
Kent Voorhees, MD, CAFP past president, continues to chair the Colorado Medicaid Reform Task Force. Sandeep Wadhwa, MD, Medicaid medical director, on speaking about Accountable Care Collaboratives, stated: “Our plan is to leverage existing medical home relationships.” The ACC first phase will be launched in November.

CALL TO ACTION
I would encourage other members to join the ranks of the warriors for Family Medicine. Those who would like to help determine the future for Family Physicians may contact me to learn about options for participation.

CAFP MEMBERSHIP
CAFP membership continues to increase as indicated by the charts below. The number of active members is currently 1,388, the highest it has ever been.

CAFP ACTIVE MEMBERS

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<th>Year</th>
<th>1,500</th>
<th>1,388</th>
<th>1,250</th>
<th>1,100</th>
<th>950</th>
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Source: http://chapters.aafp.org

CAFP MEMBERSHIP GROWTH

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Members</th>
</tr>
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<tbody>
<tr>
<td>1998</td>
<td>578</td>
</tr>
<tr>
<td>2000</td>
<td>825</td>
</tr>
<tr>
<td>2002</td>
<td>1,388</td>
</tr>
</tbody>
</table>

Source: http://chapters.aafp.org

CAFP LEGISLATIVE REPORT
By Katie Mason and Jeff Thormodsgaard

The Opening Day of the Second Regular Session of the 67th General Assembly has come and gone. On Jan. 13, both bodies welcomed new faces — Senator Mike Johnston (D-Denver), Senator Pat Steadman (D-Denver), Senator Bruce Whitehead (D-Archuleta), Representative Daniel Kagan (D-Denver), Representative Max Tyler (D-Golden, Lakewood), and Representative Brian DelGrosso (R-Loveland). It wasn’t long before they started committee work and got down to business.

We are approximately 50 days into the session, and fortunately it shows. The General Assembly has introduced 535 pieces of legislation, and the governor has warmed up his legislation signing pen. Numerous bills pertaining to removing tax exemptions and supplementing the budget are before the governor for his signature.

The budget continues to be a major issue. While most of the FY 2009-10 bills are moving to the governor’s desk, we have yet to see what is fully in store for FY 2010-11. For FY 2010-11, the governor must address a shortfall of over $1.02 billion. The balancing techniques include the avoidance of $255.6 million increases to the base budget, reduction of General Fund expenditures totaling $708.6 million, and modifications and suspensions of $131.8 million in tax exemptions and credits.

The CAFP Board and Legislative Committee have been busy taking policy positions on a myriad of health care legislation. Top priorities for CAFP include required coverage for reproductive services, medical orders scope of treatment, offering premium incentives to employers whose employees participate in wellness programs and tying the premium reduction to the outcome, improved readability and conformance in insurance policies,
forms, and benefits explanations, clean claims, corporate practice and patient safety.

The following are summaries of some of the top issues:

**Corporate Practice of Medicine:**
HB12 sponsored by Representatives Labuda, Apuan, Casso, Curry, Frangas, Gagliardi, Murray, Riesberg, Scanlan, Schafer S., and Soper, and Senator Mitchell

This bill allows the surviving spouse or designated beneficiary of a person licensed to practice medicine who is a shareholder in a professional service corporation to become a shareholder of the corporation if the physician shareholder dies. The bill specifies that when the surviving spouse or designated beneficiary ceases to be a shareholder, provision is made for the shares to be reacquired by the corporation or by a person actively practicing medicine in the offices of the corporation. This bill would allow the surviving spouse or designated beneficiary to be a shareholder for up to three years.

**Patient Safety:**
HB1283 sponsored by Representatives Riesberg, Balmer, Curry, Frangas, Kefalas, Massey, McNulty, Priola, Rice, Roberts, Schafer S., Soper, Todd, Vaad, and Senators Sandoval, Hodge, Keller, Penry, Spence, White, and Williams

The Patient Safety Bill addresses physician qualifications for licenses by attesting to a plan for ongoing professional development to obtain licensure. It also requires that physicians document participation in ongoing professional development activities to maintain licensure and provides protections for records of such activities. The bill also defines failure to comply with ongoing professional development requirements as unprofessional conduct. Language within the bill provides an exception to the restriction on mandating continuing medical education as necessary to comply with ongoing professional development requirements. Finally, the bill creates the “Patient Safety Act” which requires that health care providers verify employment history of health care worker applicants, that employers provide information to prospective employers about health care worker impairment, patient abuse, and violent crimes, and that the Joint Health and Human Services Committee identify statewide professional associations of health care providers to conduct, or compile data on, demonstration projects exploring alternatives to litigation for redress of adverse medical events. The act also allows for protected communications with patients and other interested persons as part of health care quality assessments, and sharing of health care information among certain health care providers without waiving the confidentiality or privilege of the information.

continued on next page
Required Coverage for Reproductive Services HB1021

The bill from the Health Care Task Force requires entities issuing individual sickness and accident insurance policies in this state to provide the same coverage for maternity care as is currently mandated for all group sickness and accident insurance policies. The bill also requires both individual and group policies to provide coverage for pregnancy management, including contraceptive counseling, drugs, and devices. The bill excludes abortion procedures and services from pregnancy management.

Screening Brief Intervention and Referral to Treatment HB1033

This bill also came from the Health Care Task Force. The bill adds to the list of optional services provided to Medicaid recipients screening, brief intervention, and referral to treatment for alcohol and other substance abuse services.

Colorado Health Services Corps HB1138

The bill changes the name of the state health care professional loan repayment program to the Colorado Health Services Corps (health services corps), the name of the health care community board to the Colorado Health Services Advisory Council, and the name of the health care professional loan repayment fund to the Colorado Health Services Corps Fund. Contracts for health care professional loan repayments entered into by Collegeinvest or the Primary Care Office in the Department of Public Health and Environment (primary care office) under the prior name of the program are still valid obligations.

The bill specifies the manner in which the health services corps may make a lump sum payment on an eligible professional’s education loans pursuant to a contract. The bill exempts the selection of health care professionals from the competitive bidding requirements of the procurement code. The bill repeals the $35,000 per year limit on the amount of education loan repayment that a health professional may receive under the health services corps.

Other Bills of Interest:

Health Care Reform
Childhood Immunizations
Tobacco Cessation and Education

Public Health

Primary Care Workforce

Patient Safety Tort Reform

Preventive Health Care

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

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

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

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

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

Are contributions tax deductible? Unfortunately, no. Because contributions support political candidates, the IRS will not allow a tax deduction.

Detach here and send contribution to:
CAFP, 2224 S. FRASER ST. UNIT 1, AURORA, CO 80014

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

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

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

Learn more–

www.FuelUpToPlay60.com

The Colorado Academy of Family Physicians Foundation in January named the Westminster Medical Clinic the PCMH Best Practice of 2010. The purpose of the award, which was given for the first time this year, is to encourage Family Physicians to create medical homes and to recognize excellent systems of care.

R. Scott Hammond, MD, a physician at Westminster Medical Clinic, hopes the award will inspire others to create medical homes in their practices. “The changes we have made have benefited everyone involved – the doctors, staff members from physician’s assistants to receptionists, specialists and, most importantly, our patients,” he said. “I feel the PCMH is the key to survival of Family Physicians.”

The nomination application submitted by Dr. Hammond serves as a concise guide to the medical home model. Highlights of the nomination include the following:

Certification
The National Committee for Quality Assurance recognized Westminster Medical Clinic as a Level 3 Patient Centered Medical Home in 2009.

