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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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Breakfast with Dr. Grundy

Rick Budensiek, MD, Raquel Rosen and I shared a delightful breakfast with Paul Grundy, MD, a few weeks ago. Dr. Grundy is IBM’s global director for healthcare transformation. IBM has a self-funded health plan, and Dr. Grundy requires primary care practices to be Patient Centered Medical Homes in order to participate. IBM has seen a 15 percent reduction in overall health care costs as compared to usual care models, improved employee productivity and reduced sick days as a consequence. We have met with Dr. Grundy before, and it’s always a treat to hear his latest thinking on PCMHs and health care reform. We discussed what’s going on here in Colorado and across the nation, reviewed strategies and shared concerns.

We talked about the challenges of expanding PCMHs beyond the highly structured, and typically well funded, shelter of pilot studies to wider implementation. Plenty of good studies, probably enough by my count, show that a properly run, adequately funded PCMH with recognition by the National Committee for Quality Assurance can lower overall costs while improving quality, access and the patient experience. An added bonus is increased career satisfaction among the providers in the practices. This will help fill the pipeline of future primary care physicians and perhaps avoid burn-out in our current physician workforce. All good things.

But what happens when the PCMH approach is rolled out broadly? While it works in pilots, closed health care systems and other controlled settings, what about when it hits prime time? Will exposure to countering market forces affect the function? Will a hospital-owned PCMH perform like a privately owned practice? When the definition of a PCMH gets “loose” and no longer adheres to the strict model that succeeded in most studies, will those practice types still deliver? When non-primary care physicians claim to offer medical homes, will the term become meaningless while diluting the outcomes data? One health plan has said it supports “medical home-like” practices. When those practices fail to save money or improve quality, will support for the model evaporate? When payers begin routinely paying for infrastructure and non-patient contact activities in support of PCMHs, they will expect a return on their investment.

Dr. Grundy advised that Family Medicine needs to step up and lead at this critical time. Doctors cannot shy away from insisting on what a PCMH is and isn’t or from insisting that “primary care done right” doesn’t delineate a turf battle, but reflects the idea that PCMHs deliver on the cost and quality promises.

Some have proposed a piecemeal approach where a practice might add one or a few components, like an electronic medical record and open booking, sit back and expect significant results. For most of the components of a PCMH, this does not work. Results happen when it’s built, not along the assembly line. It is the synergy among all the essential pieces, along with a fundamental shift in the practice paradigm away from straight fee for service and production that makes the magic work. If the expansion fails and, to put it in pharmaceutical research terms, the post-marketing data are poor, payment reform that supports these practices will vanish, erasing PCMHs in the process.

The movement toward home maintenance organizations was intended to cut health care costs, and in that regard they succeeded. But the movement failed as a reform because patients, physicians and the marketplace rejected it. Quality was so-so. No one bothered to get broad physician input or patient buy-in before the HMOs were rolled out. The health plans, the primary benefactors and profiteers of HMOs, had to drop this lucrative business model or lose market share. We need to be sure this is not the fate of PCMHs,
even if they’re “done right.” We are reaching out to patients, brokers, the business community and colleagues to make sure they understand the benefits and support the initiative.

When we talked to Dr. Grundy about what makes a PCMH succeed, he said he strongly believes the key ingredient is the personal physician-patient relationship. He is certain that patients have an innate need to be able to identify their primary care physician, and that satisfying that need improves their health and wellbeing. It's this personal relationship, the sense that a competent physician personally cares about you and your health, that knows you well, that's most important. Our own polling last year showed that patients highly value having a personal physician.

When pressed about how this personal touch can fit into the team-based approach in a busy PCMH, where patients may get care from other team members and not always from their primary care physicians, Dr. Grundy was ready with his answer. He suggested that every provider who sees a patient is scripted to verbalize the physician’s name during the visit. “Dr. Harris will be pleased to see these cholesterol numbers,” or “Dr. Budensiek wanted to be sure I asked you how the smoking cessation classes were going.” For scheduling, have the scheduler say something like “I see you are Dr. Casias’ patient. He likes all his diabetic patients to see the diabetes counselor at least once a year. Can I schedule that for you?”

Finally, Dr. Grundy highly recommends a quick stop-in, even if another provider is actually handling the visit that day. “Hi, Ms. Rosen, I saw you on the schedule and I know Paul will take good care of you today. Let us know if you need anything!” This preserves the bond, has nurturing effects and promotes the team-based care model, without losing the personal touch that is so important. This is the key to transforming into a larger team-based PCMH while preserving the best of a small practice: care by a personal physician!
CAFP Expands Staff, Consults with Global PCMH Authority

Staff expansions, selection of annual award winners and consultation with a global authority on Patient Centered Medical Homes are among the recent activities undertaken by the leadership of the Colorado Academy of Family Physicians.

NEW CAFP STAFF

In November 2012 the CAFP board of directors asked me to study how to grow the organization in a way that is consistent with our mission of making Coloradans healthy, while continuing to provide a high level of service and professional support to our members.

Due in part to changes in the delivery of health care in the nation, we are now a large and highly vibrant chapter with a proportionate array of activities and partners. To manage our ever-increasing agenda, the board in March approved two new staff positions. The CAFP will now have a director of communications and a director of education, events and meetings.

I am enthusiastic about the direction of our organization, the staff expansion and the opportunity to continue to provide high quality services to members. We hope our new hires will be at the April Annual Scientific Conference so you can meet them.

CAFP ANNUAL SCIENTIFIC CONFERENCE

The conference is scheduled for April 18 through 20 at the Cheyenne Mountain Resort in Colorado Springs and it’s not too late to register. Many excellent speakers and superb workshops are scheduled. And, since this will be the 65th anniversary celebration, you can put on your dancing shoes and meet us there!

NEW CAFP BOARD

The members of the CAFP have elected the following new board members:
Michael Archer, MD, Westminster
John Cawley, MD, Ft. Collins
Chet Cedars, MD, Lone Tree
Tamaan Osbourne-Roberts, MD, Denver
Wendy Richmond, MD, Pueblo

Congratulations to all and thank you for volunteering your service!

AWARD WINNERS

Winners of CAFP’s annual awards will be recognized at the annual conference.

Patrick Smith, who is in his third year at Swedish Family Medicine Residency, is the Family Medicine Resident of the Year. Dr. Smith is bilingual in Spanish and English and holds a master’s degree in public health, as well as a medical degree. Joanne Roehr, MD, who is in the Family Medicine Residency at St. Mary’s Hospital in Grand Junction, was also nominated.

The Family Medicine Teacher of the Year is Candace Murbach, DO, of Southern Colorado Family Medicine Residency in Pueblo. She is noted for her dedication, compassion, clinical teaching expertise, and strong relationships with peers, patients and residents. Kurt Dallow, MD, of Greeley and Keith Dickerson, MD, of Grand Junction were also nominated.

The Family Physician of the Year is Paul Fonken, MD, medical director of Timberline Medical in Estes Park. Dr Fonken is a leader in global health care, having worked extensively in Kyrgyzstan. Other nominees were John Bender, MD, of Fort Collins and Mary Fairbanks, MD, of Westminster.

