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Sarah E DeMoor, MD, & Lisa Young, DO, Are 2012 Residents of the Year page 28

Primary Care Partners, PC, Named 2012 Best PCMH Practice of the Year page 26
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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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I think we have started 2012 out on a very positive note. Let me explain that statement. Part of our strategic plan at the CAFP this year was to strengthen our image as Family Medicine Physicians. After much discussion the board hired a branding company to help us get started. One of the first things the branding company did was to send a poll out to Colorado residents across the state. The purpose of the poll was to find out what the people of Colorado know and think about Family Medicine Physicians. We got the results back in January. The news couldn’t have been better! It seems the people of Colorado think highly of us as a profession. This poll was not about physicians in general but was specific to Family Medicine Physicians.

Consistently, Colorado residents want to see Family Medicine Physicians, trust Family Medicine Physicians and they choose us over other types of physicians, physician assistants and nurse practitioners. The results of the survey help show that we are needed, liked and respected by the people of Colorado.

On another positive note, our child obesity grant is continuing forward. The practices involved in the grant are reporting positive changes in their participating patients. The program supported by the grant has done well enough that we will be asking for an extension. This can only continue to improve the health of Colorado. It just goes to show how a thought written on napkin can turn into something pretty amazing.

The legislative session is now in full swing. I can’t say enough good things about our lobbyist Jeff Thermosdgaard and the staff he works with at Mendez consulting. They are doing a great job of keeping us all up on what is going on at the Capitol this year. Thanks to their hard work we now have a new link to track the legislative goings on at the capital. For those of you who are interested, go to www.coloradoafp.org, click on Members Only, and then click on Legislative Affairs. The master and priority lists are there. Or you can go directly to http://www.cocapitolwatch.com/bill-tracker/0/167/2012 for the master bill list and http://www.cocapitolwatch.com/bill-tracker/0/859/2012 for the priority bills.

We had a great Doctor of the Day month in January. We had a Family Medicine Physician signed up for every day but one. I would like to challenge all of you to fill the rest of the days. It is an enjoyable experience and if you don’t want to go by yourself consider taking a resident or a medical student along with you. Personally, I have never been anywhere else where so many people were happy to see me. It is an extremely positive experience and I highly recommend it.

As the year moves quickly along we will continue to keep you up dated on the state of accountable care organizations and along with this continue to support the Patient Centered Medical Home projects. Check out the CAFP web for information on these topics. Stay tuned for upcoming webinars and please do not forget the CAFP’s Annual Scientific Conference in April at the beautiful Cheyenne Mountain Resort.

For 2012 let us all get involved a little and together we will be the Strong Medicine Colorado needs.
HE’LL NEVER JUST BE A KID AGAIN.

WE NEVER SAY NEVER.*
At National Jewish Health, we never say never. It’s one of the reasons we’re the nation’s number one respiratory hospital.* Our innovative approaches to treating children with asthma and allergies can help your child breathe easier. So don’t let severe or even mild respiratory problems hold your child back. Call 1.800.621.0505 to make an appointment or visit njhealth.org.

*U.S. News & World Report Best Hospitals Rankings
The CAFP board of directors and staff have been working hard on your behalf on many initiatives. But the real power of our efforts relies on the strong work of our 2,000 members.

**Tipping Point**
The value of Family Medicine Physicians is being recognized by legislators, employers and payers. We need to continue this momentum. We are on the other side of the tipping point, but we have much more work that needs to be done. To be successful, all Family Medicine practices need to begin the transformation to the Patient Centered Medical Home (PCMH) to realize the benefits of quality improvement and cost containment. I hope that many of you take advantage of the PCMH workshop training at the CAFP’s annual scientific conference on Thursday April 19. All of the courses offered during the conference will help you in your practices.

**Call to Advocacy**
The CAFP board had the vision to create a new Public Relations branding initiative, which will promote Family Medicine Physicians as the foundation of cost-effective quality care and a sustainable health care system. We have hired a consulting firm to help with this work and have many exciting activities planned. You can help by answering the Call to Advocacy. Information is on the CAFP web site, www.coloradoafp.org, under Members Only. You should also have received a packet in the mail with the form and brochure. We need the voices of Family Physicians to help with this advocacy initiative and there are plenty of opportunities for you, your staff and your patients to volunteer.

**Award Winners**
The CAFP Awards Committee chaired by Brian Bacak, MD, past chair of the CAFP board, selected stellar winners for the Family Physicians of the Year. Congratulations to all.
Family Medicine Residents of the Year
Sarah Demoor, MD
Lisa Young, DO
Family Medicine Teacher of the Year
Kathy Miller, MD
Other nominees were John Miller, MD, and Kurt Dallow, MD
Family Physician of the Year
Kern Low, MD
Other nominee was Chris Keenan, MD

The CAFP Foundation chose the PCMH Best Practice of the Year Award:
Winner: Primary Care Partners, PC
First runner up: Westminster Medical Clinic

Please go to www.coloradoafp.org for the press releases on these winners and see the related articles in this magazine issue.

**Leaders in the News**
The CAFP’s Family Physician Leaders are being recognized across the country.
- **Wall Street Journal** article quoted John Bender, MD, “We create a tremendous amount of value.”
- AAFP’s *Family Practice News*, quoted Bob Brockmann, MD, regarding Medicaid provider payments, “Payments need to be higher to ensure that the influx of new Medicaid patients can gain access to care.”
- In another *Wall Street Journal* article, the reporter writes about Scott Hammond, MD’s practice,

Several years ago, Dr. Hammond started methodically tracking certain measures of patients’ chronic conditions. He says he was “horrified, shamed, humbled and devastated” by how few were achieving goals like controlled blood pressure in diabetics. The push to modernize into a “medical home” is part of his effort to improve care for such patients, and in many ways it is paying off.

Today Dr. Hammond and the practice’s two other doctors stay in touch with patients via an online portal, and zap all prescriptions to pharmacies digitally.

The practice is now beating the quality targets set by insurers that are participating in the Colorado nonprofit’s primary-care improvement program.

**Annual Leadership Forum and National Conference of Special Constituencies**
Thank you to the following CAFP members for agreeing to represent the CAFP at the American Academy of Family Physicians’ Annual Leadership Forum and the National Conference of Special Constituencies:

Annual Leadership Forum:
  Kajsa Harris, MD
  Bob Brockmann, MD
NCSC Representatives:
Chandra Hartman, MD, GLBT
Mark Solano, MD, Minority
Luis Lorenzo, MD, IMG
John Cawley, MD, New
Candace Murbach, MD

**New CAFP board members**

Congratulations to the following new and current board members. New board terms will begin July 1, 2012.

**CAFP BOARD OF DIRECTORS 2012-2013**

**OFFICERS**

Chair/Past President – Kajsa Harris, MD, Pueblo
President – Robert Brockmann, MD, Englewood
President-elect - Rick Budensiek, DO, Greeley
Vice President – Candace Murbach, DO, Pueblo
Secretary/Treasurer – Ryan Flint, DO, Denver
Member-at-large – To be determined by CAFP board

**Term Expiring 2013**

Michael Archer, MD, Westminster
Flora Brewington, MD, Ft. Collins
Chet Cedars, MD, Lone Tree
Tamaan Osbourne-Roberts, MD, Denver

**Term Expiring 2014**

Chandra Hartman, MD, Denver
Glenn Madrid, MD, Grand Junction
Anna Wegleitner, MD, Denver
Sergio Murillo, MD, Pueblo

**Term Expiring 2015**

Monica Morris, DO, Denver
Wilson Pace, MD, Denver
Rob Vogt, MD, Colorado Springs
Zach Wachtl, MD, Denver

**Delegates**

Kern Low, MD, Pueblo – term expires 2012 (2nd term, two congresses, 2011 & 2012)
John Bender, MD, Ft. Collins – term expires 2013 (1st term, two congresses, 2012 & 2013)

**Alternate Delegates**

Kent Voorhees, MD, Littleton – term expires 2012 (2nd term, two congresses, 2011 & 2012)
Brian Bacak, MD, Highlands Ranch – term expires 2013 (1st term, two congresses, 2012 & 2013)

**Resident Representatives**

Joseph Castro, MD, Pueblo, grad 2013
Terry Siriphatnaboon, MD, CU, grad 2013
Carolynn Francavilla Brown, MD, Rose, grad 2014

**Student Representatives**

Nicole Struthers, CU class of 2014
The Colorado Academy of Family Physicians is working on a number of things during the 2012 legislative session. The top priority is House Bill 1052. HB12-1052 is a bill entitled “Concerning the Collection of Healthcare Workforce Data from Healthcare Professionals.” This legislation was initiated by the Colorado Rural Health Centers during the 2011 legislative session, as HB11-1152. Although CAFP was supportive of the legislation’s concept last year, there was some concern about the language in the bill, and ultimately the bill failed. This year, CAFP joined together with the Rural Health Centers and generated a much more viable bill by addressing the concerns that the Academy and other professional organizations had last year.