Physicians
In addition to Dr. Hammond, other doctors at the clinic are Robin Smith, DO, and John J. Ford III, MD. All of the physicians have been active in the medical and general communities. Dr. Ford was the 2001 CAFP Physician of the Year, and Dr. Hammond has been a tireless PCMH advocate. A CAFP Board member, he chairs the academy’s Medical Home Task Force, serves on the group’s PCMH speaker’s bureau and initiated and edits the CAFP’s Medical Home newsletter. Dr. Smith is very active with the Colorado Society of Osteopathic Medicine and served as president of the society.

Letters of Patient Support
As a member of the Patient Advisory Committee of the PCMH Pilot Project, Freda Koff is particularly qualified to comment on the clinic’s success as a medical home.

She wrote, “The practice’s involvement in the Patient Centered Medical Home project has added tremendous value to me as a patient. Being able to access my medical records online saves me valuable time and keeps me informed about my health. I especially like the ability to send e-mails to Dr. Hammond and receive quick answers to routine health questions. This reduces costs for me and avoids unnecessary medical appointments.”

continued on page 12
Department of Family Medicine--HSC
Assistant Professor, Faculty
Rose Family Medicine Residency
Job Posting # 809100
Position # 610234

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

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

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

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

Applications are accepted electronically at www.jobsatcu.com. Review of applications will begin February 16, 2010 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.”
“I am an active participant in my health care through the Patient Centered Medical Home. Dr. Hammond provides me with all of the options and pros and cons of various treatments or drugs, and together we make a decision about my medical health. Dr. Hammond is especially good at listening carefully to my questions or concerns. I never feel he is rushing me. Dr. Hammond is always amenable to referring me to a specialist when that is necessary; although, most of the time, he is able to manage my health care on his own.”

Similarly, Patrick E. Almdale wrote, “Your clinic is the first one where I have received such thorough and complete care while allowing me to share in the decision-making process.” Almdale also expressed appreciation for the clinic’s web site, the home blood pressure monitor and patient surveys. He said these things and others show the practice is “dedicated to prevention as well as treatment for my family.”

Another patient, Tricia Morris, wrote, “The personal care and attention by all staff members has been consistently outstandingly very great!”

Patient Satisfaction Surveys
The clinic conducted three surveys in the year before the nomination was submitted. One explored patient capability and interest in use of the Internet and e-mail for communication with the clinic. Another asked patients to rate such items as whether they received care right away and whether the staff was helpful. The third looked into how the clinic could improve patients’ experiences at the office.

Dr. Hammond said that information gathered by the surveys will be used to implement improvements, and the effectiveness of the improvements will be measured in future surveys.

Recommendations of Specialist Support
Donald Thompson, MD, president of Rocky Mountain Cardiovascular Associates, wrote that Dr. Hammond “has spent considerable efforts in educating my practice in this concept and is passionate regarding its potential benefit. We believe this process will improve efficiency and save time and health care costs by establishing expectations of communication and areas of responsibility for patient care.”

Alvin Otsuka, MD, of Rocky Mountain Cancer Centers in Thornton, also wrote a letter of support.

External QI Projects and Recognition
This category included ongoing participation in Improving Performance in Practice since 2006, as well as projects focused on specific diseases. NCQA recognized the clinic in both diabetes and cardiovascular disease.

Listed as internal quality improvement activities were a Diabetes LDL improvement project, training of medical assistants in delivering preventive care to diabetic patients and DARTNet participation to conduct practice-based research. The clinic follows guidelines of the U.S. Preventive Services Task Force for screening all patients.

Results of Practice Measures for Three Important Conditions
The nomination included graphs reflecting extensive data that had been gathered based on patients in the practice. The conditions that were monitored and measured included diabetes, hypertension and the metabolic syndrome.

Dr. Hammond explained that these evidence-based measures help with population management, which goes hand-in-hand with improved care for individual patients.

Care Management and Patient Education
Westminster Medical Clinic addresses seven issues through group education, care management strategies or other measures. For example, an education program dubbed Diabetes University consists of 13 sessions directed by a physician’s assistant. The mental health clinic incorporates depression guidelines of the Colorado Clinical Guidelines Collaborative, while the hypertension clinic reflects American Hospital Association guidelines. Other issues addressed include warfarin use, weight management and pain management.

Demonstration of Planned Team Care
The clinic holds daily huddles and weekly care coordination meetings, and steps have been taken to assure continuity and coordination of care for hospitalized patients. Standing orders streamline care where they are appropriate. The practice has harnessed technology to provide effective evidence-based population management.

Summary of Community Activities and Outreach
Westminster Medical Clinic has hosted many visitors interested in observing PCMH operations. In addition, community event participation by 13 staff members have ranged from walks, runs and races for diabetes, cancer and cystic fibrosis to grocery shopping for the elderly and fundraising for Veterans of Foreign Wars.

Miramont Family Medicine in Fort Collins ran a close second to the Westminster Medical Clinic.

Elizabeth Kraft, MD, president of the CAFP Foundation, wrote to John Bender, MD, that, “The CAFP Foundation Board of Trustees had a very hard time determining the winner. Your practice is outstanding, and the services you provide for your patients are commendable.”

Dr. Kraft recommended that Dr. Bender apply again for the award in 2011.
Judy Hewitt, practice manager for Belmar Family Medicine in Lakewood, can’t say enough about the value of getting patients connected to the Healthier Living Colorado program. But making that link as a part of an overall patient self-management support overhaul ended up being a longer journey than she might have originally anticipated.

What it was like in the beginning

Health care professionals talk about being patient-centered, but the realities faced in making challenging transformative changes force unfortunate interdependencies. Sometimes these unforeseen requirements create a sense that progress is slowed beyond what’s warranted by the desired change — good grief, I just want to get this patient self-management support stuff under way! Belmar Family Medicine, recently recognized by the National Committee for Quality Assurance as a Level 3 Patient Centered Medical Home under the physician leadership of Tracy Hofeditz, MD, has learned that even just recruiting patients to participate in the Healthier Living Colorado self-management support sessions required more substantive change than handing patients informational brochures about the program.

Effective patient self-management support, which is foundational to transformation into a medical home that is truly patient-centered, often requires a shifting of both the operational paradigm and practice habits. Early on, prior to beginning work on becoming an NCQA-recognized medical home, Hewitt recalled that patient self-management support took on a relatively low-key role at Belmar.

“Patient self-management support pretty much involved only the provider and consisted of telling the patient about diet, exercise, and possibly counseling. Sometimes the providers would hand the patient a specific diet plan,” Hewitt said. “It was always so frustrating for the physicians … It took extra time that they didn’t have, and the patients would come back time and time again without having made any changes. It’s hard because medicine hasn’t quite gotten it yet that it is near impossible for patients to make major life changes based on a few recommendations made during a 15-minute office visit.”

Healthier Living Colorado, the in-state equivalent of Stanford’s evidence-based Chronic Disease Self-Management Program, is licensed and sponsored through a unique private-public partnership between the Colorado Department of Public Health and Environment and the Consortium for Older Adult Wellness. Its six-week series of peer-led sessions on self-management support helps patients learn and practice skills necessary for problem solving and action planning around managing health-related issues common to having a chronic illness. In addition, the sessions prepare participants for actively engaging with the health care team in the management and care of their chronic illnesses.

“Because of my background in communication instruction, I see the huge value that gathering patients together for experiential learning in communication and problem solving in a peer support setting has for a practice that is working on patient self-management support and becoming truly patient-centered,” Hewitt explained. “The low cost, nearby location and available resource to support the referral process made this seem like a perfect fit for us to try out. I was a champion for this to work at Belmar from the get-go.”

