IN THIS ISSUE:
The Colorado Prescription Drug Monitoring Program • Page 11

FIT FAMILY CHALLENGE UPDATE:
Addressing Pediatric Obesity in Colorado • Page 12

ACO – Opportunity Knocks! • Page 14

Physician perceptions of medical homes/medical neighborhoods: Growing awareness, increasing adoption • Page 19

The 2012 U.S. Immunization Schedule • Page 25

Keep Kids Safe This Winter • Page 27
Within our power, we are committed to providing the best hospice and palliative care experience available. That commitment is expressed in our Seven Point Pledge.

Evercare Hospice & Palliative Care pledges to:

1. Admit all hospice-eligible referrals the same day, unless requested otherwise. Patients deserve timely care and action, especially as they approach end-of-life.

2. Provide direct, extensive physician involvement in the care of each patient. Experts highly trained in hospice and palliative care are involved and available to make personal visits.

3. Achieve acceptable pain control on all patients. No patient should live in pain. That's why we place such an emphasis on delivering pain management in a timely and caring manner.

4. Respond to all patient-related calls within 15 minutes, 24 hours a day, 7 days a week. A patient's condition doesn't take a day off, and neither do we.

5. Provide a hospice staff presence at the time of death. We'll be there at this important time, as we have throughout the process, to provide comfort and support.

6. Maintain an Unrestricted Options Philosophy regarding patient admissions. We believe in making hospice care available to all those who are eligible.

7. Offer palliative care consults and advanced care planning services. These continuing health care services are important, so we offer expertise in both areas.

Questions?
For questions or referrals, call Evercare Hospice and Palliative Care at:

1-877-273-5534
www.EvercareHospice.com

Services are provided regardless of patient's ability to pay.

Evercare Hospice and Palliative Care is committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regards to race, sex, religion, color, age, national origin, disability, sexual orientation or other protected factor. Evercare Hospice and Palliative Care is offered by Evercare Hospice, Inc.

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Vision Statement: Thriving Family Physicians creating a healthier Colorado.

Mission Statement: The CAFP’s mission is to serve as the bold champion for Colorado’s family physicians, patients, and communities through education and advocacy.
In September I had the privilege of attending the 2011 Congress of Delegates. I was pleasantly surprised as to how positive this event was. We as a national academy are amazingly diverse with a lot of different views on the practice of medicine. I witnessed agreement on problems but disagreement on the solutions to them and disagreement on issues that inspired quite a lot of passion. What was amazing about all of this was -- even on the “passionate” issues -- all were allowed to speak and, as a rule, they were heard respectfully. Agreement was not always reached but the level of respect that was accorded to those who spoke about their passions was truly inspirational to watch. It is a true testament to our specialty that we can disagree with this degree of respect.

The highlight of the conference for me was getting to be part of the election of Colorado’s first American Academy of Family Physicians president, Jeff Cain M.D. I am proud to say that the whole process proceeded with Dr. Cain handling the stress and politics with poise and dignity. The election was a testament to the CAFP’s staff, Colorado’s Family Physicians (many who flew in just to lend their support) and, of course, Dr. Cain. His election showed teamwork in action and was proof when we work together great things happen.

It is my opinion that teamwork is right now the foundation we need to improve health care for all people of Colorado. I hope we can build on this to accomplish all the changes that need to occur in our world of medicine. The bright spot in Colorado right now is that I am not the only one that recognizes that we will accomplish so much more if we all work together. As I was reading the Colorado Medical Society journal for September, I was happy to see an article by CMS’s new president, F. Brent Keeler, MD, pointing out how important it is going to be for Colorado physicians to work together. Dr. Keeler echoed the sentiment I witnessed at the Congress of Delegates. He very eloquently pointed out that we can have multiple points of view and still work together to accomplish positive changes. In fact he recognized diversity as an advantage and not liability.

As we move into this year’s legislative session I would like to keep teamwork as theme. Team doesn’t mean we have to agree on everything. We need to hear all your opinions. It is especially important if you are passionate about a subject. I will make a plea to all of you to sign up for Doctor of the Day at the Capitol. It supports the Family Physicians of Colorado and is your chance to help make sure our voices are heard. Together we will be the strong medicine Colorado needs.
WE NEVER SAY NEVER.

At National Jewish Health, we never say never. It’s one of the reasons we’re the nation’s number one respiratory hospital.* Our innovative approaches to treating children with asthma and allergies can help your child breathe easier. So don’t let severe or even mild respiratory problems hold your child back. Call 1.800.621.0505 to make an appointment or visit njhealth.org.

*U.S. News & World Report Best Hospitals Rankings
Opportunities for Participation Abound

As I am beginning my 25th year with the Colorado Academy of Family Physicians, I want to take this opportunity to thank you, the CAFP members, for making this organization strong, and for all of your contributions to improving the health of the people of Colorado. And thank you for the opportunity to fill my life with purpose and passion for Family Medicine.

The CAFP has a national reputation for being on the cutting edge of innovative ideas and for seeing them implemented in this state. I hope that more of you will consider being a part of our work and join the CAFP committees and board of directors. As indicated below, opportunities for participation abound.

**Extreme Makeover webinar**
What: “Extreme Makeover, HER Edition,” a Patient Centered Medical Home webinar
Presenters: Colorado Academy of Family Physicians and John L Bender, FAAFP
When: Jan. 24, 2012, 12:15-1:30 p.m.
Etc.: “Wanting something else in Family Medicine … Extinction or Evolution, you decide.”
Details coming soon.

**4th Annual medical student reception and dinner**
What: The Colorado Academy of Family Physicians and the American College of Osteopathic Family Physicians, Colorado Chapter, invite you to a fun evening with great food. Meet Colorado’s Family Physician leaders, speak informally with Family Physicians from around Colorado, and ask questions of Family Physicians from around the state.
Each Family Physician will be assigned to a table with seven medical students where they will have the opportunity to discuss the career of Family Medicine.
Presented by: Colorado Academy of Family Physicians and American College of Osteopathic Family Physicians, Colorado Chapter
When: Friday, Jan. 13, 2012, 6:00 – 8:30 p.m.
Where: The Summit Conference & Event Center, 411 Sable Blvd., Aurora, CO 80011
Fee: Open to the first 70 students at no charge
$20 to bring an extra person
Seating is limited. Please reserve early.
Send an email to eleanor@coloradoafp.org with your rsvp. Questions? Please call Eleanor at 303-696-6655, ext. 17.

**Doctor of the Day**
The Colorado Academy of Family Physicians began the Doctor of the Day program 18 years ago. This volunteer-based program provides an invaluable service to elected officials and staff at the Capitol, and also serves as an effective public relations tool between doctors and legislators.
Right now, CAFP is the sole provider group at the Capitol offering high quality health care to legislators, staff and visitors. If we aren’t there to fill this critical role, several other provider groups are eager to take our place. Help us protect this incredible market advantage by signing up today!
Dates: Wednesday Jan. 11 – Wednesday May 9, 2012
Times: Monday: 9:45 a.m. – 4:30 p.m., Tuesday – Thursday: 8:45 a.m. – 4:30 p.m., Friday: 8:45 a.m. - noon
Where: Colorado State Capitol – 200 E. Colfax, Denver
How: Sign up on line at www.coloradoafp.org. Click on Doctor of the Day.

