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Contents

PCMH Defines What a Strong Practice Does ..... 4
Accountable Care Training Offered, Workforce Planning Addressed .................. 6
Bills Addressed Medicaid, CHP+, Reform Implementation, Other Issues .................. 9
Family Medicine Congressional Congress ................. 9
Colorado Physicians Create a Medical Neighborhood ........................................ 11
2011 CAFP ANNUAL SCIENTIFIC CONFERENCE SUPPORTERS .................. 12
Next Steps for Family Medicine: Advancing the Health of our Nation .................. 15
Introducing Jeffrey J. Cain MD, FAAFP, Candidate for AAFP President ............. 16
Family Medicine at a Tipping Point ........................................ 19
Students Give Thumbs-Up To Pilot PCMH Class ......................................... 20
Colorado Trailblazers ....................................................... 22
Heart Murmurs in Children ............................................... 24
Change Is Coming ....................................................... 25
Immunizations in Primary Care Setting ............................................... 26
Michael Wiggins, MD, Dead at 42 ........................................ 26
Exemplary Interactions Were Number One Lesson in Cheyenne Wells .............. 27
Medicaid Offers More Continuous Coverage and Care for Currently Uninsured in 2012 ...... 28
CAFP Member Special Discount Programs ........................................ 30

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.

CAFP Board of Directors

Officers 2010-2011

President Luke Casias, MD
Hesperus
E-mail: lcasias@hotmail.com

President-elect Kajsa Harris, MD
Pueblo
E-mail: kajaharris@hotmail.com

Vice President Robert Brockmann, MD
Englewood
E-mail: r.brockmann@yahoo.com

Secretary/Treasurer Ryan Flint, DO
Denver
E-mail: ryan.flint@accessfamilymed.com

Members At Large Rick Budensiek, DO, Greeley
Candace Murbach, DO, Pueblo

Chair/Past President Brian Bacak, MD
Highlands Ranch
E-mail: bacakbs@yahoo.com

Board Members

Terms expiring 2011

Anna Wegleitner, MD
E-mail: awegleitner@mountainviewfamilymedicine.com

Candace Murbach, DO
Pueblo
E-mail: candacem210@aol.com

Earl Carstensen, MD
Aurora
E-mail: hpractices@qwest.net

R. Scott Hammond, MD
Westminster
E-mail: shammad@evcohs.com

Terms expiring 2012

Tracy Hofeditz, MD
Westminster
E-mail: t.hofeditz@msn.com

Wilson Pace, MD
Aurora
E-mail: wilson.pace@ucdenver.edu

Rob Vogt, MD
Colorado Springs
E-mail: rpvmd@comcast.net

Terms expiring 2013

Michael Archer, MD
Westminster
E-mail: marcher@completefamilymed.com

Flora Brawntown
 Ft. Collins
E-mail: fbrewing@gmail.com

Rick Budensiek, DO
Greeley
E-mail: rbud9023@hotmail.com

Chet Cedars, MD
Lone Tree
E-mail: chetflies@aol.com

Delegates

Larry Kipe, MD, Craig
term expires 2012 (2nd term)
E-mail: info@moftapublishing.com

Kern Low, MD, Pueblo
term expires 2012 (2nd term)
E-mail: Kernlow@centura.org

Alternate Delegates

Kent Voorhees, MD, Littleton
term expires 2012 (2nd term)
E-mail: Kent.voorhees@uchsc.org

John Bender, MD, FAAFP,
Fort Collins
term expires 2012 (2nd term)
E-mail: jibender@mirmont.us

Resident Representatives

Monica Morris, DO,
Rose Family Medicine Residency
mcorrisg@gonzaga.edu

Jessica Tennant, MD,
Denver St. Joseph
jsquared07@msn.com

Student Representatives

Victoria Cummings,
vcummings@ucdenver.edu

Marcus Salmen,
marcus.salmen@ucdenver.edu

Communications and Information Technology Committee Chair

Kajsa Harris, MD,
kajaharris@hotmail.com

Education Committee Chairs

Flora Brawntown, MD,
Fort Collins
fbrewing@gmail.com

Michael Archer, MD,
marcher@completefamilymed.com

Mindy Miller,
mdmiller@brenan.net

Legislative Committee Chair

Mary Fairbanks, MD,
mfairbanks@gmail.com

Affinity Programs Task Force

Skip Carstensen, MD, Aurora
hractices@qwest.net

IPIP

Larry Kipe, MD, Craig
info@moftapublishing.com

PCMH Committee

Scott Hammond, MD, Westminster
shammad@evcohs.com

Workforce Task Force

Tracy Hofeditz, MD,
t.hofeditz@msn.com

Tort Reform Task Force

Bob Brockmann, MD,
r.brockmann@yahoo.com

Resident Relations Task Force

Ryan Flint, DO,
ryan.flint@accessfamilymed.com

Monica Morris, MD,
mcorrisg@gonzaga.edu

Tort Reform Task Force

Bob Brockmann, MD,
r.brockmann@yahoo.com

CAFP Delegate to CMS House of Delegates

Rich Glasser, MD,
geyer8@aol.com

Staff

Raquel Alexander, MA, CAE
Chief Executive Officer
E-mail: raquel@coloradoafp.org

Cara Coxe
Wellness Programs Manager
E-mail: cara@coloradoafp.org

Leah Kaufman
Immunization Champion
E-mail: leah@coloradoafp.org

Eleanor Mills
Administrative Assistant
E-mail: eleanor@coloradoafp.org

Angel Perez, BSN
PCMH Resource Advisor
E-mail: angel@coloradoafp.org

Jeff Thomodsgaard
Director of Public Policy
E-mail: jeff@mendezconsultinginc.com

Contact Information for the CAFP

Colorado Academy of Family Physicians
2224 S. Fraser St., Unit 1
Aurora, CO 80014
phone 303-696-6855 or 1-800-468-8615
fax 303-696-7224
e-mail info@coloradoafp.org

Created by Publishing Concepts, Inc.
Virginia Robertson, Publisher
vrobertson@pcipublishing.com
14109 Taylor Loop Road
Little Rock, AR 72223
501.221.9986

For advertising information contact:
Deborah Merritt at 501.221.9986 ext. 109 or
800.561.4686 dmerritt@pcipublishing.com
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In writing this last article of my active term as president, I reflect on the five years I have served on the board and all the challenges we have faced and are still facing as an academy. The active role the academy plays in the Colorado and national health movements is truly a reflection of the strength and diversity of our board and support staff. I have been amazed at the number of organizations and other chapters that look to us for direction and leadership. With that being said, I’m also amazed at the number of other health care and health delivery organizations that desire to promote their agendas and play active roles in shaping and delivery of care. We are not the only show in town when it comes to respected opinions regarding health care and patient safety. I do believe that our desire for advocacy is the least self-centered and promotes ideals and reform methods that are centered in the delivery of care that is in the patients’ and our country’s best interest. We are in the midst of a reform movement driven by the most powerful of motivators. The inefficiency and cost of our current health care system threatens the very future of our country. The perversion of the health care delivery system away from primary care and the forces that shaped it are many, and the path toward a correction of this corruption will not be easy, nor will it be free of risk for those of us practicing, teaching and desiring to enter into primary care.

Recently at the American Academy of Family Physicians Annual Leadership Forum we had a breakout session on the upcoming federal pilot for accountable care organizations that highlighted the risks, cost and projected benefits of this pilot. It was clear to me at the end of this breakout that the road ahead is still very uncertain. The best advice that I took away from this presentation was that, unless it is financially beneficial to you as a practice, it is best not to rush into any relationship or practice model at this time. The ACO movement will be a part of our future but in what form or model we do not know yet. Do not make foolish practice decisions or give up your autonomy and power out of fear. It is clear that the pendulum is swinging back in favor of primary care. The strongest indicator of this to me is the sudden movement of hospital systems in regions our state to acquire a section of the primary care market. The Colorado Academy of Family Physicians believes our role at this time is to educate the membership about the current models and requirements of both the federal ACO program and the state Medicaid pilot. We have had a webinar and will be having all-day training on the ACO movement.

Below is a recent discussion between a leader in ACOs and PCMHs and a member that I felt addresses the concerns and vision needed to find direction through these concerns.

The member said, “I am trying to stay positive about the transformation project, but am concerned about the costs of attaining NCQA (National Committee for Quality Assurance) recognition and continued costs of maintaining that. I am growing weary of pushback I am getting in my own system (Banner Medical Group) when I speak of the need for support of NCQA certification and development of the PCMH (Patient Centered Medical Home). I was dismayed by the rhetoric about the lack of data that the PCMH saves the system money in spite of the studies from the Geisinger model and others.”

