

# CAFP NEWS

**BOLD CHAMPION FOR COLORADO FAMILY PHYSICIANS**



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**Vision Statement:** Thriving Family Physicians creating a healthier Colorado.

**Mission Statement:** The CAFP's mission is to serve as the bold champion for Colorado's family physicians, patients, and communities through education and advocacy.



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## PRESIDENT'S REPORT

By Kajsa Harris, MD

# Election of Jeff Cain, MD, to Lead AAFP was Among Many Highlights

As my year as president of the Colorado Academy of Family Physicians draws to an end I would like to say thank you to all who elected me and to all who supported me through this year. Colorado Family Physicians are amazing people!

I am going to take some time to recap the year. I truly believe that I was the CAFP president at the best time possible. I say this because I was lucky enough to be part of many very positive events. In September, as I was just starting my year as president, I attended the American Academy of Family Physicians' Congress of Delegates. Here I had the opportunity to be part of the election of Jeff Cain, MD, to be president of the AAFP. At this event I met many fascinating people and was very impressed with how respectfully Family Physicians from all over the country can disagree with each other.

I attended the multi-state forum and realized that, though we might live in different places, overall we are all facing many of the same challenges. We as a profession are finding creative ways to meet those challenges. What is truly amazing is, no matter what crazy problems the world throws at us, we continue to take care of our patients. It is my opinion that we will survive as a profession for this reason.

The Annual Scientific Conference was this April at the Cheyenne Mountain resort. This was my third year attending and every year I think it gets better. We had a great turnout, informative lectures and had a chance to interact with people from all over the state. As the outgoing president, I was privileged to recognize our chief executive officer Raquel Rosen for 25 years of service on the board. She is an amazing woman and is a big part of why our academy is as successful as it is. I am already looking forward to next year's conference and once again I get to be part of CAFP history. The 2013 conference will mark the CAFP's 65th



Luke Casias, MD, is honored by the CAFP board for his years of service and as Chair of the Board.



Chris Urbina, MD, CEO of CDPHE, discussed public health issues with the CAFP board.



Mike Archer, MD, accepts a gift in recognition of his leadership as co-chair of the CAFP education committee.



Above left: Rick Budensiek, DO, Bob Brockmann, MD, and Raquel Rosen, presented to the Colorado graduating residents at the CAFP's residents dinner. Above right: Mary Fairbanks, MD, accepted an award from the CAFP board of directors thanking her for her years of service as the chair of the CAFP legislative committee.



anniversary. We will be planning many extra special events in honor of this, so this will be a great time to attend.

Following the April conference, I flew to Kansas to attend the Annual Leadership Forum. The three days were jam packed with leadership workshops. It provided not only a chance to learn about leadership, but also an opportunity to meet and interact with Family Physician leaders from all over. My charmed year continued as I was allowed to nationally recognize Rosen for her 25 years of service to the CAFP.

Paralleling ALF is the National Conference of Special Constituencies. I am proud to say that Colorado was recognized for having all constituencies represented. We were also recognized for having 100 percent of the state's resident physicians as members of the CAFP.

I would be remiss not to mention our legislative successes this year. These successes were in large part due to the hard work of our Legislative Committee, our lobbyist Jeff Thormodsard and his associate Katie Wolf. This year they were instrumental in getting a data collection bill passed. This is important as it will allow us to figure out where Family Physicians are in the state, what we are doing and if there is truly a shortage now or coming. The second big item was the sunset of peer review. This at first did not seem like it was going to a problem, however the trial lawyers threw a late curveball. Fortunately, they were not successful and peer review for physicians remains protected thanks in part to the hard work of our lobbyist.

As my year ends I am happily turning the leadership over to Robert Brockmann, MD. Dr. Brockmann is and will be a great asset in the coming year. He is extremely knowledgeable about the legislative process, is well versed in medical policy and is fearless in his championship of Family Physicians.

I will finish by asking all of you to get involved in improving health care in Colorado over the next year. It is often the small changes we implement that can make big things happen. Improving health care for our patients can be as simple as seeing one extra uninsured patient a month, talking to our state representative or asking one of our patients to tell our story. If we do this together we will be the bold champions Colorado needs.



Kajsa Harris, MD, CAFP president, thanks Michele Jimereson, MD, for serving as one of the resident representatives on the CAFP board.

**“What is truly amazing is, no matter what crazy problems the world throws at us, we continue to take care of our patients. It is my opinion that we will survive as a profession for this reason.”**



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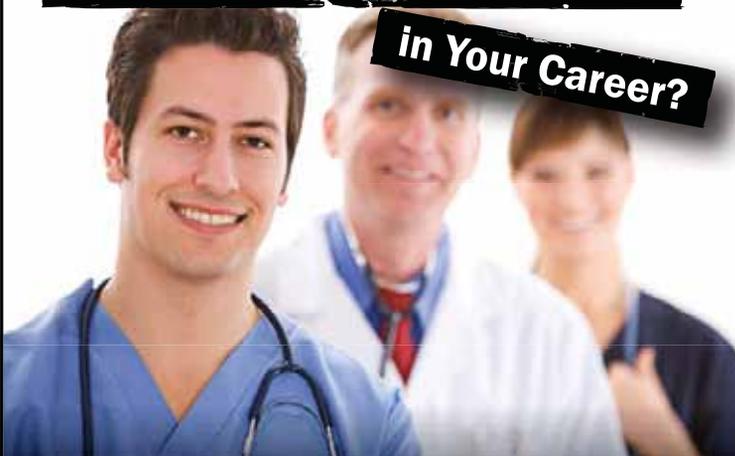
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## Raquel J. Rosen Celebrated at State and National Events

*CEO has served CAFP for 25 years*



Accolades from peers, presidents and board members marked the 25th anniversary of Raquel Judith Rosen's service to the Colorado Academy of Family Physicians. The CAFP celebrated Rosen during the Annual Scientific Conference held in April in Colorado Springs, while the American Academy of Family Physicians presented her with an Executive Service Award at the Annual Leadership Forum in May in Kansas City.

"It is an honor and privilege to be able to work for you," Rosen wrote in an email to the CAFP board of directors.

"You are truly one of the most amazing people I have ever met," wrote CAFP President Kajsa Harris, MD. "I think what I admire most is how you handle difficult situations. You are always kind but you still manage to not be a push-over."

Jeff Cain, MD, a CAFP leader and president-elect of the American Academy of Family Physicians, wrote, "We would not be here without you – on the verge of the new Golden Age of Family Medicine (nor would I personally be here without your support)."

Past President Peter I. Monheit, MD, stated, "From my vantage point, Raquel has made the CAFP what it is today. Many congratulations to a life's work well done."

Attorney Bo Bobbitt wrote that he had seen a range of Rosen's talents on a single day.

"The first was in the context of you as a master administrator

– organizing a series of articles, webinars, meetings and scientific sessions. The next was in your capacity as charming webinar host and MC. Later that day, I saw your strategic executive director side when you contacted us about strategic issues and action plans for Family Medicine in the new health care era. I am happy to join your fan club and congratulate you and the CAFP on your stellar career."

Similarly, attorney William E. Walters wrote, "Your ability to identify issues, analyze them and develop a solution has served CAFP and its leadership quite well."

Neva Santos, executive director of the Idaho Academy of Family Physicians, credited Rosen with advancing the CAFP and Family Medicine in general. Santos wrote, "Your dedication and passion for Family Medicine is humbling. You have helped local and national innovators guide primary care and Family Medicine in an optimistic direction. Family Medicine has a bright future thanks to your influence on policy makers and health care leaders. Your guidance, enthusiasm and loyalty to the Patient Centered Medical Home model of care helped Colorado gain dominance in the field. By taking the lead on the PCMH (Patient Centered Medical Home) in Colorado you have advanced Family Medicine to a new level."

Roland Goertz, president of the AAFP board of directions also congratulated Rosen. "Thank you for all you have done

## Rosen Guided CAFP Through Transformative Years

*CEO urges members to 'grab this opportunity'*

In 1987, Ken Olds, MD, then president of the Colorado Academy of Family Physicians, hired Raquel J. Rosen as executive director of the organization. She was interviewed by three past presidents: Glenn Cosh, DO, Rich Patt, MD, and Marty Kiernan, MD.

"I started out in a rented room in our lobbyist's office. We now own two office condominiums, mortgages paid in full," Rosen stated. "The specialty of Family Medicine has become more sophisticated with medical health records, disease registries, 24/7 access, and team-based collaborative care which improves the quality of care in partnership with patients.

"These are truly exciting times," she added.

During her tenure, the CAFP has grown from 800 to

more than 2,000 members and the budget has multiplied from \$100,000 to \$700,000.

Rosen told participants at the 2012 CAFP Annual Scientific Conference that her son was 1 year old when she started. "The words he heard most often during the past 25 years, besides 'I love you' have been 'I have a meeting and I have a conference call,'" she said.

Two factors kept her motivated through the years. First was the CAFP philosophy "to do what is best for patients, primarily by making Family Medicine strong." And second was "working with amazing leaders like you."

She also has been encouraged by "the exciting development that finally the health care world, employers, payers, and legislators are recognizing the value of Family Medicine

and will do,” he wrote.

The comments of Scott Hammond, MD, FAAFP, were consistent with Santos’s assessment. He told of how Rosen persuaded him to join the CAFPP board of directors, even though he felt he was too much of a “maverick” for such a political group. He wrote, “The next three years that I sat on the board was a wild and exciting adventure into organized medicine. I never realized how much CAFPP did for me and my patients and I was happy to be able to contribute in my small way while getting to know some great Family Docs. I was especially impressed and inspired by the dogged determination, finesse and passion that Raquel brought to CAFPP. Indeed she has been the true champion and savvy steward of Family Medicine in Colorado and we are all deeply indebted to her for all she has done over the years.”

Susan Hogeland, executive vice president of the California Academy of Family Physicians, wrote, “I couldn’t ask for a better Woman of the West or colleague than you, Raquel – smart, incisive, thoughtful, a great friend. It’s been such a pleasure working and playing with you these past years, and I look forward to many more ahead.”

Rosen is as dedicated to her family as she is to the CAFPP, according to her aunt and uncle. “She has proven herself to be a wonderful wife, daughter mother and niece. She is devoted and loyal to her family and friends,” they wrote.

Other CAFPP members who wrote notes of recognition and gratitude included Luke Casias, MD, and Richard Glasser, MD. Reid Blackwelder, MD, a member of the AAFP board of directors from Tennessee, also wrote.

Chapter executives who congratulated and thanked Rosen included Virginia Barzan of the Minnesota Academy of Family Physicians, as well as leaders of chapters in New Mexico and Nebraska. Gail Jones of the American Academy of Family Physicians also wrote.

Penny D. Bergsten of Cheyenne Mountain Resort, David Brown and Randall Eden of Publishing Concepts, and Reola Phelps of Headwaters Leadership Group also sent notes.

Physicians.”

She added a word of advice: “I urge you to grab this opportunity. Implement the systems in your practices to improve quality of care.”

