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THE STRENGTH TO HEAL
and protect the health of those who protect our country.

Physicians and surgeons on the U.S. Army Health Care Team take pride in caring for our Soldiers and their Families. They take pride in being members of one of the world’s most advanced health care systems. They take pride in the fact that their skills and experience will continue to grow along with their nation’s gratitude.

To learn more about the U.S. Army Health Care Team, call Sgt. 1st Class Terence Shields at (502)423-7342, email terence.l.shields.mil@mai.mil, or visit healthcare.goarmy.com/info/mcra1.

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THE STRENGTH TO HEAL
and learn lessons in courage.

The pride you’ll feel in being a doctor increases dramatically when you care for our Soldiers and their Families. Courage is contagious. Our Health Professions Scholarship Program (HPSP) helps you reach your goal by providing full tuition, money towards books and lab fees, a $20,000 sign-on bonus, plus a monthly stipend of more than $2,100.

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MEMBERS
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Board Members
Terms expiring 2014
Chandra Hartman, MD, FAAFP
Denver
E-mail: chandra.hartmann@gmail.com
Chet Cedars, MD
Lone Tree
E-mail: cthewlies@aol.com
Anna Wegleitner, MD
Denver
E-mail: awegleitner@mountainviewfamilymedicine.com
Sergio Murillo, MD
Pueblo
E-mail: sergiomurillo@yahoo.com
Terms expiring 2015
Monica Morris, DO
Denver
E-mail: mccorriga@zagmail.gonzaga.edu
Wilson Pace, MD, FAAFP
Denver
E-mail: willson.pace@ucdenver.edu
Rob Vogt, MD
Colorado Springs
E-mail: rpvm@comcast.net
Zach Wachtl, MD
Denver
E-mail: zzwachtl@gmail.com
NEW Term Expiring 2016
Michael Archer, MD
Westminster
E-mail: marcher@completefamilymed.com
John Cawley, MD
Ft. Collins
E-mail: jcawley@afmfc.com
Tamaan Osborne-Roberts, MD
Denver
E-mail: tamaan.osbourne.roberts@gmail.com
Wendy Richmond, MD
Pueblo
E-mail: wendyalexandra@hotmail.com

Delegates
John Bender, MD, FAAFP, Ft. Collins
jlbender@miramont.us
term expires 2013 (1st term, two congresses, 2012 & 2013)
Kent Voorhees, MD, FAAFP, Littleton
kent.voorhees@ucdenver.edu
term expires 2012 (2nd term, two congresses, 2011 & 2012)
Alternate Delegates
Brian Bacak, MD, FAAFP, Highlands Ranch
brian.bacak@healthonecares.com
term expires 2013 (1st term, two congresses, 2012 & 2013)
Lake Casias, MD
Hesperus
E-mail: lcasias@hotmail.com
term expires 2014 (1st term, two congresses, 2013 & 2014)

Resident Representatives
Carolyn Francavilla Brown, MD, Rose
carolyn.francavilla@healthonecares.com
grad 2013
Kevin Piper, MD, Greeley
kevin009@gmail.com
Anneliese Heckert, DO, Pueblo
anneliese.heckert@centura.org
Sarah Hemeida, MD, Denver
sarah.hemeida@ucdenver.edu

Student Representatives
Nicoie Struthers, CU,
nicole.struthers@ucdenver.edu
class of 2014

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.

Contact Information for the CAFP:
Colorado Academy of Family Physicians
2224 S. Fraser St., Unit 1
Aurora, CO 80014
Phone: 303-696-8655 or 1-800-468-8615
Fax: 303-696-7224
E-mail: info@coloradoafp.org

CAFP Board of Directors
Officers 2013-2014
Chair/Past President
Kajsa Harris, MD
Pueblo
E-mail: kajshaharris@hotmail.com
Vice President
Rick Budensiek, DO, FAAFP
Greeley
E-mail: president@coloradoafp.org
Secretary/Treasurer
Ryan Flint, DO
Denver
E-mail: ryanflint@centura.org
President-elect
Candace Murbach, DO, FAAFP
Pueblo
E-mail: candacerm210@aol.com

Editor
Kajsa Harris, MD
kajshaharris@hotmail.com
Education Committee Chairs
Chandra Hartman, MD, FAAFP
chandra.hartman@gmail.com
Anna Wegleitner, MD
wegwoods@aol.com
Legislative Committee Chair
Candace Murbach, DO
candacerm210@aol.com
Glenn Madrid, MD
gmadrid@pcpgj.com
Staff
Raquel Rosen, MA, CAE
Chief Executive Officer
E-mail: Raquel@coloradoafp.org
Manthan Bhatt
Director of Communications
E-mail: Manthan@coloradoafp.org
Sarah Roth, MA,
Fit Family Challenge Program Manager
E-mail: SarahR@coloradoafp.org
Jeff Thormodsgaard
Director of Public Policy
E-mail: jeff@mendezconsultinginc.com
Erin Watwood
Director of Education, Events, & Meetings
E-mail: Erin@coloradoafp.org

Created by Publishing Concepts, Inc.
David Brown, President • dbrown@pcipublishing.com
For advertising information contact:
Deborah Merritt at 501.221.9986 ext. 109 or 800.581.4686 dmerritt@pcipublishing.com
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As I write this first installment of the president's letter, I am numbed by the untimely death of Bob Brockmann, MD, our CAFP’s immediate past president. Bob devoted years of experience and relationship building to his presidency and will be sorely missed not only by his family, friends, and acquaintances, but also by our organization and the Colorado Medical Society. He died suddenly from a cardiac event.

According to his older brother, Bob was healthy. He ate salads in place of steaks. He exercised regularly and practiced the lifestyle he preached.

He enjoyed meaningful relationships. He took time for enjoying life as evidenced by his hang gliding adventures and passion for the out-of-doors. He enjoyed his family and was adored by his nieces and nephew who affectionately called him Dr. Bob.

I don’t know if Bob saw a primary care physician regularly, but in reflection of this tragic event, it is a time to look at our own health and habits. We think of the medically underserved as folks without insurance or finances to get medical care. How about us as physicians who deliver health care? Are we medically underserved for different reasons? Do get preventive care and have we designated a primary care physician? Are we exercising regularly and is someone (other than the “patient as doctor”) paying attention to your risk factors for disease? Do we have balance in our lives? Do we take time to develop as a whole person? We are busy and may be letting these things slide, but at what peril? Our primary care workforce is aging. Our numbers are dwindling. We need to make healthy habits and work/life balance a priority. We are too valuable to be taken at the prime of our life by preventable diseases.

Speaking of preventable diseases and family physicians, more and more, I am hearing my colleagues talk about burn-out and baby-boomer retirement in the primary care workforce. Being a baby-boomer and full time family physician, myself, I feel the increased pressure at work. First, the transition to EHR while maintaining patient satisfaction is a tough chore. Baby boomers are especially prone to struggle with this change to EHR from paper. Physiologically, as we get older, the amygdyla in our central nervous system becomes less able to adapt to change. Not having grown up with the computer as the Millenials have, the use of the computer is a new skill. It is hard enough to learn new work flows the EHRs require, let alone innovate and design new work flows that maximize efficiency while maintaining quality.

Second, the transition from quantity to quality in a fee for service compensation model to quality in a pay- for- performance model is awkward and ambiguous. This is not just a generational issue. Several of the practices that were fully committed to developing a PCMH are finding it hard to maintain now that the funding has dwindled. Several practices who participated in the Multipayer PCMH Pilot Project aren’t able to sustain that model because of a lack of compensation to maintain the staff and services which bring about transformation in our practices. Who pays for the services a PCMH provides to all insured? When does that payment start and end? What are the criteria for the increased compensation. How can we meet each Health Insurance’s quality guidelines when they are so varied, numerous, and contradictory? There are many other distressing issues, but space doesn’t permit a laundry list of them all.

So, the AAFP and CAFP have their work cut out for them. This is a window of opportunity to become the doctors we aspired to have when we entered family medicine. I have hope for a day when I can use my physician skills instead of looking for clinical information, worrying about who hasn’t shown up for their chronic disease follow up, wondering if that patient ever saw the doctor I referred him/her to, or if they got the labs I ordered completed. Instead of wondering if I reminded my patient of their care gaps, I’d know my Medical Assistant or I handled that because it is documented and discoverable! Transformation is hard, but if not us, who? If not now, when?

Having said that, it is important to learn from our colleague, Bob Brockmann. Having known Bob pretty well, I can almost hear Bob telling us these issues are important, but at the end of the day, it is about meaningful relationships, having a balanced life, maintaining a healthy lifestyle, and being a part of something bigger than ourselves.

Our organization is in a good place, thanks to the hard work Bob Brockmann and others did this past year. Thanks to Raquel Rosen, our Chapter executive, our lobbying firm, Mendez and associates and partner representing us, Jeff Thormasgaard and the dedicated physicians who serve you on the executive committee. I look forward to working with each of you on the CAFP team.
SAD NEWS

In May of this year, Bob Brockmann, MD, MS, FAAFP, passed away suddenly from cardiac arrest. He was the CAFP President and had spent many hours working on behalf of the CAFP. He was extremely dedicated to furthering the mission of the CAFP and the value and importance of Family Medicine Physicians. Dr. Brockmann was a very strong, engaged, brilliant leader and his passing created a large void. The CAFP board of directors have stepped up to continue his work. We are all very sad over this loss and he will be greatly missed.

NEW STAFF

As I reported in the last magazine, in November of 2012 the CAFP board members directed me to determine the best staffing for CAFP to meet the demands of the current environment. In March of 2013 the board approved two new staff positions. Manthan Bhatt is the new Director of Communications and is in charge of the CAFP magazine, electronic newsletter, membership, social media, and public relations. Erin Watwood is the new Director of Education, Events, and Meetings and coordinates the annual scientific conference, webinars, board meetings, and all other events. And Sarah Roth has been promoted to Director of Health of the Public and oversees the Tar Wars program as well as manages the Fit Family Challenge program. The CAFP has been infused with new energy and enthusiasm. Manthan, Erin, and Sarah, bring excellent, relevant experience and expertise to their roles at the CAFP. I am also energized and excited about the future work of the CAFP. Our new staff vision is to create a dynamic organization forwarding the goals of CAFP. This will bring increased non-dues revenue, more education opportunities, improved communications including social media, magazine, and web site, and many other enhanced programs.

ANNUAL LEADERSHIP FORUM (ALF) AND NATIONAL CONFERENCE OF SPECIAL CONSTITUENCIES (NCSC)

Thank you to Sarah Roth for coordinating the Colorado group and to the following members who represented the CAFP at ALF and NCSC:

ALF:
Bob Brockmann, MD
Rick Budensiek, DO
NCSC:
GLBT - Brea Bond, MD
IMG - Sergio Murillo, MD
Minority - Tamaan Osbourne-Roberts, MD
New Physician - Zachary Wachtl, MD
Women - Wendy Richmond, MD

MEDICAL STUDENTS

One of the focus areas for the CAFP is Family Medicine workforce so the CAFP staff have ramped up efforts to educate medical students at CU and RVU about the value and importance of Family Medicine. The growth of student interest shows in our membership numbers:

Jan. 2012 220 student members
Jan. 2013 252 student members

OVERALL CAFP MEMBERSHIP HAS GROWN

A quick recap shows that the number of members has been growing every year.

continued on next page >>
DOCTOR OF THE DAY PROGRAM – EXCITING CONTEST!

