



CAFP NEWS

BOLD CHAMPION FOR COLORADO FAMILY PHYSICIANS

2011 RECOGNIZED PHYSICIANS & PRACTICES

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Miramont is
2011 PCMH
Best Practice of
the Year



R. Scott
Hammond,
MD, FAAFP, is
CAFPA Family
Physician of
the Year



Brian A. Bacak,
MD, FAAFP,
is CAFPA Teacher
of the Year



Toby Long,
MD, M Div,
is Resident of
the Year



Drs. Moll
Put the
“Family”
in Family
Medicine



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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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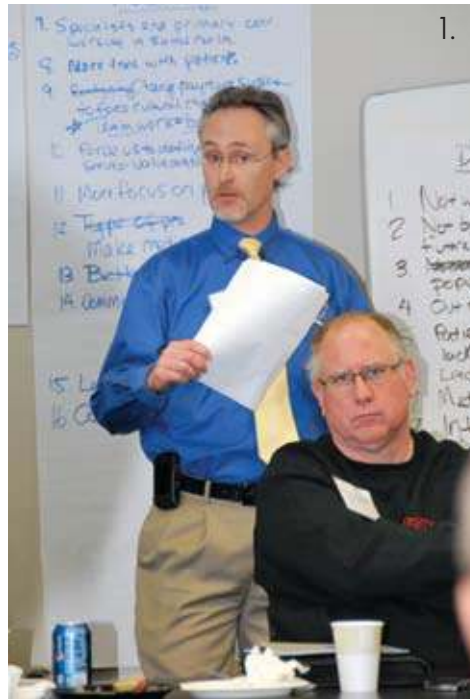
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Payment Reform and its Impact

This year's legislative process has proven to be one that has prompted much discussion and reflection on the pathway of practice and payment reform. The Colorado Academy of Family Physicians has made this reform our top issue as we feel that the Patient Center Medical Home movement requires acknowledgement of the need for reimbursement reform from state legislators, payers and other stakeholders in order to remain viable and progressive.

How and by whom the medical home is defined by statute will likely determine how this movement impacts primary care providers, and the extent to which we will follow federal reform models. It would seem that this would not be that difficult given the national discussion and data being collected from experts and pilots across the country. However, that



1. Mike Pramenko, MD, CMS President and CAFP Member, at breakout session during Payment Reform Summit. 2. Luke Casias, MD, gave the Colorado legislative update to the Multi-State Forum attendees. 3. Harold Miller presented on Payment Reform at CMS. 4. Payment Reform Summit at CMS. 5. Raquel Alexander speaks with Harold Miller at Payment Reform Summit. 6. John Bender, MD, at Payment Reform Summit.

is not the case.

As implementation of the federal reform has been primarily left up to the states, there is a void of clear direction about the definition of the medical home. The American Academy of Family Physicians has its definition, which incorporates the Joint Principles and is structured around the notion of a physician-led team approach to care delivery. But this is not the popular approach taken by many Colorado legislators and others at

the statehouse.

The recent debate over House Bill 1245, a payment reform bill from Rep. John Kefalas (D-Larimer County) and various stakeholders (CAFP, Colorado Medical Society, Health TeamWorks to name a few) illustrated that the notion of "physician-led medical homes," regardless of the data supporting this model, would not be able to be passed or even defended in a bill with hopes of making it out of committee. CAFP fought the good fight for our definition,

but the recent acceptance of mid-level providers as leaders of medical homes by the National Committee for Quality Assurance removed our footing for this debate. There are just too many stakeholders hoping to cash in on the projected earnings and place in the workforce to allow for this type of language. We then regrouped, hoping to modify the language in the statute under the pediatric medical home definition, being a little more vague but still requiring physician involvement. This, too, met

opposition. Ultimately the sponsor of the bill had to pull it as it was being modified and changed to the point that it would be ineffective and not likely to make it out of committee. I give you this history to set the stage on which the PCMH movement is being debated and playing out in our state and across the nation. In Colorado it is becoming evident that the likelihood of restrictive language in the definition of a medical home will not be a viable option. This is true regardless of the data collected in a physician-led model and the concerns over patient safety and safeguarding of care. It is with much debate and soul searching that I have come to this conclusion. The current economic and workforce issues have allowed for a distortion of information regarding patient care and this has influenced many of our political leaders regardless of party affiliation. We are not being seen as the only means of care delivery.

The exploration of expansion of providers has begun to occur. I was closely involved in the recent debates on scope expansion and prescriptive authority issues with mid-levels, and have seen every year bills attempting to expand scope for chiropractors, naturopaths and others even less trained than these individuals. These measures are presented in the name of access and guised in the cloak of cost savings. This is the environment in which we live and practice. I believe we are at a turning point in the practice of our trade. The PCMH model was accepted by the AAFP after the 2004-2005 Future of Family Medicine Study illustrated that a dramatic reform was needed in order to preserve our future. The PCMH model matched the core philosophy of our membership and provided a platform that for reform. It still holds true to the concept that a team approach to health care with primary care physicians delivers the most cost-effective and highest quality of care. Through hard work and legislative lobbying the basic principles of PCMH are now on the tongues of politicians, insurers and, most importantly, employers. The fact that we are involved in the discussion is remarkable, given the positioning we had five years ago. But make no mistake: We are still at a point of low payment and we are still not propagating as a specialty. We know that the root of these issues is the lack of value the industry has placed on us as a whole. This undervaluing of Family Physicians can be seen in federal policy and it is reflected by insurers, hospitals, training centers and, in some cases, our specialist colleagues. A clear indication of this is the current payment model. We need to see payment reform and I believe that the PCMH is the vehicle that will allow for this type of reform if we do not allow ourselves to be distracted and drawn into discussions that can be perceived to show entitlement to practice. Legislators turn off when issues are seen as being turf-driven and, in all honesty, we have lost this debate in the public arena. Our strength comes from the product we provide and our commitment to our patients' health. We are going to need to structure our practices into medical homes that deliver not only the product we have been advertising, but that also will have data to support the cost savings and bending of this cost curve. The marketplace will determine the final outcome for our specialties. At best, we can ask for a level playing field and then outperform our competition. We are not in that environment currently, but have the ability to work toward that endpoint.

As the CAFP moves forward, we will continue to strive to keep Family Physicians in an upper level role in the health care team. Per our training and performance, the majority of time we will rise to the leadership role. We need to look at other venues in seeking increased payment. These will likely not be solely legislative. We will continue to promote a definition of the medical home that ensures our role and allows for a fair business model. We plan on working with the accountable care organizations to restructure the model of reimbursement, we plan on approaching insurance companies and, when the new insurance commissioner is in place, we plan on working through that office to help reform payment. It is clear that we have a lot of ground to cover in order to help promote or specialty. I feel that we will ultimately obtain the outcome we desire as a specialty, but realize it will only be through the promotion of the PCMH model with payment reform. In the end, the current model of health care does everything it can to make delivery of care difficult and of a poor quality. It cannot continue on this path. We need to make sure we are on the progressive side of future and not lost in the past.



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FAMILY PHYSICIANS

AAFP Live!



by Raquel Alexander, MA, CAE

CAFP Congratulates and Thanks Board Members

SPECIAL THANKS TO CAFP BOARD OF DIRECTORS

Your CAFP board of directors works tirelessly on your behalf promoting Family Medicine and what would be best for your patients. Our director of Public Policy, Jeff Thormodsgaard, has set up a series of meetings with key legislators so that our Family Physician leaders can explain the importance of Family Medicine, the Patient Centered Medical Home and the crucial need for payment reform. In particular, I would like to thank Luke Casias, MD, Scott Hammond, MD, Bob Brockmann, MD, and Tracy Hofeditz, MD, for the time and effort they have put in to champion your cause. All board members are to be commended for their service.

CONGRATULATIONS TO NEW BOARD MEMBERS

Thank you to the over 200 CAFP members who sent in ballots to elect your new CAFP board of directors. The following will start their board term on July 1, 2011. Congratulations and thank you to the newly elected board members!

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John Bender, MD, Ft. Collins – term expires 2012 (2nd term)

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Marcus Salmen, graduating June 2012

Casey Weimer, graduating June 2012

WELCOME TO NEW CAFP STAFF MEMBER

The CAFP hired a new administrative assistant, Eleanor Mills, whose first day was March 1, 2011. Eleanor will assist with many CAFP activities and projects, including the Doctor of the Day program, membership, and the special discount program.

CAFP SMALL DONOR COMMITTEE

Please donate to this important fundraising initiative. The maximum donation is \$50 per year and contributions help the voice of Family Physicians to be heard.

