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Vision Statement:
Thriving Family Physicians creating a healthier Colorado.

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

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As I begin my term as the CAFP president, I look forward to all of the events, anticipated and otherwise, that will present. I also find myself looking back recalling how I ended up in this position. It all began five years ago, when I moved to Pueblo, CO. My new colleagues, both now former presidents of the CAFP, persuaded me to run for a position on the board. Dr. Kern Low and Dr. Kajsa Harris both assured me that the experience would be nearly seamless due to the expert guidance provided by Raquel Rosen, CEO…and so the journey began.

Over the past five years, I have learned a lot about Change Southern Colorado Family Medicine Residency, where I am faculty, and about the forward thinking family medicine climate in Colorado. Colorado has jumped to the front of the pack on innovation and participation in the patient centered medical home and in creating the Colorado Primary Care Collaborative (CPCC).

In the early days of June, I had the privilege of participating in the Patient Centered Primary Care Collaborative (PCPCC) held in Denver followed by the CPCC meeting. I found myself surrounded by a mix of health care professionals all participating in and shaping healthcare in the country. The triple aim of improving the experience of health care, improving the health of populations, and reducing per capita costs of health shaped the conference. Hundreds of determined health care professionals and health care consumers shared information and research to optimize the changes in health care. All of them endeavoring to attain the triple aim. It is an honor to be a part of the CAFP and an exciting time to be a Family Physician.

Certainly, we as Family Physicians must strive to help our patients improve their level of health and wellness. Self-management support is both somewhat new and eternally challenging. Ways to motivate patients to exercise, eat right, avoid smoking and other negative life choices, remain elusive, yet these are the most viable methods to improve their health. So often if seems, these are the very life habits over which we, as their doctor, have little control. These are the measures against which we will be “graded” and outcomes measured. We must work together to answer these questions and to engage patients. Over the next year, there will continue to be more demands and expectations on health care workers and Family Physicians. Fortunately, we are not alone and the CAFP along with other healthcare organizations in the state of Colorado are working to provide us with a map through this maze. It is an honor to be a part of the CAFP and an exciting time to be a Family Physician.

Colorado has jumped to the front of the pack on innovation and participation in the patient centered medical home and in creating the Colorado Primary Care Collaborative (CPCC).

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Save the Date!

2015 Annual Scientific Conference

April 23-26

Cheyenne Mountain Resort, Colorado Springs

For more information, email cairn@coloradoafp.org
BLOCKBUSTER YEAR FOR FAMILY MEDICINE

Colorado Primary Care Collaborative

Our newly formed Colorado Primary Care Collaborative (CPCC) has had two successful convening meetings on Jan. 9 and March 13 with another planned at the time of publishing this magazine on June 10. I would like to thank the following financial supporters of the CPCC. We would not have been able to continue to realize our mission without you:

$7,500 GlaxoSmithKline
$7,500 Kaiser
$5,500 Copic
$5,000 CAFP
$5,000 CAFP Foundation
$2,800 First Commercial Bank
$2,500 Anthem
$2,500 Colorado Access
$2,500 Consortium for Older Adult Wellness
$1,000 Colorado Medical Society
$350 Colorado Institute of Family Medicine
$350 HealthTeamWorks

I would also like to thank Rick Budensiek, DO, Dan Burke, MD, and Cissy Kraft, MD, for their leadership and Ellen Brilliant for facilitating the convenings. Thank you to the following CPCC steering committee members for being work group table captains at the March 13 event.

Rick Budensiek, DO
Dan Burke, MD
John Cawley, MD
Chet Cedars, MD
Angela Green, PsyD
Kevin Hougen
Barbara Martin
Kim Marvel, PhD

We now have over 300 people on the CPCC list serve who have said they are interested in supporting the Patient Centered Medical Home and Payment Reform. The momentum created by the convening meetings and the CPCC workgroups has been wonderful.

CPCC workgroups are proceeding with strategies and tactics on the following focus areas:

Payment Reform
Delivery Reform
Engaging the Public
Buying Health Insurance for Employees

Here is the list of all of our CPCC steering committee. We are so happy to have such outstanding support from many important people and organizations in health care.

Anthem: Elizabeth Kraft, MD

Aurora Chamber of Commerce: Kevin Hougen

Colorado Academy of Family Physicians: Rick Budensiek, DO, John Cawley, MD, Chet Cedars, MD, & Raquel J. Rosen

Colorado Academy of Family Physicians Foundation: Elizabeth Kraft, MD

Colorado Association of Family Medicine Residencies: Kim Marvel, PhD

Colorado Medical Home Coalition: Barbara Martin

Colorado Nurses Association: Colleen Casper

Colorado Psychological Association: Angela Green, PsyD

Colorado Business Group on Health: Donna Marshall

Colorado Institute of Family Medicine: Dan Burke, MD

Colorado Medical Society: John Bender, MD, & Alfred Gilchrist

HealthTeamWorks: Marije Harbrecht, MD

Scott Hammond, MD, Family Medicine Physician

If you would like to participate in this initiative or would like to be kept informed please let me know, raquel@coloradoafp.org.

Payment Reform

CAFP leaders have been meeting regularly with members of the Colorado Association of Health Plans. Areas being discussed to reach agreement on include definitions of the Patient Centered Medical Home and Joint Principles, care coordination, and methods of payment reform. The health plans have been open to these discussions and have said that they would like to move away from fee for service to a more value based payment system. In addition, Rick Budensiek, DO, Cissy Kraft, MD, and I have been meeting individually with the health plan leaders to discuss our CPCC and payment reform.

continued on next page >>
CAFPA Annual Scientific Conference 15 year Highest Attendance

We had great CME, and great family fun at the April 2014 conference. I hope you can join us next year.

Thanks to the CAFP staff, CAFP board, and especially to the CAFP Education Committee chairs for making this conference so successful.

Keep checking your email for news about the next conference and additional trainings on the DOT medical examiner, and SAM courses.

2014 Legislative Session

We wrapped up another productive legislative session thanks to the CAFP lobbyist, Jeff Thormodsgaard, the CAFP legislative committee, and all of the volunteers for the CAFP Doctor of the Day program. See the report in this issue for details on the bills we worked on. We are getting ready to send out a questionnaire to all legislative candidates to see if they support the issues that are important to CAFP members. We will make a determination based on that survey on which candidates to support and we will let you know the outcomes.

Thank you to the CAFP Board

I would like to especially thank Rick Budensiek, DO, our president whose term expires on July 1. Rick has been representing CAFP members at many meetings, testifying at the Capitol, and participating on numerous conference calls advocating for Family Medicine Physicians. He does a great job for all of you and has gone beyond normal expectations. In addition, CAFP board members and committee members have stepped up to help further the CAFP’s strategic plan of education, advocacy, and health of the public. Thank you to CAFP education chairs Mike Archer, MD, Chandra Hartman, MD, and Anna Wegleitner, MD. Thank you to Chandra Hartman, MD, for chairing the Health of the Public Committee. And thank you to Glenn Madrid, MD, and Candace Murbach, DO, for chairing the legislative committee.

The CAFP also has an outstanding staff who enthusiastically and energetically do their jobs. Thank you to Manthan Bhatt, director of communications, Karol Groswold, Tar Wars coordinator, Sarah Roth, director of health of the public, and Erin Watwood, director of education, events, and meetings. I think we have the best staff. We work hard but we have fun! What makes it worthwhile is being able to work for Family Medicine Physicians. We think you are the heroes of health care and are proud and happy that we can support you! Thank you for all you do.

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  - Staff Development

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The 2014 Legislative Session has officially concluded! The Colorado Academy of Family Physicians Legislative Committee spoke on many issues that affected their practices, their patients, and future family medicine physicians. Here is a recap of the bills we spoke out on:

**SB14 – 016 CDPHE REGULATE FREESTANDING EMERGENCY CENTERS: Strong Support**

The rapid growth of Independent Freestanding Emergency Departments—for-profit facilities that offer some emergency services but are not a part of a hospital or care network—is posing new challenges to health care in Colorado. These ventures, which are proliferating nationally and now have entered our state, compete head-to-head with full-service hospital emergency rooms but don’t play by the same rules. They are not required to conform to the same state and federal laws and regulations that apply to traditional hospital emergency departments, which must serve all patients in need of emergency services.

