IN THIS ISSUE:

Medical Homes, Payment Reform Top CAFP’s List, page 8

Patient Centered Medical Homes Pass the Tipping Point, page 10

Journey to PCMH Recognition, page 12

The Colorado Beacon Consortium — A Community Journey Towards Transformation, page 16

Colorado Family Physicians Support Local and Larger Communities, page 17

Hands-on Experience Made Family Medicine Top Choice, page 18

Scoliosis Treatment Depends on Age of Child, Severity of Condition, page 19

Curbside Consults: What’s Your Responsibility?, page 24
Promotional Pricing  
(for CAFP members only)

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| Package Includes: | Fast Track to the Patient-Centered Medical Home Program Binder + CD (includes all templates for NCQA-PCMH certification) |

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President’s Report ........................................ 4
Hard Work Pays Off ...................................... 6
Medical Homes, Payment Reform Top CAFP’s List ... 8
Legislative Report ........................................... 8
Patient Centered Medical Homes Pass the Tipping Point ........................................... 10
Medicare Expands Coverage of Tobacco Cessation Counseling ........................................... 15
Immunization Registry Going Forward ..................... 15
The Colorado Beacon Consortium .......................... 16
Colorado Family Physicians Support Local and Larger Communities Involvement is all over the map ........................................... 17
Hands-on Experience Made Family Medicine Top Choice ........................................... 18
Scoliosis Treatment Depends on Age of Child, Severity of Condition .................. 19
The Children’s Hospital, HealthTeacher Partner to Improve Health Literacy .......... 21
Mental Health Screenings: Promoting Efficiency and Reliability .................. 22
Curbside Consults: What’s Your Responsibility? ........................................... 24
Recommendations Restate Need for Calcium and Vitamin D .......................... 27
New Institute of Medicine guidelines increase amounts ........................................... 27
Congratulations to Colorado Fellows .............. 28
Meetings with Residency Program Reps on Full Agenda ........................................... 28

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.

Acceptance of ads does not constitute an endorsement by the CAFP of the service or product.

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Greetings and Happy New Year,

As we moved toward the end of 2010, I felt it important to comment on two areas that have been and will continue to be high priorities for the membership. The board and the staff have spent many hours representing the Colorado Academy of Family Physicians in several venues from boardrooms to the state house. We have met support and opposition at varying levels, and have found new allies while attempting to limit our loss of old constituents. As we continue to be the voice for Family Physicians we have been forced to become more aware of the political nature medicine has assumed and how this recession has thrust health care into a financial battlefield.

SGR fix vs. health care reform

I recently attended the American Academy of Family Physicians State Legislative Conference, and found it to live up to a high standard in delivering presentations on key issues affecting Family Physicians. One of the issues of discussion was what the changes the midterm elections may portend for the modest advances primary care gained or hopes to gain with the passing and enactment of the federal health care reform bill. It is clear that the mood in Washington was affected and the need for tighter financial accountability was an issue that influenced several House and Senate races. The new balance in the Legislature will affect the enactment of the various components of health care reform to an extent that is yet to be determined.

One area of concern is the need for an extension, bandage or fix of the Medicare sustainable growth rate reform. As I write this I have received an action alert from the AAFP grassroots encouraging membership to vocally support a 12-month extension to allow Congress to reconvene and, with its new members, work on a three- to five-year patch with positive differential payment for primary care. Congress is not interested in having the discussion about a permanent fix at this time and a drawn-out congressional battle over the offset for this payment extension. It will be critical that we remain vigilant and active during the upcoming reform as it is likely that legislation will be introduced that will benefit us but it may also contain offsets that will reduce or eliminate health care reform programs. The next SGR repair is the most likely vehicle for this legislation. The AAFP is currently attempting to prioritize what programs are in our interest and warrant the use of limited resources to support and defend. We also need to begin to grapple with the possibility that SGR reform may take precedence over health care reform programs or vice versa.

As this issue plays out we need to realize that legislative involvement by you, the physicians who care for the patients, is critical for your practice, your patients and your livelihood. Write letters, make phone calls and discuss issues with your patients. We openly welcome members’ involvement on the CAFP legislative committee. If you do not have the ear of your local, state or federal politician, others will advocate for their causes, and that is what sways votes, resulting in policy.

PCMH and Accountable Care Organizations

It is no shock to you that we are advocating for the adoption of the Patient Centered Medical Home as the model of care for our membership. We do so for several reasons: It is the model that supports the highest level of care for the patients, it is the model that has the most data in regard to cost saving in the health care system, it is the model that promotes systems that free physicians to practice the art of medicine and, lastly, it is the model that if crafted correctly will serve as the vehicle for payment reform to our members. I see this as the most critical aspect of the PCMH initiative, and yet we have had limited gains in this regard on a state and federal level.

This next state legislative cycle we will be exploring the avenues available to increase payment for PCMH practices at a state level. We will continue to work within the house of medicine, attempting to form new allegiances, and nurture existing relationships with our medical colleagues to help carry the message of the PCMH and the need for adequate funding to ensure its success. We once again need your continued involvement with the CAFP and advocacy throughout state government to accomplish this goal.

We have already begun reach out to the governor-elect’s office as we have become aware of the critical role that office can play in policies affecting health care payment, workforce reform and scope of practice.

The need for cost savings in medical care is a hot topic at all levels of government. Currently we are seeing the formation of accountable care organization pilot programs across the U.S. in an attempt to better understand and reform the payment model. In Colorado, Medicaid is in the process of refining an ACO model. This is an evolving process that has yet to be solidified, but it will no doubt influence how medical reimbursement will be structured in the coming years for not only for Medicaid, but also for third-party payers that adopt the same model. The questions that arise concern the role of the PCMH in these models and how we safeguard PCMH as the vehicle for payment reform for primary care physicians.

I wish I could say that we know the answer to those questions but unfortunately the system and structure of ACOs in Colorado have not been finalized. On a national level the best description of this was that of a unicorn -- we can describe one but have never actually seen one in existence. However, the work is ongoing and we at the CAFP are attempting to help shape the answers to those questions and the formation of these models. We need members to remain vocal on these issues to legislators and the new governor’s office. There is always potential for the cost saving not to make it to the providers’ practices that need to remain viable and continue providing patient care.

continued on page 12 >>
ENDING CHILDHOOD OBESITY WITHIN A GENERATION

We support school-based nutrition and physical fitness initiatives, such as Fuel Up to Play 60, that help achieve these guiding principles:

1. Increase access to and consumption of affordable and appealing fruits, vegetables, whole grains, low-fat dairy products and lean meats in and out of school.

2. Stimulate children and youth to be more physically active for 60 minutes every day in and out of school.

3. Boost resources (financial/rewards/incentives/training/technical assistance) to schools in order to improve physical fitness and nutrition programs.

4. Educate and motivate children and youth to eat the recommended daily servings of nutrient-rich foods and beverages.

5. Empower children and youth to take action at their school and at home to develop their own pathways to better fitness and nutrition for life.
Happy New Year to all. The CAFP leaders and staff worked very hard on behalf of Family Medicine in Colorado during 2010. Here are recent highlights.