HB12-1052 would request additional pieces of workforce data from health care professionals around the state to evaluate and remedy shortages in Colorado. The information would be collected through the Colorado Division of Registrations, within the Department of Regulatory Agencies, by adding two additional questions to the existing licensure and renewal application. DORA will request that all health care professionals provide the state with the address of their practices and the numbers of patient contact hours completed at each location. By collecting this information, DORA, in conjunction with the Primary Care Office, will be able to evaluate where Colorado is experiencing workforce shortages in order to remedy the situation.

This year, the General Assembly has been very supportive of this legislation, which has received bi-partisan support from both the House and the Senate. Rep. Ken Summer (R-Lakewood), Sen. Betty Boyd (D-Lakewood), and Sen. Ellen Roberts (R-Durango) are the prime sponsors on the bill and all highly respected members of the health committees. However, despite the overwhelming support, HB12-1052 has had to endure a lengthy journey through four House committees. The bill passed unanimously out of the House Health and Environment, and Finance Committees, but received some push back in the House Economic and Business Development Committee and the House Appropriations Committee, eventually passing with only 4 no votes. Though it is unusual for a bill to pass through four committees before being heard on the floor, this process ensured passage through the House. The bill is headed to the Senate next to begin the process again. Although HB12-1052 is only halfway to the governor’s desk, CAFP is very optimistic about its passage and will continue to send updates on its progress.

CAFP is also supporting several other pieces of legislation pertaining to health care. The first is House Bill 12-1017, “Extend Local Access Healthcare Pilot”. HB12-1017 is a bill that would extend a pilot program that was approved during the 2007 session. The program was instated in 2008,
Go Paperless and Get Paid
Register NOW for CMS Electronic Health Record Incentives

The Centers for Medicare & Medicaid Services (CMS) is giving incentive payments to eligible professionals, hospitals, and critical access hospitals that demonstrate meaningful use of certified electronic health record (EHR) technology.

Incentive payments will include:

- Up to $44,000 for eligible professionals in the Medicare EHR Incentive Program
- Up to $63,750 for eligible professionals in the Medicaid EHR Incentive Program
- A base payment of $2 million for eligible hospitals and critical access hospitals, depending on certain factors

Get started today! To maximize your Medicare EHR incentive payment you need to begin participating in 2012; Medicaid EHR incentive payments are also highest in the first year of participation.

Register NOW to receive your maximum incentive.

For more information and to register, visit:
www.cms.gov/EHRIIncentivePrograms

For additional resources and support in adopting certified EHR technology, visit the Office of the National Coordinator for Health Information Technology (ONC):
www.HealthIT.gov
and is intended to provide a health insurance option for uninsured patients who do not qualify for Medicaid or CHP+. Since 2008, the program has enrolled 260 individuals and 78 employer groups. Currently the pilot program is available only in Pueblo County. HB 1017 would continue the program, as is, until 2017. The academy is supporting this legislation because the pilot has been successful thus far; and it also falls under CAFP's core principles, to expand access to health care.

Another piece of legislation CAFP is actively supporting is Senate Bill 37. SB12-037, “Electronic Prescription of Controlled Substances,” is a bill that would conform Colorado state statutes to federal Drug Enforcement Agency regulations. The bill would allow pharmacies to dispense prescribed Schedule II, III, IV, or V controlled substances from electronically transmitted prescriptions. The academy is very supportive and the bill has passed seamlessly through both chambers thus far.

The last bill that CAFP is actively supporting is House Bill 1300. HB 12-1300 continues the Colorado Professional Review Act (CPRA, section 12-36.5 CRS), implements the recommendations made by the Department of Regulatory Agencies pursuant to DORA’s 2011 sunset review report of professional review committees, and amends the bill to modernize this body of law and make it more consistent. This bill, consistent with 48 other states, continues the confidentiality, privileges and immunities associated with professional review committee activities for seven years. This protection is essential to ensure open and robust discussions among members of the committee. These protections for professional review records and for the work of the professional review committee are essential to ensure the process fulfills its patient safety objectives. CAFP is also taking the lead on HB12-1297, a very similar bill, and amending it so the committee on anti-competitive conduct will not repeal as the original bill suggests. CAFP will continue monitoring the progress of HB12-1300 and HB12-1297 as they are currently being heard in their first committee of reference.

HB12-1052 would request additional pieces of workforce data from health care professionals around the state to evaluate and remedy shortages in Colorado.
The Colorado Academy of Family Physicians engaged in a public relations branding project in the fall of 2011 to enhance awareness and strengthen the overall perception of Family Medicine Physicians and their role and to increase general public awareness of the Patient Centered Medical Home model of care. A branding task force was assembled, comprising CAFP members who are providing oversight and guidance to a marketing and public relations firm that has been engaged to develop the project, which includes research, development of strategic messaging and a branding plan.

The project began with implementation of a statewide research study aimed at better understanding perceptions of Family Medicine Physicians by members of the general public in order to inform upcoming public relations efforts meant to positively influence opinions of the importance and value of Family Physicians. A professional research firm headquartered in Denver conducted the research study.

The following key findings emerged from the analysis of the survey:

- **Most Colorado residents are generally satisfied with their ability to obtain high quality health care, although a desire for better health insurance coverage is stated.** Eighty-two percent of respondents stated they were at least somewhat satisfied with their ability to obtain high quality health care, and nearly half of these were “very satisfied.”

- **Family Physicians are strongly preferred over mid-level providers.** This preference was most strongly indicated in scenarios including the monitoring of serious, ongoing health conditions and in obtaining diagnoses after not feeling well for a while. Family Physicians were also still preferred in situations such as a visit for an acute illness or for a routine visit for a long-term health condition.

Family Physicians remain the general preference over mid-level providers and internal medicine specialists for a wide range of reasons, ranging from “softer” characteristics such as “caring” and “trust,” to more concrete skills, including diagnosis and treatment. However, for the latter skills, internal medicine specialists and Family Physicians received similar ratings. “Physicians” (generically stated on the survey) were the most trusted information source, by far, when compared with other possible sources; and the preference for an individual physician was a strong driver for the selection of a health insurance plan.

- **One-half of respondents believe there are some licensed nurses who are trained and educated to provide the same level of health care that a physician does.** Almost none of the respondents believe that all licensed nurses are trained to provide the same level of care as a physician, but one-half of respondents thought some were equally trained and educated. Interestingly, younger respondents were more likely to believe that some nurses are able to provide the same level of health care as a physician does.

- **Family Physicians are regarded for their broad-based knowledge and capabilities, along with caring for entire families.** In open-ended comments, first words that came to respondents’ minds included terms such as “general knowledge,” “well-rounded,” etc., along with a perception that health care is provided for the entire family. Other soft qualities such as “caring” and “friendly” were also mentioned.

- **The role of Family Physicians is commonly seen serving as a first contact and a “first line of defense” in health care, as well as taking responsibility for referring patients to specialists.** Perceived strengths of Family Physicians include providing general health care, extensive general knowledge in the area, and the ability to provide diagnoses and treatments.

- **The most frequently noted area of improvement for Family Physicians is spending time with and getting to know their patients.** This was observed in responses to an open-ended, qualitative question asking specifically about the largest area for possible improvement. In fairness, however, some proportion of respondents perceived Family Physicians as “understanding their patients” as a strength, based on open-ended responses to a separate question. Nearly continued on page 12>>>
three-quarters of respondents rated Family Physicians as good or very good on the attribute of “understands me and develops a relationship with me,” and two-thirds of respondents rated Family Physicians as good or very good on the attribute of “spends time with me.”

