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President’s Report ........................................... 4
CEO’s Report ............................................... 5
Legislative Update ........................................... 6
CAFP on the Go ............................................... 9
Colorado Primary Care Collaborative Update ............................. 10

2014 ANNUAL REPORT .................................. 13

EDUCATION & PRACTICE ENHANCEMENTS

A Missing Component - Is Your Practice At Risk? .................. 22
Influenza Part 1-Vaccination ........................................ 24
Overlooked Diagnostic Tests ......................................... 27
Practice Redesign to Prepare for Changes in the Health Care System ... 28
Indicators of and Screening for OSA .................................. 29
SNOCAP Recap .................................................. 31
Tobacco and Kids: What Family Physicians Need to Know ............. 31
Want to Know How Your Practice Compares on Cost and Efficiency? .... 33

HEALTH OF THE PUBLIC

Family Physicians Inform Hepatitis C Screening and Care Practices in Colorado ... 34
Vaccine Update ................................................... 35
Tar Wars Adds Marijuana Curriculum ................................... 38
Syringe Access Programs In Colorado .................................. 39

MEMBERS

Putting the Family in Family Medicine ................................ 40
Congratulations to the Following CAFP Members on Their Accomplishments! .. 41

Edition 44

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 303-696-4655 or 1-800-468-8615
fax 303-696-7224
e-mail info@coloradoafp.org

Board Members
Term Expiring 2016
Michael Archer, MD, Westminster
marcher@completefamilymed.com
John Cawley, MD, Ft. Collins
jcawley@afmfc.com
Virginia Richey, MD, Denver
vr1ickey@gmail.com
Wendy Richmond, MD, Pueblo
wendyalemandr@hotmail.com
Term Expiring 2017
Carolyn Francavilla Brown, MD, Denver
carolyn.francavilla@safphealth.com
Anneliese Heckert, DO, Pueblo
anneliesheckert@centura.org
Brian Hill, MD
Castle Pines
bhillwv@gmail.com
Term Expiring 2018
Emma Stout, MD, Pueblo
emma76@hotmail.com
Craig Anthony, MD, Denver
craig.anthony.vcu@gmail.com
Monica Morris, MD, Denver
monica.morris@rvu.edu
Laurie Patton, MD, Parker
lpatton@miramont.us
Zach Wachtel, MD, Denver
zccwachtel@gmail.com

Delegates
John Bonder, MD, FAAFP, Ft. Collins
jbender@miramont.us
term expires 2015
Kent Voorhees, MU, FAAFP, Littleton
kent.voorhees@ucdenver.edu
term expires 2014
Alternate Delegates
Brian Bacak, MD, FAAFP
Highlands Ranch
brian.bacak@healthonecares.com
term expires 2015
Rick Bodensiek, DO, FAAFP
rubd5622@att.com
Term Expires 2016

Resident Representatives
Kaitlyn Christopher, MD, Denver
kaitlynchristopher@centura.org
Christine Horstmeier, MD, Denver
christinehorstmeier@centura.org
Brian Juan, MD, Pueblo
brianjuan@centura.org
Syed Gillani, DO, Pueblo
dcgillani@gmail.com
Aaron Stupp, MU, Pueblo
aaronstupp@centura.org

Student Representatives
Netana Hotmisky, RVU, grad 2016
netana.hotmisky@rvu.edu
Maggie Reinsvold, CU, grad 2016
maggie.reinsvold@ucdenver.edu
Grace Borton, RVU, grad 2017
grace.borton@rvu.edu
Lindsay Herrera, CU, grad 2018
lindsay.herrera@ucdenver.edu
Joshua Iold, RVU, grad 2017
Joshua.Iold@rvu.edu

Editor
Candace Murbach, DO
candacemurbach@centura.org

Legislative Committee Chair
Chandra Hartman, MD, Denver
chandra.hartman@gmail.com

Tamaan Osbourne-Roberts, MD, Denver
tamaan.osbourne.roberts@gmail.com

Education Committee Chairs
John Cawley, MD
jcawley@afmfc.com
Monica Morris, MD
mcorriga@zagmail.gonzaga.edu

Staff
Raquel Rosen, MA, CAE
Chief Executive Officer
raquel@coloradoafp.org

Lynlee Espeseth
Director of Communications, Marketing & Membership
lynlee@coloradoafp.org

Sarah Roth, MD
Director of Health of the Public
sroth@coloradoafp.org

Jeff Thormodsgaard
Lobbyist
jeff@medcomconsultinginc.com

Erie Watwood
Director of Education, Events, & Meetings
erie@coloradoafp.org

CAFP Board of Directors
Officers 2014-2015
Chair/Past President
Candace Murbach, DO
Pueblo
candacemurbach@centura.org

Vice President
Chandra Hartman, MD
Denver
chandra.hartman@gmail.com

President
Glenn Madrid, MD
Grand Junction
gmadrid@poggi.com

Secretary/Treasurer
Anna Weglein, MD
Denver
wegwoods@aol.com

President-elect
Tamaan Osbourne-Roberts, MD
Denver
tamaan.osbourne.roberts@gmail.com

Member-at-Large
Monica Morris, DO
Denver
mcorriga@zagmail.gonzaga.edu

External Relations/Awards Committee Chair
Rick Bodensiek, DO
rubd5622@hotmail.com
As busy family physicians in today’s medical landscape, we sometimes feel that “bricks” have been thrown at us for some time now. The Affordable Care Act, PCMH, meaningful use, electronic health records, and payment reform are just some of the “bricks.” We can place them in disorganized piles or in loose stacks, but I truly believe as family physicians, we can be the stone masons that lay the “firm foundation” for America’s health.

Family physicians are increasingly being recognized as important and vital primary care providers that are needed to lead health care reform. My partners and I in Grand Junction have been a CPCI (Comprehensive Primary Care Initiative) practice for the last 2 years. We are 1 of about 73 practices in Colorado and just under 500 in the United States. As a result, I was asked to represent our practice at the Center for Medicare and Medicaid Services in Baltimore, Maryland. Our practice was one of five in the country highlighted. The practices were from different parts of the country and represented different delivery systems from private practices to larger systems to federally supported systems. What we all had in common was success with the CPCI project, showing improved quality and lower costs.

My practice was able to hire case coordinators, a clinical pharmacist and clinical behavioral health providers in house to do “warm hand offs.” The physician lead team also includes a mid- level provider (PA, APN or both) as well as medical assistants. We meet as a team at least weekly and review risk stratified patient data, hospitalizations and ER visits. The transformation we have seen has been very satisfying.

This year the Department of Health and Human Services launched the Health Care Payment Learning and Action Network (HCPLAN). This is a coordinated effort to bring stakeholders together from the public, private and non-profit sector to help transform the nation’s health system. The emphasis is value over volume. In other words, payment reform. In March 2015, Secretary Sylvia Burwell announced a goal of tying “30 percent of Medicare fee-for-service payments to quality or value through alternative payment models by 2016 and 50 percent by 2018.” HHS has also set a goal of tying 85 percent of all Medicare fee-for-service to quality or value by 2016 and 90 percent by 2018.

I was honored to be invited to the White House for the launch of the HCPLAN and was able to meet President Obama. Several of us invitees (see photo) were invited back stage. He told me he was giving me a “shout out” in his speech. He did that very thing! He essentially spoke about the health changes we have made in our practice that have proven effective. I was also able to talk briefly with Patrick Conway, MD, MSc, the Deputy Administrator for Innovation and Quality and CMS Medical Officer. These were amazing “bricks” I am collecting on behalf of Colorado family physicians.

As part of the HCPLAN launch, we met at the Humphrey building. Stakeholders, including patients, physicians, hospitals, health plans and public officials were separated in to small groups. We literally started with a white board and created ideas and action items based on our real life practice experiences. We then came back together to share our thoughts and ideas for health care reform. It was remarkable that the federal government was asking those of us in the trenches for our opinion rather than telling us what was to happen. I am delighted and encouraged to see this process and will continue to advocate for family physicians.

So what does this mean for you and me? Health care reform is clearly upon us. It is a very exciting time to be practicing Family Medicine. We have the opportunity to take these “bricks” and continue to build a bigger and better foundation for Colorado’s health. The triple aim of better health, better quality and better cost is achievable. Please advocate for your patients and yourselves as family physicians. Sure, there are many things we do not like about our health care environment, but we can use the tools we already have to foster positive change. As the advertising slogan states, “let’s build something together.”
Michael Booth wrote in the Colorado Health Foundation’s spring 2015 quarterly journal, “If integrating behavioral and physical health, while reforming what doctors get paid for, have long been the holy grails for health system change, then 2015 may someday go down as the year the quest could claim true success.”

As Dave West, MD, a Family Medicine Physician in Grand Junction and a past CAFP president and AAFP board member stated in an email on May 17, his wish list includes:

- End of fee for service, which promotes bad care and is expensive. One related point is the UK is now rated as the best healthcare in the world by some, where GPs usually have the highest incomes and where about 50% of doctors are GPs.
- Figure out a way for doctors to get paid fairly, and especially that they get paid to educate patients and families about their conditions and choices. Why do we get paid nothing (or pennies) to have patients stop smoking or never start, but paid a lot to drain their malignant effusion?

**SGR Repeal May Help**

In April of 2015, the AAFP was successful, after many attempts over the last decade, in helping to pass the MACRA bill, which repeals the flawed Medicare Sustainable Growth Rate (SGR). It will transform Medicare physician payment in the following ways:

- Repeals the Sustainable Growth Rate methodology for determining updates to the Medicare physician fee schedule.
- Establishes annual positive or flat fee updates for 10 years and institutes a two-tracked fee update afterwards.
- Establishes a Merit-Based Incentive Payment System that consolidates existing Medicare fee-for-service physician incentive programs.
- Establishes a pathway for physicians to participate in alternative payment models, including the patient-centered medical home.
- Makes other changes to existing Medicare physician payment statutes.

What is a Merit-Based Incentive Payment System (MIPS)

The Merit-Based Incentive Payment System (MIPS) offers performance improvement incentive payments from 4 to 9 percent beginning in 2019. The MIPS consolidates several existing programs, including Medicare and Medicaid EHR Incentive Programs, Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier into a single, more simplified program.

What is the Alternative Payment Model (APM)

If you choose to participate in an Alternative Payment Model (APM), you will receive a five percent bonus on Medicare billings for years 2019 to 2014.