**AAFP CONGRESS OF DELEGATES IN DENVER**

The American Academy of Family Physicians Congress of Delegates and Annual Scientific Assembly were held in Denver for the first time ever. Both events were very successful and the AAFP plans to return in 2015. The Colorado AFP delegates Larry Kipe, MD, and Kern Low, MD, and alternates, Kent Voorhees, MD, and John Bender, MD, represented Colorado’s interests during the reference committee hearings and on the floor of the Congress. The CAFP also hosted a dinner for chapter executives. Glen Stream, MD, was elected as the AAFP president-elect. The newly elected board members were Barbara Doty, MD, Richard Madden, MD, and Robert Wergin, MD.

Members of the board of directors are:
- Roland A. Goertz, MD, MBA, FAAFP -- President
- Glen R. Stream, MD, MBI, FAAFP -- President-Elect
- Lori J. Heim, MD, FAAFP -- Board Chair
- Leah Raye Mabry, MD, RPh, FAAFP -- Speaker
- John Meigs, MD, FAAFP -- Vice Speaker
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- Conrad L. Flick, MD, FAAFP -- Director
- Laura C. Knobel, MD, FAAFP -- Director
- Barbara J. Doty, MD, FAAFP -- Director
- Russell Kohl, MD -- New Physician Member
- Heidi Meyer, MD. -- Resident Member
- Kevin Bernstein -- Student Member

1. Aris Sophocles, MD, testifies at Congress of Delegates Reference Committee
2. Larry Green, MD, accepts AAFP award during Congress of Delegates
3. Delegation dinner
4. Larry Kipe, MD, speaking at the Western States Forum
5. AAFP Welcome sign at DIA
6. Chapter Execs dinner
7. CAFP Delegates, Larry Kipe, MD, and Kern Low, MD
8. From left: Dr. Kipe, Marina, Dr. Bacak, Dr. Cedars, Mayor Hickenlooper, Raquel Alexander, Dr. Makaroff, Cara Cox
9. US Surgeon General at AAFP Congress of Delegates
10. CAFP Alternate Delegates, Kent Voorhees, MD, and John Bender, MD
Colorado Lt. Gov. Barbara O’Brien presented the Colorado Academy of Family Physicians with the October Family Health Month proclamation signed by Gov. Bill Ritter. The proclamation recognizes the contributions of Family Physicians in Colorado by stating:

WHEREAS, Colorado’s Family Physicians have historically demonstrated their dedication to the health and well-being of this state’s citizens by emphasizing the family and providing care to all patients; and

WHEREAS, Family Physicians have trained for years through medical school and specialized training to provide primary care and medical treatment for the families of this state; and

WHEREAS, this care is based on knowledge of the whole person in the context of the family and the community, and is not limited by age, sex, race, religion, or type of health problem; and

WHEREAS, Colorado’s Family Medicine practices provide high quality, cost-effective care through the Patient Centered Medical Home (PCMH). A Patient Centered Medical Home is:

• A Physician-guided team that takes responsibility to provide comprehensive and coordinated care to children, youth, and adult patients and when appropriate, families, across the complex health care system.

• An approach to patient care that ensures first-contact access and continuous, trusting relationships that provide high quality and safe care based on evidence-based medicine and shared decision-making.

• A medical model that is recognized for the medical, social and economic value brought to the health care system.

WHEREAS, the mission of the Colorado Academy of Family Physicians is to serve as the bold champion for Colorado Family Physicians, patients, and communities through education and advocacy; and

WHEREAS, The Colorado Academy of Family Physicians is the largest medical specialty society in the State of Colorado with more than 1,800 members, and is celebrating its 62nd anniversary; and

WHEREAS, the State of Colorado honors its many Family Physicians for their role in ensuring the health of families across the state; Therefore, I, Bill Ritter, Jr., Governor of the State of Colorado, do hereby proclaim October 2010, FAMILY HEALTH MONTH in the State of Colorado.

START THE JOURNEY TO PCMH

Through the Systems of Care grant from the Colorado Health Foundation, the CAFP is partnering with Health TeamWorks to train groups of Family Medicine practices on the Patient Centered Medical Home, and to help with the practice transformation as well as applying for NCQA PCMH recognition. The first group started the training in October. The next group will start in April at the CAFP’s annual scientific conference. Members who wish to participate may register by contacting Angel@coloradoafp.org or 303-696-6655, ext. 16.

CAF P SMALL DONOR COMMITTEE

Please donate to this important fundraising initiative. The maximum donation is $50 per year and contributions help the voice of Family Physicians to be heard.

YEAR IN REVIEW

The CAFP pushed ahead on several fronts, including tort reform, workforce, pediatric obesity, and immunization outreach. This was possible through strong CAFP Family Physician leadership and a dedicated CAFP staff.

CAF P MEMBERSHIP

CAF P Membership continues to grow each year. Thank you very much for your continued support!

➢ December 2008:
  ➢ Active Members 1358
  ➢ Total Members 1811
➢ September 2009:
  ➢ Active Members 1375
  ➢ Total Members 1783
➢ October 2010:
  ➢ Active Members 1404
  ➢ Total Members 1855

In addition, the CAFP continues to be financially stable.

➢ December 2008
  ➢ December 2009
  ➢ $362,915.59
  ➢ $322,004.13
➢ October 2010
  ➢ $574,259.64
Another election, another new era under the Gold Dome as the Republicans picked up six Democratic seats, enough to give the GOP a 33-32 edge in the House, a majority for the first time since 2004. The Senate Democrats lost one seat but won four tough races, giving them a 20-15 majority. Senate Democrats again elected Brandon Shaffer of Longmont as Senate president and John Morse of Colorado Springs as majority leader. In the House, the majority elected Republican Frank McNulty of Highlands Ranch to be the new speaker of the House and Republican Amy Stephens from Colorado Springs as the majority leader. Denver Mayor John Hickenlooper defeated Republican candidate Dan Maes and American Constitution Party candidate Tom Tancredo to become governor-elect. He soon became busy working with his transition committees to fill his cabinet and appoint department heads.

The Colorado Academy of Family Physicians has been working diligently to impress the leaders of each body with the importance of our priorities. Thanks to the leadership of Chief Executive Officer Raquel Alexander and board members, a letter to the governor was crafted and has been shared with both the speaker of the House and the president of the Senate, outlining our priorities for the next several years. The letter included a very detailed explanation of medical homes and the need to reform payment to primary care physicians. “Fundamentally, primary care practices need to transform to Medical Homes to provide Coloradoans with the highest quality and most cost-effective, sustainable health care. Colorado needs to support and incentivize primary care practices with payment reform to become and operate as Medical Homes,” the letter stated.

CAFP is also in the process of setting up meetings with all of the Joint Budget Committee members to have a frank discussion about reimbursement and the need to enhance the reimbursement for primary care physicians. As we all know, the economic situation in Colorado is dire and obviously asking for money in the current budget will be next to impossible. However, we feel that it is incumbent on our association to share the importance of medical homes and payment reform with the decision makers so that, when economic times improve and as we move forward on health care reform, those in positions of power will understand the paramount importance of Family Medicine.

**BUDGET IS TENOUS**

As for the state budget, it is tenuous at best. Your lobbying team is very active with the Joint Budget Committee advocating for CAFP and its members. Here is an explanation of what is going on with the budget as of right now.