The Patient Centered Medical Home Best Practice of the Year, New West Physicians, has 16 clinical sites in the Denver metro area. Nine New West clinics offer Family Medicine services, while the remaining seven offer internal medicine exclusively. Thomas Jeffers, MD, is president of New West Physicians, which comprises 65 physicians. All of the clinics have achieved Level 3 PCMH recognition from the Committee for Quality Assurance.

PATIENT CENTERED PRIMARY CARE

CAFP leaders Bob Brockmann, MD, Rick Budensiek, DO, and I met in February with Paul Grundy, MD, global director of healthcare transformation for IBM’s global well being services and health benefits. The recognized authority on new approaches to health care delivery urged all Colorado Family Physicians to begin their journey toward transforming their practices to Patient Centered Medical Homes.

Primary care providers need to show leadership, he said, adding that payers agree that “the medical home pilots show
a better result and better experience for payments.”

He recommended that CAFP members should explain that practice transformation is a matter of principle and it is the best way to care for patients. For example, he said it is unethical for Family Physicians to continue to deliver an episode of care for a diabetic. A team approach must be taken.

While the PCMH name might be changed in the future to, for instance, comprehensive primary care, he said, “The aggregation of buyers agree with these principles and want to pay differently for better care and reward primary care in a different way.”

These are indeed exciting time for Family Physicians in Colorado, as well as the organization that represents them and the people they serve. I thank all of you for the work you do for patients and to help CAFP achieve its goals.

**MEDICAID EXPANSION**

Only 5,000 of the 9,000 Medicaid providers have completed the Attestation for supplemental payment. If you sign up after March 31, 2013 you won’t get the retroactive payment but you will get paid the additional funds going forward.

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Due in part to changes in the delivery of health care in the nation, we are now a large and highly vibrant chapter with a proportionate array of activities and partners.

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One of the biggest issues the legislature will discuss this year, besides guns, is implementation of the Affordable Care Act, particularly Medicaid expansion.

Currently 15 states, including Colorado, have indicated plans to expand their Medicaid programs. Meanwhile, 10 states will more than likely decline to participate and the other 25 are still weighing their options and running the numbers. However, the states not choosing expansion may be missing out: According to the Kaiser Family Foundation, if all states expand their Medicaid programs, the federal government would pay for the vast majority of the costs, which would result in many states with significant budget savings and only modest costs.

While arguments can be made on both sides of this issue, the Colorado Academy of Family Physicians has voted to be a strong proponent for Medicaid expansion.

First and most importantly, extending Medicaid coverage will convert otherwise uncompensated care into billions of dollars of new federal spending over the next seven years. Saying ‘no’ to this plan would not save federal dollars from being spent or direct them to deficit reduction – it would simply pass them to states that expand, supporting jobs in these states with the federal tax dollars from non-expansion states. To this effect, one benefit for Family Physicians specifically is that primary care providers who already accept Medicaid will receive a “bump” in funding, up to $25 per office visit.

In addition to adding jobs and saving money for uncompensated care, another argument for Medicaid expansion is that it will expand access to care across the nation. The expanded coverage means that more Coloradans will get the care they need at the right time and in the right place. The expansion can also be translated into lives saved. The New England Medical Journal reported that there is a demonstrated reduction in mortality associated with Medicaid expansion in other states – here in Colorado alone it could translate to more than 600 lives saved per year.

According to the Congressional Budget Office, health insurance marketplaces will cover an additional 26 million people by 2020. The Colorado Medicaid expansion alone predicts it will add 275,000 Coloradans to the Medicaid rolls by 2025 or 2026. With the expanded coverage, the Colorado Health Foundation calculates that the proportion of uninsured Coloradans will drop to 7.7% percent, as opposed to 11.1 percent without the expansion. Additionally, the foundation also projected that more than 22,000 Colorado jobs will be added over the next 16 years, with more than 14,000 created in the first 18 months.

Additionally, most newly eligible Medicaid enrollees will be enrolled in private sector health plans. Employers look closely at the cost of health care in deciding whether to locate their businesses. States that adopt the Medicaid expansion will have a competitive advantage as employers will not need to underwrite the cost of uncompensated care and all potential workers will have access to a source of coverage. States could save money by moving programs currently paid for with state-only funds or by state and federal funds to Medicaid, which would allow states to receive enhanced federal match rates for these programs and services.

The key is to find a happy medium that is fiscally responsible enough to expand Medicaid eligibility without causing unnecessary financial burden on individual states. The CAFP will continue to keep members updated as this legislation makes its way through the process.

The below letter from Robert Brockman, MD, president of the Colorado Academy of Family Physicians, was posted Jan. 7 at www.timescall.com, the website for the Longmont Times-Call.

The Colorado Academy of Family Physicians thanks Gov. Hickenlooper for his efforts to expand eligibility while strengthening our state’s Medicaid program. Coupled with the insurance exchange program where affordable private insurance will be available, nearly all Coloradans will have access to primary health care.

But simply insuring more people does not automatically grant access to quality health care. All patients deserve high-quality, cost-effective, comprehensive primary care. Physician-led Patient Centered Medical Homes bring together a team providing each patient with the right care, by the right professional, at the right time. PCMHs are proven to significantly reduce costs while improving quality and the patient experience. As the largest medical organization representing primary care physicians, CAFP is a leader in promoting these medical homes as essential components in Colorado’s health care system.
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CAFP ON THE GO

Bob Brockmann, MD, at the CMS Council on Legislation.

Bob Brockmann, MD, Rick Budensiek, DO, and Raquel Rosen met with Paul Grundy, MD, Global Medical Director of IBM and President of PCPCC.

Tracy Hofeditz, MD, met with Marily Gaipa regarding Integrated Care.

Dr. Brockmann presented the PCMH model to the Colorado Chiropractic Association.

Bob Brockmann, MD, testifying at the legislature.

Bob Brockmann, MD, at the Multi-State Forum.

Bob Brockmann, MD, at the Multi-State Forum.

Tracy Hofeditz, MD, met with Marily Gaipa regarding Integrated Care.

Doctor of the Day office at the Capitol.

Jeff Cain, MD, AAFP President, at the Multi-State Forum.

SAM Course at CAFP office.

Bob Brockmann, MD, at the CMS Council on Legislation.

Dr. Brockmann talked with medical students at the CAFP’s medical student dinner.

Bob Brockmann, MD, at the Multi-State Forum.

Dr. Brockmann presented the PCMH model to the Colorado Chiropractic Association.
Vaccinating On Schedule Still Best Way to Prevent Infectious Diseases

We physicians must always watch for new developments in medicine and public health that may challenge current wisdom in disease diagnosis, treatment and prevention. Failure to note a new finding may put a patient’s health in jeopardy. Thus, we are alert to new findings that question the effectiveness of a currently recommended vaccine. For instance, we now know that our recommendation for influenza vaccine for the elderly is primarily based on data extrapolated from trials in younger persons. We desperately need better influenza vaccines. Nonetheless, it is not responsible for a physician – in the absence of a medical contraindication – to withhold the best vaccine currently available while waiting for a better one. We discussed influenza vaccination previously.

