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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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As I write my last column for the CAFP while sitting at home on Memorial Day, I first want to revisit some of what I’ve previously discussed. In “View from 35,000 feet,” I focused on our members, our profession and the CAFP successes over the past year. The list is long: the Patient Centered Medical Home project, liability reform, patient safety, primary care workforce issues, TAR Wars, disaster preparedness and our constant presence at the legislature, to name a few. In accomplishing all of this, board members have put in countless hours, and I thank them for all they do on behalf of our academy and our profession in Colorado.

I am reminded that much of the academy’s success over the years is due to our CEO, Raquel Alexander. I’ve worked with her since I first joined the board in 2004, and can offer honest reflections on her work ethic and professionalism. While CAFP presidents come and go, she has served as the constant face of the CAFP. Our academy is lucky to have Raquel at the helm, and I thank her for all that she does on behalf of our academy.

I hope that through all of our activities, we have made a difference not only in the lives of our members, but also in the lives of our patients. I wanted to speak about three that come to mind.

The first patient was a 22 year-old who came into our hospital with a spontaneous pneumothorax. He relayed that the thing that most frustrated him was being unable to get enough hours at his job to qualify for health insurance. He delayed seeking care for his shortness of breath as a result of his fear about medical costs.

The second patient who comes to mind was a 38 year-old who was a patient of mine several years ago. At his discharge, we were unable to find a way to easily pay for his anti-seizure medications so that we could “bridge” him to his primary care appointment two months away. The reason he was in our hospital was that he had undergone an evaluation of seizures costing tens of thousands of dollars instead of potentially avoiding the hospitalization through medications that cost tens of dollars.

The third patient I think of is a patient who has a commercial drivers license (CDL) and diabetes. The patient delayed insulin therapy for years out of the fear of losing his CDL. The patient confided that what was most disheartening was not the loss of the CDL per se, but the fear that with the loss of the CDL would come the loss of the job, the loss of medical insurance, the loss of income and the loss of a viable retirement plan.

In remembering each of these stories, I am able to think of some activity that the CAFP has engaged in over the past year that potentially made a difference in the “medical lives” of the patients I have mentioned. I hope that we actually DID make a difference through our efforts around health care reform, the PCMH, or other legislation that we have fostered. Their challenges revolve around both illness and the systems that exist for accessing and paying for the medical care they needed. I want to thank CAFP members across the state for the work you do every day in helping address the concerns and care of patients in Colorado.

And finally, I wanted to take a bit of “President’s license” to thank a group of people who are very special to me. Like many other family physicians in Colorado, I had the privilege of serving on active duty in the US military. The other day, when speaking to one of my friends who is still on active duty, I was reminded of the ultimate sacrifice that so many of our soldiers make. He was able to describe a MASCAL that he experienced while with the 10th Mountain Division in Iraq. What stuck out most was his description of the actions of several of his soldiers at the moment that a truck bomb attempted to breach the main gate of their compound. One soldier, in a Mine Resistant Armored Protective vehicle, pushed the probable truck bomb into a brick wall with the front bumper of the MRAP. Another soldier, outside of the vehicle, attempted to close the main gate by hand. The truck bomb, containing some 2000 lbs of explosives, detonated and leveled the compound, injuring the first soldier, and killing the second soldier instantly (the soldier outside the MRAP). A third soldier, a medic who was inside the compound, cared for 25 injured soldiers after digging himself out of the rubble. Because of a sandstorm, he spent more than half an hour by himself administering aid before help arrived.

On this Memorial Day I thought it fitting to tell this story, and to honor and thank the members of our military for the work they do every day on our nation’s behalf.

It’s been an honor to serve the CAFP as the president over the past year, and I look forward to seeing our organization continue to grow and thrive.

Sincerely,

Brian Bacak, MD, FAAFP
President, Colorado Academy of Family Physicians
These health and nutrition organizations support Fuel Up to Play 60, a partnership between the NFL and National Dairy Council impacting an expected 60,000 schools and 36.6 million students.

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

Learn more—
www.FuelUpToPlay60.com
Breaking News
The CAFP has received approval for a grant request to The Colorado Health Foundation for a pediatric obesity pilot study. If you are interested in participating in this study and receiving education for your practice regarding pediatric obesity guidelines and resources, please contact cara@coloradoafp.org.

CAFP Annual Scientific Conference
Thank you for attending the CAFP’s April 2010 Annual Scientific Conference. The CAFP Education Committee chaired by Flora Brewington, MD, and Michael Archer, MD, created an excellent program with outstanding speakers.

As you can see from the numbers below, the 2010 conference was very well attended.

<table>
<thead>
<tr>
<th></th>
<th>Attendees</th>
<th>Exhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 Colo. Springs</td>
<td>165</td>
<td>43</td>
</tr>
<tr>
<td>2009 Colo. Springs</td>
<td>127</td>
<td>26</td>
</tr>
<tr>
<td>2008 Estes Park</td>
<td>141</td>
<td>41</td>
</tr>
<tr>
<td>2007 Denver</td>
<td>82</td>
<td>40</td>
</tr>
<tr>
<td>2006 Keystone</td>
<td>92</td>
<td>42</td>
</tr>
<tr>
<td>2005 Keystone</td>
<td>68</td>
<td>39</td>
</tr>
<tr>
<td>2004 Copper Mtn</td>
<td>90</td>
<td>45</td>
</tr>
<tr>
<td>2003 Keystone</td>
<td>98</td>
<td>39</td>
</tr>
</tbody>
</table>

And thanks to the CAFP team that put the conference together.
- Kristin Bennett
- Loan Hau
- Angel Perez
- Cara Coxe
- Leah Kaufman

As you can see from the numbers below, the 2010 conference was very well attended.

CAFP Staff and Leaders Represent Family Medicine at Colorado Meetings
Here is a list of some of the meetings that CAFP staff and leaders are been participating in.

- Disaster Preparedness Meeting at Colorado Medical Society
- Medical Home Meeting at Colorado Department of Public Health and Environment
- Colorado Rural Health Center Workforce Collaborative
- The Colorado Trust Meeting on ACOs
- PCMH Operations Committee
- Primary Care Coalition
- Colorado Clinical Guidelines Collaborative Obesity Guidelines
- Meetings with Colorado Medical Society
- Colorado Rural Recruitment and Retention Network
- Legislative Committee
- Colorado Society of Association Executives
- Safety Net Medical Home
- Medical Student reception
- Colorado Community Health Network
- SOUP! event
- AAFP Annual Leadership Forum
- Executive Committee meeting
- Tar Wars Awards Ceremony
- Meeting with Grant writers
- CCGC (now Health Team Works) event
- Meeting with Paul Grundy, MD

Tar Wars
Congratulations to Cara Coxe on organizing an excellent Tar Wars Awards Ceremony at the Museum of Nature and Science and to the award winners on creating such great posters. And thank you to Elizabeth Kraft, MD, for moderating the event.

CAFP Well Represented at AAFP Conferences
CAFP Leaders attended the AAFP’s Annual Leadership Forum and the National Conference of Special Constituencies: Brian Bacak, MD, Luke Casias, MD, Kajsa Harris, MD, Raquel Alexander, Loan Hau, Angel Perez, Sergio Murillo, MD (Minority Physicians Rep), Melissa Coomes, MD (New Physicians Rep), Julie Paddock, MD (Women Physicians Rep), Brent Grauerholz, MD (International Medical Graduate Physicians Rep), and Chandra Hartman, MD (Gay, Lesbian, Bisexual, or Transgender Physicians Rep).
Upcoming Meetings of Importance for CAFP Members

- Sept. 30, 2010
- Colorado PCMH Experience Dinner Event – You are invited to attend this interactive dinner. Family Physicians from NCQA PCMH Recognized practices will give a presentation and then sit at round tables and answer questions. If you are interested in attending please contact loankim@coloradoafp.org.

Strategic Plan

The CAFP board revised the CAFP Strategic Plan at the May 15, 2010, board meeting.

Reasons for strategic planning include the following.

- To develop a road Map for the Organization, getting everyone heading in the same direction.
- To provide input to the president and executive committee, help set goals, committee charges.
- To achieve of the mission.
- To solve problems and assess opportunities in the industry or profession.
- To perform a reality check .... where are we, where are we going?
- To focus everyone in the organization.
- To increase ownership, buy-in, and consensus.
- To build team work among the board and staff. (Let others see the teamwork)
- To make course corrections --- OK to do.
- To clarify leadership assessment....roles of leaders and committees delineated.
- To inventory resource of time and funding.
- To act as visionaries, future thinking.
- To have a game plan as to what needs to be done next, a check off list as what has been completed, and a year-end score card.
- To serve as a public relations tool for members, allies, press, etc. Shows how good you can be.