CONGRATULATIONS TO THE FOLLOWING CAFP LEADERS ON THEIR AAFP COMMISSION APPOINTMENTS

• John Bender, MD, appointed to AAFP Commission on Finance & Insurance

• Kent Voorhees, MD, term expires 2012, continuing on AAFP Commission on Education

• Colleen Conry, MD, term expires 2012, continuing on AAFP Commission on Quality & Practice

CONGRATULATIONS TO THE 2011 AWARD WINNERS

Miramont Family Medicine, CAFP PCMH Best Practice of the Year

Scott Hammond, MD, CAFP Family Physician of the Year

Brian Bacak, MD, CAFP Family Medicine Teacher of the Year

Toby Long, MD, CAFP Family Medicine Resident of the Year

CAFP MEMBERSHIP CONTINUES TO GROW

• January 2010

- Active Members 1386

- Total Members 1839

• January 2011

- Active Members 1429

- Total Members 1897

CONGRATULATIONS TO ROSE FAMILY MEDICINE RESIDENCY ON ITS 40TH ANNIVERSARY



CAFP Legislative Report

By Jeff Thormsodsgaard, CAFP Director of Public Policy



Above, Top to Bottom: Martha Illige, MD, and Kern Low, MD, taught the Dec. 2010 SAM course at CAFP • Systems of Care PCMH Operations Committee • Jeff Cain, MD, attended the Multi-State Forum in February • CU med students Bob Lee and Christina Colleen training on PCMH with Raquel Alexander, Angel Perez, and Marjie Harbrecht, MD (by phone.)

Left top: Larry Green, MD, on right, at Rose Family

Medicine residency 40th anniversary celebration.

Left bottom: Brian Bacak, MD, and Kent Voorhees, MD, at the Rose Family Medicine 40th Anniversary celebration

As the legislative session got under way this year, all of the opening remarks from the House, the Senate and the governor made it clear that the budget, specifically a balanced budget, is a top priority for everyone. A balanced budget priority naturally requires that both sides of the aisle examine existing social programs and analyze their effectiveness, efficiency and monetary necessity. Health care programs are among those under scrutiny, especially with the passage of national health care reform. The Colorado Academy of Family Physicians has been watching a few legislative bills very carefully as they apply most specifically to the organization and its members.

The first bill is House Bill 1025 (HB11-1025). The short title of this bill is “Repeal Hospital Provider Fee.” In short, the bill would reverse the 2009 enactment of a hospital provider fee, severely hindering the growth and expansion of hospital resources, as well as health care availability to the general public. Originally, House Bill 09-1293, the Colorado Healthcare Affordability Act, was signed into law in April 2009. Colorado was the 26th state to pass a hospital provider fee statute. The bill was the result of a collaborative effort between the executive branch, legislative leaders, the Colorado Hospital Association, consumers and business groups. As a result of the legislation, a new fee is now assessed on Colorado hospitals. The new state revenues that result from the fee are matched, dollar-for-dollar, by the federal government. Since July 2009, the provider fee has brought millions of dollars for health care into the state of Colorado – increasing access to care for thousands of Coloradoans without relying on General Fund dollars or shifting costs to other health care consumers. The provider fee is a win-win-win because it (a) increases access to health care for medically underserved Coloradoans, (b) reduces the amount of uncompensated care for hospitals and (c) doesn’t draw any money from Colorado’s General Fund. HB11-1025 was postponed indefinitely (or killed) by its sponsor, Rep. Janak Joshi

(R-El Paso County), a retired physician. This request was made because of the expense to the state, and the opposition against it. However, we would not be surprised to see a similar bill introduced this session.

The second bill CAFP has been closely watching is Senate Bill 8, which will actually provide a savings to the state. SB 8 is the “Alignment of Medicaid Eligibility for Kids.” SB 8 removes red tape for families and makes government more efficient. By aligning eligibility, siblings will be covered by the same program, making the renewal much easier for families. It also would allow a child to continue with the same program past the age of 6. Aligning eligibility will also help providers caring for these children take advantage of federally funded enhanced payment rates in 2013 and 2014. In turn, better payment encourages more physicians to care for Medicaid patients. Currently, a Colorado family can have two kids on two different state health insurance programs, causing confusion, inefficiency and unnecessary costs. For example, in a family with two children, ages 4 and 7 with an annual income between 100 percent and 133 percent of the federal poverty level, the 4-year-old would be eligible for Medicaid and the 7-year-old would be eligible for the Child Health Plan (CHP+). This family’s children would have different health plans, different benefits, two different enrollment cycles and potentially different providers.

Another bill the academy is actively opposing is House Bill 1173, “Concerning the Regulation of Naturopathic Doctors.” This bill would allow naturopathic doctors to gain state licensure and require the newly instated license for any practice of naturopathy. The bill would also create regulations for the licensed naturopathic doctors including but not limited to: limited scope, requirement to obtain liability insurance and disciplinary procedures. Furthermore, the bill would codify penalties for unauthorized practice of naturopathy and limit the practice

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CAFP Helps Members Coordinate PCMH, Meaningful Use Standards

By Angel Perez, CAFP PCMH Resource Advisor

The Patient Centered Medical Home empowers patients, physicians and staff. With funds available through the American Recovery and Reinvestment Act to help alleviate some of the burden with the Meaningful Use criteria, now is the time for CAFP members look into starting their journeys.

Meaningful Use and National Committee for Quality Assurance PCMH standards overlap in several areas. Coordination and integration are key elements to both. Understandably there are challenges in any change to a practice, whether it is implementing health information technology or NCQA standards, but CAFP has information and resources available to members. The reference below is just NCQA Standard 1.

CAFP will host a second Journey to PCMH Recognition learning series April 14 in Colorado Springs. For questions, information or complete list of NCQA requirements and Meaningful Use, members may contact Angel Perez at angel@coloradoafp.org or 303-696-6655 ext. 16.



Top: Drs. Bender, Cedars, and Ehrenberger spoke to the medical students about the value of the Patient Centered Medical Home. Middle: John & Kathy Miller, MD, spoke about their experiences as Family Physicians. Right: Jeff Cain, MD, addressed the medical students at the January dinner.

Crosswalk between Institute of Medicine 10 Simple Rules, NCQA Physician Practice Connections-PCMH Recognition Program (2007) and Current Meaningful Use Rules (Stage 1)

5-28-10

2007 PPC-PCMH Recognition	IOM 10 Simple Rules	Current Stage 1 Meaningful Use Criteria
Standard 1 Access & Communication		
A. Written standards for patient access and communication	1. Continuous healing relationships vs. visit as unit of care.	
A. Use of data to show meeting of written standards in 1A	1. Continuous healing relationships vs. visit as unit of care.	
Standard 2 Patient Tracking & Registry Functions		
A. Use of data system for basic, non-clinical information	2. Customization based on patient values vs. system inconsistencies (<i>standard is pre-requisite</i>) 4. Free flow of information (<i>standard is pre-requisite</i>) 7. Need for transparency (<i>standard is pre-requisite</i>)	7. Demographics recorded as structured data
A. Has clinical data in searchable fields	4. Free flow of information (<i>standard is pre-requisite</i>) 7. Need for transparency (<i>standard is pre-requisite</i>)	8. Record and chart changes in vital signs (including calculating BMI) 9. Record smoking status in >13 yos. 10. Incorporate clinical lab test results into EHR as structural data
A. Uses clinical data system	4. Free flow of information (<i>standard is pre-requisite</i>) 7. Need for transparency (<i>standard is pre-requisite</i>)	8. Record and chart changes in vital signs (including calculating BMI) 9. Record smoking status in >13 yos. 10. Incorporate clinical lab test results into EHR as structural data
A. Uses charting tools to organize clinical information	4. Free flow of information (<i>standard is pre-requisite</i>) 5. Evidence-based decision-making (<i>standard is pre-requisite</i>) 6. Safety is a system property (<i>standard is a prerequisite</i>) 8. Anticipation of needs/planned care (<i>standard is a pre-requisite</i>) 9. Continuous decrease in waste	3. Maintains an UTD problem list of current and active diagnoses 5. Maintains an active medication list 6. Maintains an active medication-allergy list

Miramont is 2011 PCMH Best Practice of the Year

Fort Collins practice has improved outcomes, continues to strive

The Colorado Academy of Family Physicians has named Miramont Family Medicine in Fort Collins as the 2011 PCMH Best Practice of the Year. The purpose of the award is to encourage Family Physicians to create medical homes and to recognize excellent systems of care.

In addition to John Bender, MD, Miramont medical director, other Miramont physicians are Juan Rodriguez, DO, Kelly Lowther, MD, Douglas DeYoung, DO, Janice Weisman, DO and Linda A. Burnham, MD. The health care team also includes six mid-level providers, a nurse educator and five quality management personnel.

Patient Centered Medical Homes represent a new, transformational approach to primary care. Each is characterized by a physician-guided team that provides comprehensive, coordinated care to patients across the complex health care system. PCMHs ensure first-contact access and longitudinal, trusting relationships that provide high quality and safe care based on evidence-based medicine and shared decision-making.

A certificate in Miramont's application for the award shows that in July 2009 the practice became a Level 3 PCMH, as recognized by the National Committee for Quality Assurance. But beyond that, the application is full of evidence that the practice excels as a PCMH and continues to strive for improvement.

Access to all

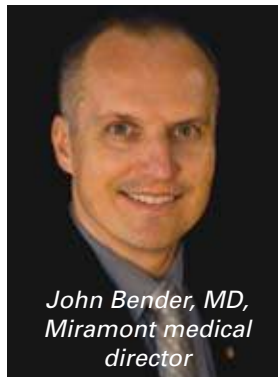
Growing according to plan at a rate of 34 percent per year, Miramont provides services to 15,000 patients in northern Colorado. The practice offers

"The atmosphere is similar to being a regular visitor to a particular restaurant or store where everybody knows your name and cares about you. ... In short, we have learned that we are just a few of the extremely lucky patients to have this kind of medical care."

services at three locations in Fort Collins and two in the rural communities of Wellington and Red Feather Lakes. Physicians round at three hospitals and 11 skilled nursing facilities.