The MACRA bill defines an APM as the following:

- Patient-centered medical home
- Any model under the Center for Medicaid and Medicare Innovation (other than a health care innovation award)
- A Medicare shared savings program accountable care organization (ACO)
- Selected Medicare demonstrations, or other demonstration required by federal law

Help for Small Practices

The MACRA law has a provision to assist practices with fewer than 15 professionals to transition to APMs or participate in MIPS. The $100 million will provide technical assistance, with priority given to rural or underserved areas.

What should you do?

As you can see, health care delivery and payment systems are changing, and your Family Medicine practice is important in the shift towards better quality and lower costs. This is your time to transform your practices and lead the change in our health care system. Seek out any assistance and coaching opportunities to move your practice towards the Patient Centered Medical Home model. And for those of you who are already on the path towards transformation, thank you!
2015 Legislative Session Summary

by Jeff Thormodsgaard, CAFP Lobbyist

The 2015 Colorado regular legislative session began on January 7, 2015 and concluded 120 days later on May 6, 2015. Of the 682 bills introduced, 364 passed, or 53.4%. Three bills were vetoed by the Governor. This compares to 2014 when 72% of introduced bills passed. The “split” chambers with one party in control of each chamber led to several bills that made it through the first house, but failed in the second. Major topics included TABOR tax refunds and other budget issues, K-12 education funding and assessments, workforce development, police and community relations, marijuana, and women’s health. This report provides an overview of the 2015 legislative session for the Colorado Academy of Family Physicians. For descriptions of bills CAFP followed visit www.coloradoafp.org/2015priorities

Overview

✓ Number of Bills Followed: 70
✓ Number of Bills Supported: 18
✓ Number of Bills Opposed: 8
✓ Success Rate On Bills Opposed: 100% including those amended to neutral position
✓ Success Rate on Bills Supported: 72% success, 13 out of 18 are now law

Bills CAFP Supported

The following bills were supported by CAFP. Unless otherwise noted, these bills passed and were signed into law by the Governor.

• SB15-228 establishes a process for the department of Health Care Policy and Financing to review Medicaid provider fee rates and requires the department to establish a schedule of rates to be reviewed so that every rate is reviewed every 5 years. The original version of this bill, HB15-1151, would have established a floor for Medicaid provider reimbursement rates, as opposed to requiring a rate review; however this version was much more costly and fiscally unrealistic for the state at this time.

• HB15-1186 expands eligibility for the Medicaid Autism Waiver Program by increasing the age limit from 6 to 8 years of age. If a child enrolls prior to his or her 8th birthday, he or she is eligible to receive services for a total of three full years. The bill removes the existing per child spending cap of $25,000 per year and instead requires a cap to be established in rule based on available appropriations.

• SB15-015 includes autism spectrum disorders in the state’s mental health parity law. The bill removes statutory references to caps on the number of visits or services concerning the assessment, diagnosis, and treatment of autism spectrum disorders under a health insurance plan.

• SB15-019 authorizes the State Auditor to perform a comprehensive performance audit on the Health Exchange, also known as Connect for Health Colorado, while SB15-256 changes the name of the Legislative Health Benefit Exchange Implementation Review Committee to the Colorado Health Insurance Exchange Oversight Committee, allows the committee to meet for an unlimited number of times during the legislative session and up to 10 times per year when not in session, and changes the number of bills that the committee may report to the Legislative Council in any year from 5 to 8.

• SB15-197 eliminates barriers for advanced practice nurses (APNs) in achieving full prescriptive authority by eliminating the required preceptorship, reducing the number of hours for mentoring to 1000 hours, and authorizing APNs with prescriptive authority to mentor nurses. However, it was amended to require at least three years of experience in order to be eligible for prescriptive authority. Additionally, it grants provisional prescriptive authority to newly graduated APNs. CAFP supported this bill as amended, and played a critical role in negotiating amendments to ensure patient safety. Additionally, CAFP supported HB15-1182, which expands the scope of practice for Certified Nurse Aides.

• HB15-1029 lifts statutory limitations on telehealth by allowing providers to utilize telehealth when they believe it is appropriate, ensures that health care providers are paid the same as in office rates, and requires that patients’ co-pays and deductibles are the same as in office visits.

continued on page 8 >>
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• HB15-1075 allows a registered naturopathic doctor (ND) to treat children under the age of two if the ND has an articulated agreement with a pediatrician or family physician, while HB15-1352 allows NDs to administer and dispense certain medications to patients. At the request of the NDs, and after thorough negotiation of the legislation, CAFP passively supported 1352, and did not oppose 1075.

• HB15-1257 would have allowed local governments to impose their own fees or licenses on cigarette retailers without losing their local share of cigarette tax revenue. Currently, local fees and licenses are only allowed for non-cigarette tobacco products without risking loss of tax revenue. Unfortunately, this bill was postponed indefinitely in the Senate.

• HB15-1238 would have created a $1,000-$1,500 state income tax credit for a physician volunteer serving as a preceptor to a Colorado graduate medical student. The preceptorship would have had to be undertaken in a health professional shortage area (HPSA). CAFP played a fundamental role in this legislation. Unfortunately, due to politics and not policy, this bill was postponed indefinitely by the House Appropriations Committee; after successful and unanimous passage through both the House Health and Finance Committees.

• HB15-1194 would have authorized $5 million in General Funds for Long Acting Reversible Contraceptive methods (LARC) through the Family Planning Initiative. Despite national recognition and remarkable results from the initiative to date, the bill failed in the Senate. The program had demonstrated significant declines in teen pregnancy, abortions, and Medicaid births.

• HB15-1039 allows a licensed health care facility (e.g. hospital, nursing care facility, correctional facility) to donate certain unused prescription drugs to nonprofit entities for dispensing to clients in need.

• SB15-053 increases access to emergency drugs for drug overdose victims by allowing licensed prescribers to prescribe, and licensed dispensers to dispense, an opiate antagonist, either pursuant to a direct prescription order or in accordance with standing orders and protocols. Naloxone (trade name Narcan) is the primary opiate antagonist that will reverse an overdose.

• SB15-116 creates an exception to arrest and filing charges for the crime of possession of drug paraphernalia if the person informs a police office or first responder that he or she has a needle or syringe prior to being searched.

• HB15-1015 created an interstate compact for EMT providers in willing and ideally neighboring states. This provision will allow EMTs from other states to help with a natural disaster or similar circumstances without needing additional paperwork or licensing.

Bills CAFP Opposed

• The following bills were opposed by CAFP. All of these pieces of legislation were defeated.

• HB15-1128 would have required CDPHE to license all abortion clinics in the state, conduct an on-site visit prior to initial licensure, conduct regular inspections, renew licenses annually, and establish rules and standards. License fees would have been $6,600 initially and $1,440 annually thereafter.

• SB15-268 would have defined an unborn child as a person for the purposes of charging homicide or assault offenses. The bill provided exceptions for acts committed by the mother of the unborn child; medical procedures performed by a physician or other licensed medical professional at the request of the mother or the mother’s legal guardian; or the lawful dispensation or administration of lawfully prescribed medication. Similarly, HB15-1041 would have defined a person, at the moment of conception. And of course, HB15-1162 would have banned sex-selection abortions, which is a bill we have seen frequently for the past few years.

• SB15-285 would have required women to obtain an ultrasound and wait 24 hours before having an abortion, and required healthcare providers to provide certain information about fetal development and obtain informed consent prior to performing an abortion procedure. Additionally, it criminalized the physician if these provisions were not met. HB15-1112 would have also criminalized physicians for not giving proper care to “born-alive” infant.

• SB15-077 would have created a “Parent’s Bill of Rights” to set forth specific rights of parents in regard to the education and physical and mental health care of their children. In particular, it would have strengthened the ability of parents to opt-out of immunizations for their children and removed state law allowing minors to consent to sexual health and mental health services without parental consent.

• SB15-275 would have declared the General Assembly as a health oversight committee under federal HIPPA law and as such, would have given any legislator access to individually identifiable health information. The bill would have also changed state law to allow state employees to share protected health and proprietary business information collected for regulatory purposes with legislators and staff.
CAFP on the Go

CAFP staff members meet with leaders of the American College of Osteopathic Family Physicians student branch at Rocky Vista University.

Dr. Candace Murbach, Chair of the CAFP Board of Directors, testifying in a house committee regarding HB 1257, regarding tobacco tax.

Speakers and organizers at the Colorado Academy of Family Physicians/Colorado Nurses Association “It’s all About the Team” event.

Dr. Chandra Hartman presents to a group of Rocky Vista University students about caring for GLBT patients.

Fit Family Challenge leaders gathered in April to thank the pilot program’s participants.

Colorado sent a full delegation and chapter staff to the Annual Chapter Leader Forum and National Conference of Constituency Leaders in Kansas City.

Dr. Jeff Cain speaks at the Colorado Commission on Affordable Health Care Cost Commission Meeting.

The newest members of the CAFP Board of Directors were welcomed at their first meeting in May.

Colorado Delegates gathered for the Family Medicine Congressional Conference in Washington.

Raquel Rosen and Alfred Gilchrist at the Colorado Primary Care Collaborative Convening Event.
Colorado Health Care: WHERE ARE WE & WHERE DO WE NEED TO GO?

On June 5, 2015, leaders from across the healthcare landscape gathered with the Colorado Primary Care Collaborative to help answer this question. Many exciting initiatives and ideas were shared.

To help capture the spirit of the day, artist Karina Mullen Branson (www.conversketch.com) sketched the conversations as they were happening. In the next few magazines we will feature her artwork and share some of the discussions that took place.

To kick off the morning, Senator Irene Aguilar, MD, a Primary Care Physician and State Senator spoke about her desire to represent family physicians in the legislature. She talked about the top issues that need to be addressed in the form of legislation, and encouraged all those who are passionate about family medicine to reach out to her, and help shape what is happening at the state level.

After Senator Aguilar’s discussion, a panel including Vatsala Pathy, Joe Sammen, Allyson Gottsman, Glenn Madrid, MD, and Perry Dickenson, MD, spoke about the need for practice transformation and how the Patient Centered Medical Home can bring better care to Colorado.

If you are interested in learning more and getting involved with the Colorado Primary Care Collaborative, contact Raquel Rosen at 303-696-6655 or raquel@coloradoafp.org.
Major Heart Surgery Without Major Surgery.

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**TOP 5**

best children’s hospital in the nation!

Please join us in celebrating! We’ve been named #5 on U.S. News & World Report’s Best Children’s Hospitals’ Honor Roll for 2015-16. This further confirms that Children’s Colorado is the best place for pediatric care in our seven-state region and beyond.