Barriers and stumbling blocks

Even with that understanding, a lot has occurred at Belmar that has contributed to making this work. As happens in most cases, to change one thing, a few other antecedent changes ended up being necessary. And then some changes that weren’t originally anticipated ended up needing to follow as well. Dr. Hofeditz whole-heartedly has supported becoming a Patient Centered Medical Home from day one. And he easily latched onto a conceptual understanding of the need to shift to true patient self-management support (from patient self-management recommendation). However, he continued to run into the brick wall of not having enough time to be able to add even just handing out a brochure and inviting patients to consider participating.

“When you look at it,” Hewitt commented, “they [the physicians] still in their minds have the same amount of time to work with the patients — and adding one more thing translates into the question of what other more clinically important piece of care do I need to eliminate in order to get this into my visit with them or have a conversation around self-management with them. And it wasn’t like the staff had any extra time either.”

Things that have contributed to making it work here at Belmar

Some of the paradigm shift that needed to happen was possibly primed by Hewitt’s facilitation of all-staff (including provider) communication and listening training, which took place before the decision to start the medical home journey. In addition to the training, Belmar has made regular and frequent team communication a longstanding priority, with daily morning “PIT (patients, internal appointments and tasks that need addressing) Stop” huddles among the entire office team.

With a healthy communication dynamic in place, there were remaining interdependent issues that still needed to be addressed to do justice to operationalizing the shift in paradigm. Not enough time and capacity still continued to be very real barriers. The breakthrough came when Belmar was able to use some of the care management funding it was receiving as a NCQA-recognized medical home pilot practice to support the promotion of Medical Assistant Pam Hohnstein to the role of full-time care coordinator.

Well loved by the patients, Hohnstein provides between-visit outreach based on the practice’s Physician Health Partners recommendations. during
istry reports, as well as follow-up with patients at the end of their visits. The follow-up is based on issues Hohnstein and Dr. Hofeditz identify during pre-clinic huddles earlier in the day. This end-of-visit process is still being built, but currently they use a laminated checklist. He completes the checklist to convey to her which additional follow-up discussions she needs to have with the patient before the patient checks out, including information about labs, tests, medications or the need for referral to the Healthier Living Colorado program.

Hohnstein has enthusiastically embraced the Healthier Living Colorado program, having just completed it herself, along with the patients from Belmar who were in her class. She can now speak about it from her own personal experience and tell what participating has meant to her.

Hewitt commented that having a PCMH coach help Belmar change some habits has been extremely instrumental in the practice’s success. The providers and staff are excited with the progress that has been made with all of these changes and with their fine-tuned communication skills. They are looking forward to engaging with those patients who have been through skill-building self-management sessions in a new and satisfying way.

“This has been a lot of work, and by no means are we done,” Hewitt said. “But to know what these sorts of changes mean to the patients – now that is really gratifying and makes all this worthwhile.”

Additional information about incorporating the Healthier Living Colorado program into patient self-management support practice improvement efforts is available by notifying a Colorado Clinical Guidelines Collaborative Improving Performance in Practice coach or by contacting Lynzy McIntosh at (303) 475-2183.

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Cavity Free at Three

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Karen Savoie, RDH, BS
Director of Education
karen.savoie@ucdenver.edu
303-724-4750

Susan Evans
Program Director
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To order toothbrush and fluoride varnish kits, contact:
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Bayaud Enterprises
(303) 830-6885 x212

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ACOs - FRIEND OR FOE?
By Ken Bertha, MD, FAAFP

Throughout the health care reform debate in Congress, all of the proposed bills have contained provisions for promoting development of Accountable Care Organizations, commonly called ACOs. So, what is an ACO? Will ACOs be good for patients? Are ACOs a positive step in the right direction for Family Physicians and other primary care physicians?

At the core, this proposed care model is a means by which physicians and other health care providers are part of a network responsible for quality and certain components of the cost of care for defined patient populations. An ACO is dependent upon a strong foundation of primary care. Ideally, this foundation is based upon the Patient Centered Medical Home model of care. From this perspective, the ACO can be thought of as the “medical home neighborhood” aligning the goals and incentives of non-primary care physicians and other providers with those of a network of PCMH practices.

Federal health care reform efforts in the U.S. are focused on increasing health insurance coverage, improving quality and controlling cost. From a health care reform perspective, the ACO model of care is aimed at cost and quality. The main goal of the ACO model is to reduce health care cost, or at least bend the cost curve down while at the same time improving clinical quality and patient satisfaction. An ACO is NOT a health maintenance organization, as it does not accept insurance risk—the risk of whether a patient who is part of the defined ACO population is sick or well.

Accountable care organizations can have various structures to fit the environment in which they function. These include:

• A collection of primary care practices working together through an Independent Practice Association (IPA) or other organizational structure
• A collection of primary care practices and non-primary care specialists working together through an Independent Practice Association (IPA) or some other organizational structure
• A clinically integrated system of primary care practices, non-primary care specialists and hospitals working together though an integrated delivery system (all physicians employed) or through a physician-hospital organization (PHO) of independent providers who are clinically integrated
• Physician and non-physician health care providers, public health agencies, social service organizations and other community organizations working jointly to improve health care for a broad patient population.

Elliott Fischer, one of the pioneer proponents of ACOs, supports the concept of virtual ACOs as long as three key ACO elements are supported:

• Local accountability for quality and per capita cost for the local patient population
• Standardized performance measurement
• Payment reform that transitions payments from encouraging volume and procedures to increasing quality outcomes and value (quality/cost).

The concept of a virtual ACO is particularly important for small- and medium-sized independent practices, especially those located in more rural areas. Formation of virtual networks of practices with infrastructures that can support data sharing and the collection of quality measures across practices will be a requirement for ACO formation.

ACOs will not happen overnight. Just like PCMH practice transformation, the medical home neighborhood transformation to an ACO model will require well organized planning, decision making and implementation under strong physician leadership. Most importantly, the foundation of the ACO care model is effective Family Medicine (primary care) emphasizing access to care, continuity of care, comprehensiveness and coordination. Harold Miller, in his white paper How to Create Accountable Care Organizations, identifies eight prerequisites for primary care practices to participate in ACOs:

• Complete and timely information about patients including the services they are receiving
• Technology and skills to support population management and coordination of care
• Adequate resources for patient education and self-management support
• A culture of teamwork in the practices
• Coordinated relationships across all practices, specialties and providers
• The ability to measure and report on quality of care
• Infrastructure and skills for management of financial risk
• A commitment by senior leadership to improving value as a top priority backed by a system to drive improved performance.

Effective and sustainable accountable care organizations cannot happen without significant payment reform. Since primary care is foundational to the ACO, the blended payment model—combining fee-for-service, care management fees and outcomes-based payments—is critical to the support of primary care within the ACO model. In addition to the blended payment model for primary care, the overall ACO payment structure should support several goals:

• Baseline payment that adequately covers the expected costs of the defined population
• Avoidance of penalties for taking on sicker patients or experiencing “adverse selection”
• Flexibility to deliver the right services at the right time in the right place
• Enhancement of ACO profitability for keeping its population healthier (relative to baseline) or reducing unnecessary services
• Enhanced payments for higher quality care and encouragement of patients to become engaged and seek out higher quality care.

A mature ACO system might thrive under a global payment model, as long as it avoids the pitfalls of traditional capitation. But developing ACOs should avoid global payments and look toward transitional payment models including combinations of shared savings, episode-of-care payments and hybrid models (partial comprehensive care payments with bonuses based on quality outcomes continued on next page
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and savings). Most importantly for primary care physicians, the ACO payment model must effectively set levels of “internal” physician payments that recognize the dependence of ACO success on a strong foundation of primary care and PCMH practices. (See Table 1 for a comparison of payment models.)