**Graduation banquet for third-year residents**
The Colorado Academy of Family Physicians will host its inaugural graduation banquet for third-year Family Medicine residents to celebrate the hard work and accomplishment of the graduating class of 2012 and to welcome them into their career as Family Physicians. The event will provide an opportunity for practicing physicians to honor the past and look to the future as the academy continues to ensure Family Medicine thrives in Colorado.
The reception will be held May 18 at Maggiano’s in downtown Denver and will be complimentary for the graduating residents and one guest per resident. A block of rooms will be available at a reasonable rate near the restaurant for those who would like to make a full evening or weekend of the event.
Those with questions or wishing to RSVP may contact Eleanor Mills at Eleanor@coloradoafp.org or at 303-696-6655, ext. 17.
Upcoming webinars on immunizations

Robert Brayen, MD, will present two webinars on immunizations. Both will take place at noon. On Thursday Feb. 2 the topic will be “Immunization Schedule 2012: Providing All of the Needed Vaccines to Your Patients.” On Wednesday May 23 the topic will be “Vaccines in the News.”

Colorado Medical Home Coalition
The CAFP is participating in the Colorado Medical Home Coalition. The vision and mission of the group is as follows.
• Vision: All Coloradans have access to and experience a patient/family-centered medical home.
• Mission: Unite partners and efforts to strategically promote a medical home approach statewide.

University of Colorado Denver and Health Sciences Center

Department of Family Medicine Assistant Professor
Faculty – Rose Family Medicine Residency
Job Posting #81572– Position #701113

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 competence 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 jobs descriptions and qualifications required can be found at jobsatcu.com and the Department’s website, http://fammed.ucdenver.edu/home/careers.aspx.

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/phs/
Applications are accepted electronically at www.jobsatcu.com.
Review of applications will begin October 3, 2011 and continue until position is filled.
When applying at www.jobsatcu.com, applicants must include:
1) A letter of application which specifically addresses the job requirements and outlines qualifications.
2) A current Curriculum Vitae
Questions should be directed to regina.garrison@ucdenver.edu.

The University of Colorado Denver and Health Sciences Center requires background investigations for employment. The University of Colorado is committed to diversity and equality in education and employment.

REGISTER FOR THE CAFP’S ANNUAL SCIENTIFIC CONFERENCE APRIL 19-22, 2012 WWW.COLORADOAFP.ORG

CAFP MEMBERSHIP STATS

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National Health Service Corps  By Eleanor Mills

Are you looking for help with your school loans? Do you want a health care job you’ll never forget?

Look no further! The National Health Service Corps is here to help and the Colorado Academy of Family Physicians is pleased to announce that we now have an NHSC ambassador on staff to work with you one on one!

What is the National Health Service Corps?

- NHSC helps build healthy communities by connecting health care professionals to areas with underserved or limited access to care.

- In return, the NHSC can help with scholarships for medical students, loan repayment for all health care professionals and job placement throughout the United States.

- The NHSC is a Federal government program that is part of the U.S. Department of Health and Human Services, or HHS. Specifically, the corps is administered by the Health Resources and Services Administration (HRSA), Bureau of Clinician Recruitment and Service (BCRS).

- Today, there are more than 10,000 NHSC members providing culturally competent care to more than 10.5 million people. This care is provided at more than 17,000 NHSC-approved health care sites in urban, rural and frontier areas.

- NHSC helps ensure access to health care for everyone.

What does an NHSC ambassador do?

- Ambassadors can help every step of the way. They are there to help medical students, residents and active physicians get scholarships, loan repayment and job placement.

- Once a health care professional is an NHSC member, the ambassador is always a local resource for additional opportunities, questions or concerns.

How can I get more information?

- Contact us! Eleanor Mills is the NHSC ambassador for the CAFP. Contact her anytime at: eleanor@coloradoafp.org

2224 S Fraser St. Unit 1, Aurora, CO 80014
(P) 303-696-6655 ext. 17
(F) 303-696-7224

- Information is also available at www.nhsc.hrsa.gov.

CAFP PROPOSED BYLAWS CHANGE

Notice of this proposed bylaws change is being included in this magazine to inform all CAFP members. Questions and comments can be directed to Raquel J. Rosen, 303-696-6655, ext. 10, Raquel@coloradoafp.org.

Article 1, Section 4

Any former active member of the Academy who is dropped from membership may apply for membership as a new member in accordance with Section 3 of this chapter. If such an application is made less than two years after having ceased to be an active member, the applicant must furnish evidence of completion during the two years immediately preceding the date of application of one hundred (100) credits of postgraduate study acceptable to the Board of Directors; except that such an applicant who was a resident member in good standing and automatically upgraded to active status upon completion of residency training but never paid dues as an active member shall not be required to satisfy this postgraduate study requirement upon reapplication within two years of completion of residency training.
Brian Bacak, MD, was promoted during the summer of 2011 to the rank of associate professor at the University of Colorado School of Medicine. Raquel Judith Rosen, chief executive officer of the Colorado Academy of Family Physicians, called his service on the CAFP board of directors “praiseworthy.”

In a letter to Frank deGruy, MD, chair of the Department of Family Medicine, Rosen wrote that, in addition to serving on the board of directors, Dr. Bacak was president from July 2009 through June 2010.

“The CAFP was very fortunate to have Dr. Bacak as its leader during this time to steward the organization through some difficult issues, including primary care workforce issues in Colorado, and patient safety/tort reform,” Rosen stated. “Due to Dr. Bacak’s clear thinking, ability to research the issues and come up with brilliant solutions, and to state the CAFP’s positions clearly and accurately, the CAFP was successful in defending and protecting what was best for Family Medicine and their patients. He is consistently professional, patient, and calm under pressure and is therefore able to answer questions from the opposition and build consensus. His efforts were very meritorious, outstanding, and courageous. He has really saved the day on many occasions for the CAFP.”

Rosen also stated, “It is a pleasure to work with such a warm, caring person who is also a strong, innovative leader.”
The 2012 legislative session is right around the corner and everyone is busy preparing legislation. This session, the Colorado Academy of Family Physicians is working on a data collection bill. Last year, a similar bill (HB11-1152) was introduced in the legislature and championed by the Colorado Rural Health Centers. Unfortunately the bill did not pass, so this year the Colorado Rural Health Centers have asked CAFP to work in conjunction with their efforts.

So far, this bill has received much more positive feedback about the bill from both chambers in the legislature and from both parties than last year’s bill. The bill will be introduced with bi-partisan sponsorship and therefore we anticipate a more successful outcome than last year. Rep. Ken Summers, a Republican from Lakewood and chair of the House Health and Environment Committee, Sen. Ellen Roberts, a Republican from Durango, and Sen. Betty Boyd, a Democrat from Lakewood and the chair of the Senate Health and Human Services Committee, have all agreed to champion the data collection bill and they are also optimistic about its passage.