Six of our specialties ranked among the top 10:
- Diabetes & Endocrinology (No. 4)
- Neonatology (No. 6)
- Gastroenterology & GI Surgery (tied for No. 6)
- Pulmonology (No. 7)
- Orthopedics (No. 7)
- Cancer (No. 9)

For more information, please visit childrenscolorado.org

Many hands, one heart.
Bright future for Family Medicine in Colorado

The Colorado Academy of Family Physicians (CAFP) believes that improving the health of Coloradans begins with Family Physicians. Thanks to the 2,200 Family Physicians of the CAFP, we have had a strong year of advocating for our patients, communities and the physicians who give care to them.

From innovative continuing medical education courses to advocacy at the Colorado State Capitol to building bridges with our primary care partners, the CAFP is an engaged organization that continues to grow, thrive and build upon the work our physician members do everyday.
Vision
Thriving Family Physicians creating a healthier Colorado

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

CAFP by the Numbers

2252 Active physician, resident and student members.

56 Doctors of the Day
2014 was a successful year for the Academy in administering the program at the State Capitol.

184 Supporting organizations for the Colorado Primary Care Collaborative.

162 Family Physician attendees at the 2014 Annual Scientific Conference.
Colorado Academy of Family Physicians Foundation

The Colorado Academy of Family Physicians Foundation is a nonprofit organization providing Family Physicians and their communities with education, resources, research, and advocacy to advance Family Medicine and improve the health of the people of Colorado.

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Recipient of the 2014 Tar Wars Star Award, Ma passion for tobacco cessation and prevention and 5th graders on the health and social prob

Colorado Tar Wars Made Big Impacts in 2014

Tar Wars is a tobacco-free education program for fourth- and fifth-grade students. It teaches kids about the short-term, image-based consequences of tobacco use, the cost associated with using tobacco products, and the advertising techniques used by the tobacco industry to market their products to youth. This year, Colorado reached 132 schools and over 9000 students.

Tar Wars was developed by Jeff Cain, MD, and Glenna Pember of the Hall of Life, a division of the Denver Museum of Natural History and Doctors Out to Care (DOC), in 1988. Since its development, the program has reached more than 10 million children worldwide.
Break Out Year for Fit Family Challenge

The AAFP Foundation awarded the Fit Family Challenge (FFC) Pilot Project the 2014 Outstanding Program Award. The AAFP Foundation selected the Fit Family Challenge Pilot Project based on the following criteria: content, presentation, creativity, measurable outcomes, and relationship of the project to the mission of the AAFP Foundation.

The FFC focuses on giving primary care providers tools to identify and treat obese pediatric patients in practices. It utilizes the relationships Family Medicine Physicians have with families, and optimizes the knowledge and compassion of their staff.

William White from Chipeta Elementary in Colorado Springs was the CAFP Tar Wars poster contest winner for 2014.
Doctor of the Day Program

The Doctor of the Day Program provides free minor medical care to legislators and their staff by CAFP physicians that volunteer their time and expertise. With 56 Doctors of the Day in 2014, the program continues to be strengthened and numbers continue to rise. This year, the CAFP installed a new EHR system and business office inside of the clinic.

Full Time Lobbyist for Family Medicine

A strong voice in health care at the State Legislature, the CAFP continued its leadership role around primary care in 2014. Monitoring 87 bills, the CAFP took positions on 27 and testified for or against 4 bills. With numerous health issues every legislative session, the CAFP works to make sure that Family Physicians are heard.

Colorado Primary Care Collaborative

The CPCC is dedicated to advancing primary care via the Patient Centered Medical Home (PCMH) by focusing on delivery reform, payment reform, patient engagement, workforce training, and benefit redesign. Securing over 180 supporting organizations in 2014, the CPCC continues to push its vision of patient-centered comprehensive and coordinated primary care services sustained through practice transformation and payment reform resulting in improved health for individuals and communities.

CAFP PC and Small Donor Committee

In order to stay vital in the 2014 November elections, the CAFP political and small donor committees endorsed and donated to State Representatives and State Senators. These vehicles were used as a resource for Family Physicians to have direct conversations about CAFP legislative priorities with candidates for office in Colorado. In order to initiate these conversations, the CAFP sent out a survey to each candidate, with questions based on membership input. The CAFP PAC and SDC endorsed or donated to 59 candidates.
67th Annual Scientific Conference

The 67th Annual Scientific Conference had its largest attendance in recent years with 162 physicians converging at the Cheyenne Mountain Conference Center in Colorado Springs. The conference featured infoPOEM “blast sessions” and traditional lecture style presentations with over 60 hours of CME available. To fit the new family friendly format, the CAFP offered child care and a western themed family dinner night at the conference.

Year-Round Education Courses

The CAFP is dedicated in its mission to provide engaging and innovative continuing medical education. From group SAM courses on pain management to Department of Transportation Medical Examiner trainings to the Patient Centered Primary Care Collaborative’s Western Regional meeting, the CAFP was busy in educating our members and supporting their practices with timely and relevant educational events.

Medical Student Meetings and Events

The CAFP works to engage medical students in primary care, the Patient Centered Medical Home and Family Medicine. With over 220 student members, CAFP hosts events throughout the year with Rocky Vista University and the University of Colorado School of Medicine to insure that students know of the promise of Family Medicine. Working with the Family Medicine Interest Groups, the CAFP enables and supports the next generation of Family Medicine physicians.
Everyday mobility and function is critical to quality of life. At University of Colorado Hospital's Orthopedics Department, your patients can expect timely appointments and access to our fellowship-trained physicians whose highly specialized knowledge allows more accurate diagnosis and treatment. From head to toe, we help hundreds of patients each year by reducing pain and regaining function while delivering award-winning care.

For a consult, transfer or direct admit, please call DocLine toll-free at 1.844.285.4555. To refer a patient to one of our clinics, please contact the preferred clinic directly.
A Missing Component - Is Your Practice At Risk?

Is there something missing in your practice that could put your whole business and livelihood at risk?

You have a business plan in place, and you seem to have all of your bases covered, right? But rather than guess, let’s take a quick inventory:

- Your calendar is full of patient appointments.
- You take care of patients with regular check-ups and follow-up visits with the goal of long term health and wellbeing.
- Your office has the appropriate service and support staff in place.

Insurance billing and payment processes are all in place.
- You have taken care of all your business necessities including an office lease, liability insurance, expense payments, payroll services and purchased the necessary medical equipment and products.
- You pay your bills and taxes on time.
- You’re making a decent income.
- You may have even installed a retirement plan for you and your staff.

What could be missing? Potentially a succession and contingency plan.

A recent study of America’s small businesses revealed that one of the most glaring holes in a small business plan is the ability to replace the business owner or key physician, particularly in a one or two person practice. Many businesses have gone to great lengths to make sure they have all the right people, processes, and systems in place, but only about 25% have a contingency or succession plan.

Without a well-executed plan in place, an injury, illness, or unexpected early retirement could be detrimental to both the business and patients. Who will serve patients, notify them, or even help them if suddenly the owner or key physician is gone? Where will they go, who will understand their current treatment plan, and where will they find someone new? If these questions cause you to be anxious, they should!

The good news is it usually only takes a few minutes to start the process. I was in the same position just about a year ago, but when it came to my attention, it was no longer time to be thinking about it, it was time to be doing something about it, for the sake of my clients, staff and family. Today, after a few months of intense work, we have both a contingency and succession plan in place, and our staff knows the who, what, where and when if anything ever happens to me. It’s never too late to start.

University of Colorado
Anschnutz Medical Campus
School of Medicine – Department of Family Medicine
University of Colorado Family Medicine Clinic at Park Meadows
Senior Instructor – Physician,
University Family Physicians at Park Meadows
Position #7840 – Job Posting #F02246

The Department of Family Medicine at the University of Colorado Denver Anschnutz Medical Campus is seeking a full-time family physician for our South Metro-Area clinic site at Lone Tree/Park Meadows. The Department’s clinical faculty members are recognized for providing innovative, integrated, patient-centered care. The Park Meadows clinic is a busy, ambulatory clinic serving a mix of patients from the surrounding community and is part of the University Hospital system. The Park Meadows clinic is certified as Patient Centered Medical Home and is undergoing practice re-design towards exemplary patient-centeredness and a superior patient experience. Applicants must demonstrate experience and competence in patient care and an interest in teaching. This position is full-time and applicants for full-time positions will have priority. 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.

REQUIRED QUALIFICATIONS: Required Qualifications: MD/ DO degree, Colorado Medical License, DEA Certificate, Board Certified/Board eligible in Family Medicine. Must obtain Medical Staff privileges at University of Colorado Hospital.

JOB RESPONSIBILITIES: Applicant will be a member of the practice clinical faculty. Sees patients and manages patients within context of a Patient Centered Medical Home practice, serving as a continuity provider for a panel of patients. Teaches residents in the provision of patient care, participates in scholarly activity, serves as a leader and role model for fellow physicians and learners.

ESSENTIAL JOB FUNCTIONS: 100% - Provides high quality patient care at University Family Medicine Clinic at Park Meadows
- Provides ambulatory care at University Family Medicine Clinic at Park Meadows a minimum of 32 hours of appointments per week
- Exemplifies the highest standards in patient care as a faculty member
- Participates in home call approximately five weeks per year
- Participates in quality improvement efforts
- Participates in education of interdisciplinary students assigned to the clinic.

PREFERRED QUALIFICATIONS: Two years of practice experience in ambulatory and Patient Centered Medical Home/Integrated Practice settings preferred. Individuals with other clinical or practice experience will be considered.

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/jobs/. Applications are accepted electronically at www.jobsatcu.com.

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."
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Shannan Kirchner, MD | Port Townsend, Washington
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*This offer does not apply to Students, Residents, Inactive, or Life Members.
Influenza Part 1- Vaccination

Review of the 2014-2015 Influenza Season

Colorado experienced an early and moderately severe influenza season in 2014-2015. Influenza A (H3N2) viruses were the predominant strain, with an increasing proportion of influenza B viruses circulating towards the end of the season. In contrast, influenza A (H1N1)pdm09 were reported rarely. Traditionally, when influenza A(H3N2) viruses predominate, there have been increased hospitalizations and deaths, in particular among children aged less than 5 years, and adults aged > 65 years. This has also proven to be the case for this most recent season. Nationally, the number of outpatient visits for influenza-like-illness was above baseline levels for 14 consecutive weeks, with higher prevalence of the drifted influenza viruses resulted in reduced vaccine effectiveness. Interim estimates of vaccine effectiveness published by the CDC indicate that the influenza vaccine was 19% effective in preventing medical visits across all age groups.