In late summer 2009, the American Academy of Family Physicians Board of Directors appointed a task force to study ACOs, especially from the perspective of small- and medium-sized Family Medicine practices. The ACO Task Force defines an ACO as “a primary care-based collaboration of health care professionals and health care facilities that accept joint responsibility and accountability for the quality and cost of care provided to a defined patient population.” The task force developed a series of ACO principles aimed primarily at small- and medium-sized Family Medicine practices considering participation in or development of an ACO. Key principles include:

• The core of the ACO is accessible, team-based primary care such as the PCMH.
• ACOs require strong physician leadership and a true partnership among all participants.
• A clinically integrated information system for point-of-care decision making is ultimately required.
• The ACO encourages continuous innovation to identify and implement best patient care practices.
• Organization structure and payment reform should be implemented in an incremental manner and monitored closely to prevent “unintended consequences.”
• The ACO should strive to incentivize active patient participation in health and wellness decision making.
• Changes to antitrust regulations and to Stark self-referral regulations likely will be needed to allow full participation of physicians, especially those in small- and medium-sized independent practices.
• Payment models must align mutual accountability and evolve over time as the ACO model transitions.
• The ACO should be financially rewarded based upon a combination of absolute standards, relative performance and improvement.
• Primary care and the PCMH model should be supported by blended pay-

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Accountable Care Organization (Shared Savings)</th>
<th>Primary Care Medical Home</th>
<th>Bundled Payments</th>
<th>Partial Capitation</th>
<th>Full Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General strengths and weaknesses</strong></td>
<td>Makes providers accountable for total per-capita costs and does not require patient “lock-in.”</td>
<td>Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs</td>
<td>Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs</td>
<td>Provides “upfront” payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients</td>
<td>Provides “upfront” payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient “lock-in” and may be viewed as too risky by many providers/patients</td>
</tr>
<tr>
<td><strong>Strengthens primary care directly or indirectly</strong></td>
<td>Yes – Provides incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians</td>
<td>Yes – Changes care delivery model for primary-care physicians allowing for better care coordination and disease management</td>
<td>Yes/No – Only for bundled payments that result in greater support for primary-care physicians</td>
<td>Yes – Assuming that primary care services are included in the partial capitation model allows for infrastructure, process improvement, and a new model for care delivery</td>
<td>Yes – Gives providers “upfront” payments and changes the care delivery model for primary-care physicians</td>
</tr>
<tr>
<td><strong>Fosters coordination among all participating providers</strong></td>
<td>Yes – Significant incentive to coordinate among participating providers</td>
<td>No – Specialists, hospitals and other providers are not incentivized to participate in care coordination</td>
<td>Yes (for those within the bundle) – Depending on how the payment is structured, can improve care coordination</td>
<td>Yes – Strong incentive to coordinate and take other steps to reduce overall costs</td>
<td>Yes – Very strong efficiency incentive</td>
</tr>
<tr>
<td><strong>Removes payment incentives to increase volume</strong></td>
<td>Yes – Adds an incentive based on value, not volume</td>
<td>No – There is no incentive in the medical home to decrease volume</td>
<td>No outside the bundle – There are strong incentives to increase the number of bundles and to shift costs outside</td>
<td>Yes/No – Strong efficiency incentive for services that fall within the partial capitation model</td>
<td>Yes – Very strong efficiency incentive</td>
</tr>
<tr>
<td><strong>Fosters accountability for total per-capita costs</strong></td>
<td>Yes – In the form of shared savings based on total per-capita costs</td>
<td>No – Incentives are not aligned across provider, no global accountability</td>
<td>No, outside the bundle, no accountability for total per-capita cost</td>
<td>Yes – Strong efficiency incentive for services that fall within partial capitation</td>
<td>Yes – Very strong accountability for per-capita cost</td>
</tr>
<tr>
<td><strong>Requires providers to bear risk for excess costs</strong></td>
<td>No – While there might be risk-sharing in some models, the model does not have to include provider risk</td>
<td>No – No risk for providers continuing to increase volume and intensity</td>
<td>No – Only for services inside the partial capitation model</td>
<td>Yes – Providers are responsible for costs that are greater than the payment</td>
<td>Yes – Services outside the partial capitation model</td>
</tr>
<tr>
<td><strong>Requires “lock-in” of patients to specific providers</strong></td>
<td>No – Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers</td>
<td>Yes – To give providers a PMPM payment, patients must be assigned</td>
<td>No – Bundled payments are for a specific duration or procedure and do not require patient “lock-in” outside of the episode</td>
<td>Yes (for some) – Depending on the model, patients might need to be assigned to a primary-care physician</td>
<td>Yes – To calculate appropriate payments, patients must be assigned</td>
</tr>
</tbody>
</table>


For those of you that have requested the ACO article written by Ken Bertka, MD, and are considering running it in your publication, please make sure that the accompanying table is appropriately attributed to Dartmouth and Brookings. I just spoke with Emily Carnahan at Dartmouth, and she has indicated that other AAFP state chapters may also reprint the table with the appropriate credit. She also has requested that she be sent the published articles that the table appears in.

Her contact information:
Emily Carnahan, Health Policy Fellow, The Dartmouth Institute for Health Policy & Clinical Practice
35 Centerra Parkway; Lebanon, NH 03766
603-653-0821; Emily.A.Carnahan@Dartmouth.edu

References

Dr. Bertka is a Family Physician in Toledo, Ohio, and a member of the AAFP Board of Directors. He served as chair of the AAFP Accountable Care Organization Task Force.
While the fate of federal health care reform is unclear, the national discourse has crystalized some things for the general public and policy makers. Health care costs must be better controlled, and providing more coordinated patient care is imperative. How the medical community responds to this call to action may profoundly affect how care is delivered in Colorado and the nation in the future.

Last fall, Colorado physicians were surveyed to understand and develop strategies to address these issues as part of the Colorado Medical Society/Specialty Society Systems of Care/Patient Centered Medical Home Initiative. This two-year grant program funded by the Colorado Health Foundation seeks to improve systems of care by supporting physicians in establishing medical homes and building integrated medical neighborhoods. The initiative represents a collaboration among CMS, Colorado Academy of Family Physicians, Colorado Society of Osteopathic Medicine, Colorado Chapter of American Academy of Pediatrics, Colorado Chapter of the American College of Physicians and Colorado Clinical Guidelines Collaborative. A multi-disciplinary steering committee, comprising primary and specialty care leaders from more than 10 specialty societies, directs the work of the initiative to meet physicians where they are and provide resources to meet the demands of this changing world of health care.

Medical Home Community Landscape

A statewide survey of 10,725 practicing physicians in Colorado was conducted last year to assess perceptions and barriers to becoming or working with medical homes. Almost 750 physicians completed the survey; 57 percent were primary care and 43 percent were specialty care. Results indicate a broader interest and readiness in medical home models than originally anticipated, with 72 percent of primary care physicians and 76 percent of specialists embracing care delivery models that promote coordinated, patient-centered care (figure 1).

Polling results confirm that both primary care physicians and specialists are motivated to find better ways to care for patients and experience similar barriers and pain points promoting several medical home concepts by focusing on engaging patients in their own care, coordinating care at key transition points and working with registries of clinical data. An important finding is that Colorado specialists, unlike their counterparts in other states, generally do not perceive the medical home as a direct threat to referrals or related practice economics — this crucial distinction, if confirmed, puts Colorado ahead of the national curve in building medical homes and medical neighborhoods.

Systems of care construction

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of an effective medical home, and the poll shows that there is still a long way to go to achieving its widespread use. According to poll results, currently only 25 percent of primary care physicians and 17 percent of specialists have fully integrated electronic health record systems. Both primary care physicians and specialists expressed concern about the funding and staffing commitments required to make the practice transformations necessary to become medical homes and work in coordinated systems. Low levels of satisfaction with communication and care coordination with fellow physicians offers both a barrier and an opportunity to building integrated systems. As one physician survey respondent noted, “It’s not about software, it’s about complicated relationships.”

