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2nd Quarter
2014 Spring

CAFP NEWS

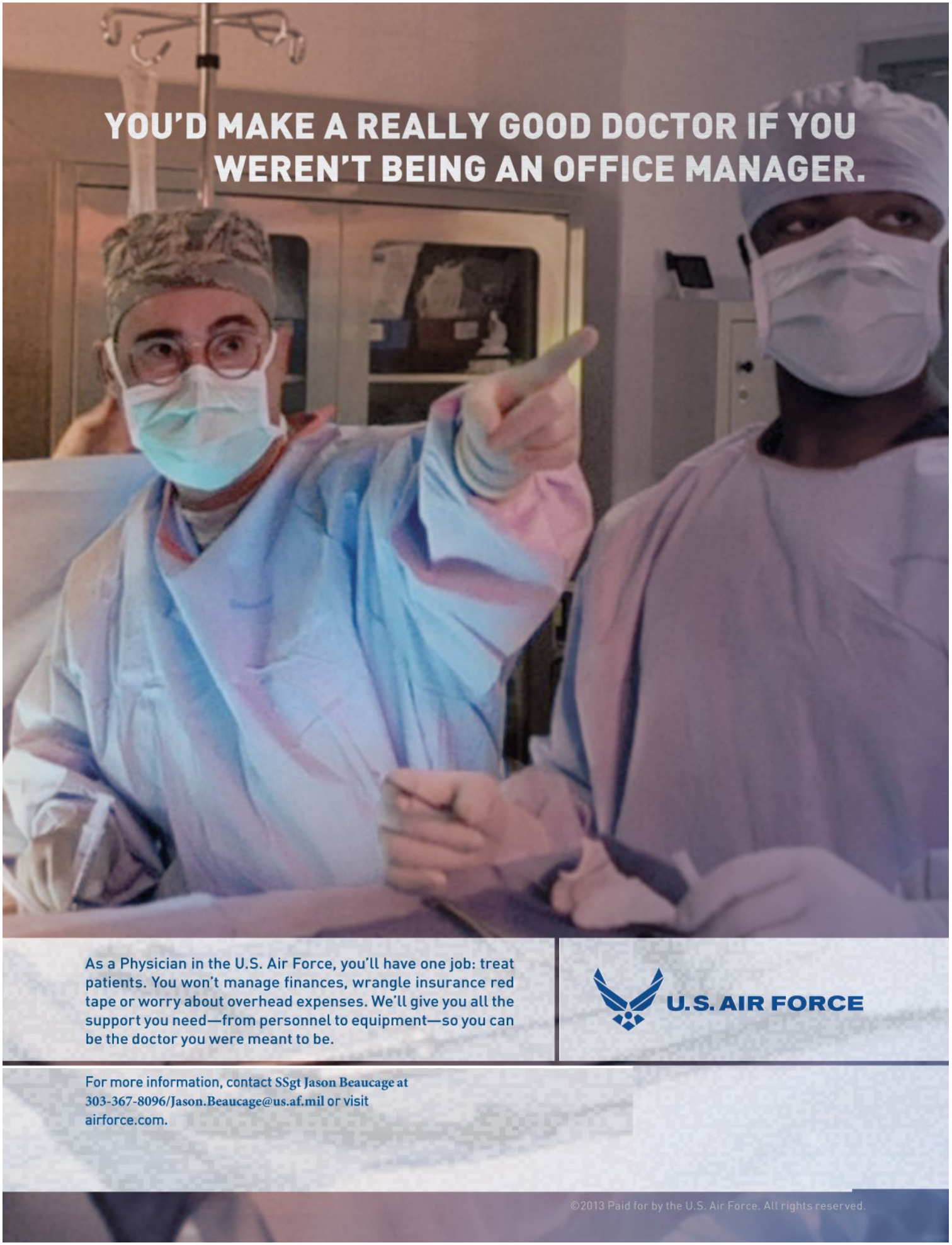
BOLD CHAMPION FOR COLORADO FAMILY PHYSICIANS

IN THIS ISSUE:

John Bender, MD, FAAFP
Awarded 2014 Family Medicine Physician of the Year

Corey Lyon, DO, FAAFP
Awarded 2014 Family Medicine Teacher of the Year

Gina Martin, MD
Awarded 2014 Family Medicine Resident of the Year



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SPRING 2014

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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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PRESIDENT'S REPORT

Rick Budensiek, DO, FAAFP

The Fourth Aim: Provider Satisfaction

We stand today at a crossroads. One path leads to despair and utter hopelessness, the other leads to total extinction. Let us hope we have the wisdom to make the right choice. – Woody Allen

I am writing this after having lost four of six physicians over the past six months in the practice I started 20 years ago. One physician retired at 62 years of age, another went to a cosmetology/dermatology practice she had been building for the past five years. Another is developing a Direct Primary Care/concierge practice. A fourth moved to care for her aging parents in another state. Factors for leaving included: frustration with EMR's, request for "just one more thing to document, doctor," spending so much time filling out forms from FMLA, "peer to peer reviews" for reconsideration of health plan denials of service/DME/prescription medications, and spending a full day at work and then spending the evenings and weekends finishing documentation.

We are familiar with the triple aim: better quality, decreased Cost and a better patient experience. A recent study by the AMA and Rand Corporation talks about the fourth aim of our health care system: provider satisfaction. A recent study by Duke University shows how physician satisfaction relates to patient care. Not only does this impact the physician's ability to interact optimally with patients and diminish the development of healing and trusting relationships with patients, it also increases medical errors.

What is the solution? I believe the Patient Centered Medical Home offers solutions to the present dilemma we find ourselves in. The "Joint Principles of the Patient Centered Medical Home" advances the concept of physician directed medical practice. No longer is it "just another thing to document, doctor!" Improved quality, decreased cost and better patient experience (and I believe improved work/life balance) can be accomplished with a PCMH approach that emphasizes the team concept. Improved processes and work flows mean no additional work for the physician while improving the care we deliver.

In spite of a small study cited in the Journal of the American Medical Association that discredits the Patient Centered Medical Home, there is a growing body of work that shows that PCMH is working. Those studies are well documented by the Patient Centered Primary Care Collaborative's (PCPCC) recent paper, "The Patient-Centered Medical Home's Impact on Cost & Quality-An annual Update of the Evidence, 2012-2013" dated January 2014 and can be found on their website, www.pcpcc.org.

As one of the 73 Comprehensive Primary Care Initiative (CPCI) practices in Colorado, I can attest to the advantages of the PCMH approach. Without increasing my work load, my team has decreased the percentage of my diabetics with a HgbA1C over 9 from 60% to 20%. How did we do it? Empower the team. We cleaned up the data, contacted the patients who were not at goal, and got them in for care. We used a team of care coordinators, diabetic educators, social workers, administrators, behavioral health team, and medical assistants to reach improved quality.

I was able to do that in my practice through the funds supplied by the multiplayer model of the CPCI. If CPCI is successful in meeting its triple aim, that model can roll out across the nation without going through the budgetary process of Congress. What about now? How does transformation to the PCMH happen in rural practices, independent practices and struggling practices across the state?

Our CAFP has been hard at work to answer that question. The CAFP, through initial leadership of the late Bob Brockmann, M.D., the passion of CAFP CEO, Raquel Rosen, and many others, has formed an organization called the Colorado Primary Care Collaborative, which is the Colorado brand of the national organization, the Patient Centered Primary Care Collaborative (PCPCC). Its mission is dedicated to advancing primary care via the patient-centered medical home (PCMH) by focusing on delivery reform, payment reform, patient engagement, and benefit redesign. Payment reform is the king pin to increasing support for PCMH practice transformation. We have been meeting with the Colorado Association of Health Plans to discuss payment reforms. We have also met with over 140 stakeholders who were invited to attend a convening on January 9th at the Warwick Hotel in Denver to introduce the concept of PCMH to business people, legislators, the insurance industry, behavioral health representatives, patient safety representatives, nurses, and others. That meeting was addressed by PCMH thought leader, Paul Grundy, MD, and PCPCC CEO, Marci Nielsen. We convened again on March 13 for a work session on how to move from ideas to action in building the public will for medical homes and improve health care in Colorado. On June 9 and 10, the PCPCC is holding the first ever 2014 Western Regional Conference with the help of the CAFP and Health Team Works, a national organization promoting PCMH and based here in Colorado. It is this level of involvement by our CAFP that has encouraged me to keep going!

I feel like I am standing at a crossroad in my career. You can imagine the chaos of losing four of six physicians, three within a span of one month. I could choose to look with "despair" at the "utter hopelessness." I could be crushed at the prospect of "total extinction." At the risk of sounding like a "Polyanna," I choose to hope for more. I hope to do this through ongoing practice transformation, using an ever growing team including midlevel providers, care coordinators, educators, behavioral health members, medical assistants, administrators, and social workers. I plan to do that through the principles of practice redesign, rapid cycle improvement and analysis, and improvement in work flow. I believe team involvement will help me achieve the "quadruple" aim and some work/life balance. Won't you join me in this hope?

CEO's Report

by Raquel J. Rosen, MA, CAE

Opportunities to Get Involved with Your Academy

CAFP Members are invited to participate in numerous opportunities to further the mission of the CAFP, serving as the bold champion of Family Physicians, patients, and communities through advocacy and education. Here are a few to help you keep a catalog of all that the Colorado Academy offers!

COLORADO PRIMARY CARE COLLABORATIVE (CPCC): This is perhaps the most exciting project the CAFP has undertaken in the last year. We have over 200 people who have said they are interested in building the public will for medical homes and payment reform. We need more Family Medicine Physicians to be involved with the initiative. For more information please go to our web site, www.coloradoafp.org/cpcc or contact raquel@coloradoafp.org.

PATIENT CENTERED PRIMARY CARE COLLABORATIVE (PCPCC) WESTERN REGIONAL CONFERENCE: The CAFP is partnering with PCPCC and HealthTeamWorks to hold the first ever western regional conference for PCPCC on June 9 & 10, 2014. We have a very exciting agenda with excellent national speakers. The conference will help participants identify models, best practices, and solutions for achieving true health care transformation. For more information please go to www.coloradoafp.org/regionalPCPCC-2.

CAFP EDUCATION COMMITTEE: Please help plan the continuing medical education activities including the CAFP's Annual Scientific Conference. We need your input on what is important for Family Medicine Physicians to learn. You will have the opportunity to work with the board education chairs and Erin Watwood, CAFP's director of education, events, and meetings. Please contact erin@coloradoafp.org for more information.

CAFP LEGISLATIVE COMMITTEE: The CAFP needs Family Medicine Physicians to participate on the legislative committee. The CAFP director of public policy, Jeff Thormodsgaard, will describe legislative bills that have been introduced and you will have the opportunity to explain how they would affect your practice. For more information please contact manthan@coloradoafp.org.

DOCTOR OF THE DAY: Please volunteer to serve as the Doctor of the Day at the Capitol. This will give you the opportunity to learn how the legislative process works, give input on bills affecting Family Medicine if you want, besides giving important medical services to the legislators and Capitol staff. Please contact manthan@coloradoafp.org.

TAR WARS PRESENTER: Help the CAFP reach fourth and fifth graders with this important message of the healthy benefits of not smoking. The CAFP Tar Wars coordinator, Karol Groswold, will help set up a presentation for you in a school in your area. Please contact karol@coloradoafp.org.