Influenza Vaccination Planning for the 2015-2016 Season

Despite reduced vaccine effectiveness during the 2014-2015 season, vaccination still remains the best strategy against influenza illness and its complications. Annual influenza vaccination continues to be recommended for all persons 6 months of age and older.

For the upcoming year, trivalent and quadrivalent vaccines will continue to be available. Quadrivalent vaccines contain two influenza A strains and two B strains whereas the trivalent products have only one influenza B strain. Quadrivalent formulations should provide better coverage when influenza B is prominent and both lineages circulate, although this is difficult to predict. Currently, the Advisory Committee on Immunization Practices (ACIP) does not express a preference for quadrivalent over trivalent. Vaccination should not be delayed in order to obtain a specific product.

In February 2015, the Advisory Committee on Immunization Practices (ACIP) voted on its annual influenza vaccine recommendations. For 2015-2016, ACIP recommends annual influenza vaccination for all adults and children 6 months of age and older with either Live-Attenuated Influenza Vaccine (LAIV) or Inactivated Influenza Vaccine (IIV), with no preference expressed for either vaccine when either one is otherwise appropriate. This differs from the prior recommendations in 2014-2015 for LAIV among children aged 2 to 8 years of age, based on more recent studies demonstrating decreased vaccine effectiveness of LAIV against influenza A (H1N1) pdm09. The composition of the 2015-2016 vaccine has been recommended by the World Health Organization (WHO) to contain an A/California/7/2009 (H1N1) pdm09-like virus; an A/Switzerland/9715293/2013 (H3N2)-like virus; and a B/Phuket/3073/2013-like virus, and for the quadrivalent vaccine to additionally contain a B/Brisbane/60/2008-like virus.

Influenza Vaccination Formulations

There are many different vaccine formulations available. Some are licensed for specific age groups, or are more appropriate for particular patient populations. The influenza vaccines currently available are shown in Tables 1 and 2. Additional formulations may become available for the 2015-2016 season (refer to: http://www.cdc.gov/flu/protect/vaccine/vaccines.htm for current information regarding available vaccines). Live-Attenuated Influenza Vaccine (LAIV) is the intranasal vaccine, and is offered solely in quadrivalent form. Inactivated influenza vaccine (IIV) is available in the trivalent or quadrivalent formulations. Children aged 6 months to 18 years may receive IIV or LAIV. Recombinant influenza vaccine (RIV) is available for adults with egg allergy.
Children aged 6 months through 8 years will need only one dose of vaccine in 2015-16 if they received any of the following:

1) At least one dose of 2014–15 seasonal influenza vaccine;

2) Two or more doses of seasonal influenza vaccine since July 1, 2010; or

3) Two or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of monovalent 2009(H1N1) vaccine; or

4) One or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of seasonal influenza vaccine since July 1, 2010.

This is to ensure that they have received the appropriate number of doses of vaccine containing influenza A 2009(H1N1), which was available in 2010, following the pandemic year.

---

**Table 1. Influenza Vaccination Formulations for Children and Adults**

<table>
<thead>
<tr>
<th>Ages</th>
<th>Trade Name</th>
<th>Manufacturer</th>
<th>Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-35 mo</td>
<td>Fluzone® IIIV3</td>
<td>Sanofi Pasteur</td>
<td>0.25mL single dose syringe 5 ml multi-dose vial</td>
</tr>
<tr>
<td></td>
<td>Fluzone® IIIV4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-49 yrs</td>
<td>FluMist® quadrivalent</td>
<td>MedImmune</td>
<td>0.2mL intranasal sprayer</td>
</tr>
<tr>
<td>≥3 yrs</td>
<td>Fluzone® IIIV3</td>
<td>Sanofi Pasteur</td>
<td>5mL multi-dose vial 0.5mL single-dose syringe 5.0mL multidose vial 0.5mL single dose vial</td>
</tr>
<tr>
<td></td>
<td>Fluzone® IIIV4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 3 yrs</td>
<td>Fluarix® IIIV3 &amp; IIIV4</td>
<td>GSK</td>
<td>0.5mL single dose syringe</td>
</tr>
<tr>
<td>≥ 4 yrs</td>
<td>Fluvirin® IIIV3</td>
<td>Novartis</td>
<td>0.5mL single-dose syringe 5.0 mL multidose vial</td>
</tr>
<tr>
<td>≥ 9 yrs*</td>
<td>Afluria® IIIV3</td>
<td>CSL/Merck</td>
<td>0.5mL single dose syringe 5.0mL multidose vial</td>
</tr>
<tr>
<td>≥ 3 yrs</td>
<td>FluLaval IIIV3 &amp; IIIV4</td>
<td>GSK</td>
<td>0.5mL single-dose syringe 5.0mL multidose vial</td>
</tr>
</tbody>
</table>

---

**Table 2. Additional Vaccine Formulations for Adults**

<table>
<thead>
<tr>
<th>Ages</th>
<th>Trade Name</th>
<th>Manufacturer</th>
<th>Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥18 yrs</td>
<td>FluceLVax® ccIIIV3¹</td>
<td>Novartis</td>
<td>0.5mL single-dose syringe</td>
</tr>
<tr>
<td>≥ 18-49 yrs</td>
<td>FluBlock® Recombinant RIV3</td>
<td>Protein Sciences</td>
<td>0.5mL single-dose syringe</td>
</tr>
<tr>
<td>18-64 yrs</td>
<td>Fluzone® Intradermal IIIV3</td>
<td>Sanofi Pasteur</td>
<td>0.1mL microinjection system</td>
</tr>
<tr>
<td>≥65 yrs</td>
<td>Fluzone® High Dose IIIV3</td>
<td>Sanofi Pasteur</td>
<td>0.5mL single-dose syringe</td>
</tr>
</tbody>
</table>

¹Cell culture based inactivated influenza vaccine.
The figure below provides an alternative algorithm, which takes into consideration only doses of seasonal influenza vaccine received since July 1, 2010.

Figure 1. Influenza vaccine dosing algorithm for children aged 6 months through 8 years

Ref: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6332a3.htm

Vaccine contraindications are listed in Table 3.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Contraindications</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactivated influenza vaccine</td>
<td>Severe allergic reaction to any component of the vaccine, including egg protein,</td>
<td>Moderate to severe illness with or without fever; history of Guillain-Barré</td>
</tr>
<tr>
<td>(II₃ or II₄)</td>
<td>or after previous dose of any influenza vaccine.</td>
<td>syndrome within 6 weeks of receipt of influenza vaccine.</td>
</tr>
<tr>
<td>Cell culture-based IIV₃</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High dose IIV₃</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recombinant influenza vaccine</td>
<td>Severe allergic reaction to any component of the vaccine.</td>
<td>Moderate to severe illness with or without fever; history of Guillain-Barré</td>
</tr>
<tr>
<td>(RIV₃)</td>
<td></td>
<td>syndrome within 6 weeks of receipt of influenza vaccine.</td>
</tr>
<tr>
<td>Live attenuated influenza</td>
<td>Severe allergic reaction to any component of the vaccine, including egg protein,</td>
<td>Moderate to severe illness with or without fever.</td>
</tr>
<tr>
<td>vaccine (LAIV₄)</td>
<td>or after previous dose of any influenza vaccine.</td>
<td>History of Guillain-Barré syndrome within 6 weeks of receipt of influenza</td>
</tr>
<tr>
<td></td>
<td>Concomitant use of aspirin or aspirin-containing medications in children and</td>
<td>vaccine.</td>
</tr>
<tr>
<td></td>
<td>adolescents.</td>
<td>Asthma in persons aged 5 years and older.</td>
</tr>
<tr>
<td></td>
<td>In addition, ACIP recommends LAIV4 not be used for pregnant women, immunosuppressed</td>
<td>Medical conditions which might predispose to higher risk for complications</td>
</tr>
<tr>
<td></td>
<td>persons, persons with egg allergy, and children aged 2–4 years who have asthma</td>
<td>attributable to influenza.</td>
</tr>
<tr>
<td></td>
<td>or who have had a wheezing episode noted in the medical record within the past</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 months, or for whom parents report that a healthcare provider stated that they</td>
<td></td>
</tr>
<tr>
<td></td>
<td>had wheezing or asthma within the last 12 months.</td>
<td></td>
</tr>
</tbody>
</table>
**CASE STUDY 1**

A primary care provider (PCP) sees a patient who is not feeling well in the morning. The exam is unremarkable and he orders a complete blood count (CBC) and chemistry panel on the patient. At 4:30 p.m., the lab calls with a report of a potassium of 6.5. The doctor has already left for the day and is not called. He is grumpy and the staff rarely calls him after he has left the office. Later that night, the patient presents to the ER with syncope and has an EKG diagnostic of hyperkalemia.

**CASE STUDY 2**

A patient goes to the ER for pulmonary symptoms. He has a CT of the chest because of concern for a pulmonary embolism (PE). Luckily, no PE is seen, but an 8-mm nodule in the right upper lobe (RUL) is noted and a follow-up CT is recommended. The PCP never sees the report and it is filed in her patient’s chart. Nine months later, the patient presents with RUL lung cancer.

Failure to follow up on abnormal lab tests, x-rays and pathology reports is a common cause of medical litigation. The tests we order are increasing in numbers and complexity. The issue may revolve around uncertainty about which tests to order, improper interpretation of results, and failure to create a follow-up plan, or in some cases, not seeing the results at all. These failures are usually not about knowledge, but relate to systems and habits.

One issue is the volume of tests that one sees. Each year in the United States, PCPs see 500 million patients and order diagnostic tests on 40 percent of their patients. That is in the range of 150–200 million test results. One study published in the *Annals of Internal Medicine* (AIM) estimated that a provider must review 800 laboratory tests, 40 radiology reports and 12 pathology tests each week.

The present system requires scanning many sheets of paper or screens on a daily basis. Is the important test that you miss the prostate-specific antigen (PSA) that comes back four days later or is located on a different page? Is it an antinuclear antibody (ANA) test that you are not sure how to interpret? Then there is the problem in the digital world of alert fatigue. Constant interruptions tell us of unimportant interactions or possible allergies. And when do we review our labs? Frequently, it is at the end of the day, when we are tired and ready to go home.

As was seen in the previous case studies, one needs to have a system to ensure the smooth processing of all information. Habit and situational awareness is key to not overlooking diagnostic test results, and setting up good systems is part of the solution.