Physician leaders from around the state took this survey data, along with information from three focus groups, and gathered at a two-day physician summit in late October to develop an action plan and communication strategy to drive the creation of medical homes and medical neighborhoods. The following directives for the initiative were developed:

- Simplify the message and create a coordinated approach;
- Provide education and resources to physician practices to support actionable steps around medical homes/neighborhoods;
- Focus on improving physician culture and communication; and
- Support policy changes that advance medical home and medical neighborhood models like payment reform and health information exchange/HIT.

**What does this mean for me?**

The SOC/PCMH initiative is using the results of the polling data to identify barriers and opportunities and to craft evidence-based resources to help physicians make informed choices about their participation with medical homes and other systems of care. While the survey research suggests a broad conceptual understanding of PCMH, focus groups and discussion at the practice level also indicate that most physicians don’t understand the mechanics and practical aspects of becoming or linking to a PCMH. There is very likely an underlying skepticism about the short-term economic viability of becoming a medical home.

**Building medical homes:** At an individual practice level, the grant provides the opportunity to connect interested practices with resource advisors to help them start the medical home journey. Resource advisors from CAFP, CSOM and CMS have combed through available services, programs and literature to offer physicians a practical toolkit to help make evidence-based decisions about medical homes. Physician education programs will provide an overview of how to translate medical home principles into everyday practice through webinars, presentations and mentoring programs. Physicians will also have opportunities to learn from their peers by seeing certified medical homes in action at various Parades of Homes.

**Building medical neighborhoods:** Primary care medical homes cannot survive without medical neighborhoods of specialists. Promoting system integration between primary care and specialty care is a critical objective for the initiative. Figure 3 illustrates that primary care physicians and specialists do not receive adequate information from one another during the patient referral process. Primary care physicians report that they receive information back from specialists on patient referrals only 51 percent of the time, while specialists report that they receive the necessary information on only 35 percent of referrals. The survey also highlights very low levels of satisfaction with communication with other facilities (15 percent and 21 percent respectively).

A key take-away from the summit and the poll is that practice constraints and loss of personal relationships adversely impact patient care by impeding effective hand-offs and clinical communication. However, 78 percent of specialists are very or somewhat willing to meet with primary care physicians interested in becoming medical homes in their area to ensure better communication and care coordination. The SOC/PCMH initiative is looking beyond strictly technical solutions by working to engage specialty societies and large systems to develop broad standards of communication to support the referral process and develop physician compacts to facilitate patient co-management.

As one physician at the summit commented, “What has been lost across the board for physicians is the joy of medicine. It is that culture that is absolutely ripe for engagement.” There is an important opportunity to engage specialists in developing collaborative models with primary care physicians that improve patient care by leveraging the shared benefits of becoming or working with a medical home.

**Physicians who are interested in learning more about the Systems of Care/Patient Centered Medical Home Initiative or who would like a resource advisor to visit their office may contact Karen Frederick Gallegos at Karen_frederick-gallegos@cms.org or at 720-858-6323. Additional information about medical homes and medical neighborhoods is available from the System of Care/PCMH section of the CMS Web site at www.cms.org/medicalhomecommunities/html.
Kent Voorhees, MD, FAAFP, is 2010 CAFP Family Physician of the Year
Champion of reform is dedicated to profession, patients
By Buffy Gilfoil

Kenton I. Voorhees, MD, FAAFP, is the 2010 Family Physician of the Year selected by the Board of Directors of the Colorado Academy of Family Physicians. In addition to serving his patients, he has supported his profession through the training of residents and through involvement in the Colorado Academy of Family Physicians and other organizations. He has volunteered his time to several activities in support of health care reform and outreach to the underserved.

“His devotion to Family Medicine is unquestioned, and his record of service to our profession is exceeded only by his willingness to take on new tasks,” wrote Brian S. Bacak, MD, program director of Rose Family Medicine Residency. Dr. Bacak’s letter recommending that Dr. Voorhees receive the award continues, “More important than his many contributions to organized medicine, however, is his commitment to his patients. … Throughout all of his different jobs, he has maintained a connection with his patients that has motivated them to follow him on his current journey.”

In 2006, Dr. Voorhees left the Swedish Family Medicine Residency to serve as the director of graduate medical education for the Department of Family Medicine at the University of Colorado Denver School of Medicine and for the Colorado Health Foundation. He left the Colorado Health Foundation to go to the university full-time, where he is now the vice chair for education for the Department of Family Medicine.

As Dr. Bacak pointed out in his letter, Dr. Voorhees rose through the ranks of the officers within the CAFP, serving in several positions before and since becoming president in 2007. Since 2006, he has served on behalf of the academy as chair of the Medicaid Reform Task Force. He also works with the Colorado Medical Society on a variety of collaborative projects, including the Congress for Health Care Reform, which has been meeting since 2006. Within the American Academy of Family Physicians, he is an alternate delegate to the Congress of Delegates, and he serves on the Commission on Education, as well as several subcommittees.

“He is known for his easy-going style and for a pragmatism coupled with strong collaborative skills, which make him uniquely qualified in his many roles,” Dr. Bacak wrote.

He is a long-time board member of Doctors Care, which attends to needs of the medically underserved.

Dr. Voorhees continues to see patients four half-days each week at University Family Medicine – Park Meadows, which is in Lone Tree. He has taken care of many of his patients for 27 years.

Dr. Voorhees graduated magna cum laude and earned his bachelor’s degree at Vanderbilt University, where he held membership in Phi Beta Kappa. He obtained his medical degree at the University of Missouri-Columbia School of Medicine, where he graduated cum laude and received the Award for Outstanding Medical Student of Family Practice. He was also a member of Alpha Omega Alpha Honor Medical Society. He performed his residency in Family Practice at St. John’s Mercy Medical Center in St. Louis, where he was chief resident in his final year. He was awarded the degree of Fellow of the AAFP in 2003. He has also completed the National Institute of Program Director Fellowship and the Regional Institute for Health and Environmental Leadership Fellowship.

Dr. Voorhees, who has two daughters and a stepson, likes spending time with this wife, Kelly. He also enjoys photography, skiing, computers, reading, exercise and watching most sports.

Dan Fahrenholtz, MD, MBA, a 16-year veteran of the North Colorado Family Medicine Residency Center in Greeley, is the Colorado Academy of Family Physicians 2010 Teacher of the Year. In addition to working with residents, he also leads hands-on workshops for medical students in the University of Colorado School of Medicine Rural Track.

“Of all the excellent teachers and mentors I have had during my medical training, I consider Dr. Fahrenholtz to be the most exceptional,” stated former student Mark Foster, DO, of Chatfield Family Medicine in Littleton. In a letter written in support of Dr. Fahrenholtz’s nomination, Dr. Foster continued, “To me, he represents the ideal of our profession, a Family Physician of superior intellectual gifts, implacable equanimity and, most of all, an intensely humane and generous approach to patient care.”

From 1976 until 1993, Dr. Fahrenholtz was in private practice with his brother, who is also a Family Physician, at Medical Arts Center in Kingman, Kan. Like others who wrote in support of the nomination, Dr. continued on next page
Born in Hutchinson, Kan., Dr. Fahrenholtz grew up on a farm about 30 miles west of there. He was one of 12 in his graduating class in Sylvia, Kan. He earned his bachelor’s degree in chemistry at Sterling College in Sterling, Kan., and went to medical school at the University of Kansas before completing his residency at St. Luke’s Hospital in Kansas City Mo., and his residency at the University of Kansas medical Center in Kansas City, Kan. He completed his Master’s in Business Administration at Colorado State University in 2002.