Our solution required any facility that uses the term “emergency” in its facility title or signage to: Comply with all state and federal laws, rules and regulations for hospital emergency departments. Treat all patients who come to the facility to the extent of its capability. Integrate into hospital functions specifically related to medical records, transfers and infection control. Be a recognized participant in the system created by the Colorado Emergency Medical and Trauma Services Act (Title 25, Article 3.5). Participate in public emergency preparedness planning (for example, response to a West Nile virus epidemic, or major trauma incident).

Unfortunately, due to the political environment, the bill was killed.

**SB14 – 032 ALTERNATIVE HEALTH CARE PROVIDERS TREAT CHILDREN: Strong Oppose**

During the 2013 legislative session, the Colorado Chapter of the American Academy of Pediatrics advocated for amendments to allow naturopathic doctors (ND’s) and alternative health care providers to care for certain pediatric patients as part of the medical home team of providers. Additional provisions for collaboration and referral, as well as appropriate pediatric training were included in the final legislation. The CO-AAP has committed to work with the naturopathic doctors over the 2014 interim to discuss pediatric training and collaboration for ND’s that choose to treat children.

SB 14-32, as amended in Senate HHS Committee, strikes all reasonable pediatric safeguards for unlicensed alternative health care providers, and creates a higher standard for registered naturopathic doctors. The preamended bill allows alternative health care providers to treat children of all ages, including the fragile 0-2 population, while naturopathic doctors are not allowed to treat children 0-2.

The bill was killed indefinitely on April 3rd, 2014.

**SB 14 – 144 FAMILY MEDICINE RESIDENCY PROGRAMS IN RURAL AREAS: Strong Support**

The bill extends the Commission’s duty to develop and maintain family medicine training programs in rural and underserved areas. Three new training sites are under development (Alamosa, Sterling, and Fort Morgan) It also requires the Commission to report annually to OSPB, HCPF, and the JBC on the use of funds. Another portion requires the Commission to complete a study concerning family medicine residency programs and how these programs will meet the primary care workforce needs of rural Colorado and other underserved areas of the state:

- Information will be gathered from other states to identify best practices for “growing your own” primary care workforce.
- The report will provide recommendations to maximize the use of federal funds to augment state funds for physician workforce training AND provide recommendations for a long-term plan to develop primary care physicians in rural and underserved areas
- The report must be submitted by March 1, 2015

The final bill passed on April 25th, 2014 and became law when Governor John Hickenlooper signed it.

**SB14-187 COLORADO COMMISSION AFFORDABLE HEALTH CARE SPONSORS: Strong Support**

SB 14-187 creates a 12-member commission to undertake a comprehensive, evidence based analysis of the principal cost drivers in health care in Colorado and the effectiveness of strategies for controlling health care

*continued on next page*
expenditures. The Commission will include representatives from across the state, appointed on a bi-partisan basis by the Governor and Legislative Leadership.

Why do we need a cost commission?

Colorado will not be able to make meaningful recommendations on controlling health care costs until we understand the principal cost drivers in Colorado as well as effective solutions to address cost drivers for our state.

Several of our Colorado mountain communities now have the highest health insurance premiums in the nation. Health insurance premiums are based on the unit costs of providing care in that region. Insurance premiums will continue to rise and outpace inflation so long as medical costs continue to rise.

Consumers need more information to make value based purchasing decisions in health care.

As high health care costs impact everyone, everyone must play a role in addressing Colorado health care cost drivers. The Commission brings together representatives of business, hospitals, health plans and brokers, consumers, and experts and charges them with making evidence based recommendations for action to the General Assembly and the Governor.

The final bill passed at the end of April and became law when Governor John Hickenlooper signed it. We are pleased that Dr. Jeff Cain, MD, immediate Past President and Chairman of the Board of Directors of the AAFP, has been selected as a representative to the commission.

BUDGET UPDATE

The CAFP strongly supported certain items in the budget for the 2014 Legislative Session. The primary care bump for Medicaid will be continued by the state through 2015. A 2% provider rate increase for Medicaid reimbursement for physicians. The continued increased line item for Family Medicine Residencies in Colorado. The budget also added an increase for Rural Residencies development of $1 million dollars, matched federally for a total of $2 million.

To see the full report, visit: coloradoafp.org/2014legislation

The Colorado Center for Nursing Excellence: Correction of Spring Magazine

The Colorado Center for Nursing Excellence serves as the only state, nursing workforce organization with over 175 clinical and educational partners from all segments of Colorado’s healthcare workforce.

The Center’s Mission is: “Building upon a foundation of evidence, the Center advocates for and provides professional education, leadership development, coaching and data analysis to continually strengthen the nursing and healthcare workforce. Our defining strategy is to convene and engage the right people, at the right time, to develop and implement solutions to emerging healthcare challenges.”

Recently, in response to the Medicaid expansion and an expected addition of 740,000 uninsured Coloradans to the insurance roles, the Center was asked to look into the current transitions to practice requirements for independent prescriptive authority to be provided to Advanced Practice Nurses (APNs). Discussions with healthcare employers, physicians and APNs highlighted that the current requirements have proved to be a barrier to practice at a time when there is a growing need for APNs with prescriptive authority. These nurse practitioners provide basic primary care support and outreach. A coalition of healthcare organizations met to further assess what actions would be appropriate to address the evidence of these barriers at this time when there are still areas in the state that have few if any primary care providers for basic care needs.

The multidisciplinary coalition engaged a large number of stakeholders in the state to discuss how to proactively address what many see as an access to care issue, especially in the rural areas of the state. The Colorado Academy of Family Physicians was consulted as well as the Colorado Medical Society in addition to many other advocacy organizations, employers and health care providers. Additionally, the coalition has worked closely with the Nurse Physician Advisory Taskforce for Colorado Healthcare (NPATCH) to assess whether the current transitions to practice rules in the state are negatively impacting access to basic care for vulnerable Coloradans.

The Center has been and continues to be an active participant in this work, but it is important to note that the most recent edition of the CAFP newsletter erroneously reported that the Colorado Center for Nursing Excellence brought a bill regarding this issue in the last legislative session which was put down by the CAFP lobbyists. This was an error. The Center did not bring a bill and is not aware of any bill ever being written, but has actively pursued the data to clarify whether the current rules regarding transitions to practice for APN prescriptive authority should be modified to better serve vulnerable Coloradans who require basic services.

The Center has historically used its system-wide perspective and consensus-building credibility to create innovative, high-leverage interventions that help improve the volume and quality of Colorado’s nursing workforce. Understanding that health care is a ‘team sport’, the Center is moving into dialogues, research, and activities that go beyond nursing to include Colorado’s entire healthcare workforce pipeline. We look forward to working closely with CAFP and the entire physician community to directly address the growing shortage of primary care providers in the state of Colorado.
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Too Many Children Are Not Getting Their Immunizations

By: Richard Budensiek, DO, FAAFP, Chair of the Colorado Academy of Family Physicians

There are still plenty of Coloradans who remember the ravages of the polio epidemic that swept the nation some 60 years ago. It was a frightening and tragic time. Of the 57,628 cases reported throughout the U.S. in 1952, the worst year of the epidemic, 3,145 people, mostly children and teens, died. Another 21,269 were left with mild to disabling paralysis. Families were torn asunder as stricken children were quarantined. Parents were terrified their children would be next to be blindsided by this insidious killer.

It was the development of the polio vaccine by researchers Jonas Salk and Albert Sabin that turned the corner in our fight against polio. Mass immunizations using a vaccine pioneered by Salk were in full swing by 1957, and the incidence of polio dropped dramatically to just 5,600 cases that year from a peak of nearly 58,000 just a few years earlier. With the subsequent introduction of Sabin’s orally administered polio vaccine, the nation’s recovery from the nightmare of polio was nearly complete. By 1961, there were only 161 new cases of polio recorded in the U.S., and the disease has been all but eradicated by the 1970s.

In fact, I was one of those children whose parents worried with every cold if I was going to suffer the paralysis of polio. I still remember the relief when my family was able to be immunized against this and other childhood diseases.

The timely introduction of the polio vaccines also had another effect on our society: It educated Americans about the need to immunize their children against disease.

And yet, today, there are still too many households where children are not getting their immunizations—across the country and right here in Colorado. Indeed, Colorado continues to have one of the nation’s lower immunization rates, and that should trouble us all.