**SUGGESTIONS**

- Review all reports and have a check system to prove that you reviewed the test results.
- Check diagnostic tests when you are fresh and try to not allow for interruptions.
- Read pathology and radiology reports thoroughly. If you are in one of these specialties, call the ordering provider when there is a significant test result. We all need to connect to each other.
- Set up a tickler file or digital reminder system.
- No news is not good news for the patient. All patients should get a notification of their test results.
- Use your office staff and your patients as a second pair of eyes. Be approachable and allow them to help in test notification.

1. Ann Intern Med. 2005 Mar 1;142(5):352-8; Gandhi

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Health is Primary is traveling to cities across the country to showcase examples of local initiatives that are improving primary care and delivering on the Triple Aim of better care and better quality at a lower cost.

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Practice Redesign to Prepare for Changes in the Health Care System:  
The Time is NOW

By Allison Gottsman

State and federal programs are currently bringing trained practice facilitators and clinical HIT advisors into Colorado primary care offices to help them become examples of excellence in advanced patient-centered care. Practices should consider taking advantage of the many grant-funded programs that will help them improve, change, redesign, transform, to the next level of patient-centered care.

As the recent Colorado Primary Care Collaborative meeting made very clear, there are major changes underway and forthcoming in the structure of our health care system and the payment system. Our practices need to carefully track these developments and plan how they will effectively adapt to these changes. For those practices that have been holding out on practice redesign efforts in order to see whether the whole thing would just blow over, the answer is no; and there are major risks inherent in not beginning work as soon as possible to redesign your practice. Making the needed changes to adopt advanced primary care approaches takes time, and practices benefit from outside support in order to be successful.

With the availability of funding from state and federal groups, there are offerings for everyone, at all stages along the path to advanced patient-centered primary care. Avoid trying to reinvent the wheel and instead use these programs to learn from trained practice facilitators, clinical HIT advisors, and peers. Many programs offer the opportunity to participate in a peer-to-peer learning network focused on identification and sharing of best practices. These resources are available now. Multiple organizations are collaborating to offer them for free, and it is not clear how long the funding may be provided in the future to be able to offer them to practices for free.

Under the leadership of Perry Dickinson, MD, a family physician from the University of Colorado School of Medicine, 17 practice transformation organizations and health systems have joined the Colorado Health Extension System (CHES) to provide cohesive, coordinated practice transformation support services to primary care practices in Colorado. With more than 30 programs across the member organizations, there truly is an opportunity for everyone to get involved.

Highlighting the level of collaboration, CHES members will be working to deliver two of the largest statewide primary care practice transformation efforts in Colorado’s history: EvidenceNow Southwest, and the Colorado State Innovation Model. EvidenceNow Southwest is part of a national program funded by the Agency for Healthcare Quality and Research (AHRQ) that will assist practices to rapidly deploy evidence based interventions with an initial focus on cardiovascular risk. EvidenceNow Southwest will engage 260 small primary care practices (208 in Colorado and 52 in New Mexico) to build critical infrastructure to help smaller primary care practices apply the latest medical research in the care they provide. CHES practice transformation organizations will provide onsite practice facilitation and coaching, expert consultation, shared learning collaboratives, and HIT support. EvidenceNow is a great program for practices early in redesign efforts to build the foundation for advanced primary care and new payment models and/or for practices particularly interested in work on reducing cardiovascular risk factors in their patients.

The State Innovation Model (SIM), a significant statewide effort led by the Governor’s office and funded by the Centers for Medicare and Medicaid Innovation, will engage 400 primary care practices over three years in practice redesign with an emphasis on advanced primary care that includes behavioral health integration. The initial cohort of 100 practices will start in February 2016, and more information regarding the application process will be available over the next few months. In addition to on-site practice facilitation and coaching, help with HIT and HIE needs, and shared learning collaboratives, business consultation is available to help practices evolve to new models of compensation based on the value of care. SIM includes four interdependent bodies of work, all focused on achieving better population health, lower cost, and a better experience of care for patients and their healthcare teams. The four interdependent pillars of SIM are practice transformation and delivery system redesign, compensation reform, data collection and reporting, and patient and community engagement.

For more information on these programs, contact: Allyson.gottsman@ucdenver.edu.
Indicators of and Screening for OSA

Matthew Scharf, MD, PhD and Ilene M. Rosen, MD, MSCE

Case: A 49 year old man with a history of GERD and depression presents for his annual physical. He denies any significant complaints except that he is exhausted which he attributes to increased demands at work. He reports difficulty staying awake at meetings and when working on his computer. He notes a 10-pound weight gain over the past 6 months. On further questioning, he endorses loud snoring and nocturnal gasping for air. Upon awakening, he sometimes finds that his wife has left the bedroom. His medications include omeprazole and escitalopram. His current blood pressure is 148/102, and his body mass index is 31.71 kg/m². A fasting comprehensive metabolic panel is normal except for a glucose of 104 (normal=70-99). He is started on hydrochlorothiazide and referred to a sleep specialist.

Obstructive sleep apnea (OSA) is a common condition in the United States and worldwide. Prevalence estimates range from 2-7% in the general population but is particularly high in certain cohorts. A prevalence of OSA of over 70% has been reported in obese Type II diabetics and in patients undergoing bariatric surgery and with drug-resistant HTN. The prevalence of OSA is also high in patients following acute stroke and acute coronary syndrome, as well as in the elderly. However, the majority of cases of OSA in the U.S. remain undiagnosed.

OSA is not a benign condition. It is a systemic disorder, as the repetitive falls in oxygen affect all organ systems. Untreated OSA can result in serious morbidity and mortality. OSA is associated with hypertension, impaired glucose control, congestive heart failure, coronary heart disease, mild cognitive impairment or dementia, depression, atrial fibrillation, and stroke. OSA, particularly severe OSA, is associated with increased mortality.

In addition to the health risks, OSA may cause problems with everyday life. Loud snoring may cause the bed partner to sleep in a separate room. Significant sleepiness may interfere with the ability to participate in social activities and perform well at work. Sleepiness is particularly concerning when operating motor vehicles. In fact, OSA has been shown to cause significant impairments in the ability to carry out a simulated driving task and increases the risk of a motor vehicle crash among drivers by two-fold.

There are a number of risk factors for OSA including obesity, increasing neck size (greater than 17 inches), male gender, craniofacial features (e.g. retrognathia and macroglossia) and increasing age. It is important for providers to ask about common presenting symptoms such as snoring, witnessed apneas, nocturnal gasping, morning dry mouth, feeling unrefreshed on awakening from sleep, and excessive daytime sleepiness (e.g. as measured by the Epworth Sleepiness Scale). Particular attention should be paid to patients with a history of stroke, refractory hypertension, coronary artery disease as well as to obese type II diabetics and to individuals with depression or new onset atrial fibrillation.

Case Discussion: The patient is obese, has loud snoring and is sleepy to the point that it is interfering with his work. He likely has OSA. This corresponds with his weight gain and sleep problems in the past 6 months, and may contribute to his borderline hyperglycemia and HTN. He requires a sleep study and would likely benefit from treatment.

While a clinical scenario may be strongly suggestive of OSA, the diagnosis of OSA is made by polysomnography. Polysomnography is typically performed in a sleep laboratory and includes electroencephalographic (EEG), electromyographic, respiratory and electrocardiographic measurements. Portable studies can be done at home as well using devices that provide respiratory and ECG monitoring but not EEG recording. An event is considered obstructive if there is continued respiratory effort observed in the thoracic or abdominal sensors with absent airflow. Apneas are scored as >90% reduction in breathing, and hypopneas are scored as a >30% reduction in breathing associated with an oxyhemoglobin desaturation of 3%. In-laboratory polysomnography can also utilize EEG arousals following a >30% reduction in airflow to score hypopneas. Both apneas and hypopneas last for at least 10 seconds in duration. The number of respiratory events per hour is called the apnea-hypopnea index (AHI). An AHI<5 is considered normal, 5-15 is considered mild, 15-30 is considered moderate, ≥30 is considered severe. In general, the adverse health consequences of OSA are higher with increasing AHI.

Home sleep studies are appropriate for patients with a high pre-test probability of OSA. In-lab polysomnography should be used for individuals with moderate pre-test probability of OSA and may also be indicated in patients for whom there is a concern of another sleep disorder (such as central sleep apnea or a parasomnia) or nocturnal hypoventilation. As the sensitivity of unattended studies is lower than in-lab studies for OSA, in-lab studies can be considered in patients for whom an unattended study is negative, but a high clinical suspicion for OSA remains. Treatment of OSA will be discussed in a separate article.

continued on 30 >>
References:


This article was developed through the National Healthy Sleep Awareness Project, a joint effort of the Centers for Disease Control and Prevention (CDC), American Academy of Sleep Medicine (AASM) and the Sleep Research Society (SRS). Visit www.sleepeducation.org for more information.

This article was supported by the cooperative agreement number U50DP004930-01 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.
SNOCAP Recap

SNOCAP is hitting the ground running in 2015! There are several things I’d like to update CAFP members on in this edition of our recap.

First, we are phasing in our new SNOCAP Coordinator, Paige Backlund-Jarquin. Paige joins us from our Community Engagement side here at the University, and will be holding the SNOCAP position along with a coordinating role for our Community Engagement work. We are excited about this transition for Paige and for SNOCAP as we continue to pull these very related worlds together.

Second, we have shifted our regular on campus monthly meeting time so that you can sign in and join our conversations about ongoing projects and potential projects. We are now meeting from noon to 1:30 on the first Tuesday of every month. The section of the meeting from 12:30 to 1pm we hope to especially focus on discussion of potential projects and project results, which we hope will be most relevant to you.

The meetings will be webcast on GoTo Meeting:
https://www.gotomeeting.com/join/141978725; and 866-779-0774, *4066550*

Tobacco and Kids:
What Family Physicians Need to Know

By Karen Wilson, MD, MPH
Section Head, Inpatient Medicine, Children’s Hospital Colorado
Associate Professor, University of Colorado School of Medicine

Even though tobacco smoking rates have decreased, secondhand tobacco smoke (SHS) exposure remains a significant source of morbidity for children. In the United States, almost 50% of children have biological evidence of SHS exposure, even though less than 18% of adults smoke tobacco themselves. Colorado has one of the lower adult smoking rates in the US at 17%, however tobacco use disproportionately affects Coloradans who have a lower socioeconomic status, or who are in other vulnerable populations, such as lesbian, gay, bisexual or transgender youth.