The leader responded, “The best business model for PCMH is to link it with meaningful use since there is much overlap and not a lot of extra to get NCQA. PCMH ROI (return on investment) is robust with Group Health returning $1.50 for each $1 invested after two years. Doubters are way off base and not connected to reality and often do not have other solutions. Competition will abound as Kaiser adopted the model. Your competitors up north are looking into this model. I know. I gave them a presentation on the medical neighborhood. Another pilot reports savings. They just keep on rolling in:

“Capital District Physicians’ Health Plan is saving $32 per member, per month, at the three primary care practices that made up the first phase of its medical home pilot. The Albany, N.Y.-based health insurer is working with 21 other area practices for the second phase, and it will select the third phase practices be the end of May.

“North Carolina is rolling out its Patient Centered Medical Home Model. The idea is starting within Medicaid; state Medicaid officials project a savings of more than $400 million this year through the initiative.”

The member said the lack of support for PCMHs by managed care organizations outside of the pilot project sends a message.

The leader responded, “Health plans in the East are paying for the model. Every month more plans are expanding.

“For example, Health Plan of Michigan, the largest of the 14 Medicaid health maintenance organizations in the state with more than 285,000 members, will start a medical home financial incentive program for its 3,300 primary care physicians on July 1. The health plan projects spending of about $15 million on the incentive program during the first year for an estimated 1,000 participating physicians.

“UMC Health Plan is moving ahead with the medical home model. Within a year, approximately 200,000 plan members will be part of a medical home, up from roughly 23,000 patients.

“Hawaii Gov. Neil Abercrombie announced Hawaii will provide medical homes for the state’s 270,000 Medicaid recipients.

“Parkland, Texas, and Health and Hospital System’s 11 Community Oriented Primary Care health centers received the Physician Practice Connections-Patient Centered Medical Home designation from NCQA.”

The member said, other than IBM, employer groups are hesitant to embrace the PCMH.

The leader responded, “Cigna plans to roll out a PCMH product to offer employers and Kaiser offers it to employers now. The president of the National Business Group on Health at the national Medical Home Summit last March called for employers
to reconsider the value of the products they are buying and support the PCMH.

The member said, “I am concerned that without financial support from payers ACOs will be another cost that struggling primary care practices can ill afford. The proposed cost of $1.2 million start-up costs for an ACO is a bit overwhelming. Talk about downside risk, the $1.2 million start-up costs are a significant risk, even if the government doesn’t ask us to risk more capital.”

The leader replied, “I am not a big fan of ACO partly due to the complexity and lack of patient and employer incentive. Government requirements did not make matters better. Organizations like Geisinger may experiment with the model. If they are successful others will follow, but I agree large-scale adoption is unlikely up front. ACOs are unproven. Hospital-led ACOs will fail. An ACO will not survive without a PCMH base.

The member asked, “How do you stop a train on a dime and turn it around the way the ACO guidelines suggest. Meeting all the parameters seems onerous. Most of us haven’t been working on reform for the last 10 to 12 years, as most of the present start-up ACOs seem to have. What hope do we have?

The leader answered, “The old system will not support an ACO transformation. ACO is just an organization. You need the transformation to be at the practice level, hence the PCMH. It is a long process and the first step is to build the foundation, which is PCMH, and then the infrastructure, which is the medical neighborhood. This alone could bend the cost curve. I believe we are being distracted by ACOs. We need to get PCMH on a firm footing first.”

I share the belief that the PCMH is the only viable platform for sustainable reform. We will continue to educate membership regarding the changing of the ACO movement in the months that follow. Please send in questions and comments and attend upcoming educational sessions.

We are in the midst of restructuring of Family Practice to assure its viability through the upcoming years of health care reform. If we remain truthful to ourselves and learn from mistakes that led to financial improprieties that hindered our specialty, we should be able to do more than just weather this storm. Nothing will be given to us for past deeds, and several other entities that are competing for our status, finances and patients.

One of our PCMH leaders expressed the outlook of our profession best, saying, “We are in the midst of a transformation of Family Practice similar to 1968 into the 1970s ... Some practices will not be willing to change and thus will not survive, but if we desire for the future of American medicine to be reflective of our value and have the level of care we believe in, we must change, adapt and fight for the type of reform that ensures not only our existence but allows us to thrive.”

I feel that we are starting on a road to reform that can lead to either our demise or our enhancement and growth, depending on whom we let drive. Seven years ago, when I joined the CAFP, we were not even having a discussion of our destiny and we feared for the survival of our profession. We still have to be fearful, but at least the PCMH has served to define what a strong practice does. As we work with others who share our vision of health care reform, the PCMH can serve as the vehicle we drive towards strong medicine. This works only if you as members take the next step and join us on the board and help shape the future of the CAFP and the rest of the country.
Accountable Care Training Offered, Workforce Planning Addressed

The Colorado Academy of Family Physicians continues to be the bold champion for Colorado’s Family Physicians, patients and communities through some very important projects. Please read on for details.

**Accountable Care Organizations**

ACOs are here. The Colorado Medicaid program has initiated a pilot using Regional Care Collaborative Organizations or RCCOs. It is modeled after some successful ACOs in the country to improve quality and decrease costs. The CAFP board of directors is very interested in empowering our Family Physicians to become leaders in the ACO movement. To learn more please attend our all-day training on ACOs by a national expert. Please contact Eleanor Mills at Eleanor@coloradoafp.org or 303-696-6655, ext. 17.

- All-day training July 30, 2011, 9:00 a.m. – 4:00 p.m. for CAFP members. To be held at the Colorado Medical Society.

What is an ACO?

- A provider-based organization
- That takes responsibility for health care needs of a defined population
- With goals of improving health, improving efficiency and improving patient satisfaction;
- That should include primary care physicians
- And produces shared savings or other financial measures to align incentives.

For more information please see the document on the CAFP web site, www.coloradoafp.org. Click on Patient Centered Medical Home, and then click on The Family Physicians ACO Blueprint for Success in the ACO section.

**Jeff Cain, MD, Candidate for AAFP President-Elect**

The Colorado Academy of Family Physicians (CAFP) Board of Directors proudly announces the candidacy of Jeffrey J. Cain, MD, for President-Elect of the American Academy of Family Physicians. The CAFP leaders stand behind Dr. Cain as a person who can “move policy into action to make a difference in the world.” Dr. Cain has a long, proven track record of creating change in the community and in policy both at the state and national level. He has served the Colorado Academy of Family Physician in many capacities, including president and Delegate to the AAFP Congress of Delegates. He now serves on the AAFP Board of Directors. Advocate, collaborator, visionary. Jeff Cain is the candidate for the AAFP President-elect.

The election will take place at the AAFP’s Congress of Delegates on Wed. Sept. 14, 2011 in Orlando, Florida. He is a champion for the Patient Centered Medical Home. He has been able to establish and maintain relationships with key people in Colorado because of his vision, leadership, and extraordinary advocacy skills. If there is an important issue in Colorado, Dr. Cain has been at the table advocating for Family Physicians and their patients. People love his wit, humor, and friendly style. He would make a great leader and spokesperson for the AAFP.

**Colorado Workforce Planning Grant**

Leaders of the CAFP met with the Colorado Department of Public Health and Environment to give input into a new grant aimed at planning the health care workforce in Colorado. In a letter to Sue Birch, the new executive director of Health Care Policy and Financing, Bob Brockmann, MD, CAFP president-elect, states:

“The three maps (as shown below) are meant to show the positive contribution family physicians make in helping to alleviate the shortages of health professionals in underserved areas. “The first map, ‘Colorado HPSA Designations Before Removing FP’s’ shows the current situation, where underserved areas are color coded to indicate the degree of shortage. Comparing this one to the second map, ‘Colorado HPSA Designations After Removing FP’s’ shows how many more areas would be underserved if FP practices were subtracted from the map. It assumes all the other primary care providers (IM’s, peds, NP’s, PAs, dental health, mental health) remain in place. In this doomsday scenario, 58 of Colorado’s 64 counties would have a serious need for primary health care providers. (HHS defines an HPSA as an area having a shortage of primary medical care, dental or mental health services). By comparing the two maps, it is clear that not only are family physicians already supporting the majority of primary care needs across Colorado, but also how dependent many communities are on FP’s to provide healthcare, and unfortunately, how tenuous the primary care network is.

“What’s most concerning are the employment trends in family medicine. As you know, Colorado’s population grows at about 2% per year. In the last two years, the number of actively practicing FP’s has grown just 0.7% and 0.8% per year. The Dept. of Labor and Employment generously estimates an average FP growth rate of 1%, but even so it is apparent the FP supply will soon fall far behind the demand.

“On the bright side, the third map, the ‘dot map’, shows the current distribution of FP practices in Colorado. It shows FP’s distributed throughout every corner of the state. A study from
the Graham Center, soon to be released, shows that family medicine is the only health profession that distributes more or less evenly with population density, that is, there are about 30 FP’s per 100,000 population regardless of the location, whether frontier, rural, suburban, or urban. This is in part due to the unique training FP’s have; no other health professional offers the broad spectrum of healthcare services, be it emergency care, hospital care, obstetrics, trauma, geriatrics, pediatrics, preventive care, that allows an FP to independently fulfill most of a community’s needs.