The language of the bill is very similar to the language in the version that was introduced last year, with some minor changes. The bill directs the Department of Regulatory Agencies, called DORA, to collect workforce data through the licensure process. This would require certain health care professionals to provide information regarding: practice location, practice setting, specialty, education/training, age and number of hours providing direct patient care. It would also create a voluntary, uncompensated advisory group including affected professionals that will develop the workforce data questions. Additionally, professionals included in the bill are all eligible for loan repayment through the Colorado Health Service Corps, including medical, mental/behavioral, and oral health providers.

The goal of this legislation is to show an accurate picture of Colorado’s health care workforce. Currently, efforts to address Colorado’s health care workforce shortages are limited by a lack of reliable and available data on our existing workforce. In other words, we don’t have a good picture of who is practicing where in our state. The only way to guarantee complete data is through the licensure process. Voluntary surveys, on which we are currently forced to rely, have low rates of return and account for the insufficient data we have now.

Health care is an economic engine for Colorado. Health care workforce development is economic development. But we can’t develop the workforce strategically if we don’t know whom we need and where we need them. Access to reliable information will simplify and improve existing state efforts to quantify its health care workforce, identify current and future gaps, and inform planning activities to ensure an adequate supply for the future. The academy is excited about the progress we have made thus far with this legislation, and we look forward to a successful outcome!
The rules associated with Colorado’s Prescription Drug Monitoring Program, or PDMP, were changed effective July 2011 to include the following key elements:

- If you write prescriptions for controlled substances, you must now tell your patients that their identifying prescription information will be entered into the PDMP database.
- State regulatory boards can now query the database, provided certain conditions are met.

Who can access this information?

Any licensed practitioner authorized to prescribe controlled substances may register and query the PDMP database as it relates to a current patient to whom the practitioner is prescribing, or considering prescribing, a controlled substance. Keep in mind, patient information entered into the PDMP is part of that person’s medical record. It’s subject to all laws regarding the release, sharing and use of medical records and health information.

Can my prescribing information be used against me?

The only way your prescribing data in the PDMP will be released is if you are the subject of an investigation by law enforcement or a regulatory agency. Law enforcement officials and state regulatory boards (as of July 2011) can query the database only if the information released is:

- Specific to an individual patient or prescriber;
- Is part of a bona fide investigation; and
- The request for information is accompanied by an official court order or subpoena.

As a physician, what actions do I need to take in terms of patient notification?

The regulations stipulate that you must notify patients receiving prescriptions of controlled substances of the PDMP. This can be communicated verbally, through a written handout, or through a sign posted in a visible patient-area in your practice. At a minimum you need to communicate the following: If you receive a prescription for a “controlled” (Schedule II through V) drug, your identifying prescription information will be entered into Colorado’s PDMP database when this drug is dispensed to you and may be accessed for limited purposes by specified individuals.

The following is suggested language to use for informing patients:

**Patient Handout**

You are being given a prescription for a “controlled” (Schedule II through V) drug. Your identifying prescription information will be entered into Colorado’s Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you. Your prescription information in the database is a protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

**Posted Signage**

If you receive a prescription for a “controlled” (Schedule II through V) drug, your identifying prescription information will be entered into Colorado’s Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you. Your prescription information in the database is a protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

What are important PDMP risk management guidelines that physicians should be aware of?

- Do not share your PDMP password with others. There are substantial fines for inappropriate system access, and the system is capable of determining whose login credentials accessed what physicians’ or patients’ information in the system. You should only access the PDMP when a legitimate physician-patient relationship exists and you are contemplating prescribing — or already prescribe — a controlled substance to that patient.
- Providers who are seeing the same patient and concurrently prescribing controlled substances can alert those prescribers to access the PDMP by using their own login. This information cannot be shared with others who do not have a legitimate physician-patient relationship with that patient and who are not prescribers of controlled substances.
- Law enforcement can access the information only as part of an authorized investigation. Prescribers cannot share their PDMP data with law enforcement prior to an authorized investigation.
The Colorado Academy of Family Physicians Fit Family Challenge is a pediatric obesity initiative that aims to reduce childhood obesity in Colorado by integrating childhood obesity guidelines and implementation of a primary care office-based intervention into clinical settings across Colorado, with a focus on rural and underserved populations. The Fit Family Challenge, or FFC, screens for pediatric obesity and identifies lifestyle habits that may put a child at risk for obesity. These habits may include low fruit and vegetable intake, greater than two hours per day of screen time, less than one hour/day of physical activity, and high intake of sugar-sweetened beverages.

Children aged 6 to 12 years who have a body mass index, or BMI, in the 85th or higher percentile are invited to participate in the challenge. Participation involves 1) weekly contact and goal-setting with the child’s primary care practice; 2) attendance at a monthly group visit with a parent(s) and other family members; 3) collection of weekly goals; collection of monthly weight, height, and blood pressure; and collection of baseline, six-month, and 12-month weight, height and blood pressure, and completion of a lifestyle habits survey. In addition, the challenge program provides training and support for practice providers on screening for childhood obesity, patient-centered counseling including motivational interviewing, and ongoing technical support.

We continue to make strides towards our deliverables and progress has been made through the following goals: 1) development of the FFC Clinical Guide, 2) development of the FFC Facilitators’ Guide for Group Visits, 3) development of the FFC Family Guide for Group Visits, 4) utilization of HeartSmart Kids technology to screen children for lifestyle habits, 5) enrollment of 14 primary care clinics across Colorado, 6) one-day training for practices on the FFC, motivational interviewing, implementation of the HeathTeamWorks Childhood Obesity Guideline, and use of the Heart SmartKids technology, 7) enrollment of approximately 150 children into the program across the 14 practices, and 8) ongoing project team support through monthly conference calls with the practices and site visits.

Through the commitment of primary care physicians and health professionals alike, challenge leaders are optimistic over the impact that can be made on pediatric obesity in the primary care setting. As a commitment to efforts to making Colorado children healthy, the CAFP will submit a grant proposal in early 2012 to expand the work of this initiative.

Additional information is available by contacting: Cara Coxe, CAFP Wellness Programs Manager, 2224 S. Fraser St., Unit 1 Aurora, CO 80014; by phone at 303-696-6655 ext. 14; or email, cara@coloradoafp.org.
Protecting your practice is not a game.

Our financial solutions keep you safe, not Sorry.

Patient care is your mission. And keeping your practice in top financial health is necessary to fulfill it.

COPIC Financial Service Group optimizes your progress toward financial health, while avoiding and overcoming challenges. Our solutions include a broad range of reliable insurance tools for doctors and health care organizations. These personal and business products not only help protect your practice now, they help to ensure a strong future for you and your staff.

Experienced and resourceful, our professionals research the industry to find the best possible coverages and precisely tailor them to your unique needs. COPIC Financial facilitates the process from beginning to end, making sure you receive personalized, professional service.

While you’re taking care of patients, we’ll be taking care of you.
Opportunity knocks! When I play the board game Monopoly, I always like to get the “Opportunity knocks!” card. It gives me strategic advantages in the game that I can use at the time or at some point later in the game. Not unlike that, the Accountable Care Organization, or ACO, model gives primary care doctors a strategic advantage we have not known in many years.