Effect of secondhand smoke on children: Secondhand tobacco causes lower respiratory infection in children, and it increases the severity of illnesses such as bronchiolitis and influenza, as well as the duration of symptoms. A causal relationship also exists between SHS and acute and recurrent otitis media. SHS increases the likelihood that a child will develop asthma, and once they have developed the disease, SHS causes and worsens exacerbations. This is true even at very low levels of exposure, as you can see with a child whose parents smoke only outside. There is also evidence that SHS exposure causes sudden infant death syndrome (SIDS), and we have seen SIDS rates decrease as smoking rates have gone down.

Behavior and cognition: SHS has been associated with decreased math design and block scores on intelligence tests. SHS is also associated with ADHD and conduct disorder, as well as sleep problems in children. Adolescents who grow up in smoking families are more likely to smoke themselves; not only may they be modeling their behavior on that of their parents, they may be exposed to enough nicotine in SHS to prime their nicotine receptors, facilitating addiction.

Electronic cigarettes: Electronic cigarettes are also known as e-cigs, electronic nicotine delivery systems (or ENDS), or personal vaporizers (their use is often referred to as “vaping”). Electronic cigarettes are battery-powered, and deliver a solution, often containing nicotine, through a cylinder where the liquid is vaporized, allowing the delivery of nicotine vapor into the lungs. This action mimics the use

continued on 32 >>
of cigarettes. The cartridges containing the nicotine solution in some models are refillable, and some people are using these devices to vaporize other solutions, such as hash oil. Recent studies have found that the “vapor” emitted by electronic cigarettes can contain nicotine and other toxic chemicals, and are not “harmless water vapor.” Companies are marketing electronic cigarettes with flavors that appeal to teens and young adults, and there is concern that they will be used not as cessation devices but as a way to initiate non-smokers into nicotine addiction with a product that doesn’t have the noxious effects of smoking tobacco. Electronic cigarettes are not regulated by the FDA and have not been proven to be effective as a smoking cessation device, therefore we don’t recommend their use, and we caution parents who do use them not to use them in the presence of children. In addition to the potential toxicity of the vapor, the refill cartridges for some brands contain enough nicotine in solution to kill a child if ingested; thus parents should be strongly cautioned to keep electronic cigarettes (and all tobacco products) completely out of the reach of children. Family physicians should also counsel parents that the use of electronic cigarettes may model smoking behavior for children and adolescents, and that they should only use electronic cigarettes away from their kids. Adolescent patients should be warned against the use of any nicotine-containing products, reduced harm or not.

Thirdhand Smoke: As we have learned more about how tobacco smoke can accumulate on surfaces and in the air, the concept of thirdhand smoke is becoming better understood. When a cigarette is extinguished, components of the smoke remain in the air and on surfaces. The tar in cigarette smoke accumulates on walls and floors, and the particulates and chemicals in cigarette smoke land on furniture, only to become airborne when someone sits down. Infants may be at particular risk as they crawl on the floor and then ingest the residue from their hands. Many parents believe that they are completely protecting their children when they smoke outside, however studies suggest that children of parents who smoke outside still have elevated cotinine levels, at levels associated with increased risk of health effects. Many health care providers encourage parents to use separate “smoking jackets” or clothes; while there are no studies that show this is effective, it is probably better than the alternative. However, parents should be cautioned that by taking these measures they are likely not completely protecting their child. In addition, parents should always wash their hands well after smoking, before handling their child. More research is needed to determine whether there are effective ways to mitigate exposure for parents who continue to smoke.

What can family physicians do?

Family physicians are key points of contact for both parents and children, and they have the advantage of often being the primary care provider for both parents and children. Providers can have a strong impact by advising parents to stop smoking and reduce children’s exposure. If parents are not willing to quit smoking entirely, helping them to set home smoking bans not only will protect the children from much of the SHS, but people who set home smoking bans are more likely to quit entirely in the future. A great source of information about the dangers of tobacco smoke, and the best ways to quit and protect children, is the website www.tobaccofreeco.org. Colorado also has an excellent Quitline; providers and parents can access more information at www.coquitline.org, or by calling 1-800-784-8669.

Summary:

Although Colorado has made excellent progress in reducing the adult smoking rate, children are still being exposed to the toxic effects of secondhand tobacco smoke, and this is especially true among vulnerable children. Family physicians and their partners who provide health care for children can help parents quit smoking and set smoke-free home rules, and they can also advocate for stronger policies to restrict smoking in their communities, where children live and play.

For more information, please contact karen.wilson@childrenscolorado.org or visit the American Academy of Pediatrics’ Richmond Center of Excellence: http://www2.aap.org/richmondcenter/; and Section on Tobacco Control: http://www2.aap.org/richmondcenter/PSOTCo/home.html.

Effects of Secondhand Smoke on Children:

- Increased lower respiratory infection in children
- Increased severity and duration of illnesses such as bronchiolitis and influenza
- Increased acute and recurrent otitis media
- Increased likelihood of asthma with worsened exacerbations
- Increased sudden infant death syndrome (SIDS)
- Decreased math design and block scores on intelligence tests
- Increased ADHD and conduct disorder
- Increased risk of adolescent smoking and addiction
Date drives change. It serves as a foundation for better understanding, comparative performance and identifying opportunities for improvement. In our rapidly changing health care landscape, data is becoming more and more important to providers and is most valuable when it is accessible and actionable. Until now, Primary Care Physicians (PCPs) have lacked access to information that demonstrates the value and efficiency of care provided relative to their peers.

For the past 18 months, the Center for Improving Value in Health Care (CIVHC) has been participating in an initiative led by the Network for Regional Healthcare Improvement (NRHI) and funded by the Robert Wood Johnson Foundation (RWJF). The main goal is to provide actionable information that allows PCP groups to understand their cost and efficiency (or resource use) performance compared to other similar practices in Colorado. Ultimately, the data is intended to help PCP groups identify strategies to bring about meaningful change and contribute to realizing the triple aim goals of better health, better quality and lower cost.

The initial pilot included five states/regions – Colorado, Maine, Midwest Health Initiative (based in St. Louis, MO), Minnesota, and Oregon – working together toward achieving common objectives:

- Generate and apply common Total Cost of Care (TCoC) and Relative Resource Use (RU) measures for PCP groups across the five partners,
- Develop regional, statewide and national benchmarks to allow meaningful comparisons,
- Report results to physician groups and engage them in using this information to help reduce health care costs and improve care.

For Colorado PCPs, CIVHC conducted analysis based on 2013 commercial claims data from the Colorado All Payer Claims Database (CO APCD). In May 2015, CIVHC provided 50 Colorado PCP groups with TCoC reports reflecting patients attributed to their respective practices. This initial distribution of TCoC reports is a modest but meaningful first step toward partnering with physicians to create actionable information based on the CO APCD.

For the first time, PCPs across the state are able to see how their cost and resources used in treating their patients compare to broader state-wide averages and similar practices. The reporting is intended to highlight areas where individual PCP practices are performing well and where opportunities may exist to make changes that ultimately improve population health and reduce costs.

The scatterplot graph illustrates the practice-level variation in cost and resource use based on the TCoC and RU measures uncovered by this initial analysis. Each point in the diagram reflects the cost and resource use of an individual PCP group compared to (normalized) state average values. In general, low resource use index scores reflect greater efficiency in the delivery of health care whereas low price scores indicate that care was delivered at relatively low cost. A practice in the upper left quadrant of the diagram is relatively efficient in delivering health care based on low resource use (compared to all PCP groups reflected in the analysis) but also has a relatively high price index (and thus costs). Moving forward, ideally we would expect to see less variation among practices relative to statewide normalized values. Improvement opportunities could be identified by looking at what PCP practices falling into the lower left quadrant are doing to provide relatively efficient and low cost care.

This information becomes actionable when a PCP group digs deeper into the results to understand what is driving their comparative performance. For example, a PCP group may have high TCoC and/or RU in the Outpatient (OP) services category. The data generated can be used to identify whether minor surgical procedures, diagnostic testing, imaging procedures or other specific categories of OP services are driving the results. Armed with this information, PCP groups can identify opportunities to alter practice patterns to address the underlying cause(s) and improve cost and resource use performance in the OP category.

As administrator of the CO APCD, CIVHC is committed to making this resource, created for the benefit of all Coloradans, as valuable as possible for all stakeholder groups. As we embark upon the next phase of this project, CIVHC plans to expand the number of PCP practices receiving these reports and provide additional granularity in specific service categories such as inpatient, outpatient, professional services, and prescription drugs. Over the next 18 months, we request and welcome your engagement, feedback and input regarding how to make the reports as helpful and actionable as possible.

If you have other suggestions on how we can improve the use of this valuable state resource or if you have specific questions regarding the APCD or TCoC project, please contact Jonathan Mathieu at jmathieu@civhc.org.
Roughly 60,000 Coloradans are living with Hepatitis C today. Many are unaware that they are infected, that they can infect others, and are themselves at risk for severe, even fatal, complications. CAFP recently surveyed its members and learned that 80% follow the CDC/USPSTF guidelines for screening, but only half follow positive screens with confirmatory RNA and genotype testing. While this is in line with primary care practices nationwide, this leaves many Coloradans undertreated for this disease.

Today, 87% of family physicians refer patients with a positive screen to a gastroenterologist or hepatologist, but these specialists are rapidly becoming overwhelmed by the numbers of referrals. With the availability of safer and more effective treatments for Hepatitis C infection, family physicians are likely to emerge as the front line of defense against this disease. We can easily screen and do confirmatory testing, and with appropriate algorithms, can stage these patients and refer only the most complicated or advanced for treatment in a specialist setting. The majority, however, can now be managed safely and definitively in the primary care setting.

If treatment reduces the long-term complications of Hepatitis C infection, and it reduces the community’s exposure to the virus, why aren’t more people being treated today?

- **Implementation.** Easy-to-implement algorithms have not yet been developed and distributed.
- **The cost of treatment.** To treat every Coloradan with Hepatitis C today would cost well over one billion dollars. This cost is shared by patients and payers. As new treatments come to market, these costs will be coming down dramatically.

- **Patient concerns about treatment still exist.** Historically, treatment has been lengthy, dangerous, and difficult to follow and tolerate. Only half of treated patients were cured. Newer treatments are far more effective, have fewer side effects, and are safer.

The CAFP survey indicated that more than half of members are interested in learning how to treat patients with hepatitis C according to modern protocols. Online courses were considered the most helpful. Members also indicated a need for mentoring and consultation with a specialist. In the coming months, CAFP, CDPHE, and the University of Colorado will be working together to provide more hepatitis C learning opportunities for members and their staff. In the meantime, here are places you can go to access online training.