CAFP HEALTH OF THE PUBLIC: The CAFP is working on projects regarding pediatric obesity, and immunizations. If you are interested in these topics please contact sarah@coloradoafp.org.

CAFP Members are invited to participate in numerous opportunities to further the mission of the CAFP, serving as the bold champion of Family Physicians, patients, and communities through advocacy and education.

The **AAFP'S NATIONAL CONFERENCE OF SPECIAL CONSTITUENCIES** is held in May of each year. If you are interested in serving as one of the representatives for Women, Minorities, International Medical Graduate, New Physician, or GLBT, please contact raquel@coloradoafp.org.

CAFP SURVEY RESULTS: Thank you to those who completed our survey for future planning. Here were the top four topics that you voted for. The CAFP will be planning these and will be sending out the calendar for the year soon.

- Additional SAM Courses
- DOT Medical Examiners Training
- Health Care Reform & Legislative Update
- Financial Planning
- ICD-10

ANNUAL SCIENTIFIC CONFERENCE: This year's conference will provide super CME, valuable networking, and family activities. Please go to http://coloradoafp.org/ASC2014 for more information or contact erin@coloradoafp.org.

Sincerely,

Raquel J. Rosen

Raquel J. Rosen, MA, CAE
CAFP CEO


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KIDS WITH ASTHMA AND ALLERGIES
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CAFP 2014 Legislative UPDATE

By Jeff Thormodsgaard & Katie Wolf, CAFP's Lobbyist

Session is officially in full swing with over 450 bills introduced to date. However, compared to the 2013 Legislative Session, this one has been downright quiet. The combination of a tightly split Senate and an election year has made it more difficult for legislators to introduce complex or controversial bills. Out of the 450, there are many pieces of legislation that the CAFP is tracking. CAFP is a trusted resource on healthcare at the Capitol and therefore asked to weigh in on many healthcare bills, below are a few highlights so far.

Family Medicine Residencies

One of the biggest bills CAFP is supporting is **Senate Bill 14-144**. This bill modifies the duties of the Commission on Family Medicine regarding the development of family medicine training programs in rural and undeserved areas of the state. There are many facts supporting the need for more family physicians, especially in rural and underserved areas of the state. Colorado faces a shortage of primary care physicians, especially in rural and underserved areas. Rural training tracks increase the number of training positions; graduates of such programs are much more likely to practice in rural and underserved areas.

The bill does the following 3 things: Extends the Commission's duty to develop and maintain family medicine training programs in rural and underserved areas. Requires the Commission to report on the use of funds; reports will be made to OSPB, HCPF, and the JBC. Requires the Commission to complete a study concerning family medicine residency programs and how these programs will meet the primary care workforce needs of rural Colorado and other underserved areas of the state.

CAFP is strongly supporting this legislation because of its focus on the importance of family medicine and access to care. So far, SB 144 has been heard in the Senate Health committee and was approved 6-1. We will keep you updated as this legislation moves forward.

Physician Report Driving Condition

On the opposite end, one of the biggest bills CAFP is opposing is **HB14-1068**, physician reporting driving condition to the Department of Revenue. The bill requires physicians to report the diagnosis or knowledge of a patient that is afflicted with a loss, interruption, or lapse of consciousness or motor function, to the department of revenue within 7 days. Failure to report is punishable by a fine of $300 or up to 90 days in jail.

The CAFP strongly opposed this legislation because of its implications for the physician/patient relationship. We had a member of our Board testify in front of the Colorado Health and Human Services committee. Our Board Member's testimony was especially impactful because the legislators found the law to be duplicative, burdensome, and overly meddling. Before the committee, we set up a fact sheet about the bill and laid out our opposition. We also worked with stakeholders, such as the Diabetes Association and the Epilepsy Association, to bring patient stories to the legislators. In the end, the bill was unanimously killed in committee.

Colorado faces a shortage of primary care physicians, especially in rural and underserved areas. Rural training tracks increase the number of training positions; graduates of such programs are much more likely to practice in rural and underserved areas.

Nurse Physician Advisory Task Force for Colorado Healthcare (NPATCH) Sunset

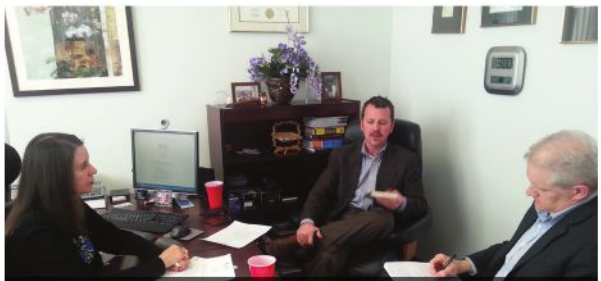
In 2009, the CAFP and the nurses association negotiated an agreement to allow for prescriptive authority for Advanced Nurse Practitioners. The collaborative agreement set up a framework that eventually became law. With that collaborative agreement in place, the Nurse Physician Advisory Task Force for Colorado Healthcare (NPATCH) was created under the Department of Regulatory Agencies (DORA) to navigate any future issues.

Every ten years this task force is evaluated by DORA, and recommendations are made to the legislature on whether or not to continue the group and any necessary changes. This year NPACTH has had their evaluation by DORA, **HB14-1181**. The recommendation was to continue the task force for ten more years, with no other substantive changes recommended. This bill has been heard in its first committee and passed unanimously.

Additionally, this year, the Advanced Nurse Practitioners, led by the Center for Nursing Excellence, brought a bill to remove the negotiated agreement we set in place in 2009. The most important clause in our negotiated agreement was to require 1800 hours of preceptorship and 1800 hours of mentorship before allowing prescriptive authority for APNs. The bill brought by the Center for Nursing Excellence, this year, removed those requirements and would allow a newly graduated nurse to have prescriptive authority without any mentorship or preceptorship. We took our complaints to NPATCH and the bill was dropped in order to allow for negotiations. We had a physician, who worked as a nurse before receiving her medical degree, testify in front of the committee. Even the nurses on NPATCH agreed with our physician. We expect that the recommendations from NPATCH will eventually become law and our influence at NPATCH is strong. NPATCH, so far, has not supported any additional changes.

CAFP ON THE GO

FFC participants graduate in La Junta. Each participant received a bicycle as a reward for their dedicated participation over the last year.



Jeff Thormodsgaard, CAFP Lobbyist, and Raquel Rosen, CEO of the CAFP, speaks with Ben Price, CEO of the Colorado Association of Health Plans on a workgroup of physicians and senior health insurance representatives regarding payment and delivery reform.

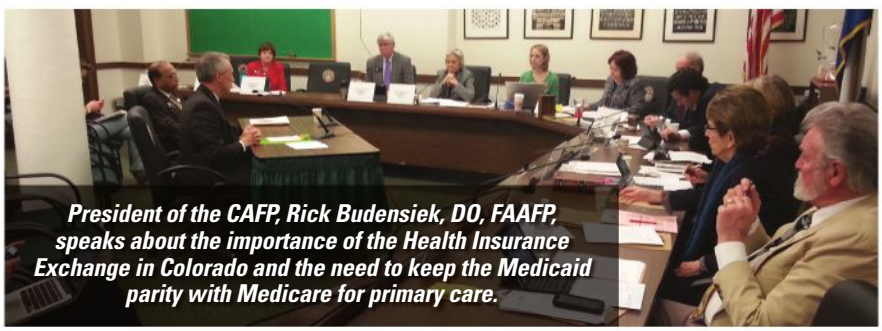
Tamaan Osbourne-Roberts, MD, President-Elect of the Colorado Medical Society attended a fundraiser for Colorado House Democrats, Colorado Senate Republicans and Colorado Senate Democrats before the 2014 Legislative Session on behalf of the CAFP.

Richard Budensiek, DO, FAAFP, served as the Doctor of the Day on the first day of the 2014 Legislative Session. He spoke with State Representatives and Senators about the need for payment reform, delivery reform and the importance of the Patient Centered Medical Home.

The CAFP Board of Directors met with the Colorado HealthOP, a new insurance company that has utilized Connect for Health Colorado to drive competition among the plans. Colorado HealthOP is the first statewide nonprofit health insurance cooperative!

The CAFP Board of Directors have met twice this year to discuss various issues regarding Family Medicine in the state of Colorado.

CAFP Member and Doctor of the Day participant, Laurie Patton, MD, speaks about the importance of post-graduation training for Nurse Practitioners at the Nurse-Physician Advisory Taskforce for Colorado Healthcare.



President of the CAFP, Rick Budensiek, DO, FAAFP, speaks about the importance of the Health Insurance Exchange in Colorado and the need to keep the Medicaid parity with Medicare for primary care.

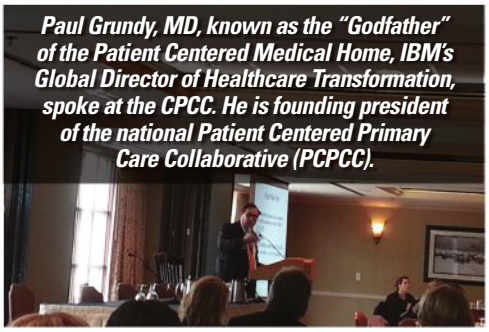
President of the CAFP, Rick Budensiek, DO, FAAFP, speaks to the Family Medicine Interest Group at CU Medical School about the importance of the PCMH model and the future of Family Medicine.

With over 150 attendees and 200 organizations signed on, the Colorado Primary Care Collaborative is dedicated to advancing primary care via the patient-centered medical home (PCMH) by focusing on delivery reform, payment reform, patient engagement, workforce training, and benefit redesign.

President of the CAFP, Rick Budensiek, DO, FAAFP, opens the first convening meeting of the Colorado Primary Care Collaborative (CPCC).

State Legislators, Chief Medical Officers of major health insurance organizations, providers, mid-levels and community leaders learned about the many studies showing the increase in patient satisfaction, the global reduction of cost, and the improved practices and mindsets of providers.

Marjie Harbrecht, MD, FAAFP, speaks about the importance of moving the PCMH forward and supporting a team-based approach to the practice of Family Medicine.



Paul Grundy, MD, known as the "Godfather" of the Patient Centered Medical Home, IBM's Global Director of Healthcare Transformation, spoke at the CPCC. He is founding president of the national Patient Centered Primary Care Collaborative (PCPCC).

Marci Nielson, PhD, MPH, CEO of the PCPCC, spoke about the importance of creating a unified voice for primary care and the Patient Centered Medical Home

ADVOCACY

What are the benefits of being a PRIMARY CARE MEDICAL PROVIDER (PCMP) in the Accountable Care Collaborative (ACC)?

The Accountable Care Collaborative (ACC) program is Colorado Medicaid's premier reform effort and the predominant services delivery system for physical health care services.

Regional Care Collaborative Organizations (RCCOs) are responsible for provider support, care coordination, and accountability of care in each region.

Per Member per Month Payment

PCMPs receive $3 per member per month reimbursement for providing medical home level services.

FFS Reimbursement

PCMPs receive FFS reimbursement for medical services.

- In July 2013, provider rates increase by 2%.
- Beginning January 1, 2013, physician reimbursement for Medicaid services increased to 100% of Medicare reimbursement for evaluation & management codes.

Incentive Payment

The Department has paid out over $1 million to providers for two quarters of performance. Every participating ACC provider has received an incentive payment.

$1 per member per month Incentive Payment may be paid based on four regional key performance indicators:

- Hospital All Cause Thirty (30) Day Readmissions
- Emergency Room (ER) Visits
- High Cost Imaging Services
- Well Child Visits

Shared Savings

All ACC providers will be eligible to receive a percentage share of medical cost savings generated by the program.