Even though the state budget for fiscal year 11/12 is not yet finished, the Legislative Council predicts the state will not have enough revenue to meet its statutorily required 4 percent general fund reserve. The state will need to consider different funding mechanisms because of the one-time fixes in FY 10/11 including; American Recovery and Reinvestment Act funding for Medicaid, federal funds for higher education and child welfare, and Amendment 35 moneys. In all, these one-time fixes amount to $617 million. The Joint Budget Committee’s assumption does not include caseload increases. The shortfall in FY 11/12 is expected to be $202 million, an amount that increases to $754 million when the loss of one-time sources of money is considered. If the General Assembly chooses to fund inflation and caseload growth, the shortfall grows to just over $1.1 billion. It is likely that tobacco dollars will be used again to offset Medicaid costs and help balance the budget.

The Joint Budget Committee analyst for Health Care Policy and Financing included an update on ARRA funding for Medicaid. Enhanced funding available through Federal Medical Assistance Percentage contributions were lower than anticipated, but Congress did approve a lesser amount, leaving the state with $67.2 million less than budgeted. Colorado’s 10/11 budget assumed an FMAP rate of 61.59 percent and the amount approved by Congress was 59.71 percent. If Congress had not approved the FMAP extension, the general fund impact would have been $213.6 million. Thus, Congressional action saved Colorado approximately $146.5 million in general funds.

The Joint Budget Committee continued to review the proposed budget for fiscal year 11/12 and to hear from the department heads and staff until Dec. 23. Watch for updates in your electronic newsletter for updates on decisions made by the Joint Budget Committee.

This upcoming session is sure to be very difficult given the budget, however with a more balanced General Assembly this bi-partisan body will have to work together to balance one of the most difficult budgets since the Great Depression. With health care reform on the horizon CAFP will have to work cut out advocating on behalf of Family Medicine. As always, it is our honor to represent you!
Small Donor Committee

Support the CAFP SDC and you help support issues in the Colorado General Assembly that matter to Family Physicians.

Do You Care About These Issues?

- Health Care Reform
- Childhood Immunizations
- Tobacco Cessation and Education
- Preventive Health Care
- Patient Safety Tort Reform
- Primary Care Workforce

What is a Small Donor Committee?
Campaign finance reforms enacted by Colorado voters in 2002 authorized “Small Donor Committees” as a new method for ordinary citizens to contribute to political campaigns and better compete with deep pocket special interest groups. Small Donor Committees can only accept contributions from individual persons – no corporate or union contributions are permitted. Individual contributions are limited to $50 per year, per person. Hence the name: Small Donor Committee. Unlike other PAC contributions, Small Donor Committees enjoy much higher limits on what they may give to candidate campaigns. This reform is intended to empower ordinary people to pool their money and compete with big business and special interest. The Colorado Academy of Family Physicians Small Donor Committee was formed to allow the Family Physician community to take advantage of the new campaign finance laws.

How much can a Small Donor Committee give to candidates?
The Colorado Academy of Family Physicians Small Donor Committee can give candidates for Governor, Attorney General or Secretary of State up to $10,600 per election cycle. Candidates for the state legislature may accept up to $4,250 per election cycle from Small Donor Committees.

Which candidates will The Colorado Academy of Family Physicians Small Donor Committee Support?
Each election year, the Legislative Committee of CAFP will determine a slate of candidates to receive financial support. Candidates will be selected based upon their support for family physicians, their viability as a candidate, the competitiveness of their race and the impact that a contribution from CAFP SDC will be expected to have. The number of candidates receiving support depends in large part on the number of small individual donors that have contributed to CAFP SDC.

Why should I contribute to The Colorado Academy of Family Physicians Small Donor Committee?
Supporting CAFP SDC is an easy way to support candidates that support family physicians. Contributions from CAFP SDC will be branded as family physicians’ money. These donations will be a visible means of rewarding elected officials and candidates that support our issues.

Do I have to give $50 each year?
No. That’s the maximum amount that each person is allowed to give per year. Smaller contributions are welcome. Donors will be solicited each year to renew their annual gifts.

Are contributions tax deductable?
Unfortunately not. Because your contribution will be used to support political candidates, the IRS will not allow us to offer a tax deduction.

Detach here and send contribution to: CAFP, 2224 S Fraser St. Unit 1, Aurora, CO 80014

Count me in. Enclosed is my contribution to The Colorado Academy of Family Physicians Small Donor Committee. I understand that only personal checks may be accepted, and my contributions may not exceed $50 per year.

Name
Street Address
City, State, Zip
The Patient-Centered Medical Home is now a proven model. Numerous studies, both national and international, show that a strong primary care foundation lowers health care costs and improves quality of care. There are now 10 large PCMH pilot studies, across all spectrums of primary care, that demonstrate improved outcomes in health parameters including patient and physician satisfaction. They consistently show a 10 percent to 30 percent decrease in hospital admissions and emergency department utilization. A successful PCMH pilot encouraged BlueCross BlueShield of South Carolina to take the leap and pay for PCMH practices across the state.

This momentum has shifted the tipping point and the PCMH model is widely accepted as the vehicle to carry health care reform forward. The National Committee for Quality Assurance is the leader in PCMH recognition programs and used by most pilots and health plans.

Yet, PCMH recognition is not easily achieved and Family Physicians face many hazards and barriers. In 2006, the American Academy of Family Physicians conducted a two-year national demonstration project to evaluate the transformation process of 36 diverse Family Medicine practices. Mistakes were made and lessons learned from this pioneering effort. Subsequent pilots have heeded these recommendations and developed resources and tools to pave the way. Despite the refining of the transformation process, several fundamental issues must be addressed by any practice starting this journey.

The PCMH transformation requires fundamental changes in how a practice delivers care. Systems designed to optimize physician workflow must be redesigned to enhance patient experience. New processes and protocols for access, scheduling, coordination and delivery of care are needed. These changes are unrelenting and continuous. Unfortunately, technology is only a tool for change and not the solution to transformation. Implementing and utilizing electronic medical records in a meaningful way is difficult, costly and time consuming. Medical teams must be created that enable staff to assume more independent roles as physicians learn to delegate tasks that were traditionally their responsibility. Care delivery shifts to relationship-centered partnerships with patients as opposed to the clinical guideline-based directives. These changes are threatening to the viability of practices and to the identity of physicians. The magnitude of this redesign project leads to change fatigue and a degree of despair when the enormity of the task is unveiled with the completion of each small step toward transformation.

It seems impossible, however, 6000 physicians in the U.S. and 350 physicians in Colorado have successfully obtained NCQA PCMH recognition and re-discovered the joy of practicing medicine.

Microlife Medical Home Solutions (MiMHS) has developed a program to address the barriers and economic risks to becoming a PCMH with their Fast Tracks to the PCMH. MiMHS created a consultant-in-a-box program to provide Family Physicians with a clinically oriented how-to manual with the tools and resources needed to transform practices. MiMHS couples documents and protocols with innovative, independently validated medical devices to integrate evidence-base guidelines into busy medical practices and build team-based care.

MiMHS blood pressure monitors deliver comprehensive in-office and out-of-office blood pressure measurements that strictly follow American Heart Association and American Society of Hypertension guidelines. Individualized treatment for weight management is based on patients’ own metabolic needs. MedGem is an easy-to-use, handheld device that accurately measures oxygen consumption (VO2) to determine resting metabolic rate.

Components of both programs include algorithms, staff workflow, patient training, billing processes and other information pertinent to effective hypertension and weight management.

This program, built by Family Physicians for Family Physicians, has been successfully recognized by NCQA for the medical conditions of hypertension and Metabolic Syndrome. Case studies demonstrate improved patient outcomes and a significant return on investment.