Rosen holds two degrees, one from the University of Denver, a bachelor’s in Psychology and Education, and the second from the University of Colorado Denver, a master’s in Counseling Psychology. She is a Certified Association Executive and is licensed to teach in Colorado.

“My mission in life has been to help people,” she says. “That is why I originally went into teaching and then into counseling. I wanted to make a larger impact on society so I decided to get into the business world.”

She came to the CAFPP after working for four years for a malpractice consulting company, on the physicians’ side. Through that work she was able to meet physicians of all specialties around Colorado and she developed an



Raquel Rosen, CAFPP CEO, thanked the CAFPP for the opportunity to fill her life with passion and purpose over the last 25 years.

appreciation for how much they worked to help their patients.

“Thank you for the opportunity to fill my life with passion and purpose for Family Medicine,” she said at the conference. “It is a blessing to be able to serve you.”

Rosen, who recently married, enjoys bicycling, hiking, Quan Yin meditation, yoga, walking, and reading.

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# CAFP Annual Scientific Conference HIGHLIGHTS



Bob Brockmann, MD, thanks Kajsa Harris, MD, for her service as CAFP President.



Best Exhibit Award - Advanced Medical Imaging



Jeff Cain, MD, addressed the attendees at the CAFP's conference banquet.



CAFP Leaders dined with Reid Blackwelder, MD, during the conference.



SAM Course taught by Kern Low, MD, and Martha Illige, MD.



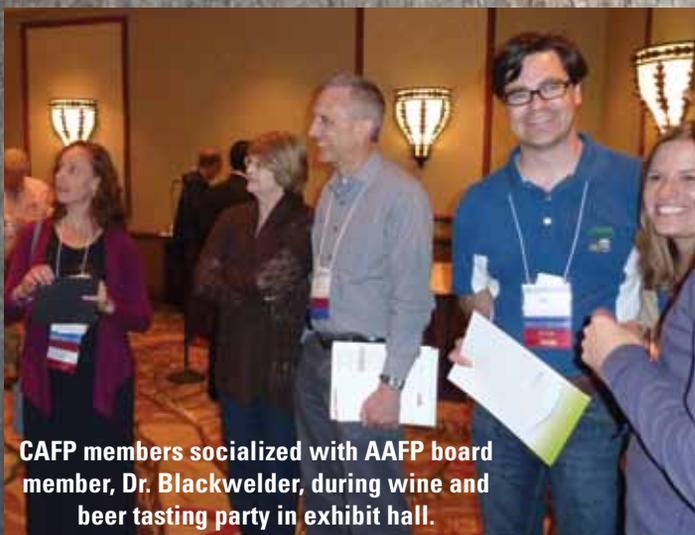
Kern Low, MD, Family Physician of the Year.



Kajsa Harris, MD, Reid Blackwelder, MD, Raquel Rosen, and Jeff Cain, MD at CAFP ASC



Reid Blackwelder, MD, AAFP board member, installed Bob Brockmann, MD, as the new CAFP president.



CAFP members socialized with AAFP board member, Dr. Blackwelder, during wine and beer tasting party in exhibit hall.



Lisa Young, DO, and Sarah DeMoor, MD, were the Family Medicine Residents of the Year.

## CAFP's Top Ten Legislative Successes 2012 Session

By Jeff Thormsodsgaard, CAFP Director of Public Policy

### 1. HB 1052 – Workforce Data Collection

HB 1052 requires the Department of Regulatory Agencies to collect health care workforce data from health care providers, by adding additional questions to the licensure, renewal or certification application with the state. The data collected will be accessible by the Office of Primary Care to pinpoint health care professional workforce shortages across the state.

*The academy strongly supported HB 1052, and the bill was successfully passed through the legislature. At press time, it was scheduled to be signed by the governor.*



Left; Testifying on 1052 Anneliese Heckert, DO, CAFP member. Below: Governor Hickenlooper signing HB1300 on Peer Review.



### 2. HB 1300 – Peer Review Sunset

HB 1300 reauthorizes and modernizes the peer review statutes. Part of this modernization includes extending confidentiality provisions to advanced practice nurses and physician assistants who are not currently protected under these statutory provisions.

*The academy strongly supported HB 1300, and the bill was successfully passed through the legislature and signed by the governor.*

### 3. HB 1297 – Anti-Competitive Conduct Sunset

HB 1297 as introduced planned to terminate the anti-competitive conduct committee as of July 1, 2012. This recommendation was made by the DORA in conjunction with the 2011 sunset review of the committee. The CAFP supported the anti-competitive conduct committee and its role

and therefore amended the bill to continue the committee until September 1, 2013. This amendment will allow the legislature to discuss alternative solutions during the 2013 session.

*The academy supported the amended version of HB 1297, and the bill was successfully passed through the legislature and signed by the governor.*

### 4. Budget (HB 1335 – The Long Bill)

The 2012 budget contained more than a few successes for the academy. The most notable was the adamant position by the Joint Budget Committee to ensure no new provider rate cuts were considered to balance the 2012 budget. Here are the most important budgetary successes for the academy:

- The Primary Care Fund will not see any cuts for safety net health clinics.
- \$33 million in additional grant funds will be provided to address tobacco use, health disparities, cancer, and cardiovascular and pulmonary disease, bringing the total to \$48 million.
- NO reduction for Medicaid provider reimbursement rates.
- NO increase in patient copayments for Medicaid services.
- NO reduction for school-based health center funding.
- NO reduction in funding for local public health agencies.

*The academy supported the relevant sections of HB 1335, and the bill was successfully passed through the legislature and signed by the governor.*

### 5. HB 1281 - Medicaid Global Payment Pilot Program

HB 1281 creates the Medicaid Payment Reform and Innovation Pilot Program. This bipartisan bill allows contractors of the current Medicaid coordinated care system (i.e. Accountable Care Collaborative or ACC) to submit payment reform proposals to the Colorado Department of Health Care Policy and Finance. Payment projects would improve quality and control costs and may include global payments, risk adjustment, risk sharing and aligned payment incentives. However, only those contractors who meet the state's financial solvency requirements for a health insurance company may submit proposals for a global payment project.

*The academy supported HB 1281, and the bill was successfully passed through the legislature. It was scheduled to be signed by the governor.*

<<< continued from page 9

**6. SB 134 – Charity Care Policies and Transparency**

SB 134 provides information and protections for uninsured individuals needing hospital services. Hospitals will be required to disclose information about their charity care policies and programs in several ways, including inpatient billing statements. For those uninsured patients whose income is below 250 percent of the of the federal poverty level, the bill prohibits hospitals from sending a patient’s bill to collections until the patient has established a reasonable payment plan and the patient is at least 30 days past due on a payment. Finally, SB 134 requires hospitals to charge low-income uninsured patients the same rate insurance companies pay.

*The academy supported SB 134, and the bill was successfully passed through the legislature and signed by the governor.*

**7. SB 37 – Electronic Prescription**

To make Colorado law consistent with federal law, SB 37 allows a pharmacy to dispense a prescribed controlled substance from an electronically transmitted prescription. It also allows a practitioner to dispense controlled substances directly to the ultimate user without a written prescription.

*The academy strongly supported SB 37, and the bill was successfully passed through the legislature and signed by the governor.*

**8. SB 1311 – Pharmacy Sunset**

HB 1311 reauthorizes and updates the regulation of the practice of pharmacy in Colorado, continuing the State Board of Pharmacy until 2021. It includes ambulatory surgery centers, long-term care facilities, federally qualified health centers and medical clinics operated by hospitals in the definition of “other outlets.” It also provides greater latitude for long-term care facilities to have a larger variety and quantity of drug stock to administer to patients. The bill establishes a new hospital satellite pharmacy registration and allows a pharmacy intern to practice under the direct and immediate supervision of a registered manufacturer or regulated individual.

*The academy strongly supported HB 1311, and the bill was successfully passed through the legislature. It was scheduled to be signed by the governor.*

**9. HB 1059 – Military Spouse Practice Act/ HB 1210 – Out of State Practice Act**

HB 1059 authorizes military spouses to practice in certain regulated professions or occupations for one year if the spouse is licensed, registered, or certified in good standing to practice in another state, and agrees to be governed by Colorado law. It applies to every type of health care profession, except physicians, physician assistants and optometrists. A related bill to allow any out of state professionals to practice their



Above: Dr. Brockmann, CAFP president-elect at the time, presented Rep. Bob Gardner with a CMS PAC check



Left: As part of the CAFP’s new PR campaign, legislators were given bottles of hand sanitizers and the foundation statement cards.

profession in Colorado without a Colorado license failed to pass (HB1210).

*The academy supported HB 1059, and the bill was successfully passed through the legislature and signed by the governor. The academy strongly opposed HB 1210, which was defeated in the Senate.*

**10. HB 1339 – CBMS Funding and Oversight**

In conjunction with the Long Bill, HB 1335, the Joint Budget Committee also introduced and passed a series of companion bills. One of these bills, HB 1339, appropriated a total of \$22 million (\$12.7 million General Fund) and 22.0 full-time equivalents to make improvements to the Colorado Benefits Management System. This bill also requires the Governor’s Office of Information Technology to provide a quarterly written report to the JBC containing specific items about the status of the CBMS project, providing much more legislative oversight of CBMS funding than has occurred previously.

*The academy supported HB 1339, and the bill was successfully passed through the legislature and was signed by the governor.*

## Colorado Springs Student Wins State Anti-Smoking Contest

### Wade Rahaman attends Chipeta Elementary

Chipeta Elementary School fifth-grader Wade Rahaman has won first place in the Colorado Tar Wars poster contest. Rahaman's poster was submitted to the state contest after winning first place in his school's poster contest. As the state poster contest winner, he and one family member have received an all-expense-paid trip to attend the July 17 National Tar Wars Poster Contest Ceremony in Washington, D.C.

Rahaman's poster depicts a light

bulb with the saying "Be Bright, Don't Light."

Tar Wars is a tobacco-free education program that discourages tobacco use among the country's youth. After a classroom presentation, students are encouraged to create posters that highlight the positive effects of not using tobacco. The program was established in 1988 by Jeffrey Cain, MD, a Colorado Family Physician and president elect of the American Academy of Family Physicians. Tar Wars is currently administered by the AAFP and coordinated locally by the Colorado Academy of Family Physicians Foundation.

Rahaman's poster will be entered in the national Tar Wars poster contest held in July in Washington, D.C. State poster contest winners will be attending from all over the U.S. and the winner of the national contest will be awarded a trip for four to Disneyworld.