The Doctor of the Day program is very important for Colorado’s Family Medicine Physicians because it showcases the breadth of the specialty. The legislators at our state Capitol very much appreciate the time and care you give when they need medical attention. Plus our Family Medicine Physician volunteers enjoy learning about the legislative process and speaking with legislators when needed to explain how particular pieces of legislation would impact your practice. You do not need to know anything about politics or legislation. Our capable lobbyist, Jeff Thormodsgaard, will take care of that. Legislators seek out our Family Medicine Physicians so that you can explain to them how a bill will effect medicine.

To show our appreciation for the time and effort it takes for you to volunteer as the Doctor of the Day, your name will be entered into a drawing at the end of the session for an iPad mini. Each time you volunteer, your name will be entered. So if you volunteer three times, you will have three chances to win! This prize is a $400 value.

You can sign up by going to www.coloradoafp.org and click on Doctor of the Day. The session will begin Wed. Jan. 8, 2014. We will automatically enter your name for the drawing.

“The CAFP has been infused with new energy and enthusiasm. ... I am also energized and excited about the future work of the CAFP. Our new staff vision is to create a dynamic organization forwarding the goals of CAFP.”

<table>
<thead>
<tr>
<th>Year</th>
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<th>Total Members</th>
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2013 SESSION HEALTH CARE WINS

This year was an extremely prosperous year for new and improved health care issues. The Academy actively supported most of the issues mentioned below; passively supporting the rest. CAFP continues to be a driving and highly respected association at the Capitol, especially this year on critical health care reforms. If you would like more information about any bill, please don’t hesitate to contact us.

MEDICAID EXPANSIONS & HEALTH CARE REFORM

One of the most anticipated, and important pieces of legislation was SB 200, Medicaid Expansion. This bill expanded Medicaid eligibility from 100 percent of the federal poverty level (FPL) to 133 percent for parents and caretaker relatives with dependent children (parents) and adults without dependent children (AWDC). It also allows the state’s share of costs for these eligibility groups, up to 133 percent of FPL, to be paid with Hospital Provider Fee Fund money. It was essential this legislation happened this session, because of the Federal requirements under the Patient Protection Affordability Care Act. Without the passage of this bill, Colorado would not be eligible to receive 100% matching federal funds for the expanded population, beginning in 2014.

Under the same purview as Medicaid expansion, SB 242, Adult Dental Medicaid Benefits, expands Medicaid dental benefits to adults allowing for matching Federal dollars if implemented before 2014. This benefit will be defined by the Colorado Department of Health Care Policy and Financing (HCPF), and is set to begin in April 2014. Both SB 242, and HB 1245, Funding for the Colorado Health Benefit Exchange (COHBE), will receive funding previously allocated for CoverColorado. HB 1245 established the funding mechanism for COHBE similar in nature to how CoverColorado was funded previously. Additionally, the bill creates two funding mechanisms for COHBE, a premium tax credit against the premium tax owed by insurance carriers for donations to the health exchange, capped at $5 million and only qualified health plans will be eligible; the second is a fee assessment for individual and small group insurance plans, $1.80 per member, per month until December of 2016. HB 1115, Repeal of CoverColorado, repealed the CoverColorado program, which insured high risk individuals denied by private insurers; this program will no longer be necessary with the implementation of PPACA in 2014, which forbids insurance companies from denying benefits to individuals with pre-existing conditions.

Additionally there were a few changes made concerning Medicaid; included in this category are: HB1068, which aligns state law concerning the inspection of Medicaid providers with federal law, allowing for unannounced inspections for audit or review. The bill also specifies that HCPF or its designated agent is required to conduct site visits of providers who are designated, under federal regulations, as moderate or high risks for fraud and abuse. Finally, HB1196 requires HCPF to make an annual report to the legislature about efforts to reduce waste and duplication within the Accountable Care Collaborative (ACC) program of Medicaid. HB1309 would have required all diagnostic breast imaging services to be covered by insurance plans and not be subject to copays or cost sharing requirements. Until the federal government could provide clarification on whether or not it would be considered a new mandate, legislators were uncomfortable passing this bill.

Other significant changes in insurance regulation include: SB 8 eliminates the 3-month waiting period for CHP+ that has required some children to be uninsured for 3 months before applying for the program. The bill will be implemented once the state plan amendment is approved by the federal government. HB1266 aligns state health insurance law with federal law to give the insurance commissioner the necessary authority to regulate health insurers with respect to new requirements of the federal law. The 150 page bill reflected extensive work by the Division of Insurance and stakeholders. HB1290 makes changes to the law regulating stop loss health insurance used in conjunction with self-insured small employer benefit plans. It sets requirements for the issuance of stop loss health insurance; including a minimum dollar amount for the attachment point and a prohibition against attachment points that vary by individual or that exclude any employee or dependent. Finally, it requires insurers to disclose information to businesses and to report information to the state.

MEDICAID BUDGET ITEMS

Items in the budget for FY12-13 and/or FY13-14 related to Medicaid and CHP+ included the following:

- 2% increase in reimbursement for Medicaid providers
- Additional 7.4 FTE (9 employees) at HCPF to improve stakeholder relations, handle increased caseload and budget, address federal requirements and reduce turnover
- Adequate FTE at HCPF for implementation of HB12-1281, Medicaid payment reform pilot
- Customer service technology improvements for the Medicaid client call center
- State funds and authority needed to build a new Medicaid claims processing system (MMIS)
- Payments of $9M to FQHCs and RHCs for CHP+ to come into compliance with federal law regarding CHP+ reimbursement for these providers
- $1.15M to HCPF for the treatment of Medicaid eligible women with breast or cervical cancer
- An increase in funding for the Commission on Family Medicine of $315,000, plus an additional $500,000 to support the establishment of rural residency(ies)
- Spending authority for Denver Health to certify funds for federal match to care for long-term patients that cannot be continued on next page >>
discharged due to lack of appropriate care facilities

PUBLIC HEALTH

More than a handful of bills passed this session impacting the success of public health. Thanks to an overwhelming effort by Dr. Brockmann, two big wins for CAFP in the public health arena include: SB 014 which will provide immunity from criminal and civil liability for a person other than a health care provider or a health care facility who acts in good faith to administer an opiate antagonist to another person who is believed to be suffering an opiate-related overdose. The bill also provides immunity from criminal and civil liability, and charges of unprofessional conduct, for licensed prescribers and dispensers of opiate antagonists, by licensing authorities for certain health professions based on good faith administration of an opiate antagonist. An opioid antagonist blocks the effects of prescription and illicit opioids. And SB 208 was also passed this session. Current law exempts employees and volunteers of an approved syringe exchange program from being charged with a misdemeanor offense under state drug paraphernalia laws. This bill expands this exemption to include program participants.

Another big win, led by CAFP was SB 222. This bill removes the prohibition for the Department of Public Health and Environment (DPHE) to create a “universal” system for purchasing vaccines. However, due to the controversial nature of a universal purchase, the final legislation did three things:

• Eliminates the current statutory prohibition thereby allowing the Colorado Department of Public Health and Environment (CDPHE) to engage in a stakeholder process about the state’s vaccine financing and delivery system.

• Directs CDPHE to engage in a stakeholder process to discuss a wide variety of issues related to vaccine financing, order and delivery, including a public/private model of vaccine purchase and delivery, existing models of vaccine financing, just-in-time delivery, inventory management, outbreak response, Colorado Immunization Information System (CIIS) linkage to inventory, vaccine shortage response, preservation of vaccine delivery in a medical home model of care and mechanisms for local public health entities to bill insurance carriers.

• Authorizes the Board of Health at CDPHE to promulgate rules necessary to implement the outcome of the stakeholder process, while preserving current models of vaccine financing, order and delivery at the discretion of the provider.

PROVIDER CHANGES

There were several pieces of legislation this session that will directly impact family physicians and all providers. In addition to the 2% provider rate increase, included in the long bill; one of the biggest changes this year that has been defeated in the past was surrounding the licensure and regulation of naturopathic doctors, and alternative health care providers. SB 215 places certain requirements and restrictions on practitioners of complementary and alternative health care services who are not otherwise licensed or regulated by the state as a health care professional. Specifically, the bill requires practitioners of complementary and alternative health care services to provide a written disclosure to clients. Additionally, the bill outlines services and practices that may not be performed by practitioners of complementary and alternative health care services, as well as procedures that may be provided with certain training. Failure to provide the required disclosure or performing prohibited services constitutes a deceptive trade practice under the Colorado Consumer Protection Act. The bill also specifically exempts complementary and alternative health care services from the definition of “practice of medicine” if the services are provided in compliance with the bill.

Unlike SB 215, HB 1111 requires naturopathic doctors to obtain a license to practice in Colorado on or after January 1, 2014. The newly created board of naturopathic medicine in the department of regulatory agencies (department) is tasked with all functions necessary to regulate naturopathic doctors, including adopting rules, establishing application procedures, approving education and training, and disciplining naturopathic doctors. The bill also included negotiated provisions, to specifically delineate the differences between naturopathy and the practice of medicine. The licensing of naturopathic doctors is subject to sunset review by the department and is set to repeal on September 1, 2019. There were several systematic changes as well. SB 277 requires the Commissioner of Insurance (commissioner) in the Department of Regulatory Agencies (DORA) to develop by July 31, 2014, by rule, a uniform prior authorization process for insurance carriers to submit and receive requests for prior coverage approval of a drug benefit. Prior authorization is an extra step that some insurance carriers require before deciding to approve coverage of a patient’s medicine. Under the prior authorization process to be developed by the commissioner, insurance carriers and pharmacy benefit management firms (carriers) will be required to:

• make the process available electronically, but must not require the prescribing provider to submit a prior authorization request electronically;

• make certain items accessible in a centralized location on their web sites;

• use evidence-based guidelines, when possible, when making prior authorization determinations;

• include certain information in its prior approval notification; and inform a prescribing provider that the covered person has a right to appeal the denial of a prior approval request.

The least popular change was SB 23 increases the damage caps under the CO Governmental Immunities Act (CGIA) from $150,000 to $350,000 for one individual and from $600,000 to $999,000 for any single occurrence. In 2018, the damage caps will be adjusted per inflation every four years. This was a compromise between those entities affected by CGIA and trial lawyers.

MENTAL HEALTH

Like other areas of health care, mental health was no exception when it came to big wins. Of all the changes, the two biggest were likely SB 266 and HB 1296. SB266 directs the Department of Human Services (DHS) to issue requests for proposals (RFPs) to create a coordinated behavioral health care system.
HE’LL NEVER SEE HER FIRST CATCH.

WE NEVER SAY NEVER.

When Jerry was diagnosed with lung cancer, he thought he would never be strong enough to get out on his boat again. But at National Jewish Health, we never say never. That’s the reason we are the nation’s leading respiratory hospital. It’s also why, today, we are a leader in lung and gastrointestinal cancers. It’s all part of our mission to help people like Jerry live longer, healthier, happier lives. Call 1.800.621.0505 or visit njhealth.org to make an appointment.
Attending the AAFP NCSC was an eye opening experience, showing me how one voice with one idea can begin to affect AAFP policy. As a first time attendee and novice to organized medicine, I will admit that I came into the conference with no agenda and little understanding about what would be happening over its 3 days. But by the time I left, I had managed to coauthor a resolution that will help to direct our organization! So I will briefly share what I experienced, to clarify for the rest of you who may have the same (lack of) understanding that I did, and inspire you to become involved as well.