Patient Panel Limits

Providers can set limits on their patient panels.

Data Analytics and Reporting Capabilities

Through the Statewide Data and Analytics Contractor (SDAC), PCMPs will receive client level utilization and risk data on the clients in their panel. The SDAC provides a web-portal dashboard for each practice that physicians can use to manage, coordinate and integrate care.

Care Coordination and Medical Management

Regional Care Collaborative Organizations (RCCOs) coordinate the services provided to clients, which may include behavioral health, long term services and supports, and government social services. Care coordinators may also link clients to non-medical community services, such as adoption and advocacy services, youth programs, housing programs, and emergency financial assistance.

Practice Support

RCCOs supply providers with practical tools and resources to fulfill the basic elements of a Medical Home. Practice support may include clinical tools, client materials, operational practice support, data, reports and other resources.

Technical Support

The RCCOs assist providers in navigating Medicaid administrative systems.

*Contact your RCCO today to get signed up.
Visit **www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675** to find out what RCCO Region you are in

RCCO Contact Information

Region 1: Rocky Mountain Health Plans ❖ **Jenny Nate** ❖ 303.967.2082 ❖ Jenny.nate@rmhp.org
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ICD-10

GET READY FOR ICD-10

The ICD-10 transition will affect every part of your practice, from software upgrades, to patient registration and referrals, to clinical documentation and billing.

CMS can help you prepare. Visit the CMS website at **www.cms.gov/ICD10** and find out how to:

- Plan Your Journey – Look at the codes you use, prepare a budget, and build a team
- Train Your Team – Find options and resources to help your team get ready for the transition
- Update Your Processes – Review your policies, procedures, forms, and templates
- Engage Your Partners – Talk to your software vendors, clearinghouses, and billing services
- Test Your Systems and Processes – Test within your practice and with your partners

Now is the time to get ready.

www.cms.gov/ICD10

CMS ICD-10

Official CMS Industry Resources for the ICD-10 Transition

www.cms.gov/ICD10

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Children's Hospital Colorado
Affiliated with University of Colorado Anschutz Medical Campus

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

Weight Management of Children and Teenagers

By Matthew Haemer, MD, MPH and Renee Porter, RN, CPNP

Obesity affects nearly 14% of children in the state of Colorado and nearly 17% nationwide.[1,2] A recent report from the CDC, showed that while rates of childhood obesity in low-income preschoolers has stabilized or is decreasing in most states, in Colorado the prevalence of obesity among low-income preschoolers is still rising.[3] More than two million children 2-18 years, or 4% of children in the US, are severely obese with BMI greater than the 99th percentile for age/gender.[4] (Table 1) Severely obese children have greatly increased risk of metabolic and cardiovascular abnormalities and are very likely to be obese as adults.[5] Intensive intervention is required to help obese children, especially severely obese children, achieve a healthier BMI. While raising awareness of obesity among parents of young children can be challenging, treatment can be more successful when initiated in the preschool years compared to older children.[6]

TABLE 1 Cutoff Points for 99th Percentile BMI According to Age and Gender

Age	99th Percentile BMI cutoff point, kg/m^2	
	Boys	Girls
5	20.1	21.5
6	21.6	23.0
7	23.6	24.6
8	25.6	26.4
9	27.6	28.2
10	29.3	29.9
11	30.7	31.5
12	31.8	33.1
13	32.6	34.6
14	33.2	36.0
15	33.6	37.5
16	33.9	39.1
17	34.4	40.8

Cutoff points are at the midpoint of the child's year (eg, 5.5 years). Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: summary report.[7]

Why is obesity different for children?

The obese child or adolescent has medical and psychosocial needs that are different from the adult obese patient. The risks for metabolic, orthopedic, and psychological comorbidities vary widely by developmental stage as do treatment approaches. Treatment must be tailored to each child's unique cognitive, emotional, and physical development, and the environment in which he or she lives. Children require the support of parents, siblings, extended family, and extended social systems to be successful at managing their weight. Families hold a wide range of knowledge, attitudes, and beliefs about a child's weight status and what constitutes a healthy lifestyle. It is critical to treat each family with respect and to tailor approaches to the unique needs of each child and family.

Addressing obesity in the primary care setting

Children's Hospital Colorado utilizes the systematic staged approach (stages 1-4) from the Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity published as a supplement to PEDIATRICS December 2007.[7] http://pediatrics.aappublications.org/cgi/content/full/120/Supplement_4/S164

The Expert Committee recommends that primary care providers participate in weight management counseling and play a critical role in identifying families who are in a state of readiness-to-change likely to benefit from referral resources (stage 1). Resources for primary care providers to utilize for treatment within their own practices include the Colorado HealthTeamWorks guidelines, which outline the goal setting process, necessary labs, and weight related health conditions (http://www.healthteamworks.org/

1. Colorado Children's Campaign. 2009-2013 Kids Count in Colorado! http://www.coloradokids.org/data/kidscount/overview.html. Accessed Feb 26, 2014 2014.
2. Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of childhood and adult obesity in the United States, 2011-2012. *JAMA*. Feb 26;311(8):806-814.
3. Centers for Disease Control. Vital Signs: Progress on Childhood Obesity. http://www.cdc.gov/vitalsigns/childhoodobesity/. Accessed Feb 26, 2014, 2014.
4. Skelton JA, Cook SR, Auinger P, Klein JD, Barlow SE. Prevalence and trends of severe obesity among US children and adolescents. *Acad Pediatr.* Sep-Oct 2009;9(5):322-329.
5. Freedman DS, Mei Z, Srinivasan SR, Berenson GS, Dietz WH. Cardiovascular risk factors and excess adiposity among overweight children and adolescents: the Bogalusa Heart Study. *J Pediatr*. Jan 2007;150(1):12-17 e12.
6. Haemer MA, Ranade D, Baron AE, Krebs NF. A clinical model of obesity treatment is more effective in preschoolers and Spanish speaking families. *Obesity (Silver Spring)*. May, 2013;21(5):1004-1012.
7. Barlow SE. Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: summary report. *Pediatrics*. Dec 2007;120 Suppl 4:S164-192.

guidelines/childhood-obesity.html). Prior to referring overweight or non-severely-obese patients without comorbidities, the Expert Committee suggests that primary care providers attempt lifestyle counseling, engage the family in any community-based programs available, and consider referring if the child fails to decrease BMI after six months of follow-up (stage 2). There are many helpful resources available in some Colorado communities: the CAFP Fit Family Challenge, the MEND (Mind, Exercise, Nutrition, Do-It)[8] program offered as a free program by the Colorado Health Foundation at many YMCAs across the state, and through Denver Health (Table 2).

TABLE 2

Program	Description	Contact Information
Colorado Academy of Family Physicians - Fit Family Challenge	Integration of prevention and management for childhood obesity into primary care	Sarah Roth sara@coloradoafp.org (303) 696-6655 ext. 16
MEND	Free Program Hosted by many YMCAs across Colorado For youth 7-13 years old who are above their healthy weight - Fun games, healthy foods, goal setting	Linda James (Denver) (720) 524-2714 or ljames@denverymca.org
Por Tu Familia	Free Program in Spanish for Children "Salsa, Salud y Sabor" Cultural connections to wellness, activity, food choices	Monica Chavez (720) 855.1102 ext. 7032 or mchavez@diabetes.org
Denver Recreation Centers	"MY Denver" Free access to 23 rec centers in Denver County for Denver students, ages 5-18	http://denverlibrary.org/files/MYDenverCardParentConsent_ENG.pdf

Primary care providers can aim to achieve just one or all three of the following goals with children and their families during an office visit that addresses obesity:

1. Raise the issue in a non-judgmental and empathetic manner, query the family's level of concern about the weight issue, and disarm a resistant family by asking permission to share the provider's concern about health consequences.
2. Work on enhancing a family's intrinsic motivation to make changes by asking the family to describe what changes they are ready to make and why they are important.
3. Sustain long-term habit change by encouraging the family to self-monitor specific goals or to complete a specific weight management program. Families with low readiness-to-change may benefit from focusing on goal #1 at the first or even several subsequent visits before they are ready to tackle the issue.

Using the term "obesity" to describe a child's unhealthy weight during an office visit has been reported to induce stigma, was offensive to families to a similar degree as the word "fat," and did not enhance motivation to change.[9] However, describing a child's weight as "unhealthy," or stating that a child is carrying "too much weight for his/her health" has been described as motivating and non-offensive to families. It may be helpful to communicate that the increased risk of diabetes or heart disease carried by a child whose BMI is above the 95th percentile can be reversed completely if a healthy BMI is attained by adulthood.[10] It is important to understand that by engaging the family to participate in selecting goals for change, the provider can maximize the likelihood that the goals and BMI reduction will be achieved. While providers may offer helpful suggestions when the family requests, this technique should minimize provider frustration and a family's resistance when a proscriptive set of instructions is given by the provider.

When families are ready to actively participate in selecting goals to change nutrition and activity habits, an effective technique involves setting specific goals that can be tracked by the child on a calendar on a daily basis, involving the parent to give positive reinforcement, and rewarding the child with an activity that gives special attention from a parent or other loved-one if the goal is achieved each week. This describes in a nut-shell an approach to counseling that is consistent with a family-centered weight management model.

When should patients be referred for specialty care?

According to the Expert panel, a child over two years of age should be referred for Severe Obesity for abnormal lab values or comorbidities related to obesity. (Table 1) Referrals are encouraged for children less than two years of age with elevated or rapidly increasing weight-for-length.

Children who are severely obese, have severe comorbidities, OR whose families are highly motivated to participate in an intensive weight management program but without severe obesity, may also be referred at any time to a tertiary care weight management program (stage 3 & 4). It is the expectation that the primary care provider continue following the patient's progress in weight management on a regular basis while involved in a referral weight management program.

Where to refer if needed?

Children's Hospital Colorado, LIFEstyle Medicine Program offers treatment options aimed at meeting

continued on page 14 >>

8. Sacher PM, Kolotourou M, Chadwick PM, et al. Randomized controlled trial of the MEND program: a family-based community intervention for childhood obesity. *Obesity (Silver Spring)*. Feb 2010;18 Suppl 1:S62-68.
9. Puhl RM, Peterson JL, Luedicke J. Parental perceptions of weight terminology that providers use with youth. *Pediatrics*. 2011;128(4):e786-e793.
10. Juonala M, Magnussen CG, Berenson GS, et al. Childhood adiposity, adult adiposity, and cardiovascular risk factors. *New England Journal of Medicine*. 2011;365(20):1876-1885.

the needs of obese children through a family-centered care approach. The program supports children and families in life-long behavior changes through enhancing motivation, education, skill-building, and support.

The weight management program at Children's Hospital Colorado has been adapted to meet the demands for treatment of severely obese children in Colorado and surrounding states. Children's Colorado has developed a comprehensive weight management program, **"LIFEstyle Medicine Program – Lifestyles Influencing Fitness and Eating,"** to meet the needs of PCPs, children and families who may need more intensive interventions, than the community programs can provide (stage 3 & 4). This might be on a less-frequent consultative basis (for out of town families) or through frequent engagement of all program resources (Denver Metro Area). The name "lifestyle medicine" was chosen, to reflect the most successful treatment approaches for childhood obesity, lifestyle interventions, and to emphasize sustainably adopting healthy habits in a supportive family environment.