In 2010, a Colorado Springs fifth-grader won first place at the national contest, marking the first time Colorado received a first place national finish. Other winners in the 2012 poster contest:

Second Place: Courtney Harlow - Holy Family Catholic School, Grand Junction

Third Place: Maddy Miller- Nativity of our Lord, Westminster

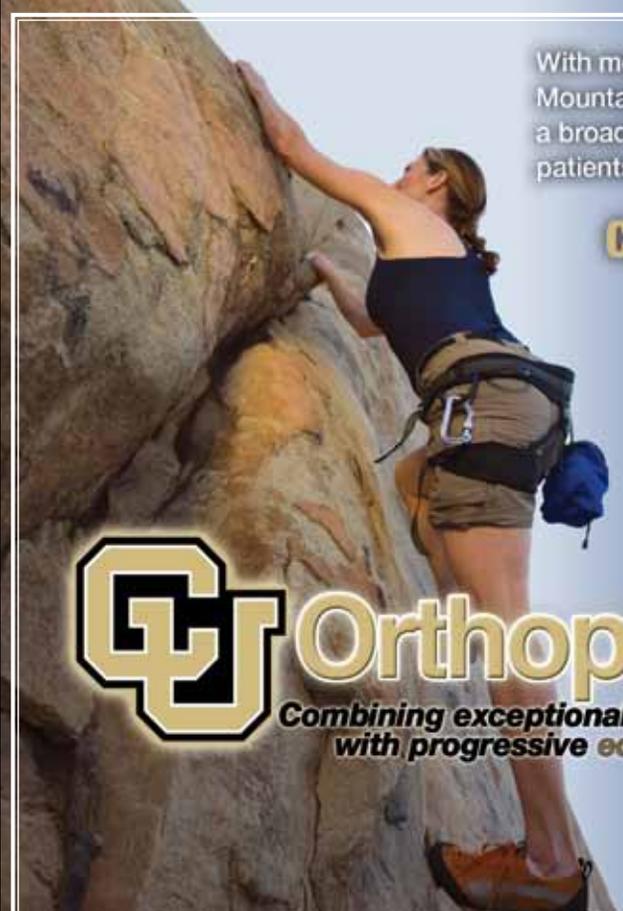
During the national contest the AAFP will take its Tar Wars campaign to Capitol Hill delivering a strong message to lawmakers about the need to support anti-smoking legislation. Nearly 50 children -- all of them winners of Tar Wars poster contests in their respective states -- will meet with their senators and representatives and talk about the need for greater tobacco-cessation efforts.

The children, ranging in age from 10 to 12 and accompanied by their parents and Tar Wars state coordinators, will hand the federal legislators color copies of their award-winning posters, along with AAFP Tar Wars brochures describing the tobacco-free education program. Colorado's winner, Rahaman, along with his mom, dad and brother, will meet with members of the Colorado delegation.

The Tar Wars Program has been implemented in all 50 states, several territories and internationally, and has reached more than 8 million children. During the 2011-2012 school year approximately 50 schools and 100 presenters participated in the program in the state of Colorado, reaching 2,000 children with the Tar Wars message.

Additional information on the Tar Wars program is available by contacting the CAFP at 303-696-6655 ext. 10.





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- **I can't see myself making such a difference anywhere else.**

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# CAFP Fit Family Challenge Pilot Results Have Positive Impact

By Bonnie T. Jortberg, PhD, RD, CDE, Assistant Professor, Department of Family Medicine, University of Colorado School of Medicine

We are pleased to provide a report on the deliverables for the Fit Family Challenge behavior change data and body mass index. The overall goal of this project is to reduce childhood obesity in Colorado through the use of integrated childhood obesity guidelines and a family-based intervention into clinical settings across the state, with a focus on rural and underserved populations. The project team and pilot practices participating have made significant progress towards our measurable results and achieving intermediate milestones.

Overall, decreases were seen for BMI and systolic and diastolic blood pressure measurements for children enrolled in the FFC. Although none of the changes reached statistical significance, these changes have very meaningful clinical significance. In general, children with a BMI that is equal to or above the 85th

percentile have significant increases each year in BMI and blood pressure. Although these are preliminary results, it is encouraging to see the data all trending in the right direction for improving the health of the children enrolled in the FFC.

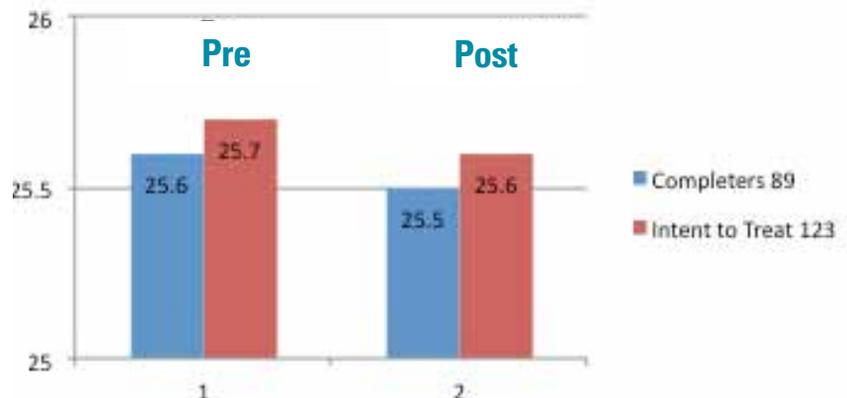
Body mass index analysis included 89 children that had both baseline and four-to-six-month follow-up weight and height data entry points. This group is referred to as completers. One hundred twenty-three children had at least one baseline and one follow-up weight and height data entry point from one to four months. These children are referred to as the intent-to-treat group. Due to the “rolling recruitment” most of these children are not considered “drops” and are currently actively enrolled in the FFC. In conclusion we found that for both groups, BMI decreased by .08 (see Figure 1 & 1.1).

FIGURE 1

Fit Family Challenge BMI Pre/Post (4-6 MO)					
	N	Pre	Post	Change	p-Value
Completers	89	25.6	25.5	-0.08	0.59
Intent-To-Treat	123	25.7	25.6	-0.08	0.58

FIGURE 1.1

### Fit Family Challenge BMI Pre/Post Completers and Intent to Treat



Examination of systolic blood pressure results is based on 90 completers and an intent-to-treat group of 123 children. Due to the “rolling recruitment” most of these children are not considered “drops” and are currently actively enrolled in the FFC. Systolic blood pressure decreased by .12 in the completer group and decreased by .25 in the intent-to-treat group (see Figure 2 & 2.1).

Diastolic blood pressures were followed for 91 completers and an intent-to-treat group of 123. For the completer group, diastolic blood pressure decreased by .78; and for the intent-to-treat group it decreased by .61 (see figure 3 and 3.1 on page 14).

In addition, we are excited to see positive changes in our

FIGURE 2

Fit Family Challenge Systolic Blood Pressure Pre/Post (4-6 MO)					
	N	Pre	Post	Change	p-Value
Completers	90	106	105.8	-0.12	0.92
Intent-To-Treat	123	106.2	105.95	-0.25	0.84

FIGURE 2.1

Fit Family Challenge Systolic BP Pre/ Post Completers and Intent to Treat



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project participants for many of the lifestyle risk factors associated with pediatric obesity. As Figure 4 describes, fruit and vegetable intake and physical activity, including family activity time, increased, while sugar-sweetened beverage consumption and sedentary activities, such as screen time, decreased.



These results, in conjunction with the results on decreases in BMI and blood pressure indicate that our project is having a positive impact on reducing the burden of pediatric obesity. We will continue to track changes of the patients enrolled in the Fit Family Challenge and hope to provide comprehensive data at 12 months.

This project was made possible due to the support of The Colorado Health Foundation and the dedicated work and efforts of the physicians and staff at the participating pilot practices.

For further questions, please contact Cara Coxe at [cara@coloradoafp.org](mailto:cara@coloradoafp.org) or 303.696.6655 ext. 14.

FIGURE 3

Fit Family Challenge Diastolic Blood Pressure Pre/Post (4-6 MO)					
	N	Pre	Post	Change	p-Value
Completers	91	66.05	65.26	-0.78	0.50
Intent-To-Treat	123	65.87	65.26	-0.61	0.58

FIGURE 3.1

**Fit Family Challenge Diastolic BP Completers and Intent to Treat**

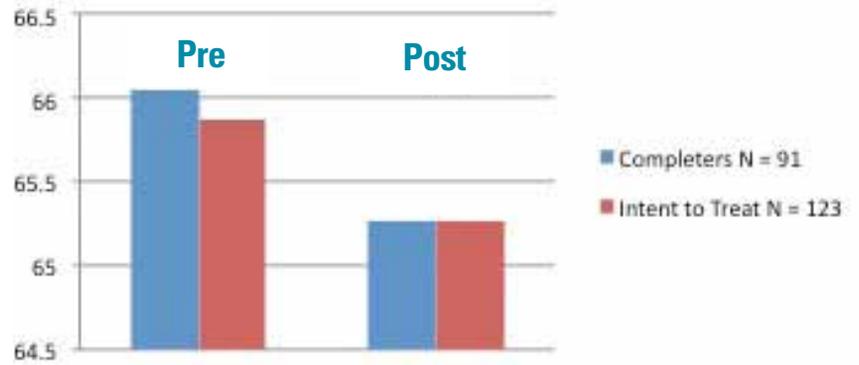


FIGURE 4

HSK Question	Pre Result	Post Result	Change (+/-)
Each day, about how many fruits & vegetables does your child eat?	2.8 servings/day	3.6 servings/day	+ .8 servings/day
Each day, about how many times does your child drink soda, juice, or other sweet beverages?	1.6 times/day	1.3 times/day	- .3 servings/day
Each day, about how many glasses of milk, cups of yogurt, or servings of cheese does your child eat or drink?	2.5 servings/day	2.9 servings/day	+ .4 servings/day
How many days per week is your child physically active, outside of school time, for at least 60 minutes? (walking, running, biking, swimming, playing outside, dancing, etc.)	4.0 days/week	4.4 days/week	+ .4 days/week
How many times per week does your family do something active together?	2.3 times/week	2.7 times/week	+ .4 times/week
In total, how many hours per day does your child watch TV or movies, or play video or computer games?	2.5 hours/day	2.2 hours/day	- .3 hours/day

# 2011 CAFP ANNUAL REPORT



## COLORADO ACADEMY OF FAMILY PHYSICIANS

**STRONG MEDICINE FOR COLORADO**

CAFP represents more than 2,000 Family Medicine Physicians and medical students and is the state's only medical society devoted solely to primary care. CAFP serves as the bold champion for Colorado's Family Physicians, patients, and communities through education and advocacy.

### **Vision:** Thriving Family Physicians creating a healthier Colorado.

The academy is pleased to report that even in an uncertain and challenging health care environment, CAFP remained a strong and growing organization throughout 2011.

To help members seize the opportunities to become leaders in the evolving health care delivery system, CAFP provided strategic educational programs and services that focus on practice transformation. Members were offered training in Accountable Care Organizations and guidance on the processes involved in achieving recognition as a Patient Centered Medical Home from the National Committee for Quality Assurance. The academy continues to embrace the physician-led, team-driven PCMH as the sustainable health care delivery model for quality, cost-effective care.