Momentum is building to change the health care reimbursement system and Family Physicians stand to benefit if we act. Though leaders in health care, Harold Miller and Bo Bobbitt, have been touting the role of Family Physicians in a changing health care environment that will reward quality over quantity. There are savings to be gained AND shared in our health care system. Community Care of North Carolina, or CCNC, saved the state of North Carolina $1.5 billion in Medicaid expenses since its inception, according to Bobbitt in an Oct. 19 live webinar hosted by the CAFP. The savings cancel fee cuts dollar for dollar if CCNC continues to save additional money. That organization, headed by a group of innovative Family Physicians, shared the savings with primary care doctors whose efforts saved the money. The Community Care physicians weren’t one and done, however. They continued to save Medicaid money and by showing continued savings compared to the costs of the usual and customary model of care, they shared in the savings.

Cost cutting in health care is inevitable. According to Bobbitt, our economy simply can’t support “business as usual.” At the present rate, in 2035, Medicare and Medicaid will spend 13 percent to 14 percent of the gross domestic product. Nineteen percent of the GDP is all government can collect. That leaves only 5 percent to 6 percent of the GDP for our infrastructure, defense, law enforcement, education, judicial system and other expenses. The present growth is unsustainable.

Community Care of North Carolina didn’t reinvent the wheel. They just allowed Family Doctors and primary care doctors to do what we do best, take care of folks. They focused on populations of patients who were sickest. The model Community Care and now others employ uses low-tech methods with high stakes for their state’s economy and the people they serve.

There are excuses galore to be cynical about the ACO concept, according to Bobbitt, and he has heard them all. In other words, he’s been to the dentist and knows that drill. (Thanks, Walt Larimore, for that one!). The fact is we have an opportunity to take leadership as primary care physicians. The job before us is not easy. Change is hard; but if you think change is hard, try being irrelevant.

This truly is our time as Family Physicians. I am reminded of the lyrics to “Light My Fire” by The Doors. “The time for hesitation’s through. There’s no time to wallow in the mire …” Educate yourself. Learn about the eight essential ingredients of a successful ACO and how to judge if participation in a particular ACO is for you. Learn more about “next steps” through the webinars that are posted on the CAFP website, www.coloradoafp.org. Go to CME PROGRAMS on the left side of the home page and click CAFP Webinars in the drop down menu.

The 2012 Colorado Scientific Meeting in Colorado Springs in April will feature Bobbitt and sessions on the Patient Centered Medical Home. We have a window of opportunity to make a difference. Get educated. Get excited. Get involved.
Accountable Care Organizations, or ACOs, or some collaborative care version thereof, are coming. Our current health care payment system is simply unsustainable, and provider-driven collaborative care with value-based reimbursement is the single most promising option. It is also becoming clear, with more data available on the high impact of Patient Centered Medical Homes as the core of successful ACOs, that Family Physicians can have a meaningful role in the accountable care movement. In fact, Family Physicians have an opportunity to lead in ACO development. Some Family Physicians have stepped up to leadership and have been very successful. Others want to but do not know where to start. There is no precedent for this.

What does Family Physician ACO leadership really mean?

Thanks to CAFP resources, you have a leadership toolkit available. The fundamentals are summarized below:

1. **Be the Most Prepared Person In the Room.** There are practical, step-by-step resources available at no charge to members, which break down each element into understandable parts. They are tailored to the Family Physician, whether employed by a health system or independent. You truly can become one of the most knowledgeable persons regarding ACOs in a matter of hours, not weeks. Before you lead, you must understand. As you start meeting regarding a particular ACO or collaborative care initiative, your knowledge and positive informed contributions will earn you the respect and confidence of others—foundations upon which leadership rests.

2. **Operate Out of Your Silo.** Accountable care is a team game. Network intentionally with other primary care physicians, specialists and hospital administrators. Seek out ways to interact. There is a window of opportunity for the physician willing to bridge gaps.

3. **Practice Quiet Leadership.** No need to seize the podium and tell others what to do. That will backfire, of course. Facilitate discussions; ask leading questions of others of what they think. Convene breakfasts with members of the medical staff in your community. Engage hospital leadership. An informed primary care physician ACO champion soon will be a much-desired commodity. Lead from behind, as it were. Your goal is to increase awareness and buy-in to a win/win vision, and, ideally, it should be the group consensus. You do not need or want to be getting the credit.

4. **Exercise Due Diligence.** Find out what is going on. What is out there? Are there medical home networks forming ACOs in your state? What is Medicaid considering? What are the payors considering? Your hospital? Evaluate these proposals against the CAFP’s *The Family Physician’s ACO Blueprint for Success* to see their strengths and flaws.

5. **Be Wise About Who Will Welcome Your Leadership.** Public and private payors want higher quality at lower cost. They are coming to understand the advantages of the medical home-centric ACO in achieving these goals. They are more open to the primary care medical home leadership. Enlightened specialists and hospitals are embracing primary care leadership for the same reason. They want to ride the winning horse, and the medical home-centric ACO is often that choice. Others, not enlightened, do not welcome loss of control and will resist.

Will it be worth it?

In our experience, Family Physician leadership has clearly been worth it to those physicians for four main reasons: their ACO or collaborative care organization is more likely to be successful. Its savings pool will be bigger and outcomes better. It has been enjoyable to restore multi-specialty collegiality from medical school. Lastly, their contributions are more valuable and ACO payments based on contributions are correspondingly more substantial.

Julian D. Bobbitt Jr., JD is an experienced ACO legal counsel who has been retained by the CAFP to assist members in preparing for the ACO era. This article is one of a series on practical strategies for the Colorado Family Physician.
As physicians, politicians and much of the public now realize, the alarming rise in American health care costs is unsustainable. Our current path will bring financial ruin upon the nation or drastic fee cuts for medical providers. Change, though essential, seemed impossible. But thanks to a surprisingly responsive federal bureaucracy, there is real promise in a pro-Family-Medicine model: accountable care.

The newly released final rule for the federal Medicare Shared Savings Program, which corrects potentially fatal flaws in earlier proposals, offers auspicious opportunities to Colorado’s primary care physicians interested in joining or launching Accountable Care Organizations.

ACOs are widely touted as a way to address the fragmentation, duplication and perverse financial incentives plaguing America’s health care system. ACOs are groups of providers who are jointly held accountable financially for meeting quality benchmarks and reducing the rate of spending growth.

The concept gained momentum initially after the Medicare Shared Savings Program was included in the 2010 federal health reform legislation. Because Medicare is the nation’s largest payor, it was predicted that if Medicare shifted to ACOs, the whole health care system would transform.

However, many gave up on ACOs after the Secretary of the Department of Health and Human Services issued the proposed rule for the Medicare Shared Savings Program on March 31, 2011. It was cumbersome, ineffective and ultimately unworkable.