Microlife Medical Home Solutions, Inc. attended and supported the Colorado Patient Centered Medical Home Experience dinner event at the AAFP conference in Denver.

MiMHS is recruiting for more pilot sites to demonstrate outcomes of the fast track program.

For more information on the Fast Track to the PCMH,
contact: Joan.hau@mimhs.com or call 303-274-2277 x106.

The AAFP Congress of Delegates met the week of Sept. 27. Here is a synopsis.

President-elect: Glen Stream (Wash.)

New Board Members elected: Bob Wergin (Neb.), Barb Doty (Alaska), Rick Madden (N.M.)

RESOLUTIONS OF NOTE

A means will be developed to track resolutions and what becomes of them. This was referred to the board for implementation and presentation to the Congress of Delegates in 2012.

Consumer alliance: A huge debate took place about the consumer alliance program in general, and the Coke alliance specifically. The president at her address to congress, and the chair of the board addressed the poor communication that led to misunderstandings about these programs. The information on these programs is complex. CAFP delegates and alternate delegates were convinced in the end that the consumer alliances are a good thing for the AAFP and that the risks of these programs are minimal. You can see the president's report and justification for this policy at:


Streaming video: The AAFP will investigate live streaming of video so that members at large will be able to see business meetings.

Email: You may not have known (we did not) that the AAFP board had planned to send third-party solicitations to you via email. The Congress of Delegates stopped this, though members may still choose to receive the solicitations.

Our resolution to introduce in the U.S. Congress legislation that would extend to physicians an exemption from antitrust like that applied to health insurers was very popular. It was referred to the board at their request, as they want to act on this quickly.

Tobacco: A resolution passed to work to prohibit the selling of tobacco products in places where health care or health counseling is provided. This would mean that the AAFP would work to stop the provision of health care at sites, including pharmacies and clinics, where tobacco is sold.

There was a resolution adopted to fund the Robert Graham Center to compile and study the literature on the comparative effectiveness of nurse practitioners, physician assistants, and Family Physicians.
CAFP to Host 2nd Journey to PCMH Learning Series

**PCMH and Meaningful Use**

The Patient Centered Medical Home is an empowering concept to patients, physicians and staff. With AARA funds to help alleviate some of the burden with the Meaningful Use criteria, now is the time for CAFP members to look into starting their journey.

Meaningful Use and National Committee for Quality Assurance PCMH standards overlap in several areas. Coordination and integration are key elements to both. Understandably, there are challenges in any change to a medical practice, and CAFP has information and resources available to members whether the change is implementing health information technology or NCQA standards.

CAFP will host a second Journey to PCMH Recognition learning series on April 14th in Colorado Springs. Information is available through Angel Perez at angel@coloradoafp.org or 303-696-6655 ext. 16.

<< continued from page 4

I feel we have had areas of gain over the past year, but clearly we are at a turning point on the federal and state levels. The recession will significantly influence the course of health care reform on several levels. We need active legislative awareness and advocacy now more than ever. Health care and, more importantly, the importance of primary care have been given a national stage that is unprecedented. Continue to work with us in CAFP at an active level to get our message across. We need to be proud of the fact that we are providing care in the manner that still advocates for the patients’ wellbeing and defends their health. I look forward to your input and involvement in the coming months.

Please feel free to contact the CAFP and me for more detailed information of involvement in committees or on issues at a state or federal level.

Sincerely,

Luke Casias M.D.
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Cavity Free at Three

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

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

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

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

By Centers for Medicaid & Medicare Office of Public Affairs

The U.S. Department of Health and Human Services expanded Medicare coverage of evidence-based tobacco cessation counseling, removing a barrier to treatment for all tobacco users covered by Medicare.

Before the recent decision, Medicare had covered tobacco counseling only for individuals diagnosed with a recognized tobacco-related disease or with signs or symptoms of such a disease. Under the new coverage, any smoker covered by Medicare will be able to receive tobacco cessation counseling from a qualified physician or other Medicare-recognized practitioner who can work with them to help them stop using tobacco. All Medicare beneficiaries will continue to have access to smoking-cessation prescription medication through the Medicare Prescription Drug Program (Part D).

“For too long, many tobacco users with Medicare coverage were denied access to evidence-based tobacco cessation counseling,” said Secretary Kathleen Sebelius. “Most Medicare beneficiaries want to quit their tobacco use. Now, older adults and other Medicare beneficiaries can get the help they need to successfully overcome tobacco dependence.”

Don Berwick, MD, administrator of the Centers for Medicare and Medicaid Services, said the new coverage builds on existing preventive services. “Giving older Americans and persons with disabilities who rely on Medicare the coverage they need for counseling treatments that can aid them in quitting will have a positive impact on their health and quality of life. As a result, all Medicare beneficiaries now have more help to avoid the painful — and often deadly —consequences of tobacco use.”

Tobacco use remains the leading cause of preventable illness and death in the United States and is a major contributor to the nation’s increasing medical costs. The U.S. Centers for Disease Control and Prevention estimate that tobacco use causes about one of five deaths in the United States each year and that, on average, adults who use tobacco die 14 years earlier than non-users. It is estimated that between 1995 and 2015, tobacco-related diseases will cost Medicare about $800 billion.

Despite the expansive list of adverse effects caused by tobacco use, and smoking in particular, about 46 million Americans continue to smoke. Of these, an estimated 4.5 million are Medicare beneficiaries 65 or older and less than 1 million are younger than 65 and are covered by Medicare due to a disability. For smokers who successfully quit, the health benefits will begin immediately and continue for the rest of their lives. These benefits include reducing their risk of death from coronary heart disease, chronic obstructive lung disease, and lung and other cancers.

The new benefit will cover two individual tobacco cessation counseling attempts per year. Each attempt may include up to four sessions, with a total annual benefit thus covering up to eight sessions per Medicare patient who uses tobacco.

The coverage applies to services under Parts A and B of Medicare and does not change the existing policies for Part D, or any state-level policies for Medicaid or the Children’s Health Insurance Program. HHS planned to issue guidance about a new benefit for pregnant women to receive Medicaid-covered tobacco cessation counseling. This benefit, a provision of the Affordable Care Act, required states to make coverage available to pregnant Medicaid beneficiaries by Oct. 1, 2010.

“We know that older adults and other Medicare beneficiaries can be successful in their struggles to stop using tobacco, as long as they have the right resources available to them,” said Assistant Secretary of Health Howard Koh, MD, MPH. He added that now “beneficiaries can access that help from qualified physicians and other Medicare-recognized practitioners.”

Under the Affordable Care Act, effective Jan. 1, 2011, Medicare will cover preventive care services, including not only tobacco cessation counseling services, but also other services such as certain colorectal cancer screening and mammograms at no cost to beneficiaries. The Affordable Care Act also gives beneficiaries access to no-cost annual physical exams so patients can partner with their doctors to develop and update personal prevention plans based on their current health needs and risk factors.

For more information, please contact Cara Coxe, CAFP Wellness Programs Manager at cara@coloradoafp.org or 303-696-6655 ext. 14.

IMMUNIZATION Registry Going Forward

Following are updates on the Colorado Immunization Information System.

Registry Replacement

Over the past few months, the Colorado Immunization Information System has been validating system requirements and reviewing proposed solutions to ensure that all of the functional needs of the registry can and will be satisfied with implementation of the new system. Major accomplishments include completion of the following tasks.

• Validation and prioritization of 353 requirements for all modules within the entire system.