NCSC had 5 constituency groups: IMG, GLBT, Minority, New Physician and Women, with representatives sent from each state. I began my conference meeting and brainstorming with the other new physician present. We were asked to put forward any ideas of what we felt needed to be addressed by the AAFP. This is when I realized that many people were more prepared than I, having been here before and coming with well planned agendas. We went around the room tossing out ideas. Feeling the peer pressure (in a good way) I contributed what I felt was a pressing issue for our state.

I did not have a specific goal in mind, but a general topic. But the response to the idea was positive. After brainstorming was done, we concluded that my idea was one of those that we would try to flush out further. I was joined by 4 other new physicians interested in the topic; one from another state with the same issue. We further brainstormed about what we wanted to focus our efforts.

We researched current AAFP policy and available patient education related to the topic, and found it to be conflicting and lacking. Our facilitators, including AAFP staff, board members, and prior NCSC attendees helped us understand what was within the purview of AAFP and how to best craft a resolution that would succeed. By the end of Day 1, we had successfully written a resolution.

The next day of the conference, our resolution was slated for testimony in front of the Advocacy Reference committee, one of 5 policy committees. Having never seen this process before, and given that our resolution was first on the slate, I was nervous about what to say and how to say it; but the good news is that I survived the process. So I got up to the mic in front of the 6 member panel and shared why I thought this issue mattered and should be addressed by the AAFP. Several other participants who were not involved in the authoring also provided support for the concept. To my surprise, no one provided dissent.

After hearing testimony on our resolution and the others on the slate, the reference committee met in closed door session with AAFP staff to research claims made and clarify intent of the resolutions presented. By the end of Day 2, the committee gave their recommendations. I was excited to see that they recommended to adopt our resolution, with only minor word changes. Other resolutions were significantly altered, and some were recommended for rejection.

Day 3 involved all of the 5 reference committees providing their recommendations to the entire group for vote. During this parliamentary procedure, I was truthfully at times confused with the motions to amend and strike and etc, but did get the hang of it eventually. In the end, the majority of the reference committees’ recommendations on the resolutions were adopted, although several resolutions were further debated and amended in the large group setting. Our resolution was accepted without further debate.

And now what exactly does that mean? In truth, I don’t fully understand yet. The resolution I coauthored will move up in the organization, and I will be watching to see where it goes and what the outcome is.

My point in sharing this all with you is to have you realize that there is the potential to have a voice to affect change within Family Medicine. Without any preconceived plan or goal, I went to this conference and in less than 3 days managed to pass a resolution I coauthored. I was also able to meet and collaborate with the current leaders of our professional society. So if you have passion about an issue and think you have a proposal to change it, you need to consider going to this conference next year. I know that if I go next year, I will be more prepared. And we’ll see what I will be able to accomplish.
health crisis response system to assist individuals experiencing a behavioral health emergency. The components of the system are to include:

- Walk-in crisis services
- Mobile crisis services and crisis stabilization services
- Respite and short-term residential services
- 24-hour crisis telephone line services
- Public information campaigns to raise awareness of behavioral health needs/available services.

The budget included a $19.8 million General Fund appropriation for implementation of this bill. HB1296 creates a task force to study and review the mental health, substance abuse and alcohol civil commitment statutes and determine the most effective and efficient way to combine them into one. It also redefines the terms “gravely disabled” and “danger to self or others” and requires the task force to ratify those definitions. The task force must report back to the Legislature by November 2013.

TOBACCO MONEY

There were two notable changes in how the state collects money from tobacco sales. HB1144 bill eliminates the state sales and use tax exemption for cigarettes. Prior to July 1, 2009, cigarettes were exempt from state sales and use taxes. Through various legislative actions, cigarettes were subject to the state sales and use tax from July 1, 2009, through June 30, 2013. This bill continues the current sales and use tax on cigarettes after July 1. Note: The cigarette sales and use tax exemption does not impact cigarette excise tax, nor the Amendment 35 tobacco tax. Additionally The JBC recommended, HB1181 which allows programs that receive tobacco litigation settlement moneys to increase their spending authority under certain conditions. The bill does not change the statutory allocation of tobacco settlement distributions. It establishes separate cash funds for programs that do not already have a dedicated cash fund and allows a cash fund to retain excess moneys at the end of a fiscal year in an amount of up to 5% of the amount appropriated.
Old guys like me remember ALF as a television personality who was a furry, intelligent, sarcastic alien with the nose of an anteater and the hair of a chow. The analogies with the AAFP Annual Leadership Forum for Chapter Executives and Presidents/Presidents elect stop at “intelligent” perhaps mixed at times with a little pinch of sarcasm! We did learn form the Graham Center presentation that the main source of new family physicians is from foreign medical graduates. Although there is a marked growth in osteopathic medical schools, the absolute number of new family physician residents from those schools is fairly flat.

The conference began by bringing Chapter Executives and Chapter leaders together to talk about assessing our leadership styles, forming effective teams, and giving a road map for growing our organization.

After that groundwork was laid, leaders met to lay out the issues facing our organizations as we prepare for the future. Recurrent themes included getting all payers to pay for the work and resources practices are using to transform practices to the PCMH model, using AAFP muscle to help chapters like New Jersey where commercial payers are reimbursing 50% of medicare rates, support of independent practices, the hindrances of the EMR in terms of productivity, the challenges of delivering quality in a payment system that still rewards mostly on a fee-for-service basis, increasing the primary care work force by putting higher value on primary care at the medical school level, and others.

During a presentation on the Comprehensive Primary Care Initiative, Julie Shilz, representative from Wellpoint, who administers the government equivalent of a Human Resources department for 90 million lives in the US, shared that Wellpoint has committed to the PCMH model not only for that book of business, but also for their commercial products of Anthem of Colorado and other states. Julie formerly worked for Health Teamworks and is based in Denver. John Bender followed that up on his “Practice Makeover” talk. His talk was well received.

It was a pleasure to raise my hand almost every time the question was asked, “Is your chapter doing….” These topics ranged from having “Doctor of the Day” programs to having a robust lobby at the state capital.

Notable soundbites included:

- “CPCI is our best hope of better compensation for the PCMH.” Glenn Stream, MD, former AAFP president.
- If CPCI is successful, the Secretary of HHS can expand the initiative without additional congressional approval.
- Employed Family Physicians now at 60%, projected to be 70% in the next year. Employed physicians are happier with the direction of the AAFP than independent physicians.
- Of 14 chronic care illness, all but 2 have a clear higher frequency of visits to primary care vs specialty care for those conditions.
- Comprehensiveness of a physicians services is inversely proportional to costs of that physician’s care.
- Army and Kaiser data show that PA/NPs working with physicians in care teams are more cost effective than having them work independently. Since this is proprietary information and not published, the AAFP is using an outside research source to corroborate that information.

Dealing with the media:

- Have talking points for yourself. When preparing for an interview, don’t ask what the reporter will ask. Have your own talking points and segway into that. Offer to give a cheat sheet of background.
- Keep your answer to 6-10 seconds when asked a question.

Crisis communication

- Be honest
- Have a crisis plan
- If media person keeps asking a question over and over, answer the same. They will usually leave you alone.
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The annual National Conference for Special Constituencies (NCSC) is a unique opportunity for physicians to directly impact healthcare policy within the American Academy of Family Physicians (AAFP). This was my first year to attend as Colorado’s gay, lesbian, bisexual and transgender (GLBT) delegate. I returned home inspired and energized.

It is critical for physicians to have a voice, to speak out for our patients. We know the reality of healthcare. We see the results of the guidelines, initiatives, recommendations and policies put forth by the government and medical societies. We understand our patients’ struggles like no one else can. Unfortunately, we rarely have time to ponder the larger context, let alone time to create and collaborate. NCSC is an incredible opportunity to do just that.

I cannot help but reflect on NCSC from a historical perspective. For GLBT people, the past 30 years have been a whirlwind of change. In the mid-1980s –the height of the U.S. AIDS epidemic-- I was a young lesbian in college. I remember the weekly funerals, the fear of the unknown, and the public panic. I remember asking my friends with bated breath, “How’s John?” meaning “Is John in the hospital? Is he still alive?” I remember the bright yellow gloves police wore when arresting ACT-UP protesters. Then the research happened, policies began to change, and medications were developed. I remember the hope that came with AZT.

Thanks to the efforts of many, HIV can now be managed as a chronic disease. GLBT lives have changed. We have more support, more protection from discrimination, and more opportunities to engage in our communities. Marriage is now a possibility for many people across the country. After years of protesting in front of the capitol, writing letters to congressmen, and organizing local GLBT communities, I was honored to be asked to get involved with NCSC and to share my voice.

This year’s GLBT constituency drafted wide-ranging resolutions which included public health recommendations and health policy initiatives:

- yearly screening for gonorrhea and chlamydia for men who have sex with men
- access to over-the-counter emergency contraception
- allowing organ donations from HIV positive patients to HIV positive patients when medically appropriate
- including gender identity and gender expression to AAFP anti-bullying policies
- various measures to prevent gun violence

Last year the conference approved a resolution supporting marriage equality as a way to eliminate health disparities and improve health outcomes for GLBT patients. The resolution will be presented to the Congress of Delegates in San Diego this September.

Thank you for allowing me to participate in NCSC. Thank you for inspiring me to get more involved in AAFP and health policy. Thank you for reminding me the importance of sharing my voice. NCSC is an amazing experience. I recommend it to everyone who is itching to speak up. Mark it on your calendar for next year: May 1-3, 2014 in Kansas City!
Raquel J. Rosen, *Chief Executive Officer*
303-696-6655  Ext. 10

Raquel J. Rosen is chief executive officer of the Colorado Academy of Family Physicians (CAFP). She assumed this position in November 1987 after extensive experience in the medical field. This year marked Rosen's 25th year with the Academy.

Rosen holds a Bachelor of Arts from the University of Denver and a Master's degree in counseling from the University of Colorado at Denver. She is also a credentialed Certified Association Executive.

Her professional affiliations include memberships with the American Society of Association Executives and the Colorado Society of Association Executives, where she served as president.

Rosen is married and resides in Aurora. Her personal interests include Quan Yin meditation, yoga, hiking, biking, and walking.

Sarah E. Roth, *Director of Health of the Public*
303-696-6655  Ext. 16

Sarah E. Roth is the Director of Health of the Public at the Colorado Academy of Family Physicians (CAFP). She joined the CAFP staff in July 2012 as the program manager for the Fit Family Challenge.

Roth holds a Bachelor of Arts degree from Saint John's University and a Master's degree in International Development from the University of Denver.

She previously worked for Higher Education Resource Services as a program coordinator. Her strengths revolve around her ability to adapt and play different roles in an organization.

Roth resides in Denver but was raised in Crystal Lake, Illinois. Her hobbies include tending to her community garden, bike riding and CrossFit training. Roth also volunteers for the Denver Rescue Mission.

Erin M. Watwood, *Director of Education, Events, & Meetings*
303-696-6655  Ext. 14

Erin M. Watwood is the Director of Education, Events, and Meetings at the Colorado Academy of Family Physicians (CAFP). She recently joined the CAFP staff in April 2013.

Watwood holds a Bachelor of Arts degree in Organizational Communication with a minor in Meeting Administration from Metropolitan State College of Denver.

She previously worked for SNAP Meeting Solutions, a Medical Education Company, as a Meeting Planner. Erin has worked in the meetings industry for the past 12 years. Her strengths revolve around her customer service skills and her attention to detail.