“CAFP is immersed in seeking solutions to the primary care issues facing Colorado, and we believe that well structured, highly functioning patient centered medical homes are an integral part of the solution.”

“We also believe a solid family physician workforce is the foundation of any successful health care system reform.”

**CAFP Pediatric Obesity Grant**

Kudos to the excellent hard-working team for completing the research phase of the pediatric obesity grant. Sixteen practices have

*continued on the next page*
now joined the pilot, which will officially begin July 1.

**CAFP Annual Scientific Conference**

The CAFP’s Annual Scientific Conference was a great success with more than 120 attendees, 40 exhibitors and 30 excellent speakers. The attendees have asked that we continue to hold the conference at the Cheyenne Mountain Resort because of its excellent conference space, superb dining room and food, great staff, and location. We have contracted with the Cheyenne Mountain Resort for the next three years.

The CAFP conference will be held in April of each year.

**Future dates of the CAFP Annual Scientific Conference:**
- 2012 Thursday April 19 - Sunday April 22
- 2013 Thursday April 17 - Sunday April 20
- 2014 Thursday April 18 - Sunday April 21

**Congratulations to Sophia Hayes from Sopris Elementary for her winning Tar Wars poster.**

**Increasing Student Membership**

The CAFP is collaborating with the Department of Family Medicine at the University of Colorado to increase medical student membership in the CAFP and American Academy of Family Physicians. You can help us by volunteering to be a preceptor to a medical student, inviting a medical student to accompany you as Doctor of the Day at the Capitol, or volunteering to mentor a medical student.

**CAFP Strategic Plan**

The American Society of Association Executives believes that associations have the power to transform society for the better. Our two main areas of focus are the Patient Centered Medical Home and advocacy. If you would like to see a copy of our revised strategic plan please contact me at Raquel@coloradoafp.org, or 303-696-6655, ext. 10. Thank you.

**Please volunteer**

You are invited to join one of three CAFP committees: Education, Legislative and Patient Centered Medical Home committees. For information on any of these please contact Raquel@coloradoafp.org.
Wednesday May 11 marked the end of the 2011 Colorado Legislative session. This year’s session proved to be a much more interesting than those of the previous few years because of the political makeup at the Capitol. The academy and the health care community in general had many notable victories. The following is a compilation of bills that will directly or indirectly impact Family Physicians and their practices.

**Medicaid and Child Health Plan (CHP+) Policy Changes**

The 2011 legislative session included several bills affecting Medicaid and the Child Health Plan Plus as follows:

- **SB 8** eliminates the Medicaid “stair step” eligibility, by moving from CHP+ to Medicaid children ages 7-18 between 100 and 133 percent of the federal poverty level. Not only is this expected to save the state significant funds, it assures that families with children of different ages have one insurance program, one set of benefits and one provider network. It also assures that children do not have to switch from one insurance program to another on their seventh birthday. Due to a new federal law reauthorizing CHP+, it is now possible to do this and still continue to get the two-to-one CHP+ federal match for these kids.

- **SB 250** moved from CHP+ to Medicaid pregnant women between 134 percent and 185 percent of FPL. The federal government made this a requirement in order for the state to receive the federal match for a newly expanded population of pregnant women in CHP+, those between 205 percent and 250 percent of FPL.

- **SB 213** adds monthly premiums for CHP+ of $20 for the first child and $10 for each subsequent child up to $50 per month for a family. This premium applies only to those families between 205 percent and 250 percent of FPL, a new expansion population under the Colorado Affordable Care Act. Several child health groups are asking the governor to veto this bill, as it presents a barrier to access to health insurance and is expected to result in a 20 percent to 30 percent decrease in CHP+ enrollment.

- **HB 1242** requires the Department of Health Care Policy and Financing to review and submit a report on the integration of mental and physical health for Medicaid, through such measures as reducing barriers to same-day billing for mental and physical health visits.

- **HB 1025** proposed to repeal the hospital provider fee that was enacted in 2009. This was postponed indefinitely with a large coalition working against it.

- **HB 1149** proposed to have individuals applying for public benefits show a social security card. This part of the bill was amended out and this bill was considered lost in the House.

- **HB 1285**, sponsored by House Majority Leader Amy Stephens (R-El Paso County) and Sen. Betzy Boyd (D- Jefferson County), removed a ban for the Department of Health Care Policy and Finacing to allow managed care for long-term care. There were significant concerns from many groups because of recent studies in New Mexico showing increases in overall costs associated with hiring a managed care company. The bill was changed in the House to be a study and was ultimately killed in the Senate Health and Human Services Committee.

- **SB 205**, which was postponed indefinitely, proposed a process for advanced practice nurses to be considered for private health insurance panels, requiring insurance companies to communicate in a timely manner and provide reasons for denials. This bill would have created an unfair advantage to APNs in adding extra protections that other providers do not enjoy. It is CAFP’s intention to meet with the APN community to discuss this issue over the summer. The CAFP looks forward to working with the nursing community to solve this problem.

**Health Insurance Coverage**

Several bills were related to private health insurance reform including:

- **SB 19** allows employers with small numbers of personnel to reimburse employees for health insurance premiums if the employer does not have and has not had a small group plan for its employees in the last 12 months.

- A number of bills introduced related to the implementation of national health care reform. As a result of the provision that no carrier can deny a child for pre-existing conditions, many health insurance companies stopped offering “child only” plans. **SB 128** requires insurance companies to offer “child only” policies as a condition of participation in the individual market. The bill creates two open enrollment periods and rules for such policies to create an even playing field. The All Kids Covered Initiative and the Colorado Association of Health Plans worked together to bring this bill forward.

The legislature proposed three different bills to address health care exchanges. Only...
DENVER — Tuesday, May 31, 2011 — Gov. John Hickenlooper today vetoed SB 213 because the bill poses adverse consequences on children’s access to health insurance through the CHP+ program.

“Expecting low-income families in Colorado to contribute when it comes to providing for, and placing a priority upon, their health care, makes sense,” Hickenlooper wrote in a letter to the General Assembly. “What is troubling about this legislation, however, is not the policy intent, but the practical, and negative impact, it will have on children in low-income families.”

Hickenlooper pledged to work with the Joint Budget Committee and the General Assembly to develop a better approach to changes in the Child Health Plan Plus program.

He said the Department of Health Care Policy and Financing will increase the annual enrollment fee through their regular, rule-making process and conduct a comprehensive analysis of cost-sharing in the program. The Department will evaluate changes in the program this summer and fall and deliver recommendations to the Joint Budget Committee on or before Nov. 1, 2011.

“The focus will be to implement a change that is minimally disruptive, administratively efficient, effective and elegant, and supports the goal of ensuring that kids have access to coverage,” Hickenlooper wrote in the letter.

Numerous community groups, health organizations and individuals have urged Hickenlooper in recent weeks to veto SB 213. Those groups and organizations include: The Children’s Hospital; Colorado Children’s Campaign; Colorado Medical Society; Denver Health Medical Center; Health District of Northern Larimer County; Kaiser; Mental Health America of Colorado; Pathways Past Poverty; Rocky Mountain Health Plan; Women’s Lobby of Colorado; United Way of Larimer County; All Kids Covered; Colorado Academy of Family Physicians; Colorado Community Health Network; and Junior League of Denver.

Here is the letter Hickenlooper delivered to the General Assembly today:

The Honorable Colorado Senate
Sixty-Eighth General Assembly
State Capitol Building
Denver, Colorado 80203

Ladies and Gentlemen:

This is to inform you that I am vetoing Senate Bill 11-213 Concerning Enrollee Cost-Sharing for Children Enrolled in the Children’s Basic Health Plan, and Making an Appropriation Therefor.

We respect the General Assembly’s intention to reduce the budget impact of increasing Child Health Plan Plus (CHP+) costs and the goal of encouraging personal responsibility by CHP+ recipients for a reasonable share of these costs. Expecting low-income families in Colorado to contribute when it comes to providing for, and placing a priority upon, their health care, makes sense. What is troubling about this legislation, however, is not the policy intent, but the practical, and negative impact, it will have on children in low-income families.

While the legislation was not intended to put children at risk, we have determined that the bill poses adverse consequences on children’s access to health insurance through the CHP+ program. Further evaluation of the program is necessary and underway in our administration. The Department of Health Care Policy and Financing will be conducting an analysis of cost-sharing and evaluating possible changes this summer and fall. As a result of that work, there will be changes in the annual enrollment fee and potentially other cost-sharing measures. The focus will be to implement a change that is minimally disruptive, administratively efficient, effective and elegant, and supports the goal of ensuring that kids have access to coverage.