Organized medicine, including the American Academy of Family Physicians, the American College of Physicians and the American Medical Association, joined most of the other 1,320 public comments in suggesting numerous improvements to the proposed rule. They objected that its requirements were onerous, the capital investments required were excessive, and all ACOs were required to accept risk of financial loss—all virtual deal-killers for primary care physicians. Hope for the benefits from ACOs evaporated.

However, on Oct. 20, 2011, HHS issued the final rule for the Medicare Shared Savings Program. On the same day, it launched the Advance Payment Model. Initial reactions from primary care leaders have been favorable. The general view is that the final rule could truly be a “game-changer” for the prepared Family Physician.

Glen Stream, MD, MBI, president of the American Academy of Family Physicians, stated that “the Medicare final rule recently released by the Centers for Medicare and Medicaid Services represents substantial steps toward mending America’s broken health care system.”

What happened? Although the final rule is 696 pages of legalese, it is clear that HHS was intent on making ACOs more practical and profitable, particularly for primary care physicians and rural providers.

Primary-care-friendly highlights include:

- **Medicare Pays Your Investment Costs:** The Advance Payment Model will prepay a portion of the anticipated shared savings to qualifying ACOs that are basically provider-only or are in rural settings. The payment may be upfront and fixed, variable, or on a per-member/per-month basis. This could remove a serious barrier to entry for the typical medical-home-centric ACO.

- **Only One Specialty Required—Primary Care:** As was mandated by the statute, the final rule has been faithful to the edict that primary care physicians are the only specialty or facility that must be in all Medicare ACOs. Internal medicine and Family Practice are mentioned specifically. In addition, although primary-care-only medical home-centric ACOs are allowed, all ACOs must have processes for transitioning patients to specialists and hospitals.

- **No Risk of Loss:** Commentators noted that a new ACO cannot know or control all the cost variables to allow it prudently to accept risk of financial loss. HHS listened, and now ACOs will be allowed to receive a hefty 50 percent of savings without taking any risk of loss for the full length of the three-year contract with CMS. This is in addition to full fee-for-service payments.

continued on page 18 >>>

By Julian D. Bobbitt, Jr., J.D.

**The ACO Final Rule – Wow!**

*It’s really happening. Now what do I do?*

CAFP NEWS
A well established rural Colorado family practice is seeking a BEBC family physician. OB interest and experience required, C-section training desirable. Part-time or Full-time
Send CV to famphy99@yahoo.com
Less Hassle: The onerous original 65 reporting requirements were reduced to 33 quality measures, with relaxed timetables for implementation.

No Mandatory EHR: Though encouraged, electronic health record usage is no longer required.

Primary Care Weighted Metrics: There is a clear preference for outpatient metrics. This is further evidence of the primary care tilt of the final rule. In other payment settings, such a shift in focus has often been a precursor to a concomitant weighting to primary care of the shared savings distribution.

Meritocracy In Payment Distributions: The savings pool distribution allocation is not fixed, so there is some cause for caution by physicians joining an ACO. But the distribution formula must be transparent to all, and the ACO must justify how it creates incentives to meet the rule’s goals for ACOs.

Bottom Line: Family Physicians Will Have Choices

Yours is the only specialty mandated. Your skills will drive many quality and savings improvements. CMS is offering upfront dollars to build ACOs, and the quality benchmarks are tilted toward primary care.

These favorable factors combine to provide the informed primary care physician with attractive options and encouraging opportunities to help lead the improvement of America’s health care system. The final ACO rule might well create the tipping point in its transformation to reward value, not volume, and be a game-changer for the rising role of primary care.

CAFP has the ACO blueprint ready for You

Fortunately, The Family Physician’s ACO Blueprint for Success, co-underwritten by the CAFP, anticipated almost exactly where these final rules and ACO trends involving payors other than Medicare, ended up. This is the foundation for a series of articles, webinars and lectures specifically tailored to optimizing the Family Physician’s role and success in the accountable care era. These are free as member benefits to CAFP members.

Julian D. “Bo” Bobbitt, Jr., JD, is a senior partner and head of the Health Law Group at the Smith Anderson law firm in Raleigh, N.C. He has many years’ experience assisting physicians in forming integrated delivery systems. He has spoken and written nationally to primary care physicians on the strategies and practicalities of forming or joining ACOs. He is author of the CAFP’s The Family Physician’s ACO Blueprint for Success and will be presenting at the CAFP Annual Scientific Conference April 19-22. This article is meant to be educational and does not constitute legal advice. For additional information, readers may contact the author at bbobbitt@smithlaw.com or 919-821-6612.
Two years ago the Colorado Medical Society set out to help improve the quality, efficiency and accessibility of health care in Colorado by educating and engaging physicians on ways to enhance systems of care. An initiative was begun focusing on advancing Patient Centered Medical Homes and Medical Neighborhoods and a 2009 statewide physician poll served as a call to action for this work. Analysis of a follow-up statewide physician poll shows progress over the last two years, demonstrating a high degree of awareness of the medical home model and an embrace of a patient-centered approach to care by physicians across the state. It also identifies opportunities for improvements moving forward.

The data highlights the impact of the Systems of Care/Patient-centered Medical Home Initiative, a collaboration among the Colorado Medical Society, Colorado Academy of Family Physicians, American Academy of Pediatrics Colorado Chapter, Colorado Society of Osteopathic Medicine, American College of Physicians Colorado Chapter and Health TeamWorks. Over the last two years the initiative reached out to more than 4,200 physicians and other health care professionals. Primary care physicians were specifically targeted to build out Patient Centered Medical Homes as a way to support comprehensive, continuous relationships that coordinate all health services in a quality, cost-effective and accessible manner. Work with non-primary care specialty physicians focused on connecting to a PCMH and building supportive medical neighborhoods to coordinate and deliver high quality, safe care.

**KEY FINDINGS**

A web-based survey was administered in 2009 to establish a baseline of physician awareness about PCMH/medical neighborhoods, what activities physicians were using to pursue these strategies and why they were adopting these changes. Results from the 2011 follow-up survey indicate that there has been substantial progress in improving physician awareness of the Patient Centered Medical Home model. Corresponding behaviors and attitudes are also trending upward. (Figure 1)

Primary care physicians in particular saw an across-the-board increase in awareness from 39 percent being “very familiar” in 2009 to 60 percent in 2011, and overall PCPs being “very” or “somewhat” familiar increased from 80 percent to 90 percent. Among primary care respondents, underlying activities that support the medical home, like health information technology, delivery system design and quality improvement also saw double-digit increases in the adoption rates. Beyond increased awareness, it appears that there is a consistent, positive trend among primary care physicians towards acceptance and adoption of the medical home model as evidenced by the likelihood of adoption. In 2011, 57 percent indicated that would likely become a PCMH; 39 percent indicated they would “definitely” (up from 25 percent in 2009) and 18 percent indicated “probably” (down from 31 percent) with a corresponding positive shift among those that continued on page 20 >>>
indicated “maybe” up 20 percent up from 16 percent (figure 2).

Non-primary care specialty physicians saw a corresponding increase in awareness with 57 percent stating that they are “very” or “somewhat familiar” with the medical home model in 2011 as compared to 39 percent in 2009. While this represents a substantial increase in familiarity among non-PCPs, there appears to be less movement in terms of adoption or changes in attitudes or behaviors by specialists that support a medical home approach.