Miramont is open to all patients. All types of insurance, including Medicare and Medicaid, are accepted and an in-house plan is available for non-insured patients. Some staff members are fluent in Spanish and American Sign Language.

"Our clinics offer extended hours, open access scheduling, in-house laboratory, X-ray, medication dispensing, IV hydration and therapy ... and many other services that are usually only available in an urgent care or emergency room setting," the application states.



John Bender, MD,
Miramont medical
director

EHR aids outcomes, communication

Miramont's electronic health record supports evidence-based medicine and improved outcomes.

The narrative states, "As part of PCMH, reports from RMD (Reach My Doctor) are reviewed and metrics are followed and reported to Health TeamWorks who distribute them to other PCMH practices and insurance payers. We grade ourselves internally by reviewing each physician's data and grade ourselves externally as a practice against the other groups in the pilot. The metrics we follow are related to Diabetes, Heart/Stroke, and Preventive."

The reports have shown improvements in such measures as LDL and A1c numbers and the practice has decreased the number of patients seen in the emergency department and admitted to the hospital on a monthly basis. "As a result, we are decreasing the cost of care curve," the narrative states.

The EHR also includes several inter-related features that work together to improve communication and efficiency and to reduce errors.



Amanda Cline exchanges the daily backup tapes in the servers of the data center.

An "Order Tracker" links incoming results with orders to verify that all consultations and test results are received in a timely fashion. Other features help providers print out appropriate handouts. The "Patient Portal" allows patients to view and comment on select portions of their charts. It also is the vehicle for sending lab results directly to patients. SureScripts, which is coupled to the e-MD prescribing module, enables providers to send and refill prescriptions electronically.

The value of the EHR was recognized in 2010 when Miramont Family Medicine received the HIMSS Davies Ambulatory Care Award, which identifies organizations with exceptional use of health care information technology. The application states, "Miramont was chosen for this national award after a site visit from the Davies Award Committee, where they observed patient care from beginning to end through our innovative systems."

Checklist, Meetings and More

Some of the items mentioned in Miramont's application are simple, but effective. A color-coded checklist, which is pocket-sized for office use, includes each item that needs to be considered by

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medical assistants. According to the application, this combines with standing orders to create “efficiencies so the provider can spend more quality time with each patient.” A nurse educator teaches patients about diabetes management, weight loss and smoking cessation.

The staff meets weekly to discuss quality of care issues. “All staff members are invited to attend and asked to bring issues forward,”



Jolietta Boyer scans paper records into .pdf files prior to shredding .

the application states. “We discuss and make changes that improve our overall efficiency and quality of patient care within our practice.”

Leadership and participation

Leadership and participation are characteristics of both Miramont and the practice’s individual staff members. Dr. Bender is a past president of the CAFP and the Larimer County Medical Society and he has served as vice president of the Northern Colorado Independent Practice Association. Other physicians in the practice are active in the Independent Physicians Association, as well as county and state medical societies and state and national specialty organizations.

Programs and groups in which Miramont or individual staff members are involved include the following:

- Colorado Multi-Payer, Multi-State PCMH Pilot Project and the Distributed
- American Academy of Family Physicians Practice Enhancement Forum
- AAFP Ask and Act Smoking Cessation program
- Ambulatory Research in Therapeutics Networks depression screening

<< continued from page 7

to naturopathic doctors only. CAFP is not supporting this bill because of the potential harm to consumers and because it would allow a scope of practice for naturopaths that exceeds their training. Many efforts were made to negotiate a bill that the medical community and the naturopaths could agree to, but an accord could not be met. The bill was postponed indefinitely after a thorough committee hearing.

Finally, one of the highest priority bills for the academy this year is House Bill 1245, “Concerning Payment Reforms for the Creation of Patient-Centered Medical Homes for Adults.” This bill is crucial for the academy because the main focus is around the definition of the Patient Centered Medical Home. The bill also outlines the payment structure for PCMHs, to be implemented no later than Jan. 1, 2014. Many stakeholders are interested in the passage of a PCMH

definition, resulting in a lot of controversy. The academy has had a large role in shaping the definition and will play a very active role throughout the entirety of the bill’s span in the Legislature. This bill was also postponed indefinitely, but the planning has already begun to resurrect the issue next session.

The CAFP is closely monitoring many other issues, which can be referenced on the academy’s web site.



Julie DeSaire teleconferences in for a meeting from a remote clinic location, while Peter Lowther, Tina Smith and Amanda Marquez look on.

Assuring Better Child Health and Development
Colorado Foundation for Medical Care prevention project
Colorado Immunization Information System
Patient Centered Medical Home Coalition of Larimer County

Support from peers and patients

The Miramont application includes several letters of support from specialists and patients.

A surgeon wrote, “I feel that patients are very fortunate that Miramont Family Medicine has such a wide range of care at one facility, not only their physician but also X-ray, physical therapy, massage therapy, psychological services, pharmaceutical services, lab services and a pain management physician.”

A patient wrote, “The multiple physicians and virtually all of the staff know us and are knowledgeable about our conditions. The atmosphere is similar to being a regular visitor to a particular restaurant or store where everybody knows your name and cares about you. ... In short, we have learned that we are just a few of the extremely lucky patients to have this kind of medical care.”

Another Patient wrote, “On countless occasions they went above and beyond to accommodate our schedules, individual needs, endless questions and insecurities. ... The most important thing to me, ALL of them ALWAYS listen, and they do so as if my questions and concerns are their highest priority.”

Runners-Up

Runners-up for the 2011 PCMH Best Practice of the Year are Clinica Family Health Services, which provides services to the poor at four metro Denver locations, Clinix Health Services in Centennial and Westminster Medical Clinic, which was the 2010 PCMH Best Practice of the Year.

R. Scott Hammond, MD, FAAFP, is CAFP Family Physician of the Year

Westminster doc is PCMH champion and leader in chronic care

By Buffy Gilfoil



R. Scott Hammond, MD, FAAFP, is the Colorado Academy of Family Physicians 2011 Family Physician of the Year. A physician at Westminster Medical Clinic since 1985 and a partner in WestMed Primary Care since 1987, Dr. Hammond has been a leader in the movement toward Patient Centered Medical Homes and Medical Neighborhoods. In 2007 he founded a non-profit foundation, the Colorado Center for Chronic Care Innovation.

"I am thrilled to receive this award as an honor for all those pioneering Family Physicians who are blazing the path to the PCMH and health care reform in Colorado," Dr. Hammond stated.

Jude James Kirk, MD, of Westmed Family Healthcare, nominated Dr. Hammond for the honor. Dr. Kirk stated Dr.

Hammond "is a champion of the Patient Centered Medical Home and is responsible for obtaining PCMH recognition for the Westminster Medical Clinic and guiding us through the process at Westmed Family Healthcare."

Westminster Medical Clinic, recognized by the National Committee for Quality Assurance as a Level 3 PCMH, was the CAFPA PCMH Best Practice of the Year last year, the first time the award was presented. Westminster Medical Clinic is also recognized by the NCQA for quality programs in both diabetes and heart/stroke and serves as a research site for DARTNet, a federated network of medical practice databases.

Patient Centered Medical Homes represent a new, transformational approach to primary care. Each is characterized by a physician-guided team that provides comprehensive, coordinated care to patients across the complex health care system. PCMHs ensure first-contact access and longitudinal,

continued on next page >>

"Two years ago, only 50 percent of Colorado Family Physicians knew about the PCMH. Now almost all do..."



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“This is clearly the direction in which Family Medicine is moving,” Dr. Hammond said. “It is the new model of practice.”

Dr. Hammond has exhibited his enthusiasm for the PCMH in a multitude of ways. Last year, he opened his clinic to tours by eight diverse groups, including Colorado state representatives, out-of-state medical directors, members of the Department of Environment and Public Health, and Family Physicians from around the state. He has shown the PCMH in operation to Family Medicine policy leader Larry Green, MD, and to Paul Grundy, MD, MPH, FACOEM, FACPM, director of Healthcare, Technology and Strategic Initiatives for IBM Global Wellbeing Services and Health Benefits. In a single year, Dr. Hammond gave 25 lectures around the state and spoke to groups around the nation, including the Patient-Centered Primary Care Collaborative in Washington, D.C.

The effectiveness of Dr. Hammond and his fellow PCMH pioneers -- including John Bender, MD, Tracy S. Hofeditz, MD, Chet Cedars, MD, and others -- is reflected in many ways. Over the past three years, the PCMH model has expanded to more practices and evolved into medical neighborhoods. The University of Colorado School of Medicine has added a PCMH elective for fourth-year medical students and all the Colorado Family Medicine residency programs are transforming in medical homes.

“Two years ago, only 50 percent of Colorado Family Physicians knew about the PCMH. Now almost all do,” Dr. Hammond said. “PCMHs in Colorado have grown from 40 physicians to over 400 in the past year. The Colorado legislature is now paying serious attention to supporting this movement and PCMH bills are being introduced this session. All the pieces are coming together for meaningful reform.”