To ensure the collective voice of Family Physicians was heard, CAFP aggressively educated legislators and policy makers on the vital role of Family Medicine Physicians and workforce issues impacting members' practices and ability to deliver care. To additionally elevate awareness of the profession and issues, CAFP initiated a strategic branding campaign. This campaign is designed to clarify the understanding that legislators, colleagues, partners, businesses and community members have of the crucial role Family Medicine Physicians play in addressing a majority of the health care needs of patients and controlling health care costs.

CAFP continued to provide opportunities for Family Medicine Physicians to give back to the community. The academy thanks members who donated their expertise and time to support outreach programs that encourage healthy lifestyles and to tend to the health needs of state legislators while they are in session. The academy also acknowledges the Family Medicine Physicians who became involved in a pilot program to address a growing health challenge of our times – pediatric obesity. All these endeavors are significant and contribute to the current and future health of Coloradans.

CAFP was in the national spotlight when former president Jeffrey Cain, MD, was elected to serve as president-elect of AAFP. This is the first time a Coloradan will hold this prestigious position. His stellar leadership will be an asset at the national level.

The strength and success of CAFP comes from the active support and involvement of members. All are invited to step up, become engaged and support the future of Family Medicine Physicians and quality care for patients.

Sincerely,

Kajsa Harris, MD  
President

Raquel Rosen  
Chief Executive Officer

### **Congratulations!**

CAFP recognized Miramont Family Medicine in Fort Collins as the 2011 Patient Centered Medical Home Best Practice of the Year.

### **Colorado Academy of Family Physicians Foundation**

The Colorado Academy of Family Physicians Foundation is a nonprofit organization providing Family Physicians and their communities with education, resources, research, and advocacy to advance Family Medicine and to improve the health of the people of Colorado. The CAFP Foundation supports Tar Wars, the Annual Scientific Conference, and the Best PCMH Practice of the Year.

# FACTS AND OUTREACH

## Family Medicine Physician Facts

- o Family Medicine is the largest specialty providing primary care in the country.
- o Family Medicine Physicians complete 150 hours of continuing medical education every three years to stay current on new treatments and medical technologies.
- o Most people in Colorado and the U.S. have their health care needs addressed in a physician's office.
- o Family Medicine Physicians comprise 57 percent of all primary care physicians in Colorado.
- o Family Medicine Physicians are the primary care providers for the majority of Coloradans.
- o Family Medicine Physicians provide the majority of care for Colorado's Medicaid population.
- o A Family Medicine Physician brings more than \$1 million in economic activity to a community.
- o Primary care physicians are found in more than 90% of all Colorado counties, and form the foundation for health care in rural Colorado.

## Significant Issues Facing Family Medicine

Family Medicine Physicians are the backbone of Colorado's health care system, but critical issues will impact the future of this specialty – the cost of education, issues surrounding compensation, and the growth rate of physicians entering primary care:

- The average debt for Colorado medical school graduates is more than \$150,000.
- The number of U.S. medical graduates choosing to enter Family Medicine residencies has fallen by almost 50 percent over the past 10 years. Medical students are electing to practice in other specialties due to disparities in annual incomes and medical education debt.
- The growth rate of primary care physicians practicing in Colorado is less than half of the population growth rate in Colorado.
- There are nine Family Medicine residencies in Colorado, generating about 65-75 new Family Medicine doctors each year.
- Absent Family Physicians, nearly 75 percent of all Colorado counties would be designated Health Professional Shortage Areas.

## Strategic Partnerships

CAFP works with many diverse organizations to benefit the health and well-being of Coloradans. These include:

- o Child Health Associate/Physician Assistant Program, University of Colorado Anschutz Medical Campus (AMC)
- o Colorado Association of Family Medicine Residencies
- o Colorado Chapter of the American Academy of Pediatrics
- o Colorado Dental Association
- o Colorado Department of Public Health and Environment
- o The Colorado Health Foundation
- o Colorado Health Institute
- o Colorado Medical Society
- o Colorado Rural Health Center
- o Colorado Society of Osteopathic Medicine
- o Health Care Policy & Finance
- o University of Colorado Department of Family Medicine

# COMMUNITY OUTREACH

## CAFP - Providing Opportunities to Give Back

CAFP is committed to strengthening the health of Coloradans. By providing opportunities for members to give back to the community, CAFP is actively working to enhance the overall health of Coloradans.

## Promoting Tobacco-Free Youth

Tobacco use is the leading cause of preventable death in the world today. CAFP's Tar Wars program places Family Medicine Physicians in fourth- and fifth-grade classrooms to educate and motivate students to make positive decisions regarding their health and live healthier, tobacco-free lives.

During the 2011 school year, 45 CAFP physicians gave 50 presentations in 30 schools throughout Colorado. Since the program's inception in 1988, more than 250,000 Colorado students have received the Tar Wars message.

## On Call for Colorado's Leaders

Through CAFP's Doctor of the Day program, Family Medicine Physicians provide health care onsite at the Capitol to legislators and staff during the legislative session. CAFP has provided this valuable and appreciated service for more than 25 years. In 2011, 35 CAFP physicians participated in this outreach program.

## Addressing Pediatric Obesity

Children who are overweight or obese are at risk for many health problems ranging from joint pain and high blood pressure to low self-esteem and depression. To proactively address pediatric obesity and reduce health issues in the future, eleven primary care practices participated in the Pediatric Obesity Pilot Project funded by the Colorado Health Foundation. The pilot is creating diagnostic tools, and establishing obesity-related clinical guidelines, and certification for primary care physicians to aid with addressing this growing health issue.

### Taking the Pulse on Public Perceptions

In the fall of 2011 CAFP retained a professional research firm headquartered in Denver to conduct a statewide survey of Colorado households regarding the perception of Family Medicine Physicians. Key findings indicated Family Medicine Physicians remain valued and are held in high esteem; are preferred over mid-level providers, especially for diagnosis and monitoring of serious, ongoing health conditions; and are regarded for their broad-based knowledge and capabilities to care for the entire family.

### Supporting the Future of Family Medicine

During 2011, representatives from CAFP served on the Colorado Workforce Collaborative, ensuring that the need for more Family Medicine Physicians and the Patient Centered Medical Home model were considered in workforce deliberations.

Cultivating future generations to practice the Family Medicine specialty is vital. To support the growth of the Colorado Family Medicine Physician workforce, CAFP works closely with Colorado's nine residency programs, having a total of 262 Family Medicine residents. Approximately 87 new Family Medicine doctors graduate every year, and studies show that Family Medicine residents tend to practice in the state where they were trained.

## ADVOCACY & EDUCATION

### Advocating for Every Family Medicine Physician and the Future of Quality Health Care

• CAFP maintained a strong presence at the Capitol to monitor and advocate for legislation that supported the business of every Family Medicine Physician and the provision of quality of health care and to defeat legislation deemed detrimental. CAFP provided perspectives and educated legislators on complex issues impacting Family Medicine and patient care to advance laws that enhance the practice and delivery of quality health care.

CAFP supported successful legislation that improved patient safety and system efficiencies, expanded access to care, and created a governance structure for the state's new health care exchange. CAFP also worked to defeat legislation that would have created a financial barrier to accessing care for some of Colorado's children; repealed Hospital Provider Fees, which would have diverted funds away from health care; and reduced regulation impacting the safety of long-term care patients. CAFP also continued to advocate for limiting the scope of practice by ancillary providers based on their education level.

**Leading Advancements and Best Practices in Medicine** • More than 140 Family Medicine Physicians attended CAFP's 2011 Annual Scientific Conference in Colorado Springs to expand their medical knowledge and discuss current issues and best practices. At this statewide forum 27 presentations provided more than 40 hours of continuing medical education on diverse topics ranging from women's health and pain management to legislative and pharmaceutical updates.

**The Future of Care Delivery – Patient Centered Medical Homes** • CAFP continued to provide educational opportunities and resources for members to support practice transformation. Growth of practices recognized by the National Committee for Quality Assurance as Patient Centered Medical Homes increased with 158 member practices receiving NCQA recognition. CAFP supports Patient Centered Medical Homes as the emerging model for delivery of quality, cost-effective care.

**The Patient Centered Medical Home** • Patient Centered Medical Home practices deliver the right care, at the right time, by the right provider, ranging from preventive care to chronic care management. Each medical home is characterized by a physician-led team that provides comprehensive, coordinated care to patients across the lifespan. This model of care provides better access and follow-up and promotes self-care, which leads to an enhanced primary care experience, and improved outcomes and cost-efficiencies. Studies show that physician-led medical homes reduce overall health care costs by more than 15 percent.

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# Talking to Parents About Vaccine Myths

*Evidence disputes common, dangerous misconceptions*

By Walt Larimore, MD, and Reg Finger, MD, MPH

Parents are constantly exposed to media reports, anti-vaccination websites, and even other well-meaning parents that may lead parents to refuse potentially life-saving vaccines by inaccurately describing their side effects.

We would like to help you guide the parents in your practice through seven of the most common vaccine myths adapting the well-researched information from Paul A. Offit, MD, and the Children's Hospital of Philadelphia's Vaccine Education Center.<sup>i</sup>

## 1) Myth: Vaccines Don't Work

Vaccines, after sanitation, may be the most effective public health intervention in history. The best recent example of the positive impact of vaccines is the Hib (Haemophilus influenzae type b) vaccine. When the current Hib vaccine was introduced, Hib was the most common cause of bacterial meningitis. For decades, Hib caused approximately 15,000 cases of meningitis and 400 to 500 deaths every year. After the current Hib vaccine was introduced, the incidence of Hib meningitis declined to fewer than 50 cases per year — rates typical of all widely used vaccines.<sup>ii</sup> Not only do vaccines work, they work phenomenally well — and they save lives!

In fact, before vaccines, each year in the United States:<sup>iii</sup>

- Polio would paralyze 10,000 children.
- Rubella (German measles) would cause birth defects and mental retardation in as many as 20,000 newborns.
- Measles would infect about 4 million children, killing 3,000.
- Diphtheria would be one of the most common causes of death in school-aged children.
- A bacterium called Haemophilus influenzae type b (Hib) would cause meningitis in 15,000 children, leaving many with permanent brain damage.
- Pertussis (whooping cough) would kill thousands of infants.

## 2) Myth: Vaccines Aren't Necessary

Just because vaccines work so well, most physicians and parents have never seen a case of measles, mumps, German measles, polio, diphtheria, tetanus, or pertussis (whooping cough). Thus it's understandable that some would question the continued need for vaccines. Even so, there are still critical reasons for immunizations:

- Some diseases (such as chicken pox) are still so prevalent in this country that a decision not to be immunized essentially guarantees that you will get this disease.
- Some diseases (such as measles, mumps, German measles, and pertussis) continue to occur, but at fairly low levels. However, when immunization rates drop, outbreaks recur and, unfortunately, some children die. For example, in 2010, more than 9,000 cases of pertussis (including 10 infant deaths) were reported in California. This was the highest incidence in 52 years.<sup>iv</sup>

- Some diseases (such as measles, polio, and diphtheria) have been virtually eliminated from the U.S., but outbreaks of these diseases still occur in other countries. Given the high rate of international travel, travelers and immigrants can easily import these diseases (as happened with measles in 2011, the worst year for measles outbreaks in the last 15 years).