When asked about the benefits of the medical home, both primary care and specialty care rank care coordination, patient satisfaction and patient outcomes as desirable outcomes, which indicates a high level alignment within the profession around models that provide well coordinated, patient-centered high quality care (Figure 3).

Coordination of care continues to be a major area of importance among both primary care and specialty care. Only 21 percent of PCPs and 24 percent of non-PCPs are “totally” or “very” satisfied with coordination of care. Most concerning is that physicians report receiving necessary information from referrals less than half of the time (Figure 4). Colorado results mirror national studies that find 69.3 percent of the time PCPs perceive that they send notification of a patient’s history and reason for consultation to specialists, while the reality is that 34.8 percent of the time specialists report receiving it “always” or “most of the time.” Likewise, specialists indicate that they send consultation reports back to primary care physicians 80.6 percent of the time, while PCPs report receiving it 62.2 percent of the time (Arch Intern Med. 2011; 171(1):56-65.). Looking forward, the most recent physician survey found that care coordination is a common pain point for physicians and offers opportunity for innovative and collaborative solutions.

Conclusions
While there has been significant progress around awareness, there is still important work to be done to increase adoption. Primary care physicians have a high degree of awareness about the medical home, although varying degrees of engagement with making the leap towards becoming a medical home. PCPs are looking for concrete tools, payment reform and efforts to build a critical mass around the medical home model to ensure that it is embedded in new health care delivery systems. Specialty care physicians are often still learning about the medical home and medical neighborhood approaches for the first time. Consequently they are trying to figure out where they fit into the overall picture. To many
specialists, its unclear if this model works in all settings and they are looking for more information before embracing the medical home approach.

One of the questions continually raised is why should a specialist consider the medical home? Isn’t the medical home largely a primary care priority? Recent policy developments link the characteristics of the medical home to underlying capabilities and competencies of payment reform strategies and integrated system capabilities. Physician practices need to be aware of those components and work to evolve their practices to achieve high quality, well-coordinated, patient-centered care.

Additional information about this survey is available by contacting Frederick-Gallegos in the Colorado Medical Society offices at Karen_Frederick-Gallegos@cms.org or 720-858-6323.

The SOC/PCMH Initiative was generously funded by the Colorado Health Foundation. The Colorado Health Foundation works to make Colorado the healthiest state in the nation by investing in grants and initiatives to health-related nonprofits that focus on increasing the number of Coloradans with health insurance; ensuring they have access to quality, coordinated care; and encouraging health living. Additional information is available at www.ColoradoHealth.org.

Karen Frederick-Gallegos is director of Quality Initiatives for the Colorado Medical Society. This article was originally printed in Colorado Medicine for September/October 2011.
Evaluation and management of back pain in adolescents

Back pain is among the most common musculoskeletal complaints that prompt visits to primary care physicians by adolescent patients. Episodic back pain will occur in more than 50 percent of teenagers, with about 10 percent of those having persistent symptoms affecting their daily lives. Fortunately, most back pain is benign and caused by inflexibility and core muscle weakness. Simple measures including education on core fitness activities, including stretching and strengthening, are usually quite successful in resolving the most common types of muscular back pain. Initial diagnosis and management of back pain in adolescents can almost always be well managed by primary care physicians.

A thorough history usually allows the provider to narrow the differential diagnosis of back pain even before confirming with physical examination (Table 1). The key to a good history is to understand the quality of the pain and most importantly evaluate for “red flag” symptoms. These symptoms include regular night pain causing awakening, leg pain > back pain, numbness or paresthesias in the legs, urinary or fecal incontinence, pain severe enough to cause the child to miss school or play activities, and pain that is increasing in severity. On examination, red flag signs include objective sensory deficit, objective motor deficit and asymmetric deep tendon reflexes. Positive red flag signs or symptoms should prompt referral to a spine specialist. In general, it is recommended to defer obtaining advanced imaging such as MRI or CT scan until evaluation by a spine specialist.

Hallmarks on examination of patients with muscular back pain are lumbar and lower extremity inflexibility. A simple test of lumbar flexibility is to ask patients to flex forward with their knees extended and attempt to touch their toes. Healthy patients will easily be able to touch their fingertips to the ground; those with inflexibility will not be able to do so. Measurement of the distance from fingertips to ground can be used to monitor progress with physical therapy. Hamstring tightness is also common in patients with muscular back pain and can be assessed by placing patients supine, flexing their hips to 90 degrees, and then extending the knees. Patients with tight hamstrings will have limited ability to extend their knees and this too can be followed to monitor progress with physical therapy. Finally, patients with muscular back pain will not have any objective deficits in their sensory or motor examination of the lower extremities and will have symmetric deep tendon reflexes at the patellar and Achilles tendons.

Imaging with plain radiographs is not necessary with symptoms less than one month in duration and in the absence of any red flag signs or symptoms. In general, however, most patients present with more chronic symptoms. Radiographs should be evaluated for signs of infection or tumor, such as abnormal lucencies, loss of disc space height, and vertebral body collapse. Spondylolysis is the most common radiographic finding in patients with back pain, although it remains far behind muscular back pain as a cause of symptoms in adolescents. Spondylolysis is usually caused by stress reaction of the pars interarticularis, which is the bony connection between the superior and inferior articular facet of the lumbar vertebra. It is present in 5 percent to 10 percent of the population. The prognosis is excellent for most types of spondylolysis and initial treatment is identical to that for straightforward muscular back pain. Primary care physicians should feel comfortable initiating

Differential Diagnosis for Back Pain in Adolescents

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What does it take to be Children’s Hospital Colorado?

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Children’s Hospital Colorado, a nationally ranked pediatric hospital, offers 15 locations with pediatric services including emergency care, urgent care, pediatric specialty clinics, therapy care, diagnostics and observation.

childrenscolorado.org/locations
A Letter to Fathers

By Bob Brayden, MD

A mother and baby came to Children’s Hospital Colorado recently for routine well baby care. The baby had several relatively minor medical problems. But what troubled me was that the mother stated that the father had instructed her to refuse vaccination for the baby. The mother followed the father’s wish, but interestingly stated that she herself believed in vaccination and wanted to be vaccinated against influenza.

As a doctor, one of my worries for an unvaccinated child concerns a disease not even spread from person-to-person. It is found in the soil. The disease is tetanus. In my 28 years of being a physician, I have participated in the care of one unfortunate young man who had tetanus. He survived this horrible disease, but he paid a steep price in the pain that he endured. If all of the citizens of the world had the rate of tetanus of those who live in Somalia, there would be 52 million cases of tetanus in the world each year. But if all of the citizens of the globe had the rate of tetanus of those who live in the United States, there would be just 630 cases of tetanus on earth each year. 52,000,000 versus 630. I know what I would choose.

There are many other diseases to which a 2-month-old baby is vulnerable that a vaccine could prevent. I remember well a father who stood over his dying baby boy, sobbing that he believed his baby was fussy for some reason other than the Haemophilus influenza that was in the baby’s blood stream. This bacterial disease is almost unknown today, but only because we vaccinate against it.

