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1st Quarter
2013 Winter

CAFP NEWS

BOLD CHAMPION FOR COLORADO FAMILY PHYSICIANS

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Twenty of

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LONE TREE HEALTH CENTER

WINTER 2013

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HEALTH OF THE PUBLIC

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David Brown, President
dbrown@pcipublishing.com
14109 Taylor Loop Road
Little Rock, AR 72223
501.221.9986

For advertising information contact:
Deborah Merritt at 501.221.9986 ext. 109 or
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CAFP Board of Directors

Officers 2012-2013

Vision Statement:

Thriving Family Physicians creating a healthier Colorado.

Mission Statement:

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

Contact Information for the CAFP

Colorado Academy of Family Physicians
2224 S. Fraser St., Unit 1
Aurora, CO 80014
phone 303-696-6655 or 1-800-468-8615
fax 303-696-7224 e-mail info@coloradoafp.org

PRESIDENT'S REPORT

Bob Brockmann, MD, MS, FAAFP

The difficult work begins…

Much has happened since our last issue. Where there was much uncertainty about "Obamacare" earlier, there is emerging clarity. Let's catch up!

We now know that the individual mandate will take effect in 2014. We know each state will have a health insurance exchange. Every state will have subsidies for those between 100 percent and 400 percent of the poverty level to aid in buying private insurance. And we know that each state has the option of opting in or out of the Medicaid expansion. In Colorado, there would be about 150,000 new Medicaid beneficiaries, and about 300,000 new privately insured folks through the exchange. This represents about a 25 percent increase in the Medicaid population, with many being single adults. No one is sure of the impact the mandate will have on the remaining uninsured.

Colorado will likely opt to expand Medicaid eligibility. Legislation that expands Colorado's Medicaid eligibility limits will be introduced this coming session. The new eligibility rules will cover all individuals up to age 65 and below 133 percent of the federal poverty level. Some states, including Colorado, have already increased eligibility for some groups above the current federal requirements. Since the Affordable Care Act was written under the belief that the expansion was mandatory, those folks residing in states not expanding and who are under the 100 percent limit (in other words the very poor), will not be eligible for subsidies, or Medicaid. As you now, the federal government will pay the costs of the expanded coverage benefits for the first three years, then the state becomes responsible for 10 percent of those costs thereafter. The federal government subsidy does not cover additional administrative costs, however. There is some possibility that Colorado will choose to expand Medicaid incrementally over a few years, but without a waiver that preserves the full federal payments, this could be a costly choice.

Assuming the Medicaid expansion is a near certainty in Colorado, assessing the costs and benefits is a daunting and imprecise task, and has been the topic of much debate in the house of medicine. As a policy position, the Colorado Academy of Family Physicians wants Medicaid to succeed. This program serves the most vulnerable among us, including the disabled, elderly and poor. We favor affordable steps to reduce the uninsured in our state. Expanding access to health care is one of our goals, and this program serves that purpose.

The benefit side of the expansion equation is easier to see, with fairly consistent estimates suggesting an additional 150,000 to 200,000 covered lives, making a substantial impact on reducing the number of uninsured. If it works, the health, social and economic benefits to Colorado will be significant. A healthier population leads to fewer unreimbursed emergency room visits for preventable and controllable conditions. The approximate $1 billion per year in new health care spending generates $1 billion to $2 billion in economic activity, as well as bolstering tax revenues. As we often say, though, having insurance is not the same as having health care. Will there be enough physicians of the needed specialties, including primary care, to care for all these new patients? There will also be more than 300,000 new patients with private insurance hitting the health care marketplace at the same time, competing for valuable slots in the office schedule. With Medicaid's relatively poor reimbursement, will physicians, as a practical matter, need to limit or exclude Medicaid patients? Will the increasing administrative burdens imposed on practices, including increased quality reporting, interfacing with Regional Care Collaboratives, and struggles with timely eligibility determinations make caring for a larger Medicaid population untenable? Will new payment schemes that shift financial risk to physicians, while intending to foster more cost-effective care, instead discourage participation? CAFP wants to be sure the physician workforce will be ready, willing and able to anchor the cornerstone of the health care system. We need stable, high quality, cost-effective primary care practices in Colorado. This is our area of expertise and our profession, and we are working closely with many governmental and nongovernmental organizations to assure that primary care is financially sustainable, that Medicaid is easy to participate in, and that Medicaid patients get the best care possible.

The cost side of the equation, though, is worrisome to many, and outside our immediate influence. Accepting that improving access to health care is a good thing, it's only responsible to ask how much it will cost, and how it will be paid for. The math is complicated, but rough estimates put Colorado's contribution at an additional $1 billion over the first 10 years, with the federal contribution at about $9 billion. This is about a 2 percent to 4 percent increase over current spending. There are many assumptions, though, and many uncertainties. These figures do not include continuing primary care reimbursement rates at Medicare parity after 2014. Also, these estimates were based on the assumption all states would be required to expand Medicaid; will there now

be a migration of needy people to states where Medicaid is available?

And what will be the magnitude of the initial bolus of unmet medical needs identified in the newly served poor adults? How many emergent surgeries, joint replacements, chemotherapies and motorized scooters will Medicaid buy in that first year? The federal "bail out" money paid to states to offset the increased demand on Medicaid during the recession ran out in 2011, but the demand has not dropped to pre-recession levels. Can we afford to cover that gap? What will happen when the next recession occurs? Will we be forced to roll back benefits, or eligibility? In the bigger state picture, we have not yet recovered from the latest recession. The general fund is at 2007 levels, but there are 700,000 more Coloradans. Eighty percent of the general fund pays for just two items, education and health care. There isn't much left to work with and there will be competing interests. And without igniting a bigger debate, it is noted that even though the feds are paying for most of the benefits expansion, it still isn't free!