- **Family Physicians generally rate very well in performance in important areas such as knowledge to make good referrals and knowledge to apply the latest treatments and protocols.** These two areas were most likely to be ranked in the top three in importance out of a list of possible physician attributes, and 82 percent to 86 percent of respondents rated Family Physicians as at least “good” in these areas with the majority of respondents indicating “very good.”

- **Family Physicians may be able to improve on communications and follow-up with patients, and should continue to keep in mind the importance of building relationships with patients and expressing care and concern.** Although Family Physicians received positive ratings overall in the areas of patient communication and follow-up, these are areas where they may be able to improve relative to the general importance assigned.

- **Impressions of the Patient Centered Medical Home are favorable.** Respondents reacted positively (47 percent “highly favorable” and 47 percent “somewhat favorable”) to a general definition of the Patient Centered Medical Home that was provided on the survey. With the research completed and review of the findings discussed with the board, consultants have developed a strategic branding communication plan that includes critical components to be applied in CAFP lobbying efforts, media outreach and public awareness activities.

Key messages have been developed to ensure that CAFP board members and staff are speaking with one voice, which will strengthen the academy’s influence. An advocacy program is being implemented to engage CAFP members, staff, allied professionals and patients to become active advocates for issues affecting Family Medicine.

A CAFP public service announcement is currently being produced to inform and engage the public. It will be distributed to broadcast stations statewide.

Additionally, consultants proposed the production of a television program that features Family Medicine Physicians. Program content will address the Family Medicine Physician’s ability to provide a continuum of care through the lifespan, with a focus on keeping Coloradans healthy. Five CAFP members have volunteered for the project that will air exclusively on Comcast Entertainment Television October through December 2012.

To raise awareness of CAFP initiatives and its overall brand, ongoing media relations will be executed to advise the public of CAFP’s newsworthy accomplishments.

Members may obtain ongoing information on Facebook, where updates on the branding project will be provided. In addition, members can go to www.coloradoafp.org, Members Only section, to find out how to become involved with the new programs that will benefit the continued success of Colorado’s Family Medicine Physicians.

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**The value of Family Medicine Physicians is being recognized by legislators, employers and payers.**
The American Board of Family Medicine reported that they will not put expirations on the certifications anymore as doing so will save $70,000 a year in printing costs. Patients who are concerned can look their physicians up on the ABFM website. Since the website is updated daily, the ABFM feel it is more accurate than a piece of paper.

There will be changes coming with questions in the next two to three years. The questions will be more clinic-based and involve more complex patient scenarios. These questions will likely be tested on members taking their boards in 2013.

If members do not keep up with their credentialing cycles by doing the SAMS and METICS required they will be required to do another year of residency. They will be given catch-up time but in the seven years if they do not catch up they will lose their board certification and their board eligibility.

It was very interesting to hear the legislative reports from the different states. The Texas legislature meets only every other year and will not be in session this year. New Mexico’s legislature meets every year but alternates between a 30-day and a 60-day schedule. This year New Mexico had a 30-day schedule and the legislature has adjourned for the year.

Common themes across the board are scope of practice, the Patient Centered Medical Home, payment reform, budgets for residencies, trying to make states smoke-free, work force issues and personhood amendments.

Most states have a doctor advocacy day; only a few do a doc of the day the way the Colorado Academy of Family Physicians does.

One issue New Mexico faced was non-medical people trying to write policy for how opioids will be prescribed. This was an unexpected event and by report not very well done. Had proposed legislation passed it would have been very onerous to follow and not been good for physicians or patients. Fortunately, no such policy became law but physicians in the state are going to be proactive and make sure they are involved with any upcoming policy making for next year. Colorado physicians may want to make sure they don’t get blindsided as this policy is a popular topic right now.

Roland Goertz, MD, MBA, FAAFP, spoke about the Relative Value Scale Update Committee and indicated the direction of the update should become clear by spring. The American Academy of Family Physicians is actively monitoring this.

Dr. Goertz asked all members to be bold with the PCMH, which he stated Family Physicians have been working to develop. He said, “It belongs to us,” adding “we are the most qualified to lead the medical home.” He also stated that “nurse practitioners don’t have any business telling us differently.”

To learn more, call 1-877-406-9579 or visit healthcare.goarmy.com/p276.
The Tdap shot – tetanus and diphtheria toxoids and adult pertussis vaccine – is recommended for all adults, now including those age 65 and over.

The Associated Press reported in February that the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention “voted to expand its recommendation to include all those 65 and older who haven’t gotten a whooping cough shot as an adult.”

Medscape reported, “The ACIP reached its decision after considering the rebound that pertussis has made in the United States over the last 30 years. The number of reported cases peaked in 2010 at 27,550, with roughly 700 involving seniors, according to the CDC.”

MedPage Today reported, “The vote by the (ACIP) effectively establishes a recommendation of ‘universal’ Tdap vaccination for all patients ages 19 and up.”

**Tdap and Influenza during Pregnancy**

The CDC is emphasizing giving Tdap and influenza vaccines to pregnant women to protect mothers and newborns. The CDC also recommends a one-time Tdap vaccine for all persons who are or will be close contacts of infants younger than 12 months of age (e.g., parents, grandparents, and child-care providers) and who have not received Tdap shots previously. This provides a “cocoon of protection” for the child until he or she is vaccinated.

Although Tdap (Adacel, Boostrix) can be given after delivery, that strategy leaves the newborn unprotected until they get their first pertussis vaccination (usually at 2 months of age).

The CDC says to vaccinate pregnant women after 20 weeks gestation if they haven’t previously received Tdap and need only a booster.

If a pregnant woman’s vaccine history is unknown or incomplete, the entire three-shot series should be given: one dose right away, the second four weeks later, and the third six to 12 months after the first. Directions call for Tdap for the first vaccine in the series and Td for the second and third.

Injectable influenza vaccine (Fluzone, etc) can be given during any trimester. But the nasal mist vaccine (FluMist) should not be used. Since it’s a live vaccine, it’s not recommended during pregnancy.

Some patients request thimerosal-free vaccines, even though there’s absolutely no evidence thimerosal is harmful to pregnant women, infants, or pre-born children. Nevertheless, if a patient wants to avoid thimerosal, she’ll have to get the vaccine with one of the products that come in prefilled syringes. The one exception is Fluvirin, which has trace amounts of thimerosal.

**Hepatitis B and HPV.**

More patients are now candidates for hepatitis B (HBV: Engerix-B, Recombivax HB) and Human papillomavirus (HPV: Gardasil) vaccines.

The CDC is now recommending HBV for adults with diabetes who are under age 60. Why? Adults with diabetes have twice the risk of contracting hepatitis B and are more likely to develop chronic hepatitis B than adults without diabetes.

Prescriber’s Letter explains that one case of hepatitis B can be prevented for every 124 adults with diabetes age 60 who are vaccinated.

HBV can be considered for diabetic patients age 60 and up, but the vaccine is somewhat less effective in these older patients.

The CDC is also recommending the HPV vaccine for boys age 11 to 12, as well as those up to 21 who haven’t gotten the vaccine yet. Why? CDC says vaccination reduces the risk of genital warts and some precancerous lesions in males, as well as possibly reducing HPV spread to future sexual partners. The recommendation for boys is to vaccinate for HPV only with Gardasil, as Cervarix doesn’t protect against the appropriate HPV types and is not approved for males.

In addition, the CDC now recommends HPV vaccine for previously unvaccinated males 22–26 years of age who are immunocompromised, or who test positive for human immunodeficiency virus (HIV) infection, or who have sex with men.

**Shingles**

There are also new developments concerning the shingles vaccine. You may have heard that the Food and Drug Administration (FDA) has now approved Zostavax for people age 50 and up.

However, the CDC is sticking to its guns and recommending the vaccine only for people age 60 and older. Why? The administration is concerned about the vaccine supply. Lowering the age from 60 to 50 would add 40 million more patients and really stretch the vaccine supply.