Recently, pertussis has re-emerged in the United States, with large outbreaks occurring in California in 2010 and nationally including in Colorado in 2012. Careful epidemiologic analysis revealed that acellular pertussis vaccine, introduced in the early 1990s to avert the side effects experienced with whole-cell pertussis vaccine, induces an immune response that wanes more rapidly with time than previously realized. What should the physician’s response be to this? As difficult as it may be conceptually to write papers and give lectures sounding the call for rapid development of new vaccines – while still emphasizing daily to patients the need to use the best tools we currently have – that is what we need to do.

Even in outbreaks in which the majority of ill persons were vaccinated, analyses almost always reveal that vaccine efficacy is high – that is, an unvaccinated person is at substantially higher risk. This was observed in the California pertussis epidemic. Furthermore, an unvaccinated individual is often implicated as having started an outbreak. Sometimes this individual has traveled to an area where the disease is widely circulating. Often, the index case is one who has claimed exemption to required vaccines.

Exemptions to vaccination, especially “philosophic” exemptions, which are those for which a parent does not have to attest to a medical or religious principle, are being claimed by an alarmingly high – and rising – percentage of parents in those 18 states that allow them. Colorado, at 5.6 percent of kindergarteners, has the nation’s fourth highest percent of exemptors, and most of these have taken philosophic exemptions.

A study conducted in Colorado some time ago revealed alarmingly higher risks of measles and pertussis in exempt children and in schools and counties that had higher rates of exemptors. By taking the time to explain the benefits of immunization and by stepping carefully through the reasons parents give for objecting to vaccines, the physician can be very influential in convincing many parents not to exempt their children from vaccination.

Meanwhile, we need to remember that adults, too, need to keep up with recommended vaccinations. Here, exemptors are not the issue — as adults are not subject to school requirements. The more likely problem is that adult patients – and we, their physicians – simply neglect to get the vaccine into the arm at each available opportunity. Vaccinating adults is especially important for pertussis and influenza, because adults spread these infections to infants who are too young to be vaccinated. These young infants are at highest risk of dying from these diseases.

Finally, let us address the issue of the increasing number of parents seeking to delay vaccines for their children, a movement stimulated by pediatrician and author Robert W. Sears, MD, who practices in California. He says that he is not against vaccinations, but recommends a non-traditional “alternative” schedule that delays shots and spaces them further apart. He believes this approach will allow parents who are concerned about “too many vaccines too early” to give their kids at least the “bare minimum” of vaccinations.

The alternative and selective vaccination schedules of Sears and others have not been approved by the Centers for Disease Control and Prevention or any other public health group. However, one group of child vaccine experts wrote, “At the heart of the problem with Sears’ schedules is the fact that, at the very least, they will increase the time during which children are susceptible to vaccine-preventable diseases. If more parents insist on Sears’ vaccine schedules, then fewer children will be protected, with the inevitable consequence of continued or worsening outbreaks of vaccine-preventable diseases. In an effort to protect children from harm, Sears’ book will likely put more in harm’s way.”

Since this was published, researchers from the Oregon Immunization Program analyzed records for children exposed to two specific alternative schedules that parents in Oregon, whom they called “consistent shot limiters,” commonly followed: the one created by Sears, and the other recommended by Stephanie Cave, MD. The researchers reported that the proportion of consistent shot-limiters in Oregon increased from 2.5 percent to 9.5 percent between 2006 and 2009.

For children born in the Portland, Ore., metropolitan area between 2003 and 2009, 4.6 percent of children (4,502 of 97,711) met the researchers’ definition of “consistent shot limiters.” By 9 months of age, these children had not only had fewer injections (6.4 compared with 10.4) but also had more doctor visits for immunizations (4.2 vs. 3.3), compared to kids who followed the recommended vaccine schedule. Furthermore, most delayers never ended up receiving all the recommended vaccines.

Paul Cieslak, MD, medical director of the Oregon Immunization Program, said, “They’re getting less protection for more hassle.” He went on to comment, “The main problem with alternative schedules is they’re tough to stick to. It is harder for parents to pull it off.”

The current vaccination schedule is both safe and effective. Especially since the vaccines are scheduled at the earliest possible
age, when the vaccine works best with the child’s immune system. Furthermore, unvaccinated kids can and do endanger other children who either cannot take a particular vaccine or have responded with a suboptimal immune response. The Centers for Disease Control and Prevention cited unvaccinated children and adults as one of the reasons behind a number of recent epidemics.

Let us keep the whole issue in historical perspective: many deadly infectious diseases have all but disappeared from our population because of immunization, and the bulk of the decreases occurred in previous decades with vaccines not so well engineered as the ones we have now. While we are waiting for better tools to arrive, let us make the best use of the ones we have.

3. Centers for Disease Control and Prevention: MMWR 2010; 59(26):817

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**On Call for Colorado Poster and Video**

**DVDS HAVE BEEN MAILED TO ALL CAFP MEMBERS**

Family Medicine Physicians On Call for Colorado is a television program created by the CAFP and aired on Comcast Entertainment Television, channel 105.

The CAFP has mailed each CAFP member a copy of the video on a DVD. You may run the DVD in your offices.

Please display the poster to inform your patients about the video.

Please go to http://www.coloradoafp.org/pdf/OnCallPoster.pdf to download the poster for your offices.
Kids will spend 8 minutes decorating their little brother. How about two minutes to brush their teeth?

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Top Ten Tips for Prescribing Pain Medication
By COIC’s Patient Safety and Risk Management Department

There is an epidemic of substance abuse, overdoses and deaths related to opioids. According to data from the Centers for Disease Control and Prevention, it appears that the role of prescription opioids in this epidemic started in the early 2000s and has escalated. There are challenges in this area and prescribing opioids requires careful considerations.

The following are not guidelines; they are merely suggestions or tips for clinicians to consider when they are prescribing these medications:

1) Make sure the clinical diagnosis is correct
Is the opioid you’re giving indicated for the diagnosis you’re treating? When pain is out of proportion to the disease, you need to consider if there is another process or even a malignancy causing the severe pain. A thorough history and physical is helpful in sorting through what is going on. Make sure the opioids are necessary and if they are not working ask, “What else is going on?”

2) Consider alternative treatments
If the pain is from neuropathy or shingles, consider some of the many other neurologic medicines that work for these illnesses. If treating fibromyalgia, remember that there are no controlled studies that suggest opioids help with the condition. Again, consider alternative (often neurologic) drugs. Finally, if the patient was a 7 out of a 10 before starting opioids and is still at the same level after a month, then consider a different treatment regimen.

3) Check the Colorado Prescription Drug Monitoring Program
The Prescription Drug Monitoring Program, which is overseen by the Colorado State Board of Pharmacy, is your friend. It’s easy to use and you should consider checking the program whenever you consider chronic opioid therapy, and in some instances before acute therapy. It can help you sort out questions such as:

- Is the patient telling the truth about where he or she received medications?
- Is the patient getting different prescriptions and filling at different pharmacies?
- Is the patient currently using other controlled substances?

We suggest transparency when you are checking the drug-monitoring program. Tell the patient how it works and why it is valuable.