• Identification and prioritization of 87 customizations for the Patients, Immunizations and Education modules for inclusion in the first code release Dec. 20, 2010.

• Development of testing scripts and scenarios that CIIS will use to validate the customizations for the Patients, Immunizations and Education modules.

CIG

CIIS has been hard at work on the Colorado Immunization Gateway, or CIG, which will authenticate and validate Health Level 7 messages sent to CIIS from Electronic Health Record systems used by health care providers. HL7 is an American National Standards Institute standard for health care specific data exchange between computer applications. It collectively defines a series of electronic messages to support administrative, logistical, financial and clinical processes.

CIIS recently participated in a demo of Colorado Regional Health Information Organization to gain a better understanding of how the system works and where CIIS data may potentially be accessed within the system.

CIG development continues and the pilot is expected to begin in mid-January 2011.
The Office of the National Coordinator for Health Information Technology oversees a variety of programs that support adoption of health information technology, or HIT, and promote a nationwide health information exchange, or HIE. Among those funded by stimulus dollars is the Beacon Communities Program, which is designed to accelerate and demonstrate the ability of HIT and HIE to transform local health care systems, support health care providers in delivering quality care, and improve Americans’ health and health care.

Western Colorado is one of the 17 communities awarded a Beacon Communities grant. Leading the Colorado Beacon Consortium is collaboration among Quality Health Network, the Western Colorado HIE, St. Mary’s Hospital and Regional Medical Center, Mesa County Physicians Independent Practice Association, and the Colorado-based non-profit health plan, Rocky Mountain Health Plans. The Colorado Beacon Consortium covers seven Western Colorado counties and will positively impact 300,000 lives within these counties. Patrick Gordon, consortium program director explains, “The Beacon program represents a significant opportunity to build upon the longstanding collaboration among independent, community-oriented health organizations in western Colorado.”

The goal of the consortium project is to maximize the use of data through practice transformation to achieve the following outcomes in the western Colorado community:

- Bending the cost curve
- Reducing variation and improving quality for all
- Enhancing community accountability for health and health care
- Delivering patient and family centered care

The consortium will coordinate resources around these outcomes and provide support to help eligible practices and hospitals. Within the consortium area, Quality Health Network will serve as a federally funded regional extension center for HIT. In its capacity as a regional extension center, and as an executive member of the consortium, Quality Health Network will provide guidance, contracting support and enhanced data exchange. “More than 145 disparate organizations are linked together electronically through QHN to facilitate a highly collaborative network of care for patients,” states Dick Thompson, chief executive officer of Quality Health Network.

The consortium’s Practice Transformation program specifically targets primary care practices with the goal of supporting 75 practices and their associated medical neighborhoods. Marc Lassaux, QHN technical director, comments, “The Beacon program allows QHN to greatly accelerate HIT and HIE expansion in support of practice transformation and quality improvement activities.”

The consortium’s Practice Transformation program is supported by expertise from Health TeamWorks and utilizes the six Institute of Medicine aims described in “Crossing the Quality Chasm” and the Triple Aim model from the Institute for Healthcare Improvement to guide development of the primary care focused quality improvement program.

The models used to promote these two objectives include:

- The Care Model developed by Ed Wagner, MD, MPH, and the MacColl Institute.
- Model for Improvement developed by Associates in Process Improvement.

The consortium’s Practice Transformation resources that support learning are the Institute for Healthcare Improvement Breakthrough Series Collaborative Learning Model and the consortium’s Transformation Team.

Here are some of the reasons practices are excited to participate in the Beacon Transformation program:

“...its focus on the medical home and quality of care is the future of primary care,” stated David Adamson, executive director, Mountain Family Health Center, Glenwood Springs.

“The team approach is very important to our staff and our patients. It helps our entire team become the ‘solve it’ group, ensuring great outcomes for all,” reported Terry Moss, chief operating officer/practice administrator, Western Valley Family Practice, Grand Junction.
We look forward to learning a more efficient way to handle our document flow. We currently use our old paper flow superimposed on an EMR system instead of a document flow designed for the EMR,” stated Thomas Wiard, MD, Pediatric Associates, Montrose.

The Colorado Beacon Consortium is honored to be one of the 17 communities across the country developing, testing, and learning from new approaches to technology-enabled transformation in primary care. A collaborative approach ensures both deeper learning and rapid improvement, bringing the Triple Aim within reach.

Alison Leifert is a quality improvement advisor with the Colorado Beacon Consortium. She can be reached at Alison.Leifert@coloradobeaconconsortium.org. Julie Schilz BSN, MBA, is director, Community Collaboratives and Practice Transformation, for the Colorado Beacon Consortium. She can be reached at Julie.Schilz@coloradobeaconconsortium.org.

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Institute of Medicine-- http://iom.edu
Model for Improvement--http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/
Office of the National Coordinator for HIT-- http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

Figure 2. The Colorado Beacon Consortium Adapted Institute for Healthcare Improvement Breakthrough Series Collaborative Learning Model

Colorado Family Physicians Support Local and Larger Communities

Involvement is all over the map  By Buffy Gilfoil

In Wheatridge, a Family Physician serves polio survivors. One in Windsor participates in Karios prison ministry, while one in Ouray is involved in community theatre and the performing arts, as well as the Elks Club. In Brush and Pueblo, as well as many points in between and beyond, Family Physicians offer free or discounted sports physicals. Throughout Colorado, Family Physicians help to support their communities and to meet the medical needs of people close to home and around the world.

Sixty-three members of the Colorado Academy of Family Physicians responded to a survey on community involvement that concluded in August 2010. They represent all areas of Colorado and a wide range of practice sizes and types. Their answers reflect tremendous support for their local communities, as well as the global community.

Altruism in action – An overwhelming majority of respondents, 62.9 percent, answered that they participate in altruistic or humanitarian activities or organizations, and comments reflected great variety among approaches. A Denver practice sponsors Habitat for Humanity and many offer free or discounted medical services to the underserved, uninsured and homeless.

International Service – At least six of the respondents who are involved in humanitarian and voluntary activities provide services outside of the U.S. For example, one residency program sends a team to provide medical care to the underserved in Quito, Ecuador, each year. A Denver doctor who is a board member of Family Medicine Education International has been a consultant on medical issues in Kyrgyzstan, Albania and Kosovo. Others have volunteered for medical work in Africa, Asia, Haiti and Central America.

Support for sports -- Nearly half, 47.5 percent, provide medical care or participate in other ways with local sports teams. Many provide free or discounted sports physicals, as well as medical coverage at sporting events. Some serve as team physicians for local high schools and one practice serves as primary care physicians for a professional team.

Special populations focus – Nearly half of the respondents, 48.2 percent, reported that they take care of special populations. In addition to indigent and uninsured patients mentioned above, populations served include refugees, foster children, the frail elderly, those with HIV and those who are disabled in any way – developmentally, physically or intellectually. Family Physicians also serve those with limited English proficiency, chronic pain or depression, and the deaf. In addition, more than half, 52.5 percent, take care of patients in nursing homes.  

Continued on page 23 >>
The following is part of a series of articles about the Rural Track at the University of Colorado Denver School of Medicine, http://medschool.ucdenver.edu/ruraltrack. Family Physicians interested in hosting a Rural Track student can contact program director Mark Deutchman, MD, at mark.deutchman@ucdenver.edu or 303-724-9725.