The CAFP Strategic Plan has two main goals.

Goal One: Successfully implement and sustain Patient Centered Medical Homes and Medical Neighborhoods.

<table>
<thead>
<tr>
<th>Objectives</th>
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<tbody>
<tr>
<td>Provide high quality relevant education to members.</td>
<td></td>
</tr>
<tr>
<td>Support creation of medical neighborhood.</td>
<td></td>
</tr>
<tr>
<td>Assist CAFP members to achieve NCQA PCMH recognition.</td>
<td></td>
</tr>
<tr>
<td>Market PCMH to key stakeholders: Businesses, patients, legislators, specialists, students, residents.</td>
<td></td>
</tr>
<tr>
<td>Help members assess, improve, demonstrate quality &amp; safety in their practices.</td>
<td></td>
</tr>
<tr>
<td>Promote, brand, demonstrate the high standards and quality of care provided by Family Medicine:</td>
<td></td>
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<tr>
<td>- To the public</td>
<td></td>
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<tr>
<td>- To legislators</td>
<td></td>
</tr>
<tr>
<td>- To insurance companies.</td>
<td></td>
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</tbody>
</table>

I urge you and your practice to begin the path towards NCQA PCMH recognition. Please contact angel@coloradoafp.org for help, information and resources.

Goal Two: Leaders in Advocacy.

<table>
<thead>
<tr>
<th>Objectives</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>We will be leaders in advocating for our profession, patients, practice, community and systems of care.</td>
<td></td>
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<tr>
<td>- PCMH</td>
<td></td>
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<tr>
<td>- Tort Reform</td>
<td></td>
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<tr>
<td>- Scope of Practice</td>
<td></td>
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<tr>
<td>- Primary Care Workforce</td>
<td></td>
</tr>
</tbody>
</table>

If you would like to support these strategic efforts please contact raquel@coloradoafp.org.

These are exciting times for Family Medicine. The Patient Centered Medical Home and the value and importance of Family Medicine as the key foundation in the health care system now have national recognition. The CAFP board of directors and staff are working full-time to provide you with the tools you will need to be successful in the future.

ooops!

Our Publisher Goofed!

They failed to add the caption beneath the picture that accompanied the article on Belmar Family Medicine in our Spring issue.
The CAFP Board of directors is proposing the following changes to the bylaws (changes are in red). Members who have comments, questions or concerns may call Raquel Alexander at 303-696-6655, ext. 10, or email her at raquel@coloradoafp.org.

a. Amend bylaws: Licensure

The AAFP’s bylaws state, “He or she must be duly licensed to practice in the state in which he or she practices.” The AAFP suggests that the CAFP mirror this language since a chapter’s bylaws cannot be more restrictive than those of the national organization.

Proposal: Section 2. Active

Members. Physicians who hold an unrestricted license are duly licensed to practice medicine in the State of Colorado, and who also meet the qualifications and conditions further set forth in the Articles of Incorporation and Bylaws of the Colorado Academy of Family Physicians (CAFP) shall be eligible for active member status in the CAFP. Exceptions may be made at the discretion of the CAFP secretary/treasurer.

b. Amend Bylaws: Resident representative on board.

CAFP Bylaws Article 1, Section 9

Full-time physicians, who are in good standing in Colorado family practice medicine residency programs accredited by either the ACGME or the AOA, as well as physicians in AOA-approved rotating general or family practice internships or hold a license to practice medicine in Colorado, and be a resident in good standing in an ACGME or AOA accredited residency outside of Colorado, or AOA-approved general or family practice residencies, shall be eligible for Resident Membership in the CAFP, provided that they meet applicable American Academy of Family Physicians membership requirements.
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**Interventional Procedures**
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**Breast Center**
Full Field Digital Mammography • Breast Ultrasound • Stereotactic Biopsies • Cyst Aspirations • Breast MRI & Biopsies
The 2010 Colorado legislative session began Jan. 13 and concluded 120 days later on May 12. To say the least, this session was one of the more difficult sessions that Colorado has endured in years. The economic downturn and the state’s budget dominated the discussion, but several other issues received significant attention.

Health Insurance Reform

During the 2010 session Colorado legislators decided to implement two health policy reforms three years ahead of the federal health care reform timeline. HB 1008 eliminates the practice of “gender rating,” or basing health insurance premiums on gender. HB 1021 requires maternity coverage in individual health insurance plans for those who apply prior to becoming pregnant. HB 1021 provides an additional option for maternity coverage beyond Medicaid, CHP+, CoverColorado and a new high-risk pool required by federal health care reform available this fall. Both bills are effective Jan. 1, 2011, and were supported by the Colorado Academy of Family Physicians.

Bills related to private insurance:

- **SB 20** requires CoverColorado to establish a fee schedule for participating providers that exceeds Medicare reimbursement levels; prohibits health care providers from balance billing participants in excess of the established fees, establishes a specific process to be followed prior to limiting any new enrollment, and clarifies that any funds received by CoverColorado to implement and administer the new temporary high-risk pool required of states under federal health care reform cannot be commingled with CoverColorado’s funding sources.
- **SB 183** continues indefinitely the prohibition on balance billing, requiring health insurers to hold consumers harmless for charges over and above the in-network rates for services rendered in an in-network facility.
- **HB 1004** requires a standardized format for policy forms and explanation of benefits forms for health benefit plans, limited benefit health plans and dental plans effective Jan. 1, 2012.
- **HB 1166** requires insurance policy information to be written at or below the 10th-grade reading level, in 12-point type or larger, and to contain an index or table of contents for pieces that are longer than three pages or 3,000 words.
- **HB 1242** simplifies the process of applying for individual health insurance policies by requiring an initial uniform application form for individual health benefit plans to be used beginning Jan. 1, 2012. The form will include basic questions concerning medical conditions for which the carrier may refuse to issue coverage. Applicants who are denied coverage based on the information provided are eligible for CoverColorado.
- **HB 1330** requires Health Care Policy and Financing to establish an advisory committee to make recommendations to the governor for the creation of a framework and implementation of a Colorado all-payer claims data base which will be designed to facilitate the reporting of and provision of information about health care, health quality and health cost data. The data will assist with improving transparency for purchasers. It also directs HCPF to seek funding for the creation of the database and, if sufficient funding is secured by Jan. 1, 2012, to establish the database by 2013.
- **HB1332** creates the Medical Clean Claims Transparency and Uniformity Act requiring HCPF to establish a task force to develop a standardized set of payment rules and claim edits to be used by payers and health care providers in Colorado. $50,000 was appropriated to implement the act.

Health insurance companies’ treatment of cancer screening and treatment legislation:

- **HB 1202** requires plans that cover cancer chemotherapy treatment to provide coverage for prescribed, orally administered anticancer medication at the same cost to the patient.
- **HB 1252** requires mammography screening to be covered for individuals...
possessing at least one risk factor including, but not limited to, a family history of breast cancer, age of 40 years or older or a genetic predisposition to breast cancer.

- HB 1355 prohibits a plan from limiting or excluding coverage for a drug approved by the FDA for the treatment of one specific type of cancer on the basis that the drug has not been approved by the FDA for another specific type of cancer if the drug is recognized for treatment for that cancer in the reference compendia as identified by the U.S. Department of Health and Human Services and the treatment is for a covered condition.