Nevertheless, Zostavax may be recommended to patients age 50 or older, but only with the warning that not all insurers will cover it for those aged 50 through 59. Patients who most need Zostavax are those 60 and over, those starting chronic immunosuppressive therapy, or those not able to tolerate shingles due to chronic pain or other conditions. Zostavax should be avoided in patients who are already immunosuppressed.

Also, it’s important to note that there is a conflict between Zostavax labeling and CDC recommendations. The labeling suggests spacing shingles and pneumococcal vaccines four weeks apart. But the CDC does not advocate waiting. The CDC points out that recent evidence shows that giving them together does not
reduce efficacy. Therefore, doctors can feel comfortable giving Zostavax at the same time as pneumococcal and/or flu vaccine.

Zostavax should be given to patients who have a history of having had shingles in the past. Although Zostavax is not proven to prevent recurrences (yet), the CDC recommends the practice and it’s not harmful. It can be given as soon as the acute symptoms are gone.

Other Changes in the Schedule for Persons Age 0-18 years

• **Meningococcal**: Quadrivalent meningococcal conjugate vaccine (MCV4) purple bar has been extended to reflect licensure of MCV4-D (Menactra) use in children as young as age 9 months. Information regarding the recommended age (16 years) for the booster dose of MCV4 has been added.

• **Hepatitis B**: New guidance is provided for administration of hepatitis B (HepB) vaccine in infants with birth weights less than 2,000 grams and greater than or equal to 2,000 grams. Clarification is provided for doses after administration of the birth dose of HepB vaccine. If a mother’s HBsAg status is unknown, within 12 hours of birth HepB vaccine should be administered for infants weighing 2,000 grams or more, and HepB vaccine plus HBIG should be administered for infants weighing more than 2,000 grams. The mother’s HBsAg status should be determined as soon as possible and, if she is HBsAg-positive, HBIG should be administered for infants weighing 2,000 grams or more (no later than age 1 week). Guidance for use of Hib vaccine in persons aged 5 years and older in the catch-up schedule has been updated.

• **Hepatitis A**: HepA vaccine footnotes have been updated to clarify that the second dose of HepA vaccine should be administered six to 18 months after the first dose.

• **Haemophilus influenza type b**: Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, human immunodeficiency virus (HIV) infection, or anatomic/functional asplenia.

• **Measles, Mumps, Rubella**: Guidance is provided for use of measles, mumps, and rubella (MMR) vaccine in infants aged 6 through 11 months. MMR vaccine should be administered to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with two doses of MMR vaccine, with the first given at ages 12 through 15 months and at least four weeks after the previous dose, and the second at ages 4 through 6 years.

• **Influenza**: Influenza vaccine footnotes also have been updated to clarify dosing for children aged 6 months through 8 years for the 2011–12 and 2012–13 seasons.

• **Tetanus, Diphtheria, Pertussis**: Tdap vaccine recommendations for children aged 7 through 10 years have been updated. Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years.
Working Group Focuses on PCMH Spread and Sustainability

Timely news during times of great changes in health care  By Tracy Hofeditz, MD

The times they are a’changin. We need change as Family Physicians and our patients need a higher functioning health care system. We must be ready for change, embrace it and guide it. Over the past few weeks major initiatives have started locally and nationally that acknowledge the Patient Centered Medical Home as a proven model for better care. They promise to bring direct financial support for practices that are transforming, becoming and maturing as PCMHs. If you have been on the fence, now is the time to get off.

Can you hear the whistle blowing? The value of the PCMH is being recognized and enhanced payments are becoming available outside of pilots. Those of you waiting at the station or to buy a ticket, now is the time to board the PCMH train!

PCMH Spread and Sustainability

On Feb. 7 the first PCMH Spread and Sustainability meeting convened in collaboration with Marjie Harbrecht, MD, of HealthTeamWorks and Edie Sonn of the Center for Improving Value in Health Care. A large coalition of health plans, provider groups, and advocates for the PCMH model, including Raquel Rosen and me representing the CAFP, has been brought together to answer the question: How can we sustain practices that have already become medical homes and spread the proven model to other practices across the state? Anthem, Cigna and United have pledged to provide additional payments to recognized medical homes! Such a commitment will be a watershed event for the medical home movement in Colorado. It is now up to our working group to hammer out the details. Issues to be addressed include the following:

1) PCMH definition – Should a recognition program be required? If so, which one(s)?
2) Measures and benchmarks – Agree on standards across all payers for quality, cost and patient satisfaction.
3) Data Aggregation and Reporting – Establish standard data requirements from both practices and payers.
4) Payment Models - Determine standard methods of payment that support the enhanced care processes in a PCMH and incentivize quality improvement.

By May 1, our work will be done and enhanced payment for the enhanced care from a PCMH will be available nationwide by the end of this year.

Can you hear the whistle blowing? The value of the PCMH is being recognized and enhanced payments are becoming available outside of pilots. Those of you waiting at the station or to buy a ticket, now is the time to board the PCMH train!

Join us on the journey of practice transformation to higher quality, lower cost care that is more satisfying and safe for our patients and ourselves.

Important events and leaders show the way

Physician Health Partners (PHP) was chosen by the Centers for Medicare and Medicaid Services to be one of the 32 pioneer accountable care organizations across the nation. “These Pioneer ACOs represent our nation’s leaders in health systems innovation, providing highly coordinated care for patients at lower costs,” said Marilyn Tavenner, acting administrator of the centers. “Physician Health Partners has demonstrated significant experience in providing high quality, coordinated care, and we are excited to partner with them,” Tavenner said. Physician Health Partners and its partnering IPAs (Primary Physician Partners, South Metro Primary Care, and KEY

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School-based Wellness Initiative Joins Ready, Set, FIT! and Tar Wars

By Cara Coxe

The Colorado Academy of Family Physicians received funding to implement a comprehensive school-based wellness project that incorporates two existing programs; Ready, Set, FIT! and Tar Wars. More specifically, we wanted to increase the number of kids in Colorado receiving education on physical activity and health in rural communities. Offering both the Ready, Set, FIT!, and Tar Wars together would be an effective comprehensive approach which aims to motivate and enable young students to maintain and improve their health, prevent disease, and reduce health related risk behaviors. Ready, Set, FIT! teaches third- and fourth-grade students about the importance of health through physical activity, nutrition, and emotional well-being; and Tar Wars is a tobacco-free program that aims to educate students about the harmful risk of tobacco use and how youth are targeted in the media.

Implementation of the project began with a partnership with the St. Mary’s Family Medicine Residency Program in Grand Junction. A staff person employed by St. Mary’s served as a coordinator between the CAFP and the Mesa County School District. Nisley Elementary, Pomona Elementary and Rick Rock Elementary were the three participating schools. Residents of St. Mary’s were responsible for going into the classrooms and delivering the program. In addition to program implementation, CAFP created new evaluation tools, as well as utilizing existing assessments; however interpretation of assessment results and outcome data is limited. Obtaining accurate data and providing thorough evaluation require extensive training, time, and work that were not planned for in the original proposal. To close this gap, the CAFP would like to conduct research and studies over a suggested period of time to determine effectiveness. The academy would like to evaluate health education programs by systematically conducting a process evaluation to determine the extent to which teachers are delivering health education, and utilize state and local assessments to determine program effectiveness.

There is a great need for educating students on healthy living and encouraging them to be responsible for their health. Health education gives students the knowledge and skills to thrive physically, mentally, emotionally and socially. This knowledge helps students meet the challenges of growing up by giving them the life tools to become physically and intellectually healthy individuals. Comprehensive school health education helps students to recognize the causes of ill health and to understand the benefits of prevention. Through health education, students become aware of the dimensions of good health: physical soundness and vigor, mental alertness and ability to concentrate, healthy emotional expression, critical thinking skills, and positive relations with others. Health education also includes a set of skills to help students be better consumers of information, to manage stress and conflict, and to make better decisions in the face of conflicting messages, thus assisting them in living healthier lives. Family Physicians, residents, and medical students all can take part in these efforts.

Additional information is available by contacting Cara Coxe, Wellness Programs Manager, cara@coloradoafp.org. Those interested in delivering the program may also contact Coxe.