To be sure, some parents have sincere—though, arguably, unfounded—objections to immunization. Yet, many others simply seem unaware of the dangers their children face. And in yet other households, the failure to immunize is part of a broader pattern of neglect of children’s health care due to a variety of social and economic factors. All told, too many of our children are attending school unprotected against disease—and are putting others at risk.

Colorado’s General Assembly has acknowledged this troubling reality and took an important step this spring toward improving our state’s record. It passed House Bill 1288.

Significantly, the legislation, which was signed into law by Gov. John Hickenlooper, also requires every school in Colorado to make the immunization rate of its students publicly available upon request. Parents have a right to know how well their own children will be safeguarded from debilitating and even fatal diseases when they attend school.

It also is reasonable to expect public institutions like our schools to fully and publicly disclose their immunization rates so we know the potential dangers to which our children are exposed. Unfortunately, this portion of HB 1288 was eliminated in the bill that passed.

We know what an epidemic like polio can do, and we know what immunization can do to prevent it. Let’s learn from history—for the sake of our children.

Rick Budensiek, D.O., is a family physician in Greeley and is Chair of the Colorado Academy of Family Physicians.
GET READY FOR ICD-10

STAY ON THE ROAD TO 10 STEPS TO HELP YOU TRANSITION

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

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

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• Train Your Staff—Find options and resources to help your staff get ready for the transition
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• Talk to Your Vendors and Payers—Talk to your software vendors, clearinghouses, and billing services
• Test Your Systems and Processes—Test within your practice and with your vendors and payers

Now is the time to get ready.
www.cms.gov/ICD10
Background: The NCSC is the primary forum in which representatives from the state chapters of the AAFP gather to discuss, debate and resolve issues affecting certain member groups within the academy. Currently, there are five groups referred to as ‘Constituencies’ representing certain interests. These are:

1. Women
2. Ethnic Minorities
3. International Medical Graduates
4. New Physicians, and
5. Gay, Lesbian, Bisexual and Transgender (GLBT)

From 2015, the conference will be known as the National Conference of Constituency Leaders – NCCL.

NCSC conference: The 2014 AAFP NCSC conference was the 24th in its history. I was honored to be the IMG delegate for the state of Colorado this year. This year saw the highest number of attendees at the conference – 185 for the NCSC and 219 for the ALF. There were also 24 IMG representatives from across the country. The conference was hosted at the Sheraton Kansas City Hotel at Crown Center and started with a ‘Pre-conference’ on 04/30/2014 and continued through 05/03/2014 with a host of business and leisure activities, culminating in debates over the resolutions from the Reference Committee hearings.

I did not arrive in time enough to attend any of the pre-conference meetings but was able to register as a ‘First Time Attendee’ and the Colorado IMG delegate. During the meet and greet, I was pleased to meet some of the other delegates from Colorado who had arrived the same day, specifically, Glenn Madrid, MD (CAFP board chair) and Manthan Bhatt (CAFP director of communications). We had dinner together and were able to exchange ideas.

First day activities started with a networking breakfast during which I met delegates from other state chapters. After this came the opening and plenary sessions, with an interesting talk by Paula Braveman, MD, on health disparities in the US. This was followed by the various constituency discussion groups which I found to be very informative, followed by resolution writing. Then there was a joint session caucus during which we heard speeches from the 2015 Convener candidates and the New Physician board candidates, one of whom was from the Colorado chapter.

As the IMG representative, I met with delegates from other chapters as well as other conference attendees who were not representing their chapters but had come to take active part in the process (although they would have no voting rights with regard to the resolutions being presented by any particular constituency). I learned first-hand about how resolutions are created - from the seed of an idea through to its finally becoming an AAFP adopted motion. I am proud to have co-authored a resolution that was adopted by the Reference Committee and will be presented at the AAFP conference of delegates. The resolution is titled: CERTIFICATION/RECIPROCITY STANDARDS FOR FAMILY MEDICINE RESIDENCY TRAINING DONE OUTSIDE THE USA. (It urges the AAFP to support an alternate pathway to residency training for Family Medicine physicians who are trained and certified outside the USA that may include a shortened period of US residency training).

Day two activities included several lectures as well as the five constituency meetings to discuss the Reference Committee agendas/resolutions as well as elections for the 2015 Co-Conveners, Convener and New Physician board representatives. Voting for the Special Constituency Alternate Delegates and the AMA-YPS delegate also occurred.

Day three saw the final debates to adopt or reject the resolutions discussed by the Reference Committee and the closing of the conference.

As a first time attendee, I was pleasantly surprised to find that the conference exceeded my ideas and expectations. As a Family Physician, I had not thought to get involved with the political and decision making processes of the AAFP as I had always considered myself apolitical. Since attending this conference, I have come to realize the value of getting and staying involved while learning a great deal about our decision making process. I would encourage every Family Physician, whether an AAFP member or not, to attend at least one such conference to experience the diversity of people and views, as well as the camaraderie, even if they also consider themselves apolitical.
Dan Burke, MD, Donna Marshall, and Raquel met with Bob Jamieson, director of benefits for Boulder Valley School District to talk about PCMH and payment reform.

The CAFP had a nearly full delegation to the Annual Leadership Forum and the National Conference of Special Constituencies. From the left, Rick Budensiek, DO, FFAFP, Francis Thompson, MD, Tamaan Osbourne-Roberts, MD, Manthan Bhatt, Chad Knaus, MD, Glenn Madrid, MD, and John Bender, MD, FFAFP.

Glenn Madrid, MD, speaks with a physician leader from Ohio on the Colorado Primary Care Collaborative and the Legislative Committee of the CAFP.

Glenn Madrid, MD, speaks with a physician leader from Ohio on the Colorado Primary Care Collaborative and the Legislative Committee of the CAFP.

2014 is the Year of the Family Physician in California and we had many physicians from the beautiful state at our Western PCPCC.

The attendees at the Western PCPCC learned how to successfully transform practices, advocate for system changes and the leadership qualities needed to move the Patient Centered Medical Home forward.

The attendees at the Western PCPCC learned how to successfully transform practices, advocate for system changes and the leadership qualities needed to move the Patient Centered Medical Home forward.

The Colorado Primary Care Collaborative (CPCC) held its third convening meeting. The action plan that was created by the over 300 supporting organizations will be implemented with subgroups created by the convening meetings.

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

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

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

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

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

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

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

Applications are accepted electronically at www.jobsatcu.com.

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

When applying at www.jobsatcu.com, applicants must include:
1) A letter of application which specifically addresses the job requirements and outlines qualifications.
2) A current Curriculum Vitae

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

“The University of Colorado Denver and Health Sciences Center requires background investigations for employment.”

“The University of Colorado is committed to diversity and equality in education and employment.”
Children's Hospital Colorado is pleased to announce the expansion of allergy care for children and adolescents in the Rocky Mountain region. Dan Atkins, MD is the new section head of the department of allergy at Children's Colorado. The expanded care team also includes board-certified pediatric allergists Kirstin Carel, MD; David Fleischer, MD; Dan Searing, MD; and Jessica Moore, PNP; and psychologist, Jane Robinson, PhD. The goal of our allergy team is to significantly improve the quality of life for our patients and their families.

Our multidisciplinary team approach incorporates family involvement and includes close collaboration with primary care providers. Areas of expertise include the evaluation and management of asthma, exercise-induced asthma, vocal cord dysfunction, allergic and non-allergic rhinitis, chronic sinusitis, atopic dermatitis, food allergy, drug allergy, animal allergy, insect sting sensitivity, angioedema, acute and chronic urticaria (hives) and anaphylaxis.

For more information about our Allergy Program, please visit childrenscolorado.org/allergy.

Many hands, one heart.
Pediatric Hip Conditions in Primary Care

Eduardo Novais, MD

Six percent of all clinic visits in children and adolescents in the primary care setting are related to musculoskeletal complaints. This issue of Kids Corner will focus on the common pediatric hip conditions seen in primary care ranging from developmental disorders including developmental dysplasia of the hip (DDH), Legg-Calvé-Perthes disease (LCPD) and slipped capital femoral epiphysis (SCFE) to inflammatory and infection problems.