The LIFEstyle Medicine Program provides medical evaluation and necessary follow-up for each patient. Our medical providers are trained in pediatric obesity management, and include Pediatricians, Pediatric Nurse Practitioners, and a Physician Assistant. The team provides a thorough evaluation, performs necessary lab tests, orders additional studies to diagnose comorbid conditions as needed, and provides timely communication with the PCP. The LIFEStyle Medicine Program also includes endocrinologists, cardiologists, and gastroenterologists for those patients who may need additional diagnostic assessment or rarely, medication treatment, for a comorbid condition.

An essential component of a stage 3 weight management program, is the multidisciplinary team of pediatric dietitians, pediatric psychologists, and an exercise physiologist, each providing unique and coordinated services within the program. The multidisciplinary team delivers several group options, exercise classes, and individual sessions. The program delivers care for out of town families through less frequent visits to the Anschutz Medical Campus in Aurora, coordinated with more frequent visits with their PCP, local weight management programs, local dietitians, or other community-based resources to complete the treatment plan.

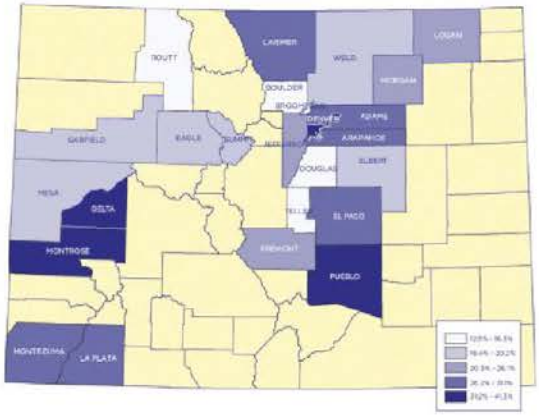
Pediatric weight management experts at Children's Hospital Colorado recognize the need for engagement from all sectors in healthcare and the community to tackle this epidemic. Not all families require the LIFEstyle Medicine Program to treat a child's obesity, as some will succeed with lifestyle changes with support from their primary care provider and other community programs. Please call our LIFEstyle Medicine Program Coordinator if you have questions about a particular patient and seek guidance for treatment. Renee Porter, RN, PNP 720-777-3352.

Matthew Haemer, MD, MPH
Assistant Professor of Pediatrics, Section of Nutrition, University of Colorado School of Medicine
Medical Director, LIFEStyle Medicine, Children's Hospital Colorado

Renee Porter, RN, CPNP
Senior Instructor, University of Colorado School of Medicine
Obesity Nurse Coordinator, Children's Hospital Colorado

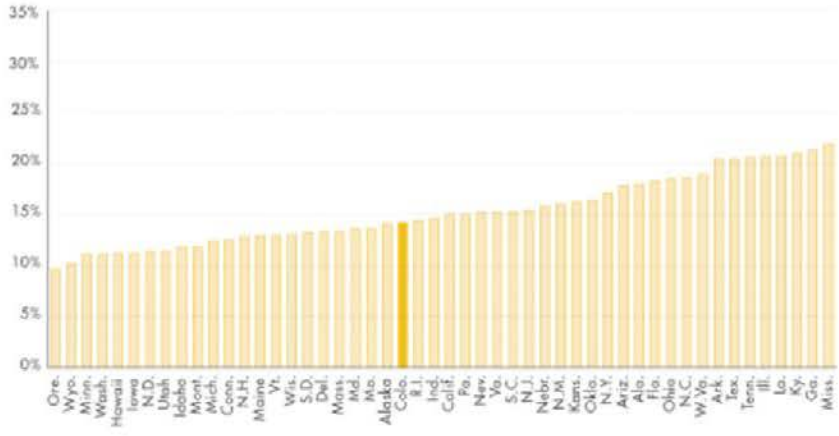
Kids Corner is a regular feature of the CAFP News brought to you by the Children's Hospital Colorado Department of Family Medicine. For questions about this article or suggestions for future topics please contact Dr. Jeffrey Cain, the Chief of Family Medicine at Children's Colorado, through One Call at (720) 777-3999 or (800) 525-4871.

Figure: Percent of Children Overweight or Obese 2010-2011



Data Source: Colorado Department of Public Health and Environment. Health Statistics Section, 2010-2011 Child Health Surveys. Health Statistics Regional data (http://www.chd.dphe.state.co.us/healthProfiles.aspx). No Data Available for Blank Counties.

Graph: Childhood Obesity Prevalence by State.



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health (2007). Published in the Colorado Health Foundation 2012 Colorado Health Report Card http://www.coloradohealthreportcard.org/ReportCard/2012/subdefault.aspx?id=6006

Allergy

Pulmonary Medicine

Urgent Care

Working together to provide the
best care for kids with Asthma

Respiratory Care

Inpatient Services

Certified Asthma Educators

Our comprehensive Asthma Program addresses the needs of children of all ages and all levels of asthma severity, offering convenient access to our clinics, urgent care, inpatient and intensive care units. Our experts in pediatric lung disease and asthma are available for around-the-clock consultation for your patients with asthma.

The evaluation, treatment, and education provided by the Asthma Program is tailored to each child's individual needs. The goal of our program is to optimize asthma control and improve the quality of life for the child and the family. Our team of pediatric pulmonologists, allergists, respiratory therapists, and pediatric nurses is committed to partner with you in the care of these patients and offer the most advanced treatment options.

For more information on our Asthma Program at the Breathing Institute, please visit **childrenscolorado.org/breathing**.

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PRINCIPLES TO FOLLOW IN TALKING WITH PATIENTS ABOUT OTHER CLINICIANS' ERRORS

COPIC's Patient Safety and Risk Management Department

While much attention, literature and training has been developed over the past decade on the subject of one's own medical errors and the process of disclosure, very little has been explored regarding how to respond to patients, clinicians and colleagues when one becomes aware of the errors of other clinicians. Supported by a grant from the Greenwall Foundation and by the Risk Management Foundation of the Harvard Medical Institutions, an international panel assembled to develop a collaborative approach to the issue. Subsequently, The *New England Journal of Medicine* (NEJM) recently published an article[1] entitled "Talking with Patients about Other Clinicians' Errors."

Some of the excerpted principles and observations of the study included:

"Clinicians might be tempted to use the patient's medical record to raise concerns about a potential error without initiating a direct conversation."

This approach can be viewed as counterproductive to the aims of improving the patient's medical care, informing and potentially educating the practice pattern of the previously erring clinician, and provides evidence that could be taken out of context in a subsequent liability action.

"Patients and families should come first."

Disclosure is ethically required, and patients and families should not bear the burden of digging for information about their care. There is a professional ethical responsibility to treat the patient and to not put the needs of themselves, or the anxieties of an uncomfortable discussion with the other clinician, above that.

"Explore, do not ignore."

While an ethical duty to disclose exists, that disclosure process must also contain the appropriate factual information in an appropriate setting over an appropriate course of time. The NEJM article contains a useful table outlining various clinical situations, the participants in the disclosure, and the rationale for disclosing harmful errors in common situations involving other clinicians. Communication with all the previous clinicians, and an attempt to resolve the factual history and the correct subsequent course should precede the disclosure process with the patient and family. However, the patient's time frame and "need to know" dictates that the communication among clinicians be as time sensitive as is practically possible. These situations do not get better with a delay of time.

"Institutions should lead."

Colleague-to-colleague discussions and an investigation into the facts and a resolution of the proper subsequent course requires an institution that is supportive and ultimately expects accountability and professionalism of its members. Just-in-time coaching programs can assist with these difficult situations. Involvement of trusted leaders and physician champions can greatly assist. It is important to develop a "just culture," which the article describes as "atmospheres of trust in which people are encouraged, even rewarded, for providing essential safety-related information—but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior."

[1]*N Engl J Med 369;18 1752-1757–October 31, 2013*

PERSONS WITH DISABILITIES PARKING PRIVILEGES APPLICATION FORM CHANGE

By: Colorado Department of Health Care Policy & Financing

All Colorado Medicaid providers need to be aware that the Colorado Department of Revenue, Division of Motor Vehicles, recently made revisions to the DR 2219 Persons with Disabilities Parking Privileges Application. The changes includes the clarified penalty statements for both the person with a disability as well as the signing provider. Changes also include the following:

If you or the patient makes a mistake on the form, please complete a new form. Do not write over, white out, cross out, or otherwise alter information. This will void the form.

Impairments are now defined as follows:

- **PERMANENT** – a condition that is not expected to change within a person's lifetime
- **EXTENDED** – a condition that is not expected to change within 30 months after the issuance of the plates or placard
- **TEMPORARY** – a condition that is expected to last less than 30 months after the issuance of the plates or placard
- **SHORT TERM** – a condition that is not expected to last more than 90 days after the issuance of a placard

Additionally, providers who knowingly misuse or who make false statement to help someone obtain or retain a placard may be fined up to $500,000 for a Class 4 Felony or $1,000 for a Class one misdemeanor.

The old forms will be accepted by the Division of Motor Vehicles until February 28, 2014. As of March 1, 2014, only the new forms with the revision date of "12/27/13" in the upper left hand corner of the form will be accepted.

Any patient who does not appear with the new form will be turned away and told to contact your office for further assistance. A copy of the revised form is provided as Attachment A at the end of this bulletin.

Please contact Gina Robinson at Gina.Robinson@state.co.us or 303-866-6167 with any questions.

Link to form: http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251924173662&ssbinary=tru

CAFP NEWS

INTRODUCING THE

LONE TREE BREAST CENTER

Front row: *(from left to right)* Colleen Murphy, MD, Dana Knapp, Eamon Berge, MD, James Borgstede, MD
Back Row: Candace Drew, Larissa La Breche, Melissa Klausmeyer, MD, Sara Amateis, Lori Swanson, RN, BSN, Christine Cedilotte, PT, DPT, MS, CLT

University of Colorado Hospital and the CU School of Medicine are proud to announce the opening of the new Lone Tree Breast Center, one of the Colorado's most comprehensive breast health facilities. The Center offers **3-D mammography for all patients as a standard of care with no additional cost to our patients**, and walk-in appointments are always welcome.

Other services include:

- Breast and axillary ultrasound
- Breast biopsies: stereotactic, ultrasound and MRI-guided
- Breast MRI: available in the Lone Tree Health Center across the plaza from Lone Tree Breast Center
- Wire localizations for surgery
- Screening and diagnostic mammography
- Breast Patient Navigator
- Genetic counseling
- Screening and management of patients at high risk for breast cancer
- Breast reconstruction
- Breast cancer nurse navigation
- Medical oncology (Infusion services are provided at the Lone Tree Health Center across the plaza)
- Treatment for and management of benign breast disease
- Multidisciplinary clinic for breast cancer patients
- Breast cancer surgeries including lumpectomies, sentinel lymph node biopsies, axillary dissections and mastectomies (Outpatient surgeries performed at Lone Tree Surgery Center 1/4 mile away)
- Radiation Oncology is available to patients at the UCH TomoTherapy treatment facility, one mile south of Lone Tree Breast Center

Meet Our Comprehensive Breast Health Team:

Colleen Murphy, MD – Breast Surgery, Medical Director, Lone Tree Breast Center
Eamon Berge, MD – Medical Oncology
Melissa Klausmeyer, MD – Plastic and Reconstructive Surgery
Wei-Shin Wang, MD – Breast Imaging
Lara Hardesty, MD – Breast Imaging
James Borgstede, MD – Breast Imaging
Lori Swanson, RN, BSN – Nurse Navigation
Christine Cedilotte, PT, DPT, MS, CLT – Lymphedema Therapy
Candace Drew R.T.(R)(M)CBPN-IC – Mammographer and Breast Imaging Patient Navigator

University of Colorado Hospital
UNIVERSITY OF COLORADO HEALTH

School of Medicine
UNIVERSITY OF COLORADO

LONE TREE HEALTH CENTER

Hours: 8:00 am-5:00 pm | **Scheduling Phone number:** 720-553-1200 | **Fax:** 720-553-1201
Street Address: 9544 Park Meadows Drive, Suite 100, Lone Tree, CO 80124

When Bad Things Happen –
How to Talk With Patients to Enhance Communication

By Tim Garrington, MD

"When I first started as a pediatric oncologist, I'd be shaking going into the room if I knew I had to deliver bad news to a family," says Timothy P. Garrington, MD. Here we talk with Dr. Garrington about his process of learning to communicate difficult and sometimes devastating news to patients, and about his efforts to teach these skills to residents and fellows at Children's Hospital Colorado and the University of Colorado School of Medicine.