Dr. Hammond grew up in Miami, Fla., and attended Johns Hopkins University in Baltimore before transferring to Pomona College in Claremont, Calif., where he earned his bachelor's degree in Zoology. He obtained his medical degree at the University of Miami School of Medicine in Miami, Fla., where he was elected to the Alpha Omega Alpha Honor Society. After coming to Denver, he served his internship in Medicine/Surgery at Presbyterian Medical Center, worked as an Emergency Department physician at St. Anthony Hospital System in Denver and completed his residency in Family Medicine at Mercy Medical Center.

In addition to his leadership in the areas of the PCMH and chronic care, Dr. Hammond is an associate clinical professor in the Department of Family Medicine at the University of Colorado Health Sciences Center. In 2010, he co-authored two research papers on obesity that were published in peer review journals. He has held several academic positions and he serves as a Foundations of Doctoring preceptor for medical students. Other activities have ranged from participation on an Alpine Rescue



Dr. Hammond hosts a Parade of Medical Homes.

Team to serving as medical director for organizations involved in home health and travel health.

Dr. Hammond has spearheaded the movement toward the PCMH within the CAFP, representing the academy on the PCMH Pilot Physician Advisory Board, speaking on the PCMH through the CAFP speakers' bureau and serving on the board of directors as chair of the CAFP Medical Home Task Force. He is executive editor of the academy's Medical Home Muse newsletter. In 2009, he served as a mentor for the American Academy of Family Physicians Practice Enhancement Forum.

“Colorado has been making tremendous innovations. We've put together a very robust environment for reform,” he said. “And CAFP has been in the middle of it all.”

In addition to the Colorado Academy of Family Physicians, the many other professional organizations in which Dr. Hammond has been involved include the Colorado Medical Society, International Society of Travel Medicine, Physicians for Social Responsibility and Clear Creek Medical Society. He served as medical director of the Systems of Care/PCMH Pilot directed by the Colorado Medical Society and he participates in the Colorado Multi-State, Multi-Stakeholder PCMH Pilot, the Ideal Medical Practices project and Improving Performance in Practice.

Dr. Hammond has been a volunteer in Honduras with Americans Care Teaching Sharing and in the Dominican Republic with the Timmy Foundation.

Patients Joe and Kathy Helm praised Dr. Hammond for his treatment through cancer, seizure disorder and pain management, as well other more and less serious conditions. The patients noted that he has always provided health histories to referring physicians and that he listens to what patients say before making his diagnoses. They also stated, “It is a very exciting time to be able to report that we have a ‘medical home.’ We realize that this is something that hopefully everyone will have, it feels great.”

When he is not working, Dr. Hammond enjoys hiking, skiing and traveling.



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Brian A. Bacak, MD, FAAFP, is CAFP Teacher of the Year

Rose residency director known for outstanding teaching, transformational leadership

By Buffy Gilfoil

Brian S. Bacak, MD, FAAFP, is the Colorado Academy of Family Physicians Family Physician 2011 Teacher of the Year. A former CAFP president, Dr. Bacak has been program director since 2006 of the University of Colorado Family Medicine Residency at Rose Medical Center, where he also serves as vice chair of the Department of Family Medicine.

Kent Voorhees, MD, FAAFP, nominated Dr. Bacak. He stated Dr. Bacak “has not only done a great job in leading this residency, but has also done a wonderful job in teaching his residents.” Dr. Voorhees explained that Dr. Bacak has led systemic change and built excellent relationships between the program and others, including Rose Hospital administration and The Colorado Health Foundation. Dr. Voorhees observed, “Brian’s calm demeanor in handling problems has resonated with his faculty and residents. He has earned the respect of all through his ability to successfully guide this program.”

Both Dr. Voorhees and former resident and current instructor Amber Koch-Laking noted that Dr. Bacak led the relocation of the clinic for the residency program.

Dr. Koch-Laking wrote, “I began my residency at a quaint but aging clinic about five miles from Rose Medical Center. Dr. Bacak worked diligently during his first year as the program director to research potential work spaces for the new clinic. His hard work ended with a newly constructed, technologically advanced ‘Rose Family Medicine Residency’ clinic located on the Rose Medical Center campus, which I was able to use for the last two years of my training.”

Other program changes noted by Dr. Voorhees include guiding the residency to an electronic medical record and conducting retreats that have “helped to bring his faculty together.”

Pam Sullivan, residency administrator for HealthONE Rose Medical Center Family Medicine, stated that Dr. Bacak “compiled assessments made by clinical staff co-workers, resident colleagues and faculty peers in addition to my own personal observations.” She wrote that “he diligently works as leader to facilitate communications among the several high-profile stake holders in our program, and as servant, masterfully coordinates the various missions of each into a cohesive whole.... Essentially, Dr. Bacak has woven a unity of purpose where none existed before.”

Former resident Frank Tong, DO, reported that Dr. Bacak “is known for challenging each and every resident. Somehow he has a special skill of identifying the best way someone learns, and realizes that everyone learns differently. ... This is a special skill set that not all teachers have, but the good ones certainly do.”

Dr. Koch-Laking stated, “He has a way of speaking that engages and energizes his listeners. This also includes his patients, who hold him in very high regard.”

Dr. Bacak earned his bachelor’s degree in Biology from Trinity University in San Antonio, Texas, before obtaining his Doctor of Medicine degree at the University of Texas Health Science Center at San Antonio Medical School.

He then entered active duty in the U.S. Army, where he held a series of clinical positions. He was the chief resident in the Family Medicine residency at Martin Army Community Hospital in Fort Benning, Ga., and then clinic commander at Wiesbaden Health Clinic in Germany.

“That experience was THE seminal event in my career, cementing my identity as a leader and teacher,” Dr. Bacak stated. He oversaw the clinical care of 12,500 beneficiaries, as well as a staff of 30, including eight full-time physicians and providers. He also oversaw “a clinical pharmacy, an optometry clinic, a physical therapy clinic, social work services, a separate soldier clinic and preventive health efforts for the community at large.”

When he returned to the United States, he was at Eisenhower Army Medical Center in Georgia, where he was first chief of a health clinic and an adjunct member of the teaching faculty for the Family Medicine residency. He later served for two years as staff faculty physician in the Family Medicine residency.

After receiving an honorable discharge with the rank of major, Dr. Bacak joined the staff at the University of Colorado Health Sciences Center and Rose Medical Center Family Medicine Residency. Positions held before his current one included medical director of the residency clinic and assistant program director. Dr. Bacak is currently an assistant professor in the Department of Family Medicine.

In addition to serving as CAFP president, Dr. Bacak has held several other offices within the organization. He has also been active in other professional groups, such as the Colorado Commission on Family Medicine and the Colorado Association of Family Medicine Residencies and the Society of Teachers of Family Medicine. He completed a leadership fellowship in the Regional Health and Environmental Leadership program at the University of Denver, as well as a residency director’s fellowship sponsored by the National Institute of Program Director Development and the American Academy of Family Physicians.

Dr. Bacak has presented at both regional and national conferences and has authored work published in peer-reviewed, professional publications. Topics have ranged from pediatric depression and heartburn in the elderly to obstetric ultrasonography and management of chronic pain.

Dr. Bacak and his wife, Laura, enjoy downhill skiing, travel and ballroom dancing and he describes himself as a golf fanatic.

Toby Long, MD, M Div, is Resident of the Year

St. Mary's resident led expansion of services to the homeless

By Buffy Gilfoil

Toby Long, MD, M Div, of St. Mary's Family Medicine Residency in Grand Junction, is the recipient of the 2011 F. William Barrows Award for Outstanding Family Medicine Resident. The award is presented each year by the Colorado Academy of Family Physicians.

Sherman Straw, MD, program director of St. Mary's Family Medicine, nominated Dr. Long and he and others wrote about Dr. Long's efforts to expand services to the homeless population of Grand Junction at the city's Marillac Clinic.

Paul D. Simmons, MD, FAAFP, faculty physician at St. Mary's Family Medicine Residency, wrote, "Dr. Long has, over the last two years, started a weekend outreach clinic for the homeless in downtown Grand Junction, gaining the support of our program, hospital and several organizations supporting the underserved in our community. He has done much of the staffing himself, but also recruited his resident colleagues to volunteer their (significantly limited) time for the homeless."

Dr. Straw wrote, "He saw a need, investigated all necessary policies/procedures and enlisted help from his entire senior resident class. His effort will double their capacity for care during the winter months."

The path that led Dr. Long to Family Medicine was atypical. While many Family Physicians have bachelor's degrees in the sciences, Dr. Long majored in English literature at Western Michigan University. He then directed social services and oversaw a homeless shelter for the Salvation Army in Isabella County, Mich., before obtaining a Master of Divinity degree from Princeton Theological Seminary. He earned his medical degree from Michigan State University's College of Human Medicine.

"The more time I spent with books,

the more I wanted to serve in a manner that tangibly benefited others and evidenced the idea that all humans are valuable," Dr. Long wrote. "I chose Family Practice because people mattered more than salaries or the social esteem attached to certain subspecialties."

His ultimate goal as a future Family Physician is "to treat ordinary or overlooked persons who struggle to receive adequate health care."