Goldie Hawn, Kevin Costner, Martina Navratilova, Antonio Banderas and Melanie Griffith — all are names that are widely known to be associated with Aspen.

But most of the approximately 6,500 people who live in the Pitkin County seat are not celebrities. They include middle-class professionals, such as teachers and law enforcement officials, as well as service personnel. And, for six weeks during the summer of 2010, the mountain resort was home to Tim Clement, a student in the Rural Track at the University of Colorado School of Medicine.

While he was a in Aspen, Clement worked and learned at Aspen Medical Care, an independent clinic with offices in the city and nearby Basalt, a community of about 3,300. His preceptor was Kim Scheuer, MD, but he also learned from the other two Family Physicians at the clinic, as well as the two pediatricians. In addition, an osteopathic doctor was on the staff part of the time he was there and a physician assistant began working there after Clement completed his time there.

“People have a stereotype of Aspen that isn’t helpful in understanding the city’s health care challenges,” Clement said. “There are lots of underserved patients.”

Clement observed that many of the people who own houses in Aspen don’t live there, while most who work in the city don’t own homes there. According to information he presented to his Rural Track classmates, the median household income in Aspen is $64,693, far from enough to afford the average-priced home, which costs approximately $1.8 million.

Founded in 1997, Aspen Medical Care was “born out of a vision to merge old-fashioned health care with modern medical services,” according to practice literature. Services include the full spectrum of adult medicine, such as Workman’s Compensation evaluations, urgent care, X-Rays and physical examinations. All three Family Physicians see all types of patients and provide the full range of services, but each also takes the lead in one or more areas. One is primarily responsible for the Basalt clinic, Dr. Scheuer looks after many women’s concerns and Spanish-speaking patients, and the other Family Physician does a large number of procedures, such as sutures.

“There was no typical day,” Clement said. He learned from all of the doctors and saw several procedures and conditions, including circumcisions, ear infections, allergies and well-child visits. He also was involved with management of chronic conditions, like diabetes and hypertension. He conducted a research project on tick-borne infections.

“After getting hands-on experience this summer, my top choice of specialties would be Family Medicine and the whole reason was the Rural Track preceptorship,” Clement said. “Family Medicine suddenly went from not being on my list to being at the top of my list.”
Scoliosis Treatment Depends on Age of Child, Severity of Condition

Scoliosis Definitions

Scoliosis is defined as coronal plane curvature of the spine greater than 10 degrees. In most cases, no underlying diagnosis is identified and the condition is termed idiopathic scoliosis. Scoliosis also can occur in association with neuromuscular disease (cerebral palsy, spina bifida, muscular dystrophy, etc), syndromic conditions and due to congenital malformations of the vertebral bodies. If there is associated spinal deformity with any of these conditions, prompt referral to a pediatric orthopedic center is indicated.

Idiopathic Scoliosis

Idiopathic scoliosis can occur at any age, but most frequently presents during the adolescent years. The age at onset of idiopathic scoliosis can be 0 to 3 (infantile), 4 to 9 (juvenile), and 10 and older (adolescent). There is a slightly greater male to female ratio in infantile and juvenile scoliosis. The gender ratio reverses in adolescent scoliosis. Among adolescents that require orthopedic treatment the gender ratio is 7:1 female to male. The overall prevalence of scoliosis is 1 percent in the American population, with only 10 percent of those with curvature greater than 30 degrees.

Infantile and Juvenile Idiopathic Scoliosis (Ages 0-9)

Parents or caregivers usually bring infantile scoliosis to the attention of the primary care physician. This is often noticed when the child is undressed for bathing as either a curvature of the spine or elevation of one shoulder. Clinical evaluation of the spine should include assessment of shoulder height, coronal plane deformity by visualizing and palpating the spinous processes, continued >>
and rotational deformity appreciated by scapular asymmetry or posterior rib prominence. The flexibility of the spine can also be evaluated by suspending the child from his axilla and noting any correction of the deformity. Skin should be examined for hairy patches and dimples, which are signs of spina bifida. Any sacral dimple that does not have a visible floor should be evaluated by ultrasound or MRI for spina bifida.

Diagnosis of scoliosis in either the infantile or juvenile age group should prompt referral to a pediatric orthopedic center. There is a 10 percent to 15 percent incidence of spinal cord pathology in these age groups, of which up to 50 percent require surgical management. A total spine MRI is recommended to evaluate for spinal cord pathology. The MRI should be ordered by the treating pediatric orthopedist since the required sedation/anesthesia may be coordinated with treatment of the deformity.

Treatment of infantile and juvenile idiopathic scoliosis focuses on maximizing growth of the thoracic cage (a surrogate for lung development) while preventing worsening of deformity. Full body casting and bracing are being used increasingly to avoid surgical fusion of the spine in these young children. When this fails, growth-sparing surgery may be considered either with implants distracting the spine or implants that distract the thoracic cage. These require periodic admissions for lengthening of the devices under anesthesia. Spinal fusion is usually done once children reach the teen years to permanently stabilize the spine and provide additional correction of the deformity.

Adolescent Idiopathic Scoliosis (Age 10 and older)

Idiopathic scoliosis is most frequently diagnosed in the adolescent population. Spinal alignment can quickly and easily be checked during annual well-child examinations. The child's back should be visualized without clothing (a bra may be kept on). Signs of scoliosis include shoulder height difference, scapular prominence, and curvature of the spinous processes (Figure 1). Idiopathic curves almost always have a convexity to the right in the thoracic region. Convexity to the left is rare, and associated with spinal cord pathology that should be evaluated with an MRI.

A hallmark of idiopathic scoliosis as opposed to many other forms of scoliosis is rotational deformity. This can be assessed simply by asking the patient to slowly bend forward with his or her feet together and knees kept extended. Rotational deformity manifests as prominence of the ribs on the convex side of the curve. Lumbar muscular prominence is also appreciated with compensatory curves. Primary lumbar scoliosis is less frequent than curvature in the thoracic spine, but also presents with rotation deformity on forward bend.

Use of a scoliometer is recommended for screening. It is a simple inclinometer that should be run down the spine with the patient bent forward (Figure 2). The maximal reading is recorded in both the thoracic and lumbar region. Any reading greater than five degrees is an indication to order radiographs. These should include AP and lateral full spine radiographs. Isolated thoracic and lumbar radiographs do not allow for accurate measurement of deformity. If the curve measures greater than 10 degrees on radiographs the patient should be referred to a pediatric orthopedic center. Readings between zero degrees and five degrees on the scoliometer are consistent with spinal asymmetry that does not require radiographs but rather serial observation. The scoliometer can be obtained for $48 and is reusable (http://www.scoliosis.org/store/scoliometer.php).

Scoliosis progresses only during the time a child’s spine is growing. The orthopedist will follow growth by serial height measurements, bone age measurements, status of the triradiate cartilage and iliac apophysis on radiographs, Tanner staging and menarchal status. Long-term

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Table 1: General guidelines for treatment of adolescent idiopathic scoliosis

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<tr>
<th>Degree Range</th>
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<tr>
<td>&lt;20 degrees</td>
<td>Observe</td>
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<tr>
<td>20-45 degrees</td>
<td>Brace</td>
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</tr>
<tr>
<td>&gt;45 degrees</td>
<td>Surgery</td>
<td>Surgery</td>
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Table 2: Indications for referral to a pediatric orthopedic center

- Infantile or Juvenile Scoliosis (ages 0-9)
- Scoliometer > 5° if unable to obtain full length spine radiographs at your institution
- Curve greater than 10° in a growing child
- Curve greater than 40° in a child who has completed growth
- Neurologic signs/symptoms
- Congenital, Neuromuscular or syndromic scoliosis
Scoliosis Treatment

Now through the 2014-2015 school year, Children’s will underwrite the HealthTeacher curriculum and teacher training for participating schools. In addition to providing financial support, Children’s is committed to providing pediatric expertise regarding modification of existing resources or creation of new resources and development of evaluation tools to measure the effectiveness of the program. Children’s also plans to identify opportunities to develop additional health and safety programming and support in schools that are participating in the Health literacy collaborative, as well as resources to help ensure sustainability. The program is staffed with two local education coordinators who are charged with training teachers in participating districts and providing ongoing support.