Because the expected timeline of SB11-213 would have been sometime in 2012, the process we will follow will implement a cost-sharing structure on a similar or earlier timeline. The Department will share these proposals to the JBC for approval on or before November 1 as required in C.R.S. 25.5-8-107(b).

The fees required by SB11-213 represent a 1000% increase in the cost of the current CHP+ program to enrollees in the 205% of federal poverty level (FPL) to 250% FPL income bracket. The Department of Health Care Policy and Financing (the Department) modeled potential impacts of the bill and estimates that approximately 20% of the children currently enrolled in the CHP+ program, or 2,500 kids, would drop off the program because of the dramatic increase in cost.

Research from across the country and in Colorado indicates that if children drop off the CHP+ program, they would likely become uninsured. Increasing the number of uninsured children in the state will result in a rise in uncompensated costs in the health care system thereby increasing cost shifting to those with insurance. At a time when employers large and small are struggling to continue to provide health insurance to workers, it doesn’t make sense to heap additional costs on the health care system in the form of uncompensated care.

We appreciate the work of the General Assembly and understand that the intention of legislators was to make sure that we are appropriately utilizing scarce state resources in these challenging economic times. We share these goals and will work with the General Assembly to develop policies that bend the cost curve, improve efficiencies and protect children. Put bluntly, we believe the cost savings to taxpayers contemplated in SB11-213 are outweighed by the unintended costs of children going without access to affordable care and ending up instead, in emergency clinics.

Instead of allowing SB 11-213 to become law, we would rather work with the Joint Budget Committee and the General Assembly to develop a better approach.

Sincerely,
John Hickenlooper
The Patient Centered Medical Home movement continues to gain momentum. The National Committee for Quality Assurance has recognized more than 9000 physicians and is receiving 100 recognition applications monthly. There are now 485 recognized practices and physicians in Colorado that represent more than 15 percent of the Family Physicians in the State. Fourteen major pilots have demonstrated positive outcomes in improved quality and cost reduction. In a few states, health plans have extended payment to all PCMH recognized practices.

Yet, the PCMH model faces significant unaddressed challenges. One of the seven joint principles of the PCMH is to coordinate care across all elements of the complex health care system. The typical primary care doctor, however, interacts with an average network of 229 other physicians from 117 practices. This presents several barriers to the successful implementation of the PCMH and threatens the clinical and economic advantages of the model. Effective care coordination requires the willingness of specialists and other medical providers to participate in shared decision-making. In 2008, Elliot Fisher, MD, MPH, called for a medical neighborhood to address these concerns. The medical neighborhood should define accountability among providers, align incentives to encourage collaboration and include measures to evaluate the patients’ experience with care.

In 2009, the Systems of Care-PCMH Initiative was funded to build relationships between primary care providers and specialists regarding care coordination. A poll of all Colorado physicians showed that only one-third of PCPs and specialists received the information they needed from a referral. This data mirrored a recent study revealing a misperception of successful bi-directional communication among physicians. The initiative kept abreast of the developmental work being done by the American College of Physicians in order to develop a compact, create a process to define relationships and provide practical tools for implementation that could be generalized across diverse populations.

**PLANNING AND IMPLEMENTATION**

The medical neighborhood project was started at a pilot site in Westminster, a suburb northwest of Denver. A job description and care coordination protocol was developed for both external care coordination (to define mutual responsibilities with specialists and hospitals) and internal care coordination (to identify high-risk patients for case management). The protocol outlined the necessary duties, responsibilities and policies while taking into consideration the available resources of a small primary care practice. The policy and protocol satisfied NCQA 2008 Standard 3E - Care Coordination criteria. Comprising a list of specialists that encompassed most referrals, and inviting them into the neighborhood via a personalized letter or phone call started the process. More than two-thirds of the specialists contacted responded with interest. Follow-up material was sent to them that included an action plan that outlined the “Six Steps to Become a Medical Neighbor.”

Dialogue that was centered on the compact or agreement quickly identified common ground and shared practice values. The compact provided physicians with a foundation that improved bi-
2011 CAFP ANNUAL SCIENTIFIC CONFERENCE SUPPORTERS

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Awards Dinner at the Annual Scientific Conference.

Advanced Medical Imaging won the CAFP’s Best Exhibit.

SAM Course at CAFP’s Annual Scientific Conference.

Dr. Lowther accepted the PCMH Best Practice of the Year award for Miramont Family Medicine.

Drs. Budensiek and Hofeditz tied for first place at the ASC 5k run.

Jeff Cain, MD, AAFP board member, updates the attendees.

Scott Hammond, MD, accepted the Family Physician of the Year Award.

Exhibit Hall at the Annual Scientific Conference

Kajsa Harris, MD, was installed as the new CAFP president with past presidents standing with her in support.

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

**Incentive payments will include:**

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

Get started early! To maximize your Medicare EHR incentive payment you need to begin participating in 2011 or 2012; Medicaid EHR incentive payments are also highest in the first year of participation.

**Registration for the EHR Incentive Programs is open now, so register TODAY to receive your maximum incentive.**

For more information and to register, visit:

www.cms.gov/EHRIncentivePrograms/

For additional resources and support in adopting certified EHR technology, visit the Office of the National Coordinator for Health Information Technology (ONC):

www.HealthIT.gov
directional communication and outlined the core elements of the medical record essential for safe and effective transfer of care. A toolkit was developed that included all the forms, checklists, surveys, documents and policies needed to form a neighborhood.

EVALUATION AND SUSTAINABILITY

Regular audits of adherence to the compact encouraged accountability and improved performance. Monthly emails maintained the neighborhood viability and spread quality improvement performance tips.

Over a year, the neighborhood grew to 16 practices and more than 40 specialists. Patient satisfaction surveys reflected high marks. Communication has improved and PCP-specialist teamwork is building. The model sets the stage for enhanced collaboration that will be a necessity as reform marches toward accountable care organizations and other forms of integrated care. Additional information, as well as the free facilitation guide, compact and toolkit are available by contacting karen_frederick-gallegos@cms.org or angel@coloradoafp.org.

University of Colorado Denver and Health Sciences Center

Department of Family Medicine—HSC
Assistant Professor, Faculty
Rose Family Medicine Residency
Job Posting # 809100
Position # 610234

The Department of Family Medicine at the University of Colorado Denver Health Sciences Center is seeking a full-time ABFM-certified or eligible family physician for our community-based program. The Rose Residency is located at Rose Medical Center, ranked nationally as a top 100 hospital, and is supported by the Colorado Health Foundation, a non-profit organization dedicated to making Colorado the healthiest state in the nation. Applicants must possess or be eligible for medical licensure in the State of Colorado. Applicants must demonstrate experience and competence in teaching and patient care. This is a full-time position with obstetric duties and hospital call required. Women and minorities encouraged to apply. Detailed job descriptions and qualifications required can be found on jobatcu.com and the Department’s website, http://family.ucdenver.edu/rose/careers.aspx.

Job Responsibilities: Applicant will be a core member of the Residency Teaching Faculty: Teaches residents, supervises residents and students in the provision of patient care, provides direct patient care in the inpatient and outpatient setting, participates in scholarly activity; serves as a leader and role model for residents.

Required Qualifications: MD/DO degree, Colorado Medical License, DEA Certificate, Board Certified/Board eligible in Family Medicine. Practices full spectrum of Family Medicine, including Obstetrics and inpatient medicine. 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.

Preferred Qualifications: Experience in family medicine teaching/practice preferred. 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/benefits.

Applications are accepted electronically at www.jobsatcu.com. Review of applications will begin February 16, 2010 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.

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.

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I love being a Family Medicine Physician with CPMG because...

Donna Baldwin, D.O.

- We help to decide what is on the formulary and what tests should be ordered using a strong evidence-based approach to practicing medicine. Family Medicine Physicians make the decisions on how we care for our members at every level.
- We are encouraged and supported in using our unique broad-based family oriented skills.
- Our Health Plan Partners are not-for-profit. I am proud to be a part of a group that commits to bettering the health of our members within our communities.
- My career and leadership development are valued, as we are offered medical group-run CMEs and physician-based quality and service committees.
- We have a primary care core with rich support and built-in quality tools and registries to work to prevent illness.
- I have the ability to care for patients through e-mail, telephone visits, group visits, chronic disease care managers and clinical pharmacists.
- I don’t have any call or practice OB. I focus on providing excellent outpatient, preventive, continuity medicine for my patients. And after all, it is the Rocky Mountains, so I find plenty to do with my spare time.
- I can’t see myself making such a difference anywhere else.