"Simply put, Toby is a superb resident. He embodies many ideal qualities of a Family Physician, demonstrating humility, calm, thoughtfulness and wisdom well beyond his years."

Dr. Long has a long history of helping others in both global and local communities. In supporting his nomination, his pastor, Tom Hansen of First Presbyterian Church in Grand Junction, wrote, "As a teenager he was awarded an opportunity to travel with World Vision Africa, where he was touched deeply by poverty. Upon returning to the U.S., Toby mobilized thousands of people to donate shirts – then found a way to get the clothes to those in need."

When he was an undergraduate, Dr. Long served for about nine months over a three-year period as a medical volunteer at a hospital in India. While there, he conducted research on home-based care for patients living in slums outside of Mumbai, India, with HIV/AIDS. In medical school, he lobbied for increased funding for graduate medical education at community-based clinics and mentored two pre-med students. He served on medical teams during two trips to the Dominican Republic, totaling five

weeks. He conducted research on rural health.

Dr. Long has exhibited leadership during his residency. As a second-year resident, he helped recruit students to Colorado residencies at the National Conference for Family Medicine Residents and the following year he was one of two chief residents. He has served as the liaison between residents and faculty and is "deftly able to navigate

the middle way between the two groups," according to Dr. Simmons.

In a letter supporting Long's nomination, Keith Dickerson, MD, Dr. Long's faculty advisor, wrote, "Simply put, Toby is a superb resident. He embodies many ideal qualities of a Family Physician, demonstrating humility, calm, thoughtfulness and wisdom well beyond his years."

Born in Seattle, Wash., Dr. Long grew up on the West Coast and in Michigan. He teaches Sunday school to teens. He and his wife, Andrea, are the parents of three young children.

After he completes his residency, Dr. Long plans to fulfill his National Health Service Corps obligation by practicing full-spectrum Family Medicine at an inner-city clinic in violence-plagued Saginaw, Mich. His pastor wrote, "He never wants to take the easy road – which returning to Grand Junction would be – and ignore those with deep needs elsewhere."

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4. Educate and motivate children and youth to eat the recommended daily servings of nutrient-rich foods and beverages.
5. Empower children and youth to take action at their school and at home to develop their own pathways to better fitness and nutrition for life.



Drs. Moll Put the “Family” in Family Medicine

Loyal husband-wife team serves people of Walsenburg

By Buffy Gilfoil

Drs. Michael Moll, MD, and Lori Moll, MD, of Walsenburg began their careers functioning as a single doctor and, while the arrangement was unconventional, it has apparently suited them, their patients and their community.

According to Dr. Lori Moll, what makes her and her husband most interesting is their teamwork. “We shared a residency position and until recently we functioned as one doctor (one pager).” Dr. Lori Moll stated.

The Molls met when they were undergraduates majoring in Biology at the University of New Mexico. They had mutual friends and some classes together and he proposed to her just two weeks after they met. They married a year before entering medical school.

Dr. Lori Moll said going through medical school together at the University of New Mexico was like being in practice with a partner. “It was great to have someone to study and go to class with,” she said. He was planning to be a surgeon and she thought she would be an obstetrician. They had no interest in living in a small town.

The Molls’ fourth and final year of medical school was eventful. She spent much of the year pregnant and they did a rural rotation together in Raton, N.M. She said the doctor who mentored them reported, “She didn’t ask for a quarter and she got none,” meaning I didn’t ask for anything special and he didn’t give me any breaks.”

The Molls found they liked the small-town atmosphere and the opportunity to see a wide range of patients and conditions. “It was so much fun to see everything,” Dr. Lori Moll recalled. They decided to pursue careers in Family Medicine, with the likelihood a practicing in a small town. “That rural rotation really changed everything,” Dr. Moll said.

With a child, the Molls obtained permission to attend residency as one. For six years, they attended on an alternating schedule. He would work one month and she’d work the next. “We were poor, but we got to spend time with our family,” she said.

By the time they had completed their residencies, the Molls had a second daughter. They worked for a year in Silver City, N.M., before settling in 1996 in Walsenburg, a community of about 4000 in a county of about 8000 in southern Colorado. They were originally in private practice, but are now affiliated with Spanish Peaks Regional Health Center.

For many years, the Molls have worked on alternate days and shared a pager. Around the time their third child, a son born in Walsenburg, entered school, they modified their arrangement. Now he works full-time and she works part-time.

Dr. Lori Moll sees many advantages to practicing with her husband.

It’s good for the practice. “We talk a lot about work – not just about patients, but management, too,” she said.

It’s good for patients. “We get two brains working on

tough problems,” she said. Together they’re often able to fill the wishes of patients who are particular about the gender of their doctors. “We have several couples where the husband will see Mike and the wife will see me,” she said.

It’s good for their family and community. Since they’re not both working full-time, they have more time and energy for other things. Dr. Michael Moll has coached boys’ and girls’ basketball, they’ve both loaned their expertise to the schools through lectures and programs and they participate in community health fairs. Even with a long line of patients, she talks to each about blood test results. In the past, they served as preceptors for medical students.

And, the arrangement has been good for their marriage. “When things are really hard, we have a built-in support system. We won’t judge each other. It’s tougher for people who don’t have anyone they can share these things with,” she said. And, even when things are going well, she is in awe of patients and what they survive. “The practice of medicine is so amazing,” she said.

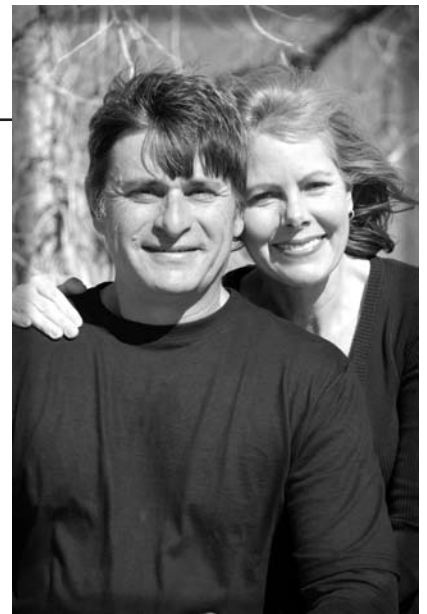
R. David Zehring, MD, and his wife, Peggy, began going to the Molls when they moved to Walsenburg in the 1990s. “They were recommended to us and that’s always significant,” Dr. Zehring said. “And they’re both board-certified Family Physicians, which is important to me as a retired physician.”

Dr. Zehring, who is chairman of the board for Spanish Peaks Regional Health Center, lists a litany of the Molls’ contributions to the community. At the top is loyalty to Huerfano County, the citizens and the medical community. “I think they both have a very highly developed sense of responsibility to patients and the community,” Dr. Zehring said.

In addition, they are good physicians and nice neighbors, who have sent their children to the public schools. Dr. Zehring credits Dr. Lori Moll with “almost single-handedly” establishing continuing medical education in the county and he said Dr. Michael Moll has an outstanding record as medical director of the Colorado State Veterans Nursing Home.

In addition to liking the practice of Family Medicine with her husband, Dr. Lori Moll likes living in a small town. The pace is relaxed, the traffic nonexistent and the people are friendly. She feels the easy familiarity of seeing patients in places like the grocery store is an added benefit. “It’s just so much fun to know people in so many ways,” she said.

The feeling is apparently mutual.



Med Student Saw Chronic Problems, Solutions in Cortez

By Buffy Gilfoil

Jason Yost learned from Dianna Fury, MD

The following is part of a series of articles about the Rural Track at the University of Colorado Denver School of Medicine, <http://medschool.ucdenver.edu/ruraltrack>. 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.

“You can’t get any farther from Denver and still be in the State of Colorado.”

That’s what medical student Jason Yost stated on a slide that he presented to his peers in the Rural Track at the University of Colorado School of Medicine. He spent four weeks during the summer of 2010 in Cortez, which is located in Montezuma County in the southwest corner Colorado. While there, he learned and worked under the guidance of Dianna Fury, MD, a Family Physician who is chief of staff of Southwest Memorial Hospital, a 25-bed critical access facility.

In addition to serving as chief of staff, Dr. Fury also sees patients about four days a week and, as one of four doctors who deliver babies in Cortez, “she delivers a lot of babies,” Yost said.

“I was able to gain exposure to rural medicine and all the dynamics that go into running a rural hospital,” he said. “I got to see all the different hats you can wear as a physician practicing in a rural area.”

As Yost explained to his classmates, Cortez is home to almost 8,000 people. The median income for a family is \$35,533 and 14.8 percent of families and 18.6 percent of the population live below the poverty line. In Montezuma County, the population is almost 24,000 people, including 9,200 households and 6,500 families. The racial breakdown is 81 percent white, 10 percent Native American and 9 percent other.

“I got to see all the different hats you can wear as a physician practicing in a rural area.”

Yost observed or assisted with a long list of conditions, ranging from acne and anxiety to cancer, cuts, a delivery, hives, pain, pink eye, pneumonia and pregnancy.

“Jason is a wonderful young man who seems to love what he’s doing,” Dr. Fury said. “He really communicated well with my patients and that means a lot to me when he’s seeing my patients with me.” She added that young patients, in particular, gravitated toward Yost and he did a lot to educate them.