Other bills on which the Colorado Academy of Family Physicians took active positions to either proactively enact or amend:

- HB 1033 came from the Health Care Task Force. The bill adds to the list of optional services provided to Medicaid recipients screening, brief intervention and referral to treatment for alcohol and other substance abuse services. This bill’s funding is tied to HB 1284, Medical Marijuana Sales Tax.
- HB 1122, Medical Orders Scope of Treatment, provides a form, to be filled out by patient, effective with emergency medical technicians, physicians, hospitals and other health care professionals, for medical directives.
- HB 1244 allows an heir of a person licensed to practice medicine who is a shareholder in a professional service corporation to become a shareholder of the corporation for up to two years if the physician shareholder dies. The bill specifies that when the surviving heir ceases to be a shareholder, provision will be made for the shares to be reacquired by the corporation or by a person actively practicing medicine in the offices of the corporation. The bill makes the surviving heir a nonvoting shareholder unless the deceased beneficiary was the only shareholder of the corporation.
- SB 124, the Skolnick Act, requires medical providers to disclose to the Board of Medical Examiners (which then makes the information public), any history of disciplinary actions, health care related employment contracts and other information. This bill expands the scope of the Skolnick Act to other health care providers and makes other changes to the act.
- HB 1160 was a controversial bill supported by insurance brokers and companies with strong opposition from consumer advocates and providers. It was amended significantly throughout the process to address the opposition’s concerns. The bill allows health insurance companies to offer premium and cost-sharing discounts to small businesses, individuals within those small businesses and people purchasing insurance through the individual marketplace. People “earn” these discounts by achieving specific health outcomes established by carriers. Those outcomes are related to reductions in “health risk factors.” For example, reducing cholesterol to a certain level or reaching a set weight or body mass index could result in a discount. The term “health risk factor” is broadly defined. For example, exposure to ultraviolet radiation is one factor specified in the bill. The academy’s concerns were focused on the unintended consequences of passing such legislation, such as interference in the physician-patient relationship. Several restrictions and requirements were included in the bill, along with a repeal date of July 1, 2015, requiring a legislative review and passage of a new bill to continue the law. Mendez Consulting will be monitoring this law and will be sure to be involved in any necessary fixes that come up.

Health Care Providers and Workforce Policy Changes:

- HB 1138 maximizes federal and private dollars for Colorado’s student loan repayment program. The bill changes the name of the program to “The Colorado Health Service Corps.” Providers working in underserved areas can qualify, including those that provide mental health services, primary care, oral health and other services. The program recently announced approval of $1.5 million in student loan repayment awards.
- HB 1175 allows an applicant from another state to demonstrate competency in his or her particular field rather than meeting a period of work or practice requirement. It applies to chiropractors, dentists, dental hygienists, optometrists, nursing home administrators and physical therapists.
- HB 1260 was the sunset review for the Medical Board of Examiners bill. It renames the State Board of Medical Examiners to the Colorado Medical Board, streamlines the appointment process by the governor, increases the number of members on the board to include a physician assistant, creates a new type of license for physicians and physician assistants who have not actively engaged in their respective practices for two years and creates a continuing competency requirement. It allows physicians to supervise up to four physician assistants, rather than two, and permits physician assistants to be shareholders in a professional service corporation formed by licensed physicians.
- HB 1414 requires a facility to report the name and date of birth of any individual responsible for the diversion of injectable drugs. This bill is a response to the spread of Hepatitis C by a health care worker.
- HB 1415 requires surgical assistants and surgical technologists to register with the Department of Regulatory Agencies and requires employers to check the registry prior to hiring.

FY 09-10 Budget

The legislature adjusted the FY09-10 budget through supplemental bills to bring spending into balance with reduced revenue. A total of $2.19 billion in general funds needed to be cut or raised as new revenues declined due to the recession. During the 2009 legislative session, the General Assembly cut $1.55 billion from the original proposed budget. Governor Ritter’s office developed plans to keep the budget in balance as follows: cuts of $313.4 million on Sept. 1, 2009; cuts of $271.4M on Oct. 28, 2009, cuts of $276.6M in December; and cuts of $47.5M on Jan. 27, 2010. The March revenue forecast indicated state revenues were no longer continuing to decline, though they had not started to increase.

continued on next page
FY ‘10-‘11 Budget
Fiscal year 2011-2012 is expected to be worse than ‘09-‘10 or ‘10-‘11 because the federal American Recovery and Reinvestment Act funds have helped avoid further cuts. The enhanced match for Medicaid is scheduled to end in December 2010, however, the state’s ‘10-‘11 budget accounts for a six-month extension of these dollars. When these funds end the ‘11-‘12 budget will have to increase the general fund by $230 million. ARRA funds have also helped support higher education, K-12 education and other areas of the budget. Thus, larger and deeper cuts are expected in ‘11-‘12.

Medicaid and Child Health Plan (CHP+) Policy Changes
The first Medicaid and CHP+ expansions from HB09-1293 became effective May 1, 2010. CHP+ eligibility for pregnant women and children increased from 205 percent to 250 percent of the Federal Poverty Level and Medicaid eligibility for parents of eligible children increased from 60 percent to 100 percent of the poverty level. This is expected to result in an additional 44,000 parents and 22,000 pregnant women and children with health coverage.

Departures and New Leadership
Several legislators are term-limited or not seeking re-election including: Sens. Gibbs (D-Summit County), Keller (D-Wheat Ridge), Kester (R-Las Animas), Penry (R-Grand Junction), Sandoval (D-Denver), Schultheis (R-Colorado Springs), Tapia (D-Pueblo) and Reps. Carroll (D-Denver), who is House speaker, Frangas (D-Denver), Judd (D-Denver), S. King (R-Grand Junction), May (R-Parker), who is minority leader, McFadyen (D-Pueblo), Merrifield (D-El Paso County), Pommer (D-Boulder), Roberts (R-Durango), and Majority Leader Weissmann (D-Louisville).

Generally, leadership elections are not held until after the November general election. With Sen. Penry (R-Grand Junction) leaving to manage Jane Norton’s campaign for the U.S. Senate, the Senate minority has selected Sen. Kopp (R-South Jefferson County) as the new minority leader.

Three Joint Budget Committee members are term-limited—indicated in bold above. Sen. Tapia (D-Pueblo) has already resigned and was replaced by Sen. Hodge (D-Brighton). The other new JBC members have not been named yet.

With a tremendous number of veteran legislators leaving the capitol this year, next year will surely be an interesting one. And, of course, as always we at Mendez Consulting have greatly appreciated representing the Family Physicians of Colorado!

If you BC/BE in Family Medicine or Emergency Medicine, these are full-time employed positions offering an excellent chance work/life balance! Clinics operate seven days a week. Monday-Sunday Shifts range from 8-12 hours. Scheduling is done 2 months in advance!

Full time providers receive a host of outstanding benefits including: Competitive Salary, PTO, CME allowance, health-dental-vision-life insurance, 401k and paid malpractice.

We are also seeking part-time and/or per diem physicians for shifts at the various clinics. Please indicate which specialty you are interested in: Urgent Care and/or Family Medicine

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Rocky Mountain Urgent Care and Family Medicine is a leading provider of urgent care and occupational medicine, with clinics open 7 days a week. The Rocky Mountain Urgent Care and Family Medicine team is committed to providing high quality, affordable healthcare every day of the year. Rocky Mountain Urgent Care and Family Medicine owns and operates 9 clinics. Locations:

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- Boulder
- Commerce City at Reunion
- Englewood
- Longmont
- Westminster
- Union Square at N. Lakewood
- Westminster
- Weigh to Wellness Clinic in Denver

Rocky Mountain Urgent Care and Family Medicine is looking for Providers who are passionate about providing quality health care in a cutting edge, fast paced environment! If you want the opportunity to demonstrate your outstanding communication skills, friendliness, caring attitude, empathy for others and ability to work with a team, this is the place for you! Please email CV to employment@rm-uc.com
The University of Colorado School of Medicine Department of Family Medicine has promoted Aris Sophocles, MD, MBA, JD, to the position of Distinguished Clinical Professor. Dr. Sophocles holds advanced degrees in medicine, business and law and his professional experience includes experience in all three fields. In addition to writing prolifically for both traditional and electronic media, he has taught professionals at various levels of their careers ranging from medical school through continuing medical education.

Both of Dr. Sophocles’ parents were health care professionals. His father, a Greek immigrant, was an otolaryngologist, while his mother, the first Greek girl born in Lancaster, Penn., was an optometrist. He grew up in Yardville, N.J., where they both practiced. Dr. Sophocles earned his bachelor’s degree at Harvard University, graduating cum laude. He earned his medical degree at Jefferson Medical College and performed a rotating internship at Presbyterian Medical Center in Denver and a fellowship in immunology at the University of Colorado. He reached the rank of Major in the U.S. Army Reserves before being honorably discharged.

Recreation for the disabled, research
From 1974 until 1983, Dr. Sophocles operated a rural Family Practice in Breckenridge, Colo. Notable achievements while he was there included publication of ground-breaking research, co-founding a center that expands recreational opportunities for the disabled, serving more than 3,000 students per year. He has served four times as chairman of the board, a position he holds in 2010.