4) Perform an addiction screen
Many screens are available. The CAGE screen is simple and well known. Some of the others, such as the Screener and Opioid Assessment for Patients in Pain (SOAPP), are made especially for chronic opioid use and are subtler, but more likely to uncover the patient who is at high risk. It is important to know if the patient has a high risk for addiction and/or if there is an underlying psychological disorder or prior abuse that makes opioids have a higher addiction potential. These types of screens can provide information that is important to know prior to prescribing chronic, potentially addictive drugs.

5) Do a urine toxicology screen
In conjunction with the above, a urine toxicology screen should be considered before embarking on treatment. It can help answer several questions:

- Is the patient using street drugs?
- Is the patient claiming that he or she is not taking opioids, yet testing positive on the toxicology?
- Is the patient supposedly on drugs, yet the toxicology screen is negative? Consider diversion in this situation.

Check with your lab to see what drugs show up on the screen for the patient. Not every urine toxicology screen checks for the same drugs and has the same sensitivities. You can make random urine toxicology screens a condition of your continued prescribing via the opioid contract/agreement, but must still inform the patient that you are doing the test (it cannot be done surreptitiously).

6) Have the patient sign a pain consent form
The informed consent form is a tool to help you review the risks and benefits for using opioids as well as the potential side effects (constipation, sexual dysfunction and drowsiness are among the many potential side effects). Remember to warn patients about using opioids while driving or using heavy machinery. And make sure you talk about the interaction with other drugs, especially alcohol and marijuana.

7) Also consider a pain agreement
This is distinct from the informed consent form. It is similar to that discussion you had with your teenager when you gave him or her car keys for the first time. The agreement establishes the boundaries, rules and regulations that you’ve set up around the prescribing of opioids. An example rule

continued on page 25 >>
The American Academy of Pediatrics and the Centers for Disease Control and Prevention recently released the 2013 immunization schedules, which include minor changes to recommendations. It also includes a new, condensed birth through 18 years schedule, replacing the previous one separated into birth through 6 years and 7 through 18 years of age.

Most notably, the 2013 updates contain a recommendation that pregnant adolescents and adults receive a Tdap vaccine during the second or third trimester of each pregnancy. The rationale behind this recommendation is that vaccinating pregnant women near delivery passes immunity onto the infant, thus protecting the infant before and after birth against pertussis. It is especially important for pregnant women and those who come in contact with a baby — parents, siblings, grandparents, caregivers on so on—to receive a DTaP booster to help shield or “cocoon” the baby until he or she has received three doses of DTaP.

Pertussis is on the rise in Colorado and across the United States, with 1,510 cases reported in Colorado as of Dec. 29, 2012. Over the past five years, Colorado has averaged 324 cases per year. Health officials cite several reasons for the rise in cases, including increased surveillance, waning immunity in adolescents who received the acellular DTaP versus whole cell DTP vaccine as children, and changes in the circulating strains of pertussis bacteria.

Vaccination refusal may also play a role in the rising incidence of pertussis. Colorado has the fourth highest vaccine refusal rate in the nation, with 5.6 percent of students with parents or guardians who have elected to refuse vaccines for their children through “personal” exemption. A recent Kaiser Permanente study shows that nearly 50 percent of U.S. children are undervaccinated. More and more parents are turning to delayed and alternative immunization schedules as a result of inaccurate information on vaccine safety.

The Colorado Children’s Immunization Coalition, or CCIC, understands the need for credible, parent-friendly vaccine information, which is why the coalition launched the Immunize for Good campaign, www.ImmunizeforGood.com, in 2011 in partnership with the Colorado Department of Public Health and Environment and the Vaccine Advisory Committee for Colorado. The statewide campaign delivers the facts and addresses parents’ concerns in a fun, easy-to-digest format to communicate the safety and importance of childhood immunization. Immunize for Good covers it all – from the diseases vaccines protect against to vaccine ingredients and common misperceptions – to help parents make an informed choice for their child.

Immunize for Good offers several free tools and resources to help patients and their families get the facts and stay on track with the CDC-recommended schedule:

- **Immunize for Good cards** feature three designs, each with a shot-soothing tip for easing a child’s shot pain, along with information about what parents can find at ImmunizeForGood.com. The cards are intended to be given before a child’s shot visit, so parents can...
arrive at the doctor’s office feeling confident and armed with informed questions. This way, providers have more time to attend to all the other important aspects of the well child visit.

- **Immunize for Good posters** encourage parents to visit www.ImmunizeforGood.com and include a space for practices to advertise their clinic information.

- **Good to Go** is a free mobile web tool that delivers a condensed version of the CDC-recommended vaccine schedule up to age 6 and allows parents to create a personalized record tailored to each child’s birth date. Good to Go also includes detailed information about each vaccine and the disease(s) it prevents, customized email reminders for each vaccine, and a progress bar that shows parents how they’re doing in their effort to keep their child protected from vaccine preventable diseases. Parents can also print a list of their child’s current and recommended vaccines. Good to Go is free and accessible on any device that has an Internet connection (www.ImmunizeforGood.com/GoodtoGo or m.ImmunizeforGood.com on mobile devices).

- In addition, Colorado Children’s Immunization Coalition provides **immunization schedule cards** designed to be worn on providers’ badges as quick and easy reminders of the 0-18 vaccine schedule and associated contraindications. The coalition will also be launching a Spanish version of Immunize for Good in spring 2013.

To order materials or get involved in CCIC, please visit www.ChildrensImmunization.org.

Stephanie Wasserman (Stephanie.wasserman@childrenscolorado.org) is the executive director of the Colorado Children’s Immunization Coalition.

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Autism Spectrum Disorders

By Elizabeth McMahon Griffith, PhD, Terry K. Katz, PhD, and Sandra L. Friedman, MD, MPH

Over the past decade, awareness has increased about autism spectrum disorders, or ASDs. The current prevalence is approximately one in 110 children, affecting people of all races, ethnicities, and socioeconomic status. While some children with autism can be easily identified and diagnosed, many require a more extensive assessment that includes an in-depth parent interview, direct observation and diagnostic tests by an interdisciplinary team. Despite the need for comprehensive assessment in many situations, definite steps can be taken whenever there is a concern about ASD, which includes autism, Asperger Disorder, and pervasive developmental disorder, not otherwise specified.

What are Autism Spectrum Disorders?

ASDs are characterized by impairments in the development of core social interaction skills, delayed or unusual communication, and by the presence of repetitive or unusual (stereotyped or intense) behaviors and interests in the place of typical play. No one specific behavior defines the disorder – it is the constellation of symptoms in these three different areas, called the autism triad. Symptoms must be present prior to 36 months of age for a diagnosis to be made. Autism is commonly called a spectrum disorder because the core characteristics can present differently across children, and children may be mildly to severely affected. There is no single cause. Current research indicates a strong genetic component, with developmental presentation largely determined prenatally. Environmental factors may also play a contributing role. We do know that ASDs are not due to poor parenting.

Should we really be looking for these disorders in young children?

Some children show evidence of problems in infancy, while others may appear to be developing appropriately until 18 to 24 months, when they may lose previously acquired language or social skills or both. Most parents suspect that something is “wrong” by the time their children are 18 months of age and seek medical assistance by age 2. However, diagnosis of ASD often is not made until later.