Watwood currently resides in Parker with her husband, stepdaughter, and cat. She was born in Oklahoma and raised in Colorado. When Erin isn’t cheering at her stepdaughter’s volleyball games, she is listening to music. She loves spending time with her family and friends, going to concerts, reading, and cooking.

Manthan Bhatt, *Director of Communications*
303-696-6655  Ext. 17

Manthan Bhatt is the Director of Communications at the Colorado Academy of Family Physicians (CAFP). He recently joined the CAFP staff in April 2013.

He holds a Bachelor of Arts degree in Economics from the University of Denver.

He previously worked as the Managing Editor of the DU Clarion and the Communications Director for Daniel Kagan for HD3, the largest house campaign in the 2012 Colorado election.

Manthan currently resides in Denver with other recent graduates of DU. He was born in India and raised in Colorado. When he isn’t volunteering in Colorado politics, he is playing hockey and reading non-fiction.
2012 ANNUAL REPORT
KEEPING COLORADANS HEALTHY
I am pleased to present the Colorado Academy of Family Physicians’ 2012 Annual Report, which reflects another strong year filled with successes and achievements.

Membership in our professional organization continues to grow in spite of the recent recession, the move from private practice to employed physician models and the ongoing financial stresses in many of our practices. **We can boast that nearly 80 percent of Colorado Family Medicine Physicians and every single Family Medicine resident is a member of CAFP.**

I believe our impressive membership numbers are a reflection of CAFP’s ongoing relevance to every Family Physician. The vital work we do advocating for Family Medicine as the backbone of the evolving health care system, along with our very public advocacy for patients, resonates with Family Medicine Physicians regardless of circumstances.

We continued to nurture our strategic alliances, while expanding our horizons. The new world of health care will require physician-led teams of health care providers, all working in a coordinated, comprehensive and cost-effective system of care that emphasizes a patient’s health care needs throughout their lifespan. This is the service Patient Centered Medical Homes (PCMH) deliver. We continued to help build medical homes, have reached out to dentists, physician assistants, chiropractors and patient advocacy groups, to name a few, all with the same message - there is a place for every health care provider within the medical home. Some will join, some will continue to insist on their own silo, but in the end patients and payers will demand the medical home model care.

This year for the first time, we endorsed specific candidates for office, and backed up those endorsements with contributions from the small donor committee and our PAC. Our objective style of choosing candidates was well received and clearly sent a message that CAFP is driven by enduring and fundamental principles supporting patients and the PCMH.

The rate of change in health care has dramatically quickened and CAFP has engaged in many initiatives, projects and sustaining efforts to respond. Notably, we enhanced our website to provide more health information for consumers, we produced a television show covering several common primary care topics, and continued educational efforts regarding the PCMH. We also continued to make a concerted effort to be the source of information for media, consumers and legislators regarding “all things primary care.”

The Board authorized a makeover for the internal structure of CAFP as our successes and growth required us to reshape office staffing and functions. This involved internalizing core functions and hiring a set of directors for each area of focus. As CEO, Raquel Rosen is overseeing this transition and we are all very impressed with the great team she has assembled.

Finally, I want to thank each and every member for continuing to support CAFP, as the organization simply would not exist without you! Please be sure that Family Medicine Physicians in your practice renew their membership. If you would like to get more involved in the vital and exciting work of CAFP, let us know - there is plenty to do!

Robert Brockmann, MD, MS, FAAFP
President

**Colorado Academy of Family Physicians**

The Colorado Academy of Family Physicians (CAFP) serves as the bold champion for Colorado’s family physicians, patients, and communities through education and advocacy. Representing 2,000 physicians and medical students, CAFP is the largest primary care specialty organization in Colorado and is the only medical society devoted solely to primary care.
Advocacy and Education
CAFP maintained a strong presence at the state Capitol, which led to the passage of legislation supportive of Family Medicine Physicians and the health of Coloradans. Legislative successes supported by CAFP included:

- Expanded workforce data collection on licensure, renewal and certification applications with the state, which will help to identify if and where there are professional health care workforce shortages.
- Reauthorization and modernization of peer review statutes, including extending confidentiality provisions to advanced practice nurses and physician assistants.
- Approval for pharmacies to dispense prescribed controlled substances from electronically transmitted prescriptions, allowing physicians direct communication with pharmacies.

Looking ahead to the 2013 legislative session, CAFP continued to lead the medical community in its support for Medicaid eligibility expansion. CAFP also established an Advocacy Network to tap grassroots support for its legislative efforts.

Continuing Education and Best Practices
CAFP held its 64th Annual Scientific Conference in Colorado Springs to provide an engaging forum for members to explore health care trends and issues, increase cutting-edge medical knowledge and share best practices. More than 148 members attended 29 credits worth of continuing education presentations over four days.

Strategic Partnerships
CAFP collaborated with a wide range of organizations to foster the health of Coloradans.

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

CAFP has invested time and resources to adapt Family Medicine practices to the Patient Centered Medical Home model of care. As a result, Colorado has been leading the country in implementing medical homes, which are a proven means of delivering higher quality care, better outcomes and greater patient satisfaction, while lowering costs.

Transformational Health Care Delivery – Patient Centered Medical Home
CAFP remained a strong proponent of the Patient Centered Medical Home (PCMH) – an approach to care delivery that provides continuous, comprehensive, coordinated care for patients of all ages. Medical Homes comprised of a physician-led team of health care professionals ensures that patients receive the right care, from the right provider at the right time.

PCMH Pilot Validates Enhanced Care and Savings
CAFP participated in a four-year Colorado Multi-Payer PCMH Pilot, which concluded in 2012. The demonstration was designed to test whether more resources given to primary care practices using the PCMH model of care resulted in better health at less cost. While final data is still being
Compiled, preliminary indicators support PCMH efficiencies and effectiveness.

**Growing of Patient Centered Medical Homes**

Currently, 75 Family Medicine practices were recognized as Patient Centered Medical Homes by the National Committee for Quality Assurance in the state of Colorado. These Family Medicine practices in Colorado have met the criteria to attain NCQA recognition.

**Patient Centered Medical Home Best Practice of the Year**

Primary Care Partners, PC, in Grand Junction, was honored as the 2012 Patient Centered Medical Home Best Practice of the Year. The multi-disciplinary group provides primary care for more than 30 percent of Mesa County residents. The practice achieved PCMH recognition of the National Committee for Quality Assurance in September 2010, making it one of the first 100 medical home practices in Colorado.

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**SUPPORTING THE HEALTH OF COLORADANS**

Family Medicine Physicians are committed to giving back to improve the health of community members throughout Colorado through diverse programs and initiatives.

- **Educating Tobacco-Free Kids:** Tar Wars, a tobacco-free education program presented in fourth- and fifth-grade students across Colorado. Tobacco use is the leading cause of preventable death in the world today. CAFP Family Medicine Physicians made presentations to schools to raise awareness of the consequences associated with tobacco use and to motivate the children to make positive and healthy life choices.

- **Promoting Family Physicians to Colorado’s Legislators:** For more than 25 years, CAFP has provided health care services to legislators and staff at the Capitol during the legislative session through its Doctor of the Day program. Family Medicine Physicians volunteered their time and medical expertise on 48 days during the legislative session, which continues to be valued and appreciated by Colorado’s elected leaders.

- **Tackling Childhood Obesity:** Pediatric obesity continued to be a health issue of high concern in Colorado and across the nation. Knowing that obesity places children at risk for long-term health challenges, 11 practices participated in CAFP’s Fit Family Challenge initiative, which works with children and their families in primary care settings to incorporate positive lifestyle changes that decrease obesity. Thanks to positive and encouraging outcomes, CAFP received a second three-year grant from the Colorado Health Foundation to continue and expand this initiative, while broadening participation to 21 primary care practices.

- **Broadcasting Health Information:** CAFP produced a 30-minute TV program – On Call for Colorado - that provided rich content and useful health information to benefit viewers. The program featured five CAFP physicians who addressed health issues affecting people across the lifespan. The program was broadcast exclusively on Comcast Entertainment Television October – December 2012 and continues to air on many community access channels statewide. A public service announcement was also produced encouraging the public to take charge of their health. A downloadable KNOW card was offered on CAFP’s website to provide an easy way for individuals and families to record their personal health footprint.

- **Sharing Consumer Health Tips and Resources:** A Family Health section was added to CAFP’s website, where Colorado Family Medicine Physicians clarify health myths, provide health tips specific to living healthy in Colorado and describe the Patient Centered Medical Home. Also featured are links to the American Academy of Family Physicians’ comprehensive health and wellness website www.familydoctor.org.

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**CAFP 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 improve the health of the people of Colorado. The Foundation supports Tar Wars, the Annual Scientific Conference, and the Patient Centered Medical Home Best Practice of the Year.
Clara’s Early Arrival and Early Intervention

By Kelly McMullen, MD, Clinical Faculty, Exempla/Saint Joseph Family Medicine Residency

Clara was born early. Sometimes I describe it as 2 months early, but if the listener thinks that a month is 4 weeks, then she would have been a lot bigger when she came. So other times I say 2 ½ months early, which seems a bit more accurate given that she came in the middle of November, but wasn’t due until the end of January. But then it sounds like I’m splitting hairs. However, I never describe her birth as 3 months early, because while she was 11 weeks ahead of schedule, I know that 3 months early implies a whole lot smaller baby with a whole lot more problems than I believe my little Clara to have.

That’s the problem with being a doctor who is a patient, and describing my own little being’s unique entrance to the world to non-medical people. I know too much to make it simple, and too much to relax about it. I always have a sigh of relief when I learn that my audience is a medical professional. Then I can describe Clara’s early birth, and why it happened, with terminology that I feel implies all that we went through:

Clara was born at 29 wks 3 days (implied here: a fine time to be born in the medical world in terms of survival, but still with a certain amount of risk of all sorts of complications). She came early by c-section because I had HELLP syndrome (implied here: the baby was just fine, but had to be delivered to cure the mama). I was diagnosed with HELLP because my platelet count was 80 on the CBC that was done on my routine glucose tolerance test (implied here: I was feeling just fine and got my routine tests done at 28 wks, so this was a bit of a shock). My husband, another doctor, saw my platelet count first when I casually asked him to check my labs on Friday night after work. My platelet count prompted me to take my blood pressure, which, sure enough, was 150/90 (implied here: that is way too high for a pregnant lady). We continued on next page >>
went to the hospital, we were admitted, we got steroids and an ultrasound. The little one was in the 50th percentile for weight, estimated to be 1280 g, right on target. We learned that this baby would be a little girl (implied here: our baby looked like she was doing well and unaffected by my disease, and preemie girls do better than preemie boys). Clara and I were “observed” for several days. We had daily fetal heart monitoring, lots of blood pressure checking, many lab draws. I hoped that we could get a whole month more out of my abdominal incubator, or maybe even 6 weeks (implied here: prognosis for a 32 or 34 weeker is a whole lot brighter than for a 28 weeker). But I knew that HELLP wasn’t a disease that classically allowed all that much waiting (implied here: statistical max time for expectant management with severe pre-eclampsia is 7 days). I braced myself for all of the possibilities (implied here: I remember from my training, the earlier the delivery, the more increased risk of CP, retinopathy, blindness, deafness, ADHD, musculoskeletal disorders, neurological disorders, feeding problems, developmental disorders, NEC, pulmonary disease, requiring oxygen...increased risk of mortality). For Clara’s benefit, we managed to squeeze one more week of pregnancy out of my body (which apparently has quite a distaste for pregnancy as this was my second case of HELLP).