Dr. Fahrenholtz and his wife, Diana, have four children and two (soon to be three) grandchildren. One son is a fourth-year medical student in Kansas City, and one daughter is completing her degree as a dietitian.

His interests outside of medicine range from music to flying. According to Dr. Foster, “He is an accomplished pianist, a voracious reader, has an MBA, and is a skilled pilot as well. Not such a bad golfer either. He loves medicine, but he has not let it define him, and I think that is an excellent example to all of us.”

Zach Wachtl, MD, of Rose Family Medicine Residency, is the Colorado Academy of Family Physicians Resident of the Year. According to those who supported his nomination, Dr. Wachtl has advocated for residents in various venues; he is liked and respected by patients and peers, and he is dedicated to serving the underserved.

Martha Illige, MD, stated he “is both smart and humble, an uncommon combination.” Her letter of support for his nomination also stated, “A clone-worthy resident clearly deserves to be resident of the year.” Dr. Illige, an assistant professor at the University of Colorado Denver School of Medicine/RFMR, was recognized as CAFP Teacher of the Year in 2005 and as an American Academy of Family Physicians Exemplary Teacher in 2006.

She and others wrote of Dr. Wachtl’s advocacy. Brian S. Bacak, MD, FAAFP, RFMR program director, reported that Dr. Wachtl represented residents at the AAFP student/resident fair in Kansas City. In 2009, Dr. Wachtl was selected to be one of two chief residents, and he was elected resident representative for the CAFP Board of Directors.

Dr. Bacak wrote, “In his current position, he has distinguished himself through excellent leadership skills and a superb clinical set. He is widely respected by his peers as a fair, honest broker to their concerns. … He possesses excellent collaborative leadership skills and sound judgment and has wonderful potential within the field of Family Medicine.”

Erika Wentarmini, MSW, wrote, “As a social worker, I see Dr. Wachtl not only as a physician but as a strong patient advocate. Dr. Wachtl feels that his patients deserve the best care and will go above and beyond the duty of a physician to ensure that his patients do in fact get the care that they deserve.”

She added that she had accompanied him on home visits, where “I saw patients full of delight that Dr. Wachtl was their physician and that he redefined the true meaning of a Family Physician. … He handled each home visit with class and respect, which in my opinion these patients may not always receive.”

Born in Wausau, Wis., Dr. Wachtl earned his bachelor’s degree in biochemistry and Spanish at the University of Wisconsin-Madison. He began his residency in 2007 after completing medical school at the University of Wisconsin School of Medicine and Public Health in Madison. While there, he was a student leader in an organization that provided social and medical support to pregnant mothers, and he served as a medical Spanish translator for patients at a clinic for under-resourced patients.

Along with his wife, Dr. Wachtl enjoys cooking, experiencing new restaurants, traveling and skiing. He is interested in working in community health in the Denver area.

CAFP 2010 Resident of the Year is Zach Wachtl, MD

Rose resident advocates for peers and patients

By Buffy Gifford
MRI & CT

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Where You, Your Patient, & Your Staff are Our Top Priority
Making decisions in conjunction with families about when young athletes with concussions can return to play has become increasingly challenging in primary care because of changes in concussion management guidelines and research in the past few years. Pediatric and adolescent concussions commonly cause anxiety for the treating physician because of the possibility of Second Impact Syndrome, called SIS, a rare condition in which the brain can swell rapidly and fatally after a person suffers a second concussion before symptoms from an earlier one have subsided. Another question can arise about when to refer a young patient to a concussion clinic/specialist when symptoms are not resolving within the typical 10- to 14-day recovery period. New guidelines for concussion management have helped with initial treatment and return-to-play decisions. Yet with the recent abandonment of the older concussion grading scales, many providers are concerned that they are not providing the most up-to-date care for these patients when making return-to-play decisions.

Severity of concussion is now determined by the nature of the head injury, burden on the patient/athlete and the duration of the clinical post-concussive symptoms. The role of post-traumatic amnesia as a measure of concussion severity is unclear at this time. Most concussions do not involve loss of consciousness, and there is a great variability in presentation and post-concussive symptoms.

The exam in the primary care office should include a concussion history and detailed neurological examination focusing on mental status, cognitive functioning, gait and balance. Post-concussive symptoms can include headache, loss of consciousness, feeling like in a fog, increased emotionality, amnesia, irritability, slowed reaction times, difficulty with concentration or memory, fatigue, blurred or double vision, sleep disturbances and sensitivity to light or noise. It is important to determine whether there has been improvement or deterioration in clinical status since the time of injury. The primary care physician...
must also determine if there is a need for an emergent CT scan.

If the young patient/athlete is stable clinically, then education on concussion and Second Impact Syndrome should be completed and the parents and athlete introduced to the Return to Play Protocol. In 2004, the Return to Play Protocol was published as part of the Consensus Statement on Concussion in Sport (Table).2 Scientific evidence does not provide a guide for the exact number of days before individuals can return to sport. There is also no definite number of concussions sustained before one is retired from contact sports. These decisions are made on an individual basis and differ from case to case.

| TABLE 1

<table>
<thead>
<tr>
<th>RETURN TO PLAY PROTOCOL - PRAGUE GUIDELINES</th>
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<tbody>
<tr>
<td>• No activity with complete physical and cognitive rest</td>
</tr>
<tr>
<td>• Light aerobic exercise</td>
</tr>
<tr>
<td>• Sport-specific exercise</td>
</tr>
<tr>
<td>• Non-contact sport-specific training drills</td>
</tr>
<tr>
<td>• Full contact practice after medical clearance</td>
</tr>
<tr>
<td>• Return to competitive play</td>
</tr>
</tbody>
</table>

Before beginning the protocol, the youth/athlete must be completely asymptomatic. The athlete can continue on to the next level of play if he/she has been asymptomatic for 24 hours at the current level. It should take around one week for a young athlete with a concussion to complete the Return to Play Protocol. If any symptoms occur, then the athlete should drop back to the previous step and try to progress again after a 24-hour period of rest without symptoms has passed.2

Return to play in an adult should still follow the same basic management principles. Every athlete, regardless of age, must recover clinically and cognitively before consideration for return to play.3 It was acknowledged in the Zurich guidelines that there is evidence some adult athletes are able to return to play more quickly than youth, and some may even return to play the same day without a risk of recurrence or complications.1

Pediatric and adolescent athletes may have neurological deficits after a head injury that may not be evident on the sidelines and are more likely to have delayed onset of symptoms. These young athletes should never be allowed to return to a practice or game on the same day they suffer a concussion and should be treated more conservatively than adults with concussions.

The most current data shows different physiological responses and longer recovery with head injuries in the younger population. The increased risk of Second Impact Syndrome in youth must be a constant reminder to be careful with this group of athletes and mandates more cautious return-to-play decisions.3

It is important that younger athletes have cognitive rest from both physical and mental activities until asymptomatic. Limitations should be placed on school performance, text messaging and even videogame playing to avoid prolonging symptoms.1 The treating physician may need to extend the amount of time of rest or the length of the Return to Play Protocol in children and adolescents. No athlete should ever be returned to play while still symptomatic, regardless of time between concussion and athletic event.

Referral to a concussion clinic or specialist should be considered when the post-concussive symptoms have lasted more than 14 days. MRI of the brain should also be considered in these cases to evaluate for any underlying malformations, intracranial cysts or other structural anomalies that may be responsible for the delay in recovery of the athlete. Structural anomalies may put the athlete at increased risk when returning to contact sports. In these situations, referral to a neurosurgeon for decisions on return to specific sports may be indicated.