OPPORTUNITIES IN DENVER/BOULDER AND BRIGHTON, COLORADO

The Colorado Permanente Medical Group recognizes and values Family Physicians as a key cornerstone in our healthcare delivery model. If you are interested in learning more about our full-time and part-time opportunities, we invite you to contact Dr. Donna Baldwin, Family Medicine Physician, at 303-699-3764 or donna.m.baldwin@kp.org. To apply, please contact Chantal Papez, Physician Recruiter at 866-239-1677 or forward your CV to chantal.papez@kp.org. EOE/M/F/V

http://physiciancareers.kp.org/co

Colorado Permanente Medical Group P.C.
Dr. Cain compares today’s iPhones and BlackBerries to the black bags that held the tools of the profession of the Family Physician of the past. Outcome-based medical information and even electronic medical records can now be accessed right from a smart phone. Yet with all of today’s advances in technology, the most important value remains the relationship between the doctor and patient.

Jeffrey J. Cain, MD, FFAFP, pledges to lead continuing efforts in the area of advancing family medicine if he is chosen president-elect of the American Academy of Family Physicians. While one of Dr. Cain’s goals as an AAFP board member has been implementation of the medical home, he has been committed to broadening this goal with a larger vision.

“It’s been an exciting time to be on the AAFP board as we have wrestled with national issues and health care reform,” he says, adding that the landscape is changing. “It’s important to know we’re now moving from a legislative phase to the equally important regulatory phase. It’s time to translate law into practice, which may be a quieter phase for members, but requires a very active role for the AAFP’s legislative team.”

The AAFP lobbies for priorities set by the Congress of Delegates:
- Access for all Americans
- Increased reimbursement for primary care
- Improvements in graduate medical education
- More effective insurance for patients
- Tort reform

“Some of our goals were improved with last year’s Affordable Care Act; some weren’t,” he says. “I believe there are many aspects in current reform policy that are good for primary care and Family Medicine – but it’s not enough.”

The fact that the AAFP has been involved in the health care reform process, he explains, has meant a 10 percent bonus for primary care physicians and the inclusion of Title 7 educational funding with increased funding for some residency programs. While some advances have been made in the areas of reimbursement, graduate medical education and Patient Centered Medical Home pilots, changes are still needed in the areas of improving the health care system and tort reform.

In pursuing health care reform, Dr. Cain describes, “The role of the AAFP is not to advocate for either political party, but for our patients and our practices. It’s important that Family Medicine remains at the table, whoever is in charge.”

With over 25 years of full-spectrum experience, Dr. Cain practices at the A.F. Williams Family Medicine Center in Denver and serves as Chief of Family Medicine at The Children’s Hospital.
Introducing Jeffrey J. Cain MD, FAAFP, Candidate for AAFP President-Elect
Tar Wars Co-Creator Ready to Lead AAFP into the Future

Jeffrey J. Cain, MD, FAAFP, a candidate for president–elect of the American Academy of Family Physicians, has demonstrated transformational skills in several arenas, including the following.

• He was a co-creator and national president of Tar Wars, which is now an international AAFP program.
• As a member of the board governing Medicaid in Colorado, he was instrumental in the passage and implementation of legislation defining the medical home.
• A double below-knee amputee, he led successful national and multi-state efforts to require insurance coverage for prosthetic arms and legs.
• During more than 25 years of clinical practice, he has cared for thousands of patients and delivered almost 1,000 babies.

Dr. Cain grew up in the small town of Sherwood, Oregon, before earning his Doctor of Medicine degree at Oregon Health Science University in Portland. He moved to Denver for residency at the Mercy Family Medicine Residency Program, where he served as chief resident. He later participated in the Primary Care Faculty Development Program at Michigan State University.

In 1988, Dr. Cain and Glenna Pember, PA, created the Tar Wars youth tobacco-free education program that has grown from a local Denver activity into an international campaign. Through the program, Family Physicians have reached more than 8.5 million children in all 50 states and in 14 countries. For his work with Tar Wars, Dr. Cain received the AAFP Public Health Award and was recognized by the World Health Organization.

Dr. Cain has served as president and ongoing board member of Colorado’s 11-member Medical Services Board, which oversees Colorado’s Medicaid and Child Health Plan Plus program. On this board, which is under the Department of Health Care Policy and Financing, he was instrumental in the passage and implementation of state legislation defining the medical home and in improving access to care. In Colorado, the new legislative definition of the medical home includes the principles established by the AAFP, and the number of children with a medical home has increased.

As a member of the board of directors of the CAFP and of the Colorado Children’s Immunization Campaign, Dr. Cain collaborated with members of both organizations to achieve the passage in 2007 of legislation that builds, in three ways, on Colorado’s existing voluntary immunization information system. It expanded the statewide registry to track patients who are 18 and older, as well as younger people. It added newborn screening to the registry. And, it provided a directive for the Colorado Department of Public Health and Environment to explore more effective methods of increasing access to and delivery of immunizations throughout the state. The CAFP received an AAFP...
Legislative Award for its work on the bill.

In clinical practice since 1988, Dr. Cain has delivered close to 1,000 babies and he continues to see patients at the A.F. Williams Family Medicine Center in Denver. As Chief of Family Medicine at The Children's Hospital of Denver, he creates and promotes an environment that reflects Family Medicine’s essential role in providing primary care for approximately half of the children of Colorado. He is also an associate professor in the Department of Family Medicine at the University of Colorado Health Sciences Center and has been active nationally and internationally as a speaker, addressing national media and teaching in various settings.

Dr. Cain’s service with the AAFP is substantial and noteworthy on both state and national levels. While serving as a member of the board of directors of the AAFP and the AAFP Foundation, his understanding of the mission and vision of the academy has expanded through experience with the AAFP commissions on Governmental Advocacy, Continuing Professional Development, Member and Membership Service, and Education.

Dr. Cain has also been instrumental in a national campaign for insurance reform. After a 1996 airplane accident, he walks with bilateral below-the-knee prosthetic legs. While he was fortunate to be able to purchase his prosthetics himself, he was surprised to find that insurance companies generally did not cover them.

To change the situation, he founded and led an organization in Colorado that successfully passed the nation’s first law requiring insurance coverage for artificial arms and legs. With this success, he joined the board of directors of the Amputee Coalition of America, or ACA, where he has provided vision and leadership to the organization, establishing the ACA’s Advocacy Committee and...
spearheading the national Prosthetic Insurance Fairness campaign. Due largely to the group’s advocacy, 19 states have passed laws similar to Colorado’s and bipartisan federal legislation has been introduced. An additional 24 states are organizing to introduce similar legislation in 2011.

“These experiences have prepared me to lead the AAFP in advocating for Family Medicine’s issues in the national arena.”

Dr. Cain also has supported fitness within the amputee community by teaching adaptive sports both nationally and internationally and introducing a new adaptive device, the ski bike, to resorts in North America. He continues flying as an active pilot with the Antique Airplane Association and has enjoyed introducing more than 500 children to the sky through their first flight in an open-cockpit biplane.

Dr. Cain’s top-rated speaking presentations have focused on youth tobacco prevention, health care reform and adaptive athletics.

Today, in the richest country on earth, we have 50 million Americans without health insurance. It is a moral travesty that every American does not have access to a Family Physician or other primary care physician. As an Academy we need to re-commit to the principles of health care for all.
Jeffrey J. Cain, MD, FAAFP, a former president of the Colorado Academy of Family Physicians and current Chief of Family Medicine at The Children's Hospital of Denver, is a candidate for president-elect of the American Academy of Family Physicians.

“Family Medicine is at a tipping point,” Cain says. “As a nation, we are at a critical stage in the evolution of health care. Family Physicians have a historic opportunity to contribute to transformations in health care delivery that will improve the lives and longevity of future generations, while re-energizing the profession at the same time.”

If elected, Dr. Cain will focus on three related goals:

• Making sure reimbursement rates reflect the value of Family Physicians’ services.
• Increasing the number and proportion of new doctors choosing to go into primary care.
• Making certain every American has the insurance resources to be able to access a Patient Centered Medical Home.

At times, AAFP members have questioned whether the academy is a mission-based organization with a focus on the health of the country or more of a guild with a focus on the financial health of members’ practices. Dr. Cain responds, “Today, the answer is not either-or; the answer is both. Improving our health care system for our patients requires strong and viable family medicine practices.”

PCMH means better reimbursement, better outcomes, happier FPs

Higher reimbursement rates and the PCMH go hand in hand, according to Dr. Cain. Medical homes represent a new, transformational approach to primary care. Each is characterized by a physician-guided team that provides comprehensive, coordinated care to patients across the complex health care system. PCMHs ensure first-contact access and longitudinal, trusting relationships that provide high quality and safe care based on evidence-based medicine and shared decision-making.

“The Patient Centered Medical Home is in many ways a symbol of how the academy can speak to the value that Family Physicians bring to their patients,” he says, adding, “I believe the PCMH is one of the best tools for bending the cost curve.”