The Friday after we had learned I was sick, my platelet count started to drop so much that the team caring for me worried it was no longer an option for me to be pregnant, so Clara was delivered by c-section. I was lucky enough to be awake for her birth thanks to a brave anesthesiologist, and heard her cry out as soon as they passed her to one of the gaggle of NICU attendants at her birth. Her Apgars were 8 and 9 (implied here: she initially appeared just about as healthy as any baby could be). Her weight was 1315 g (2# 14oz). She was given CPAP (implied here: she was breathing well), and whisked away in the incubator, stopping briefly about 5 feet from my eyes so I could take peek at the little life that we were trying so hard to protect. My husband could see her better, and told me she looked like a Clara. So that is what we called her.

It is impossible to tell Clara’s story without telling about her birth. She was tiny. And like most sopping wet babies, she got even tinier as she dried out over the next couple of days. I didn’t think too much about it because she was getting a highly scientific concoction of TPN and colostrum by NG tube, and I didn’t think there was much more we could do about it. Each evening she was put on the scale like a little wrestler, and her weight was posted on her NICU bay wipe board. Her nadir was 1195 g, which we learned the following morning from the physical therapist who attended to her, would qualify her for Early Intervention. What? Kids in NICUs automatically qualify for Early Intervention? I had referred kids to EI for evaluation of speech problems or global assessment for autism or other developmental problems in my practice, but I didn’t know that some kids were automatically eligible. A social worker brought us the referral form to fill out, which was essentially
a release of medical information to EI, Clara’s qualifying factors, and my signature. That was it.

Clara’s NICU stay lasted 2 months. Her stay was complicated by having to get intubated for a couple of days, and later by a life-threatening cold transmitted to her via her toddler brother. Her stay was highlighted by lots of kangaroo style snuggles and her being one of the few breastfed only graduates in many years. A couple of weeks before Clara was discharged, we were contacted by our case manager with Denver Options to set up a meeting to talk about how they would help us when Clara came home. She informed us that with Denver Options (now Rocky Mountain Human Services), Clara would have a case manager, and a team of therapists to help her meet her greatest potential. We learned that all of the services she got would be at our home. We were told that we would meet regularly as a team to discuss and assess how Clara was doing. And she asked us what our goals for Clara’s care were. We found out that we had access to therapists by asking for services ourselves (we didn’t need a referral, and no parent ever does). We found out that all of this is paid for by the state, so we didn’t have to worry about our insurance changing.

Whoa. What an incredible resource. So within 2 weeks of our arrival home, a team with PT, OT, a comprehensive developmental therapist and our social worker met with our family to talk about what we could do for Clara. My husband and I identified that we wanted to do everything possible to ensure that Clara met her cognitive developmental potential. After her assessment, everyone concurred that Clara was on target so far, but that we should continue to have a comprehensive developmental therapist come to visit once or twice a month. This therapist would evaluate how Clara was doing and make recommendations to help us work with her and exercise with her and integrate her into our family.

Because I am who I am, every month or 2 we take the ASQ to see where Clara stands; we take it for her adjusted gestational age and also for her actual age. Carol, our developmental therapist is very diplomatic about taking care of my husband and me, the doctors. She speaks to me in a way that makes sense, but doesn’t presume I know more than I really do. She seems to get that I’m not an expert in what she does, but appreciates my input and knowledge base. Clara was doing really well on the ASQ except in the speech category; she was rather quiet and when she did vocalize, she did a lot of growling. My husband and I tried all the exercises we knew of to stimulate language development, and we tried what Carol suggested, too. When it didn’t seem to make much of a difference, Carol suggested maybe we should see a speech therapist. And poof. Nicole came over with a Mary Poppins bag of toys and books and exercises and recommendations for what to do with Clara, and now she says “mama”.

Clara is only 10 months old now, or maybe I should say she is 10 ½ months at the time this was written. Which means she was supposed to be only 7 ½ months old, or maybe I should say 8. It’s hard to be precise when anyone asks me how old she is. Clara seems to be mostly on target for one of those measures when we do her ASQ, but more importantly, she is solidly doing the things a baby should do. I don’t know what the future holds for Clara, but for that matter, I don’t know what it holds for me. I don’t know if the therapy has changed what might have been for Clara or if she is just doing what she was destined to do, but as a physician-patient-parent, I’ve learned that sometimes I know just enough to get nervous, and not enough about what to do about it. All I can say is that she smiles, and says “mama”, and I’m thankful for all the tools to help that we get from Early Intervention.
One of the most common reasons for referral of a child to a pediatric cardiologist is for evaluation of a heart murmur. Heart murmurs are extremely common in children, heard in up to 80 percent of children at some point in childhood, especially around three or four years of age. Given that the incidence of congenital heart disease is only 0.8 percent of live births, it is often difficult to determine which child with a murmur (common) has a serious heart problem (uncommon), and when to refer to a specialist. We hope the following discussion will make this decision easier.

To begin discussing murmurs it is important to be able to categorize them. The first (and easiest) variable is timing (systolic, diastolic and continuous murmurs). In addition one should evaluate the murmur in terms of intensity (grade), location, transmission (radiation) and quality (harsh, vibratory, etc.). It is sometimes difficult to determine all these qualities in a murmur, especially if the child is not particularly cooperative and/or has a fast heart rate. Patience and persistence are key in this scenario.

**Timing**

Murmurs should be determined to be systolic, diastolic or continuous. Systolic murmurs are either ejection or holosystolic. Systolic ejection murmurs are very common and usually have a crescendo-decrescendo quality to them. They begin after S1 (tricuspid and mitral valve closure), and are indicative of blood flow acceleration across a stenotic semilunar valve (pulmonary or aortic) or importantly, a greater volume of blood than usual across a normal semilunar valve (anemia, atrial septal defect, pregnancy, anomalous pulmonary veins, PDA or pulmonary or aortic regurgitation). Holosystolic murmurs begin coincident with S1 and last throughout systole. They are caused by blood flowing from a high pressure chamber to a low pressure chamber. Examples include ventricular septal defects, tricuspid regurgitation and mitral regurgitation. Importantly, the intensity of a murmur associated with a VSD will actually get louder as the defect gets smaller (and the pressure difference between the LV and RV increases.)

Diastolic murmurs are either early, middle or late diastole. Diastolic murmurs are never normal and should always be referred to a pediatric cardiologist. Early diastolic murmurs begin right after S2 (closure of aortic and pulmonary valves) and are indicative of aortic or pulmonary valve regurgitation. They are decrescendo murmurs (louder during early phase when pressure difference between artery and ventricle are greatest, becoming quieter as pressure equalizes). Mid-diastolic and late diastolic murmurs are related to flow from the atrium to the ventricle across either the tricuspid or mitral valve. They can be from normal blood volume crossing a stenotic valve (rare in children) or from increased blood volume crossing a normal valve (seen with atrial septal defect, ventricular septal defect and PDA). These murmurs are rumbling in quality and the later murmurs are accentuated by the contraction of the atrium in late diastole.

Continuous murmurs last throughout the cardiac cycle (although not the same intensity throughout), and are always indicative of vascular abnormalities. Most commonly a continuous murmur is caused by a patent ductus arteriosus (PDA). The pressure gradient from aorta to pulmonary artery through the PDA is greatest during systole (louder murmur) and decreases during diastole (quieter murmur), but pressure does not equalize before the next systole, so the murmur is continuous, and has been described as “machinery” in quality. Continuous murmurs can also be caused by more unusual vascular
Murmur intensity
Murmurs are graded from I to VI in intensity.
• Grade I is barely audible
• Grade II is soft but easily heard
• Grade III is loud but without a palpable thrill
• Grade IV is similar to Grade III but has a palpable thrill
• Grade V is audible with the edge of the stethoscope only touching the chest
• Grade VI is audible with the stethoscope hovering over but not touching the chest.

Location and transmission
Murmurs are usually loudest over the site of turbulent blood flow. As a general rule of thumb, the aortic valve is best heard at the right upper sternal border, the pulmonary valve at the left upper sternal border, the tricuspid valve at the left lower sternal border, and the mitral valve at the apex. Transmission of the sound occurs along the direction of the acceleration. A few examples are peripheral pulmonary stenosis (PPS), atrial septal defect, ventricular septal defect and PDA.

In PPS, a common murmur heard in infancy which is usually of no clinical border, and transmission of the murmur can be heard in the axillae.

An atrial septal defect with a large shunt will cause a systolic ejection murmur at the left upper sternal border from the increased blood volume across the pulmonary valve (which can also close late and cause a split-second heart sound).

A ventricular septal defect will have a holosystolic murmur along the lower left sternal border (often distinctly louder when the stethoscope is directly over the hole), but if the shunt is large a mid-diastolic rumble will also be heard at the apex (excessive volume across the mitral valve creating relative stenosis).

The PDA will be a continuous murmur, which varies in intensity throughout the cardiac cycle and is usually best heard at the left mid-clavicular region.

Innocent heart murmurs
Innocent heart murmurs are composed of a variety of sounds, which as the name indicates, pose no medical problem to the child. As stated above, the innocent murmur is exceedingly common in childhood. In general, it is made up of the sound of “noisy” blood flow moving through and out of a structurally normal heart. The most common innocent murmur in childhood is the Still’s murmur, which also goes by the names “innocent,” “vibra-tory,” “functional” and “physiologic.” It is not completely clear the exact cause of the murmur, but it is usually 2-3/6, and is described as musical, vibratory or twanging. Another cause of innocent murmurs is peripheral pulmonary stenosis (described above), which is seen in infancy and usually disappears by six months of age. A third cause is a pulmonary flow murmur best heard in thin children in the eight to 14 year age range. In this

continued on next page >>
case there is no accompanying click or thrill, as there would be in pulmonary valve stenosis. Finally there is a venous hum, which is continuous, and best heard over the left or right upper chest. The innocent hum usually disappears with changes in head position.

**When to refer to a pediatric cardiologist**

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

**Through experience, careful cardiac examination and listening to a multitude of murmurs, the practitioner will gain ability in distinguishing pathologic murmurs from innocent ones, and will be able to confidently find the “needle in the haystack.”**

In general, one should evaluate the murmur in the context of the patient's overall situation. Neonates and young infants may not have had time to develop clinical symptoms and the threshold for referral should be lower than in older children and teenagers, who by the fact that they're growing and thriving have proven they aren't likely to have significant congenital heart disease. Any child with a known syndrome associated with cardiac defects should be referred for evaluation. In particular, any child suspected or proven to have Down syndrome should have very early evaluation for congenital heart defects, as the incidence of such is approximately 50 percent. A child with a murmur but a normal history and otherwise normal physical examination is less likely to have a congenital heart defect than a child who is not thriving, constantly tachypneic or cyanotic. And again, diastolic murmurs are never normal and should be referred for evaluation.

**The role of Electrocardiography and Echocardiography**

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

In conclusion

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

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

**New codes and coverage established by CMS**

*New codes and coverage established by CMS (Medicare) effective 1/1/13. As far as I know, every carrier contracted with Medicare should be allowing and covering these codes. The primary purpose is to improve patient care with better continuity and using the quality of the primary care physician’s relationship and knowledge of the patient to reduce readmissions and recognize the value of the PCP. Whether you are a PCMH or not, these are the levels of care we have been trained to do and expect to do but finally CMS will reimburse for our value.*

The PCP office (staff may carry out the first contact) must be in touch with the patient or caregiver within 2 business days. This contact is expected to include and document at least a review of the medications at discharge, how the patient is doing and making sure the patient is on schedule for any follow up at the PCP office within either the 7 or 14 day period based on the severity and complexity of their problems.