Rural Track student Jason Yost learned from Dianna Fury, MD, in Cortez.

Common chronic health problems Yost saw included diabetes, heart disease, smoking and obesity. Additional problems affecting health were poor family planning skills, poverty, substance abuse and patient apathy.

Southwest Memorial Hospital network, which includes 18 of the area’s 20 primary care physicians, is implementing solutions. For example, the network offers the Cortez community the services of a rural health clinic, such as regular appointments and a daily walk-in clinic. In addition, the hospital is designated as a critical access hospital and is restructuring to add hospitalist coverage to the medical/surgery floor.

Other improvements that would help in meeting the health care needs in Cortez include having additional primary care physicians and physicians who are trained to perform Caesarean sections, according to Yost.

Dr. Fury often mentors students at levels ranging from medical school to residency. “I learn as much from the students as they learn from me,” she said. “The whole office gets into teaching them and they become part of our family.”

Yost grew up in Montezuma, Kan., a community of about 750 located about halfway between Denver and Oklahoma City. So, he was comfortable with the size of Cortez. And when he wasn’t working he enjoyed outdoor activities including fly-fishing and camping.

Moving there after he becomes a doctor is one among many possibilities, he says. “It was a really positive experience,” he says. “Of course, there are a lot of contingencies in life.”

And Family Medicine is at the top of Yost’s list for possible specialties. “I enjoy the scope and different aspects of practicing – being able to do so many different things,” he said.

CENTER FOR EXCELLENCE IN RURAL TRAINING OPENS IN FORT MORGAN

Win-win program provides training ground for students, community resources

By Buffy Gilfoil

Through a collaborative effort, the first Colorado Center for Excellence in Rural Training, or CERT, was designated in December 2010 in Morgan County.

The stated mission of the CERT program is “to increase the number and variety of health care professionals who choose to live and work in rural areas of Colorado. ... Through experiences at CERT sites, students will learn about professional and personal life in rural communities and be attracted to return to rural areas to live and work upon completing their training.”

Family Physician Mark Deutchman, MD, director of the University of Colorado School of Medicine Rural Track, helped to shape the program. He said, “The best way for future doctors and other health care providers to decide whether they’re suited for life and work in a rural community is to try it out. We are very lucky in Colorado because many of the rural professionals and communities are willing to foster opportunities that allow students to do just that.”

CERT partners at the Anschutz Medical Campus are the School of Medicine, the Department of Family Medicine and Area Health Education Centers. Partners in rural communities include individual health professionals, clinics, hospitals, other health care facilities, community organizations and individuals.

The initial institutional partners in Morgan County include Salud Family Health Center in Fort Morgan and the Colorado Plains Medical Center. Family Physician Jeffrey S. Cook, MD, is among the health care professionals at the heart of the program. Involved community members include Kerry Hart, president of Morgan Community College; Mike Patterson, chief executive officer of Colorado Plains Medical Center; and County Commissioner Laura Teague, who is a member of the Healthcare Horizons Council, which is dedicated to improving local health care. Other health care providers and community organizations will join in to host students in the health professions for rotations and introduce them to life and work in Morgan County.

Morgan County was selected to be the first CERT largely



because of its proven commitment to training rural health care providers and because of the county’s need for providers. “CERT sites are identified based on previous and projected numbers of students rotating to the site. A major criterion for becoming a CERT site is a commitment to accept learners on a regular basis throughout the year so that the providers, staff, community and patients recognize that the site has embraced the role of a teaching practice.”

In addition to providing students with experience in the delivery of health care services in a rural setting, CERT also introduces students to the community life. Program literature states that each community is asked to include “a town tour and orientation, meetings with community leaders and invitations to social activities.”

In exchange for serving as CERTs, participating sites receive a range of support that includes faculty development activities, continuing professional education, and access to library and electronic clinical resources. The rural providers also benefit from the engagement of rural medical educators, who serve as mentors for medical students’ research projects, which are based in the communities.

“It’s a win-win situation,” Dr. Deutchman said. “CERT benefits from the support from local areas and the local areas benefit from the added resources. And, ultimately, in some cases, the students will return to the communities as professionals, helping to fill gaps in health care delivery.”

Currently only medical students and residents are involved in the CERT program, but the plan is to include students in such disciplines as dentistry, pharmacy, nursing and allied fields.

Population densities are low enough that 43 of Colorado’s 64 counties are classified as rural or frontier. While 20 percent of the state’s population lives in these counties, only 12 percent of the physicians are there. Many of these counties experience chronic shortages of health care professionals.

Stakeholders Gather to Focus on Pediatric BEHAVIORAL HEALTH



Kajsa Harris, MD, represented the Colorado Academy of Family Physicians at a February gathering of more than 80 community stakeholders who came together at The Children's Hospital to take on what may arguably be one of the biggest challenges facing Colorado communities – the behavioral health of youth.

A recent community needs assessment conducted by the Colorado School of Public Health¹ concluded that “self destructive behavior in adolescence may be the single largest health problem among Colorado children. About 1 in 4 teens report feeling sad or hopeless; 1 in 7 report having contemplated suicide; 1 in 9 report having planned suicide, and 1 in 12 report having actually attempted suicide in the past year.”

With this and a slew of other alarming statistics in mind, behavioral health professionals, pediatricians, Family Physicians, parents and advocates from across Colorado met at Children's Feb. 15 for a Community Behavioral Health Retreat. Also participating were representatives of commercial and state payers, foundations, and government and community organizations. The purpose of the retreat was to develop a common vision for pediatric behavioral health in Colorado, and to begin a collaborative set of discussions among participants, resulting in specific actions that will improve children's mental health in Colorado.

“The most meaningful part of the

meeting for me was the diversity of people that were willing to work together on the problem,” Dr. Harris said. “I was amazed at the teamwork that occurred very quickly. This is a big problem and it is going to take the ‘village’ to fix it.”

Dr. Harris, one of several Family Physicians in attendance, practices with the Southern Colorado Family Medicine Residency, where more than 50 percent patients do not have any insurance, making behavioral health issues a real challenge.

Small groups met throughout the morning to develop a common vision around where Colorado should be in terms of population health, quality and service, access, innovation, and cost regarding behavioral health services for youth. One key theme included working toward an integrated payment system, as the current fragmented system creates significant challenges for providers and families. Other topics discussed included increasing the number of trained specialists in Colorado to meet the demand for services and the use of technology, including telemedicine to support telemedical consults. Early intervention and improving resources for rural communities were also common themes.

An afternoon session on prioritization built consensus among stakeholders that the areas warranting the most focus include:

- Integration of mental health with primary care
- Diagnosis, treatment and prevention resources for younger children
- Coordination and integration with school systems
- Building capacity in the provider community

The Children's Hospital plans to reconvene participants in the coming months to continue the work that is under way, and to begin to build some structure around the near-term and long-term action items identified.

MEASLES OCCURRENCE AT DIA SHOWS IMPORTANCE OF VACCINES

By Leah R. Kaufman

In late February, a person with measles passed through Denver International Airport, reminding us that though the disease was declared eliminated from the United States in 2000, there are still incidences of importation.

Measles is a very contagious viral disease that spreads through coughing, sneezing and secretions from the mouth. It develops seven to 18 days after exposure and can stay in the air for several hours. Some of the early symptoms of measles are fever, runny nose, cough and red, watery eyes. Usually, one to four days after the early symptoms, a red rash appears on the face and spreads to the rest of the body. A person with measles is contagious beginning four days before the rash appears, according to the Colorado Department of Public Health and Environment. Ninety percent of people who haven't been vaccinated for measles will get the disease if they live in the same household as an infected person.

The last case of measles in a Colorado resident was in 2006. Before that, the state had one case in 2004 and two cases in 2000. Those born in the United States before 1957 are considered immune to measles, as well as those who previously had measles or have had two measles shots.

Health care providers should continue to emphasize the importance of routine childhood vaccinations, like the measles-mumps-rubella vaccine, or MMR, with patients. Parental education and re-education are critical, especially in the wake of the retraction and subsequent fraud investigation of Andrew Wakefield's autism study. It is important to understand that many parents do need continuing education and encouragement in regard to what kinds of vaccinations their children should be receiving and the facts and myths surrounding immunizations. A wonderful immunization resource to provide to parents is www.immunizeforgood.com. Additional information is available by contacting Leah at Leah@coloradoafp.org or 303-696-6655 ext. 15

HEADACHE IN CHILDREN: Where to start and what not to miss?

By Sita Kedia MD

Keeping Colorado's family physicians up-to-date on children's health topics

Headache in children is a common presentation in the primary care setting and it is important to recognize and differentiate the common from the more serious causes. Approximately 11 percent of children and 28 percent of adolescents experience recurrent headaches. The first step is to determine if the headache is from primary or secondary causes. Primary headaches include tension-type headaches, migraines with or without aura, and, less commonly, cluster headaches. Some causes of secondary headaches include meningitis, sinusitis, sleep apnea, pseudotumor cerebri (idiopathic intracranial hypertension) and intracranial masses. History and physical

examination are the center of evaluation and may include red flags that require further work-up and evaluation. Once secondary causes are eliminated, correct diagnosis of specific primary headache disorder will guide treatment and management. Herein is a guide for the evaluation and recognition of red flags in children and adolescents who suffer from recurrent headaches.