A decision to withhold vaccines is not a decision to avoid risk. The decision to not vaccinate allows a risk to persist – the risk of potentially getting a disease. Nothing is completely, completely safe. Please look carefully at the benefits and the risks of vaccination. I believe the benefits greatly outweigh the risks.

Robert Brayden, MD, is a professor of Pediatrics at Children’s Hospital Colorado and president of the Colorado Children’s Immunization Coalition.

Cavity Free at Three

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

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

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

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

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

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
The 2012 U.S. Immunization Schedule

By Reginald Finger, MD, MPH and Walt Larimore, MD, FAAFP, DABFP

At the October 2011 meeting of the Advisory Committee on Immunization Practices (ACIP)\(^1\) of the Centers for Disease Control and Prevention (CDC), the routine immunization schedule for the United States for 2012 was adopted. The ACIP has 15 voting members, selected by the HHS Secretary for their expertise in epidemiology, public health practice, immunology, and vaccine science, as well as 8 non-voting ex officio members from other federal agencies and 30 non-voting representatives from various medical organizations such as the AAFP. One of us (RF) served as a voting member of ACIP from 2003 to 2006 and attended part of the October 2011 meeting as a guest.

Because ACIP’s minutes have not yet been published, the material described in this article must be regarded as unofficial but is based upon the slides of the meeting presenters\(^2\) and notes published by one of the liaison representatives.\(^3\) Each year, the ACIP approves a new series of immunization schedules and recommendations\(^4,5\) for clinicians, as well as simpler versions for patients and parents.

Most of the changes in 2012 will consist of corrections and clarifications to the numerous footnotes which cover special situations. These will not be detailed here. The most significant, substantive change in the 2012 schedule is that human papillomavirus (HPV) vaccine is now recommended for males. Boys are to be routinely vaccinated at 11-12 years of age, with recommendation for catch-up vaccination up through age 21. For those males ages 22-26 the ACIP voted for a “permissive” recommendation, meaning that it can be administered at the discretion of the patient and the clinician. HPV vaccine (either the quadrivalent or bivalent vaccine) is now recommended for males. Boys are to be routinely vaccinated at 11-12 years of age, with recommendation for catch-up vaccination up through age 21. For those males ages 22-26 the ACIP voted for a “permissive” recommendation, meaning that it can be administered at the discretion of the patient and the clinician. HPV vaccine (either the quadrivalent or bivalent vaccine) continues to be routinely recommended for girls at age 11-12, with catch-up vaccination through age 26.

Other changes to the schedule in 2012 will include the following:

1) Meningococcal vaccine is now FDA-licensed down to 9 months of age (previously it was 2 years). ACIP recommends this vaccine beginning at 9 months of age for those with persistent complement component deficiency, or living in or traveling to a country endemic for meningococcal disease, or present during an outbreak of a vaccine-preventable meningococcal serogroup.

2) Meningococcal vaccine is now recommended up to age 21 (if not previously received at age 16 or later) for first-year college students or students living in a freshman dormitory. Previously, this recommendation covered only college freshmen with no previous vaccination.

3) Children from age 6 months through 8 years now need two doses of influenza vaccine only if they did not receive flu vaccine in the previous season.

4) Pregnant women may now receive tetanus-diphtheria-pertussis (Tdap) vaccine when due for a routine booster (formerly, only Td was recommended).

5) HPV has been added to the list of vaccines specifically recommended for those health care professionals who are in the recommended age groups.

The following changes to prior recommendations were published in 2011:

1) The Td/Tdap vaccination footnote has language added to indicate that persons aged 65 years and older who have close contact with an infant aged less than 12 months should get vaccinated with Tdap; the additional language notes that all persons aged 65 years and older may get vaccinated with Tdap.\(^6\)

2) Also added is the recommendation to administer Tdap regardless of interval since the most recent Td-containing vaccine.\(^7\)

3) In March 2011, the Food and Drug Administration (FDA) approved the use of herpes zoster vaccine (Zostavax, Merck) in adults aged 50 through 59 years. In June 2011, the ACIP declined to recommend the vaccine for adults aged 50 through 59 years and reaffirmed its current recommendation that herpes zoster vaccine be routinely recommended for adults aged 60 years and older. However, with the FDA approval, Zostavax is available in the United States for use among adults aged 50 years and older. Contraindications to the use of Zostavax remain unchanged.\(^8\)

Reginald Finger, MD, MPH  Walt Larimore, MD
Colorado Springs, CO  Monument, CO

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\(^1\) http://www.cdc.gov/vaccines/recs/acip/default.htm
\(^2\) http://www.cdc.gov/vaccines/recs/acip/slides-oct11.htm#chad
\(^3\) http://www.pharmacist.com/AM/Template.cfm?Section=Home2&CONTENTID=27249&TEMPLATE=/CM/HTMLDisplay.cfm
\(^4\) http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#hcp
\(^5\) http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm
\(^7\) http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#chgs
\(^8\) Ibid.
Since 2006, HealthTeamWorks has provided in-office coaching and technology support to primary care practices at no cost to those practices. To date, the nonprofit based in Lakewood, Colo., has assisted more than 250 practices in Colorado — most of them Family Medicine groups — on their journey to the Patient Centered Medical Home, or PCMH.

If you want your practice to benefit from HealthTeamWorks’ transformation guidance at no cost, take action soon. The organization’s grant support runs out in 2013, and additional funding is uncertain. HealthTeamWorks will enroll practices into its grant-supported transformation programs in February, June and October 2012, with coaching to be completed by October 2013. Thereafter, the organization may need to charge for coaching support.

The first step is to register for an informational webinar about HealthTeamWorks’ services by calling 303-446-7200 or e-mailing info@healthteamworks.org.

For 2012, HealthTeamWorks has funding to support an additional 45 practices. Funding from multiple sources, including the Robert Wood Johnson Foundation, the Colorado Department of Public Health and Environment, Caring for Colorado Foundation, The Colorado Trust, Merck, and most recently the Colorado Health Foundation, which provided a four-year, $5 million grant, has allowed HealthTeamWorks to support its mission to redesign the health care delivery system and promote integrated communities of care using evidence-based medicine and innovative systems.

HealthTeamWorks started as the Colorado Clinical Guidelines Collaborative in 1996 to improve health and health care on a foundation of evidence-based guidelines. Under the leadership of Marjie Harbrecht, MD, a Family Physician, HealthTeamWorks expanded its services to include practice coaching for primary care practices to implement and measure guidelines at the point of care. Dr. Harbrecht’s vision built an organization that continues to develop and disseminate clinical guidelines, and also helps primary care practices make the journey to the PCMH and adopt and optimize information technology.

Practices that enroll in HealthTeamWorks’ coaching in 2012 will get a full year of grant-funded transformation support. The National PCMH Demonstration Project showed that most groups need at least two years of guidance to evolve into PCMHs1, so the earlier a practice starts in 2012, the more coaching support is available. Funding expires in October 2013.