While in Breckenridge, Dr. Sophocles decided to enroll in the Executive MBA program at the University of Denver. “Ten years into my practice, I realized I didn’t have adequate business training to run the Breckenridge practice,” he said. He drove to Denver one day a week for classes until he completed the degree.

Law, publishing and teaching
In 1983, Dr. Sophocles moved to Denver, where he continues to operate an urban Family Practice.

While he was studying for his MBA, Dr. Sophocles had been particularly fascinated with business law, largely because of the importance of law in many areas of medicine. Shortly after moving into the Park Hill neighborhood, he enrolled in the University of Denver Law School, which was then located nearby in northeast Denver. For five years, while he continued to work full-time as a clinician, he attended night classes and worked toward his law degree.

“It was just irresistible,” he says. Opportunities for other professional pursuits arose around the time he completed his law degree. Even before he graduated from law school, he was asked to take on administrative positions and eventually he did. While continuing to work part-time as a clinician, he served as medical director of Prudential Colorado Group Operations and later Lincoln National Health Plan and TakeCare of Colorado.

Also around the time he completed his law degree, a publisher approached him about writing about risk management and a number of other areas that involved law and medicine. Among the results were the 1990 publication of Risk Management: Safeguarding Your Career and the 1994 publication of Preventing Malpractice Claims.

The many other multi-media publications by Dr. Sophocles include a three-volume set on pain management and palliative care. He has written a text on the Health Insurance Portability and Accountability Act of 1996, generally called...
Students Always Present
Throughout his career, Dr. Sophocles has precepted hundreds of students and supported medical education in other ways. “I almost always have a medical student and often a pharmacy and a physician assistant student, too,” he says. “We work together as a team and it’s really fun.”

Dr. Sophocles has also supported physician education in more fundamental ways. He helped create the Foundations of Doctoring program, through which all University of Colorado medical students work with community-based doctors. The students spend a half-day each week with their preceptors for three of their four years of medical school.

Since he moved to Denver in 1983, Dr. Sophocles has served on several academic committees. In 2010, he is on the Department of Family Medicine Appointments and Promotions Committee, a position he has held for 20 years, and the School of Medicine Senior Promotions Committee. Both consider high-level promotions for clinical professors.

A divorced father of two grown children, Dr. Sophocles enjoys fresh and saltwater fly-fishing, Nordic and Alpine skiing, reading and writing. He also continues to learn through lessons in bridge, ballroom dancing and golf.

“It’s just a never-ending itch – the urge to keep learning,” he says.

Fuel Up to Play 60 Tackles Childhood Obesity

Children today are increasingly overweight yet undernourished – missing out on essential nutrients because they are not choosing enough nutrient-rich foods. Overall, only 2 percent of school-aged children consume the recommended daily number of servings from all major food groups. Only 14 percent of adolescents in grades nine through 12 enjoy three servings of milk per day, while only 21 percent eat at least five servings of fruits and vegetables per day. Given these statistics, it’s critical that the concept of nutrient density – foods that provide substantial amounts of vitamins, minerals and other nutrients, yet relatively few calories – remain a cornerstone of dietary recommendations and meal planning for children.

The Western Dairy Association works with Colorado schools on a variety of programs to help increase consumption of nutrient-rich foods, including low-fat and fat-free dairy foods, fruits, vegetables and whole grains. Identified by the 2005 dietary guidelines, these four food groups are recognized as the food groups to encourage because they are under consumed by most Americans. One such program is Fuel Up to Play 60, a partnership between the National Dairy Council and the National Football League that is implemented locally by the Western Dairy Association and Denver Broncos.

Fuel Up to Play 60 empowers students in grades 4 through 10 to take action and engage their peers to improve nutrition and physical activity at their schools.

The ultimate goal is to motivate them to make wellness a priority in their schools, and help them develop life-long healthy eating and physical activity habits such as getting 60 minutes of daily physical activity and eating more of the food groups youth need most. Some success stories from Colorado include students working with school nutrition directors to implement breakfast in the classroom, a school-wide dedication to 60 minutes of play a day with in-class activity breaks and a commitment to making the school plate more colorful by selecting a variety of healthy foods. Many Fuel Up To Play 60 teams are also incorporating healthy snacks and creating walking clubs.

The U.S. Department of Agriculture has joined Fuel Up to Play 60, along with multiple health organizations and several major corporations. Fuel Up to Play 60 gives leaders in health, business, government and communities nationwide the opportunity to be a part of a movement that relies on participation, collaboration and action by youth and adults to help them develop and maintain healthy habits to last a lifetime.

Family Physicians, too, can be a part of the Fuel Up to Play 60 team by recommending appropriate goals for nutrition and physical activity. To help with getting started, the Western Dairy Association is offering a free set of 50 dry-erase, magnetic Fuel Up to Play 60 trackers. This colorful piece provides a hands-on opportunity for patients to track and reach their daily healthy eating and physical activity goals. Trackers may be ordered by taking the following steps:

1. Log on to www.westerndairyassociation.org.
2. Click on Fuel Up To Play 60 tracker offer in the right-hand margin of the home page.
3. When the page loads, fill in the required information.
4. Enter the password TRACKER and then select “submit.”

Additional information about Fuel Up to Play 60 is available at www.fueluptoplay60.com. Information on additional wellness programs is available at www.westerndairyassociation.org.

REFERENCES

The Center for Personalized Education for Physicians, the “Gold Standard” in physician competence assessment, is proud to announce the celebration of its 20th anniversary. Founded in 1990, CPEP has provided competence assessments and education to more than 2,000 health care professionals in all 50 states and Canada.

Located in Denver, CPEP is nationally renowned for its innovation and ground-breaking approach to physician competence and improvement. It provides a consistent and outstanding means of addressing quality-of-care concerns related to practicing physicians and other health care professionals.

CPEP continues to expand its vision by developing services targeting specific educational needs of physicians and other health care professionals. CPEP’s Clinical Practice Reentry Program provides a means for professionals to identify educational needs, demonstrate competence and receive educational support as they return to practice. CPEP offers intensive seminars in documentation and communication to help physicians and other health care providers meet ever more rigorous record-keeping requirements and improve their interactions with colleagues and patients. CPEP also offers the Professional/Problem-based Ethics or ProBE Program, a rigorous, focused educational workshop that expands health care professionals’ understanding of their obligations to patients and society.

Bill Fischer, CPEP’s board president stated, “I’m excited to be in my new role as CPEP’s board president as we venture into this new era of health care delivery focused on patient safety and involving expanded use of electronic health records and other technology. CPEP’s longevity and success are a tribute to the Colorado medical and health care organizations that founded and continue to support the program.” As CPEP looks ahead to the challenges facing physicians and other health care providers in this changing environment, the relevance of CPEP’s services has never been more critical, he added.

Additional information is available at www.cpepdoc.org or by contacting Stephanie McGee at 303.577.3232, ext. 18, or smcgee@cpepdoc.org.

The mission of CPEP is to improve the quality of patient care and promote patient safety by providing clinical competence assessments and education services for physicians and other healthcare professionals.
There are two major types of stroke: hemorrhagic (stroke due to bleeding) and ischemic. Ischemic stroke is an event or process leading to brain tissue injury, caused by too little blood flow and/or supply of oxygen and other nutrients to the brain. Often, this occurs in an arterial distribution (i.e., arterial ischemic stroke). This article focuses on ischemic stroke in neonates and older children.

Why is ischemic stroke important in children?

Ischemic stroke in children occurs less commonly than in elderly adults, but its consequences can be equally devastating. The incidence of pediatric stroke is approximately one in 4,000 during the neonatal period and one in 100,000 in older childhood. The risk of recurrent stroke is 3 percent or less for neonatal stroke but is approximately 20 percent when the initial event has occurred beyond the neonatal period (i.e., what is called “childhood-onset stroke”). Issues of evaluation for causes and risk factors, short-term stroke treatments, rehabilitation and long-term prevention of future strokes all play a very prominent role in stroke care for children. Recent data from a large international series indicate that acute neurological deficits are seen in approximately 70 percent of children [1], and other published data from single institutions suggest a similar rate of long-term impairment.

Because stroke is a rare disorder in children, optimal stroke care in young people requires expertise from a variety of medical specialties, including coagulation hematology, neurology, radiology, rehabilitation, neuropsychology, and in some cases cardiology, neurosurgery and rheumatology. Although some guidelines have been proposed for the evaluation and treatment of stroke in U.S. children [2, 3], the particular circumstances of each patient must also be considered. This highlights the importance of expertise in stroke care for young people.