Dr. Cain says several researchers and implementers, including Barbara Starfield, MD, MPH, Paul Grundy, MD, MPH, FACOEM, FACP, and L. Allen Dobson, Jr., MD, FAAFP, have provided evidence that the PCMH is cost-effective and leads to better outcomes.

This proven value is something government and business understand, Dr. Cain says, pointing to IBM and Seattle-based Group Health Cooperative as organizations that understand the value of primary care and the medical home. Led by Dr. Grundy, IBM has eliminated co-pays for primary care visits. Group Health allows primary care physicians more time with patients and greater team participation in care. The results, Dr. Cain says, are “better outcomes at lower costs and Family Physicians who are happier in their day-to-day practice of medicine.”

Dr. Cain plans to spearhead AAFP cooperation with the Centers for Medicare and Medicaid Services so that the CMS’s Relative Value Update Committee reflects the values of the medical home.

A call to reallocate residency funding

“We need to transform our medical education system,” Dr. Cain says. He says most students indicate an interest in primary care in their medical school admission essays, but abandon that ideal during the course of their studies. He would like to see a minimum of 40 percent to 50 percent of medical school graduates select primary care residencies.

“The U.S. invests $9.5 billion annually in graduate medical education, yet vastly underproduces the primary care physicians that our country needs,” Dr. Cain says. He feels it’s important that those funds be used effectively. In addition to recruiting more medical students to primary care residencies, the AAFP is now joined in lobbying for improved primary care graduate education by other groups including the Medicare Payment Advisory Committee, or MedPAC, and the Council on Graduate Medical Education, or COGME.

“We’re expected to practice outcome-based medicine. It’s time to expect outcome-based graduate medical education,” he says.

In addition to being concerned about attracting students to primary care residencies, Dr. Cain wants to make sure the AAFP stays relevant to future generations of physicians. With fewer people joining organizations than in the past, he wants the AAFP to be able to show young doctors – who are often interested in relevance and in immediate access to information – how the organization can make a difference in their practices and their lives.
Students Give Thumbs-Up To Pilot PCMH Class

Elective combined didactic and experiential components

Students’ reactions were entirely positive to “PCMH: Concept and Practice.” The pilot two-week elective was offered in February 2011 to fourth-year students at the University of Colorado School of Medicine.

“The class met and exceeded all of my expectations,” student Robert Lee stated. “I sincerely hope that the class will be continued in the coming years and that more and more students will be exposed to the Patient Centered Medical Home model in this manner.”

As indicated by the class title, “PCMH: Concept and Practice” included both didactic and experiential components. The two students in the class spent their mornings in clinics, where they observed the Patient Center Medical Home in action. Preceptors were Scott Hammond, MD, for Christina Crumpecker and Tracy Hofeditz, MD, FAAFP, for Robert Lee. In the afternoons, the students attended two-hour presentations, many of which were made by CAFP members who participate in the Colorado PCMH Multi-Payer, Multi-State Pilot.

Each didactic session included an extensive reading list of articles and the final projects focused on efforts to improve the quality of care for patients.

“Christie and I got to see many different practices and interact with many different physicians, all of whom are involved in adopting the Patient Centered Medical Home model within their practices,” Lee stated. “It was a wonderful opportunity to witness how this model is transforming care across a wide variety of practices – large and small, urban and rural, serving all sorts of different patient populations. It was also a wonderful opportunity to see the many different ways in which practices are tackling the problems they face as they rebuild the primary care experience for the patient.”

Crumpecker stated she took the course “because I am beginning my career in Family Medicine and think that the PCMH model is the ideal format for future primary care delivery.”

Lee plans to specialize in internal medicine with a subspecialty in pulmonary and critical care. But he stated, “I am also very interested in models of health care delivery and the impact that such models have on both health care providers and patients. I also believe that in the current environment of health care reform, it is imperative for all physicians – not just primary care doctors – to understand the challenges faced by primary care doctors, and to be literate in all aspects of primary care reform. I strongly believe that having an intimate understanding of primary care and primary care reform will one day allow me to serve as a better subspecialist to my patients and to their primary care physicians. Additionally, I hope that in the current environment of health care reform, such an understanding will allow all physicians to better advocate for our patients with a cohesive, unified voice.”

Marcus Salmen, a third-year medical student and student representative on the CAFP board of directors, worked with Scott Hammond, MD, to help create the class and arrange the preceptors. He is confident that the class will attract more students next year now that it has been piloted and can be publicized.

“It made sense that we could find a way to integrate the PCMH into the education of medical students,” Salmen said. Because participants in the PCMH pilot taught the class, students were able to learn from “the people who are leading the charge in Colorado,” he added.

Crumpecker stated, “I think the class should be continued and I wouldn’t change it.” She cited “good variety of practice sites and styles, appropriate balance of didactics and clinical work.”

In addition to Drs. Hammond and Hofeditz, physicians who helped lead the course included John L. Bender, MD, Chester Cedars, MD, David L. Gaspar, MD, FCFP, Marjie Harbrecht, MD, Laura Makaroff, DO, and Linda Montgomery, MD. Angel Perez and Raquel Alexander provided support.
Western Dairy Association serves as the regional Dairy Council for Colorado, Montana and Wyoming.

The Dairy Council has been a leader in nutrition research since 1936. Our goal is to ensure health professionals, school nutrition professionals, educators and the media have a credible body of nutrition knowledge upon which to educate or base health recommendations.

Our science-based education materials cover a wide variety of topics including: general nutrition, bone health, lactose intolerance, child nutrition, healthy weight, sports nutrition, Dietary Approaches to Stop Hypertension (DASH), and more.

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CAFP Congratulates the First One Hundred CAFP Member Practices to Achieve NCQA Recognized Patient Centered Medical Homes

The Colorado Academy of Family Physicians congratulates you as a physician leader of one of the First One Hundred NCQA recognized Patient Centered Medical Homes in Colorado. As one of the “early adopters” of the Joint Principles of the PCMH, we admire your commitment to your patients and your profession. CAFP also recognizes the contributions of Advance Practice Nurses and Physician Assistants as leaders and essential team members of this model.

The CAFP has embraced the concepts of the PCMH as the best model for the transformation of primary care practices to meet the health care needs of Coloradans in the 21st century. We have developed a wide variety of resources, initiatives and partnerships to help primary care physicians learn about and become leaders of Medical Home teams. We recognize your example as a powerful inspiration for other physicians and primary care clinicians to become part of the medical home movement.

Our patients deserve a reformed and sustainable health care system that provides higher quality care at lower cost with higher patient satisfaction. Such a system inevitably will provide higher satisfaction for the providers of care as well. Primary care practices like yours, functioning as Medical Homes, will be the foundation of that reformed system. We look forward to supporting your maturation as a Medical Home in the years to come.

Tracy Hofeditz MD, FAAFP
Chair, PMCH Committee
Colorado Academy of Family Physicians
Physician leader, Belmar Family Medicine, Level 3 PCMH

CAFP acknowledges the following Members NCQA recognized as Patient Centered Medical Home

Pamela R Abrams MD  Christia E Ambrose DO  Brad D Anderson MD  Faranghise S Babbage MD  Glenn Baker MD  
Paulanne Balch MD  Robert B Beeson MD  Sarah J Bell MD  John L Bender MD  Kimberly Bezek Benage MD  
Jennifer Blair MD  Scott Blitz MD  Brea A Bond MD  Marcia Bourgeois MD  Amy O Bratteli MD  
John S Bratteli MD  Kevin A Briggs MD  Michael H Bross MD  Daniel J Burke MD  Jeffery Cain MD  
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David W Dirks MD  Robert M Douglas MD  Robert Victor Doyle DO  Michelle L Drury MD  Manija Dubrick MD  
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Jennifer M Johnson MD  Ingrid M Justin MD  David L Kaufman MD  Christopher J Keenan MD  Barbara F Kelly MD  
Morteza Khodaei MD  Larry W Kipe MD  Jude J Kirk MD  F Paul Knapp MD  Lorea A Koza DO  
Paula Stoudt Krogh MD  Peter Sundehl Krogh MD  Jennifer E Kuhl MD  Amy L Lemke MD  David F Lieuwen MD  
Ann Christine Linares MD  Pia B Lisle MD  Jennifer A Lomonaco McLean MD  Kelly H Lowther MD  Wendy S Madigosky MD  
Glen M Madrid MD  Laura A Makaroff DO  Barry Martin MD  Angie N Martinez MD  Rebecca L Marshburn MD  
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Phillip J Mohler MD  Michael A Moll DO  Lori S Moll DO  Linda Curchin Montgomery MD  Morris Moore MD  
Jeffery M Morse MD  Timothy Gerard Moser MD  Carol D Navsky MD  David M Nuhfer MD  Karen S Ordelheide MD  
Patrick W Page MD  John Panozzo MD  Suzanne L Parsons MD  Ian E Parsons MD  Karla C Pstrana MD  
John R Pearse MD  Kerry A Peel MD  Matthew A Pfieger DO  Kathryn E Pierce MD  Michael J Pramenko MD  
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Robert J Rhodes MD  Craig W Robbins MD  Gregory L Roberts MD  Susan J Robertson MD  Juan B Rodriguez DO  
Mark Douglas Rojcer MD  Holly Runstadler DO  Amy H Russell MD  Colleen M Ryan MD  Tracy Saffer MD  
Monica P Salas- Meyer DO  Michele D Salli MD  E Mark Sarinopoulos MD  Susan M Sayers MD  Malinda A Schlicht MD  
Britta Seppi MD  Carl D Severin MD  Carolyn M Shepherd MD  John C Shepherd MD  Robert M Sims MD  
Robin L Smith DO  Petra C Soule DO  Susan Snowden Stamm MD  Marshall T Steel MD  Helen M Story MD  
Paul H Sturges MD  Daniel P Sullivan MD  Barbara Jane Taylor MD  Franklin T Thom MD  Ronnie G Thomas MD  
Margaret S Thompson MD  Warren G Thompson MD  William A Van Eimeren MD  Pamela Jean Wanner MD  Donald G Ward DO
Family physicians find new heart murmurs in children every day, offering the challenge to determine which murmurs are “innocent” and which murmurs require further evaluation. Heart murmurs are extremely common in children, heard in up to 80% of children at some point in childhood, and are especially frequent among children around 3 or 4 years of age. Given that the incidence of congenital heart disease is only 0.8% of live births, it is often difficult to determine which child with a murmur (common) has a serious heart problem (uncommon), and when to refer to a specialist! Hopefully the following discussion will make this decision easier.