Neuropsychological testing remains a very controversial topic in concussion assessment and management. It should never be used solely as a tool for return-to-play decision making. A good history and clinical exam cannot be replaced by computerized neuropsychological testing. Each case should be considered on an individual basis. Sideline assessment using the SCAT or SAC tools have been used by some, but not most, high schools. It is important for the primary care physician providing game coverage to be familiar with neuropsychological testing and sideline assessment tools. The Zurich guidelines also emphasize that neuropsychological testing is best analyzed by neuropsychologists and not by sports medicine physicians or primary care physicians.1

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Dr. Provance’s clinical areas of interest include pediatric concussions and pediatric musculoskeletal injuries. His current research involves analyzing barriers to ski helmet use in children, the role of MRI spectroscopy in sport concussion assessment and patient/family education on concussions in the emergency department/urgent care setting.

Kids Corner is a regular feature of the CAFP News that focuses on children’s health needs that are of interest to Family Physicians. If you have questions for the authors or suggestions for future Kids Corner columns, you may contact the authors directly at The Children’s Hospital thru OneCall at 720-777-3999.

References
Legislative advocacy is one of the most effective ways to better communities for children. Many times, children’s voices are not heard when it comes to their unique health care needs, and therefore advocates must come forth to support laws and policies that are good for children and oppose ones that are not.

At The Children’s Hospital, we diagnose and treat hundreds of kids every day with immediate medical needs. Though our clinical work is the most visible part of our mission, our dedication to the welfare of children runs much deeper. Through our advocacy program, we influence decisions that relate to children’s health policy issues, such as injury prevention and access to quality care. The Children’s Hospital’s advocacy efforts span across Colorado to ensure that children’s needs are addressed and met through public policy.

Since 1999, The Children’s Hospital Grassroots Advocacy Network, or GAN, has been one avenue concerned citizens in Colorado have taken to support the hospital’s advocacy mission. The network is an e-mail database of more than 3,500 “virtual volunteers” who care about children and their needs. Rather than donate time or money, these individuals are alerted via e-mail when elected officials are debating issues pertaining to the hospital and children in Colorado. Advocates then speak up by sending e-mails and making phone calls to friends, neighbors and colleagues to raise awareness and influence public policies.

The hospital makes it easy for community advocates to take action by providing background information on the issues and even sample e-mail messages for the advocates to use. In the past, The Children’s Hospital has advocated and influenced public policy on issues such as passenger safety, immunizations and the expansion of health care coverage for children.

In addition to sending e-mail communications, network members can stay connected to children’s health policy issues throughout the year. They are invited to advocacy events, including lunch-and-learns, advocacy training and learning opportunities, and are also provided with online advocacy tools, resources and newsletters to stay informed and educated.

Additional information about advocacy at The Children’s Hospital and the Grassroots Advocacy Network is available at www.thechildrenshospital.org/advocacy or by e-mailing advocacy@tchden.org.

“Children don’t have a vote. So, it’s important that they have a voice in the political process. We provide that voice. It’s important for all of us who are advocates for children and children’s health to speak up on their behalf. It takes a handful of us to let our voices be heard and to get a message to our elected officials, to have a huge impact.”

-- Jim Shmerling, DHA, FACHE, President and CEO, The Children’s Hospital

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Asa Ware saw hip replacement and snake bites in summer program

Preceptorship was a homecoming for med student from Wray

By Buffy Gilfoil

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

During the summer of 2009, medical student Asa Ware observed complicated medical procedures and assisted with simpler ones in Wray, Colo. The activities were part of his studies in the Rural Track of the University of Colorado School of Medicine.

Ware helped remove a fishhook from a youngster’s finger. At first, he said the patient “really liked the lure” and efforts were made to preserve it, but as the procedure unfolded, the youngster just wanted to be finished. Eventually, the lure was sacrificed and the patient was fine.

Another case involved removal of a cactus needle from a gardener’s tongue. Ware said, “I still don’t know why she brought the gloved hand up to her mouth, but she did, and she subsequently got a thorn in her tongue.”

And, he saw two rattlesnake bites within 24 hours. One patient was a farmer who encountered the snake in the field. The other was a young woman. “Apparently, she has always loved picking up snakes and playing with them, so she sees a snake – it was a baby rattler, so it didn’t have the rattle – and picks it up and she’s swinging it around and watching it coil up on her hand, and it bit her twice.” With a high demand in a short time, anti-venom had to be gathered from the surrounding communities. “Note to self: Do not pick up snakes,” Ware said.

Unlike most Rural Track students, Ware could speak with the knowledge of one who was rooted in the community when he reported to his classmates on his summer experience. Three sets of his great-great grandparents had homesteaded near the town, and though he was born in Seattle, his family moved to Wray when he was 1 month old. His father was a band teacher, his mother – a Wray native – worked as a nurse, and his uncle is the town’s pharmacist.

“I always knew that Wray was lucky to have such a great medical team and facility so nearby,” Ware stated. “After working there, my thought was reinforced.”

Located in northeastern Colorado, Wray is just nine miles from Kansas and 12 from Nebraska. (Growing up, Ware would go bowling in Kansas.) The 16-bed Wray Community District Hospital and an adjacent clinic serve not only approximately 2,200 people who live in Wray, but also those in the surrounding agricultural area. Facilities include a cardiac rehabilitation clinic and a clinic where visiting specialists – in at least 10 disciplines ranging from dermatology to urology and oncology to orthopedics – come for consultations and to see patients.

Additional facilities and services are wide ranging and include MRIs, which are available twice a month in a semi truck. The Wray Rehabilitation and Activity Center serves as both a recreation center and a site for physical therapy. Ware reported that more lab work is done in Wray than is typical for a town of 2,200.

The medical community includes three Family Physicians and a general surgeon, who divides his time between Wray and nearby Yuma. Also on staff are two physician assistants, one to two residents, two nurse anesthetists and approximately 25 nursing staff.

Ware’s primary preceptor was Monte Uyemura, MD, but he also got to work with the other Family Physicians and physician’s assistants.

“I coached Asa in Little League baseball, and now I considered it a privilege to be involved in Asa’s medical training. He is extremely bright and just an all-around mature and classy young man,” Dr. Uyemura stated. “I think it is vital to train and encourage students like Asa to become rural Family Physicians. In fact, I believe we need more rural Family Physicians with their broad scope of practice and small-town rapport in every town and scattered in our big cities.”

On the very day that he began in the program, Ware found himself performing chest compressions on a dying patient. But, he said, most days ran more routinely. Typically, they began at 8 a.m. with reports, followed by obstetrical ultrasounds, which were always done in the morning. Seeing patients in the clinic, which houses 16 exam rooms and two procedure rooms, filled most of the day, lasting from 8:30 a.m. until 5 p.m. or later.

In all, Ware assisted with 11 obstetrical ultrasounds, 25 well-child checkups and 21 obstetrical visits. He completed 67 one-on-one interviews with patients. Among the procedures he saw were a total hip replacement, Caesarian sections, laparoscopic gall bladder surgery, removal of lesions and moles and stress tests.

One problem Ware observed was a gap in home services. He said home care is available, but the “middle ground,” where someone just needs help with things like taking out the garbage, is missing.

In addition to his work, Ware also participated in community activities, including the annual Wray Daze, which attracts many expatriates. The event includes a parade with “a lot of tractors,” he said, as well as a children’s bicycle race and rubber duck race in the Republican River.

Ware doesn’t know where he will practice after he graduates from medical school, saying, “I am certainly interested in rural medicine, and Wray is a place that’s constantly on my mind,” he said. “It would be an honor to give back to a community that has given so much to me.”
Enjoy SOUP at Immunization Fundraiser

Restaurants gather for Shots Offer Unrivaled Protection

Do you want to thank your staff, protect children from disease and get a tax-deductible donation for your business? Enjoy a night of SOUP!