Children with ASD need to be identified as early as possible. Early identification and specific interventions are associated with better outcomes. Although it is never too late, the ability to alter behavior and underlying brain connections decreases after the preschool years. Not all children who are suspected of having an ASD will actually have this diagnosis, but most will qualify for some developmental diagnosis (typically a language or global developmental delay) that would warrant intervention.

How can we identify ASD early?

The first steps to early identification should be completed during routine well-child visits.

- Practice developmental surveillance at all well-child visits. If concerns are raised, additional screening needs to be performed. A family history of ASD also warrants close observation.

- Red flags requiring further developmental evaluation:
  - No response to name by 12 months
  - No babbling, pointing, or gestures at 12 months
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• Psychological evaluation, including measures of developmental/intellectual and adaptive functioning
• Evaluation for other disorders and/or co-morbidities
• Assessment of speech, language and communication
• Assessment of motor development
• Medical assessment by a developmental pediatrician or child neurologist, to rule out the presence of associated medical conditions and/or co-morbidities
• Assessment of the caregivers’ knowledge of ASD, coping skills, and available resources and supports

What does a medical assessment include for children with ASD?
• Audiologic assessment needs to be done on ALL children, to document normal hearing. If hearing testing is not successful, an auditory brainstem response test should be obtained.
• Lead screen
• Genetic testing because of the strong heritability factors. We recommend chromosome microarray, fragile X testing for both boys and girls, and testing for the MECP2 gene for girls. If insurance does not cover the microarray, then high-resolution karyotype should be performed. For children with significant macrocephaly (more than 2.5 SD about the mean) PTEN gene testing is recommended because of its association with tumor development.
• Metabolic testing if there is a history of regression of developmental skills.
• Electroencephalography if there is concern about seizures, due to the increase risk for seizures. Sometimes a 24-hour EEG is obtained if there is significant developmental regression, particularly without evidence of notable gains after intervention is initiated.
• MRI of the brain generally is not performed routinely, however this would be recommended in the context of abnormal neurologic examination, microcephaly, or disproportionate change in head circumference.
• Other tests, as indicated:
  o Thyroid function tests, if child has poor growth or other concerning symptoms
  o Complete blood count, ferritin, iron studies if poor sleep; low ferritin and iron stores (even in the absence of anemia) are associated with poor sleep and may be responsive to ferrous sulfate treatment.
  o Ophthalmologic assessment if vision concerns, or concern for some metabolic disorders
• Evaluation of a child’s eating and sleeping patterns, as these are often disturbed and adversely affect quality of life for the child and the family.

What types of interventions are available?

Children need to receive interventions as soon as developmental concerns are raised. Children under 3 years of age are served through local Early Intervention teams. Children ages 3 to 21 years are served through their local school systems. Services are accessed through a Child Find evaluation and are free to the family.

Autism-specific interventions must be added to existing interventions. Children with ASD frequently do not respond as well to typical intervention techniques, in part because these techniques rely on an individual’s social engagement. The National Academy of Sciences’ “Educating Children with Autism” (2001) gave these key recommendations:
• Intervention by highly trained staff as soon as ASD is even considered
• Active engagement in intensive programming at least 25 hours per 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 alterations of program techniques as needed

Just as there is a spectrum of clinical presentations, all children do not require the same types of services. Among the many types of interventions, some are behaviorally based while others focus more on play or relationship interactions. Parents need help to choose interventions that are specifically geared to their children’s needs and delivered by providers with expertise in ASD. Having positive experiences with typically developing children is also associated with better outcomes.
While some children with autism can be easily identified and diagnosed, many require a more extensive assessment that includes an in-depth parent interview, direct observation and diagnostic tests by an interdisciplinary team.

**What types of medical interventions are recommended?**

While no medical treatments are available for the core symptoms of ASD, we do treat some of the co-morbidities with medications. When medication is used, behavioral therapy to address the co-morbidities must also be in place. Some of the co-morbid behaviors that may be treated include problems with:

- Attention and hyperactivity
- Mood issues, including anxiety, depression, and mood instability
- Aggression or self-injurious behaviors or both
- Obsessive compulsive behaviors
- Sleep problems

**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 that help families access care and advocate for their children include the following:

- The Arc of Colorado (303-864-9334; http://www.thearcofco.org
- Parents Encouraging Parents (303-866-6694) www.cde.state.co.us/cedesped/PEP.asp
- Program Eligibility and Application Kit, or PEAK (719-531-9400); www.peakparent.org
- Parent to Parent (877-472-7201);

Children’s Hospital Colorado offers a number of services including early intervention, behavioral therapy, education classes and a support group for families of children diagnosed with ASD.

Elizabeth McMahon Griffith, PhD, is an assistant professor of Pediatrics at the University of Colorado School of Medicine with a specialty in children with neurodevelopmental disorders and autism spectrum disorders.

Terry Katz, PhD, is a senior instructor at the University of Colorado School of Medicine, specializing in psychology with areas of special interest in autism spectrum disorders, Rett syndrome and sleep disorders.

Sandra Friedman, MD, MPH, is the medical director of the Child Development Unit and the section head of Neurodevelopmental and Behavioral Pediatrics at Children’s Hospital Colorado.

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 Jeffrey Cain, MD, chief of Family Medicine through OneCall: 720-777-3999.

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Spring is right around the corner, which means it is time for spring break, spring cleaning and spring training! With that in mind, I am happy to share one key news item – this year the Colorado Academy of Family Physicians will participate as a Charity Partner in the Colfax Marathon to raise money and awareness for the Fit Family Challenge.

This means we need you, CAFP members, to register to run! Start your spring training off right by running for a good cause. You can choose any of the many race distance options and support the great work of Family Medicine in Colorado. Registration fees do not go to the CAFP Foundation; however, you can contribute to the foundation. Ask your family, your friends, your colleagues and your patients to sponsor your run! All donations will go toward the Fit Family Challenge pilot project and helping all Colorado families live a healthy, nutritious, and active lifestyle.

In other news, the pilot project continues to make positive progress. In January, the Fit Family Challenge project team completed the final on-site rapid improvement activities for the 14 new FFC practices. I would like to extend a huge thanks to HealthTeamWorks and HeartSmartKidsTM for their contributions and helping to make all 14 training sessions successful!

At the time of writing, I am excited to report that most of the pilot sites have begun their monthly group visits with families. We look forward to sharing data and results from the second pilot in the summer issue of the CAFP News. Thank you to the membership for your continued support of this project.

To find out more about the Fit Family Challenge visit our website at http://coloradoafp.org/pobesity or contact Sarah Roth, Program Manager Fit Family Challenge, 2224 S. Fraser St., Unit 1; Aurora, CO 80014; by phone at 303-696-6655 extension 16; or by email sarah@coloradoafp.org

Spring Healthy Living Tip: Get Gardening!

Gardening is a great way to help families incorporate fruits and vegetables into their daily diet on a budget. Kids enjoy getting their hands dirty and eating the “fruits” of their labor. Early spring is a great time to start greens like spinach and lettuce varieties. Don’t have a yard? Lettuce grows great in containers by a sunny window. Just plant, water, wait, and enjoy!