**Timing**

Murmurs should be determined to be systolic, diastolic, or continuous. Systolic ejection murmurs are common, and usually have a crescendo-decrescendo quality to them. They begin after S1 (tricuspid and mitral valve closure), and are indicative of blood flow acceleration across a stenotic semilunar valve (pulmonary or aortic), or importantly, a greater volume of blood than usual across a normal semilunar valve (anemia, atrial septal defect, pregnancy, anomalous pulmonary veins, PDA, or pulmonary or aortic regurgitation). Holosystolic murmurs begin coincident with S1 and last throughout systole. They are caused by blood flowing from a high pressure chamber to a low pressure chamber. Examples include ventricular septal defects, tricuspid regurgitation, and mitral regurgitation.

Diastolic murmurs in children are never normal, and should always be referred to a pediatric cardiologist. Early diastolic murmurs are decrescendo, and begin right after S2 (closure of aortic and pulmonary valves), and are indicative of aortic or pulmonary valve regurgitation. Mid-diastolic and late diastolic murmurs are rumbling in quality, and are related to flow from the atrium to the ventricle across either the tricuspid or mitral valve. They can be from normal blood volume crossing a stenotic valve (rare in children), or from increased blood volume crossing a normal valve (seen with atrial septal defect, ventricular septal defect, and PDA).

Continuous murmurs last throughout the cardiac cycle, and are indicative of vascular abnormalities. The most common cause in children is a patent ductus arteriosus (PDA). The pressure gradient from aorta to pulmonary artery through the PDA is greatest during systole (louder) and decreases during diastole (quieter), but pressure does not equalize before the next systole, so the murmur is continuous. Continuous murmurs can also be caused by other vascular abnormalities such as arteriovenous fistula, coronary-cameral fistula, and by turbulent flow in arteries (i.e. coarctation) and veins (i.e. venous hum).

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**It takes many hands, one heart.**

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

Murmur Intensity

Murmurs are graded from I to VI in intensity. Grade I is barely audible, Grade II is soft but easily heard, Grade III is loud. Grade IV is similar to Grade III but has a palpable thrill, Grade V is audible with the edge of the stethoscope only touching the chest, and Grade VI is audible with the stethoscope hovering over but not touching the chest.

Location and Transmission

Murmurs are usually loudest over the site of turbulent blood flow. As a general rule of thumb, the aortic valve is best heard at the right upper sternal border, the pulmonary valve at the left upper sternal border, the tricuspid valve at the left lower sternal border, and the mitral valve at the apex. Transmission of the sound occurs along the direction of the acceleration. For example, in peripheral pulmonary stenosis a systolic ejection murmur can be heard at the left upper sternal border and transmits to the axillae.

Innocent Heart Murmurs

Innocent heart murmurs are composed of a variety of sounds from blood flow moving through and out of a structurally normal heart. The most common innocent murmur in childhood is the Still’s murmur, also called “innocent,” “vibratory,” “functional,” or “physiologic.” They are systolic and usually 2-3/6 in intensity, and are described as musical, vibratory, or twanging. Other causes of innocent murmurs are peripheral pulmonary stenosis (described above), pulmonary flow murmurs, and venous hums.

When to Refer to a Pediatric Cardiologist

The prospect of a patient who may have significant congenital heart disease can certainly cause anxiety in the busy practitioner. Murmurs are common, but significant disease is rare, and the consequences of missing the diagnosis or coming to the diagnosis late can be life-threatening. At the same time, it is neither practical nor cost-effective to refer every patient with a heart murmur for evaluation. A comfort level about separating congenital heart disease from innocent murmurs comes with years of experience or additional training.

In general, one should evaluate the murmur in the context of the patient’s overall situation. Neonates and young infants may not have had time to develop clinical symptoms, and the threshold for referral should be lower than in older children and teenagers, who by the fact that they’re growing and thriving have proven they aren’t likely to have significant congenital heart disease. Any child with a known syndrome associated with cardiac defects (for example Down Syndrome) should be referred for evaluation. A child with a murmur but a normal history and otherwise normal physical examination is less likely to have a congenital heart defect than a child who is not thriving, is constantly tachypneic, or is cyanotic. Again, diastolic murmurs are never normal and should be referred for evaluation.

The Role of Electrocardiography and Echocardiography

A pediatric cardiologist evaluating a child with a murmur will almost always perform an ECG, as it is a cost effective screening tool for cardiac chamber enlargement and/or hypertrophy. With a normal ECG, history, and unremarkable physical examination other than an innocent-sounding systolic murmur, many cardiologists will forego the more expensive echocardiogram. However in the modern era, the echocardiogram is an excellent non-invasive test which can (in a cooperative patient) completely rule out congenital cardiac defects and provide peace of mind to a worried family. Most cardiologists will use clinical judgement to determine the need for this test, including the age of the patient, presence of any associated syndromes, clinical history, and quality of the murmur.

In Conclusion...

Most heart murmurs are innocent in nature, and if there are no other worrisome factors on exam or with growth, the practitioner can comfortably follow these patients without immediate referral to a pediatric cardiologist. When clinical suspicion is high, referral is appropriate. Through experience, careful cardiac examination, and listening to a multitude of murmurs, the practitioner will gain ability in distinguishing pathologic murmurs from innocent ones, and will be able to confidently find the “needle in the haystack”.

Bruce Landeck MD is board certified Pediatric Cardiologist in the Echocardiography Lab of the Children’s Hospital Heart Institute and an Assistant Professor of Pediatric Cardiology at the University of Colorado-Denver School of Medicine.

Kids Corner is a regular feature of the CAFP News brought to you by the The Childrens Hospital Department of Family Medicine. For questions about this article or suggestions for future topics you may contact the author or the Chief of Family Medicine, Dr Jeffrey J. Cain, through OneCall at 720-777-3999.
Michael Wiggins, MD, Dead at 42
Exemplary doctor was competing in triathlon

Colorado Academy of Family Physicians member Michael Wiggins, MD, 42, died May 28 while competing in the Pelican Fest Triathlon in Windsor, Colo.

Dr. Wiggins, who graduated in 1998 from Rose Family Medicine Residency, had been chairman of the Department of Family Medicine and a board member of Banner Medical Group in Loveland. He had also served as president of the Larimer County Medical Society.

Peter McNally, executive director of Banner Medical Group’s Western Region, was quoted as saying, “Not only was Michael a gifted physician, he was a dear friend. He was always one of the first people to volunteer for any board or committee that he thought could help improve patient care.”

According to reports, safety spotters found the Fort Collins physician floating face down in Windsor Lake near the end of the half-mile swimming course, which was the first leg of the triathlon.

Dr. Wiggins was reportedly receiving treatment for atrial fibrillation, but the cause of death was not apparent at the time of his autopsy.

Survivors include his widow, Jackie, and three daughters.

Janet Seeley, MD, who followed Dr. Wiggins as president of the Larimer County Medical Society, praised him professionally and was also quoted saying, “He was a wonderful father and very loving husband. ... He was so proud of his daughters.”