Special considerations based on age group

Newborn and infant (ages 0-3 years)

Development dysplasia of the hip includes a spectrum of disorders of development of the hip joint that have different presentations based on the child’s age. At birth the hip may be truly dislocated when there is a complete loss of contact between the femoral head and the acetabulum or partially dislocated (subluxated). The hip can also be well reduced but be found unstable (dislocatable) during physical examination. Physical examination of the newborn hip includes gentle hip abduction and adduction with the hip flexed. The Barlow test is performed with the baby supine, the examiner adds and gently pushes the hip to attempt to subluxate or dislocate the hip. Repeated maneuvers are not encouraged. The Ortolani test identifies a hip that is dislocated and can be reduced by abduction of the hip and gentle pull on the greater trochanter (Figure 1). When positive the femoral head will reduce in the acetabulum a clunk of reduction can be felt. True hip dislocation is estimated to affect 1.5 cases per 1000 live births. Currently literature from both the AAFP and AAP recommend that every newborn be screened by means of a physical examination. Referral to a pediatric orthopedic surgeon is recommended if the hip is found to be Ortolani or Barlow positive. Risk factors related to DDH include female gender, positive family history and breech presentation. These risk factors should take into consideration for further orthopedic referral if a patient has equivocal exam findings. A baby girl that is breech at birth should be further evaluated routinely with ultrasound. Currently ultrasound is recommended as the best image modality to assess the hip in the newborn period until four to six months of age when an anteroposterior radiographic of the pelvis may be obtained. To avoid false positive interpretations, ultrasound is recommended at six weeks of age. Conservative treatment of DDH in the newborn period most often is possible with a Pavlik harness that is used for an average of 12 weeks. When DDH is detected after 6 months of age bracing is less likely to benefit the patient and further treatment may include closed versus open reduction of the hip joint and immobilization in a spica type of cast.

Child (4-10 years)

In this age group the most common complaint related to the hip joint is pain and or limp. An isolated painless limp may be secondary to limb length inequality associated with a dislocated hip. A painful limp typically associated with limited range of motion of the hip (specially abduction and internal rotation with the hip in flexion) in a child may be secondary to transient synovitis of the hip, Legg-Calvé-Perthes disease, traumatic injuries, septic arthritis of the hip and juvenile arthritis. History and physical examination help differentiate between these entities.
but further imaging and laboratory tests are crucial.

Transient synovitis of the hip is the most common cause of hip pain and limp between the ages of three and eight years old and presents as acute onset of hip pain typically with antecedent viral illness. The main differential diagnosis is with septic arthritis. In transient synovitis the child may have fever but typically the white cell count, C-reactive protein level and erythrocyte sedimentation rate (ESR) are within normal limits or slightly elevated. A hip ultrasound may show effusion in both conditions. Aspiration of the joint typically reveals white blood cell (WBC) count between 5000 and 15000 cells in transient synovitis and higher than 50000 in septic arthritis. Transient synovitis is treated with rest and anti-inflammatory medications while septic arthritis typically requires surgical intervention and antibiotic therapy.

Legg-Calvé-Perthes disease is a disorder of the blood supply to the femoral head resulting in osteonecrosis. It typically affects children between 4 and 12 years of age with male predominance. In the early presentation the child has an antalgic limp and reduced hip motion. Radiographs of the hip including an anteroposterior and frog lateral views are the imaging of choice (Figure 2). The initial changes on the femoral head include sclerosis, and smaller ossific nucleus. Later in the disease process the femoral head will collapse with fragmentation. There is currently increasing evidence to support perfusion MRI in diagnosis of early disease. Treatment may include a series of casts (Petrie cast) with both hips in abduction followed by bracing and most commonly surgical intervention with a femoral osteotomy.

Adolescent (ages 11-19) 

Slipped capital femoral epiphysis is a disorder of the proximal femoral growth plate in which the femoral head displaces posteriorly and medially in relation to the femoral neck. It typically occurs in boys between age 12 and 15 and in girls between 10 and 13 years of age. SCFE may present acutely similarly to a femoral fracture with severe pain in the groin or hip area and inability to bear weight in the lower extremity. However, in the chronic type, SCFE may present with insidious onset of hip or knee pain, associated with a limp and loss of motion of the hip, mainly in internal rotation. SCFE is related to childhood obesity and should be ruled out when an overweight adolescent presents with knee or hip pain. Imaging evaluation initially includes an anteroposterior and frog radiographic views (Figure 3). Treatment is based on the severity of the deformity but usually involves fixation of the proximal femur to stabilize the physis.

Adolescent hip dysplasia is another cause of hip pain and limited function in adolescents, especially those that are physically active. These patients may or may not have a history of DDH during childhood. In this age group imaging investigation is typically performed with pelvic radiographs and magnetic resonance imaging to assess the quality of the acetabular labrum (Figure 4). The acetabular labrum is a rim of fibrocartilage that surrounds the acetabulum and contributes to joint stability as well as to sealing the joint keeping fluid pressure. The acetabular labrum may also be torn as a consequence of femoroacetabular impingement (FAI). FAI is a clinical syndrome of pain and limited motion of the hip – internal rotation with the hip flexed at 90° – and damage of the joint secondary to abnormal mechanical contact between the proximal femur and the acetabular rim. Basically two morphologies are described: the femoral side CAM deformity and the acetabular side Pincer deformity (Figure 5). Treatment of FAI includes conservative measures and surgical intervention when those fail.

In summary, pediatric and adolescent patients may present to the primary care physician with complaints related to hip pain, limp and abnormal motion. The key aspects of evaluation include a complete history and physical examination that determines further imaging tests for treatment in the primary care setting for some and pediatric orthopedic referral when indicated.

Eduardo Novais, MD is the Director of the Child and Young Adult Hip Program at Children’s Hospital Colorado within the Orthopedic Institute and an Assistant Professor with the Department of Orthopedics at the University of Colorado School of Medicine.

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 author or Dr. Jeffrey Cain, Chief of Family Medicine through One Call: 720-777-3999.
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Website: www.bop.gov

The Federal Bureau of Prisons is an Equal Opportunity Employer
From groundbreaking projects to inspiring CME to leadership in state advocacy, 2013 was a transformative year full of memorable moments for Family Physicians of Colorado. We are proud to present the CAFP’s 2013 Annual Report.

LOSS OF A LEADER
The premature death of Bob Brockmann, MD, FAAFP, CAFP President was hard on all of us. There were many pieces that had to be picked up and put back together because of the huge void that was created. The CAFP worked with his family to create the CAFP Foundation Medical Student and Resident scholarship fund and with the CAFP education committee to create a physician health and wellness talk at the ASC. The CAFP is stronger because of Bob’s work and we will never forget his dedication to Family Medicine and universal health access.

OPERATION: POWER-UP
At the request of the board, we created the Operation Power-Up project to study the best staffing for the CAFP and future planning and drafted a plan for board approval. The board approved the hiring of two new staff persons who were hired on April 1 and a third staff person hired on July 1. Because of the intense interviewing, assessment process, and background checks, we believe that we now have a stellar crew on board. Much of the first few months were filled with education and training of the new staff and the development of our team. The CAFP has been fired up with new energy and creativity.

COLO. PRIMARY CARE COLLABORATIVE
Bob Brockmann, MD, past president of the CAFP, had the vision to create a Colorado organization similar to the national Patient Centered Primary Care Collaborative (PCPCC). The Jan. 9, 2014 Convening Meeting of this new initiative had over 150 attendees and there are close to 300 people and organizations who are interested in the vision and mission of this project.

LEGISLATIVE ACTIVITIES
We created a plan to improve the Doctor of the Day program and to improve legislative communications. The CAFP continues to have a strong and successful presence at the Capitol due to the energy and devotion of our Family Medicine Physician leaders and also because of our outstanding lobbyist, Jeff Thormodsgaard.

The CAFP successfully lobbied for the Medicaid Primary Care Bump. Effective 2013 in Colorado, Medicaid payments for primary care services will parity Medicare levels, a nearly 75% increase. With the passage of SB222, the CAFP is working with the Colorado Department of Public Health and Environment to lower the cost of purchasing childhood vaccinations.

2013 SUCCESSES
The 2013 CAFP Annual Scientific Conference was a success with a strong number of exhibitors and attendees.

The CAFP’s new website launched with great success. It is easier to sign in, follow current events and communicate with your fellow colleagues.

We continue to have a strong board and strong leaders who continually put Family Medicine and the CAFP in the limelight. We hope to continue this strong work into 2014 and beyond.