Changes in the national health care arena — current and coming — make it imperative that practices evolve to a different model of care delivery. Payers, policy-makers, standard-setting organizations and even patients are calling for value over volume, outcomes over output in health care. Organizations large and small must demonstrate their quality to participate in new compensation plans. We are trying to move away from visit-based care (what Mark Laitos, MD, calls “conveyor belt” medicine) to the patient as the unit of care delivery, not CPT codes and RVUs*. Major national initiatives from the Centers for Medicare & Medicaid Services drive home this point. For example:

- The Health Care Innovation Challenge will award up $1 billion to

By following a systematic approach to the adolescent with back pain most adolescents can be treated with relief of their systems without need for advanced imaging or referral to a specialist.

Sumeet Garg, MD, is an assistant professor with the Department of Orthopedics, University of Colorado School of Medicine, and Children’s Hospital Colorado with specialty training and research interests in spinal deformity.

Mark Erickson, MD, is the Rose Brown Chair in Pediatric Orthopedics and the medical director of the Spine Center at Children’s Hospital Colorado. He is an associate professor at the Department of Orthopedics, University of Colorado School of Medicine

Kids Corner is a regular feature of the CAFP News provided by the Department of Family Medicine at Children’s Hospital Colorado. For questions about this article or suggestions for future topics, readers may contact the authors or Dr. Jeffrey Cain, chief of Family Medicine, through OneCall: 720-777-3999.
As winter gets under way, snow and the holidays open up fun winter activities for children but also bring risks. Children are at increased risks of carbon monoxide poisoning, fires and burns, and injuries associated with winter sports such as skiing/snowboarding, ice skating and sledding. For all winter sports, children should always wear an approved multi-sport helmet. Here are some key tips for parents to prevent injuries this winter for their children.

**Carbon Monoxide**
- Prevent CO buildup in the first place - make sure heating appliances are in good working order and used only in well-ventilated areas.
- Install a CO alarm outside every sleeping area, on every level of the home and at least 15 feet away from every fuel-burning appliance.
- If a CO leak is suspected, open windows to allow fresh air into the home. If someone who has been in a poorly ventilated room with a fuel-burning appliance exhibits symptoms including headache, fatigue, nausea, vomiting or confusion, move the victim to fresh air and call 911.

**Fires and Burns**
- Keep matches, gasoline, lighters and all other flammable materials locked away, out of children’s reach.
- Never leave a burning candle unattended. Place candles in a safe location away from combustible materials and where children or pets cannot tip them over.
- Place space heaters at least three feet from curtains, papers, furniture and other flammable materials. Always turn space heaters off when leaving the room or going to bed.
- Test all smoke alarms every month and change the batteries once a year, even if they are hard-wired. Smoke alarms are also available with 10-year lithium batteries.
- Set your water heater thermostat to 120 degrees Fahrenheit. Consider installing water faucets and showerheads containing anti-scald technology.
- Allow children to help with cooking only through age-appropriate cooking activities. Children should be supervised and within reach at ALL times while cooking.

**Skiing and Snowboarding**
- Be sure children wear proper eye and sun protection.
  Even on cloudy days, the sun’s rays can be very intense.
  - Teach children to ski in control and not to go too fast.
  - Stay off of icy hills. Injuries increase with icy conditions.
  - Make sure children stay in designated areas and on marked trails. They should never ski or snowboard alone.

**Sledding and Tubing**
- Children should sled and tube on debris-free, packed snow. Do not sled on ice! Be sure to check carefully for rocks, trees or tree stumps.
  - Compared to other positions, it is much safer to sit up with feet forward while sledding and tubing.

**Snowmobiling**
- The American Academy of Pediatrics recommends that children under the age of 16 never operate a snowmobile.
  - Children under the age of 5 should never ride on a snowmobile, even with an adult.
  - Never tow anyone behind a snowmobile on a tube, sled or skis.
  - Never allow anyone to ride with someone who has been drinking alcohol.

**Ice Skating**
- Stick to public indoor and outdoor skating rinks.
  - Discourage children from playing unsafe games such as “crack the whip.”
  - If the ice breaks, teach children to stretch their arms over the ice and kick as if swimming in an attempt to crawl back onto solid ice. Have a companion call 911.
Travis Crawford, MD, Dies Unexpectedly
Boulder County FP loved mountains

The board of directors of the Colorado Academy of Family Physicians was saddened to learn of the Aug. 7 unexpected death of Travis Allen Crawford, MD, a Family Physician who had lived in Superior and practiced at Avista Medical Center in Louisville. He was 40 years old.

A notice posted by the physicians and staff of Boulder Medical Center stated, “This is a devastating loss for his family, Boulder Medical Center and our community.”

Dr. Crawford, whose father was in the U.S. Navy, was born in Fairfield, Calif., and lived in several states while he was growing up. He graduated from Seneca High School in Seneca, Ill., as salutatorian before earning his bachelor’s degree, graduating summa cum laude, from Illinois State University in Bloomington, Ill. He graduated from the University of Illinois Medical School with a specialty in Family Practice before completing his residency at Poudre Valley Medical Center in Fort Collins.

An Illinois newspaper report published after his death referred to him as a “compassionate healer” and stated, “Travis had a profound spiritual connection with nature and the Rocky Mountains. He found solace recreating in the outdoors and enjoying the beauty of Colorado in all its splendor. A high mountain vista, the sight and sounds of a bugling elk herd, a quick hike in the open space behind his house or a hilly bike ride allowed him to find balance in the world. His desire for personal health and fitness was evident in his yearly tradition of training and riding at least one century bike ride in Colorado.”

The same article stated that his teams were the St. Louis Cardinals, the Chicago Bears and Fighting Illini.

Dr. Crawford was survived by his widow, Crystal, who had been his high school sweetheart, and their two school-age children, as well as his parents, two siblings and three grandparents.

Contributions may be made to the Travis Crawford memorial College Fund (on behalf of Jacob and Jessica Crawford) at Liberty Savings Band, 1697 E. Coalton Rd., Suit A, Superior, Colo. 80027, or to the American Heart Association.

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These government-backed endeavors are laying the groundwork for a new health care paradigm in which care delivery and compensation are driven by the value of care provided, rather than the number of RVUs delivered. All providers will have to adopt new processes and new ways of thinking to succeed under this new model.

applicants who implement compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and the Children's Health Insurance Program;

• The Comprehensive Primary Care, or CPC, initiative fosters collaboration between public and private health care payers to strengthen primary care for all Americans. The CPC seeks to boost primary care by inviting payers to join with Medicare in investing in primary care in up to seven locales across the country;

• The Bundled Payments for Care Improvement initiative seeks to improve patient care through payment innovation that fosters improved coordination and quality through a patient-centered approach; and

• The ACO Shared Savings model, in which Medicare will share up to 50 percent of the cost savings for accountable care organizations that can demonstrate improved quality and cost reduction.

These government-backed endeavors are laying the groundwork for a new health care paradigm in which care delivery and compensation are driven by the value of care provided, rather than the number of RVUs delivered. All providers will have to adopt new processes and new ways of thinking to succeed under this new model.

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* CPT - Current procedural terminology; RVU - relative value unit

Source
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