The response has been tremendous and Children’s is thrilled to announce that as of November 2010, 12 districts throughout Colorado had committed to participate in the 2010-2011 school year, including: Adams 12 Five Star Schools, Adams County School District 14, Aspen School District, Aurora Public Schools, Bennett School District, Byers School District, Charter School Institute, Cherry Creek School District, Douglas County School District, Eagle County Schools, Mapleton Public Schools, School District 27J (Brighton) and Sheridan School District.

Additional information about HealthTeacher is available at www.healthteacher.com.

We know that healthy kids are better learners, and we really see this program as an opportunity for Children’s to partner with Colorado schools in a much more comprehensive and collaborative way to impact the health of our kids.”
Mental Health Screenings: Promoting Efficiency and Reliability

By John H. Genrich, MD, FAAP

Following a steady stream of supporting data and endorsements from health policy and professional organizations, mental health screening for adolescents ages 12 to 17 is now standard of care. The U.S. Preventive Services Task Force (USPSTF),1 the American Academy of Family Physicians (AAFP) 2 and the American Academy of Pediatrics 3 (AAP) recommend depression screening for adolescents ages 12 to 18 at annual wellness visits. Screenings are now included as a covered preventive service in health care reform.

These recommendations presume that identification of adolescent mental illness is the responsibility of primary care physicians. As a pediatrician in practice for more than 40 years, I could not agree more. With data showing that more than 70 percent of adolescents see a primary care physician at least once a year,4 the primary care office is the logical setting for routine mental health checkups. Our expertise in managing chronic disease, our familiarity working with specialists and our status as the patient’s “medical home” leave us best-suited to address this emerging adolescent public health issue.

An estimated 2 million young people, or 8 percent, experienced at least one major depressive episode during the past year, yet only 39 percent received treatment.5 More than 11 percent of U.S. children and adolescents suffer from a serious mental disorder causing significant impairment,5 but 80 percent of mentally ill youth are not identified and do not receive mental health services.6 Left untreated, depression and mental health disorders can lead to school absenteeism, decreased school performance, emotional distress, and potential for suicide. Suicide is now the third leading cause of death in youth.7 On average, the symptoms of mental illness present two to four years before onset of full-blown disease.8 This leaves a lengthy window of opportunity for prevention.

Incorporating mental health screenings into a hectic practice stretched for time and resources may not be as daunting as it seems. My experience has shown that systematizing mental health screenings by administering a validated screening tool prior to an interview can be efficient and economically relevant. I have found that this approach can save time and produce more reliable outcomes than general physician inquiry. Completed by the teenager in the waiting room or exam room, the confidential screen has been readily accepted by our adolescent patients who seem more comfortable filing out a written questionnaire than verbally responding face-to-face with the physician.

The questionnaires that we use, developed and standardized at Harvard and Columbia universities, include the PSC-Y, a 35-item questionnaire addressing internalizing, externalizing, attentional and suicidal issues; the modified PHQ-9, an 11-item depression screen that includes two questions on suicide ideation and incidents and the CRAFFT questionnaire that asks nine questions about alcohol and substance abuse.

Time and Cost Efficiencies

The three screens that we use in the practice are brief, easy to administer and rapidly
scored. They streamline interview time in the examination room by directing the encounter to the issues pertinent to each patient.

Regarding payment, there is a growing list of private insurers that are reimbursing for mental health screenings. In our experience, using a 96110 as the mental health screening code can promote reliable reimbursement.

**Resources and Referrals**

In our practice, we rely on a core group of mental health professionals for referral of patients who score positive. In the event of a mental health emergency, our office staff contacts our mental health colleagues to secure a same-day appointment. In rare cases, we refer to an emergency department.

Training staff, gaining reimbursement and making appropriate referrals can be simplified through the TeenScreen National Center for Mental Health Checkups at Columbia University. Affiliated with the Columbia University Division of Child and Adolescent Psychiatry, TeenScreen’s Primary Care program offers support to physicians by providing screening questionnaires, instructional materials for staff training and referral information free of charge.

As primary care clinicians, our commitment to the holistic health of the patient often hits the wall of daily time constraints and pressures. Screening tools and resources can help ease these very real burdens by offering clear-cut, effective and time-efficient strategies that can support us in improving the lives of our adolescent patients.

**Dr Genrich is the Physician Advisor to TeenScreen National Center for Mental Health Checkups**

**REFERENCES**


<< continued from page 17

Obstetrical and emergency care ---

Slightly more than one-third, 36.2 percent, of respondents provide prenatal care and almost as many, 34.4 percent, also deliver babies. A few, 6.8 percent, work in emergency rooms.

Education of future providers – More than two-thirds of respondents, 71.7 percent, participate in teaching medical students and just over half, 50.8 percent, participate in teaching Family Medicine residents.

Strength in numbers -- Well over half of respondents, 61.9 percent, participate in medical or professional organizations in addition to the American Academy of Family Physicians and its Colorado chapter. Nearly one-third, 31.1 percent, find time to participate in other community-based organizations, such as those related to the arts or hobbies.

Approximately half of the respondents, 49.2 percent, are affiliated with suburban practices, with the remainder almost evenly divided between rural and urban practices. Together, the practices serve more than 200,000 patients.

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**University of Colorado Denver and Health Sciences Center**

**Department of Family Medicine--HSC**

**Assistant Professor, Faculty**

**Rose Family Medicine Residency**

**Job Posting # 809100**

**Position # 610234**

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

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

**Required Qualifications:** MD/DO degree, Colorado Medical License, DEA Certificate, Board Certified/Board eligible in Family Medicine. Practices full spectrum of Family Medicine, including Obstetrics and inpatient medicine. Must obtain Medical Staff privileges within the HealthONE LLC d/b/a Rose Medical Center and obtain Medical Staff Privileges at University of Colorado Hospital.

**Preferred Qualifications:** Experience in family medicine teaching/practice preferred. Salary is commensurate with skills and experience. The University of Colorado offers a full benefits package. Information on University benefits programs, including eligibility, is located at http://www.cu.edu/pbs/.

Applications are accepted electronically at www.jobsatcu.com. Review of applications will begin February 16, 2010 and continue until position is filled. When applying at www.jobsatcu.com, applicants must include:

1) A letter of application which specifically addresses the job requirements and outlines qualifications
2) A current Curriculum Vitae

Questions should be directed to regina.garrison@ucdenver.edu.
Defense counsel working on behalf of a COPIC-insured physician secured summary judgment in a Denver District Court case regarding alleged liability from a curbside consult. The district judge determined that a physician whose only involvement with a patient is a “curbside consult” or a brief conversation with the treating physician does not have a physician-patient relationship. Therefore, the consulting physician cannot be liable for malpractice, regardless of the outcome.