What causes ischemic stroke in children?

Causes for stroke in children are more heterogeneous than among elderly adults. Stroke in elderly adults is typically due to high blood pressure, atherosclerosis or arrhythmia. In children and young adults, stroke can be caused by abnormalities in blood vessels in the brain or neck (e.g., cervical arterial dissection, cerebral arteritis), cardioembolism (e.g., cardiac catheterization in a child with congenital cardiac disease), hypercoagulable states (also called “thrombophilia”), sickle cell disease and certain heart or metabolic conditions. Often, however, the cause of stroke in young people remains unclear. This is especially true for stroke occurring in the perinatal period, where gestational factors causing maternal-placental-fetal insufficiency are being actively researched.

How is ischemic stroke diagnosed in children?

Ischemic stroke in young people may occur with a variety of signs and symptoms, depending mainly on the area of the brain that is affected. These signs and symptoms can include: new-onset seizure; one-sided weakness or numbness; facial droop; slurred speech; sudden change in vision; difficulties with walking, balance, or coordination; or unexplained change in level of consciousness. In neonates, seizure is the most common presentation; in older children, focal neurologic deficits predominate, although seizure is a frequently associated sequela.

By Neil Goldenberg, MD, PhD, Timothy Bernard, MD, and Jennifer Armstrong-Wells, MD, MPH
Radiologic imaging tests
Suspected stroke is confirmed by radiologic scans, typically magnetic resonance imaging (MRI) of the brain. Computed tomography (CT) of the brain is often also performed initially, and is effective in first establishing whether the patient’s signs/symptoms are explained by intracerebral hemorrhage. When brain MRI is performed to confirm ischemic stroke, magnetic resonance angiography (MRA) is used to evaluate for associated abnormalities of the cerebral and cervical arterial circulation. Diffusion weighted imaging as part of a stroke imaging protocol in children helps to establish the timing of onset of the ischemia; particularly in cardioembolic subtypes of stroke in children, both old and new areas of infarct may be found. Fat-saturation imaging of the neck during MRA also assists in the identification of arterial dissection.

Laboratory tests and other exams
Key components of the diagnostic evaluation include echocardiography with agitated saline injection to evaluate for anatomic defects serving as a source or route for embolism (e.g., right-to-left shunting lesion), and laboratory testing for thrombophilia. Thrombophilia testing for stroke risk factors can vary across treatment centers. However, because thrombophilia is common in young stroke patients and has the potential to affect treatments and secondary prevention, comprehensive thrombophilia testing is routinely performed at many specialty centers.

When underlying rheumatologic conditions and/or infections are suspected, the evaluation also includes blood and often cerebrospinal fluid (CSF) testing for these etiologies. In some cases, laboratory evaluation for specific genetic and metabolic disorders may be warranted based on the clinical history, associated findings and/or infarct pattern.

How is ischemic stroke treated in children?

The initial treatment of ischemic stroke in young people is complex and varies with condition and etiologic subtype.[4] Recent international experience in over 600 cases of childhood-onset ischemic stroke reflects this variability [1]. To date, other than in sickle cell disease patients, no clinical trials have been completed to guide the initial treatment of ischemic stroke in children.

Acute management includes the safe medical control of blood pressure, oxygenation, fluid and electrolytes, glycemia, and seizure. Additional important treatment decisions involve consideration continued on next page
of the identified causes and risk factors for stroke, the amount and area of the brain affected and the medical status of the patient. Acute anticoagulation (i.e., unfractionated or low-molecular weight heparins) is often employed in dissection and cardioembolic subtypes of stroke, whereas acute antiplatelet therapy (i.e., aspirin) is typically used for other stroke etiologies. With very large strokes (e.g., two-thirds or more of a cerebral hemisphere), these antithrombotic therapies may be withheld initially due to a high risk for hemorrhagic conversion, and then carefully instituted when the peak of brain edema has passed. Also, given the low risk of recurrence in most cases of non-cardiogenic ischemic stroke in neonates, antithrombotic therapy is generally not administered in this setting. Unlike ischemic stroke in adults, the role of acute thrombolytic interventions (e.g., intravenous or catheter-directed tissue plasminogen activator infusion) have not been studied in children; their use is consequently recommended only at a highly experienced pediatric stroke center and ideally in the context of a closely monitored clinical trial [3].

Rehabilitation therapies are also a key component of stroke care in children. Physical, occupational and speech therapies are often needed. In addition, neuropsychological assessment may identify academic, mood and behavioral concerns requiring intervention. A multidisciplinary approach to pediatric stroke management is therefore necessary in order to optimize outcomes for these children.

Dr. Neil Goldenberg, board certified, pediatrics, internal medicine, and pediatrics

Dr. Timothy Bernard, board certified, child neurology

Dr. Jennifer Armstrong Wells, board certified child neurology

Drs. Goldenberg, Bernard, and Armstrong Wells are members of The Children’s Hospital Stroke Program and clinics, providing 24/7 on-call guidance through the Pediatric Stroke Alert System at TCH. They may be contacted for consultations or patient referrals through the TCH OneCall physicians line at 720-777-3999.

Kids Corner is a regular feature in the CAFP News focusing on pediatric health issues of interest to Family Physicians. Readers who have questions or suggestions for future Kids Corner topics may contact Jeffrey J. Cain MD, the TCH chief of Family Medicine at 720-777-3980.

References
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Immunizations and Chemoprophylaxis

Vaccines for Travel 2010

By Leah R. Kaufman

“With the exception of safe water, no other modality, not even antibiotics, has had such a major effect on mortality reduction…” (3)

Vaccines are estimated to prevent more than 3 million deaths per year in the United States, which translates to a savings of over $1 billion per year. (1) With millions of Americans traveling abroad every year, the need for up-to-date travel vaccinations is more important than ever. The World Health Organization estimates that if childhood vaccines guidelines are adopted and coverage rates can be maintained at 90 percent, 2 million more deaths per year could be prevented in children under the age of 5 by the year 2015. (2) While illness and disability are major contributors to the global poverty epidemic, their prevention increases health and welfare. Research and development of new vaccines, strengthening of health care and immunization programs, innovative delivery strategies and sustainability of current achievements are all important factors in achieving global health goals.

In the 2009 Statement of the World’s Vaccines and Immunizations, WHO emphasizes the importance of immunizing in the context of global interdependence. The importation of infectious disease is high among travelers and immigrants. Travelers visiting friends and relatives are at a significantly higher risk compared to the general population. Every year 80 million people worldwide travel from resource-rich countries to resource-poor countries, where they are exposed to diseases not prevalent in their country of origin. (4) Immunization is one of the most cost-effective medical interventions. The average cost of vaccination per live birth has risen from $3.50 to $5.00 in the 1980s to a projected $18.00 in 2010. (2)

Administering travel vaccines to patients visiting abroad reduces the importation of disease and can also reduce world anxiety over emerging medication resistance patterns – most recently, campylobacter in Asia, malaria and multi-drug-resistant tuberculosis. Patient education is another critical component in preventative medicine.

Typically, many Americans do not feel threatened by diseases such as measles and tuberculosis. Many do not realize that these diseases still occur in their states and even in their neighborhoods. It is often not until a pandemic occurs, as we saw with the H1N1 virus in 2009, that the public seeks out vaccination.

A complete list of travel vaccine updates for 2010 and information on how to best prepare patients for foreign travel is available on the CAFP web site at www.coloradoafp.org under the Members Only section – Immunization Initiative tab.

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PREVNAR UPDATE

Switch from PCV7 to PCV13

By Robert Brayden, MD

In February 2010, the Food and Drug Administration approved a 13-valent pneumococcal vaccine. It is intended to replace the PCV7 (Prevnar) vaccine.

The reason for the increased number of pneumococcal serotypes in the new vaccine is that some of the types not covered by the original PCV7 vaccine had increased in frequency. Empyema, in particular, had been observed to be increasing in the U.S., and researchers in Utah had found that the types associated with empyema were not in the PCV7 vaccine.

The good news is that all three types the Utah researchers found to be associated with empyema will be in the new PCV13 vaccine.

Made by the same manufacturer (Wyeth), the vaccine can be given to complete the pneumococcal conjugate series. If a child has completed four PCV7 vaccines but is less than 5 years of age, a fifth dose of PCV13 is recommended.