The University of Washington - Seattle Prevention Training Center
http://depts.washington.edu/hepstudy/
CME/CNE credits

The University of Alabama at Birmingham - KnowHepatitis.org
http://www.knowhepatitis.org/

Medscape Education
(Must have a Medscape Log In)

- CDC Expert Commentary: Hepatitis B Vaccine for Adults With Diabetes https://login.medscape.com/login/sso/getlogin?urlCache=aHR0cDovL3d3dy5tZWRrZ2FwZS5jbnZvb29md2FjdGlvbGUvNzk5NTkwZDA4MzI3&ac=401

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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 when you register online at the NPI Web site so that our chapter receives credit for your attendance. Visit NPI online at www.npinstitute.com to view course descriptions, learn about NPI’s outstanding faculty, find a chapter in your area and register. Don’t forget to enter the name of our state in the Referral Code field during the registration process and start getting more out of your membership with NPI.

NCPLUS: NCPLUS Incorporated, the nation’s leading accounts receivable management firm. As opposed to collection companies that charge a percentage of the patient bill, or a flat fee and a percentage, NCPLUS charges CAFP members only a low flat fee. Because of their customer service focus, NCPLUS reports a recovery rate that is more than twice the national average. CAFP members who enroll in this program receive a free Bonus Upgrade Package that includes: • Guaranteed 400% R.O.I. • Complimentary computer maintenance fee • Free debtor reporting to the major credit bureaus
A strong focus on service and competitive rates translates into a valuable benefit for our members. To get started in this low-cost and effective collections system, please contact NCPLUS Representative, Polly Kideras, at 303-704-8896, or send email to pklidaras@ncplus.com.

Northwestern Mutual Financial Network: James O’Hara offers a broad range of financial planning services and products. Consultations are complimentary. Some of the areas of practice are non-qualified executive benefits, retirement planning, and education funding. Visit www.nmfn.com/jamesohara.com for more information on James O’Hara, his team and the products available from Northwestern Mutual as well as informative articles and calculators. Contact James O’Hara at 303-996-2379.

Office Depot offers Colorado Academy of Family Physician members a 10% discount off retail catalog price (excluding technology items & business machines). Members can also get discounts on the print and copy center. Use the Acct # 43244917 when ordering. Please contact Rob Boyer at 303-576-1117 or e-mail: rob.boyer@officedepot.com.

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VACCINE UPDATE

Yet Another Study Finds No Association Between MMR Vaccine and Autism or ASD

A study of nearly 100,000 children who received the MMR Vaccine, published April 21 in the Journal of the American Medical Association, found no association between the vaccine and autism spectrum disorders in children with an older sibling who had the disease. Experts say the study leaves no doubt that the two are not connected. This study joins numerous other well-done studies around the world, including research conducted by the US Centers for Disease Control and Prevention, done in response to parental fears or anecdotal reports of children who seemingly develop autism after receiving a vaccine, that have determined there is no association.

Updated HPV Vaccination Recommendations of the ACIP

During its February meeting, the Advisory Committee on Immunization Practices (ACIP) recommended 9-valent human papillomavirus (HPV) vaccine (9vHPV, Gardasil 9, Merck) as one of three HPV vaccines that can be used for routine vaccination. 9vHPV is a noninfectious, virus-like particle (VLP) vaccine. Similar to quadrivalent HPV vaccine (4vHPV), 9vHPV contains HPV 6, 11, 16, and 18 VLPs. In addition, 9vHPV contains HPV 31, 33, 45, 52, and 58 VLPs.

ACIP recommends that routine HPV vaccination be initiated at age 11 or 12 years. The vaccination series can be started beginning at age 9 years and is also recommended for females aged 13 through 26 years and for males aged 13 through 21 years who have not been vaccinated previously or who have not completed the 3-dose series. Males aged 22 through 26 years may be vaccinated. Vaccination of females is recommended with 2vHPV, 4vHPV, or 9vHPV, while males should receive 4vHPV or 9vHPV.

2vHPV, 4vHPV, and 9vHPV all protect against HPV 16 and 18, types that cause about 66% of cervical cancers and the majority of other HPV-attributable cancers. 9vHPV targets five additional cancer-causing types, which account for about 15% of cervical cancers. 4vHPV and 9vHPV also protect against HPV 6 and 11, types that cause anogenital warts.

Fourth Inactivated Strain Improves Flu Vaccine Effectiveness

The addition of an inactivated influenza B strain boosts the effectiveness of the flu vaccine, according to research published February in the journal Vaccine. The addition of a fourth strain increases the odds that the vaccine will match influenza B strains in circulation, St. Louis University researchers said. Adding the strain improved antibody response to that strain without weakening response to other strains included in the flu vaccine, the study showed.

Study Shows Nasal-Spray Flu Vaccine Appears Safe for Egg-Allergic Children

A study in the February edition of the Journal of Allergy and Clinical Immunology looked at 282 egg-allergic children who received the live attenuated influenza vaccine (LAIV; FluMist) via nasal spray. Researchers found that 26 had wheezing or coughing, eight reported mild reactions and none had severe or systemic allergic reactions up to three days after receiving the vaccine. “On the basis of this data, we do think the intranasal flu vaccine (LAIV) is safe in children with egg allergy,” said Paul Turner, who led the new study. The CDC recommends nasal flu vaccines for healthy children between two and eight years old, but also still excludes those with asthma or allergies to eggs.

FDA Recommends Changes to Flu Vaccine for 2015-16 Season

The FDA’s Vaccines and Related Biological Products Advisory Committee recommended an overhaul for the influenza vaccine for the 2015-16 season. This was because the vaccine for the 2014-15 season proved to be largely ineffective, as it did not include the A/Switzerland/9715293/2013-like virus, which turned out to be the most prevalent strain. The World Health Organization has recommended that this strain be included in next year’s vaccine, along with the H1N1 A strain A/California/7/2009 pandemic09-like virus, and B/Phuket/3073/2013-like virus, a new B strain. The FDA and CDC have concurred with the WHO’s suggestion.

ACIP Ends LAIV Preferential Recommendation in Children

The CDC’s Advisory Committee on Immunization Practices rescinded its preferential recommendation for the live attenuated influenza vaccine (LAIV) in young children because data from this year’s flu season showed it did not work against the influenza A (H1N1) virus. This year’s data affirms the trend first seen the previous flu season. Jamie Loehr, M.D., the AAFP liaison to the ACIP, said both the inactivated influenza vaccine and LAIV (FluMist) will be recommended for young children and patients ages 9 to 49 in the 2015-2016 season. Loehr said there had been many other flu seasons during which LAIV was very effective. “So on balance, an argument could be made that LAIV still has more data in favor of its use than against, but not enough data to recommend it preferentially,” he said.
CDC: Older People, Children Hardest Hit by 2014-2015 Flu Season

Adults age 65 and older were five times as likely to be hospitalized with the flu compared with other age groups, CDC researchers wrote in the Morbidity and Mortality Weekly Report. Data show that as of February 21, there were 258 flu-related hospitalizations per 100,000 seniors and 46 hospitalizations per 100,000 children younger than 5. Nearly 80% of deaths associated with flu or pneumonia involved seniors, while the flu season also claimed the lives of 92 children.

Study Examines Frequency of Flu Infections Among Adults

A study in the March edition of PLOS Biology found that adults older than 30 tend to get influenza about once every five years, based on analysis of antibodies in blood samples from volunteers in south China. Flu infections are more common among children, and decrease in frequency as people age.

One-fifth of Vaccinated Adults Got Flu Shot at a Pharmacy

About 20% of vaccinated adults in the U.S. went to a pharmacy to get a flu shot, according to the CDC, and two-thirds of the nation’s pharmacists (including virtually all pharmacists employed by Walgreens, CVS, Rite Aid and Walmart) are certified to provide flu shots and other vaccinations. The federal government and other public and private health plans are endorsing vaccines given at pharmacies because of the cost savings and greater availability. However, the AAFP still strongly recommends that all vaccines be administered in a patient’s medical home.

AAFP Webinar Provides Up-to-Date Information on Seasonal Influenza Issues

Looking to brush up on the latest influenza vaccine news? Need pointers on how to boost influenza immunization uptake in your practice? Want to find out more about standard- versus high-dose vaccine in your older patients? You can view a free AAFP webinar moderated by family physician Thomas Koinis, MD, of Duke Primary Care, for answers at http://tinyurl.com/nhzvseb.

Walt Larimore is an award-winning family physician and best-selling author who lives in Monument. Reg Finger is a public health physician, a former member of CDC’s ACIP, and an assistant professor at Indiana Wesleyan University in Indiana.

The Colorado Department of Public Health and Environment Retail Marijuana Education Program introduces:

Marijuana Pediatric Exposure Prevention and Pregnancy and Breastfeeding Clinical Guidance

Evidence-based guidance for Colorado health care providers to talk with patients about marijuana exposure.

Visit Colorado.gov/CDPHE/marijuana-clinical-guidelines for

➤ Marijuana Pregnancy and Breastfeeding and Pediatric Exposure Prevention Clinical Guidance
➤ Marijuana Factsheets for Patients
➤ Marijuana Clinical Guidelines Educational Webcast
➤ Additional resources for health care professionals

Walt Larimore is an award-winning family physician and best-selling author who lives in Monument. Reg Finger is a public health physician, a former member of CDC’s ACIP, and an assistant professor at Indiana Wesleyan University in Indiana.
The recent legalization of recreational marijuana in Colorado has raised a lot of concerns about the safety of children and adolescents. What kinds of messages are we sending to our kids about marijuana? How can we approach the topic in an engaging yet informative manner? A new resource available through the CAFP is the Tar Wars – Marijuana curriculum. In the spirit of Tar Wars, this is an interactive presentation geared towards 5th grade classrooms. Activities that presenters may choose to use include analyzing marijuana advertising, discussing how marijuana may impact the students’ ability to pursue their dream jobs, and educating about edible products. A PowerPoint presentation is available with examples of advertisements and edible products to help facilitate the discussion. The activities also serve to elicit the students’ questions about marijuana, allowing the presenter to debunk myths and rumors. The presenter’s handbook helps to inform these answers, with a brief overview of the current literature regarding marijuana’s acute and chronic health effects and the current state laws regarding marijuana. As a current hot topic in our state, this presentation captures students’ interest and allows them to learn about marijuana in a safe setting from informed adults. The Tar Wars – Marijuana materials can be used alongside the Tar Wars tobacco materials or independently.