The court’s opinion lists factors to consider when deciding whether a liability relationship is created. The factors include: the extent and length of telephone conversations, a prior relationship with the patient, whether the consultant performed a physical exam prior to the phone call, whether the consultant had access to the medical chart, the relative experience of the primary care physician, whether the primary care physician expressed exclusive reliance on the consultant, whether the consultant was paid, the relationship between the consultant and the primary care physician, and the emergent nature of the care necessitating consultation.

Additional factors that we’ve seen the courts consider include: whether the patient was aware of the informal consultant being contacted, whether the patient requested that the informal consultant be contacted, and whether other physicians had also been contacted.

COPIC believes the reasoning is sound in this area and sheds light on an important subject. We offer the following risk management advice:

Health care provider requesting the curbside consult

• Provide the consultant with adequate clinical information. Do not provide
only the information that supports your diagnosis, treatment or management plan in an effort simply to include an agreeing opinion in the chart.

- Provide the consultant the opportunity to formally consult and possibly actively manage the patient if he or she requests to do so.
- If you document the discussion, state that “Dr. < > provided the following opinion without formal consultation and did not personally interview or examine the patient or the patient’s record.”
- Keep in mind that you can accept or reject the advice received by the consultant as you see fit.

Health care provider providing the curbside consult
- State whether you agree to provide a curbside consult.
- Request that you be formally consulted if you believe the case warrants.
- Remind the requestor of the curbside consult the proper manner for him or her to document the above discussion.
- If you document the discussion, state that “I discussed the general treatment of <patient name> with Dr. < >, and I did not formally consult, personally interview, or examine the patient or the patient’s record.”

When curbside consultation is likely inappropriate
- Patients who are critically ill or whose condition is rapidly deteriorating and are in need of direct consultation. The curbside consult may be inadequate to provide the consulting physician with adequate information and the ability to actively intervene and manage the patient in a timely fashion (should a formal consultation occur and the patient deteriorates, it could be alleged that the consultant’s involvement and legal responsibility began earlier).
- Patients in active labor. We continue to see cases in which the consulting obstetrician is asked an opinion on a small portion of the case (such as the interpretation of the EFM) without being given the benefit of the complete and pertinent facts of the patient’s history, prenatal course, gestational age, and labor progress. Later, when the consulting obstetrician is called in to intervene due to deterioration in the maternal or fetal condition, it is alleged that his/her involvement on a consultative basis began at the time of the curbside consult, and therefore responsibility for the management time and decision time is extended even though the consulted obstetrician did not have the opportunity to actively intervene at the time of the curbside consult.

Conclusion
The majority of courts are hesitant to extend liability to informal consultants as this places a chilling effect upon such informal consultations, which the majority of courts believe should be promoted as sound public policy. That said, COPIC believes it’s prudent to consider the above risk management advice.
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Drink your milk. A likely admonishment from your parents.

Maybe they were right. Milk is the number one food source of calcium and vitamin D, which have been identified by the 2010 Dietary Guidelines Advisory Committee as nutrients of concern – nutrients that Americans are underconsuming.

The Institute of Medicine’s new report, Dietary Reference Intakes for Calcium and Vitamin D, reiterates the importance of these two nutrients by increasing current recommendations. The report recommends that most Americans up to age 70 need 600 international units of vitamin D per day to maintain health, and those 71 and older may need slightly more – up to 800 IUs per day. As for calcium, recommendations range, based on age, from 700 to 1,300 milligrams per day (see tables below).

As for vitamin D status, the report states that total intake of vitamin D is below the median requirement, but that national surveys show the average blood levels of vitamin D are above the level the Institute of Medicine committee found to be adequate to support bone health. Despite interest in vitamin D’s role in cancer, heart disease, autoimmune disease and diabetes, as well as other diseases, the report cited evidence supporting a role for these two nutrients only in bone health, but not in other health conditions.

However, over-reliance on supplements can in fact be bad. That is why the American Dietetic Association, National Institutes of Health and the American Academy of Pediatrics believe that individuals should attempt to meet their nutrient needs through food first. While a calcium supplement may help you meet your daily calcium needs, you likely miss out on other important nutrients that foods provide. For example, together milk, cheese and yogurt provide eight other nutrients in addition to calcium. Nevertheless, in some cases, supplements may be warranted.

Meeting these new dietary recommendations is simply a matter of choosing nutrient-rich foods first. An eight-ounce glass of milk provides approximately 300 milligrams of calcium and 100 IUs of vitamin D. Three servings of dairy daily gets a person well on the way toward meeting these goals.

Additional tips for increasing intake of calcium and vitamin D include the following:

• Enjoy a wholesome glass of low-fat or fat-free milk with meals
• Top French toast with creamy vitamin D-fortified yogurt
• Sip a glass of calcium and vitamin D-fortified orange juice with breakfast
• Enjoy fatty fish, such as salmon and tuna, for its vitamin D punch
• Create creamy soups and sauces by adding milk instead of water
• Satisfy a sweet tooth with a cup of hot chocolate, made with milk, as an after dinner treat

Additional information on the Institute of Medicine report findings is available at www.iom.edu/calcium. Patient resources can be found at www.westerndairyassociation.org.
The Degree of Fellow recognizes American Academy of Family Physicians members who have distinguished themselves among their colleagues, as well as in their communities, by their service to Family Medicine, by their advancement of health care for the American people and by their professional development through medical education and research. Fellows of the AAFP are recognized as Champions of Family Medicine. They are the physicians who make Family Medicine the premier specialty in service to their communities and profession. From a personal perspective, being a fellow signifies not only “tenure” but also one’s additional work in the community, within organized medicine and within teaching, as well as a greater commitment to continuing professional development or research or both.

**CONGRATULATIONS to Colorado Fellows**

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**MEETINGS WITH RESIDENCY PROGRAM REPS ON FULL AGENDA**

Report on Family Physicians National Conference for Residents and Students

By Megan Tripp-Addison

Attending the 2010 American Academy of Family Physicians National Conference for Family Medicine Residents and Students was a fantastic experience. I truly enjoyed being surrounded by individuals who were as excited about the field of Family Medicine as I am.

While at the conference, I was able to participate in numerous activities. First, I attended the student congress with the student delegate from Colorado. While in the student congress, I learned about parliamentary procedure, heard annual reports from residents and students involved in the various committees, listened to candidate speeches and helped the delegate vote for candidates for national positions, and listened to, offered feedback on, and voted on student resolutions. I was also able to attend numerous lectures on topics such as how to get involved in the academy, health care reform, and applying to residency programs. Through both the student congress and the lectures, I was able to meet students and residents from across the country.

The social events at the conference allowed additional opportunities to spend time with students and residents and to learn more about their involvement in the AAFP.

Finally, I was able to meet with residents and faculty from Family Medicine residency programs across the country at the exposition hall. This was extremely useful as I was able to gather information about the different programs and ask questions about each, which was beneficial when deciding which residency programs to apply to this fall. I was also able to attend a dinner jointly hosted by all of the Colorado Family Medicine residency programs, which enabled me to learn even more about each of these programs.

Overall, attending the 2010 American Academy of Family Physicians National Conference for Family Medicine Residents and Students was an invaluable experience for me, and I greatly appreciate the Colorado Academy of Family Physicians’ assistance in enabling me to attend the conference.
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