The story of preventing pneumococcal infections is not likely over. While I believe this is an improved vaccine and will provide an expansion of pneumococcal coverage, it is likely that pathogenic pneumococci will continue to evolve and change, requiring changes in future vaccines. Stay tuned!


Robert Brayden, MD, is a professor of Pediatrics at the University of Colorado School of Medicine.
Eight Winners Announced in Tar Wars Poster Contest

More than 15 contestants and their families from throughout Colorado attended the 22nd annual Tar Wars poster contest awards ceremony Saturday May 8 at the Denver Museum of Nature and Science. Representatives of Kaiser Permanente were also there with a display on the benefits of not using tobacco. In addition to first-, second- and third-place winners, judges also recognized five honorable mentions.

First Place -- Jared Gorthy (Chipeta Elementary, Colorado Springs)
Second Place -- Ryan Bowen (Holy Family Catholic School, Grand Junction)
Third Place -- Shelby Kelley (Willow Creek Elementary, Highlands Ranch)
Honorable Mention -- Viken Christianian (Superior Elementary, Superior)
Honorable Mention -- Madeleine Doyle (Christ The King, Denver)
Honorable Mention -- Adam Ginther (Nativity Of Our Lord, Brighton)
Honorable Mention -- Nicole Doll (Prairie Elementary, Ft. Morgan)
Honorable Mention -- Katie Till (Penrose Elementary, Penrose)

Tar Wars Grant Funding

The Colorado Academy of Family Physicians Foundation is excited to announce Kaiser Permanente’s Community Benefit Leadership Team has approved funding in the amount of $10,000 to support the Colorado Academy of Family Physician’s Tar Wars program! Program’s managers are very appreciative to receive enduring and continued support from Kaiser Permanente.
First, I want to thank the Colorado Academy of Family Physicians for the unique opportunity to attend the 2010 NCSC conference in Kansas City. I have had so many things to think about since going to the first-time attendees’ meeting on the first day. First, what an incredible opportunity! I look at where I am at in my career and where I came from. As an International Medical Graduate, I would have never thought I would be able to participate in a forum such as this. To be in the same room with members of the board of directors of the American Academy of Family Physicians and even the president was humbling and inspiring at the same time. I think of the road that got me to the place I am at now. Had I gone to medical school in the U.S. rather than in Grenada at St. George’s University, I wonder if I would have ever had this opportunity and perhaps may have never been aware that this opportunity even existed.

There are several things I continue to ponder as I reflect on the time spent in meetings and lectures at the NCSC. First and foremost, this conference has given me time to ponder the reality of government -- not only the government within the AAFP, but also government as a whole both at the local and national levels. I began by wondering and thinking, “Is this all really worth it?” Is the time spent here at this conference creating resolutions really worth the energy spent and will things ever get done as a result of these meetings/discussions? However, the more I learned, I began to understand that without this process, nothing would ever get done or move forward. Furthermore, it also enforced the reality of why it takes so long to get things done in a democratic society where everyone’s voice counts and has a forum to be heard. This is an event that I think each member of the AAFP would benefit from attending.

I also understand with better clarity that the medical establishment and particularly primary care will have to evolve and adapt as new rules and regulations are discussed and implemented at the national level. This particular venue, the conference, gave me a “bird’s eye” view of how that evolution is being directed and influenced by our own academy, myself, my colleagues as IMGs, and fellow members of the CAFP. I think this conference will continue to be a place where we as Family Physicians of all different backgrounds can continue to air our grievances, as well as come together and create ideals and ideas to push us in a positive direction for the future. I was also enlightened and surprised when listening to others’ concerns, as I previously had no idea these were items of concern to people outside of my world. Furthermore, during the midst of sometimes intense debate, I felt lucky and privileged to practice in a state where we have an active academy, an active medical society in the Colorado Medical Society, and a well run malpractice company in Copic that truly understand the needs and concerns of practicing physicians in Colorado. We as physicians in Colorado, and particularly Family Physicians, are well thought of by the public and are privileged to be able to practice in a health care environment more “friendly” than that in other parts of the U.S. Our active lobbyists on the state level have prevented malpractice premiums from driving us out of business. Furthermore, as we continue to adapt to a changing practice environment I feel that the CAFP and the AAFP will again be on the watch for items that directly affect how we take care of patients and how we as members can support their/our cause as well.

Overall, I can’t think of a more challenging and uplifting three days in the past years than the few days I spent with members of the CAFP in Kansas City. I wonder what the next few days, weeks and years will hold for physicians across this country and in particular Colorado and Greeley. Quoting the speaker during the lunch plenary session, Capt. Charlie Plumb, I hope to be a “parachute packer” for my colleagues and staff as we venture on the yet unknown and scary next chapter in health care. Since Congress has passed this new health care legislation, I think it will be even more prudent for us as Family Physicians to be ambassadors for the CAFP/AAFP and advocates for our patients’ health and the health of our nation as we go forward.

“The National Conference of Special Constituencies convened for its 20th anniversary session April 28 through May 1 in Kansas City, Mo. This year’s program built on momentum from last year and first-time participants brought many new ideas and lots of energy to the proceedings. For the uninitiated, NCSC is the American Academy of Family Physicians’ premier policy development event addressing member issues specific to women, minorities, new physicians, international medical graduates, and those who are gay, lesbian, bisexuals or transgendered, or GLBT. Physician leaders from around the country convene to discuss, author, debate and pass resolutions pertaining to our profession and the lives and health of our patients. Run concurrently with the Annual Leadership Forum, NCSC is also a great opportunity to meet our national leaders in AAFP and discuss issues of importance to all of us. This year a total of 155 people attended, including 71 first-time attendees. A total of 52 resolutions were written and considered.

This was my second year attending NCSC, and it was even better than last year. I had the opportunity to represent Colorado as a delegate to the GLBT constituency and we worked hard drafting resolutions that could help care for our patients with GLBT-specific health issues.
One of our resolutions asked for the AAFP Board of Directors to issue a statement of support of the Military Readiness Enhancement Act, which would repeal the U.S. military’s controversial “Don’t Ask, Don’t Tell” policy. The resolution soundly passed the business session vote on Saturday and we look forward to the response from our board of directors.

The most spirited debate came from a resolution asking the AAFP to rescind its Consumer Alliance Program contract with The Coca-Cola Company. Proponents of the resolution cited concerns about the link between obesity and consumption of sugary beverages. However, opponents of the resolution felt it is important to keep avenues of negotiation and alliance open with various companies that may benefit AAFP and the patients we serve. AAFP board president, Lori Heim, MD, FAAFP, also testified that The Coca Cola Company provides funding for our web site familydoctor.org and AAFP retains full editorial control over the content. After much debate, the delegates decided against passing the measure.

From the women’s constituency came a resolution to create educational resources for physicians and programs for patients that educate and inform regarding the U.S. Preventive Services Task Force (USPSTF) grading system for evidence-based guidelines. Recently enacted legislation at the federal level requires all insurance companies to cover preventive services that carry a grade A or B recommendation. Grade C, D and I services may or may not be covered by various insurance companies. The resolution is an effort to provide up-to-date information regarding covered services for both physicians and patients, in an attempt to reduce high charges for tests and services to patients. Testimony during the Reference Committee session used prostate cancer screening as an example, citing the USPSTF’s Grade D recommendation regarding prostate cancer screening in men younger than 75 years of age. Physicians and their patients may not be aware that a popular test, the Prostate Specific Antigen, may not be covered by their insurance, and should be knowledgeable regarding the out-of-pocket cost that may be incurred. The delegation was in agreement and the resolution passed.

At a more local level, the Colorado chapter won another award for sending a full complement of delegates to the NCSC. For those of us who practice in the state, this means the needs of our patients and our colleagues were represented to the best of our ability at a national level. Many of the resolutions written may directly impact the health of our state’s citizens and more information can be obtained through aafp.org. As follow up to the NCSC, six delegates will be sent to the Congress of Delegates this fall in Denver to advocate for and vote on these resolutions and others brought to the Congress of Delegates. In this way, we can bring the needs of our traditionally underrepresented constituents to the national debate and continue to work hard for their health.