The 99496 cannot be billed if the follow up is beyond the 7 days regardless of the severity of the problems and just because a visit is within 7 days does NOT qualify for the 99496 if the severity is not truly high complexity.

The initial visit is not a billed service but any additional E/M services during the first 30 days may be billed. A bill for the codes 99495 or 99496 are submitted independent of a visit toward the end of

**Summary follows and CAC details at end.**

The 99495 or 99496 are submitted independent of a visit toward the end of
Legal Protections for Providing Care Under Emergency and Volunteer Circumstances

By COPIC’s Patient Safety and Risk Management Department

Physicians and other licensed medical providers often provide uncompensated care in emergency circumstances or when acting as volunteers. This article focuses on the Colorado Good Samaritan laws, the Volunteer Services Act, and the Federal Aviation Medical Assistance Act.

Persons rendering emergency assistance exempt from liability

The Colorado Good Samaritan laws protect physicians and others from civil liability if they, in good faith, render emergency care or assistance to a person not presently their patient at the place of an emergency, accident or health care institution. It is important to remember that the person rendering emergency assistance cannot receive compensation and his or her actions cannot be grossly negligent, willful or wanton, in order to receive this protection from liability. It is also important to note that this is a Colorado law and other states will have different laws that apply.

Persons rendering competitive sports emergency assistance—exemption from civil liability

Additionally, Colorado also protects licensed physicians, osteopaths, chiropractors, nurses, physician therapists, podiatrists, dentists, optometrists or persons certified as emergency medical providers from liability, who in good faith and without compensation, render emergency care or assistance, including on-field or sideline care to an individual requiring emergency care or assistance as a result of having engaged in a competitive sport. Again, the liability protection does not apply if the acts or omissions constitute gross negligence or willful and wanton conduct.

Colorado Volunteer Services Act

Volunteers also have protection from liability under Colorado law, which incorporates the Federal Volunteer Protection Act.

To qualify for this immunity, however, the volunteer must meet certain requirements. Volunteer means a person including licensed physician, licensed physician assistant, and licensed anesthesiologist assistant. Additionally, the volunteer must perform services for a nonprofit organization, a nonprofit corporation, a governmental entity, or a hospital without compensation, other than reimbursement for actual expenses incurred. Private organizations do not qualify. The liability protections afforded also have limitations. The volunteer must be acting within the scope of his or her responsibilities and the conduct that caused the harm cannot be willful, reckless, criminal, or the result of flagrant indifference to the person harmed.

Federal Aviation Medical Assistance Act

Physicians also have protections under the Federal Aviation Medical Assistance Act of 1998 for providing emergency assistance on flights. Under the Act, an individual is not liable for damages for any acts or omissions in providing or attempting to provide assistance in the case of an in-flight medical emergency unless that person is guilty of gross negligence or willful misconduct. This Act, however, may not apply to foreign carriers or on foreign soil because federal law may not be applicable.

Examples of Volunteer Immunity Scenarios

EXAMPLE #1: As an obstetrician, you are asked to accompany your son to an out-of-state camp where you will act as camp physician for the campers and other attending adults during that week. In return for your services, your room and board will be free during the week. In the past, the camp has primarily had to treat minor trauma, bug stings, patients with asthma, etc. Should you agree to do this, and would you be covered by the Volunteer Service Act for your activities? (The camp, by the way, does have

continued on next page >>

the 30 day time frame from the discharge date from the appropriate facility.

As stated in the CAC minutes of the 2/19/13 meeting.

• These services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transition in care from an inpatient hospital setting (including acute hospital, rehab hospital, long term acute care hospital), partial hospital, observation status in a hospital or skilled nursing facility/nursing facility, to the patient’s community setting (home, domiciliary, rest home or assisted living)

• Two new codes have been created:

 o 99495 TCM Services with the following elements: Communication within two business days; Medical Decision Making (at least moderate complexity during the service period) and Face to Face visit within 14 calendar days.

 o 99496 TCM Services with the following elements; Communication within two business days; Medical Decision Making (high complexity during the service period), and Face to Face visit within 7 calendar days

• TCM Services can be billed by one provider within the first 30 days post discharge

• TCM can be provided by physician or other NPP

• First E/M is included in payment

• Additional E/M services in the time frame are billable

• If unable to contact the patient in the first element on multiple occasions, TCM still applicable for payment---documentation is required regardless. (This means if your office has made attempts to contact patient or caregiver and cannot within the 2 business days, document those attempts.)
SNOCAP RECAP

By Don Nease, MD and Tabria Winer, MPH

Greetings from the Shared Networks of Colorado Ambulatory Practices and Partners (SNOCAP), the Colorado based consortium of practice-based research networks (PBRNs) based at the University of Colorado - Anschutz Medical Campus. As the Director of SNOCAP, I’m very excited about this opportunity to report to you on our activities, and hopefully engage your interest in being a part of the important research we do. You may be asking yourself why I would consider our research to be important. Well, if you have ever had the following run through your head...

- Most of what I see in journals has to do with patients that don’t look anything like the ones I see.
- Does anyone care about the vexing clinical or practice questions I face?
- Why hasn’t anyone asked docs like me before making policy decisions that affect my practice?

...you will find our work in SNOCAP to be relevant. In future columns we’ll use this space to report on some of our most recent research results from the field. For now, however, we’d like to give you a sense of what SNOCAP is. Here are some of our vital statistics:

- roughly 30 years of history of practice based research in Colorado
- 4 core Colorado-based primary care PBRN’s
- touching aproximately 120 practices
- serving over 400,000 patients
- A Colorado-based public health PBRN
- 2 affiliated national PBRN’s
- 12 projects currently in the field in our core networks ranging from federally funded clinical trials to pilot level card studies.

Our current projects are addressing issues like improving how we care for diabetes, relevance of NCQA’s PCMH standards to routine primary care practice, and communication between patients and providers about use of medical marijuana.

Our core academic team meets monthly to review progress on studies, hear and discuss new study ideas, and talk about how to best make our work valuable to you, our partners and constituents. We try to only take on projects that are relevant and applicable to primary care practice, and view it as a priority to make working with our studies enjoyable and as low impact on your practice as possible. Ideally the work you do on one of our studies will address an issue you and your practice are interested in and help you improve your care while answering an important research question for our field.

We are very interested in hearing from you the questions that you are struggling with, whether they are clinical questions or questions of how to implement the many changes facing primary care practices. Our most interesting and important questions and studies have often arisen from our member practices.

If we’ve already piqued your interest, and would like to be on our monthly mailing list of news and study opportunities, you can contact either of us at our e-mail addresses below!

Until next time!

Don Nease, MD - donald.nease@ucdenver.edu
SNOCAP Director and Vice Chair for Research
Dept. of Family Medicine
Univ. of Colorado - Anschutz Medical Campus

Tabria Winer, MPH - tabria.winer@ucdenver.edu
SNOCAP Coordinator
Dept. of Family Medicine
Univ. of Colorado - Anschutz Medical Campus

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1 Colorado law defines gross negligence as willful and wanton conduct, that is, action committed recklessly, with conscious disregard for the safety of others.
Annual Wellness Visits, IPPE, and Routine CPX Updates

By Richard H. Glasser, M.D., FAAFP

Although this AWV has been in effect for more than 2 years there is still considerable confusion and inconsistency in its implementation.

In an effort to help our members I shall try to simplify and/or clarify.

As the CAFP representative to our state CAC (carrier advisory committee) I’ve been able to discuss the following information on a few occasions with the regional medicare carrier medical director, and have also discussed these issues with providers to establish their positions (so far United Medicare Complete—at least the PHP groups of PPP and SMPC but it theoretically should apply to all of Medicare Complete (the old Secure Horizons as most of us still call it) and RMHP (a letter went out in January and some of the information was clarified since).

The AWV called the Annual Wellness Visit is just that. It IS NOT A PHYSICAL as so many patients, providers and physicians have misinterpreted it to be.

It is the intent of CMS (Medicare) to improve preventative care and allows payment for review of preventative planning which had never before be reimbursable.

There are now 3 categories of AWV
1) Welcome to Medicare Visit (misnamed a physical exam). Known formally as IPPE (Initial Preventative Physical Exam)
   Only covered during the first 12 months of Medicare eligibility for Part B this can also be in a Medicare Advantage program.
   The only “physical” elements are:
   Height
   Weight
   Vision screening
   BMI
   Other routine measurements as deemed appropriate based on medical and family history.
   An EKG is also allowed and encouraged at this visit (the only wellness visit where it is covered).—Report and Interpretation and EKG G0403
   History: both PMH and Family History
   Use of medications including OTC and herals.
   Review of risk factors for depression, falls, independent living, hearing loss risk and home safety.
   A list of current providers (and suppliers such as oxygen companies, home health services).
   Detection of cognitive impairment issues.

The patient should be provided a written preventative care plan. It can be as simple as a list of timing of preventative maintenance steps. (to include items such as current and next cholesterol screening, diabetes screening, mammogram planning, last and next prostate cancer screen or PAP/Pelvic, DEXA, eye exam for glaucoma or diabetic retinopathy screening, dietary advice)

This may be an appropriate time to cover Advance Directives, DNR and Durable Medical POA but could be done at the First Annual Wellness Visit as this is usually a more complex visit (the IPPE).

Code G0402

2) After a year has passed since Part B eligibility, the patient cannot receive the IPPE but now qualifies at any point for the First Annual Wellness Visit.

The first AWV after the 1 year Part B is always considered the FAWV even if it is the first ever done (no prior IPPE) or if it has been 8 years since the IPPE. CMS Medicare has indicated that if an IPPE was done, the AWV can be in the same calendar month a year later (doesn’t need to be 365 days!)

This visit covers all of the elements of the IPPE except the EKG.

I”d advise checking with other Medicare Advantage programs to verify their policies regarding both AWV and CPX but be persistent, their first “gut” response has often been to claim they are the same exam and that is not a correct interpretation.

Lastly a reminder that many more preventative care services are now covered by Medicare. This is a list as best I know and if there are comments please notify me or contact CMS directly (Medicare, although I think the CMS Colorado Medical Society can occasionally help.)

Breast check and pelvic (Pap) if appropriate in average risk women—once each 2 years.

Screening Mammograms in average risk patients—once each 2 years.

Prostate cancer screening-DRE and PSA currently once each 365 days (yes, it probably is 366 in leap years.)

Colon cancer screening-Low risk patients are permitted one colonoscopy each 10 years, other screening tests as appropriate such as yearly stool tests.

DEXA for specific patients—Currently postmenopausal women and other high risk (such as 3 months of steroid use equivalent to 5 mg day of prednisone, hyperparathyroidism, etc.) Controversial but currently CMS policy does not routinely cover men over 70 years old or testosterone deficiency.

Screening for glaucoma-frequency.

Yearly screening for diabetes, cholesterol (they have specific codes for each but I apologize for not having them handy.)

Diabetes Outpatient Self-Management Training (must be by a certified diabetes educator.)