Q: You've been involved in changing how doctors communicate with patients — specifically in how doctors deliver bad news. When you started your work, how was this skill taught?

Garrington: The short answer is that it wasn't. Forty years ago, medicine was very paternalistic and we didn't even tell patients they were dying. Now we teach communication skills at the medical student level, but in my opinion, communication skills training needs to continue beyond medical school into residency and fellowship, where trainees need these skills in real settings. As far as residents and fellows, there really wasn't much of anything when I was in training, and I don't think people had a sense of how to go about it — you learned by doing and developed whatever habits you developed.

Q: Were some residents developing better habits than others?

Garrington: Well, yes. Some are naturally better at communication than others, and the belief has been that you're either good at it or you're not. But what we found is that the ability to deliver bad news and communicate well with patients is related to a specific set of skills that can be taught to anyone.

Q: Like what?

Garrington: First, there's a model we follow and teach. And then there are

some important things we've learned from our experience along the way, too. The model is called SPIKES, which stands for Setting (you can't be in a busy hallway or have your beeper going off); Perception (what do the families already know and what are they worried about?); Invitation (you invite patients and families to tell you the kind of information they want — how much or how little, test results or just big picture); Knowledge, (this is where you deliver the bad news in an organized and straightforward way and provide the time and space to answer all of their questions); Empathy (you show the patient you empathize with their feelings of sadness or even anger); and Steps (the plan moving forward).

Q: But you said there are also things you've learned from experience?

Garrington: Yes, absolutely. We help residents and fellows work with real patients, and we even did a study, led by Dr. Gee Mei Tan, at Children's Colorado, using actors to play the part of patients. One huge thing we see is that after communicating the information — the "K" step of *knowledge* — doctors want to jump in and fill the space that inevitably comes after. There's a basic human need to make other people feel okay. And so a doctor might tell a family that a scan came back bad, but then jump right into what we're going to do about it and why everything's going to be okay. Giving space allows time for patients to process the information and lets the next step happen, which is *empathy*.

Q: I can see why it would be hard for doctors to allow themselves to empathize day in and day out…

Garrington: It's difficult and uncomfortable and that's why so many doctors avoid empathy, or even try to avoid the process of delivering bad news altogether. But this is important: What we see from experience is that doctors need this step of empathy too. When a patient starts crying or even when a patient expresses anger, the tendency is to minimize the emotion — to smooth it over. But let me tell you, a doctor is experiencing this emotion too. We know a diagnosis can be unfair and we're sad and angry right along with patients. In the long run, empathizing is essential for a doctor — it makes one more satisfied with what you're doing. There's less burnout and less risk of disengagement. Empathy is as critical to the experience of being a doctor as it is to the experience of being human.

SPIKES — A Six-Step Protocol for Delivering Bad News

Setting
Perception
Invitation
Knowledge
Empathy
Steps

Tim Garrington is an Associate Professor of Pediatrics and the Director of the Pediatric Hematology, Oncology and Bone Marrow Transplant Fellowship Program at the University of Colorado School of Medicine, and a Pediatric Hematologist/Oncologist and Program Leader of the Solid Tumor Team at Children's Hospital Colorado.

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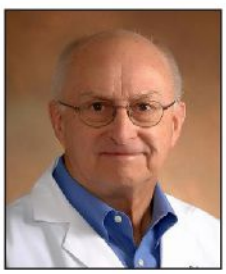
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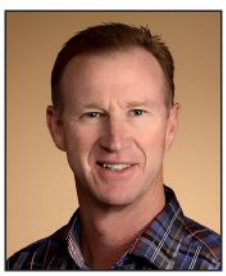
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UNIVERSITY OF COLORADO DENVER SCHOOL OF MEDICINE
Department of Family Medicine
Assistant/Associate Professor
Medical Director – Rose Family Medicine Residency
Job Posting – Position # 611655, Posting # F00956

The Department of Family Medicine at the University of Colorado Denver School of Medicine is seeking an outstanding Family Physician and Clinician Educator to serve as Medical Director for our residency practice located at Rose Medical Center.

Rose Family Medicine Residency exists today as a unique collaboration between three entities: the University of Colorado, Rose Medical Center and The Colorado Health Foundation. The residency is administered by the University of Colorado as one of three residency programs falling under the Department of Family Medicine, which provides access to a full array of educational, clinical, research and academic resources to faculty and residents alike. The residency is located at Rose Medical Center, a 250 bed community hospital in central Denver. Rose is a national leader in patient safety and patient satisfaction, with consistently excellent quality and safety scores. The residency is also supported by the Colorado Health Foundation, a non-profit organization dedicated to making Colorado the healthiest state in the nation.

The residency is comprised of 18 residents, 7 physician faculty members, a PhD psychologist, two social workers, and two pharmacists. The residency practice clinic is currently an NCQA Level-II Patient Centered Medical Home (PCMH) and a winner of the STFM/Family Practice Management Practice Improvement Award. The residency has a strong emphasis on patient safety and quality improvement, utilizes an electronic medical record for patient care and data collection, and will be implementing a patient portal and additional population management tools in 2014

JOB RESPONSIBILITIES: The Medical Director will lead the residency practice in its continued PCMH transformation to include Level-III NCQA certification, care integration, service expansion and continuous quality improvement. The Director will oversee the practice's involvement in Colorado's Medicaid Accountable Care Collaborative. The Director will work closely with hospital leadership in developing additional clinic services, in planning for clinic expansion, achieving quality and productivity benchmarks, and in meeting goals for superior patient care and satisfaction. As a member of the residency faculty leadership, the Director will teach and supervise residents and students in the provision of patient care, provide direct patient care in the inpatient and outpatient setting, participate in scholarly activity, and serve as a leader and role model for residents and faculty.

QUALIFICATIONS: Must possess or be eligible for medical licensure in the State of Colorado; Board Certified in Family Medicine by the ABFM, with a minimum of 5 years practice experience; Prior clinic administrative/leadership experience; Outstanding communication and leadership skills; Demonstrated experience and competence in teaching and patient care; Prior experience in GME preferred; Ability to balance a visionary and strategic approach with an orientation to details.

This position is full-time and reports to the Residency Director. Obstetrics and hospital call required. Women and minorities encouraged to apply. Detailed job descriptions and qualifications required can be found on jobsatcu.com and the Department's website, http://fammed.ucdenver.edu/home/careers.aspx. Must obtain Medical Staff privileges within the HealthONE LLC d/b/a/ Rose Medical Center and obtain Medical Staff Privileges at University of Colorado Hospital.

Salary is commensurate with skills and experience. The University of Colorado offers a full benefits package. Information on University benefits programs, including eligibility, is located at http://www.cu.edu/pbs/
Applications are accepted electronically at www.jobsatcu.com.

Review of applications will begin December 15, 2013 and continue until position is filled.

When applying at www.jobsatcu.com, applicants must include:

1) A letter of application which specifically addresses the job requirements and outlines qualifications.

2) A current Curriculum Vitae

Questions should be directed to regina.garrison@ucdenver.edu

"The University of Colorado Denver and Health Sciences Center requires background investigations for employment."
"The University of Colorado is committed to diversity and equality in education and employment."

THE NAMASTE HOSPICE MODEL

By Nathan Pollack, MD

My own hospice team is different from many others for we have thoughtfully and businesslike decided to care for patients first, rather than to operate primarily from fear of bureaucratic penalties. We are motivated by altruism, not intimidation. Hospice service is our art more than it is our trade. We do not decline to care for a patient because she has no payment source; or because he is undocumented or homeless; or because her care will cost us more than the *per diem* allowance covers; or because his real clinical predicament doesn't fit smoothly and fully under a single label (a bureaucratic umbrella called by some "hospice diagnosis"); or because her debility is so far advanced there is no simple way to quantitate "decline" (for the slightest further decline will be death). I know some other hospices are similar to ours, but too few; I also know every hospice has such a core of spiritual purpose as we have, whether or not it easily can be accessed.

I shall try briefly to describe the attitudes and actions of our little hospice as it seeks to promote direct personal relationship with patient and family. From our first contact we assign a hospice guide to stick with family and patient throughout the journey. This guide or hospice counselor will be always available, always dedicated to the comfort and welfare of the patient to the end of the patient's life, and through thirteen months of grieving thereafter. Along with this guide comes an inseparable partner whom we would in ordinary terms recognize as the nurse case manager, also always personally available. The rest of the larger professional hospice team is immediately ready as well, to be called in for particular tasks (such as medical supervision, direct personal care, spiritual, psychological and nutritional counseling, social work tasks). The communicating and coordinating team in the office are essential to our functioning, of course, and accomplish the maintenance of communication, medical records and accounting as well.

We use an old and different language to make our team-members' names mean something new, to help us understand our relationship with patient, family and with each other in a somewhat different fashion from the titles of the roles we have become used to, those old "checklist-tasks." Our name *Namaste* is spoken Sanskrit for "I greet you" or more pertinently (in my own interpretation) "The part of me that does not die salutes the part of you that lives forever." *Acharya*, is a term meaning guide, the name we use for the hospice counselor who makes first contact and engages in a long-term understanding of the patient, the family, the history, the needs; this member of the team engages and coordinates the others as they are needed in the care of the patient. The nurse on our team bears the name *sukhada*, literally "the one who gives happiness" or "comforter"; this double unit *(acharya/sukhada)* formulates and updates the basic plan of care for review, in close confirmation with the clinical supervisor ("*sukhada* elder") and the physician (whom we may call names, but not in Hindu). We call the support team "*karana*" ("instrument," "cause" or "doer"). Some of our colleagues have feared we no longer use chaplains or social workers, but that is not at all so for we include spiritual counseling and practical assistance with support agencies as important aspects of our *karana* resource pool, and we enlist and coordinate with professional clergy of that patient's particular sect as the patient desires. The coordinating team at the office is the *adhvan*, whose translated meaning includes "means" or "method" or even "traveler"; so for me adhvan is something like a companion or helper on the journey.