For those of you reading this who have not participated before, NCSC is a wonderful opportunity to engage in the national conversation and have your voice heard regarding health care and the changes and challenges we all face. We all have patients who cannot fight for themselves, and as Family Physicians, we advocate for them, at many levels. NCSC is yet another opportunity to do so, and I urge you to get involved. It is an energizing way to engage in our health care system. I look forward to seeing you next year!
Group Focused on AAFP Position on Care of Undocumented Patients

2010 NCSC Minority Report
By Sergio Murillo, MD

This year’s Colorado delegation was complete. I represented our state in the Minority Constituency. As a second-time attendee, I felt more empowered to be more proactive. While I presented my candidacy for co-convener, I did not win.

This year’s discussion revolved around immigration laws and how the AAFP as a body should handle it. While conversing with representatives from different states about “universalization” of care, we realized other constituencies (International Medical Graduates; Women; New Physicians; and members interested in Gay, Lesbian, Bisexual and Transgender issues) have been discussing the same topics.

It seemed clear that universalization of care was a simple concept; however, we came to realize that even among physicians, this idea was not well understood. This, as expected, became a point of controversy and topic of prolonged discussion. Our constituency participated by elaborating a motion in which the 2007 AAFP policy would be reiterated and recapped by AAFP members. This policy states that: The American Academy of Family Physicians believes that medical care decision-making occurs between the physician and the patient. The AAFP opposes actions that would criminalize the medical care of undocumented foreign-born individuals.

Our main objective was not to change or to add to this policy, but rather to advocate for those physicians who feel disadvantaged due to limited guidance regarding medical care if a patient is undocumented. During our discussions, the exact wording was relevant in elaborating our resolution. Terms like “undocumented,” “illegal alien,” “unauthorized” and “unlawful” were sensitive to the vast majority present in the room.

We decided to move forward with our resolution in such a way we could accommodate everyone’s needs. During the plenary, our resolution was adopted for presentation to the AAFP Congress in Denver later this year.

Our resolution states:
Promotion of American Academy of Family Physicians’ Policy on Criminalization of Care Provided to Undocumented Patients
RESOLVED, That the American Academy of Family Physicians (AAFP) create educational tools for both physicians and the public to promote the AAFP policy on criminalization of care provided to undocumented patients.

Although, not a delegate myself, I plan to attend AAFP Congress session in Denver to continue advocating for patients, physicians and our home state. Hope to see you there!

“Adversity is a terrible thing … to waste.”
NCSC New Physician report
By Melissa Coomes, MD

Representing the new physicians of Colorado at the American Academy of Family Physicians’ National Conference for Special Constituencies was quite an honor for me this past April. Being a rather new physician to begin with, I have had little experience with participating in the academy on a national level. Becoming more involved in the decision making was exhilarating and eye opening at the same time. I have learned the process through which new resolutions are brought forth to the academy board as well as elections. Also, this conference provided excellent lectures on leadership building skills, as well as the opportunity to network. Lastly, I found it fascinating to learn of the different resources that the AAFP offers from the various booths that were available for viewing between sessions.

The process in which resolutions are first constructed and then brought forth to the board was very new to me. It now makes sense to me that such a large organization would have to have measures put in place, such as parliamentary procedure/resolutions etc., in order to have the 90,000 or more active members’ voices heard. I also learned a lot about different topics throughout the country that really make a difference to new physicians. In addition, I found a great benefit in networking with physicians throughout the country that have a true interest in pursuing leadership roles in their careers. Through various discussions throughout the conference with my peers, I gained insight as to various leadership activities that I, too, could pursue in order to make a difference in my community.

For example, I have not yet gone to any AAFP Congress session in Denver later this year. We decided to move forward with our resolution in such a way we could accommodate everyone’s needs. During the plenary, our resolution was adopted for presentation to the AAFP Congress in Denver later this year.

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“Always Events” Ensure Safe, Consistent Patient Care

By Alan Lembitz, Vice President of Patient Safety and Risk Management, COPIC

Systems in your office help ensure consistent and safe patient care. Here in no particular order are 10 “always events” to help busy offices ensure that nothing falls through the cracks, using proven techniques in communication, documentation, and systems development.

Laboratory and imaging result tracking. When tests are ordered, especially for acute or potentially life-threatening conditions, be sure that the tests are performed as ordered, that the results are returned and that they are seen by the clinician and acted on with documentation. This can be accomplished electronically (through an electronic medical records) or with paper flow sheets. It is not sufficient to just “set aside” the patient’s chart for this task as the chart may be picked up for another function and not returned.

Patient tracking for return appointments or referrals. When patients are advised to see a specialist or to return to the office for a serious or potentially life-threatening condition, a mechanism should be in place to be sure that this happens — whether an electronic or a manual system is used.

Telephone call charting. Care is often delivered over the phone and may be documented just like an in-person appointment. This not only allows your insurer to help defend care but also ensures that “covering” providers are aware of what a patient has been advised regarding your treatment plan. While it is impractical for any and all contacts between a patient and a provider to be documented, there are specific instances in which this documentation is important. These instances include:

- When a significant change in the treatment plan is made.
- When direction to a medical facility for urgent or emergent evaluation is given.
- When a prescription is ordered, or when a significant diagnosis is made that requires subsequent care or follow-up.

These circumstances should be documented in the record or in a separate file in chronological order for later reference.

Refilling medications. Develop a policy for how refills are performed and how this is documented. In general, the provider ordering the original medication should be the one determining whether the refill is made and the instructions that should go with it, including when the patient should return. Review the chart to make sure this is consistent with the treatment plan established at the last visit and document the details of the refill ordered. Refills for routine and low-risk medications can be delegated so long as the practice guidelines are followed. The guidelines should clarify the number of refills, the appropriate monitoring or follow-up intervals and any necessary monitoring.

Avoiding wrong-patient procedures. COPIC still receives reports about the wrong patient receiving injections, biopsies, and prescriptions. The key to making this a never event (as opposed to a rare event) is establishing a consistent communication system. The provider giving the order needs to be sure that all required information is included and the receiver of the order needs to read back the order in its entirety. This mandatory read-back system is routine in aviation, military and other critical systems that require high reliability of information transfer.

Tracking medications dispensed in the office. It is tempting to hand out free samples without recording them; however, handing out samples is equivalent to prescribing. The elements of appropriate prescribing and medication delivery are the same for samples as they are for a prescription filled by the pharmacy. When meds are dispensed in the office, record in the patient chart the name, strength, quantity, directions and lot number. Keep a log of the medications that are kept in the office (including lot numbers) to help track the medications.

Regularly assessing the performance of physician assistants and nurse practitioners. This assessment should ideally address the scope of supervised practice and what conditions the supervising physician believes (at a minimum) should involve a discussion at the time of clinical decision-making. Due to their complexity or risk, some conditions may warrant a formal consultation in which the supervising physician sees the patient and documents the interaction in an independent note.

Avoiding specimen mix-up. When Mr. Jones finds out that he didn’t have melanoma after all, and Mr. Smith finds out that what he thought was a benign mole was a melanoma, it can be very difficult to determine where the mix-up occurred. Systems need to prevent these mix-ups in the first place. Each office that collects specimens should have a system to ensure proper labeling of specimens. The provider obtaining the specimen should label and remove the specimen container from the room prior to bringing in the next patient. Give special care when obtaining multiple biopsies from the same patient, noting the nature of the biopsy and location.

Establishing and following on-call sign-out procedures. Now officially known in the patient safety world as “handovers,” the practice of signing out to a partner or covering physician needs to be standardized. It’s not sufficient to merely hand over a list of patients. A consistent process of handovers should be developed that includes time, place, pending tests and specific patient concerns. This allows the covering physician to be fully prepared.

Reporting and reviewing adverse events in the office. The first step in improving care in any office is being able to identify when problems occur so that steps can be taken to improve processes and prevent recurrence of adverse events. Staff is more likely to report unexpected events when invited to do so and when they know that their concerns are taken seriously. Each office should encourage reporting of unanticipated outcomes and they should be reviewed at regular staff meetings, with mutual investment in the steps that are taken to improve systems that aren’t working or to develop new ones that are needed.

This list is not intended to be comprehensive.
When Jennifer Eggebroten went to Gunnison, Colo., for about a month during the summer of 2009, she sutured wounds, froze warts and helped with well-child check-ups and sports physicals. As a medical student at the University of Colorado School of Medicine Rural Track program, she also spoke Spanish, attended meetings, participated in rounds and wrote notes.

“Most medical students don’t have this type of clinical experience until their third year, but Rural Track students get an early start,” she said.

Eggebroten also delivered a baby. She and the mother of the baby had developed a bond during prenatal visits and the mother wanted Eggebroten to attend the delivery. “With assistance from Dr. Marie Matthews, I helped welcome a little girl into the world,” Eggebroten said.