Immunizations in Primary Care Study
By Leah R. Kaufman

In 2010, Colorado family physicians participated in a study aimed at calculating the actual cost of providing immunizations in a primary care practice by using a Web-based electronic system. Study participants spent months collecting data on every immunization-related expenditure from exam gloves to physician time and then input the cost of each item into the computer.

In the last several decades physicians have begun to observe that payers’ payment levels for vaccinating – for the product and its administration – are inadequate. Payment levels for immunizations vary between states and regions, and many physicians claim that they actually lose money giving immunizations. The final study report cites one survey that indicates 5-10% of family physicians and pediatricians are seriously considering no longer offering immunizations.

An AAFP survey indicated that forty-two percent of family physicians responding to a 2008 survey routinely refer to public health clinics for immunizations due to inadequate reimbursement.

The Vaccine Manager program, designed by Sanofi Pasteur is currently in the development stage. This study tested the program in primary care settings, with the goal of eventually developing a system of vaccine management that can be used by primary care providers with little to no outside assistance, in order to obtain data that can be used to open evidence-based conversations with payers and assist high-cost offices in determining where they vary from low cost offices.

Specific Aims and Objectives:
1. Determine the feasibility of using an electronic system for tracking immunization information at a practice-level.
2. Understand the barriers that practices encounter while using the electronic system for tracking their immunization information.
3. Determine the usefulness of the electronic system for tracking immunization information in primary care practices.
4. Determine whether facilitators trained in the electronic system are helpful to practices while they are using the system.

The Colorado Academy of Family Physicians (CAFP) partnered with the American Academy of Family Physicians (AAFP) National Research Network (NRN) to collect data. The Georgia and Illinois chapters of the AAFP also participated in the study. Practices were recruited by the AAFP and state chapters. Study facilitators from the AAFP and state chapters conducted interviews and assisted with implementation of the tool in each practice and data was collected over a period of several months.

Overall, the data collected suggests that it is feasible for primary care to use the Vaccine Manager program, though there are some changes that could be made to improve effectiveness. Study findings show that there was not strong support for the usefulness of the program and many primary care offices found the layout of the program problematic. The greatest barrier stated by practices was that gathering data to input into the tool was a difficult process that often involved asking several different people within the practice for information. The layout of the tool was also cited as a problem. Practices with an internal locus of control found more benefit with the tool than those belonging to hospital systems or larger organizations, as they were better able to access cost information and realize a direct benefit to using the tool. Study coordinators at each primary care office were asked to rate the usefulness of facilitators. Most participants stated that they preferred having someone to ask questions. Due to the expense and time-consuming nature of having a live facilitator, study coordinators were asked what suitable alternatives they would prefer. Most participants cited that a tutorial or webinar program would be a suitable option.

Overall, the study proved useful in examining the many different costs associated with giving immunizations and the feasibility of using a tool such as vaccine manager to assess these costs. Practices with more control over their own billing and ability to make changes were more motivated to complete the vaccine manager. Of the practices surveyed, it was notable that the mean values for all vaccines examined were below private sector costs for those vaccines. Further research is needed to assess whether or not the use of this tool will lead to practices contacting payers to negotiate reimbursement.

To read the full Immunizations in Primary Care Final Report, please visit the members only section of the CAFP website and click on the Immunization Initiative tab. www.coloradoafp.org

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Campos-Outcalt, Doug, Jeffcott-Pera, Michelle; Galliher, James; Stewart, Elizabeth; McDermott, Michelle. Immunizations in Primary Care. American Academy of Family Physicians. 2010 Oct
Exemplary Interactions Were Number One Lesson in Cheyenne Wells

Melissa Mouton learned from Christopher Williams, MD

“A different way of relating to patients” was the “number one lesson” medical student Melissa Mouton reported taking from her 2009 month-long preceptorship in Cheyenne Wells, a community of about 1150 people located east of Colorado Springs near the Kansas state line. As a student in the Rural Track at the University of Colorado School of Medicine, she learned in a variety of clinical settings from Family Physician Christopher Williams, MD.

“Dr. Williams upheld the principle of patient autonomy, while at the same time providing excellent care supported by evidence-based medicine,” Mouton stated.

“Dr. Williams not only knew his patients very well, but also talked to them in a way that exemplified the idea of ‘patient-centered care.’ He took enough time to explain the diagnosis and treatment options available to the patient, rather than simply deciding what needs to be done and suggesting that plan to the patient.”

As an example, she described how Dr. Williams interacts with his patients with diabetes. “He explained their lab results and discussed options to change their diet, exercise or medicines. Depending on what the patient was most interested in or capable of doing, he helped them come up with a plan that would be most effective for them. He also explained to them the evidence behind diabetes treatment and was able to communicate complex medical concepts in a way that each patient understood. There were no cookie-cutter treatments; each patient was given individualized options and was allowed to tailor treatments that best fit their situation.”

As one of only two doctors in the area, Dr. Williams has a diverse practice, Mouton said. She was able to follow him as he worked in the local Family Medicine clinic, the hospital and the emergency department, which serves as a level IV trauma center.

“I could spend mornings at the hospital, afternoons in the clinic and make trips to the emergency department when something interesting came in. Everything was on the same campus so it was easy to move from one area to the next. You never knew what was going to walk in the door that day or what type of patients you would see. It kept you on your toes and I never got bored.”

Mainly as a matter of convenience, Mouton lived in a small apartment on the top floor of the hospital.

“The staff were so helpful and made it very fun to live there. The food was made from scratch at the hospital and was amazing. The people were very friendly and made me feel right at home, even though I was only there for a few weeks.”

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Cavity Free at Three

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

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

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

To see how you can become involved contact:
Karen Savoie, RDH
Education Director
Cavity Free at Three Program
karen.savoie@ucdenver.edu
303-724-4750

Cavity Free at Three Program
karen.savoie@ucdenver.edu
303-724-4750
157,805 Colorado adults without dependent children with incomes up to 100% of the federal poverty level are currently uninsured, which leads to higher emergency room usage, delayed or forgone care, and more adults in poorer health.

These adults are under 65 years of age and do not have dependent children, meaning they traditionally have been unable to get Medicaid in Colorado; in 2012, this will change. Thanks to great foresight on the part of our legislature, an historic expansion will occur in the state’s Medicaid program to provide coverage for this population with funding from a hospital provider fee and federal matching dollars. When it is fully implemented, it will cover uninsured adults without dependents between 19 and 65 years of age with incomes up to the federal poverty level, or those earning single incomes of up to $900 a month.

This coverage expansion can move us collectively toward a healthier Colorado by addressing the needs of the underserved. Other states who have offered this coverage in their Medicaid programs have realized the value of the program when:

The Connect to Coverage, Connect to Care Campaign aims to ensure this expansion’s success by supporting the state’s efforts in the movement toward thriving systems, effective community outreach efforts, and ready and accepting care providers.

The state plans on opening the program to the lowest income tier first, then phasing it in by consecutive tiers. The exact structure of this has not yet been determined, but those in the first income tier will likely have the highest medical needs, and this tiered approach is an attempt to keep the system from becoming overwhelmed.

<< continued from page 25

through. Not so hopeful were all of the talks regarding just how much money we all need to have to even be heard in Washington. I knew the political scene there was grim, but didn’t realize just how deep some pockets need to be.

I did attend two CME talks and found them both interesting, although one much more useful than the other. The talk regarding 12 things to do in the next year to be heard was interesting and the speaker was very good, but not very realistic. I do think that advocacy of Family Medicine is necessary, but don’t see that the average Family Physician will be able to do the things described by the speaker. The talk on speaking like a pro was, however, fantastic and after it I felt as if I wanted to have a reason to give a talk soon, just so I could use the tips and tools given.

All in all, I really enjoyed myself at this conference. I have been wanting to get more involved, if not on the national level at least locally or in the state. This conference helped me to understand a lot of the things that are going on at the national level with health care reform and other issues and this is important because I think that too many of us are just standing by, watching and complaining about the things that are happening, but have not figured out how to have a voice.
Further, coverage for the newly eligible is meaningless without access to care. This population will need access to providers in their area who accept Medicaid, which is key to ensuring that the newly covered will benefit from more continuous care as well as from better response to health care needs as they arise.

Because the state recognizes the importance of ensuring that both the coverage and care pieces are met, the state is working to simplify provider enrollment. If you or another provider is interested in becoming a new Medicaid provider, please visit the state website for provider enrollment to apply by specialty and provider type: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1214992377067 or contact Amy Brown at amy.brown@state.co.us.

If you wish to learn more about the Connect Campaign or if you have any other questions, please contact Aubrey Hill with the Colorado Coalition for the Medically Underserved at aubrey.hill@ccmu.org.


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- The proportion of very low-income residents who used hospital emergency rooms as their main source of care fell from 3% to less than 1%;
- The proportion of women over age 40 who did not get regular mammograms dropped by one-third;
- Uncompensated hospital charity care fell by more than one-third.

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