## 3) Myth: Vaccines Are Unsafe

Despite what is often falsely reported in the media, all recommended vaccines are extraordinarily safe. When you consider that the 3.5 to 4 million children born every year in the United States receive more than 20 different vaccines to protect them from at least 11 different preventable diseases by the time they are 6 years old, and that some of these vaccines have existed for more than 50 years, it is clear that the record of vaccine safety in this country is remarkable. Vaccine side effects are usually limited to pain and tenderness where the injection is given or to low-grade fever.



CAFP Members support immunizations at the SOUP event.

## 4) Myth: It's Better to Be Naturally Infected Than Immunized

It is true that natural infection usually causes better immunity than vaccination. Natural infection causes immunity after just one infection, but vaccines usually create immunity only after several doses over a period of time. Therefore, many vaccines require more than one injection.

The difference lies in the price paid for immunity. The price paid for vaccination is the cost of the vaccine, the inconvenience of several shots, and an occasional sore injection site. However, the price paid for a single natural infection may be paralysis from natural polio infection, mental retardation or hearing difficulties from natural Hib infection, liver failure or death from natural hepatitis B infection, deafness from natural mumps infection, or pneumonia from natural varicella infection, etc. Most parents are not willing to take these risks once they understand them.

## 5) Myth: Vaccines Weaken the Immune System

Natural infection with certain viruses can weaken the immune system. So when children are infected with one virus, they can't fight off other viruses or bacteria as easily. For example, children infected with chicken pox are susceptible to certain bacterial infections (necrotizing soft tissue infection, for example). Children infected with measles are more susceptible to bacterial infections resulting in sepsis. But vaccines are different. The viruses in the measles

and chicken pox vaccines (the so-called vaccine viruses) are very different from those that cause measles and chicken pox infections (the wild-type viruses). Vaccine viruses cannot and do not weaken the immune system.

### 6) Myth: The MMR Vaccine Causes Autism

Fortunately studies are now showing that the majority of parents understand that this myth has been totally disproven<sup>vi</sup> and all available research reveals there is no association between the combined measles, mumps and rubella vaccine and autism.<sup>vii</sup>

Furthermore, the Special Masters of the U.S. Court of Federal Claims, as part of the Omnibus Autism Proceeding, created by the National Vaccine Injury Compensation Program to handle the large volume of claims (more than 4,900) that vaccines induce autism, has issued three separate decisions ruling that the MMR vaccine was not a causal factor in the development of autism or autism spectrum disorders.<sup>viii</sup>

Nevertheless, up to one-quarter of parents still believe this myth, making the education that we Family Physicians provide them a critical part of their decision-making process.<sup>ix</sup> Fortunately, nine out of 10 parents believe that vaccination is a good way to prevent diseases for their children and don't let their concerns outweigh their decision to get their children vaccinated.<sup>x</sup>

### 7) Myth: Vaccine-Preventable Diseases Occur More Often in Vaccinated People Than in Unvaccinated People

Superficially speaking, this statement is true. However, it is important to understand why. Paul Offit, MD, and Louis Bell, MD, explain:<sup>xi</sup>

*Let's say that among 100 young adults living in a college dormitory, 95 were vaccinated against measles and five were not. An outbreak of measles then strikes. Six of the 95 vaccinated people get measles, as do four of the five unvaccinated ones. This would seem to indicate that vaccinated people get measles more commonly than unvaccinated people.*

*But let's look more critically. The attack rate for measles in the unvaccinated group was 80 percent (four of five), whereas the attack rate for vaccinated people was only 6 percent (six of 95).*

So people were much less likely to get measles if they received the measles vaccine. In fact, a study reported in the *Journal of the American Medical Association* found that unvaccinated people were 35 times as likely to get measles as vaccinated people.<sup>xii</sup>

More information on each of these myths, as well as refutations of a number of other vaccine myths, can be viewed and downloaded from the website of the Children's Hospital of Philadelphia's Vaccine Education Center at <http://www.chop.edu/service/vaccine-education-center/home.html>.

*Walt Larimore, MD, DABFP, FAAFP, is the medical director of Mission Medical Clinic in Colorado Springs ([www.MissionMedicalClinic.org](http://www.MissionMedicalClinic.org)). Reg Finger, MD, MPH, is a public health expert and researcher, as well as a former member of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. This article is excerpted from Dr. Larimore's book, *The Highly Healthy Child*, and is used with permission.*

>>>

## Cavity Free at Three

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

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

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



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



For additional information on our program visit our website at: [www.cavityfreeatthree.org](http://www.cavityfreeatthree.org).

To see how you can become involve contact:  
Karen Savoie, RDH  
Education Director  
**Cavity Free at Three Program**  
[karen.savoie@ucdenver.edu](mailto:karen.savoie@ucdenver.edu)  
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# FAQs About Importing Prescription Drugs

## *What are the risks and what do physicians and their patients need to know?*

By COPIC's Patient Safety and Risk Management Department

Patients hoping to save money on prescription medications may consider importing these drugs from other countries. They should be aware that this is illegal except in limited circumstances. Importing drugs from outside the U.S. can also be risky, even when they appear to come from “safe” Canadian suppliers.

### **What is the law regarding drug imports?**

The Food and Drug Administration is responsible for protecting the public health by assuring the safety, effectiveness and security of drugs. Foreign companies that produce or prepare drugs to be imported into the U.S. must be registered, and it is the importer's obligation to show the imported drugs have been approved by the FDA. An unapproved drug includes any foreign-made version of a U.S.-approved drug that has not received FDA approval. The law allows only drug manufacturers, not individuals, to import prescription drugs that were not originally produced in the U.S. into this country. There is an exception for emergency use.

### **Are there exceptions when patients acquire drugs for personal use?**

The FDA has developed guidance for FDA personnel titled “Coverage of Personal Importations”<sup>1</sup> where it may refrain from taking legal action when drugs are imported illegally in the following circumstances:

- When the intended use is appropriately identified; the use is not for treatment of a serious condition; and the product is not known to represent a significant health risk; and
- When the intended use of the unapproved drug is for a serious condition for which an effective treatment may not be available domestically; the drug is not promoted commercially in the U.S.; the drug does not present an unreasonable risk; and the person seeking to import the drug affirms in writing that the drug is for the patient's own use (generally no more than a three-month supply) and provides the name and address of the doctor licensed in the U.S. responsible for his or her treatment with the product, or provides evidence that the product is for the continuation of a treatment that began in a foreign country.

### **What are the risks of using imported drugs?**

- Drugs may not have been manufactured using quality assurance procedures for safety.
- Drugs may not have been stored safely or may be outdated.
- Ingredients, even if legal in foreign countries, may not meet U.S. standards for safety and effectiveness.
- Drugs may have dangerous contaminants, especially those originating from third-world countries.
- Some drugs bearing the name of a U.S.-approved product may be counterfeit.
- Labeling may be in a language the patient doesn't understand and may not accurately reflect precautions or side effects.
- Even drugs from supposedly safe Canadian Internet sites may pose a risk. An FDA operation in 2005 found that, of nearly 4,000 imported pharmaceutical parcels examined, 43 percent had been ordered from “Canadian” Internet pharmacies.<sup>2</sup> Only 15 percent of the drugs actually originated in Canada. The remaining 85 percent were manufactured in 27 different countries.

### **Recommendations**

Patients purchasing medications online should make sure the site requires a prescription and has a pharmacist available for questions. Patients should buy only from licensed pharmacies located in the U.S. The National Association of Boards of Pharmacy has a program to certify online pharmacies. It lists Internet pharmacies that comply with state licensing and survey requirements, and follow recommended safe practices. It also lists online pharmacy sites that are not recommended. This information is accessible at <http://www.nabp.net/consumers/buying-medicine-online/>.

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<sup>xii</sup> Salmon DA, Haber M, Gangarosa EJ, Phillips L, Smith NJ, Chen RT. Health Consequences of Religious and Philosophical Exemptions from Immunization Laws: Individual and Societal Risk of Measles. JAMA 1999; 282:47-53.

# Quality Improvement Coaching for Primary Care Practices: No-Cost Program Enrolling Practices Now

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Since 2010, HealthTeamWorks has provided in-office coaching and technology support to 118 primary care practices at no cost, thanks to generous support from The Colorado Health Foundation. Most are Family Medicine groups. They embark on the journey to the Patient Centered Medical Home because they recognize the value — in patient outcomes and practice efficiency — that this model of health care brings.

HealthTeamWorks is a Lakewood-based nonprofit dedicated to redesigning health care delivery. If you want your practice to benefit from transformation guidance at no cost, take steps soon. The organization's grant funding runs out in 2013. HealthTeamWorks has room for approximately 30 practices in its October cohort. These clinics will receive grant-supported transformation assistance through October 2013. Thereafter, the organization may need to charge for coaching support.

## Community Health Services on the transformation path

Community Health Services, a busy safety-net clinic for low-income children in Adams County, is an example of transformation in progress. CHS joined HealthTeamWorks' PCMH Foundations program in October 2010. Quality Improvement Coach Shelli James helped the practice establish the ReachMyDoctor patient registry, which allows it to monitor care for specific patient populations, such as children with asthma.

"We can't see a future without technology," says Rebecca Lusk,

PNP, one of the providers. "We want to know: 'How can we use it more?'" She says the registry "has been a wonderful first step for us, to use data to support the job we do. We have tightened the use of clinical guidelines, and we have seen improvement in asthma care by using flow sheets for daily [patient] management. The registry helps us know what things will be like when we get an electronic medical record."

The five CHS clinics in the PCMH Foundations program have made significant changes in the way they provide care for patients and their families, and for asthma patients in particular. "They hit the ground running, writing new protocols and revising tools, using their registry for planned care and completing action plans," James says. "The clinics made their medical assistants an integral part of the team — responsible for data collection, outreach to patients, and with greater involvement in patient care. The clinics are continually examining their processes to learn how they can improve."

In addition to the registry, HealthTeamWorks has helped CHS improve its work flow and encouraged the organization to give more responsibility to medical assistants, freeing time for other health care professionals. Lusk says that the medical assistants "have enjoyed the additional responsibility and greater involvement in patient care." Because of HealthTeamWorks' process redesign, CHS now devotes time during provider meetings for data review. "We are now accountable to the data and use it to guide us," James says.

## Sign up for PCMH coaching today

If your practice wants to benefit from HealthTeamWorks' grant-funded, on-site coaching, apply online at [www.healthteamworks.org/medical-home/foundations.html](http://www.healthteamworks.org/medical-home/foundations.html), call 303-446-7200 or e-mail [info@healthteamworks.org](mailto:info@healthteamworks.org).