History

Carefully evaluating the child's headache history can help accurately diagnose and identify potential secondary causes of headache. Pain assessment should include quality, location, duration, severity,

frequency, and alleviating and exacerbating factors. Triggers of head pain can include stress, sleep deprivation caffeine, and specific foods (e.g., MSG or nitrites).

Migraine headaches are generally episodic, unilateral (bilateral in young children), throbbing, severe headaches with a combination of photophobia, phonophobia, nausea, and/or vomiting. However, vomiting and feeling off balance during or between headache episodes may indicate increased intracranial pressure, and neuroimaging may be warranted. It is not one single symptom that usually points to a secondary cause; rather, it is a constellation of symptoms.

Tension-type headaches involve a tight band dull sensation that is either constant or episodic. Children who complain of posterior/occipital headaches warrant further work-up. When individuals experience more than 15 headaches per month, the condition is considered chronic in nature, and medication overuse must be excluded.

Past Medical, Family History and Review of Systems

Past or present histories of cyclic vomiting or motion sickness are migraine variants and may be helpful in establishing a migraine diagnosis. Similarly, family history of migraines or motion sickness is helpful, given a majority of children with migraines have a positive family history.

Children and adolescents without a family history of migraines should be carefully considered for secondary causes, especially if their headaches are new. Potential confounding or secondary causes of headaches may be history of recurrent sinusitis, obstructive sleep apnea signs and symptoms, or severe seasonal allergies.

Review of current medications may reveal headache side effects; for example, acne medications may be associated with possible pseudotumor cerebri and oral contraceptives may be associated with possible headache exacerbation. Table 1 describes pertinent Red Flags. As noted, children who have an ominous secondary cause generally have more than one red flag.

Physical Examination

General examination includes review of

TABLE 1 : Red flags, secondary causes, and suggested work up.

Red Flag	Possible Secondary Cause	Consider the following:
Headache in child less than 5 years	Tumor	MRI brain and dilated eye exam
New and worsening headache in a previously healthy child ("explosive onset")	Tumor Increased intracranial pressure	MRI brain and dilated eye exam
Acute headache that is worst headache of life	Subarachnoid hemorrhage	CT brain and LP
Unexplained fever	Infection/Tumor Autoimmune (if recurrent fevers)	MRI brain/LP ANA, ESR, CRP
Nighttime awakenings secondary to headache or vomiting	Posterior fossa tumor Increased intracranial pressure	MRI brain, LP, dilated eye exam
First thing in the morning headache; First thing in the morning headache/vomiting	Sleep apnea Increased intracranial pressure	Sleep study MRI brain/eye exam/LP
Headache worse with straining	Increased intracranial pressure	MRI brain and dilated eye exam
Posterior headaches	Chiari malformation or posterior fossa tumor	MRI brain
Neurological deficit	Tumor or Vascular malformation	MRI and MRA brain
Postural headache Worse when lying Worse when standing	Increased intracranial pressure Low pressure/spontaneous CSF leak	MRI brain/LP/eye exam Trial of caffeine, may need myelogram
Over 15 headaches per month	Medication overuse	Withdraw medication
Change in personality or decline in school performance	Tumor	MRI brain
Neurocutaneous stigmata (café au lait spots, hypopigmented macules)	Tuberous sclerosis or Neurofibromatosis	MRI brain and dilated eye exam

vitals and evaluation for macrocephaly, signs of chronic allergies or sinusitis, and tonsillar hypertrophy. Providers should evaluate the heart for undiagnosed arrhythmias or murmurs, the skin for any neurocutaneous stigmata and the back for musculoskeletal tightness and scoliosis.

Given time constraints, providers should focus neurological examination on high-yield components: fully evaluate cranial nerves (including fundoscopic examination), strength (including pronator drift), coordination, reflexes and gait. If any neurological component is abnormal, further work-up is warranted.

Work-up

The presence of red flags indicates the need for an appropriate work-up (Table 1). Generally, computed tomography is of low utility unless a child presents acutely with the worst headache of his or her life or with acute neurological deficit. MRI is preferred to limit exposure to radiation when neuro-imaging is warranted.

An inexpensive way to evaluate for increased intracranial pressure is by fundoscopic examination, which is

continued >>

Table 2: Criteria for migraine without aura and tension-type headache diagnosis for children (adapted from International Classification of Headache Disorders second edition criteria)

Migraine without aura (ICHD-II, 1.1):

- A. At least five attacks fulfilling criteria B–D
- B. Headache attacks lasting 1–72 hours
- C. Headache has at least two of the following characteristics:
 - 1. Unilateral or bilateral location; occipital headache in children is rare and calls for diagnostic caution.
 - 2. Pulsating or throbbing quality
 - 3. Moderate or severe pain intensity
 - 4. Aggravation by or causing avoidance of routine physical activity
- D. During headache at least one of the following:
 - 1. Nausea and/or vomiting
 - 2. Photophobia and phonophobia (inferred from behavior)
- E. Not attributed to another disorder

Infrequent episodic tension-type headache (IHCD-II 2.1):

Diagnostic criteria:

- A. At least 10 episodes occurring on <1 day per month on average (<12 days per year) and fulfilling criteria B–D
- B. Headache lasting from 30 minutes to 7 days
- C. Headache has at least two of the following characteristics:
 - 1. bilateral location
 - 2. pressing/tightening (non-pulsating) quality
 - 3. mild or moderate intensity
 - 4. not aggravated by routine physical activity such as walking or climbing stairs
- D. Both of the following:
 - a. no nausea or vomiting (anorexia may occur)
 - b. no more than one of photophobia or phonophobia
- E. Not attributed to another disorder

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Childhood Obesity: Physicians' Role in Early Intervention

By Marisa Dzarnoski, *Clinical Dietitian at Children's Hospital*

The obesity epidemic in the United States has been a well-known problem for the last two decades, however the focus on childhood obesity has only recently become the buzz-issue among health professionals and community stakeholders alike. Here in Colorado, though we continue to be one of the leanest states, the childhood obesity rate increased by 23 percent from 2003 to 2007 and has doubled since the 1970s.

Because childhood obesity can negatively affect cardiovascular, musculoskeletal, pulmonary, endocrine and mental health for a lifetime, prevention of obesity and overweight is the ideal treatment. Colorado's primary care physicians should be the first to educate families on the severity of the co-morbidities associated with overweight and obesity, and to help identify children at risk of becoming overweight. Additionally, the PCP can prescribe the first interventions to improve the lifestyles of both the children and families struggling with overweight status.

Early intervention includes a unique approach catered toward each family and the child. The most likely causes of the child's weight gain should be identified through family-based interviewing and follow-up. In Colorado, the primary causes of excess weight gain are sedentary lifestyle, food choices high in sugar and fat and economic struggles. Interventions for lifestyle change should be based on the family's level of motivation for change, as well as any of the child's associated medical conditions. Some patients and families may not be as concerned about developing co-morbidities of obesity

as others, and they may require further education before any recommendation to improve diet choices can be made. Still other families may lack resources and access to the tools necessary for diet changes or increasing physical activity. Gaining an understanding of each family's needs, cultural beliefs and capabilities is necessary for recommendations to be adhered to and be effective.

Once an intervention has been conducted, regular follow-up and support are ideal. Follow-up appointments should include laboratory evaluations, such as fasting glucose and lipid profile checks, as well as obtaining diet records and discussing goals achieved. Many children do well with regular visits that involve affirmation and positive reinforcement. Follow-up is also a great time to identify candidates for more aggressive treatment or for interviews with a registered dietitian.

The dietitian can provide specific strategies, recipes and guidelines for both families and the child to assist them in meeting their goals. He or she can provide medical nutrition therapy to help families improve their diet choices through step-by-step interventions catered to their needs and abilities. A dietitian may prescribe a diet high in mono- and poly-unsaturated fats to improve heart health or a diet geared toward meal patterns and choices that promote control of hyperglycemia. Many of these interventions will involve changes in food choices, cooking methods and portion sizes for which the dietitian can reliably provide consistent education and



support. The registered dietitian can also help motivate the child or family to increase physical activity, and provide local resources and ideas for making these changes.

The first opportunity for preventing and treating childhood obesity lies with the family's primary care physician—they are stakeholders in the nation's future welfare. An essential part of any intervention providers may perform with their patients and families is gaining an understanding of the needs and capabilities of those they serve. The PCP should also be the driving force for identifying and implementing a multi-disciplinary approach for an overweight child with special needs. Information on local nutrition resources is available at the Denver Dietetic Association's website at http://www.eatrightdenver.org/find_a_dietitian.

The Huffington Post, 2/9/2011. "Colorado's childhood obesity rate rising faster than the nation's." http://www.huffingtonpost.com/2011/02/09/colorados-child-obesity-r_n_820947.html
http://www.coloradokids.org/our_issues/child_health/child_health.html "Childhood obesity in Colorado: a growing problem."
The Handbook of Pediatric Nutrition, 3rd Ed. King K, Samour PQ.

<< continued

facilitated by a dilated eye evaluation. If papilledema is discovered, children should be referred for MRI of the brain with venogram to rule out structural lesion, obstructive hydrocephalus or sinus venous thrombosis. If no tumor or hydrocephalus is found, children with papilledema require a lumbar puncture and a measure of opening pressure.