More healthy living tips are available on our Facebook page at www.facebook.com/Colorado5210
Supplemental Payments for Eligible Primary Care Physicians

FREQUENTLY ASKED QUESTIONS

What providers are eligible for the supplemental payments?
Physicians who are enrolled in the Colorado Medicaid program and who practice primarily in family medicine, general internal medicine or pediatric medicine and who attest to meeting certain requirements are eligible.

1) Physicians must be board certified; or
2) Physicians who provided 60 percent of Medicaid claims for E&M codes 99201 through 99499 or vaccine administration codes 99201-99499, 90460, 90461, 90471, 90472, 90473 and 90474. Supplemental payments only cover those services paid for by Colorado Medicaid.

- Physician assistants and advance nurse practitioners must be identified as being personally supervised by an eligible physician.
- It is possible that a physician might maintain a particular qualifying board certification but practice in a different field. Services provided by a physician in these circumstances are not eligible for supplemental payment and the physician should not attest to eligibility for supplemental payments. Similarly, a physician board certified in a non-eligible specialty (for example, surgery or dermatology) who practices within the community as, for example, a family practitioner could attest to a specialty designation of family medicine, internal medicine or pediatric medicine and that 60 percent of their recent Medicaid claims submitted by or for them were for the E&M and vaccine administration services. Should the validity of that physician’s self-attestation be reviewed by the state and found to be inaccurate, the supplemental payments made for these services would be recovered.

What services qualify for the rate increase?
- E&M codes that are part of Colorado Medicaid coverage between 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473, or their successor codes. Supplemental payments only cover those services paid for by Colorado Medicaid.

Do physicians practicing in FQHCs and RHCs qualify for the supplemental payment?
- No. The supplemental payments do not apply to services provided under another Medicaid benefit category such as clinic, FQHCs or RHCs.

Do supplemental payments apply to CHP+?
- No.

How do I self-attest?
- The online self-attestation tool is accessed through the Provider web page.

- The supplemental payment cannot be made without evidence of self-attestation.

Can my clinic attest for me?
- No. Even if someone else makes the entries into the Web site page on your behalf, we will hold you personally responsible for your attestation.

If I practice for a clinic, do I submit my practitioner provider ID and NPI or those for the clinic for which I practice?
- Use your practitioner provider ID and NPI. You must attest that you meet the qualifications above.

When am I eligible for supplemental payments?
- If you self-attested before March 31, 2013, payments will be retroactive to January 1, 2013. If you attest after March 31, 2013, the supplemental payments will be for eligible services provided after the date of self-attestation.

How will I know if I filled out the form correctly?
- All attempts at attestation will be acknowledged by electronic mail. The acknowledgement will confirm that the attestation was accepted or will report what prevented the attestation from being accepted.

What if I filled out the attestation form and I forgot some information?
- You may re-attest with that information using the same Web page. We will define the payment start dates based on the first accepted attestation. Physicians who re-attest for the purpose of adding advanced practice professions that they supervise do not need to re-enter previously identified APPs.

Will payments be retro-active to January 2013?
- Yes, payments will be retro-active for services from physicians who attest before March 31, 2013 and for advance practice professions who are identified by their
supervising physician before March 31, 2013. For physicians that attest or advanced practice professions that are identified on or after March 31, 2013, the supplemental payments will be for eligible services provided from the date of self-attestation forward.

How much is the increase per procedure?
- The increase is the difference between the Colorado Medicaid rate and the Medicare rate. For the most used office visit codes the increase will be around $25.

How often will payments be made?
- Payments will be made quarterly.

How do I get paid?
- The payments will be a supplemental payment distributed as other Medicaid reimbursement.

Is a state required to cover all of the primary care service billing codes specified in the regulation and then reimburse all qualified providers at the Medicare rate in Calendar Years 2013 and 2014?
- A state is not required to cover all of the primary care service billing codes if it did not previously do so. To the extent that it reimburses physicians using any of the billing codes specified in the final rule, the state must pay at the Medicare rate in Calendar Years 2013 and 2014.

would be “no refills on the weekend or at night.” These established rules also help you deal with stories you may hear such as “the cat ate the Oxycodone,” “my script got stolen,” or “I lost my pills down the toilet.”

8) Understand the street price
Law enforcement has stated the range of the street price for Oxycodone as $1 to $2 per 1mg. This means that a one-month script of 120 Oxycodone (5mg) could be sold for as much as $1,200. Like Oxycodone, Percocet and Oxycontin can demand high prices.

9) Understand the buzz words
Addiction is the compulsive use of a drug that results in personal harm. Cases of addiction often involve psychological dependence and a history of preexisting abuse. Tolerance refers to decreased effectiveness over time. The important issue is to avoid labeling patients as “addicted” when they are really becoming tolerant and need to increase their medication. Finally, there is physical dependence, which is the abstinence syndrome that occurs when discontinuing opioids. Withdrawal symptoms following discontinuation of opioids do NOT indicate that the patient is an addict; most patients can suffer some withdrawal symptoms following a course of continuous opioids even when indicated and appropriately administered.

10) Listen
Some of the most difficult patient conversations occur around these drugs. These conversations often involve complex issues. The patient wants pain relief and physicians have an obligation to relieve suffering. On the other hand, it is clear at times that opioids are not what are best for the patient. “Primum Non Nocere” is the first precept of medical ethics. Instead of starting the boundaries discussion with a resounding NO, listen to what the patient is concerned about, understand his or her fears, and see if there is a compromise that will meet the patient’s needs and still be considered safe medicine.

1 http://www.painedu.org/soap.asp
Paul Fonken, MD, medical director of Timberline Medical in Estes Park, is the 2013 Colorado Academy of Family Physicians Family Physician of the Year. In addition to managing a full panel of patients, he has also been a leader in global medicine and medical reform to improve the lives of patients.

“Dr. Fonken is one of the most caring and compassionate people I have ever known,” wrote his Timberline Medical colleague Bruce Woolman, DO. “In spite of his lofty accomplishments he still remains grounded with a humility that allows him to interact with patients, clinic and hospital staff, and colleagues in a very personal manner. He earns the respect of anyone he associates with. He is also one of few physicians in this day and age who still provides house calls for his patients.”

Dr. Fonken’s general international interests started during childhood while living twice in Pakistan, where his father was working as an American consultant on irrigation projects. He was valedictorian when he graduated from high school in Laramie, Wyo., He graduated with honors when he earned a degree in natural studies at the University of Wyoming in Laramie. He attended medical school at the University of New Mexico in Albuquerque, where he was in one of the early classes of the school’s innovative Primary Care Curriculum, which heavily emphasized problem-based learning and included a four-month rural preceptorship at the end of the first year.

He completed his residency at North Colorado Family Medicine, where his honors included selection as alternate for the Mead Johnson Award for Graduate Education and he served on the Colorado Family Medicine Residency Council.

Dr. Fonken became involved with global medicine when he was in medical school. He was co-founder and first newsletter editor of the International Community-Oriented Medical Students Association. He was a guest twice at the Suez Canal University School of Medicine in Egypt. He conducted a study of community-based health care in Kenya.