Richard L. Budensiek, DO, FAAFP
2013 CAFP President, on behalf of the CAFP Board of Directors

Membership At-A-Glance

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<td>2,184</td>
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<tr>
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Jeff Cain, MD, FAAFP
Chairman of the American Academy of Family Physicians

Colorado’s own Jeffrey Cain (left), MD, FAAFP, spent 190 days on the road as the President of the American Academy of Family Physicians. He was successful in bringing a unified voice of 100,000+ Family Physicians to policymakers, medical students, health care leaders and many more!

Dr. Cain was influential in passing and implementing legislation defining the medical home in Colorado and improving access for the underserved. A public health champion, he also co-founded Tar Wars, a tobacco-free education program that has reached 8.5 million children in 50 states and 16 countries.

Rick Budensiek, DO
President of the Colorado Academy of Family Physicians

Testifying multiple times before both the Colorado State House and Senate, volunteering as the Doctor of the Day, and Chairing the Colorado Primary Care Collaborative’s Steering Committee, Dr. Budensiek’s leadership was invaluable for the CAFP.

With big ideas, a thoughtful approach, and the courage to push the value of Family Medicine Physicians, Dr. Budensiek was successful in progressing a robust, medical home driven, health care model in Colorado. The CAFP depends on physicians like Dr. Budensiek to help move ideas to action.

John Bender, MD
President, Colorado Medical Society & CEO of Miramont Family Medicine

The CAFP delegates, Kent Voorhees, MD, and John Bender, MD, and alternate delegates, Brian Bacak, MD, and Rick Budensiek, DO, did a fabulous job representing our Colorado members during discussions and debates at the AAFP Congress of Delegates.

The CAFP was especially proud that our native son, Dr. Bender, was elected as President of the Colorado Medical Society. Dr. Bender has testified multiple times on behalf of Family Medicine Physicians at the State Capitol this year and he hopes to represent a unified voice for all physicians in Colorado.

Jeff Thormodsgaard
CAFP Lobbyist

The 2013 Legislative Session was successful for the CAFP. Jeff lobbied for Medicaid parity with Medicare, a 3% increase in medicaid reimbursements, starting the process to dramatically lower the cost of vaccinations for small practices, progressing payment reform forward, and protecting Family Medicine Physicians from onerous regulations.

In 2014, an election year, Jeff hopes to set up meetings between Family Physicians across the state with their State Legislators to build a strong endorsement process.
## CAFP 2013 Award Winners

- Paul Fonken, MD  
  Family Medicine Physician of the Year
- Candace Murbach, DO  
  Family Medicine Teacher of the Year
- Patrick Smith, MD  
  Family Medicine Resident of the Year
- New West Physicians  
  PCMH Best Practice of the Year

## CAFP 2013 Programs

### Fit Family Challenge
**Tackling Childhood Obesity**

Bonnie T Jortberg, PhD, RD, CDE, Luke Casias, MD, FAAFP, and Sarah Roth, MA, have led a 21 practice pilot that encourages lifestyle changes that decrease obesity. In 2013, the Fit Family Challenge showed clinically significant results including Body Mass Index (BMI) reduction, lifestyle changes, and increase in exercise.

Funded by a Colorado Health Foundation grant, Fit Family Challenge is aiming to tackle pediatric obesity in a replicable, practice-based way. The pilot revolves around the 5-2-1-0 recommendations: 5 fruits and vegetables, 2 hours or less of recreational screen time, 1 hour or more of physical activity, and 0 sugary drinks.

### Family Medicine Interest Groups
**Inspiring the Next Generation of Family Physicians**

The Colorado Academy of Family Physicians hopes to inspire and advocate for students interested in Family Medicine. This year, we had eight hosted events that connected Family Physicians across the state with FMIG students at both the University of Colorado Medical School and Rocky Vista University.

The Colorado Academy of Family Physicians highly values the contributions made by family medicine residents and medical students. We are one of the few organizations that have both medical student and resident leadership in our Board of Directors and these leaders have been successful in advocating for new physicians.

### Tar Wars
**Tobacco-free Program Led by Family Physicians**

Tar Wars is a tobacco-free education program for 4th and 5th grade students that is designed to teach about the dangers of tobacco usage by pairing Family Physicians across the state of Colorado to classrooms in their community. Albert Burkle, 5th grader from Colorado Springs and the winner of Colorado’s Tar Wars poster contest, took third place at the national Tar Wars contest.

Karol Groswold, the CAFP’s new Tar Wars Coordinator, was successful in reaching 132 schools and over 9,000 students. Karol hopes to revise the curriculum in 2014 to include marijuana and e-cigarette curriculum.
University of Colorado Hospital and the CU School of Medicine are proud to announce the opening of the new Lone Tree Breast Center, one of the Colorado’s most comprehensive breast health facilities. The Center offers 3-D mammography for all patients as a standard of care with no additional cost to our patients, and walk-in appointments are always welcome.

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

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

Hours: 8:00 am-5:00 pm | Scheduling Phone number: 720-553-1200 | Fax: 720-553-1201
Street Address: 9544 Park Meadows Drive, Suite 100, Lone Tree, CO 80124
Can Gathering and Managing Patient Information Be Less Challenging?

CORHIO Community Outreach Staff

One of the biggest complaints we hear from physicians, as well as nurses and other practice staff, is how difficult and time-consuming it can be to collect complete clinical histories for new patients, or manage the needs of complex and chronic disease patients who are seen by multiple physicians. Often there are many phone calls back and forth between offices and stacks of paper faxes for which the relevant patient information is hard to find. Even worse, the information you need today may not arrive until weeks after a referral appointment or hospital discharge. The process of gathering and managing patient records is frustrating and most health care professionals have just learned to accept it.

As a physician, you may not spend countless hours gathering and organizing patient information yourself, but your medical assistants or support staff are likely tied up with it. Or perhaps you’ve become adept at filling in large gaps of missing information with rapid fire questions during patient appointments?

Information Gathering Made Simple

Although you and your team have developed into expert information gatherers, there is a way to cut back on this tedious and inefficient work. In Colorado we have one of the nation’s most advanced health information exchange (HIE) networks managed by the Colorado Regional Health Information Organization (CORHIO). More than 2,500 office-based providers, 49 hospitals, 133 long-term and post-acute care facilities, 27 behavioral health centers and five medical laboratories have joined the network. CORHIO, a nonprofit organization governed by an impressive board of health care leaders, including three practicing physicians, has installed a highly secure, high-speed electronic network that allows providers to share clinical information for care coordination. And while the ultimate aim is to improve the quality of patient care, it also provides many efficiencies to a busy primary care practice.

Using an encrypted Web portal, in just a few mouse clicks (or a few taps on your handheld tablet computer) you can view a new patient’s consolidated record with up-to-the-minute lab results and hospitalization records. Additionally, hospital or outpatient labs, radiology reports and other information can be seamlessly and automatically routed into the electronic health record (EHR) you use every day. Very soon, as ambulatory EHRs capabilities catch up to interoperability standards, the CORHIO network will support office-based physicians’ ability to electronically share clinical summary documents (also known as CCDs).

Many of your peers have already joined the network, including Dr. Clark Zimmerman from Hilltop Family Physicians in Parker, Colo. Dr. Clark recently commented, “CORHIO has allowed me to treat my patients in real time. In the past, I felt like I was always trying to recover the information I needed after it was required. Now it’s at my fingertips and has improved the accuracy and timeliness of patient care.”

When Efficiencies Go Up, Costs Go Down

With automated and streamlined information exchange, practices become more efficient and are able to reduce some costs related to paper, printer ink and fax lines. Many physician offices participating in the CORHIO network report that with access to HIE data, they are able to repurpose one-half of a full-time employee toward other more strategic office responsibilities.

One such practice is Alpine Urology, which receives lab results from CORHIO seamlessly into their EHR. Since staff no longer wastes time tracking down patient information or scanning documents, the amount of personnel time has been greatly reduced. Practice administrator Bill Carlton estimates they have saved the cost of a part-time office staff member. “Being able to retrieve lab results electronically has also reduced what we spend on paper and toner cartridges,” he said.

Hospital Participation Growth - HIE

![Hospital Participation Growth - HIE](chart)
“All of that adds up after a while.”