For more information on Tar Wars please visit coloradoafp.org/tarwars.

A few quick tips and fun facts:

Even if you do not have the time or inclination to get out in the community and present in front of a group, the presenters handbook can help inform your discussions with patients of all ages. A “Marijuana 101” and “FAQ” section outlines the recent literature regarding the health effects of marijuana.

Candy is a great motivator to get shy students to speak up in front of their peers – bite sized chocolates work great! Just don’t forget to ask the teacher’s permission first.

Calls to poison control centers regarding children under 9 who consumed marijuana products went up 30% in states that legalized marijuana.

Teens that used cannabis more than once a week had worse cognitive function performance while sober than their peers.
Syringe Access Programs In Colorado

Lisa Raville
Executive Director
Harm Reduction Action Center
www.harmreductionactioncenter.org

People use drugs. While we wholeheartedly support substance abuse prevention and treatment efforts, we live in reality and know that the most effective way to prevent the spread of HIV and Hepatitis C (HCV) is to stop it at its source: the needle. We know that people who inject care about their lives and their wellbeing. Stigma and shame have done nothing for people who inject except drive their drug use underground where they have acquired HIV, HCV, and died of opiate overdoses; all of which are 100% preventable with access to sterile syringes and the lifesaving drug Naloxone. Old-fashioned laws and attitudes surrounding drug addiction, accidental overdoses, and the spread of blood-borne pathogens like HCV and HIV have historically served to perpetuate the problems they sought to resolve. Syringe access programs are based on science, data, and compassion, all of which are good for the health and safety of everyone in our community.

While Colorado pharmacies can sell syringes, they do not offer the ability to properly dispose of syringes. Access programs give participants the ability to properly dispose of syringes, and that helps many members of the community, including homeless diabetics or folks taking fertility treatments.

Syringe access programs provide the tools, resources, and education communities need, by facilitating safer injection practices and harm reduction methods. All of the top health associations are highly supportive of this excellent opportunity to save lives through this best-practice intervention. Over 250 studies support the efficacy of these programs. Syringe access programs are also highly cost-effective. The average lifetime cost of medical care for each new HIV infection is close to $500,000; our needles cost a dime.

While Colorado pharmacies can sell syringes, they do not offer the ability to properly dispose of syringes. Access programs give participants the ability to properly dispose of syringes, and that helps many members of the community, including homeless diabetics or folks taking fertility treatments. Most importantly, syringe access programs provide a crucial entry point into medical care, detox, substance abuse treatment, mental health treatment, healthcare enrollment, and health education.

There is a common misconception that people who inject do not care about their health. That is false, and it is demonstrated in our work every day. One of the greatest benefits of a syringe access program is that people are seeking us out to be pro-active about their health. People are not mandated to enroll in an SAP, they enroll to keep themselves safer. People can realistically talk about their drug use in a safe environment where staff and volunteers can promote factual, correct health information and dispel myths.

The Harm Reduction Action Center (HRAC) has been the primary gateway to emergency, health, and human services for people who inject since 2002 and meets clients “where they are at” in the spectrum of drug use. HRAC’s successes include engaging people who inject in decision-making, providing comprehensive and flexible services with a range of commodities, becoming certified as a syringe access program in February 2012, passing 6 statewide legislations regarding syringe access and overdose prevention, and providing personally meaningful opportunities for participants to self-advocate for their needs. The HRAC has grown to become the largest of seven syringe access programs in Colorado and the most successful vehicle for IDU-centered health advocacy. Programs like ours work closely with physicians, law enforcement, lawyers, and elected officials to reduce the harms associated with drug use.

So, what can your practice do to support a healthier and safer community? First, refer your injectors to their local syringe access program. We will welcome them with open arms. Second, please prescribe Naloxone to all opiate users and their loved ones. Dead addicts don’t have the opportunity to recover. COPIC, the Colorado Medical Professional Liability Insurance, “encourages physicians, physician assistants, advanced practice nurses, and pharmacists to understand their important role in providing this tool to at-risk individuals, their families, or those likely to encounter such persons.” Third, do not hesitate to contact me regarding questions, issues, concerns, or for a presentation in your office.
For Dr. John Bender, two things in life have been constant: his desire to support Primary Care Physicians, and his dedication to family. The two are closely linked, and have been since the beginning.

Dr. Bender married his childhood sweetheart, Teresa, when they were teenagers. As Dr. Bender pursued his education their family grew, and he had two children by the end of his undergraduate education.

While the task of raising a family and getting an education wasn't an easy one, it didn't deter Dr. Bender. Indeed, the challenge helped to bring about his entrepreneurial spirit. To support his family, he opened a business selling sunglasses on the 16th Street Mall and in kiosks around the Denver area. It proved to be such a success that by the time he was accepted into medical school he had 16 employees and was able to sell the business in preparation for the next step in his education.

Dr. Bender's path to family medicine was very different from what many medical students experience today. He attended Creighton University on a Health Professions Scholarship from the United States Navy. He was sent to do a surgery internship in 1992 and while the traditional nature of surgery didn't appeal to him, he was given the unique opportunity to work as a navy flight surgeon. That position allowed him to work consistently with the same pilots and their families, and develop long-term relationships with them. That experience fueled his passion for family medicine, and Dr. Bender went back into residency to train as a Primary Care Physician.

Military service remained a large part of Dr. Bender's life as he turned his attention to primary care, this time in service to the United States Army. He and Teresa moved 17 times in 17 years of marriage for military duties; and as he was about to finish residency and start a new job in Kansas, Dr. Bender was called to serve in Kosovo as the Medical Director for an Acute Care Center in the surgical hospital at Camp Bondsteel. When his service in Kosovo was complete, both Dr. Bender and Teresa were homesick. They were ready to come back to Colorado.

"After all of that travel we liked Colorado the best, it was home," says Dr. Bender. "I sold everything I had to move back to our hometown. I realized, as difficult as Kosovo had been, the world was more in need of us to roll up our sleeves than ever before."

Dr. Bender took out a loan to purchase a small family practice in Ft. Collins, and Miramont Family Medicine was born. He started with one employee and one computer, with Teresa working as their Office Manager, and started to grow the business.

Growing up in a small community, many of Dr. Bender's professional role models owned their own businesses and were their own bosses. It felt natural for him to go into practice on his own, and work to make Miramont the business he knew it could be.

And indeed the business has had many successes. They became one of the first practices in the state to utilize electronic medical records, and in 2010 won the HIMSS Davies Award of Excellence in recognition of outstanding achievements in health information technology. Miramont has also received recognition for their achievements in meaningful use, and was one of the first practices in Colorado to receive their NCQA recognition as a Patient Centered Medical Home.

The practice now has 80 employees and six locations across the Front Range. Even as the business grew, it stayed true to the family focused values that Dr. Bender holds dear.

"A lot of it is because friends and family believed in us, believed in Miramont. Family medicine is not a get rich scheme. It's about building community, taking care of people and being able to impact and manage really difficult situations,” he says. “Business in medicine is a difficult situation. It requires a lot of guts to figure out and come up with solutions that work. A lot of it is undying resolve and a commitment to seeing it through, despite the obstacles. Our family can see that and they've always been extremely supportive.”
That support from family has not just been from afar. Over the years Teresa hasn’t been Dr. Bender’s only relative on the payroll.

“We’ve put the family back in family medicine, that’s for sure,” Dr. Bender says. “It’s hard to find a relative who hasn’t worked for us.”

Having his family behind him has been important for Dr. Bender as he takes Miramont into the sometimes very difficult future of medicine.

“The challenge is knowing what is the next thing coming in payment reform or healthcare regulations. How can we best take care of patients in that environment,” Dr. Bender says.

Rather than just wait to see what those changes may be, Dr. Bender has taken an active role in leadership for over a decade with the American Academy of Family Physicians (AAFP), the Colorado Academy of Family Physicians (CAFP), and other organizations. He started as a New Physician delegate at the National Conference of Constituency Leaders (then the National Conference of Special Constituencies) with the AAFP, which sparked Dr. Bender’s passion for representing physicians at a state and national level.

“I was motivated by trends where I saw family physicians closing their doors, and more and more people having to go to the emergency room. I was interested in national policy work to try and create a more sustainable economy to help family physicians,” he says.

Since then, Dr. Bender has gone on to serve as President of the CAFP, President of the Colorado Medical Society, delegate to the AAFP, and on the AAFP Commission on Finance, ultimately as chair. As he now runs as a candidate for the AAFP Board of Directors, there are a number of issues for which Dr. Bender hopes to advocate.

“I’m very interested in Medicaid reform. I believe when primary care is allowed to see Medicaid patients for an honest day’s pay, an honest day’s wage, we can impact and reduce healthcare costs globally,” he says. “That has value for the community as a whole. We need to replicate the model that we’re building here in Colorado and that a few others states have done as well, and get that out nationwide. We need to make that happen.”

Dr. Bender is also passionate about graduate medical education funding, and making sure that there are family physicians available to care for many more generations of patients.

“We need to fight the good fight and make sure graduate medical education dollars are going towards primary care programs that aren’t exclusively specialty centric,” he says.

Finally, as he looks towards the future, Dr. Bender also sees an exciting time for direct primary care.

“I see a day 10 years from now where the vast majority of fee-for-service is replaced, and direct primary care becomes one of the mainstays of healthcare delivery. It needs regulatory changes in many states to make it work. It needs better education of legislators and insurance commissioners so that the product can be brought to the marketplace without a lot of friction for family physicians. I want to be a part of that.”

Despite the growth of his business and his leadership across many organizations, Dr. Bender still likes to remember where he started out. He can always be seen wearing a pair of sunglasses around his neck, no matter if he is in a suit, lab coat or jeans. These sunglasses are a reminder of the first businesses he started, and the work that it took to get to where he is today.

“It reminds me of my roots and where I came from, so now they’ve become my signature.”

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**Congratulations to the Following CAFP Members On Their Accomplishments!**

- John Cawley, MD, FAAFP, received his Degree of Fellow from the AAFP
- Carolyn Sze-Yun Chen, MD, FAAFP, received her Degree of Fellow from the AAFP
- James Kennedy, MD, was elected Chair of the American Board of Family Medicine (ABFM)
- Colleen Conry, MD, was elected to the American Board of Family Medicine (ABFM) Board
- Tamaan Osbourne-Roberts, MD, was named to the *Denver Business Journal* 2015 class of 40 Under 40

Do you have exciting news about yourself or a colleague that should be recognized? Email Lynlee Espeseth at lynlee@coloradoafp.org
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