HIV testing

I hope this provides less confusion rather than more.
Throughout the world, hundreds of thousands of individuals experience the benefits of equine-assisted activities and therapies (EAAT). At PATH Intl., which is a global authority, resource and advocate for EAAT, those activities may include therapeutic horseback riding, hippotherapy, carriage driving, interactive vaulting (similar to gymnastics on a horse), carriage driving, equine-facilitated psychotherapy and equine-facilitated learning. A physical, cognitive or emotional special need does not limit a person from interacting with horses. In fact, such interactions can prove highly rewarding.

Take, for example, Carly Renguette, winner of the 2011 PATH Intl. Youth Equestrian of the Year award. Carly had sustained a cervical spinal cord injury that left her with spastic quadriplegia and placed her first on a ventilator then in a wheelchair. Part of her rehabilitation included therapeutic horsemanship, to which she credits much of her progress. Carly progressed from a wheelchair to a walker and is now using arm crutches, just recently taking a few steps independently. While Carly’s progress cannot be considered typical and in no way suggests a cure through EAAT, her experience does highlight the possibilities for people with physical challenges to move toward greater health, independence and quality of life through the addition of EAAT to participants’ goals.

Experiencing the rhythmic motion of a horse can be very beneficial. Riding a horse moves the rider’s body in a manner similar to a human gait, so riders with physical needs often show improvement in flexibility, balance, muscle strength, coordination, circulation and breathing. The unique relationship formed with the horse provides such benefits as increased confidence, patience and self-esteem as well as improving relationships and social skills.

Individuals of all ages and from all walks of life who are served by PATH Intl. may face any number of challenges, including paralysis, stroke, Alzheimer’s disease, multiple sclerosis, autism spectrum disorder, Down syndrome, substance abuse, traumatic brain injury, post-traumatic stress disorder or amputation. In many instances, licensed physical therapists, occupational therapists and psychologists are involved. Individual goals are related to the participant’s needs.

Scientific research on the effectiveness of EAAT has been increasing in recent years as anecdotal evidence has captured public interest and media awareness, raising the need for quantitative data. A large amount of research in EAAT has involved children with cerebral palsy. One published study measured head and trunk stability changes in children with CP after 12 weeks of hippotherapy treatments provided by an occupational or physical therapist. The children showed very significant improvements in control of their trunks and heads at the end of the intervention period and maintained improvements after a 12-week period without treatment.

Silkwood-Sherer and Warmbier (2007) studied the effects of hippotherapy on postural stability in persons with multiple sclerosis. They found that the group receiving hippotherapy demonstrated a statistically significant improvement in balance following seven weeks of intervention. The comparison group showed no improvement in balance.

To see more research findings, visit the Learn More About EAAT page at www.pathintl.org and scroll down to EAAT Benefits.

PATH Intl. Strides, the association’s quarterly magazine, has published stories on research studies affiliated with its centers. The Spring 2011 issue was dedicated to research, featuring the results of a pilot study conducted by Colorado Therapeutic Riding Center, a PATH Intl. Premier Accredited Center (PAC) in Longmont, and Children’s Hospital in Denver on using therapeutic riding as an intervention for individuals with autism spectrum disorder. Another article reported on the research partnership between HorsePower Therapeutic Learning Center, a PAC in Colfax, NC, and the University of North Carolina at Greensboro Department of Communication Sciences and Disorders to study the benefits of EAAT on the cognitive impairments associated with traumatic brain injury when paired with traditional treatments.

Simply put, lives are changed through interaction with horses, and research is beginning to substantiate the stories of people like Carly. Carly is not the only one. Visit the PATH Intl. website to read the research articles in Strides and to read the inspiring stories of other individuals whose lives have been changed and enriched by the equines with whom they partner.

Winners Named in Colorado
TAR WARS Poster Contest
For 25 years, students have been turning what they learn about tobacco use into positive messages.

Chipeta Elementary School 5th grader, Albert Burkle, won first place in this year’s annual Tar Wars contest.

Chipeta Elementary School 5th grader, Albert Burkle, won first place in the Colorado Academy of Family Physicians statewide Tar Wars poster contest. His poster was submitted to the state contest after winning first place in his school’s poster contest.

Depicting a skateboard mid-flip saying “You can catch air if you don’t smoke”, Burkle’s poster will be entered in the national Tar Wars poster contest held in July in Washington DC. Each year at the AAFP invites state winners from across the country to compete and to celebrate youth, creativity, and being tobacco free. The winner of the national contest will be awarded $1500.

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. Our Colorado winner, Albert Burkle, along with his Dad, will meet with his Colorado Legislators.

Other winners in this year’s poster contest:
Second Place:
Nova Yu, Holy Family Catholic School, Grand Junction
Third Place: Emily Reeder, Penrose School, Penrose
Honorable Mentions:
Kenton Bogan, Julesburg Elementary, Julesburg
Greer Harper, Nativity of Our Lord, Broomfield
Joe Byerly, Shrine of St. Anne, Arvada

Tar Wars is a tobacco-free education program that discourages tobacco use among the country’s youth. The program, which was established in 1988 by AAFP president and Colorado physician Jeffrey Cain, MD, is supported by the American Academy of Family Physicians and managed locally by the Colorado Academy of Family Physicians Foundation.

Thousands of Family Physicians and healthcare professionals across the country present Tar Wars programs to fourth- and fifth-graders in their local schools every year. They discuss not only the long-term effects of smoking on the body, but also focus on the short-term, image-based effects of tobacco use.

To find out how you can become involved in this fun, informative and innovative program to help the kids in your area stay tobacco free call Sarah Roth, Director of Health of the Public by phone: 303-696-6655 ext. 16 or email: sarah@coloradoafp.org.
Current levels of vaccination coverage among adults are unacceptably low. Family physicians are, in general, aware of the importance of routinely assessing patients’ vaccination histories and recommending and providing routinely recommended vaccines. Strong recommendations from health-care professionals are associated with an increased utilization of vaccines. Other interventions shown to increase vaccine uptake, such as implementation of reminder/recall systems and standing orders, have been summarized in a practical Community Guide by the Centers for Disease Control and Prevention (CDC.)

**Full vaccine schedule safe for kids**

In the last edition of CAFP News, we noted that delayed vaccine schedules were significantly more expensive and less effective than the current recommended vaccine schedule for children. However, at least 10% of parents of young children continue to skip or delay routine vaccinations, often out of concern that kids are getting “too many shots, too soon” and that “too many shots too early” may “overwhelm the child’s immune system and/or lead to autism.”

A study just published in the Journal of Pediatrics confirms that children who receive the full schedule of vaccinations have no increased risk of autism. This study is the latest of more than 20 studies showing no association between autism and vaccines, whether either individually or as part of the standard schedule. In addition, the study is the first to consider not just the number of vaccines, but a child’s total exposure to the vaccine components that trigger an immune response.

The new research confirms the findings of a 2010 study in Pediatrics, which compared “regular” versus “delayed” vaccine schedules and found no neuropsychological differences, such as stuttering, facial tics, or lower scores on IQ tests.

**New Recommendations**

The Advisory Committee on Immunization Practices (ACIP) reviews and updates the adult and child immunization schedules and there have been a number of new recommendations this year in regards to pneumococcal, diphtheria, tetanus, and pertussis vaccines.

**Pneumococcal conjugate 13-valent vaccination (PCV13)**

CDC now recommends two kinds of pneumococcal vaccines for adults and this year’s update includes first-time recommendations for the use and timing of administration of the 13-valent pneumococcal conjugate vaccine (PCV13) relative to the 23-valent pneumococcal polysaccharide vaccine (PPSV23) in adults:

- Adults > 19 years with immunocompromising conditions (including chronic renal failure and nephrotic syndrome), functional or anatomic asplenia, sickle cell disease, CSF leaks, or cochlear implants, and who have not previously received PCV13 or PPSV23 should receive a single dose of PCV13 followed by a dose of PPSV23 at least 8 weeks later.
- Adults > 19 years with the aforementioned conditions who have previously received one or more doses of PPSV23 should receive a dose of PCV13 one or more years after the last PPSV23 dose was received.
- For those that require additional doses of PPSV23, the first such dose should be given no sooner than 8 weeks after PCV13 and at least 5 years since the most recent dose of PPSV23.
- When indicated, PCV13 should be administered to patients who are uncertain of their vaccination status history and there is no record of previous vaccination.

As a reminder, all adults 65 years and older should still get one dose of pneumococcal polysaccharide vaccine (PPSV23).

Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination

For Tdap, recommendations have been expanded to include routine vaccination of adults aged 65 years and older and for pregnant women (including pregnant adolescents) to receive Tdap vaccine with each pregnancy.

- Administer one dose of Tdap vaccine to all pregnant women (irrespective of age) during each pregnancy (preferred during 27–36 weeks’ gestation), regardless of number of years since prior Td or Tdap vaccination.
- Administer Tdap to all other adults who have not previously received Tdap or for whom vaccine status is unknown. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-toxoid-containing vaccine.

There are also new recommendations for Tdap use in children. (Minimum age: 10 years for Boostrix, 11 years for Adacel). For routine vaccination:

- Administer one dose of Tdap vaccine to all adolescents starting at age 11 through 12 years (or any older adolescent who has not received Tdap).
- Again, Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.

Meningococcal conjugate vaccines (MCV). (Minimum age: 6 weeks for Hib-MenCY, 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM]).

Here are the latest recommendations for meningococcal vaccination of children with high-risk conditions:

- 19 months of age or younger with anatomic or functional asplenia (including sickle cell disease), administer an infant series of Hib-MenCY at 2, 4, 6, and 12-15 months.
- 2 through 18 months with persistent complement component deficiency administer either an infant series of Hib-MenCY at 2, 4, 6, and 12 through 15 months or a 2-dose primary series of Menactra (MCV4-D) starting at 9 months, with at least 8 weeks between doses.
- 19 through 23 months with persistent complement component deficiency, who have not received a complete series of Hib-MenCY or MCV4-D, administer 2 primary doses of MCV4-D at least 8 weeks apart.
- 24 months and older with persistent complement component deficiency or anatomic or functional asplenia (including sickle cell disease), who have not received a complete series of Hib-MenCY or MCV4-D, administer 2 primary doses of either Menactra (MCV4-D) or Menveo (MCV4-CRM).
- If Menactra (MCV4-D) is administered to a child with asplenia (including sickle cell disease), do not administer MCV4-D until 2 years of age and at least 4 weeks after the completion of all PCV13 doses.

We recommend you consult the full ACIP vaccine recommendations if you have questions about these new recommendations and bear in mind that additional updates might be made for specific vaccines during the year between updates to the vaccine schedule.

2. CDC. Influenza vaccination coverage among pregnant women—2011–12 influenza season, United States. MMWR 2012;61:758–63.


11. CDC. Recommended immunization schedules for persons aged 0–18 years—United States, 2012. MMWR 2012;61(5). http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6105a5.htm.

REDEFINING “Disability” through RECREATION

By S. Bryan Wood, CTRS

Defined as the specialized application of recreation for the specific purpose of intervening in and changing some physical, emotional, or social behavior to promote growth and development of the individual (Carter, Van Andel, & Robb, 1995), Therapeutic Recreation (also known as recreational therapy) is an often-overlooked discipline in the modern world of rehabilitation. Unlike Physical Therapy, Occupational Therapy, and Speech and Language Pathology, Therapeutic Recreation is broad and diverse in application.

The National Institute on Disability and Rehabilitation Research concluded that Therapeutic Recreation provides the following benefits: 1) improves physical, cognitive, social and emotional functioning; 2) develops skills needed to enhance independence for community living and promotes a higher quality of life; 3) provides disabled individuals with mechanisms to prevent declines in physical, cognitive and psychological functioning, and as a result, reduces the need for health care services; and 4) reduces secondary disability and associated health care costs.