**HIE Options Based on Your Needs**

CORHIO offers four different ways in which practices can connect to the HIE network, depending on whether you use an EHR or if you are participating in the Medicare or Medicaid EHR Incentive Programs:

1. Results Delivery – Your patients’ lab results and other data, including radiology and newborn screening reports, are automatically routed into your EHR (or Web portal inbox). Having lab results available in your EHR can help you meet Meaningful Use Stage 2.

2. Community Health Record – Using our PatientCare 360® Web-based application, you can search for a patient and retrieve up-to-date, comprehensive and consolidated information (i.e. longitudinal health record).

3. Direct Messaging and HISP Services (point-to-point communication) – This is a simplified version of HIE, which works like secure email. You can Direct message another specified provider for referrals or transitions of care, or even a patient directly (recipient must have a valid Direct address). Direct messaging can help you meet Meaningful Use Stage 2.

4. Public Health Immunization Reporting – For providers planning to attest to Stage 2 of Meaningful Use, CORHIO can automatically route your patients’ immunization information directly to the state health department, CDPHE. Cancer reporting and other health department data exchange is coming soon.

The ability to earn a living is an employee’s most valuable asset. Help your staff protect that asset with strong **Employer Group Disability Insurance** offered through the AAFP Insurance Program.

This affordable coverage is the best in the industry ... with benefits guaranteed for every member of your group and customized for each specialty. You can often get it without medical questions or examinations. Enhance your employee benefits with this valuable income protection plan today.

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* CDA 2013 Employer Disability Awareness Study

Half of all workers would find themselves in financial trouble after a month without a paycheck.*

And What About You ... and Your Staff?
Introducing Solid Food

By Pathways.org

Parents often rely on their child’s healthcare provider for information and support regarding infant feeding practices and nutrition. The American Academy of Family Physicians recommends introducing solid food to an infant’s diet around 6 months of age. However, the results of a 2013 survey, which included 1,334 new mothers, indicated that 40 percent of respondents introduced solid foods to their infants much earlier – prior to 4 months of age. Given the short-term and long-term risks associated with early solid food introduction, it is essential for healthcare providers to give clear and accurate feeding recommendations at early well-child visits.

Every infant develops at his or her own pace and parents should be instructed to watch for the following signs of solid food readiness near 6 months of age:

- Able to hold his or her head up when sitting
- Opens mouth when food approaches
- Able to move food from a spoon or fork into throat

Infants can start their transition to solid food with thinly pureed fruits and vegetables, such as bananas, peaches, and squash, as well as single-grain cereals mixed with breast milk or formula. Particular foods should be avoided for the first year, including honey, cow’s milk, salt, and artificial sweeteners. Honey contains spores that can cause infant botulism, and infants’ digestive systems cannot process the protein present in cow’s milk.

Parents may be tempted to start solid foods early if their infant seems particularly fussy or hungry. They may also follow the common misconception that consuming solid foods before bedtime helps an infant sleep through the night; research shows that there is no evidence to support this claim. Healthcare providers can encourage a healthy transition to solid food by communicating the risks associated with starting too soon. Introducing solid food too early may:

- Cause an infant to choke – in their first few months, infants cannot hold their heads up in a sitting position and have not yet developed the coordination needed to swallow food
- Result in stomach aches, gas, and constipation – an infant’s digestive tract is not prepared to process solid foods until closer to 6 months of age
- Replace breast milk or formula with food that may not meet an infant’s nutritional needs – breast milk or formula should remain an integral part of an infant’s diet until the first birthday
- Increase the risk of obesity and diabetes

Founded in 1985, Pathways.org empowers parents and health professionals with free educational resources on the benefit of early detection and early therapy for children’s motor, sensory, and communication development. For more information, visit www.pathways.org or emails friends@pathways.org. Pathways.org is a 501(c)(3) not-for-profit organization.


2014 Annual Scientific Conference: 
Continued Success and Growth

With over 160 attendees and 43 exhibitors, the 2014 Annual Scientific Conference was the most successful annual conference we’ve ever had! This year, we focused on creating a family friendly event and we believe that is why so many first time attendants were able to join us. With a western themed reception this year, we had a packed ballroom at the Cheyenne Mountain Resort in Colorado Springs.

Our Annual Scientific Conference was also able to raise $1,100 for the CAFP Foundation. The Colorado Academy of Family Physicians Foundation is a nonprofit charitable organization providing Family Physicians and their communities with education, resources, research, and advocacy to advance Family Medicine and to improve the health of the people of Colorado.

We did all of this while providing amazing CME that ranged from infoPOEMs, OBGYN Workshops, evidence-based marijuana guidelines, and a lecture on Direct Primary Care.
**ER/LA Opioid REMS:** Achieving Safe Use While Improving Patient Care

6 Free CO*RE Webinars Coming This Year!

The State Academies of Family Medicine are pleased to invite you to attend a FREE webinar on Extended-Release/Long-Acting Opioids: Achieving Safe Use While Improving Patient Care. We have scheduled 6 webinars during the next several months — one of them should be perfect for your busy schedule.

The 90-minute webinars meet the FDA requirements for ER/LA opioid risk management and mitigation strategies (REMS), and include cases, tools use and more. A post-activity assessment will help you gauge your increase in knowledge and competency. Upon completion of the assessment and evaluation you will receive 1.5 AAFP Prescribed credits and we’ll send you both the faculty slides and additional resources you can use to improve your care of patients.

**REGISTER TODAY!**

June 23 – Monday
June 24 – Tuesday

September 23 – Tuesday
September 25 – Thursday

November 11 – Tuesday
November 13 – Thursday

If you have any questions, feel free to contact Shelly Rodrigues at srodrigues@familydocs.org

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LEGISLATIVE SESSION CLOSES WITH PROGRESS ON REAL MARIJUANA POLICY, BUT MORE WORK REMAINS

By Heidi Baskfield, JD Executive Director of Advocacy, Children’s Hospital Colorado

Since the passage of Amendment 64, the retail availability of marijuana edible products has skyrocketed. One can now purchase common baked goods, cookies, candies and sodas—all infused with marijuana, and all impossible to visibly differentiate from a non-THC infused product.

Many of these pot products look and feel exactly like food products that have been historically marketed to children. (The list is nearly endless, but a few examples include gummy bears, goldfish, Swedish fish, rainbow bands, and peanut butter cups.)

Accidental exposures of marijuana products to children have increased in the past 3 years, since the medical marijuana industry in Colorado started growing rapidly in late 2009, and even more so since retail marijuana became available to adults 21 years of age or older on January 1, 2014. We know this based on the rising rates of Emergency Department visits and admissions at Children’s Hospital Colorado.

These children are typically of toddler age, and their symptoms vary anywhere from mild sleepiness, to poor respiratory effort, to coma requiring insertion of a breathing tube. Many of these children are getting into edible products with high concentrations of THC.

Children’s Hospital Colorado alone has seen 20 children in the Emergency Department due to accidental marijuana ingestion since Colorado’s proliferation of legalized retail marijuana and edible products.

That toddlers would be exposed to marijuana products at increasing rates is not surprising. After all, the state’s medical marijuana registry, created by a ballot measure in 2000, currently contains about 2 percent of Colorado’s population (112,000 people out of 5.27 million total). In contrast, of course, retail marijuana can now be purchased by nearly any adult age 21 or over, or about 75 percent of the state’s population.

At the same time, we see news reports about the influx of children with severe epilepsy into our state in order to access medical marijuana. Given the medical complexity of epilepsy and the difficult decisions facing these families, their stories are both incredibly moving and completely understandable—because any parent of a child with such a life-altering condition would do everything in their power to make their child better.

The recent stories of children who have had positive outcomes from the marijuana derivative, cannabidiol (CBD), give reason for hope and should encourage further studies. Any treatment decision, however, must involve an assessment of benefit versus risk. The trouble is that there is at present no clear, scientific evidence that marijuana improves epilepsy in children.

In response, this session the state legislature grappled with, and ultimately passed, a number of bills designed to curb increasing youth access to marijuana (both accidental and intentional) in the wake of legalization. There were also bills to allocate marijuana tax revenues and invest in scientific research that can help state officials and healthcare providers—as well as desperate patients and their families—to assess with more certainty the claimed medical benefits of marijuana-derived cannabinoids.