Comments from teachers:
“My students had the opportunity to participate in the Ready, Set, Fit activities this past fall. It was wonderful to have an actual doctor come in and talk with students about healthy choices. One student in particular, decided to join an after school activity called Girls on the Run. She wanted to continue making healthy lifestyle choices. I asked her why she chose to start running, and she told me that I need to exercise my heart!” - Nicole Stephens, Pomona Elementary

“I think Ready, Set, FIT! is a great start to learning about the importance of fitness and a great way to include the family, which is key!” - Cindy Cooper, Rim Rock Elementary
Anthem BCBS Announces New Patient Centered Primary Care Strategy

**PC2 program builds on PCMH pilot**

By Elizabeth Kraft, MD, MHS

Anthem Blue Cross and Blue Shield in Colorado recently announced a new Patient Centered Primary Care program, called that will fundamentally change its relationship with primary care physicians by significantly increasing the company’s investment in their practices and in the health of their patients. Through this initiative, which is called the PC2 program, Anthem will increase revenue opportunities for participating primary care physicians, enhance information sharing and provide care management support from Anthem’s clinical staff.

Building on the success of the Colorado multi-payer Patient Centered Medical Home pilot, Anthem believes that primary care is the foundation of medicine, and it can and should be the foundation of its members’ health. Primary care physicians will get paid more than they do today if they are committed to:

- Expanding access
- Coordinating care for their patients through the establishment of formal care plans developed with their patients
- Being accountable for the quality of care and health outcomes of those patients

Analysis of year two of the Colorado PCMH pilot program reflect significantly improved utilization. Preliminary highlights include an 18 percent decrease in acute inpatient admissions per 1000, compared to an 18 percent increase in a control group; a 15 percent decrease in total emergency room visits per 1000, compared to a 4 percent increase in a control group; specialty visits per 1000 remained around flat compared to a 10 percent increase in a control group; and overall return-on-investment estimates ranged between 2.5:1 and 4.5:1. Further confirming Anthem’s new approach, the quality improvement results collected by HealthTeamWorks, the convening organization of the pilot, showed improvements in quality care measures for diabetes, heart-stroke and preventive medicine.

The program is intended to be rolled out later in 2012 in Colorado and be available in all 14 of Anthem’s affiliated health plans over the next two years.

Commonly asked questions include the following:

**What is the patient centered primary care program?**

Anthem’s new Patient Centered Primary Care – or PC2 – program, will make a meaningful investment in primary care by increasing revenue opportunities for primary care physicians, enhancing information sharing and providing direct care management support from Anthem’s clinical staff. This program

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**STEVEN M. ATKINS, D.P.M.**
Executive Committee Explores Academy ACO

By Rick Budensiek, DO

Most physicians have heard of the Accountable Care Organizations. What if the Colorado Academy of Family Physicians formed an ACO for its members? This is the question facing the CAFP executive committee. The savings would be sure to go to members. The members could use the increased compensation to keep their practices viable, improve care and save costs.

What are the risks involved in setting up an ACO? The CAFP executive committee met with local health care legal expert Gerry Niederman with the firm Polsinelli Shughart. We reviewed the costs of setting up an ACO as well as the risks and potential rewards of such an ACO to its members and to the CAFP. After a thorough discussion with legal counsel, the executive committee considered the risks to exceed the benefits of setting up an ACO.

There were numerous reasons for that decision. First, primary care physicians can join only one Medicare ACO. Many members will be committed to their Independent Practice Associations, hospitals, or local entities’ ACOs. Second, the costs are not insignificant. Although the cost of an ACO start-up can be financed by the Colorado Medical Society, according to the final rule for the Centers for Medicare and Medicaid Services’ Accountable Care Organization and Shared Savings Program published in November in the Federal Register, the cost of ACO set-up is around $500,000. Third, in order to be successful, the ACO would have to be selective and include those physicians who were most cost effective. What criteria would be used to select those physicians or practices? Level 3 recognition of Patient Centered Medical Home by the National Committee for Quality Assurance? In addition to the $500,000 set-up costs, clinical guidelines would need to be set up. Metrics would need to be followed. Leadership would need to be salaried. These, among other considerations, led to the executive committee’s decision. Readers who would like to discuss this may call CAFP office at 303-696-6655.

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is voluntary and builds on the success Anthem has experienced with the multi-payer Patient Centered Medical Home pilot in which HealthTeamWorks is the convening organization. Primary care physicians who participate in the program will have the opportunity to earn additional revenue through a shared savings model.

What if PCPs do not participate?

There is no penalty for not participating; it is voluntary.

How does the program work?

The Patient Centered Primary Care program will increase the revenue stream to primary care physicians in three ways:

1. Increases to the primary care provider fee schedule will support transformation to patient centered care for participating physicians. The amounts of increases will vary across and within markets.

2. Payments will be made for “non-visit” services not currently reimbursed, such as preparing and monitoring care plans for patients with multiple and complex chronic conditions.

3. Shared savings payments will be made for reduced cost trends. To be eligible, PCPs must first achieve a threshold level of quality based on physician quality performance. Once that threshold is met, doctors will qualify to receive 20 percent to 30 percent of the savings achieved through the program.

Does this apply to all lines of business – Medicare Advantage, individual and commercial?

Yes, in most situations, this program applies to physicians working with customers in all these areas.

What’s the timeframe for deployment?

This is a collaborative program, and Anthem wants to work with each market’s providers every step of the way. Anthem will spend the next several months finalizing the specific details market-by-market and expects to begin contracting with physicians by the end of the year. The enhanced tools and information, as well as clinical staff resources, are intended to be available right out of the gate, along with the increased fee-schedule reimbursement and reimbursement for care planning activities. The shared savings will be calculated based on a full year of performance.

As Anthem is paying PCPs more, will the insurer pay specialists less?

Anthem does not anticipate any fee decreases to specialists because of this program. This program should pay for itself, based upon the performance of the practices in the PCMH pilot.

What are the minimum quality thresholds providers must meet to qualify for the program?

To participate in the shared savings, physicians must meet plan quality requirements, which reflect standards established by organizations such as the National Committee for Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics and others. Standards may apply to such measures as the percentage of patients receiving immunizations and preventative care screenings, as well as management of chronic diseases such as diabetes and high blood pressure. These quality threshold programs aren’t new – Anthem has had physician quality performance programs and traditional physician pay-for-performance programs, such as the current Anthem Quality Insights program, for many years.

Those who would like additional information may work with their provider relations contacts or contact Cissy (Elizabeth) Kraft, MD FAAFP at elizabeth.kraft@anthem.com or 303-831-2824.
There has been recent increased awareness of autism spectrum disorders, or ASD. While some children with ASD -- including Autism, Asperger Disorder, and Pervasive Developmental Disorder, Not Otherwise Specified -- are easily identified, many require more extensive evaluations. Despite this need for comprehensive assessment, the primary care provider has an important role in this process.

What are Autism Spectrum Disorders?

ASD are characterized by impairments in core social interaction skills, delayed or unusual communication, and the presence of repetitive or unusual (stereotyped or intense) behaviors and interests. There is no one specific behavior that defines the disorder – it is the constellation of symptoms in these three different areas (autism triad). These symptoms generally present prior to age 3. Children may appear quite different in symptom presentation and severity. ASD are neurodevelopment disorders, without single cause, and with strong genetic influences. Environmental factors also may play a contributing role. ASD are not due to poor parenting.

Why look for ASD in young children?

Some children show evidence of problems in infancy, while others may appear to develop appropriately until 18 to 24 months, and then lose previously acquired language or social skills or both. However, the diagnosis of ASD often is not made until later. Early identification and specific interventions result in better outcomes, thus underscoring the need to identify and treat children as soon as possible.

How can we identify ASD early?

Practice developmental surveillance at all well-child visits. Perform formal screening if concerns arise.

- Red flags requiring further evaluation:
  - No response to name, babbling, and/or gestures by 12 months
  - No pointing to objects to show interest by 14 months
  - No single words at 16 months
  - No early functional play (e.g., feeding doll) by 18 months
  - No spontaneous two-word utterances by 24 months
  - Avoidance of eye contact and preference for being alone
  - Repetitive words or phrases
  - Repetitive motor movement (e.g., hand flapping, spinning)
  - Language or social skill regression
  - Obsessive interests (e.g., lining up toys repeatedly)

- Standardized developmental screening at specific intervals

for ALL CHILDREN, per American Academy of Pediatrics guidelines

- General screening: 9, 18, 24 or 30 months (e.g., ASQ, PEDS), AND
- Autism screening: 18 and 24 months (e.g., M-CHAT, PDDST-II)

What if the screening is positive?