## Opinion: AAFP Should Advocate for Parity

*Otherwise physicians will continue to lose ground to allied professionals*

By John L. Bender, M.D., FAFP

You may not care that the Federal Trade Commission recently investigated the Dental Board in North Carolina and basically told them they did not have the power to regulate their competitors, even if it meant not being able to decide who could and could not practice dentistry in their own state. What you may not know is that the Colorado Hospital Association recently lobbied the Federal Trade Commission to also provide similar "strong oversight and enforcement" to "expand ... scope of practice up to the

legally permitted level." In other words, the feds and organized hospital systems have a mutual interest in seeing that non-physicians are able to do what historically the Colorado Medical Board allowed only physicians to do. What does all this mean?

It seems to me the core challenge to Family Medicine at this time is responding to this de-regulation of ancillary providers, hospitals and health insurers amidst the escalating regulation of Family Physicians. This issue of ancillary de-regulation would be much more

palatable to Family Physicians were it not for the un-even hand of the legislature and the executive agencies, including the FTC, in how they are applying new rules. We now live in an age where an advanced practice nurse is performing colonoscopies in a Colorado hospital while Family Physicians are specifically excluded from doing so. I care no longer if advanced practice nurses, chiropractors and naturopaths are my equal. We now face becoming subordinate and

*continued on page 29 >>>*

# Outpatient Concussion MANAGEMENT

By Rachel A. Coel, MD, PhD and Aaron J. Provance, MD

Recent changes in concussion management guidelines and new research over the past few years have made treating head injuries more of a challenge for the primary care physician. Pediatric and adolescent concussions commonly cause anxiety for the treating physician because of concern for return-to-play issues and potential second impact syndrome. Determining when to refer a patient to an emergency room acutely or to an outpatient concussion clinic/specialist remains another difficult decision for the primary care physician. New guidelines for concussion management have helped with initial treatment and return-to-play decisions.

Concussion is an increasingly common diagnosis and is likely underreported. One in five high school football players will suffer a concussion each academic year, and concussion accounts for nearly 10 percent of all high school athletic injuries. The highest risk sports for high school boys include football and for high school girls include basketball and soccer. Other sports at greater risk for concussion include rugby, ice hockey and lacrosse. Evidence has shown that girls incur a higher rate of concussion than boys participating in the same sport.

Currently, there is no universal definition of concussion. The Zurich Consensus Statement states, "A concussion is a disturbance in brain function caused by a direct or indirect force to the head." Severity of concussion is now determined by the nature of the head injury, burden on the patient/athlete, and the duration of the clinical post-concussive symptoms. Most concussions do not involve loss of consciousness, and there remains great variability in presentation and post-concussive symptoms. These symptoms can typically be classified into four categories: physical, cognitive, emotional and sleep. Confusion and amnesia often present as cardinal features. Other post-concussive symptoms may include headache, loss of consciousness, feeling like in a fog, increased emotionality, irritability, slowed reaction times, difficulty with concentration or memory, fatigue, blurred or double vision, sleep disturbances, and sensitivity to light or noise.

If a concussion is suspected, an athlete should immediately be removed from play for medical evaluation. A concussed pediatric or adolescent athlete must not be returned to sport on the same day. According to the 2008 Zurich Consensus Statement, a clinician should consider the diagnosis of concussion in a patient who demonstrates one or more of the following:

1. Symptoms (such as headache),
2. Physical signs (such as unsteadiness),
3. Impaired brain function (such as confusion),
4. Abnormal behavior.

The exam in the primary care office should include a detailed concussion history and comprehensive neurological examination focusing on core neurologic function, mental status, cognitive performance, gait and balance. A thorough concussion history should determine whether there was prolonged loss of consciousness



(greater than 30 seconds), other associated signs (vomiting, seizures), prior history of concussion or other head injury, confounding factors (history of migraines or other headache disorders, learning disorders, psychiatric diagnosis [depression, anxiety, etc], sleep disturbances), and whether the patient has attempted to return to school/work or sports. It is important to establish whether there has been improvement or deterioration in symptoms and clinical status since the time of injury; hence, it is appropriate to follow the patient with serial visits on a regular basis. The Sport Concussion Assessment Tool 2 (SCAT2) proves a useful instrument to guide clinicians in the evaluation of concussion. Currently more research is needed to identify the implications of the final point score, as these remain unclear due to lack of normative data. However, if used serially, SCAT2 can help track overall improvement versus decline in symptoms, signs, cognitive and neurologic function, and balance.

Evaluating clinicians are often faced with difficult decisions during the assessment and treatment of concussion. The primary care physician must determine if there is a need for emergency room referral for an emergent CT scan. Due to concern over ionizing radiation, particularly in children, many emergency departments are limiting their use of CT scans to current evidence-based indications. In the first 24 to 48 hours after a head injury, an emergent CT scan may be indicated if any of the following are evident in the concussed patient: seizures; any focal neurological deficits; history of prolonged loss of consciousness greater than 30 seconds; suspicion of skull fracture; severe headache (patient rating nine to 10 out of 10); slurred speech; significant drowsiness; or actively vomiting three or more times. From days two to five post-injury, physicians should consider emergency room referral if the concussed patient describes worsening severe headache, particularly if it is relieved with vomiting.

If the patient/athlete is stable clinically, education on concussion and second impact syndrome should be completed and the return-to-play protocol needs to be explained thoroughly. Additionally, primary care providers should provide guidance and recommendations for home care of the injured patient. Any individual diagnosed with

concussion should not be left alone for the first 24 hours. They should not operate motorized vehicles. Concussed patients should avoid alcohol consumption, sleep aids, and narcotic pain medications in the first 48 hours after injury in order to better monitor and evaluate their post-concussive symptoms. Patients with concussion require both physical and cognitive rest, including limiting their exposure to television, computers, internet, video games, cellular phone texting, and loud music or movies. School-aged children and employed adults may need academic or workplace accommodations for the first one to two weeks.

In 2004, a concussion return-to-play protocol was published as part of the Prague Consensus Statement (below). Return-to-play guidelines pertain to any physical exertional activity, ranging from organized team sports to recreational fitness to physical education classes or recess periods in the school setting. Scientific evidence lacks the exact number of days before individuals can return to sport; however concussed patients must be symptom-free prior to initiating the return-to-play protocol. Importantly, athletes must be symptom-free without the use of pain medications, such as narcotics, ibuprofen, naproxen or acetaminophen. There

is also no scientific evidence defining the number of concussions sustained before one is retired from contact sports. These decisions are made on an individual basis and will differ from case to case.



**Return to Play Protocol - Prague Guidelines**

- No activity with complete physical and cognitive rest until symptom-free
- Light aerobic exercise
- Sport-specific exercise
- Non-contact sport-specific training drills
- Full-contact practice after medical clearance
- Return to competitive play

It is important to emphasize that the athlete/patient be completely asymptomatic prior to beginning the protocol. Each step requires 24 hours to complete. The athlete should continue to the next level if asymptomatic at the current level both during the activity and for 24 hours at rest after the activity. If uncomplicated, the return to play protocol requires approximately one week to complete. If any symptoms occur, the athlete must drop back to the previous step and try to progress again after he or she is symptom-free and a 24-hour period of rest has passed.

Every athlete, regardless of age, must recover clinically and cognitively before consideration for return to play. The Zurich guidelines acknowledge that there is evidence that some adult athletes are able to return to play more quickly, with possible same-day return to play without a risk of recurrence or complications. Pediatric concussions should be treated more conservatively than adult concussions. These athletes should never be allowed to return to a practice or game on the same day and should follow more cautious return to play. Current data demonstrates different physiological responses and longer recovery with head injuries in the youth population. Pediatric and adolescent athletes may have neurological

*continued on page 27 >>>*

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# Is there a doctor (counselor) in the house?

## *Collocated Mental Health and Primary Care Services*

By Tracy Hofeditz, MD

The look on the medical student's face told me there was trouble. He had just interviewed Marilyn, a 62-year-old widow whose depression had been difficult to manage for years. Her mother with advancing Alzheimer's dementia and increasing care needs had moved in with her three years ago. Marilyn had never done well with antidepressant medications and always refused to see a counselor. In his interview with her today, she revealed to the medical student recurring thoughts of harming her mother.

As we discussed the challenges of this situation and all of the barriers, I struggled to find the best advice for Marilyn. Then the medical student reminded me, "What about your new counselor?" A therapist had just started seeing our patients in our office, a place where Marilyn was comfortable and everyone knew her. The medical student and I were relieved when she agreed to meet later that week with the new therapist in our office, Marilyn's medical home.

We all know how common mental illness and substance abuse are in primary care practice and see the toll it takes every day. As primary care providers, we must also acknowledge what we already know and what is clear in the literature: mental illness is more common in our patients with chronic disease and, when untreated, leads to worse outcomes. The following emphasize this reality:

- 1) Half of our visits are with patients who have a significant mental illness.
- 2) Primary care provides half of all mental health care.
- 3) We prescribe 80 percent of antidepressants and 70 percent of psychotropics.
- 4) Seven of every 10 visits to primary care providers concern a chronic disease. The incidence of depression and anxiety disorders is about doubled in this group, according to a 2007 report from the Centers for Disease Control and Prevention.
- 5) When we refer for outside mental health counseling, only about one in 10 patients actually completes the referral.

Barriers to getting needed mental health counseling are many and include negative cultural stigma, limited coverage for such services by health insurers, and logistical difficulties of going to an unfamiliar location to discuss intimate issues with an unfamiliar therapist. However, practices that are Patient Centered Medical Homes seek to improve our patients' access to needed care. We help patients overcome barriers to getting needed care and to making healthy behavior change. The collocation of a mental health care provider in a primary care office is one strategy to remove barriers to better mental health care. Several of the Colorado Multipayer PCMH pilot practices have already established their own collocated mental health services unique to their own practice settings.

Since September 2011 our small practice at Belmar Family

Medicine has had a counselor on site, initially two half days per week, now three half days. We were challenged to find a therapist who fit our office culture and who could see any of our patients who needed her. Credentialing with insurers and payment difficulties further complicated matters.

The Jefferson Center for Mental Health became an ideal partner by offering a selection of several therapists and being able to bill any insurance or offer sliding scale fees to our patients without health insurance. Don Bechtold, MD, vice president for Healthcare and Integration and Dan Fishbein, PhD, vice president for Corporate Business at the Jefferson Center, understand this vision for better mental health care. Their cooperation has paved the way to our success. We added some comfortable furniture to a less used exam room and engaged a staff member to help scheduling. Our therapist is completely independent with documentation and billing. She does not pay rent or any other fees to our office. Our staff has been energized to encourage our patients to consider her services. Our patients are always impressed we have such care available in their medical home.

**"The collocation of a mental health care provider in a primary care office is one strategy to remove barriers to better mental health care."**

Family Care Southwest, under the leadership of Helen Story, MD, is another small practice that has been successful in bringing mental health services to her patients in their medical home. They, too, have partnered with Drs. Bechtold and Fishbein at the Jefferson Center to bring a therapist to their small practice two half days per week. Dr. Story's receptionist plays an active role in scheduling, copay collection and reminder calls. She is quick to acknowledge this service does not increase revenue to the practice but the cost is low and she perceives the value to her patients and staff to be high.