As to the physician's role, it will be instructive to consider the true history of the physician in hospice care, how it has changed *de facto* (the way we act) but not *de jure* (the way the regulations read, what they have intended). Ancient hospice work was resurrected in America in the 1960's as a humanitarian support of dying patients, aimed toward their comfort and to support of their families' grieving. Such kindness hardly fit with "the medical model" in vogue in this economy, so physicians were included only peripherally. Hospice care was so impressively successful that Congress made it a Medicare benefit especially for the conservation of resources; of course physician involvement was required by regulation because medical treatment can only be legal as ordered by a licensed physician in one of the several states. Physicians' participation tended then to be limited to signing documents more than to participating in ongoing evaluation and decision-making in the care of patients. Prior to 2010 when "face-to-face" examinations became required, a hospice physician might never meet a hospice patient. With the August 2013 "final rule" refining "multiple diagnoses" Namaste Hospice

> PALLIATIVE APPROACHES AND ATTITUDES ORIENTED TO THESE SEVERAL PROBLEMS BELONG WHEREVER FAMILIES AND COMMUNITIES ENCOUNTER SUFFERING, AND IT IS MOST ECONOMIC TO PROVIDE WHAT IS NEEDED RATHER THAN TO INTIMIDATE AND DEPRIVE THE SUFFERER.

continued on page 22 >>

(and eventually all hospices) will integrate the physician centrally into the team in the fashion the regulations have always required; professional team cooperation will be needed from the time of admission for the selection of diagnoses appropriate to each individual and that very patient's care plans.

There have been many misunderstandings of hospice regulations on the part of professionals in general and even on the part of Medicare's own surveyors. Some of these assumed "requirements" are not specified in the regulations at all nor are they necessarily in concert with them. The Interdisciplinary Team (IDT) is required to review and update the plan of care for each patient at least every fifteen days, but there is no requirement that the entire team sit at the same table for the many hours such a meeting usually consumes. That is very expensive in human resources when we might be out in the community attending to patients. We at Namaste will continue to review treatment plans thoroughly and timely, especially the *acharya/sukhada* unit, concurred in by the clinical director and the physician. We are in the process of setting the big meeting aside without sacrificing personal and professional communication. We will use a whole-team meeting, a "gathering around the fire-pit," to share the human aspects of our care for our patients, to support each other as we always have, to cry together as we need to. (I was convinced I had done well to have joined this team when at my first IDT meeting I watched us cry aloud four separate times--I knew I was with people who have hearts.)

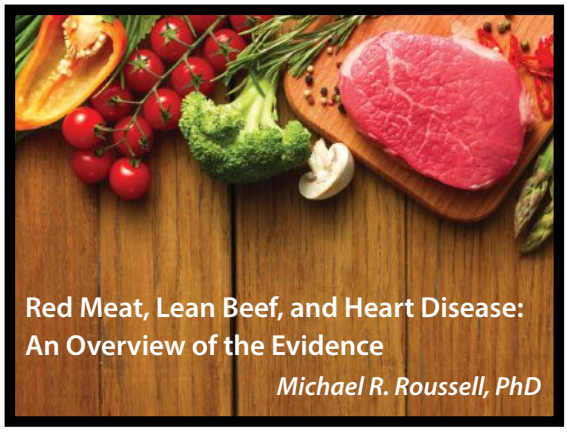
"The last six months" is not the best sort of measure of what we seek to comfort. There is no "Six Month Rule" that tells the patient to die by that deadline or give up being cared for. A debilitated person may need and benefit from consistent professional support beyond six months, and the regulations clearly accommodate that contingency. My expert prognosis as a physician is not a death sentence but an assessment of the patient's current condition and the likely course which will ensue. Such misinterpretations can be set aside to allow integrity in clinical care.

Palliative approaches and attitudes oriented to these several problems belong wherever families and communities encounter suffering, and it is most economic to provide what is needed rather than to intimidate and deprive the sufferer. Palliative care in general (of which hospice is the end-of-life aspect) is the sort of work family physicians have done all along; comfort for the ailing, not delusions of immortality, is the core aim of medicine throughout human history. Hospice is for living, not for dying.

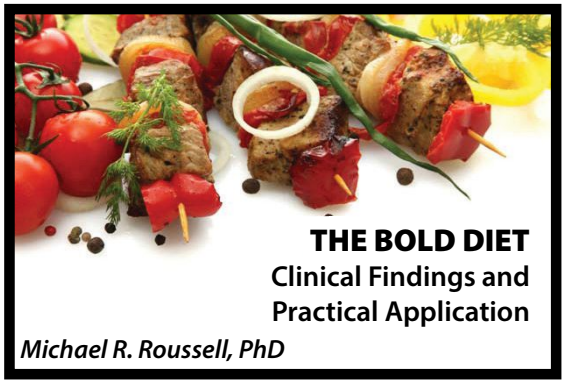
Nathan Pollack, MD
Medical Director
Namaste Hospice and Palliative Care
1633 Fillmore Street #300
Denver, Colorado 80206
303-860-9915

A Heart Healthy Diet: Should We Be Updating Our Recommendations?

Two webinars offered for Continuing Medical Education credit through February 2015
Each webinar is approved for 1 Prescribed credit by the American Academy of Family Physicians
There is no cost to participate. Credit certificates will be issued to participants.



This one-hour web presentation offers new information to consider when advising patients who are adopting a heart-healthy diet and lifestyle as a preventative or risk reduction strategy for cardiovascular disease. Comparative data from several diet studies are presented regarding observed effects on cholesterol and reduction of CVD risk factors. Current research regarding the role of lean beef in a heart-healthy diet and lifestyle offers new findings and links to dietary adherence which is relevant as we explore more effective ways to combat our nation's #1 killer, cardiovascular disease.



This one-hour web presentation describes the Beef in an Optimal Lean Diet study (BOLD), previously published in the American Journal of Clinical Nutrition, and the observed impacts on patient health and cardiovascular disease risk factors. Content includes practical information and strategies for physicians helping patients make dietary changes aimed at a reduction in cardiovascular risk factors. Strategies included address enhancing adherence to a heart-healthy diet by including lean protein sources, and working with patients' taste preferences, familial eating patterns, and social/economic constraints.

Web-based presentations for Colorado family physicians and other healthcare professionals offered by our affiliate chapter, the Oklahoma Academy of Family Physicians.

www.heart-healthynutrition.com

OAFP

This educational opportunity is offered by the Oklahoma Academy of Family Physicians, a state chapter of the American Academy of Family Physicians (AAFP) which represents over 105,000 physicians, residents and medical students in the United States

Educational grant support for the program provided by the Oklahoma Beef Council and supported by the Colorado Beef Council.

Colorado Beef Council

Free Resources to Help Health Care Professionals and Patients Compare Treatment Options

By Peter Sheehan, Contractor AHRQ

Health care professionals (HCPs) and patients working together to make the best possible health care decisions need the facts about treatment options, including their benefits, risks, and possible side effects. Physicians and other providers want reliable, evidence-based tools to maximize their time and effectiveness with patients; and patients want clear, unbiased information they can trust.

The Agency for Healthcare Research and Quality (AHRQ) offers a growing library of free resources, including summaries of research findings for both you and your patients. The summaries address a variety of health conditions—such as heart conditions, diabetes, and mental health—and are presented in short, easy-to-read formats. These materials, developed through AHRQ's Effective Health Care (EHC) Program, can help you and your patients understand which treatments work best and how their risks compare, while allowing for individual choices.

As an advocate of informed and shared decisionmaking, the Colorado Academy of Family Physicians is partnering with AHRQ's EHC Program to ensure you have access to these important resources.

For Health Care Professionals: Get the Clinical Bottom Line

AHRQ understands that, for health care professionals (HCPs), every minute with a patient counts. The EHC Program clinician research summaries are designed to help HCPs quickly learn the "Clinical Bottom Line"—what the evidence says about treatment options benefits and risks, and the strength of evidence behind research findings. Each research summary also includes useful background on the health condition being addressed.

To access these resources and learn more, visit www.ahrq.gov/clinicalbottomline. To order free print copies of research summaries, as well as patient research summaries, call the AHRQ Publications Clearinghouse at 800–358–9295 and use code C-02, or contact Pete Sheehan with AHRQ's Denver Regional Partnership Development Office at pater.sheehan@ahrq.hhs.gov or 303.527.4624. Other resources for physicians include:

- Free, accredited continuing medical education/continuing education activities based on EHC Program comparative effectiveness research report. More at: http://www.effectivehealthcare.ahrq.gov/index.cfm/tools-and-resources/cmece-activities/
- The *EHC Inside Track* newsletter, delivered via email to help clinicians stay up-to-date on AHRQ's comparative effectiveness research and EHC Program clinician and patient resources. Sign up today: http://www.effectivehealthcare.ahrq.gov/index.cfm/join-the-email-list1/?PC=EHCITall

Podcasts and Web conferences. Visit www.effectivehealthcare.ahrq.gov

For Patients: Know Your Treatment Options

AHRQ's new *Treatment Options: Explore. Compare. Prepare.* initiative encourages patients to use the resources to *explore* treatment options for a health condition, *compare* the benefits and risks of each, and *prepare* to discuss their options with their health care provider. In addition to the patient treatment summaries, the initiative includes:

- A set of three, short promotional videos to help patients—whether a newly-diagnosed patient or an existing patient—and caregivers understand the value of comparing treatment options.
- A text-messaging program to connect patients and caregivers with AHRQ's treatment summaries. Patients and caregivers text COMPARE to 22764 to join the text-messaging program.
- A Facebook page, which is also available in Spanish, to easily connect patients and caregivers with resources for specific health conditions. They may "like" the resources at www.facebook.com/yourtreatmentoptions.

Videos, treatment summaries, and other information can be found on the *Treatment Options: Explore. Compare. Prepare.* initiative Web site at www.ahrq.gov/treatmentoptions. All treatment summaries can be downloaded directly from the site. Free print copies are available by calling the AHRQ Publications Clearinghouse at 800–358–9295 and using code C-02, or by contacting Pete Sheehan in AHRQ's Denver Regional Partnership Development Office as noted above.

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WHAT'S GOOD FOR THE GOSLINGS…

By Reginald Finger, MD, MPH and Walt Larimore, MD, FAAFP

The old saying, "what's good for the goose is good for the gander," is said to have first appeared in Aesop's Fables in 1692 and is now used to suggest that if a particular type of behavior is acceptable for a male, it should also be acceptable for a female."

Because I (Reg) have always been inclined to write a different, creative verse to an old song or to find an "off the wall" new twist to an old saying, one day I decided that "what's good for the goslings … is good for the goose!" would make the ideal tag line for adult immunizations.

How many times, in the family physician's office, does a hurried, worried parent bring in his or her child, or children, insisting on the best and timeliest care for each child, but deflecting any questions about his or her own health with "I'm just too busy for that" or "I've got just enough money saved to make sure the kids are cared for."

Understanding that a key principle of family medicine is to see patients as parts of family units,[1] we do our best to counter with the assertion that a healthy parent is best situated to take care of his or her family. So, we should ask these parents to reconsider and stop long enough to get the needed vaccine(s) for themselves.

In the case of pertussis, about which we wrote at some length last year, we explain that the best way to protect an infant is to make sure the adults around her receive timely vaccination – that the child be protected by the "cocoon strategy."[2]

Not so long ago, varicella vaccination was one instance in which we could proceed to deal with the child without thinking about the parent. Prior to the 1990s, varicella infection was so nearly universal that the clinician could assume the parent to be immune. Antibody studies verified this fact independent of a clinical history of chickenpox.[3] Now, however, the vaccine has been around long enough that the combination of decreased natural incidence and imperfect vaccine coverage has produced a gap in immunity – and many of the persons in this gap are now old enough to be parents.