A positive screening may not result in an ASD diagnosis. Following a positive screen, primary care providers can take the following actions:

- Referral to Early Intervention or Child Find
- Hearing testing
- Lead level testing
- Referral for ASD diagnostic evaluation
- Referral to allied health providers (speech/language, occupational therapy) for targeted evaluations
- Initiation of medical work-up for specific associated medical conditions

What does a diagnostic evaluation look like?

A comprehensive ASD diagnostic evaluation should include:

- Clinical focused interview with a caregiver
- Structured behavioral observations
- Psychological evaluation
- Evaluation for other disorders and/or co-morbidities
- Assessment of communication skills
- Assessment of motor development
- Assessment by developmental pediatrician or child neurologist, to rule out associated medical conditions
- Assessment of the caregivers’ knowledge of ASD, coping skills, and available resources and supports

What does a medical work-up include when a diagnosis of ASD is made?

- Hearing testing, if not performed recently
- Lead screen, if not previously obtained
- Genetic testing: Chromosomal microarray analysis (high resolution karyotype if there are insurance restrictions), and fragile X testing. MECP2 gene testing for girls. PTEN gene sequencing with significant macrocephaly (more than 2.5 SD above mean)
- Metabolic testing, for history of developmental regression.
- EEG for seizure concerns; overnight EEG and/or neurology referral for significant regression or active neurological process
CLINICAL ARTICLES

Early identification and specific interventions result in better outcomes, thus underscoring the need to identify and treat children as soon as possible.

• Active engagement in intensive programming at least 2.5 hours/week
• Systematic, planned, developmentally appropriate instruction
• Highly structured/supportive environment
• Individualized attention (1:1 or 2:1)
• Inclusion with typically developing peers when appropriate
• Parent education/family involvement
• Individualized goals with ongoing assessment and program alterations as needed

All children do not require the same types of services. Interventions must be based on each child’s specific needs. Interventions typically emphasize behavior, play, and social interactions. Positive experiences with typically developing children are also encouraged.

What types of medical interventions are recommended?

While there are no medical treatments for ASD core symptoms, some co-morbidities are treated with medications. It is helpful to have behavior therapy in place when medications are used. Some of the co-morbid behaviors treated with medication may include problems with:

• Attention and hyperactivity
• Mood, including anxiety, depression, and mood instability
• Aggression and/or self-injurious behaviors
• Obsessive compulsive behaviors
• Sleep disorders

How can I best support families of children with ASD?

Families need support to access services that are available in the community. The Autism Society of Colorado (720-214-0794; www.autismcolorado.org) provides a number of services for families including support groups and respite care. Other agencies include:

• ARC of Colorado (303-864-93340)
• Parents Encouraging Parents (1-877-834-0588)
• PEAK (719-531-9400)
• Parent to Parent (1-877-472-7201)

Children’s Hospital Colorado offers a number of services including assessments, therapies, and support for families.

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Kids Corner is a regular feature of the CAFP News brought to you by the Department of Family Medicine at Children’s Hospital Colorado. For questions about this article or suggestions for future topics you may contact the authors or Dr. Jeffrey Cain, Chief of Family Medicine through OneCall: 720-777-3999.
What does it take to be Children’s Hospital Colorado?

It takes collaboration with our community partners and a pledge to work together to provide the best care for children. It takes a shared, single focus of our nationally-ranked pediatric specialists focused on one goal: healing children.

It takes many hands, one heart.

Children’s Hospital Colorado, a nationally ranked pediatric hospital, offers 15 locations with pediatric services including emergency care, urgent care, pediatric specialty clinics, therapy care, diagnostics and observation.

childrenscolorado.org/locations

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.

Dental decay is the most chronic childhood disease, yet it is preventable. Oral health is an integral part of overall health

As a health professional, you can play an important role in the prevention of early childhood caries in children.

We offer comprehensive training opportunities to address the prevention of oral health disparities of children under the age of three.

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

To see how you can become involved contact:
Karen Savoie, RDH
Education Director
Cavity Free at Three Program
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303-724-4750
Occurring in nearly one in 700 live births, Down syndrome is the most commonly identifiable cause of intellectual disability. Historically, individuals born with Down syndrome had significantly shorter life spans with minimal educational opportunities and community engagement. As recently as the 1960 and 1970s, families were encouraged to institutionalize their loved ones with Down syndrome and denied medical interventions.

Life for Individuals with Down Syndrome Today

Since that time, the medical community has made tremendous strides in the care of persons with Down syndrome. The average life expectancy for an individual with Down syndrome today is approximately 60 years, up from 25 years in 1983 and 49 years in 1997. These improved outcomes have been achieved by deinstitutionalization, access to life-saving therapies, improved developmental and educational interventions and increased expectations by society. In the U.S., nearly all youths with this condition attend and complete high school, many go to community college or school-to-work transition programs, and the occasional individual with Down syndrome graduates from a university.

Many adults with Down syndrome are able to live independently and to have highly responsible jobs. For example, Tim Schlewitz, who happens to have Down syndrome, is an anesthesia technician at Children’s Hospital Colorado, where he and his colleagues keep the operating rooms stocked: http://www.childrenscolorado.org/news/pr/2010-News/project-search-Tim-Schlewitz.aspx. Karen Gaffney, who has Down syndrome, swam the English Channel as part of a relay team, swam Lake Tahoe and Lake Champlain solo and has her own foundation: http://www.karengaffneyfoundation.com/. There are actors and actresses, artists, athletes, baristas, legal assistants, models, musicians, office workers, and teachers’ aides who have Down syndrome, and there are many more with abilities who cannot find meaningful employment opportunities – the next challenge for families.

Changing the Conversation from Perception to Reality

Children and adults with Down syndrome deserve respect, as do all individuals. “People-first language” places the emphasis on the individual – a child with Down syndrome is not a Down’s child. Parents have been very clear with this message to professionals. Even now, many parents relate verbatim their difficult experiences with negative comments about Down syndrome made by doctors and nurses in the delivery room or the nursery. They are appalled that physicians and nurses say how sorry they are that the new baby has Down syndrome and the information they provide is inaccurate. The birth should be congratulated, noting that the baby just happens to have Down syndrome and the information they provide is inaccurate. The birth should be congratulated, noting that the baby just happens to have Down syndrome and therefore requires additional tests. Referral to a parents’ group for Down syndrome is also extremely important at this time.

The Sie Center for Down Syndrome

Made possible by the generosity of the Anna and John J. Sie Foundation and the Global Down Syndrome Foundation, the Sie Center for Down Syndrome is a referral clinic within Children’s Hospital Colorado for persons through 25 years of age with Down syndrome.

Providers at the Sie Center meet with patients and their families referred by primary care physicians to deliver comprehensive, Down syndrome-specific medical assessments. Clinicians then provide referring physicians with suggestions to optimize care of these and similar patients in their primary care practices. Directed by Fran Hickey, MD, a developmental and behavioral pediatrician, the clinic coordinates medical and developmental care with physical therapy, occupational therapy, speech therapy, feeding therapy, and social work. A team of highly qualified subspecialists interested in the clinic’s patients is available after the initial visit.

The newest addition to the clinic staff is Kristin Jensen, MD, who trained in pediatrics and internal medicine. She will be developing a program to assure an effective transition from the child- and youth-focused Sie Center to adult Down syndrome services. This service will continue to work with
The average life expectancy for an individual with Down syndrome today is approximately 60 years, up from 25 years in 1983 and 49 years in 1997.

referring providers to facilitate screening for adult-onset comorbidities associated with Down syndrome (e.g., early-onset dementia) and to optimize adult-focused primary care.

A genetic counseling clinic has been developed by Ed McCabe, MD, PhD, a pediatrician and medical geneticist, working with a genetic counselor. Families are referred to this clinic if they request information regarding the cause for Down syndrome in their child or the chance of them or their children having another child with Down syndrome.