The benefits of recreation (including sports) for all people are well documented. Therefore, it is no surprise that recreation also helps to improve the lives of people with disabilities. Those born with disabilities find that recreation provide them with a sense of freedom and joy. For others with new injuries or diseases, when first faced with the reality of a disability, many experience depression and a sense that a full life is no longer possible. For them, Therapeutic Recreation offers a view to possibilities and provides a chance to reunite family and friends in a shared activity. People with disabilities who participate realize the depth of their abilities while improving overall health and self-confidence.

Therapeutic Recreation really shines in the world of adventure-based or outdoor recreation. Activity in the outdoors is a powerful modality that can show people with disabilities what they are truly capable of. Everyday life for a person with disabilities can be a challenge whether it is stairs for one who uses a wheelchair or other barriers for one with limited sight. Nature presents barriers to able-bodied and disabled without discrimination. Advances in adaptive equipment and teaching techniques can now level the playing field for anyone with a desire to learn a sport.

With the playing field leveled, people with disabilities can discover many things about themselves. First, what society deems as disabled is only a dot on the continuum of ability. Everyone has his or her challenges; the difference is in the way one chooses to adapt. Just because one has use of their legs and another does not, has no bearing on the outcome of learning and enjoying any recreational activity.

Family and/or friends recreating together add to quality of life for all. When a person with a disability is included, these opportunities may appear to be limited or seem impossible. However, TR and adapted sports programs can help overcome barriers to inclusion.

With the summer season upon us, one example is flat water kayaking. For a person with a spinal cord injury or traumatic brain injury, a kayak can be adapted with stabilizing outriggers and specialized seating. For a double or even quadruple amputee, specialized sockets that fit the residual portion of arms and/or legs add to comfort and stability of the boat paddler. These adaptations are inexpensive, safe, and easy to use providing the modifications that can make any disability less obvious and inclusion with family and friends possible.

An additional benefit is independence. A disability can be devastating to a person when it comes to living day to day depending on others. The emotional benefit of gaining independence in an activity and participating at the same level as family and friends is immeasurable.

Kayaking is but one recreational activity with therapeutic value for people with disabilities. All paddle sports can be adapted, as well as other summer activities including sailing, rock climbing, hiking, camping, horse riding and cycling.

Winter outdoor activities, too are fun and have therapeutic significance. Modifications can be made to almost any equipment and instruction is available for snowboarding, alpine and Nordic skiing, despite the disability. For example, the calming effect of cross-country skiing on a child with autism is unmistakable.

With an increasing awareness of the benefits of Therapeutic Recreation, the need for adapted programs has grown tremendously. Resources for Therapeutic Recreation and adapted sports throughout the state are many and varied from lessons to sports leagues. One of the oldest and nationally-recognized is the National Sports Center for the Disabled (NSCD). It was established in 1970 and provides over 20,000 lessons for over 3,000 participants year round. Winter and summer programs provide instruction and adapted equipment for never-ever athletes learning a new activity to competitive athletes preparing for the Paralympics.

Bryan Wood is a Certified Therapeutic Recreation Specialist. He is the Metro Denver Program Coordinator and Adapted Ski Instructor for the National Sports Center for the Disabled with offices located in Denver and Winter Park, CO (www.nscd.org)
Two one-hour web-based presentations offering new information to consider when advising patients who need to follow a heart-healthy diet. The presentations include current data, research findings, and practical information and strategies for physicians helping patients make dietary changes aimed at a reduction in cardiovascular risk factors.

Two webinars offered for Continuing Medical Education credit through February 2015

Each webinar is approved for 1 prescribed credit by the American Academy of Family Physicians. There is no cost to participate. Credit certificates will be issued to participants.

This educational opportunity is offered by the Oklahoma Academy of Family Physicians, a state chapter of the American Academy of Family Physicians (AAFP) which represents over 105,000 physicians, residents and medical students in the United States.
More than 700 new neural connections form in the brain every second during the first few years of a child’s life, according to research from Harvard’s Center on the Developing Child.

Seven hundred new connections every second.

These neural connections serve as the brain’s architecture, laying the foundation for future health, behavioral health and learning. The interaction between a young child’s genes, experiences and environment determine the quality of these connections, yet we also know that a child’s life expectancy is predicted by her zip code than her genetic code.

This research is helping to fuel an early childhood movement across the country with President Obama calling for universal preschool, and states like Colorado leading the way. Our state is at the forefront of this movement through state and community-level collaborations that bring together child health, early learning and family support organizations to improve the quality of child care, expand access to health services and provide families with parenting knowledge and resources. In many of our communities, collaboration has resulted in an emerging early childhood system of care that is better coordinated and connected locally.

This local momentum is happening through 31 Early Childhood Councils that exist across the state. You have one in your community. Councils were created by the Colorado legislature to create a “seamless early childhood system” of care for young children and their families by bringing together early childhood experts to improve services in their communities. We aim to be the local “hub” for all things birth to five. This includes connecting professionals and families to child health, early childhood mental health and early learning resources.

As a family physician, you have a critically important role to play in this early childhood system. Not only are you the trusted source for many parents about their child’s development, but you are an “access point” for a family in need of additional connections to their early childhood community. Knowledge of the services and systems that your families navigate is part of a medical home, yet we often hear that PCPs are not sure how child care, Early Intervention, Child Find, or home visitation systems work, and therefore do not refer their families to services they are not familiar with.

We also know that parents of young children don’t always know what questions to ask when it comes to their child’s development, and well-child visits are not always conducive to in-depth conversations. “Is my child where she should be?” is the universal question about whether each child is meeting her developmental milestones.

A standardized developmental screen tool (SDST) such as the Ages and Stages Questionnaire (ASQ) primary purpose is to identify children with a developmental delay. The ASQ allows parents to be reflective about their own child’s development and can spark a conversation between you and the parent that goes beyond the standard questions. Research has demonstrated that physicians who use a SDST like the ASQ identify 50% more children than when they rely on clinical judgment and informal methods such as milestone checklists (PEDIATRICS, Volume 118, Number 1, July 2006). A more recent study also concluded that children will be identified at an earlier age, when therapeutic interventions will have the greatest effect, if a SDST is used rather than an informal milestone checklist. (PEDIATRICS, Volume 131, Number 1, January 2013) This supports the recommendation that all children be screened with a SDST at 9, 18 and 24 or 30 months of age with their well-child exam.

Delays in development are only one of the health challenges facing our young children. Social-emotional skills, nutrition and physical activities, and oral health habits have a significant impact on the overall wellbeing of young children. Challenging behaviors, obesity, and tooth decay are some of the most pressing child health issues facing our work. Young children are being expelled from child care at a higher rate than the K-12 system, because teachers (and parents) have not been trained in how to handle challenging behaviors. Overweight and obesity rates in children 2 to 14 have spiked to 28 percent statewide (Colorado Department of Public Health & Environment, 2011). And what would you guess is the most prevalent chronic disease among young children? Tooth decay.

This is where an Early Childhood Council steps in – when services and funding are limited – to leverage and connect the various pieces of the puzzle into a quilt of care for young children. Improving access and quality are our top priorities, but we also know we must tackle the issue of equity. The newest data from the Census Bureau (2011) is staggering; 21 percent of Colorado’s children birth to age six are living in poverty, and our Hispanic children are experiencing it at three
times the rate of our white children.

Poverty impacts so many aspects of a child’s life including how well they are able to access the services they need. This brings us back to those neural connections and those community connections. While we cannot impact a child’s genetic code, we know we can impact their environments and experiences. Part of that experience happens when a child and family steps into your office. Providing them with a Medical Home creates a connection that paves the way for that family to better understand the health and development of their young child during this critical time.

The Early Childhood Council in your community has an important role to play in your work. We want to support each and every professional who is a champion to young children. We have finger on the pulse of where the quality resources are for families, and most importantly, we want to hear from you. What are the issues facing your families? What are your challenges in serving them, and how can we help you tackle these challenges?

Pick up the phone. Send an email.

Make a connection.

Jenna began working in early childhood in Governor Romer’s Office and now works on child health issues with the Denver Early Childhood Council. To learn more about how to connect with your local Early Childhood Council (http://tinyurl.com/c9sxy9j) please contact her at jenna@denverearlychildhood.org, 720/644-2563,

To learn more about standardized developmental screening and how to implement into your practice while earning CME credit in the convenience of your office, please contact Eileen Auer Bennett at Eileen@coloradoabcd.org, 720/333-1351

Bob Brockmann, formerly of Hinsdale, Illinois, passed away in Englewood, CO on May 10, 2013. He attended Hinsdale Central High School and was a member of the gymnastics team. He received his BS in Microbiology from the University of Illinois. He moved to Colorado and obtained an MS in Microbiology, working for the Boulder County Health Department.

Bob attended the University Of Colorado School Of Medicine, specialized in Family Medicine, and practiced as a Hospitalist. He was a Board member and President of the Colorado Academy of Family Physicians, a Board member of the Colorado Medical Society, a Board member and Past President of the Arapahoe-Douglas-Elbert Counties Medical Society and on the Board of the Society of Hospital Medicine. He was a tireless advocate for improving health care in Colorado. Bob was an avid outdoorsman and embraced all Colorado offered, especially hang-gliding, skiing, tennis, golf, hiking and riding his motorcycle.

Those left to cherish his memory include his mother, Lillian; brother, William; sister-in-law, Lorraine; nieces, Lindsey and Katie; and nephew, Charles. He was preceded in death by his father, Leonard; and sisters, Susan and Barbara Anne. Bob will be greatly missed by his friends, colleagues, and the Colorado health care community.

The Memorial Service was held Saturday, May 25th, 2013 at 1:00 PM at Horan & McConaty Family Chapel.

In lieu of flowers, donations may be made to the Bob Brockmann, MD, Student and Resident Scholarship Memorial Foundation, payable to the CAFP Foundation, 2224 S. Fraser St., Unit 1, Aurora, CO 80014.

Congressman Polis visits Miramont, shown successes of the PCMH

Congressman Jared Polis (CD-2) visited Miramont Family Medicine at their Wellington office on April 2, 2013. John Bender, MD, FAAFP spoke to Congressman Polis about the CAFP’s excitement to participate in the Comprehensive Primary Care Initiative. Dr. Bender also showed him how Miramont’s robust Patient Centered Medical Home model has allowed Miramont to build and maintain a successful family medicine office in the small town of Wellington, Colorado where two hospital led initiatives had previously failed. Congressman Polis mentioned he wants to see a permanent fix to SGR, and his office maintains a constituent advocate on staff who can assist patients and physicians with Medicare payment problems.
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Health E-careers Network: FPJobsOnline is the official online job bank of the Colorado Academy of Family Physicians and provides the most targeted source for Family Physician placement and recruitment. Accessible 24 hours a day, seven days a week, FPJobsOnline taps into one of the fastest growing professions in the U.S. Please visit www.FPjobsOnline.com or call 1-888-884-8242! Mention you are a CAFP member to receive discount.

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National Procedures Institute: NPI offers you an exciting opportunity to bring new procedures to your practice and generate revenue for your state academy at the same time. When you attend an NPI course, NPI will send $50 to the Colorado Academy of Family Physicians. All you have to do is enter “Colorado” in the Referral Code field during the registration process and start getting more out of your practice with NPI.

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