UNDERSTANDING THAT A KEY PRINCIPLE OF FAMILY MEDICINE IS TO SEE PATIENTS AS PARTS OF FAMILY UNITS, WE DO OUR BEST TO COUNTER WITH THE ASSERTION THAT A HEALTHY PARENT IS BEST SITUATED TO TAKE CARE OF HIS OR HER FAMILY.

The current ACIP recommendation for varicella vaccine specifies that a person born in or after 1980 cannot be assumed to be immune.[4] Thus, the clinician now needs to check on parents bringing an infant in for care, to see if they have received the needed doses of varicella vaccine.

The same phenomenon occurred with measles several decades previously. Those of us who have been deemed immune to measles due to our age have now reached our late fifties and early sixties. We are now used to the notion that all younger and middle-aged adults need to verify receipt of measles vaccination. Interestingly, so few of today's clinicians have seen a case of measles, that physician diagnosis of measles is no longer considered a valid criterion of immunity by the CDC.[5]

The bottom line for the family physician is that immunization of every adult in his or her practice is a high priority. The most recent national schedule for adult immunizations specifies that influenza, varicella, and tetanus/diphtheria/acellular pertussis vaccines – and for some age groups, MMR, HPV, and zoster vaccines – need to be administered to adults.[6]

We all know that the adult vaccination rates in almost everyone of our practices are well below national goals of 90%. Yet the average patient in our practice over a 27-month period will average 1.3 (± 1.9) acute visits, 6.9 (± 5.1) chronic visits and 0.48 (±0.91) preventive visits (mean ± SD).[7]

Research shows that missed opportunities to vaccinate in primary care range from 38.4 to 94.5% of visits. The rates were aggravated by failure to vaccinate at acute care visits and low frequency of preventive visits. In addition, a health maintenance flow sheet can prompt us to discuss vaccination at most office visits. In fact, vaccination rates in primary care practices are higher if medical records included health maintenance flow sheets.[7]

Family physicians should use every opportunity; even office visits for acute problems, to vaccinate adults. Granted, there are some clinical encounters during which it would be inappropriate to raise the issue of immunizations. For example, an office visit dealing with a medical crisis so severe that the patient or family is in emotional shock. However, for every one of these, there are five to ten routine visits which would not be disrupted by the inclusion of a routine immunization, IF the office is set up to negotiate and provide it efficiently.

We are confident that the more diligent family physicians are in this regard, the lower the likelihood of outbreaks of preventable disease, and the healthier our patients, neighborhoods, and communities.

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CAFP HEALTH OF THE PUBLIC COMMITTEE UPDATE

By Sarah Roth, MA

Through our Health of the Public efforts, a primary goal on the CAFP's strategic plan, the Academy assumes a leadership role in health promotion, disease prevention, and chronic disease management.

In December, the Health of the Public committee sent out a survey to the membership to identify which public health issues are most pressing for physicians across the state and which public health issues you would most like to see the academy address. Respondents identified improved vaccination rates, better lifesytle choices, and increased mental health access as the top issues.

In addition to the in-depth public health work that the academy conducts through the Tar Wars and the Fit Family Challenge pilot project, we work diligently to address many of the public health issues you raised in this survey. The information below outlines recent work by the academy to help improve immunication rates in Colorado and mental health access.

Improved Immunization Rates

SB222 "Increasing Access for Childhood Immunizations" – Since vaccines represent the 2nd largest operating expense for Family Physicians, providing a cheaper and more efficient method of obtaining vaccines is important to our members. The CAFP, with many hurdles, was able to create a coalition with other organizations to pass a bill that the pharmaceutical industry heavily lobbied against.

Currently, the CAFP is monitoring and shaping the stakeholder process at the Colorado Department of Public Health and Environment. The first draft of the stakeholder process, which is still in development, included many of the policy changes the CAFP advocates for. Reforms, that are in the first draft and supported by the CAFP, are: physician resources on vaccine purchasing, offer optional centralized billing, credentialing, and contracting services for Local Public Health Agencies, provide standardized reimbursement rates for vaccines and vaccine administration costs, and to allow the return and refund of expired vaccines.

Improved Behavioral Health Access

Colorado SIM Grant – The federal Center for Medicare & Medicaid Innovation (CMMI) has awarded Colorado $2 million to strengthen a plan that Colorado submitted in September 2012. The revised and updated plan will describe Colorado's overall strategy to achieve the Triple Aim of better health, better patient experiences and lower costs. It will also detail Colorado's proposed health care innovation model, which focuses on integrating behavioral and physical health in patient centered medical homes. In short, the state innovation plan – which is called the Colorado Health Care Innovation Plan – will be Colorado's strategic roadmap to transforming our health care system.

The CAFP, representing over half of all primary care physicians in Colorado, was a crucial stakeholder in the mission to integrate primary care services with mental health services. We worked to insure that the PCMH and payment reform were at the center of the Colorado SIM grant. Our ideas, ranging from delivery transformation to the need for payment reform to broadening the capacity of primary care delivery to creating the medical neighborhood, were all integrated into the final plan.

SNOCAP RECAP

By Don Nease, MD, Jodi Holtrop, PhD, and Tabria Winer, MPH

Hey Colorado AFP members! This is our third installment of the Recap, and it seemed time to use this to give a brief rundown or FAQ on SNOCAP. So here we go!

WHAT IS SNOCAP AND WHY DOES IT EXIST?

Have you ever felt that you were just seeing patient after patient and wondering "isn't there something more? Is there a way I can make an impact in improving health care beyond just the patients that pass through my door?" or wondered how to do a better job at delivering patient care, or at least minimize inefficiencies? Then, SNOCAP might be a good fit for your practice. SNOCAP is an acronym for State Networks Of Colorado Ambulatory Practices and partners. It is an umbrella group of practice-based research networks. The purpose of these networks is to identify relevant questions of importance to primary care and then get answers to those questions through research conducted in real primary care practices. Put simply, a PBRN is a mechanism to bring evidence from practices to practices. If you've ever found yourself reading a journal, or even UpToDate, and thought to yourself, "That article really doesn't speak to the kind of patients I see or my practice," you understand the need for evidence that comes from primary care practices.

For example, here are some of the studies we are either conducting or exploring right now:

- How to implement health assessments in primary care that meet meaningful use requirements
- How to handle chronic pain prescription meds in primary care patients
- How to implement self-management support tools to support chronic disease management
- How to take advantage of new billing codes for obesity in primary care
- How to have patients monitor and report their own blood pressures

Much of our best work has come from questions raised by Family Physicians in our networks. We are always interested in what is relevant to you and the nagging things you are struggling

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with. In fact, that's one reason we often say "No thanks," to our academic colleagues who come wanting access to your practices. If it doesn't sound like a question or issue that will interest you, we try to protect you from those.

Not only do we try to protect you from studies that may not interest you, we try to ensure that the research done in our networks places as low a burden on you and your staff as possible. For us that's a core value.

WHAT KIND OF RESEARCH DOES SNOCAP DO?

As you can probably tell, we strive to do research that matters to you. At any given time we typically have 10 studies or projects in the field ranging from large federally funded studies to small pilot or card studies. Studies involve practice participation from days (card studies) to months (larger trials). Another core value for us is that our projects should always strive to give value back to the practice. Sometimes a card study may just help you answer a question of interest. For a larger study, we strive to bring resources with the project that help you in your daily work. That might be a practice improvement coach, a piece of technology or help with implementing a particular care protocol.

DOES A PRACTICE HAVE TO COMMIT TO DOING A CERTAIN NUMBER OF PROJECTS?

No. You can be involved in as many as you like or as few as you like. It's up to you. We are most interested in your ideas and questions. Hopefully, you'll find a project that fits your interests and ability to participate every few years.

HOW DO I SIGN UP?

That's easy! Just send Tabria, our SNOCAP Coordinator an email at tabria.Winer@UCDenver.edu. That will get you onto our mailing list. We promise to not flood your inbox, rather we'll send you our newsletter with projects and study results no more often than once a month, and you can opt out at any time.

Tar Wars®

PLEASE VOLUNTEER FOR THE 2013-2014 SCHOOL YEAR!

Volunteer as a Tar Wars presenter and help educate 4th and 5th grade students about the harmful effects of tobacco use! As a Tar Wars presenter you will be teaching young children about tobacco use awareness and prevention.

This year, medical students who present the Tar Wars Program to the most students between September 1, 2013 and April 1, 2014 have the opportunity to win up to $500 for their FMIG (Family Medicine Interest Group). Tar Wars will grant three awards to the FMIGs with the most outstanding community service effects of presenting Tar Wars on May 1, 2014.

- First Prize: $500
- Second Prize: $300
- Third Prize: $200

To apply for the award, a medical student must complete the AAFP Tar Wars Feedback for Presenters on behalf of your FMIG by April 1, 2014.

If you need further information or assistance with signing up to be a Tar Wars volunteer presenter, please contact Karol Ann Groswold at the CAFP office.

Email: karol@coloradoafp.org
Phone: 303-696-6655 ext. 15

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Denver, Colorado

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Health care delivery reform is taking off nationwide with the continued expansion of Patient-Centered Medical Homes, Accountable Care Organizations, and a focus on connecting to the medical neighborhood. However, with many previous attempts, what will it take to ensure success this time around?

Join us in Denver at the PCPCC 2014 Western Regional Conference, where you can network and dialogue with colleagues and friends about key opportunities and challenges that lie ahead in our efforts to achieve the goals of the Triple Aim. Together we'll address challenges head on and generate momentum to REACH THE SUMMIT!

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AF WILLIAMS

Awarded 2014 Patient Centered Medical Home of the Year

AF Williams, which comprises of 20 primary care physicians offering primary care services in the Denver Metro area, has been recognized as the 2014 Patient Centered Medical Home Best practice of the Year by the Colorado Academy of Family Physicians (CAFP) foundation. AF Williams, located in Stapleton, became an NCQA Patient Centered Medical home in 2011 and is level-3 recognized, the highest quality ranking for Patient Centered Medical Homes.

AF Williams, headed by Corey Lyon, DO, FAAFP, supports over 12,000 patients through their "pod" style team-based approach to care.

"My desk is right next to my medical assistants and other providers," said Dr. Lyon. "We all work together, side by side."

The team-based Patient Centered Medical Home model that AF Williams represents is being taught to the next generation of physicians at AF Williams. Currently, AF Williams has 18 Family Medicine Residents.

"For my residents, the PCMH is just the way we organize ourselves." Said Dr. Lyon. "It's the way they've been taught about delivering care."

The Patient Centered Medical Home, according to the AAFP, is defined as an approach to providing comprehensive primary care for children, adolescents and adults. The PCMH is a health care setting that facilitates partnerships between patients and physicians that is team based, whole-person oriented, integrated and coordinated and focuses on quality and safety improvements.

Of the numerous quality improvement initiatives at AF Williams, their "Shared Care Plans" initiative shows the value of the PCMH model when fully applied. The Shared Care Plans is a yearlong, structured quality improvement project involving population management with AF Williams' complex patient registry. The quality improvement team is led by their third-year resident class and focuses on identifying complex patients and arranging a "Shared Care Plan." The plan is created by a healthcare team of providers, social workers, care managers, pharmacists, nurses and, but certainly not limited to, behavioral health specialists.

"Our initiatives have gone farther than just team care," said Dr. Lyon. "We've been able to offer extended hours, same-day clinic appointments, group visits and our patient portal helps encourage communication between the patient and the providers."