At a three-physician, two-PA practice, Westminster Medical Clinic, Scott Hammond, MD, and his team have followed a longer path over several years finding billing difficulty working with private therapists. High co-pays or lack of insurance limited many patients' access to the therapist. Finally, with the benefit of collaboration with Community Reach, a community full-service mental health organization, a counselor is on site 20 hours per week requiring no co-pay or expense to the patient for the first six visits. If more care is needed, the therapist arranges continuing care at Community Reach or in the community. Though currently grant funded, with successes Dr. Hammond expects it to become self-supporting. The counselor has become an active part of his medical home team by sharing electronic health records and communicating directly with providers and

staff about patient progress.

In Fort Collins, John Bender, MD, and Miramount Family Medicine have established a different model suited to their multiple-site practice over several years. They now have a full-time, independent, private psychologist who rotates among three of their four clinic locations. Their psychologist is considered a visiting consultant who maintains his own clinical records and does his own billing, but he also pays a monthly facilities fee in return for referrals, space and office services. Over time, most of his practice has come from those referrals. He has become credentialed with all of the insurance payers for Miramount and also accepts new Medicare and Medicaid patients, as does Miramount. Beyond his role as therapist, their psychologist also helps arrange outside mental health and social services depending on patient needs. Dr. Bender is convinced of a higher rate of successful completion of referrals for counseling and emphasizes the value this brings to patient and payer.

Barriers have been overcome by these practices and opportunities are emerging. We can further build our medical neighborhood by partnering with like-minded groups in our community. As Dr. Bechtold at the Jefferson Center has said, "As the Community Mental Health Center for Jefferson, Gilpin and Clear Creek counties, we believe that we share in the responsibility for the mental health of our entire community, not just those in the medically indigent and publicly-funded safety net, so we have been most appreciative of the opportunity to partner with you in the private community."

Of course, the chance to reduce the burden of mental illness and the toll it takes on chronic disease outcomes is clear. Greater patient satisfaction and staff excitement can be expected. But does having a counselor in a medical home really make a difference? The opportunities for clinical research are rich. Given the burden of mental illness and our current unsatisfactory results, collocation of mental health care providers in primary care offices is an opportunity worth embracing

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Above information from April/May 2012 Colorado Medicine article, *Payment Reform Gets Real* by Chet Seward

**TRANSFORM YOUR PRACTICE**

# Opioids & Public Health: *Education for Physicians*

By Lyndsay Kopp, Liliانا Tenney, MPH, Lee Newman, MD, MA, and Kathryn Mueller, MD, MPH

36,450. According to the Centers for Disease Control and Prevention, this was the number of drug overdose deaths in the United States in 2008, and one that has been on the rise since the late 1970s. Prescription opioids are a major contributor to this figure, despite federal and state guidelines that currently exist to prevent cases of addiction and abuse. In many states, the number of unintentional deaths from opioids exceeds that of traffic accidents, as well as that of cocaine and heroin combined. Of the mortality from prescription drug overdose, opioids account for almost 74 percent (CDC 2011). Prescription drug abuse is a public health emergency in this country that must be urgently addressed. Although a problem of this magnitude will require coordination at multiple levels of health care and policy systems, much of the prevention rests in the hands of primary health care providers who are responsible for understanding and practically applying the federal and state guidelines for pain management.

A recent Morbidity and Mortality Weekly Report by the CDC entitled “CDC Grand Rounds: Prescription Drug Overdoses - a U.S. Epidemic” outlines some of the disturbing statistics surrounding this issue. The report states, “for every unintentional overdose death related to an opioid analgesic, nine persons are admitted for substance abuse treatment, 35 visit emergency departments, 161 report drug abuse or dependence, and 461 report nonmedical uses of opioid analgesics” (CDC 2012).

The population most at risk for opioid abuse and overdose are those who use these physician-prescribed substances for the management of non-surgical, non-cancer, chronic pain. Among these patients, approximately 80 percent are prescribed a low dose (less than 100 mg morphine equivalent dose per day) by a single practitioner and these patients account for an estimated 20 percent of all prescribed drug overdoses. The remaining 20 percent of chronic pain patients either take high daily doses of opioids (equal to or more than 100 mg morphine equivalent dose per day) and/or are seeking out multiple physicians for their prescriptions in a practice referred to as “doctor shopping.” Together, these patients account for 80 percent of prescription opioid overdoses.

## **Use non-prescription approaches first**

A number of evidence-based studies demonstrate the efficacy of non-narcotic approaches to pain management, including therapeutic procedures such as acupuncture, biofeedback and cognitive behavioral therapy. Unfortunately, despite these proven methods of pain management and treatment, the prescription rate of opioids has increased dramatically in recent years. There are several reasons for this trend. For example, for many years, physicians were taught to give higher doses of pain medicines in order to “control the pain.” We now recognize that this approach may, in some special instances, be helpful, but usually not. We take a different approach to chronic pain management. Today, the goal is to emphasize using medication and other therapies to improve and restore physical function.

## **Warning signs**

There are clear steps that should be taken by clinicians prior to deciding to continue opioid therapy in non-surgical, non-cancer pain cases. At every visit, we should ask, “Why is this person on opioids?” and “What was the underlying diagnosis?” “Has function improved?” As a rule of thumb, if a non-surgical patient is

continuing to require opioids for more than six weeks, the patient is reporting that pain and function are not improving, or if the dose of opioids is approaching 80 to 100 mg morphine dose equivalent, then it is time to reassess. For many practitioners, these may be reasons to seek consultation from a pain specialist.

## **Addressing Issues Early pays**

If the decision is made to continue opioids beyond the first six to 12 weeks after an injury, then it is important to follow guidelines for treatment of chronic pain. The physician should:

- Assure that treatment has included other appropriate medications for the condition as well as active therapy.
- Confirm single prescriber status through the state’s Prescription Drug Monitoring Program (PDMP).
- Screen for abuse potential and depression.
- Establish a provider-patient contract with the patient.
- Generally avoid high doses.

It is important to set expectations for patients. Help the patient understand that the medications alone will not “eliminate” pain, but should result in some pain reduction (usually 30 percent at best). More importantly, focus each visit on the return of function, more than on the severity of the pain. Patients should also be made aware of potential side effects, including not only the risk of dependency and addiction, but also other side effects that range from severe constipation to lethargy and disorientation. Drug screening should be undertaken for most patients prior to beginning a provider-patient contract and randomly thereafter to help prevent and to monitor for use, misuse and diversion, as some of those patients abusing opioids may use or abuse other prescription or recreational drugs or sell the medication to others. Studies have shown that doctors are not good at predicting which patients are misusing opioids; therefore, drug screens should be an accepted part of treatment, just as providers conduct hepatic and renal tests when monitoring the use of other chronic medications. Drug screening should be done for the specific metabolites of the prescribed opioid as well as for those of recreational drugs.

To help physicians properly treat and manage chronic pain patients, national and state guidelines have been established and are accepted as best practices. Nevertheless, there is significant evidence indicating that many physicians do not adhere to these guidelines. In recognition of this problem, the U.S. Food and Drug Administration requires that opioid manufacturers develop Risk Evaluation and Mitigation Strategies, or REMS, for most opioids. A required element of REMS is the provision of impartial, accurate, trustworthy continuing education for physicians who prescribe these drugs. Additionally, a number of states, along with academic and private organizations, have created educational materials that help address some of these issues, including training on state-specific guidelines, such as those in Washington state and Colorado. There are many resources, tools and recommendations available for implementing the guidelines and managing chronic pain that can be found online, through the CDC, Colorado Workers’ Compensation, Washington state and the American College of Occupational and Environmental Medicine, called ACOEM. For any workers’ compensation injury in which chronic pain management is necessary, there is a z code utilized specifically for opioid case management in Colorado;

ACOEM is hoping to work with American Academy of Family Physicians to make this a nationally available Current Procedural Terminology code. In addition, Washington state has created an online continuing education module that offers free guidance for best practice and guideline implementation, as well as dosing calculations and integrated therapies that have been quite successful in raising physician awareness of these issues and led to a reduction in opioid prescriptions in that state. AAFP also offers several well-done continuing medical education programs.

While the recommendations and guidelines for proper pain management exist, programs designed to train physicians specifically on guideline implementation are hard to find -- the available resources are not necessarily streamlined for optimal physician use. Therefore, an important first step in using existing guidelines is to provide high-quality, accessible continuing medical education for physicians. Most states, including Colorado, do not currently maintain such a program for opioids. In response, the Colorado School of Public Health and the Mountain & Plains Education and Research Center, or MAP ERC, are developing an online, state-of-the-art continuing education module to fill this significant void. The MAP ERC is one of 17 Education and Research Centers funded by the CDC/National Institute for Occupational Safety and Health. The

training is made possible by an unrestricted educational grant from Pinnacol Assurance, the leading provider of workers' compensation in Colorado. The content of the opioid education module, which will be available for continuing medical education credit, will address the core FDA and Colorado guideline requirements that are applicable to workers' compensation and non-compensation alike, and will include leading regional and national experts as speakers. The goal of that educational program will be to overcome barriers to guideline adherence and to improve the understanding and adoption of best practices for physicians who prescribe opioids. As in Washington state, this module will be one of the first of its kind in the country, and will help lead the way to more effective pain management that is sustainable for public health by reducing the excessive morbidity and mortality attributed to opioids.

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CDC Morbidity and Mortality Weekly Report.

"Vital Signs: Overdoses of Prescription Opioid Pain Relievers - United States, 1999-2008." Nov. 4, 2011 / 60(43); 1487-1492

CDC Morbidity and Mortality Weekly Report. "CDC Grand Rounds: Prescription Drug Overdoses — a U.S. Epidemic." Jan. 13, 2012 / 61(01); 10-13

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deficits after a head injury that may not be evident on the sidelines and are more likely to have delayed onset of symptoms. Second impact syndrome, a rare, catastrophic event currently reported only in cases of patients less than 24 years of age, may arise when a second concussion occurs while the athlete is still symptomatic and healing from a prior concussion. Rapid swelling around the brain may transpire, causing seizure, coma, severe neurological damage, or death.

Referral to a concussion clinic or specialist should be considered when the post-concussive symptoms have lasted more than 14 days. MRI of the brain should also be considered in these cases to evaluate for any underlying malformations, intracranial cysts, or other structural anomalies that may be responsible for the delay in recovery of the athlete and may not be visualized on CT scan. Certain structural anomalies may also put the athlete at increased risk when returning to contact sports. In these situations, referral to a neurosurgeon for decisions on return to specific sports may be indicated.

Computerized neuropsychological testing remains a controversial topic in concussion assessment and management. It should never be used solely as a tool for return-to-play decision-making. A good history and clinical exam should not be replaced by computerized baseline and serial neuropsychological testing. Each case should be considered on an individual basis. Neuropsychological testing may be



helpful in situations of severe concussion, prolonged post-concussive symptoms, multiple concussions, or questions of athlete truthfulness. Neuropsychological testing is best analyzed by neuropsychologists and not by sports medicine or primary care physicians.