Children’s Hospital Colorado supported and helped to strengthen most of these marijuana-related bills this year:

- **House Bill 1361**: Will establish equivalency limits for purchasers of

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retail marijuana equal to not more than one ounce of dry, loose-leaf MJ per transaction. (Previously it was ambiguous whether buying one ounce of “marijuana” meant only the loose-leaf plant or, for example, one ounce of THC concentrate, about a 90-fold difference in the amount of THC being sold.) Passed on May 6 and awaiting the Governor’s signature.

- **House Bill 1366**: Requires the state Department of Revenue—the main regulatory agency in marijuana policy—to establish regulations that will ensure edible products themselves (not just their packages) are “clearly identifiable” as marijuana products. Today, in many cases, teachers, parents, children, and law enforcement have no way to visually distinguish an infused piece of candy from a regular gummy bear or tootsie roll. Status: passed on May 7 and awaiting the Governor’s signature.

- **Senate Bill 215**: Specifies for the upcoming fiscal year how retail marijuana tax revenue may be spent, including on marijuana education and prevention campaigns, substance abuse treatment programs, and child welfare issues specifically related to marijuana. Status: passed on May 7 and awaiting the Governor’s signature.

- **Senate Bill 155**: Allows $10 million of medical marijuana registry monies to go toward research specifically focused on potential benefits to patients of medical marijuana. Status: passed on May 5 and awaiting the Governor’s signature.

While this year’s legislative and regulatory efforts represent substantial additions to the protections that were put in place in 2013, the myriad public health issues posed by legalization have not been solved, even as new and unexpected challenges arise. Future advocacy efforts may focus less on accidental ingestions of marijuana by young children and begin to put more emphasis on what programs and messages can prevent teens from becoming habitual users of marijuana. Survey data shows a rising misconception among teens that marijuana isn’t harmful; policy makers, child health advocates, healthcare providers, and educators need to adjust their tactics to the new environment we live in, where marijuana is more widely available and less socially stigmatized. Also critical will be ensuring that adequate behavioral health and substance abuse resources are in place for youth and teens who need them.

Colorado’s experiment with marijuana legalization is still very much a work in progress. Everyone with a stake will continue to grapple with these difficult issues for years to come—knowing that if other states begin to legalize marijuana, many will rightly look to the Centennial State as a model for successful regulation.
William White is an energetic 12 year old from Chipeta Elementary in Colorado Springs, Colorado. He is the middle child and only boy in a family of five. William was awarded the 2014 Tar Wars poster contest winner for Colorado. This year, the CAFP Tar Wars program reached over 132 schools and over 9,000 students.

William has many endeavors in life such as: running, basketball, football, saxophone, guitar, and chess. He also loves to spend time outside swimming, hiking and playing with his siblings. But most days you will find William lying on the couch with a book in his hand. He has a true passion for reading and spends endless hours finishing series after series of different books.

At school, William enjoys classes such as language arts and math/science. This past year, he had the opportunity to participate in Battle of the Books and competed with his team at the regional level to show his knowledge of 40 different books. He also has been working on building a roller coaster in his math class and finds any type of hands-on learning very intriguing.

William will attend the National Tar Wars Conference in Washington, DC and speak with his legislators about the importance of strong tobacco cessation policy.
On February 7, 2014, the Center for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP) released its updates for immunizing adults\(^1\) and children and adolescents.\(^2\) The schedule was reviewed and approved by the American Academy of Family Physicians (AAFP), American College of Physicians, American College of Obstetricians and Gynecologists, and American College of Nurse-Midwives. According to the AAFP,\(^3\) the highlights that would most interest family physicians include:

- Most changes to the 2014 schedules involve refinement and clarification of existing recommendations, with just a few exceptions.
- The adult schedule, for example, now recommends a single dose of Haemophilus influenzae type b (Hib) vaccine for people with functional or anatomic asplenia and those who have sickle cell disease if they have not been vaccinated previously.
- New research shows that rates for a number of adult immunizations remain well below target levels, and researchers point to possible missed opportunities to vaccinate as a chief cause.

Perhaps the biggest and most useful change for practicing physicians is that for the first time the familiar figures, footnotes and tables have not been published in full in the CDC’s Morbidity and Mortality Weekly Report (MMWR). Instead, electronic versions of the schedules have been posted to the Vaccines and Immunizations section of the CDC website so they can be swiftly revised if errors or omissions are discovered.\(^4\) These electronic schedules are also available at the AAFP website as PDF files for both the adult\(^5\) and child or catch-up\(^6\) schedules.

### What’s New or Improved in the 2014 Schedules?

We especially like that brand names are included for each vaccine simply because they are more familiar to most clinicians and staff. For example, in the child and adolescent, the legend and footnote for the meningococcal conjugate vaccine have been updated to reflect a recent recommendation to use quadrivalent meningococcal conjugate (MenACWY-CRM) vaccine (Menveo) in infants as young as age 2 months. Previously, only bivalent meningococcal conjugate vaccine and Haemophilus influenzae type b conjugate (Hib-MenCY) vaccine (MenHibrix) was recommended for infants this young.

Other changes include:

- Influenza vaccine footnotes have been updated to guide dosing for children ages 6 months through 8 years during the 2013-14 and 2014-15 seasons,
- Pneumococcal vaccine footnotes have been updated to guide vaccination of people with high-risk conditions, and
- Hepatitis A vaccine footnotes have been updated to provide guidance for unvaccinated people who are at increased risk for infection.

The catch-up schedules for Hib conjugate vaccine, pneumococcal conjugate vaccine, and tetanus, diphtheria and acellular pertussis (Tdap) vaccine also have been clarified.

For patients scheduled to undergo elective splenectomy, a single dose of Hiv vaccine should be given at least 14 days before the procedure. Also new this year, family physicians no longer need to consider Hib vaccine for individuals with HIV infection, because the likelihood of Hib infection is low in this population.

Other changes to the adult schedule include:

- Moving the row for the pneumococcal conjugate 13-valent vaccine (PCV13) on top of that for the pneumococcal polysaccharide (PPSV23) vaccine as a visual reminder that PCV13 should be administered before PPSV23 in patients for whom both vaccines are recommended (i.e., those with immunocompromising conditions, functional or anatomic asplenia, cerebrospinal fluid leaks, or cochlear implants);
- Modifying the meningococcal vaccine footnote to clarify which patients need either one or two doses of vaccine, as well as to clarify which patients should receive the meningococcal conjugate (MenACWY-D) vaccine (Menactra) versus MenACWY-CRM vaccine; and
- Adding information about the recombinant influenza vaccine (RIV) and use of RIV and inactivated influenza vaccine (IIV) among egg-allergic patients to indicate that RIV or IIv can be used in patients with hives-only allergy to eggs.

Jamie Loehr, MD, the AAFP’s liaison to the ACIP, has published some other highlights for family physicians to consider:

- Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) revaccination appears to be safe and effective, but the pertussis protection wanes quickly, going from 98% effective at one year to 71% effective at five years. However, the pertussis work group is not recommending a second dose of Tdap because the cost-benefit ratio was judged to be poor.
- If a tetanus booster is needed and a patient has had Tdap in the past, the recommended booster is tetanus and diphtheria toxoids (Td). The only exception is pregnant women (including adolescents), who should be given the Tdap vaccine with each pregnancy, optimally between 27 and 36 weeks of gestation.

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**Update on the Immunization Schedules and What Flu Vaccines to Order**

Walt Larimore, MD, DABFP, FFAFP
Reginald Finger, MD, MPH
• The human papillomavirus (HPV) work group provided data showing a decrease in warts and abnormal Papanicolaou smear results for patients receiving HPV vaccine. The assumption is that over time, this will translate into fewer cervical cancers, but the studies are ongoing. In addition, the Merck pregnancy registry for the quadrivalent papillomavirus vaccine (Gardasil) did not show any increased risk of spontaneous abortion, fetal death, or congenital anomalies. HPV coverage is still poor, with only 50% of adolescent girls receiving one dose, and only 30% receiving all three doses. The HPV vaccination rates for three doses are around 30% for young adult women.

Dr. Loehr reminds each of us, “Overall adult vaccination rates are poor, ranging from 15% for the herpes zoster vaccine to 50% to 60% for pneumococcal and tetanus vaccines. We have a long way to go towards protecting our adult patients against vaccine-preventable diseases.”