The Sie Center for Down Syndrome represents the clinical arm of the Linda Crnic Institute for Down Syndrome, which also incorporates research and advocacy missions.

Together, these centers are working to change the conversation about individuals with this condition. The mission of the Sie Center for Down syndrome is to maximize the abilities and improve the lives of all people with Down syndrome. This is not an intractable disorder. These individuals are able to live complete and long lives, and, given the chance, they can make significant contributions to society. Staff at the centers are dedicated to their responsibility to recognize this fact, treat these remarkable individuals with the respect they deserve, and assure they get the best possible care.

Contact information for the authors of this article is as follows:
Edward RB McCabe, MD, PhD, Executive Director, Linda Crnic Institute for Down Syndrome; Anna and John J Sie Endowed Chair in Down Syndrome Research and Clinical Care; Professor, Department of Pediatrics, University of Colorado School of Medicine

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Additional information is available at www.CrnicInstitute.org.

IN MEMORIAM:
Richard Orlen Gritzmacher


Dr. Gritzmacher earned a medical degree at the University of Wisconsin and a master’s degree in Public Health from Yale University. He worked with the Indian Health Service in Arizona before joining a private practice in Old Saybrook, Conn. During his 30 years there, Kathryn Hepburn was among his patients. From 1998 until 2008, he worked as a temporary physician for communities in the Southwest and elsewhere in the U.S. At the time of his death, he was medical director of Quay County Family Health Center in New Mexico, a Presbyterian Medical Services facility.

“He worked serving the underserved in Tucumcari, N.M., right up until August,” stated his widow, Carolyn Hayes, RN. “His death was totally unexpected then in October.”

In addition to Hayes, survivors include three sons and two grandchildren.
Primary Care Partners, PC, is the Colorado Academy of Family Physicians Patient Centered Medical Home Practice of the Year.

The large, multi-disciplinary group in Grand Junction provides primary care for more than 30 percent of Mesa County residents, who, according to surveys, are generally well satisfied with the care and services they receive.

“The board was very impressed with the outstanding care that you provide to your patients and the quality initiatives and improvements of your practice,” wrote Elizabeth Kraft, CAFP Foundation president. “We applaud Primary Care Partners for the care management and patient education it provides as well as the team care approach.”

A Patient Centered Medical Home, or PCMH, is an innovative practice model designed to improve primary care. Primary Care Partners achieved Level 3 PCMH recognition from the National Committee for Quality Assurance in September 2010, making it one of the first 100 PCMH practices in Colorado.

Primary Care Partners – a professional corporation or PC – comprises three practices: Family Physicians of Western Colorado, Western Colorado Pediatric Associates and Western Colorado Physicians Group. Each practice is staffed with physicians, physician assistants, nurse practitioners, and nursing, clerical and support personnel. Among more than 247 employees, 40 are physicians and eight are physician assistants.

At the forefront on PCMH

Primary Care Partners has been at the forefront in introducing new ways of doing things that are part of the medical home. The group has used electronic health records for 12 years. “Our offices are paperless and wireless,” the award application states. “Patient records are available at all sites, in the local hospitals, emergency rooms and assisted living facilities.”

The group has built on existing relationships to help develop a medical neighborhood. The award application states, “We have developed solid relationships over the past 35 years. We are linked to them and all local health facilities through the Quality Health Network (QHN).” Facilities are provided for physicians outside the area for specialty clinics.

After-hours medical care is offered through DOCS ON CALL, which is staffed daily by physicians, nurses, technologists and receptionists. The service is available every evening and on weekends and holidays.

The group also staffs clinics at two assisted living facilities and offers house calls and nursing home visits. Telephone triage by qualified nursing personnel is offered daily, including weekends and holidays, and translation in hundreds of languages is available through an outside service.

Primary Care Partners has established quality improvement programs in areas including immunizations, diabetes care and hypertension care. In each of these areas, the group maintains a registry allowing patients with certain risk factors, such as high blood pressure and no recent appointment, to be identified. The programs provide protocols for contacting potentially at-risk patients and following up with appropriate care.

In addition, the group offers disease state management in such areas as high-risk obstetrics, asthma and depression. “Health surveillance is monitored and encouraged through recall letters for mammograms, pap smears, physicals and other follow-up care,” the application states.

Emergency room use and hospitalization are both relatively low among patients of Primary Care Partners. According to the application, in 2009 there were 112 emergency room visits per 1,000 patients compared to a regional norm of 216. In 2008 the number of hospital days was less than half the national average.

“To reduce unnecessary hospital emergency room utilization, we have an aggressive program to educate our patients before and after emergency room visits,” the application states. “Our staff contacts every patient that uses the emergency room when another resource would have been more appropriate and conducts education for future responses to urgent medical issues.”

Other areas where Primary Care Partners seeks to meet patients’ needs in a cost-effective manner include pharmacy and ancillary services. Drug utilization management includes a formulary and independence from pharmaceutical representatives. Grand Junction Diagnostics, a division of Primary Care Partners, provides services that include x-ray, mammography and laboratory.

Patients more than satisfied

Like other Patient Centered Medical Homes, Primary Care Partners solicits frequent feedback from patients. “Patients are surveyed in all divisions at least twice a year,” the application states. “Results are distributed to appropriate providers and management for continued improvement.”

Surveys submitted with the application showed “excellent” ratings by large majorities of responders in categories ranging from experiences with various staff to “communication between you and your physician.”

Moving forward, Primary Care Partners is one of 11 Colorado practices selected to participate in Advancing Care Together, a three-year program that focuses on better integration of primary care, mental health care and substance abuse treatment.

Staff of Family Physicians of Western Colorado includes Amy Bratteli, MD, John Bratteli, MD, Joshua Campbell, MD, David Dirks, MD, John Flanagan, MD, Jill Hilty, MD, Andy Mohler, MD, Mike Pramenko, MD, James Quackenbush, MD, Susan Sayers, MD, Britta Seppi, MD, Stephanie Shrago, MD, Paul Sturges, MD, Dan Sullivan, MD, Christopher Weaver, MD, and Peggy Wrich, DO.

Family Physicians on the staff of Western Colorado Physicians Group include Lynn Holliday, MD, Glen Madrid, MD, Rebecca Mashburn, MD, Greg Omura, MD, Pat Page, MD, and Marshall Steel, MD.
Kern Low, MD, FAAFP, is 2012 CAFP Family Physician of the Year

Peers, patients praise Pueblo doctor who chaired national conference in Denver

Kern Low, MD, FAAFP, is the CAFP Family Physician of the year. Liked and admired by his patients, the Pueblo doctor has been active for many years in the American Academy of Family Physicians at both the state and national levels. He chaired the AAFP Annual Scientific Conference that was held in Denver and served for four years on the AAFP Commission on Continuing Professional Development.

Writing in support of Dr. Low’s nomination, Kent Voorhees, MD, wrote, “Kern has demonstrated that he is a very hard worker, dedicated to making things better for all Family Physicians and puts others first to make this happen.”

Born in Salinas, Calif., Dr. Low earned his bachelor’s degree in Psychobiology at the University of Southern California and his Doctor of Medicine degree at Chicago Medical School in N. Chicago, Ill. He performed his residency and internship at Tripler Army Medical Center in Honolulu.

Laura Stein, his partner at the Centura Family Care Center in Pueblo, wrote, “Dr. Low is a loyal and good friend. He is a team player and a pleasure to work with. He is reliable and always willing to help in a crunch.”

Candace Murbach, DO, has also worked in recent years with Dr. Low. She wrote, “As a colleague, Kern is considerate, professional, flexible and supportive. He is an excellent example of a Family Physician and role model to residents and peers alike.”

Patients also praise Dr. Low. Brian Bentz, wrote, “From the first visit, I knew that Dr. Low was exceptional. He listened to me complain, listened to my concerns about my health, did a full physical exam, changed my medications to similar medications that were cheaper, and actually addressed each of my concerns. … It was the first time I left a medical appointment and felt that I had been both heard and treated well.”

Patient Diann Logie wrote, “Dr. Low treats four generations of my family and we all feel the same about him. He is a gentle soul who cares about not only our health, but our lives as a whole. We all simply adore him.”