Diagnosis

Diagnosis of primary headaches in children utilizes the same criteria as in adults, although recent criteria are more sensitive for children with primary headaches.

(International Classification of Headache Disorders- <http://ihs-classification.org/en> and Table 2)

When should referral to pediatric neurology be considered? (noting that a referral never supersedes the need for urgent imaging in the presence of red flags):

1. Unable to control headaches with a trial of at least one prophylactic medication at adequate dose
2. Uncertain of diagnosis
3. Abnormal neurological examination

Sita Kedia MD is the director of The Children's Hospital Headache Clinic and an instructor of General Pediatrics and Child Neurology at the University of Colorado Denver Health Sciences Center. He can be reached thru OneCall at 720-777-3999.

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

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Youth Sports Concussion Bill May Mean FPs See More Cases

By Jeffrey J. Cain, MD

As of March 1, when this article went to press, Senate Bill 40 had passed the state Senate and awaited a committee hearing in the House of Representatives. More up-to-date information on the bill's status is available at www.leg.state.co.us.

Family Physicians know the value of physical activity for kids. Organized sports are a great outlet for youthful energy, and they build coordination and strength, teach self-confidence, cultivate social skills involved with working as part of a team, and help start children on a lifelong path toward healthy, active living.

Still, as Family Doctors, we know better than most sports also pose certain injury risks for kids, including the risk of a concussion.

I wanted to use this column to let CAFP members know about concussion stats in Colorado, update you on the details of important concussion legislation moving through the Colorado legislature, and tell you about resources for treating more serious concussion and traumatic brain injury cases in children and young adults.

Concussions are a hot topic in the news, with organizations like the National Football League and National Collegiate Athletic Association paying increasing attention to the incidence of concussion and other head injuries among collegiate and adult athletes. Now, in response to heightened public awareness and an accumulating body of medical evidence about the dangers of sports concussion, a number of states are taking steps to protect younger athletes.

While more common in some sports, concussions can and do occur in every sport, from football and ice hockey to cheerleading and tennis. Rough estimates suggest that between 1,500 and 2,500 youth athletes visit Colorado emergency departments for sports-related concussions each year, but the total number of concussions is likely to be much higher, as this figure does not account for children who seek non-emergency care, or whose concussions are not diagnosed or treated.

The number of children treated in the outpatient Concussion Program at The Children's Hospital has risen steadily over the last three years at an average rate of 32

percent per year, probably due at least in part to increased rates of diagnosis. For kids seen in the Concussion Program, our most recent data shows that 70 percent of concussions were related to sports or recreation.

Concussions pose particular dangers to children and young adults, whose brains are still developing and take longer to recover after an injury. Kids are more likely to get concussions in the first place, and another impact before a prior concussion has fully healed can lead to permanent injury and disability or, in rare cases, even death.

That's why a new political team of sports medicine and rehabilitation physicians and pediatric neuropsychologists has been an active part of a coalition supporting a concussion bill in the state legislature, Senate Bill 40, known as the Jake Snakenberg Youth Concussion Act. The bill is named after a high school football player who died in 2004 of suspected "second impact syndrome." Having likely suffered a concussion in a game the prior week, Jake took a hit and collapsed on the field. Doctors suspect the second hit fatally compounded his initial injury.

SB 40, crafted by a coalition of groups led by the Brain Injury Association of Colorado (BIAC), aims to keep young athletes safe by helping to prevent repeat concussions in three important ways. First, the bill ensures that coaches of all youth sports, for kids aged 11-18, get training in how to understand the nature and risk of concussions so they can recognize the signs and symptoms that indicate a young athlete may have sustained a concussion. Many suitable training courses are available for free online, and most take 30 to 45 minutes to complete.

Second, if a coach suspects that a player has sustained a concussion, the athlete must be removed from practice or play and cannot return that same day (unless the signs and symptoms of a concussion can be readily explained by another condition).

Third, SB 40 requires that the player be evaluated by a qualified health care provider and receive the provider's written clearance before returning to practice or play.

SB 40 is modeled on the bylaws of

continued on page 29 >>

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LARGE PRIMARY CARE GROUP PRACTICES

By Roger Shenkel, MD, and James Sprowell, MD

The business landscape for Family Medicine has always had a good bit of regional variation and has changed somewhat over time. There have never been the challenges and opportunities that face us now.

Control of primary care practices has been of interest to those outside Family Medicine, pediatrics and general internal medicine, not because of profit opportunities, but

because of referral sources to various profit centers. Our lack of profitability compared to many other areas of medicine may be the reason that we can have this discussion of opportunities at this time.

The current dialogue surrounding the future of health care delivery in the United States draws more attention to the value of quality primary care, given the models under consideration. To gain control of

future health care dollar distribution, some of the currently well capitalized components of the medical industrial complex (hospital systems and medical insurance companies) are positioning themselves to look “primary care friendly.” Opportunities for primary care physicians to be employed by non-physicians will likely be increasing.

There is a sentiment that a component of our health care delivery system would be well served by primary care physicians functioning independently of entities coveting their referrals. This would provide the opportunity for selection of the highest-quality, lowest-cost secondary and tertiary services, without regard to business alignment. With the increasing regulatory complexity coupled with persistent reimbursement issues plaguing primary care, maintaining independence and physician control continues to be challenging. It takes financial depth to develop a robust electronic business and health records system. Several groups of primary care physicians in Colorado have formed large groups to address these issues.

Traditionally, the American Academy of Family Physicians and, more specifically, its Colorado chapter have addressed the needs of small practices. In 2010, the Colorado Academy of Family Physicians gathered together leaders of several large Colorado primary care groups and formed the “Large Group Practice Forum.” At this time, a “large” group is defined as 15 providers or more with physician ownership. The CAFP and the groups’ leaders felt there was a need for support of this business model, and dissemination of information about the advantages and challenges. The time seemed ripe as many small practices are, of necessity, examining the several options for their future.

The details of the current “large primary care” groups in Colorado vary significantly. The common denominator is becoming large enough to be able to afford the management and infrastructure necessary to deal with the regulatory challenges, the electronic opportunities and the needs of a changing provider work force. All the groups are trying to develop their own “cash cow” to augment the meager revenue stream of



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primary care and avoid outside ownership and management.

So what do these groups look like? They are spread across the state and include:

- 40 Family Physicians and 10 mid-level providers at three sites with central management, an after-hours clinic, lab and X-ray/mammography/dexa services, and a close relationship with a local health plan.
- 80 Family Physicians, general internists, mid-level providers and hospitalists at 17 sites with central management and a risk arrangement with a health plan.
- 20 Family Physicians at three sites with expanded procedural services.

Leadership of these groups is meeting with CAFP leaders to decide how to best disseminate information about large primary care group practices and share operational challenges and solutions. James Sprowell, MD, of Fort Collins is the chairman of the forum. He and CAFP Chief Executive Officer Raquel Alexander would like to hear from you with suggestions as to whether and how this business dimension of primary care should unfold. They can be reached at jsprowell@afmfc.com or raquel@coloradoafp.org.

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the Colorado High School Activities Association, which currently require that all Colorado high schools ensure that their coaches are trained in concussion recognition, that athletes with a suspected concussion be removed from play, and that a licensed, qualified health care provider sign off before the athlete returns to play.

The bill codifies those rules in state law, and expands them to cover middle schools, private club sports and public recreation leagues. The Children's Hospital is supporting similar legislation in Wyoming.

If signed into law, the bill will take effect Jan. 1, 2012. Family Physicians may see more adolescent athletes presenting with signs of concussion as a result of the legislation and, hopefully, the increased awareness it brings to those involved with youth sports.

Most concussions fully heal in a few weeks or months. For most kids, adequate rest, followed by a gradual reintroduction of physical and cognitive activities, with careful observation to check for returning signs and symptoms, is sufficient. Family Physicians can use the Prague "Return

to Play Guidelines" (Spring 2010 CAFP News) to help children return to play safely.

For more serious concussions or other head injuries, one great resource in Colorado is the Concussion Program at The Children's Hospital. In addition to offering the full spectrum of top quality care in a high-quality, multidisciplinary clinical setting, the Concussion Program also provides scientifically accurate and up-to-date information about pediatric head injury and conducts research to help clinicians better understand and manage the difficulties that can follow a concussion. Online resources are available at: www.thechildrenshospital.org/concussion.

As SB 40 moves forward, it is important to spread the message about sports concussion to parents, coaches and athletes themselves: while less visible than a broken arm or a sprained ankle, a concussion is an injury to the brain and every concussion is serious. Unfortunately, Jake's story and others like it provide a compelling reason to ensure better recognition of and care for head injuries in youth sports, and a stark reminder of the dangers of returning to play too soon.

Cavity Free at Three

● Cavity Free at Three is a Colorado based educational program aimed at preventing oral disease in young children. We aim to engage physicians, dentists, nurses, dental hygienists, public health practitioners and early childhood educators in the prevention and early detection of oral disease in pregnant women and children.

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For additional information on our program visit our website at: www.cavityfreeatthree.org.

To see how you can become involve contact:

Karen Savoie, RDH
Education Director

Cavity Free at Three Program
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