After completing his residency, he joined Timberline Medical, P.C., a Family Medicine clinic in Estes Park, which has remained Dr. Fonken’s clinical base in the U.S. for his entire career. This clinical continuity within a small community has allowed him the satisfaction of caring for up to five generations of patients from the same family. In addition to providing outpatient care, he has enjoyed serving at Estes Park Medical Center in a variety of roles, including chief of the medical staff, medical director of the nursing home and member of multiple committees.

From 1997 through 2005, Dr. Fonken worked primarily in Kyrgyzstan helping to introduce the specialty of Family Medicine into this newly independent post-Soviet republic. He worked with teams from multiple organizations to train teachers of Family Medicine, then helped these new teachers retrain the country’s primary care doctors and establish a Family Medicine residency, a professional association and a continuing medical education system. Dr. Fonken liked the combination of hands-on clinical teaching and direct involvement in health system reform. In 2004, Kyrgyzstan’s Ministry of Health recognized Dr. Fonken with an Outstanding Medical Worker award.

During these years, Dr. Fonken and his family returned to Estes Park every other summer, where he worked at Timberline Medical, LLC, which is now affiliated with the University of Colorado. After returning full-time to Timberline in 2005, he maintained his interest in global medicine and health systems improvement. He consulted briefly for Boston University, teaching a delegation from Vietnam about Family Medicine development in Kyrgyzstan.

In addition to helping to establish Family Medicine in Kyrgyzstan and elsewhere, Dr. Fonken has been a leader in practice transformation at Timberline, where he serves as medical director. He spearheaded the efforts to incorporate electronic health records, designing most of the clinical protocols and templates. The practice was one of the first in the state to be recognized for “meaningful use” of electronic health records.

He led the practice in achieving recognition by the National Committee for Quality Assurance as a Level 3 Patient Centered Medical Home with a score of 99.75 percent. He was instrumental in Timberline’s successful application to participate as a pilot practice in the national Comprehensive Primary Care Initiative. He is grateful for the entire team at Timberline Medical for their flexibility and hard work, which have resulted in these accomplishments.  

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PAUL FONKEN MD, IS FAMILY PHYSICIAN OF THE YEAR
Estes Park doc excels in global medicine, reform, patient care

By Marjie Grazi Harbrecht, MD

Members
CAFP NEWS

Candace Murbach, DO, Named CAFP Teacher of the Year

Southern Colorado educator inspires residents

Candace Murbach, DO, is the 2013 Colorado Academy of Family Physicians Teacher of the Year. On the faculty at Southern Colorado Family Medicine Residency in Pueblo, she is noted for her dedication, compassion, clinical and teaching expertise, and strong relationships with peers, patients and residents.

Calling her a “tremendous addition to our program,” Kern Low, MD, FAAFP, who is also on the faculty at Southern Colorado Family Medicine Residency, outlined four key contributions she has made.

First, he reported, she championed the transition of the residency to a Patient Centered Medical Home with Level 3 recognition by the National Committee for Quality Assurance. Second, she accompanied students on medical missions to Haiti. Third, she has demonstrated commitment to her community and profession through activities in such organizations as the YMCA board of directors and the CAFP Executive Committee.

“Fourth and most importantly,” he stated, “she truly cares about her patients, the residents and her peers.”

Born in Columbia City, Ind., Dr. Murbach was a nurse before she became a doctor. She obtained both associate’s and bachelor’s degrees in nursing from Purdue University and later she earned her medical degree at the Michigan State University College of Osteopathic Medicine. She returned to Indiana to complete her Family Practice residency at Ft. Wayne Medical Education Residency.

She worked and volunteered in Ft. Wayne until 2009 when she took her position on the faculty of Southern Colorado Family Medicine Residency.

“She is highly intelligent and knowledgeable about Family Medicine with excellent procedural skills including obstetrics,” stated Charles Raye, MD, a Family Physician who is chief medical officer at St. Mary-Corwin Medical Center.

Laura Stein, MD, who is also on the faculty of the Pueblo program, noted that Dr. Murbach often takes residents to the CAFP Doctor of the Day program. Dr. Stein wrote, “From the start she has been full of wonderful teaching ideas and gets the residents engaged and excited about learning.”

Chief resident Joseph Castro, DO, called Dr. Murbach a trusted confidant and true resident advocate. “As my residency mentor, she not only keeps me on top of my residency duties and responsibilities but she motivates me to continue to push my limits and step out of my comfort zone. She recently encouraged me to present a poster at a regional conference and research is something that I try to hide from typically,” he stated. Dr. Castro further stated that other residents also look to Dr. Murbach for “support, guidance and additional educational opportunities.”

Elaine Blinn, LCSW, wrote in support of Dr. Murbach’s nomination of the award, stating, “As the behaviorist, I so appreciate her teamwork and sensitivity to the treatment of the whole person by the faculty and residents of this program.”

Julie Eggleston, LPN, noted that Dr. Murbach started out as a nurse. “I have personally seen her take raw, insecure interns and help mold them into capable, enthusiastic, dedicated Family Physicians,” Eggleston wrote.

In addition to the CAFP Teacher of the Year Award, Dr. Murbach has received many honors throughout her career. In 2010 and 2012 she received the David B. Smith Faculty Excellence Award and in 2011 and 2012 she was recognized as Faculty of the Year.

Dr. Murbach is the mother of three grown, college-educated children, who live in Florida, Indiana and Pennsylvania. Her one grandson, a toddler, lives in Orlando with her son and daughter-in-law. She enjoys traveling and visiting her friends and family, “walking anywhere in the Colorado sunshine” and relaxing at home with her dog. “The thing I value most are relationships and spending time with those I love,” she said.

Others nominated for the Teacher of the Year award were Kurt Dallow, MD, of Greeley and Keith Dickerson, MD, Grand Junction.

<< Dr. Fonken has made numerous presentations at annual meetings of the American Academy of Family Physicians. Many focused on various aspects of global medicine.

He is an assistant clinical professor within the Department of Family Medicine University of Colorado Health Sciences Center School of Medicine.

He participates in church activities and local community health fairs and with a variety of local camps. He volunteered during the start-up phase of the Crossroads Clinic, which eventually became Salud Family Health Clinic in Estes Park, where services are arranged to improve access and reduce barriers to care.

Also nominated for Family Physician of the Year were John Bender, MD, of Fort Collins and Mary Fairbanks, MD, of Westminster.
Patrick Smith, MD, MPH, is Outstanding FM Resident

Swedish FM resident has demonstrated commitment to global health

Patrick Smith, MD, MPH, a third-year resident at Swedish Family Medicine Residency, has been selected for the 2013 F. William Barrows Award for Outstanding Family Medicine Resident. The co-chief resident, who is fluent in Spanish and English, has already demonstrated his commitment to global health, as well as public health and obstetrical care.

“His knowledge base is strong and his clinical performance has been excellent,” wrote Bradford Winslow, MD, program director of Swedish Family Medicine Residency. “He is one of the most motivated and energetic residents I’ve known, and he is smart and committed to his patients and to Family Medicine.”