AF Williams also focuses on another core-tenant of the PCMH: Chronic pain management. Patients with chronic nonmalignant pain have better outcomes if they are using a comprehensive approach that integrates strategies to improve pain. For instance, once patients are evaluated in the clinic, a formalized treatment plan is developed with the patient that includes group visit session that assist in changing the focus from pain medications to functioning with chronic pain.

AF Williams isn't just "checking the boxes" but applying the tenants and goals of the PCMH. The benefits include improved patient continuity and health, community engagement, and integrated and coordinated care for all patients.

JOHN BENDER, MD, FAAFP

Awarded Family Medicine Physician of the Year

John Bender, MD, FAAFP, CEO of Miramont Family Medicine and current President of the Colorado Medical Society, has been named the 2014 Colorado Academy of Family Physicians Family Physician of the Year. In addition to managing a growing enterprise and a full panel of patients, Dr. Bender is a physician leader in advocating for reforms that support primary care and the Patient Centered Medical Home (PCMH).

Dr. Bender, receiving his medical degree and PhD from Creighton University in 1992, became a Flight Surgeon in the United States Navy. Dr. Bender's service in the US Navy lasted from 1988 to 2000 with multiple tours. He then joined the US Army and was an Army Physician touring in Kosovo with NATO Allied Forces.

"Before I moved back, I was bouncing around for almost twenty-years," said John Bender, MD. "I had moved seventeen times in seventeen years with the Navy and Army."

In 2002, Dr. Bender and his wife, Teresa, purchased a Family Medicine practice in Fort Collins, Colorado. Since then, Miramont Family Medicine has been growing all across the state of Colorado, including in rural and underserved areas.

When Dr. Bender and Teresa purchased the small practice, at that time consisting of about 1,000 patients, the office had one computer and one employee. During that same time, 34 primary care physicians had left the area and eight practices had gone bankrupt. Today, Miramont Family Medicine has seven locations and the enterprise sees over 30,000 patients with over a quarter coming from Medicaid,

Current President of the CMS and Delegate for the CAFP, John Bender, MD, FAAFP, sits as a Liaison on a reference committee at the annual Congress of Delegates for the AAFP

CAFP NEWS

Colorado's public health insurance program for those who earn less than 133% of the poverty line.

From 2001 to 2012, Miramont Family Medicine grew exponentially with revenue growing from $169,000 to $4.8 Million a year. Dr. Bender and Teresa, his wife and practice administrator, accomplished this with a set of practice transformation techniques and quality improvements.

"Practices that fail often are the ones that have not effectively managed labor costs," said Dr. Bender to Medical Economics in their cover story about Dr. Bender titled Family Medicine's Revival: Managing Escalating Costs and Reinventing Primary Care Delivery. "I cannot simply pay my staff less. If anything, I have to pay them more because we are in such a high-density of services and digitalization. What Miramont does differently is through Lean principles and leveraging information technology."

Dr. Bender's practices follow the five principles of lean production that originated from the Toyota Production System. Lean principles are used to help identify value and eliminate waste. For more information on Lean, please visit lean.org

Miramont Family Medicine also became an NCQA recognized Patient Centered Medical Home in 2008.

"Becoming NCQA recognized meant a lot but where it had the most impact was the workflow redesign process," said Dr. Bender. "We put pedometers on our providers and staff in order to make our practice more efficient and require the least amount of steps."

In 2011, the Colorado Academy of Family Physicians recognized Miramont Family Medicine as the Patient Centered Medical Home of the Year and in 2010 won the national HiMSS Nicholas E. Davies Award of Excellence for outstanding achievement in the implementation and value from health information technology.

In 2013, Dr. Bender took his years of practice experience and became the President of the Colorado Medical Society. Before his ascension to his current position, Dr. Bender had served as the President of the Colorado Academy of Family Physicians, Delegate to the AAFP Congress of Delegates and was a delegate at the American Medical Association. Several of Dr. Bender's resolutions are now policy with the American Medical Association, the Colorado Academy of Family Physicians and the American Academy of Family Physicians.

As the new President of the Colorado Medical Society, Dr. Bender wants to move current laws into the 21st century.

"[Pointing to his iPhone] this would have been illegal 50 years ago," said Dr. Bender. "Medicaid won't pay for my dispensary but every other payer does. We have to change and update the laws that Medicaid and others work on because those laws are from the 70's. I'm trying to run a modern practice."

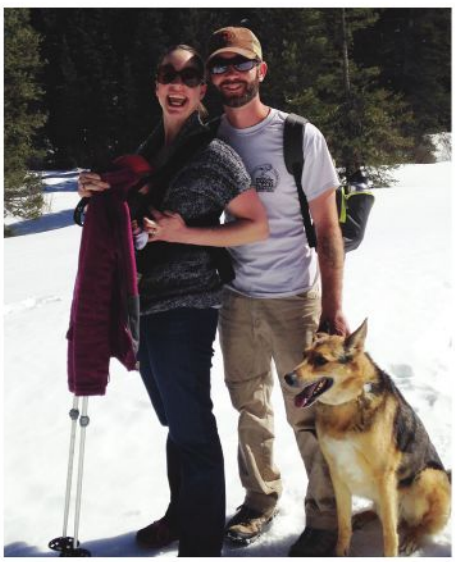
Dr. Bender has testified multiple times on behalf of Family Medicine Physicians at the State Capitol this year and he hopes to represent a unified voice for all physicians in Colorado.

GINA MARTIN, MD

Awarded 2014 F. William Barrows Resident of the Year

Gina Martin, MD, of St. Mary's Hospital & Regional Medical Care in Grand Junction, Colorado, has been named the 2014 F. William Barrows Resident of the Year by the Colorado Academy of Family Physicians. If the letter of recommendations for this award are a sign of future success, Dr. Martin will be a rockstar Family Physician. Her peers and mentors admire her dedication, resilience and leadership in medicine that stem from her rural upbringing and passion to help the underserved.

"Gina is a special type of person. I think sometimes she isn't even aware that she is smiling because she does it so often; it becomes contagious," said Fred Barbero, MD, Medical Director of the Emergency Department at Family Health West Hospital. "She took it upon herself to start attending the meetings of our Mesa County Medical Society and soon she wasn't satisfied as an attendee at the Medical Society meetings. She began to proffer the point of view of young physicians."



This leadership quality was shown early by Dr. Martin during her undergraduate and medical education at Oregon Health Sciences University. On campus, she was recognized with an international award for her work with the National Marrow Donor Program.

"I think, being in my program, we have such a great support staff and mentors. I wouldn't have asked to go anywhere else, everyone has been so receptive, helpful and supporting," said Dr. Martin. "They are very lifestyle focused and it's not just about the work but work-life balance."

During her residency program, she married her long-term boyfriend Jeff and, in 2014, welcomed her first child, Lilliahna Grace Martin, into the world.

"Life has not slowed down for Dr. Martin," said Randall Reitz, PhD, Director of Behavioral Sciences at St. Mary's Family Medicine Residency. "Her passion for safety net care and medical advocacy prompted her early involvement [at medical societies]. Her fellow physicians were so impressed with her leadership that they recently voted her president of the Mesa County Medical Society – the first resident so recognized."

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Dr. Martin will continue on the path of providing care to the most underserved in Delta, Colorado, a population of 8,800, where she will practice full-spectrum Family Medicine, including surgical OB.

"She helps lead our Spanish prenatal group and developed a project to increase collection of umbilical cord blood gases based on ACOG guidelines," said Dr. Reitz. "She aggressively pursued OB proficiency, including performing 96 deliveries, and 79 C-sections, during her first 2.5 years of Residency."

Dr. Martin's passion for primary care comes from her own rural upbrinings in a small logging town in Oregon. She was inspired to medicine through her relationship with her local Pediatrician, Thomas Roe, MD.

"Gina excels in all aspects of full-spectrum family medicine patient care," said Elvera Whiteford, MD, Family Medicine Faculty at St. Mary's Family Medicine Residency. "She has tirelessly pursued surgical OB skills and has worked diligently to increase her experience by taking extra calls and volunteering to come in on off hours and weekends. She comes from a humble beginning and has embraced it as a strength."

"The best experience of residency is the continual confidence building. How much you learn in a 3-year time period is amazing," said Dr. Martin.

When asked what she would convey to medical students, Dr. Martin offers this advice: Keep an open mind and know that you'll change.

"Your residency program is going to change your mind about so many things," said Dr. Martin. "When I started, we had just started being a [Patient Centered Medical Home]. The team approach to health care is really helpful and something new that I had not totally been ready for. Goal setting and involving the patient in their care is a big part of my practice, and my residency program taught me that."

COREY LYON, DO, FAAFP

Named 2014 Family Medicine Teacher of the Year

Corey Lyon, DO, FAAFP, is the 2014 Colorado Academy of Family Physicians (CAFP) Teacher of the year. Medical Director for the AF Williams Family Medicine Center, Dr. Lyon serves as the Associate Program Director for the Family Medicine Residency Program overseeing 30 Family Medicine Residents.

"He's taught us all so much and it all seems second nature for him," said recently graduated resident Rachel Woodruff, MD, MPH. "The principles of the [patient centered medical home] is just the way I've been taught."

A native Coloradan, Dr. Lyon attended medical school at Kansas City University of Medicine and Biosciences. After joining the US Navy and completing his own family medicine residency training at Naval Hospital Jacksonville, in Jacksonville Florida, Dr. Lyon was stationed overseas at Naval Hospital Sigonella in southern Italy.

"I learned so much during my own residency," said Dr. Lyon. "I'm truly proud to teach the next generation about delivering successful and compassionate care."

The level of compassionate care provided by Dr. Lyon to his patients is mirrored in his approach to teaching where residents describe him as caring, resourceful, enthusiastic, accessible and cheerful.

"Dr. Lyon is always accessible to residents and learners, and always happy to help," said Dr. Woodruff. "He's always cheerful and ready with a fitting joke; not many people can make journal club full of laughs or consistently make the preceptor room a conduit for comic relief – but Corey can and does."

In addition to CAFP Teacher of the Year Award, Dr. Lyon has received numerous awards for his teaching and leadership in Family Medicine. In 2004, Dr. Lyon was recognized as the Residency Teacher of the year and in 2008 was recognized as the John McGuire Resident Advocate of the year at the Research Family Medicine Residency Program in Kansas City.

"I've been so lucky since coming back to Colorado," said Dr. Lyon. "There has been so much support and my residents have done incredible things."

Under the leadership of Dr. Lyon, AF Williams allows residents to lead many quality improvement programs. One such program, their "Shared Care Plans" is a yearlong, structured quality improvement project involving population management with AF Williams' complex patient registry. The quality improvement team is led by their third-year resident class and focuses on identifying complex patients and arranging a "Shared Care Plan."

"He is one of the most energetic, dynamic, funny and caring persons I have ever encountered," said Linda Montgomery, MD, FAAFP, Program Director for the University of Colorado Family Medicine Residency. "His enthusiasm for teaching and practicing Family Medicine is contagious."

When Dr. Lyon isn't teaching the next generation of Family Medicine physicians or managing his own panel of patients, he spends his time with his three daughters and wife.

"Incredibly reliable, insightful regarding resident and staff issues, and innovative in his solutions to the problems we encounter in our residency, Corey is the person I go to when I want to make sure something gets done well," said Dr. Montgomery. "He has high expectations for the performance of our residents but expresses these in ways that residents find helpful and supportive."

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