Treat your team to a night at Colorado Children’s Immunization Coalition’s annual fundraiser. Shots Offer Unrivalled Protection, or SOUP, will be held April 27, 2010, from 6 to 9 p.m. at the Cable Center on the University of Denver campus. Not only will your staff get a night of soup-tasting and socializing, but you will get a tax-deductible donation for your business.

In addition to raising funds and awareness for childhood immunizations, the soup-tasting event will honor the Big Shot of the Year, Lt. Gov. Barbara O’Brien.

Tasty soups will be dished up from Denver’s premier restaurants, including Abrusci’s, Coral Room, Dazzle, Il Posto, Jax’s Fish House – Denver, Le Central, Lola, Red Tango, Root Down, Strings, Sushi Hai, Table6 and others.

Table sponsorships start at $500 and include eight tickets to the event, as well as marketing opportunities for your practice. Otherwise, tickets to the event are $50 per person, $90 per couple or $35 for professionals under 35.

To learn more about the event, contact Dawn Crawford at 720-777-8917 or crawford.dawn@tchden.org. Get all the details on the event at www.childrensimmunization.org/soup.

PUTTING THE VACCINES AND AUTISM MYTH TO BED

By Robert Brayden, MD

For over a decade, Family Physicians have been fielding questions from concerned parents about the perceived connection between vaccines and autism. Now one more fact has emerged to ease parents’ minds. In January, the study that concluded a connection between the measles, mumps and rubella vaccine and autism was officially retracted by The Lancet medical journal.

So what does this mean for patients?

The Wakefield Study and the 2010 General Medical Council Ruling

The 1998 article concluded that eight of the 12 children in the study showed signs of developmental regression within days of being given the MMR shot. The parents and physicians of these children linked the vaccination with the onset of autism.

This study has a troubled history. By 2004, 10 of Dr. Wakefield’s 12 co-authors had retracted their involvement in the article, and in 2009, the United Kingdom’s Sunday Times revealed evidence that Dr. Wakefield fixed the data of his 1998 study.

In February 2010, the General Medical Council in England found that Dr. Wakefield acted in an unethical way by taking blood samples from children at his son’s birthday party and performing spinal taps on children at a hospital without due regard for how they might be affected. The council also found that Wakefield had falsified data in the study and failed to disclose that he received funding from parents who believed that the MMR vaccine caused autism.

Due to this new information, The Lancet has fully retracted the 1998 study, discounting it as false. The council is considering revoking Wakefield’s medical license in England.

Parents Should Not Worry About the MMR Vaccine

There have been more than 20 different studies conducted in the past 12 years by the Centers for Disease Control, National Institutes of Health and scientists around the world. None of these studies have been able to recreate Dr. Wakefield’s findings or find any connection between the MMR vaccine and autism.

In February 2009, The U.S. Court of Federal Claims found that MMR and thimerosal-containing vaccines do not cause autism after reviewing 5,000 pages of transcripts, 939 medical articles and 50 expert reports, and hearing testimony from 28 experts.

The power of Dr. Wakefield’s single study has resulted in millions of dollars in studies trying to recreate what is now found to be a false study by an unethical physician.

What does this mean for patients?

This news means that parents can be fully confident in vaccinating their children. All the possible connections between MMR and autism have been exhausted. They are not the smoking gun some hoped they would be.

Doctors may naturally empathize with concerned parents who want to find an answer to why the autism rate continues to climb. Many, including me, are advocates for finding research dollars to explore avenues for learning the causes of this devastating diagnosis.

Doctors need to protect children from disease to save lives. Parents cannot continue to hold onto misplaced fear that by avoiding the MMR vaccine they can save their child from a diagnosis of autism. Recent information indicates a single right course of action: Protect children, immunize them.

Robert Brayden, MD, is the president of the Colorado Children’s Immunization Coalition Board, an associate professor of Pediatrics at the University of Colorado School of Medicine, a pediatrician at The Children’s Hospital and an advocate for vaccination. Additional information about how individuals can help keep children healthy is available from the Colorado Children’s Immunization Coalition at www.childrensimmunization.org.
MEMBER SPECIAL DISCOUNT PROGRAMS

Members are invited to take advantage of the special rates from CAFP’s 19 special discount programs. If there is a service or product that you would like to receive discounts on and to see on this list, please contact the CAFP.

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Health E-careers Network: FPJobsOnline is the official online job bank of the Colorado Academy of Family Physicians and provides the most targeted source of professional jobs in our area. FPJobsOnline is the fastest growing professional in the U.S. Please visit www.FPJobsOnline.com or call 1-888-984-9247 Mention you are a CAFP member to receive discount.

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Law Consulting by Michele Law: Michele offers consulting services for physician clients with regard to their contractual arrangements with insurance carriers, health maintenance organizations and/or networks. We advise, analyze and make recommendations regarding contracts and their reimbursement schedules, and upon request, we directly negotiate the terms of those agreements. Law Consulting operates a messenger model consulting service where the physician client retains the final and ultimate business decision regarding their contract. Law Consulting offers a discount to CAFP members. Please contact Loan Hau @ 303-696-6655 ext. 17 for more questions.

Lehrer’s Flowers: Lehrers Flowers has been a family owned and operated business for over 50 years. We are committed to serving our clients with the utmost importance. Our clients are very special to us and we want to give them the respect, trust, and personal touch they deserve. Thinkflowers.com is a subsidiary of Lehrers and is committed to providing the highest quality and service as a florist among many others. We will always be focused on our goal of giving our client the very best possible experience when dealing with us for any occasion. Please enjoy the company benefit of getting 10% off flowers, plants, and baskets by ordering through www.thinkflowers.com/cAFP.

Lippincott, Williams & Wilkins: Lippincott Williams & Wilkins is a unit of Wolters Kluver Health, a group of leading information companies offering specialized publications and software for physicians, nurses, students and specialized clinicians. Products include drug guides, medical journals, nursing journals, medical textbooks and medical pda software. Members receive 10% discount using Code#W6EEAZZZ.

Medplexus: Medplexus is the total Software and Business solution for your medical practices to improve revenues and cash-flows, reduce costs, and improve patient care. Receive great discounts when you use the promo code MPXAFP-COL-003. For more information please contact CM Mallipeddi at 1-408-990-9006

Microlife: Microlife Medical Home Solutions, Inc. (MMHS) provides evidence-based tools and solutions that will help reduce excess bodyweight and improve hypertension management among patients at risk or already living with chronic disease. Please contact Loan @ 303-696-6655 ext 17 for more information and for the discounted rates on these products.

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

NCSPlus: CAFP members can now take advantage of the new debt-collection benefit program offered by NCSPlus Incorporated. Unlike other collection agencies, NCSPlus does not charge percentage fees – and unlike other national fixed-fee collection agencies, NCSPlus incorporates telephone collections, letters, attorney contact, debtor audits, insurance recovery and credit bureau reporting. A strong focus on service, and a recovery rate more than twice the national average equals a valuable benefit for our members. To get started with this low-cost and effective collections system, please contact NCSPlus Representative Parker Norwood at 303-351-1601, or email npnorwood@ncsplus.com.

Office Depot offers Colorado Academy of Family Physician members a 10% discount off retail catalog price (excluding technology items & business machines). Members can also get discounts on the print & copy center. Use the Acct # 43244917 when ordering. Please contact Rob Boyer at 303-576-1117 or e-mail: rob.boyer@officedepot.com.

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njhealth.org

*U.S. News & World Report
Involved
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