Dr. Matthews, an MD, was Eggebroten’s preceptor. “She has volunteered as a preceptor for several Rural Track students, enabling them to practice their clinical skills during the summer following the first year of medical school,” Eggebroten explained.

Dr. Matthews is a physician at Gunnison Valley Family Physicians, which includes three full-time physicians and one who is transitioning toward retirement. The practice, one of two Family Medicine practices in the mountain town of approximately 5,300, also includes a nurse, two physician assistants, three medical assistants, five front office staff and “one incredible office manager,” according to Eggebroten.

“The summer preceptorship gave me the opportunity to learn about rural Family Medicine and practice many of the clinical skills I learned during my first year,” Eggebroten said. “All of the doctors and medical professionals that I worked with in Gunnison were so welcoming and willing to teach. They made this month a fantastic learning experience. This is a great chance to get out of the classroom and work with real patients.”

Eggebroten explained that the Rural Track program provides extensive training before sending students to practice in rural and underserved communities. “Starting early in the first year of medical school, participants in the Rural Track learn skills from suturing to ultrasound scans to delivering babies, all in preparation for the summer preceptorship and our eventual careers,” she said. “In addition, students discuss challenges to rural practice and are given information on loan forgiveness programs.”

Eggebroten reported that tourism, led by Crested Butte Mountain Resort, is the major industry in Gunnison, followed by education, led by Western State College, and ranching. Because it is a resort area, the cost of living is high. Food and housing are particularly expensive.

The health care system in the town, which is in a county of approximately 14,300, includes a 24-bed critical access hospital with a
level 4 trauma center. Other facilities and services include Mountain Home Health, Gunnison Living Community, Willows Assisted Living, and Hospice and Palliative Care of Gunnison Valley.

Leaders in Gunnison, like those in many towns that host Rural Track students, hope some of the students who participate in preceptorships will return when they become doctors, according to Eggebroten.

During her time off, Eggebroten enjoyed many of the recreational opportunities that attract tourists to the Gunnison Valley. She and Dr. Matthews went mountain biking. And other students in the Rural Track program who were in clinics in nearby towns joined her for fishing, hiking and camping. “My classmates were spread across the state from Wray to Telluride. A few of us were able to get together for a hike up Mt. Yale,” she said.

Eggebroten grew up in Washington state, but her grandmother was born and reared in Telluride and Eggebroten has visited the Four Corners region since she was a child. She moved to western Colorado after earning her bachelor’s degree in Psychology at Middlebury College in Middlebury, Vt., and met her husband, a native of Grand Junction, in Crested Butte. They hope to return to the Western Slope after she completes her training.

Jennifer Eggebroten was joined on top of Mt. Yale by fellow Rural Track students Avery MacKenzie, and Jenn Hissett, as well as her husband, Cris Barbero.
Using Achievement of “Meaningful Use” to Support Transformation to a Patient-Centered Medical Home

By Deb Barnett, RN, MS, FNP
Coordinator, Grants Management & Program Development—Health TeamWorks

Nearly a decade ago the Institute of Medicine set forth six aims for a new 21st century health care system which would mitigate its observed quality concerns. The recommended changes to the system had six aims. The new system would be patient-centered, efficient, equitable, effective, safe, and timely. In its landmark report, Crossing the Quality Chasm: A New Health System for the 21st Century, the Institute of Medicine proposed 10 Simple Rules for this new system which would support the achievement of these aims (see Figure 1).

Figure 1. Quality Chasm 10 Simple Rules1

- Care is based on continuous, healing relationships—not a visit as a unit of service.
- Customization, and therefore variation, is based on patient needs and values—not unpredictable systems.
- The patient is the source of control.
- Knowledge and information is free flow and shared between patient, provider and system.
- Care demonstrates evidence-based decision-making.
- Safety is a system property and not entirely dependent on human vigilance.
- Transparency in making information available to patients and families helps with informed decision-making, including choosing certain services based on publicized quality measures.
- The practice and system is structured to anticipate patient and family needs.
- The practice continuously decreases waste.
- Cooperation among clinicians for the purposes of coordination of care is a priority.

Since the publication of the report, progress toward making these types of changes has been slow but persistent. The introduction of the Patient-Centered Medical Home approach to care has served as a catalyst and venue for these ten rules to be implemented. Across the United States, all but two states are currently participating in Medical Home demonstration pilots. Recently, in February 2010, the Federal government awarded ARRA funding to 20 states in the first round of funding, through a competitive process, to support the formation of state level Regional Extension Centers which would assist a state’s priority providers in selecting, implementing and maximally using an electronic health record, ultimately to support the state’s (and eventually nation’s) achievement of Health Information Exchange. Colorado, with CORHIO as the lead agency, was named as one of these states. Seven additional partners make up the Colorado REC (http://www.corhio.org/REC/Partners.html ).

Successful achievement of “meaningful use” of health information technology as well as being able to actively participate in Health Information Exchange substantially moves the system forward toward being a system which is characterized by the “free flow of information” between provider, health care system and patient; also a system exhibiting supports for “evidence-based decision-making”, “safety” which is built into the system, “transparency” which allows for continual improvement and knowledgeable selection of services based on quality and value, ongoing elimination of “waste”, and maximal cooperation among clinicians, both within the practice setting and across the health system. As an incentive for providers to adopt the use of an electronic medical record and accomplish “meaningful use” of the resource the Federal government is offering bonus funding through either the Medicare or Medicaid programs during the years 2011 through 2015. By 2016, penalties will be exercised in instances where providers and hospitals are not able to demonstrate this accomplishment.

The current Meaningful Use Rule details 25 criteria pending Department of Health and Human Services finalization (See Figure 2). Based on the current criteria, “Meaningful Use” very closely aligns with IT requirements for patient-centered medical home transformation. Twenty-one of the twenty-five criteria directly support NCQA’s 2008 PPC-PCMH Recognition Program requirements.

NCQA recently released its Draft Standards for the 2011 version of the PPC-PCMH Recognition Program. Achievement of alignment with Meaningful Use, as currently understood, is described by the organization as being an important priority along with several other aims for this upcoming version.

“With this version NCQA is seeking to:

- Enhance patient-centeredness and the use of patient experience survey results
- Strengthen alignment of the requirements with processes demonstrated to improve quality and eliminate waste
- Have practices use clinical performance measurement and results to demonstrate improvement
The Federal government has taken a step out in front to reward practice changes which align with a vision for patient-centeredness, safety, transparency, free flow of information, evidence-based decision-making, and continual demonstrations of quality and elimination of waste. The momentum behind progress in system level transformation continues to build.


Figure 2. Current Meaningful Use Rule Criteria

<table>
<thead>
<tr>
<th>Computerized provider order entry</th>
<th>Drug-drug, drug-allergy, drug-formulary checks</th>
<th>Maintenance of an UTD problem list</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generation of electronic prescriptions</td>
<td>Maintenance of an active medication list</td>
<td>Maintenance of active medication allergy list</td>
</tr>
<tr>
<td>Recording of specified demographics</td>
<td>Recording of specified changes in vital signs</td>
<td>Recording of smoking status in teens and adults</td>
</tr>
<tr>
<td>Incorporation of lab test results in EHR as structured data</td>
<td>Generation of patient lists for quality improvement, outreach, and reduction of disparities</td>
<td>Sending of reminders to patients for preventive/follow-up care</td>
</tr>
<tr>
<td>Implementation of 5 decision support rules relevant to high clinical priority, including the ordering of diagnostic test and documenting tracking</td>
<td>Electronically checking insurance eligibility for both private and public payers</td>
<td>Electronic submission of private and public insurance claims</td>
</tr>
<tr>
<td>Provision of electronic copy of health information upon patient request</td>
<td>Provision of timely electronic access to patients’ own health information within 96 hours of information being available</td>
<td>Provision of clinical summaries to patient after each office visit</td>
</tr>
<tr>
<td>Capability to electronically exchange key clinical information among providers of care and others authorized by patient to receive</td>
<td>Performance of medication reconciliation at each transition of care and any other relevant opportunity</td>
<td>Provision of summary of care record for each transition of care and referral</td>
</tr>
<tr>
<td>Capability to electronically submit data to immunization registries</td>
<td>Capability to electronically provide surveillance data to public health departments</td>
<td>Protection of health information created by EHR</td>
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