On March 29, 2011, the state of Colorado signed into law Senate Bill 40: "The Jake Snakenberg Youth Concussion Act." The bill focuses on concussion safety and education for all youth athletes ages 11 to 18 years through three stipulations. First, coaches are required to complete either free online concussion training or attend a concussion presentation that meets the requirements of the bill. Second, athletes showing any signs or symptoms of a concussion are removed immediately from the playing field by the coach and are not allowed to return to play. Parents should be contacted by the coach to inform them of the head injury. Third, the athlete must be seen by a licensed health care professional and written clearance is required

prior to return to activities or sports. Qualified health care professionals include MDs, DOs, physician assistants, nurse practitioners, and neuropsychologists. After medical clearance, certified athletic trainers may guide athletes through the return-to-play protocol.

While concussion remains a challenging diagnosis to identify and manage for primary care providers in the outpatient setting, current research and guidelines may assist practitioners in providing safer care for their injured patients. Ongoing research is needed to elucidate healthier approaches to head injury and concussion management.

*Rachel Coel, MD, PhD, is co-director of Sports Medicine for Young Athletes at Children's Hospital Colorado and assistant professor in the Department of Orthopedics at the University of Colorado School of Medicine.*

*Aaron Provance, MD, is co-director of Sports Medicine for Young Athletes and of the Concussion Program at Children's Hospital Colorado, assistant director of the Pediatric Primary Care Sport Medicine Fellowship at the University of Colorado and assistant professor in the Department of Orthopedics at the University of Colorado School of Medicine.*

*Kids Corner is a regular feature of the CAFPP News brought to readers by the Department of Family Medicine at Children's Hospital Colorado. For questions about this article or suggestions for future topics, readers may contact the authors or Jeffrey Cain, MD, chief of Family Medicine, through OneCall: 720-777-3999.*

# John L. Bender, MD, FAAFP, Seeks Top CMS Post

## *Leader in medical home movement promotes medical neighborhoods*

John L. Bender, MD, FAAFP, a leader in both the Colorado Academy of Family Physicians and in the medical home movement, is running for the office of president-elect of the Colorado Medical Society. If elected, he would become president after one year as president-elect.

His chief goal, if elected, will be to lead initiatives that support both medical homes and medical neighborhoods.

“The Patient Centered Medical Home doesn’t work without a medical neighborhood,” Dr. Bender said. “The new model is dependent on strong, integrated relationships.”

Patient Centered Medical Homes represent a new, transformational approach to primary care, according to Dr. Bender. 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. Medical neighborhoods extend the same concepts to specialists and providers in the medical community of the PCMH.

PCMHs lead to reductions in both hospital admissions and emergency room utilization. “We’re making actual progress,” Dr. Bender said.

Two specific areas in which Dr. Bender plans to press for change are tort reform and accountable care organizations, or ACOs.

He champions legal reforms that would end “out-of-control” malpractice awards and institute practices that could “actually help people,” he said. He would work toward a no-fault approach to cerebral palsy that would include a fund to help families with children who suffer from the illness.

He would take steps to assure more physicians participate in hospitals’ ACOs, which are panels that tie provider reimbursements to quality metrics and reductions in total cost of care.

Research done by the Colorado Medical Society over the past three years has shown that specialists’ awareness of and interest in Patient Centered Medical Homes and neighborhoods has increased dramatically, Dr. Bender said, adding that specialists view the medical home model as a “quality approach.”

He said emergency room physicians are not threatened by the patient load that shifts from them to primary care physicians

because this opens the way for greater emphasis in the emergency room on care that is truly urgent. Anesthesiologists receive referrals for patients needing management of chronic pain. Specialists do not spend time on cases that do not require the level of care only they can provide.

The practice Dr. Bender and his wife, Teresa, bought in 2002 in Fort Collins demonstrates the power and effectiveness of the medical home model. When they purchased Miramont Family Medicine in 2002, the practice included one physician, one employee and one computer in a single location.

Over the course of a decade, as other Larimer Care primary physicians abandoned their practices, the Benders’ grew to become a network of four Patient Centered Medical Homes delivering full-spectrum primary care services in suburban and rural communities. With Dr. Bender serving as president and chief executive officer, Miramont comprises 14 providers, 50 employees and 80 computer workstations networked through an integrated data center to serve more than 27,000 patients.

Miramont Family Medicine in 2008 received recognition as a Level 3 medical home from the National Committee for Quality Assurance. In 2010, Miramont won a national HiMSS Nicholas E. Davies Award of Excellence for outstanding achievement in implementation of and value from health information technology. In 2011, the practice was honored as the CAFP Patient Centered Medical Home of the Year.

Dr. Bender was CAFP president in 2007 and 2008 and he currently serves as a CAFP delegate to the American Academy of Family Physicians Congress of Delegates and as a member of the AAFP Commission on Finance and Insurance. He has served as president of the Larimer County Medical Society and Northern Colorado Independent Physicians Association. He currently serves on the board of the Colorado Medical Society and is a member of the society’s Finance Committee.

In February 2012, Dr. Bender testified before the Health Subcommittee of the U.S. House of Representatives Ways and Means Committee on programs that reward physicians who deliver high quality and efficient care.

The president-elect of the Colorado Medical Society will be selected by approximately 300 delegates representing constituent organizations. CAFP members can support Dr. Bender by talking to society members, including medical students, about the value of Patient Centered Medical Homes and medical neighborhoods to the medical profession, as well as patients and payers.

## MEMBERS CORNER - SEND YOUR STORIES

The CAFP would like to receive articles and stories from you and your patients. Please write about your Family Medicine successes in your practice or community. Send articles to [raquel@coloradoafp.org](mailto:raquel@coloradoafp.org).

How you helped a patient • How a patient says you helped them • How you helped your community

irrelevant, with larger debt, less quality of life, and the paradox of more regulation and liability compared to most ancillary provider. Why would anyone want to become a Family Physician????

In the next decade we can choose to advocate for parity and de-regulation of physicians -- that is where the debate is headed, and this is our opportunity to be proactive. What is likely to happen is not that legislators will make less statutes (there is not a great mechanism for this) or that regulators like the FTC will scale back enforcement, but that test cases will present an opportunity in the courts for successfully overturning some of these egregious disparities in the marketplace.

The limiting factor is that defending (or initiating) these cases is expensive, and beyond the capacity of most Family Physicians and even most state chapters. But

the American Academy of Family Physicians could consider establishing a legal defense fund, and further define what sort of cases or case law would be beneficial for setting new precedent or ideal to seek judicial injunction, etc., such that marketplace barriers for the fair trade and practice of Family Medicine might be dismantled for the sole purpose of achieving parity with dissimilar competitors like retail clinics, advanced practice nurses, hospital-owned ambulatory clinics, etc.

A good example might be the Stark laws, which apply only to physicians. Advance Practice Nurses can own oxygen supply companies and self-refer and they are immune from Stark. And there is absolutely no interest whatsoever in adding them to this federal statute. Likewise, corporate practice of medicine laws in many states prevent cash strapped Patient Centered Medical Homes from seeking the investment venture capital they need without facing discipline from

the Boards of Medicine for “unprofessional conduct.” But again, a hospital can sell a bond, an advanced practice nurse can sell stock to a private placement entity and build across the street from a Family Physician – and no one is going to challenge this as unethical or strange.

We have to dismantle the real barriers to free trade in the marketplace now or go extinct. There is no option to reverse the trends on scope of practice expansion. There is an option for us to say nationally “the law is unfair and we will fight for parity in the courts.” Properly selected cases will also provide opportunities for discussion in the press and the public square, and allow for the framing of issues that highlight the importance of the Family Physician in America. By selecting which cases to defend, the AAFP Legal Defense Fund would implement a potentially new and cost-effective strategy for shaping public policy.

## Proposed Resolutions Address Concerns of International Physicians

### NCSC – International Medical Graduate caucus report

By Luis Lorenzo, MD

I want to thank the Colorado Academy of Family Physicians for letting me attend the 2012 National Conference of Special Constituencies. I’ve been there before and it’s always a thrill and a privilege to represent Colorado. The conference is a unique experience and everyone that I know who has been there says the same thing – they come home refreshed, energized and with renewed commitment to Family Medicine. To those of you who’ve never heard of NCSC, I encourage you to participate and call CAFP to learn more about it.

This year, the International Medical Graduate caucus came out with significantly important resolutions that I hope will have enough traction to get to the Congress of Delegates or the AAFP board. Among the many ideas and resolutions proposed, these are noteworthy:

- Resolution to amend current AAFP policy on Resident Education Discrimination to include nondiscrimination based on geographical training or status as international medical graduates – Item No. 7: Resolution No. 2011.

This generated impassioned debate and support across the constituencies during the general business session.

([http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/cme/courses/conf/leader/refcomreports/educrpt.Par.0001.File.tmp/Education.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/cme/courses/conf/leader/refcomreports/educrpt.Par.0001.File.tmp/Education.pdf))

- Resolution to improve awareness among residency program coordinators who may not consider qualified IMGs into a residency position because of the burden (perceived or otherwise) associated with the visa application process – Item

No. 6: Resolution No. 2010. ([http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/cme/courses/conf/leader/refcomreports/educrpt.Par.0001.File.tmp/Education.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/cme/courses/conf/leader/refcomreports/educrpt.Par.0001.File.tmp/Education.pdf))

- Resolution encouraging Family Physicians to participate in local and state medically underserved programs for at least 7 percent of their population – Item No. 6: Substitute Resolution No. 3011.

This resolution was well received during reference committee hearing and had wide support across the constituencies.

([http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/cme/courses/conf/leader/refcomreports/hpsrpt.Par.0001.File.tmp/HealthofPublicScience.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/cme/courses/conf/leader/refcomreports/hpsrpt.Par.0001.File.tmp/HealthofPublicScience.pdf))

- Resolution encouraging state chapters to develop leadership opportunities for IMGs post residency – Item No. 8: Substitute Resolution 4010. ([http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/cme/courses/conf/leader/refcomreports/oandrpt.Par.0001.File.tmp/Organization-Finance.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/cme/courses/conf/leader/refcomreports/oandrpt.Par.0001.File.tmp/Organization-Finance.pdf))
- Resolution to expand marketing of the virtual Family Medicine Interest Group to IMGs – Item No. 9: Resolution No 4011. ([http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/cme/courses/conf/leader/refcomreports/oandrpt.Par.0001.File.tmp/Organization-Finance.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/cme/courses/conf/leader/refcomreports/oandrpt.Par.0001.File.tmp/Organization-Finance.pdf))

For readers who are not familiar but are curious about NCSC there are videos of the different sessions posted at the AAFP website. (<http://www.aafp.org/online/en/home/cme/aafpcourses/conferences/leader/ncsc/videos.html>)



## MEMBER SPECIAL DISCOUNT PROGRAMS

Please take a look at all these companies! We've teamed up with them to bring more benefits to members. If there is a service or product you would like to see on the list, please contact Raquel J. Rosen at 303-696-6655 ext.10.

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