**New Meningococcal Vaccine Recommendations for Children**

In an interview with Medscape Medical News regarding the schedule for children and adolescents, Michael T. Brady, MD, from Nationwide Children’s Hospital, Columbus, Ohio, pointed out, “There are now two additional meningococcal conjugate vaccines available for infants. The schedule provides information for which children these vaccines should be considered and when they should be administered,” Dr. Brady went on to say, “Menactra (Sanofi Pasteur) was included in the 2013 immunization schedule. It was the first ‘infant’ meningococcal vaccine approved and for which AAP and CDC had recommendations for a 2-dose schedule starting at age 9 months.”

The 2014 meningococcal vaccine recommendation now include guidance for the use of 2 new “infant” vaccines, Menveo (Novartis) and MenHibRix (GlaxoSmithKline). Each vaccine is approved starting at 2 months of age, with a 3-dose primary series and a booster dose at 12 to 15 months of age starting at 2 months of age for high-risk children, such as those with anatomic or functional asplenia, including sickle cell disease, and children with persistent complement component deficiency.

“None of the infant meningococcal vaccines is recommended for routine use in infants,” Dr. Brady emphasized. “They are only recommended for infants with an increased risk for meningococcal infection due to an immunodeficiency or those who travel to an area with high rates of meningococcal disease.”

**Should I Order Quadrivalent Influenza Vaccine for the Fall?**

According to a study published in the New England Journal of Medicine (NEJM), the quadrivalent vaccine to protect children from four different flu strains, could be more effective than the standard three-strain vaccine which, for the 2013-2014 season, was only 61 percent effective, according to the CDC. Even so, influenza vaccination reduced the risk for influenza-associated medical visits by approximately 60 percent.

In an online interview with HealthDay, one of the study’s co-authors said, “The results showed that, by preventing moderate to severe influenza, vaccination achieved reductions [of up to 77 percent] in doctors’ visits, hospitalizations, absences from school, and parental absences from work.”

The researcher also pointed out, “(We) also showed an 80 percent reduction in lower respiratory tract infections, which is the most common serious outcome of influenza. Therefore, vaccination of children in this age group can help to reduce the significant burden placed on parents, doctors and hospitals every flu season.”

Dr. Lisa Grohskopf, a medical officer in CDC’s influenza division, reminds us to not forget that “The nasal spray vaccine is a quadrivalent vaccine.” Grohskopf said, because of the short supply of the four-strain vaccine, the CDC is not recommending one vaccine over another. … The most important thing is that kids get a flu vaccine, even if it’s the older trivalent one.”

Walt Larimore, MD, DABFP, F AA FP, is a best-selling author and medical journalist who works with Concentra Medical Clinics in Denver and Colorado Springs and volunteers at Mission Medical Clinic in Colorado Springs.

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His website and medical news blog can be found at www.DrWalt.com. Reginald Finger, MD, MPH, serves on the faculty of the School of Health Sciences at Indiana Wesleyan University, and is a former member of the CDC’s Advisory Committee on Immunization Practices (ACIP) and of the Colorado Children’s Immunization Coalition.

Endnotes


5 http://tinyurl.com/k8bj9yo.

6 http://tinyurl.com/m86b86v.


Screening for Alcohol in Primary Care:  
A report from Colorado

Carolyn Swenson, MSPH, MSN, FNP  
Manager, Training and Consultation - SBIRT Colorado

According to the Centers for Disease Control, at least 38 million Americans drink too much and most do not have an alcohol use disorder. Yet, only 1 in 6 people has ever talked with their physician or other healthcare professional about alcohol. Drinking too much includes binge drinking (more than 3 drinks/occasion for women; more than 4/occasion for men), weekly consumption above a moderate level (more than 7 drinks/week for women; more than 14/week for men), and any alcohol use under age 21 or by pregnant women.

Colorado is the only state to be awarded two consecutive 5-year grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement routine screening and brief counseling into healthcare settings around our state. A patient-centered medical home is an ideal place to address alcohol as part of overall health and well-being across the lifespan. We believe that family physicians play a particularly important role in leading the way on this issue since they care for the whole person, and have an ongoing relationship with patients and families. In addition, since we know that stigma is a barrier to helping patients who drink too much, we believe that family physicians can open the door to talking about an issue that is too often not addressed until it becomes a very serious problem.

Screening can be as quick as asking one question of all patients age 18 or older: “How many times have you had X or more drinks in a day?” where X is 4 for women and 5 for men, and a response of 1 or more times is considered positive. Brief counseling can be as simple as interpreting the screening result for the patient so they are aware of what constitutes moderate drinking, and giving advice to cut back or abstain. Screening and brief counseling can reduce alcohol consumption by as much as 25%. The earlier we intervene to address drinking above moderate levels, the more likely we are to prevent progression to a substance use disorder, prevent and improve other chronic health conditions, and prevent injuries and violence. Our experience in Colorado confirms the effectiveness of this prevention service. Since 2007, over 140,000 Coloradans have received screening and brief counseling. Follow-up interviews conducted with a sample of patients from 2007-2011 found a 49.3% reduction in alcohol use and a 47.5% reduction in illegal drug use six months following screening.

What about adolescents? We know that the earlier a young person starts using alcohol, tobacco or another drug, the greater their risk of developing a substance use disorder. In Colorado, almost 20% of young people reported drinking alcohol (more than a few sips) before age 13, and 36% of high school students reported drinking in the past month. A trusted family physician could make a lasting difference in the life of a young person by routinely addressing alcohol and other drug use. The 6-item CRAFFT screening questionnaire was developed for use in primary care to assess alcohol and drug use in youth aged 12-17 years.

Different members of the healthcare team can help to carry out screening and brief counseling. The SBIRT Colorado program at Peer Assistance Services, Inc. offers training and technical assistance to help practices in Colorado implement alcohol screening and brief counseling. We can also provide additional information about reimbursement by private health plans, Medicaid, and Medicare, and the option to assess alcohol use to meet qualifications for 2014 National Committee for Quality Assurance (NCQA) Patient Centered Medical Home recognition. Contact Carolyn Swenson for more information: cswenson@peerassist.org

Citations:
Now that summer is here, we have begun planning our annual meeting to bring together SNOCAP practices! This year, we’re excited to be holding this convocation in conjunction with Colorado AHEC and our other partners! “Engaging Communities in Education and Research: Cultivating Campus-Community Partnerships for a Healthy Colorado” will be held in beautiful Vail, Colorado Friday September 26 – Sunday September 28, 2014. Up to approximately 10 hours of CME credit will be available, and we are especially glad that once again the conference and lodging is completely free to attendees. Your only cost is gas to get to the meeting!

This conference celebrates partnerships at every link of the chain with more than 400 attendees representing physicians, communities and academia. Attendees have the opportunity to learn about research projects, developments in healthcare and health education, and how best to integrate community and research perspectives on a variety of health and health care issues. This event will also provide preceptors the opportunity to receive preceptor development and continuing education credits and to build linkages with community partners.

The Engaging Communities in Education and Research (ECER) Conference is about engagement, a concept that shapes the structure and operations of Area Health Education Center (AHEC), the Shared Networks of Collaborative Ambulatory Practices and Partners (SNOCAP) and the Community Engagement Council of the Colorado Clinical and Translational Sciences Institute (CCTSI), to be thought provoking and encourage collaborations among many different disciplines. This year, the ECER conference is two and half days aimed at bringing rural and urban underserved community members and interprofessional health care providers together with academic educators and researchers and community-based organizations to improve the health of all Colorado.

New to the conference this year, we are pleased to host the CCSTI Partnership of Academicians and Communities for Translation (PACT) Community Engagement Research Exchange and Networking forum. This poster session will provide opportunities to learn about flourishing partnerships between community-based organizations and academic researchers across the state, programs designed to improve relationships and build trust between academicians and communities and how you can get involved and showcase work in translational and community engaged research.

Please save the dates and plan to join us at the Vail Marriott Resort & Spa for a fun and information-packed three day event. This year’s conference will have something new for everyone. Again lodging and most meals are free to attendees, but space is limited so please register soon! Online registration will begin July 1, 2014. For more details, please contact Jodi Holtrop (Jodi.Holtrop@ucdenver.edu, 303-724-5339) or Tabria Winer ( Tabria.Winer@ucdenver.edu, 303-724-1371).

Attendees have the opportunity to learn about research projects, developments in healthcare and health education, and how best to integrate community and research perspectives on a variety of health and health care issues.
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