The son of a naval officer and a mother who instilled a sense of community service, Dr. Smith was born in Honolulu and moved several times before settling in Littleton, Colo., where he graduated from Heritage High School.

He earned three degrees at the University of North Carolina at Chapel Hill. While working toward his bachelor’s degree in chemistry with a minor in biology, he played goalkeeper on the varsity soccer team. He later earned his master’s degree in Public Health and his medical degree at the same time.

Between his graduate and post-graduate studies in North Carolina, Dr. Smith first worked as a counselor and teacher at a wilderness camp for at-risk children and later served as a health volunteer with the Peace Corps in the Amazon jungle of Ecuador.

Dr. Smith’s activities during his post-graduate studies at the University of North Carolina included work as a Spanish interpreter and part of the medical team with the Student Health Action Coalition, or SHAC, reportedly the oldest student-run free clinic in the U.S. The clinic serves indigent and homeless patients. He also created a Boot Camp for Dads program, where fathers teach dads-to-be how to care for new babies. In addition, he completed an Albert Schweitzer program, where fathers teach dads-to-be how to care for new babies. In addition, he completed an Albert Schweitzer Fellowship by starting a program that provides Hispanic parents with tools to help them help their children succeed in school.

Also during his post-graduate studies in North Carolina, Dr. Smith conducted research into the relationship between functional health literacy in Spanish and English speakers and their subsequent ability to adhere to discharge instructions from the emergency department. He received a short-term student grant from the National Institutes of Health to complete the research and presented the project at the UNC School of Medicine Student Research Day and before the American College of Emergency Physicians. The project was awarded the University of North Carolina Impact Award, which recognizes research that provides special benefits to the people of the state.

“Patrick is one of the hardest working students I have ever worked with,” wrote Jane M. Brice, MD, MPH, professor in the Department of Emergency Medicine at the University of North Carolina. “He is mature, responsible, dedicated and passionate. He has great attention to detail but does not lose sight of the big picture.”

In addition to rising to co-chief resident, Dr. Smith has continued his tradition of service and leadership in many other ways. He has made presentations to young people about careers in medicine and he has participated in the Colorado Academy of Family Physicians’ Doctor of the Day program. He serves on the hospital’s Ethics Committee.

Dr. Smith has demonstrated his commitment to obstetrical medicine, assisting more than 170 deliveries. He completed an obstetrical elective at Denver Health and went to Peru on a women’s health medical mission.

He is the recipient of a National Health Service Corps scholarship.

“Dr. Smith’s skills in patient care, interpersonal relationships, leadership, professionalism, community involvement and social commitment are all exceptional,” wrote Suzanne Hutchinson, MD, who is on the faculty of Swedish Family Medicine Residency and the University of Colorado Health Sciences Center.

Upon completion of his residency, Dr. Smith plans to “work in a federally qualified health clinic in Colorado, practicing full-spectrum Family Medicine, including surgical obstetrics,” He wrote, “I love every aspect of my job, from babies to elderly, and enjoy connections with patients and colleagues.”

Dr. Smith and his wife, Omayra, a native of Ecuador, met while he was in the Peace Corps. They are the parents of four children – Elva, Thomas, Christian and Emilia. He describes the children as “amazing and “the light of my life.” He stated, “People ask how I managed school and residency with children; they keep me grounded and teach about life.”

Joanne Roehr, MD, who is in the Family Medicine Residency at St. Mary’s Hospital in Grand Junction, was also nominated.
New West Physicians Named PCMH Best Practice of 2013
Team care makes Multi-site metro practice stand out

New West Physicians, which comprises 65 physicians and 16 mid-level providers offering primary care services at 16 sites in the Denver metro area, is the 2013 Patient Centered Medical Home Best Practice of the Year. Nine New West clinics offer Family Medicine services, while seven offer Internal Medicine exclusively, and all have achieved Level 3 Patient Centered Medical Home recognition from the National Committee for Quality Assurance. A 17th location houses the New West management service organization.

“The board was very impressed with the outstanding care that you provide your patients and the quality initiatives and improvements of your practice,” wrote Elizabeth Kraft, MD, president of the Colorado Academy of Family Physicians Foundation. “We applaud New West Physicians for the care management and patient education it provides as well as the team care approach.”

Thomas Jeffers, MD, president of New West Physicians, said the practice is “honored by this recognition.”

Their submitted application provided documents that detail how the New West team-based approach integrates many aspects of the medical home.

“The majority of health care rendered to a New West patient starts at the primary care provider’s office,” Dr. Jeffers said. In addition to advance appointments for routine and follow-up care, the practice offers same-day scheduling and an urgent care center that provides walk-in service seven days a week with extended hours until 9 p.m.

Medical assistants working at the top of their licenses can provide a wide range of services that includes COPD screening and asthma control testing, immunization administration following protocol, diabetic foot exams, population of flow sheets and registries, and review of upcoming appointments for identification of gaps in care. Specialized services are provided at a behavioral health center located at one of the Family Medicine centers and at a diabetes and nutrition center.

For cases that call for specialist care, the New West referral department coordinates care internally and through an Independent Physician Association. “We maintain a philosophy of tight communication between specialists and our primary care physicians,” Dr. Jeffers stated.

Similarly, the New West hospitalist team – with 12 physicians and two mid-level providers – cares for hospitalized patients. The team’s access to the outpatient electronic health record and direct communication with primary care physicians assures continuity of care and reduces the likelihood that services will be duplicated.

Hospitalized patients may also be visited by registered nurses who are case managers, while social workers are dispatched as needed for face-to-face visits in hospitals, extended care facilities and home settings.

When patients are discharged, a mid-level discharge coordinator provides medication reconciliation and coordinates primary and specialty care follow-up, as well as home care and equipment. New West has partnered with Denver Hospice on a program that involves both pre-palliative and palliative care and has resulted in the lowest Medicare readmission rate along the Front Range.

New West has made significant capital investments in its advanced information systems, which play an important role in practice management. A recent addition is a web portal where patients can view test results, request appointments or medication refills, and pose non-urgent questions.

New West offers active and ongoing provider education. Quarterly activities mentioned by Dr. Jeffers include a forum that is “designed to take the most current literature evidence on best practices and fast track it into daily practice,” didactic presentations for providers, and publication of patient satisfaction and quality outcome studies, as well as quality improvement initiatives based on the results of the studies.

In addition, New West, which was established in 1994, has maintained an active clinical research program since 1997.

Additional PCMH activities range from daily patient huddles and quarterly patient education newsletters to population health management and shared savings with four health plans.

New West and individual staff members support community activities in a myriad of ways. For example, the practice is involved with the Colorado Business Group on Health and the Denver Chamber of Commerce, as well as the CAFP and other medical organizations. The practice has supported the USA Pro Cycling Challenge and each of the 16 practice sites has a philanthropic budget. Staff members volunteer at medical clinics and in support of school sports and they participate in education on many levels.

In addition to achieving Level 3 PCMH recognition from the National Committee for Quality Assurance, all eligible New West providers are NCQA recognized for heart/stroke and diabetes. In 2011, the American Hospital Association focused on just delivery systems for a national accountable care study. New West Physicians was chosen as the primary care model.
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