The many CAFP offices Dr. Low has held have included president and chairman of the board. He is a delegate to the AAFP Congress of Delegates. He is a member of the Pueblo Medical Society and an active member of local hospital medical staffs.

Dr. Low and his wife are the parents of two teenage sons, Brandon and Christian. He is a member of the First Presbyterian Church.
Sarah F. DeMoor, MD, and Lisa Young, DO, Are 2012 Residents of the Year
The Greeley Family Physicians are administrative co-chief residents

By Buffy Gilfoil

Sarah F. DeMoor, MD, and Lisa Young, DO are recipients of the F. William Barrows Award for Outstanding Family Medicine Resident. The two serve as administrative co-chief residents at North Colorado Family Medicine Residency.

Dr. DeMoor noted for service, skills and leadership

“My pursuit of medicine started in the mountains of Colorado, advanced on the plains of Nebraska, was solidified in the slums of Haiti and will be continued again in Colorado.”

Dr. DeMoor made this statement in a brief essay. It refers to her growing up in Buena Vista, Colo., earning her bachelor’s degree at Colorado State University and her medical degree at Creighton University, doing medical missionary work in Haiti and returning to Colorado for her residency and practice.

Those who wrote in support of her nomination as Resident of the Year noted her leadership and patient care skills, as well as her dedication to service.

John W. Volk, MD, stated, “Not only is she a physician of the highest caliber but she is a woman of deep personal integrity with a heart for service – particularly to the most vulnerable among us. During her training she has spent time working in the Third World and I know she plans to do this as part of her future practice. I am delighted that, after graduation, she will be joining us at Sunrise Monfort Family Clinic to serve the poor of Weld County.”

David B. Smith, MD, program director of the North Colorado Family Medicine Residency Training Program, wrote, “She is now a third-year resident physician and one of our two administrative chief residents. Her work of managing our very complicated schedules and ‘riding herd’ on our large group of resident physicians has been outstanding. She has proven to be highly effective and timely in this large task, all the while maintaining a calm and kind attitude despite the enormity of the job. Her administrative success is even more impressive when one remembers that she accomplishes all of this success while also excelling in her provision of impeccable patient care in all settings of her training experience.”

Dr. Smith also mentioned Dr. DeMoor’s service through Heart to Heart International following the earthquake that devastated Haiti. “That experience led her to present a very thought-provoking continuing medical education lecture to the North Colorado Medical Center medical staff on potential benefits and harms of short-term medical mission trips.”

Sam Ogden, MD, faculty physician at North Colorado Family Medicine, wrote, “Her ability to process the incredible amount of medical, social, emotional and administrative information that day-to-day patient care presents to Family Doctors is without equal. She provides compassionate, efficient and evidence-based care to patients who adore her. She is a participant in our advanced maternity care track which requires even more of her time and energy.”

Dr. Young focuses on healthy life choices

Dr. Young explained her approach to her profession, stating “For me, being a family practice osteopathic physician is about listening, learning, understanding and helping build healthier life choices.”

She continued, “Many of my projects have been large-scale, but the essence is the individual. It’s about education, support and flexibility. I believe I can make a difference in fostering preventive care and empowering people to take better care of themselves.”

Formerly a nurse, Dr. Young is a graduate of the Arizona College of Osteopathic Medicine in Glendale, Ariz.

She became interested in the medically underserved when she worked in San Francisco with end-stage AIDS, injection drug-using, homeless and mentally ill patients. In the United States, she has worked in Alaska and on an Indian reservation in Arizona. Internationally, she has also worked in rural communities in Mexico, Tibet, Ecuador, Haiti and Kenya.

Ruth Ann Alles, RN, wrote in support of Dr. Young’s nomination. She stated, “Dr. Young is a very patient mentor to her fellow peers. She teaches her peers in a non-threatening atmosphere with great results. Dr. Young has an aura about her that is very open and inviting. She is very detail oriented but does not push her ideas on anyone without a discussion about what is best for her patients in the care she is giving them.”

Dr. Smith stated that she provides exemplary patient care and her interpersonal relationships could not be better. “She embodies what I believe to be the most critically necessary components of being an excellent Family Physician. She is an outstanding teacher and demonstrates unparalleled compassion with all ...”

Service to others was a topic in both Dr. Young’s essay and a letter from family friends William and Florence Murnane.

Dr. Young wrote, “Volunteering at needle exchanges, working with troubled youth and impoverished populations, and grasping economic and political struggles in developing countries have been valuable experiences. Managing chronic pain and obesity in my local community and working closely with patients inside and outside the hospital have been remarkable. These opportunities have taught me about the cultures and influences that help govern people’s decisions and lifestyles.”

The Murnanes stated, “Wherever Lisa has been – San Francisco, traveling, Phoenix, Colorado – she has always found time to help others, mostly the poor and disadvantaged. She is truly a gem of a person.”

Dr. Young’s other honors include receiving a 2011 American Academy of Family Physicians Award for Excellence in Graduate Education and receiving a Citizen Life-Saving Award from the Denver area’s North Metro Fire Rescue District. The former was for leadership, civic involvement, exemplary patient and aptitude for and interest in Family Medicine. The latter was for performing CPR on man who collapsed at a shopping mall.
The Colorado Academy of Family Physicians has named Katherine Monserud Miller, MD, the 2012 Family Physician of the Year. Dr. Miller retired in January as associate director of the University of Colorado Family Practice Residency Program Denver Health Track.

Lucy W. Loomis, MD, MSPH, Denver Health director of Family Medicine, nominated Dr. Miller for the honor. Dr. Loomis wrote, “Dr. Miller has enhanced teaching in the DH track of the Family Medicine residency in a multitude of ways, with her own personal teaching skills, her ability to provide a warm and supportive environment for the residents, her organizational skills and her work in developing the teaching skills of the rest of the faculty. In her tireless support for the residency, she has made immeasurable contributions to both the academic development of Family Medicine at Denver Health, and the strengthening of the overall residency training program at the University of Colorado Family Medicine Residency.”

Dr. Miller graduated with high distinction when she earned her undergraduate degree in biological science and a certification in secondary education at Colorado State University. She received her Doctor of Medicine degree at the University of Colorado School of Medicine before performing her internship and residency at the University of New Mexico Department of Family Medicine in Albuquerque, finishing in 1978. She then worked for the U.S. Public Health Service at Gallup Indian Medical Center in New Mexico in positions involving medical education.

From 1983 through 1991, Dr. Miller shared a private practice, Canon City Family Medicine Clinic, with her husband, John Miller, MD. They offered the full scope of services, including obstetrics while serving at the same time as community preceptors for Mercy Family Medicine Residency.

In 1991, the pair joined the faculty of St. Anthony Family Medicine Residency. Dr. John Miller remains there, while Dr. Kathy Miller joined the University of Colorado Family Medicine Residency Program in 2000.

Daniel J. Burke, MD, associate vice chair for Educational Program Development at the Department of Family Medicine University of Colorado Anschutz Medical Campus, wrote in particular about Dr. Kathy Miller's unique role in supporting the residency at the university when it was in jeopardy.

“Our residency needed to undergo transformative change to distinguish ourselves as a national leader in Family Medicine residency education,” Dr. Burke wrote. “The residency became involved in the Family Medicine national demonstration project known as P4 (Preparing the Personal Physician for Practice). In this project we restructured our curriculum entirely and built a new one over three years. This has been arduous work and the brunt of the day-to-day management of this curriculum redesign has been borne by Dr. Miller.”

“P4 has revived the residency and given it a razor sharp focus,” wrote Jay H. Lee, MD, assistant professor, University of Colorado Department of Family Medicine. He also noted, “She manages many ‘difficult’ patients, including the refugee population who can present many cultural and linguistic challenges.”

Haley Ringwood, MD, MPH, Family Medicine resident, wrote that Kathy Miller spearheaded Chautauqua months, which prepare interns for “rotations in every specialty, making us both confident and competent in areas as diverse as internal medicine, surgery, OB/GYN and newborn nursery.” She continued, “These blocks are something truly unique to our residency when compared with others around the nation. They are what we advertise to applicants and what we love about our program. We have Dr. Miller to thank.”

Drs. Miller are the parents or four children.
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