I am sharing these thoughts not to sound discouraging or rally opposition to Medicaid or "Obamacare." We all know the health care system needs fixing, and this is the start of that painful process. There will be many revisions. CAFP supports expanding access to health care, and we want this expansion to succeed, for physicians, for Colorado, and most importantly for our patients. But it is naïve to pretend significant challenges don't threaten that success, and we are working hard to be part of the solution!

"Do what you can, with what you have, where you are." Theodore Roosevelt

CEO's Report

by Raquel J. Rosen, MA, CAE

CAFP Ends Productive Year

While some predicted the end of the world on Dec. 21, 2012, the opposite has occurred in Family Medicine in Colorado. As the new year begins, Family Medicine is experiencing a convergence of forces that is catapulting the profession into a key pivotal role in assuring quality health care for the current and future generations.

Several factors are contributing to sea changes in health care, including Obamacare, the Comprehensive Primary Care Initiative and Colorado Medicaid Regional Care Collaborative Organizations. All are aimed at a goal that Family Physicians have embraced for years: Cost-effective, high quality health care for all.

While the goal of Family Medicine remains the same, the tools available to reach those goals have changed dramatically with technology, bringing about transformations in the way Family Medicine is delivered. To succeed in this new environment, practices need to implement quality initiatives and become Patient Centered Medical Homes. They need to use electronic health records and administer and track care, not just for individual patients, but also for groups of patients. Everyone in Family Medicine offices needs to play a role in patient care.

Though these new tools are cost-effective, they do not come cheaply, nor is the payment for added services readily reimbursed. CAFP leaders and dedicated members have devoted many hours to help other stakeholders in the health care system recognize the value of Family Medicine and institute systemic changes to pay for new ways of practicing. In addition to transforming your own practices, I would urge all members to do their part by getting involved with the CAFP so we can continue to effectively advocate for the profession.

FAMILY PHYSICIANS PROGRAM AVAILABLE ON DVD

The CAFP ended a very busy 2012 advocating for our members in many ways. I hope you have had the opportunity to view the TV show, Family Physicians on Call for Colorado, and have disseminated the dates and times to your patients. We will continue to promote the TV show through different avenues.

If you would like the TV show on DVD please let me know and we will send it to you. You can show it in your offices. You can also refer your patients to the CAFP's new consumer area on the web site that has excellent patient health information.

Raquel Rosen with fellow western state chapter execs

CAFP INVOLVED WITH ELECTIONS, OBESITY, NATIONAL ISSUES

The CAFP's legislative candidate reception was a big success. It gave CAFP leaders the opportunity to educate candidates about the CAFP. Candidates who received CAFP's support had answered positively to questions on the CAFP legislative candidate survey.

Our Fit Family Challenge pediatric obesity pilot is going well with 21 practices participating. Results of decreased blood pressure, decreased body mass index, and increased healthy living habits are all encouraging and astonishing. We hope to roll this program out soon to all primary care physicians.

Your delegates and alternates represented Colorado very well at the American Academy of Family Physicians Congress of Delegates. If you are interested in a particular issue to change policy on the national level please let me know.

We are very proud of Jeff Cain, MD, the current president of the AAFP. He gave a spectacular speech to the attendees of the AAFP's Scientific Assembly and is a strong advocate for Family Medicine Physicians.

CAFP'S 65TH ANNIVERSARY

Please plan to attend the CAFP's Annual Scientific Conference and 65th Anniversary Gala celebration on April 18-21, 2013 at the Cheyenne Mountain Resort. We have excellent speakers lined up plus a delicious dinner and dancing at the gala. For more information please go to the CAFP's web site, www.coloradoafp.org.

CAFP Legislative UPDATE

By Jeff Thormsodsgaard, Vice President, Mendez Consulting Inc.

With the 2012 election cycle officially over, we are a mere few weeks away from the beginning of the 2013 Legislative Session! This year will mark the First Regular Session of the 69th General Assembly, convening on Wednesday Jan. 9, 2013. The 2012 elections shook up the political composition of the General Assembly quite significantly, but ironically did not change the federal delegation at all.

Democrats took back the House and maintained the Senate; once again giving the Democrats a majority in both houses, and control of the governor's office. The Senate Democrats kept their five-seat majority, 20 Democrats to 15 Republicans. However, the House changed drastically from a 33-to-32 Republican majority, to a 37-to-28 Democrat majority, giving the House Democrats a nine-seat advantage.

In addition to the new political climate the election created, it also resulted in 32 new freshman legislators, including four senators and 19 representatives. Thirty-two new legislators make this the largest freshman class in Colorado history. Additionally the House also elected the first gay man to preside over the chamber, Mark Ferrandino, who is the fourth gay speaker in the United States. Needless to say, the 69th General Assembly will have a different political agenda than the Sixty-Eighth.

Although we are still weeks away from the opening day, the senators, representatives and senator/representative-elects are all very busy working on legislation. With the federal elections guaranteeing that health care reform will continue moving forward, this legislative session is bound to bring a plethora of health care legislation. Some of the possibilities could range from Medicaid expansion, to health care co-ops, to adult Medicaid dental coverage, and there are bound to be anti-reform bills as well.

The Colorado Academy of Family Physicians was busy all fall preparing for the new session. Because of the impending health care legislation, the academy was asked to weigh in on many issues weeks before the start of the session. There are still a lot of conversations to have, and details to be worked out before the academy's legislative committee will decide on a firm agenda. We will share our progress more throughout the upcoming year.

In the interim, one of the topics on which we might see legislation is a universal vaccine purchase. There is not yet an official bill draft for this topic; therefore the academy does not have an official position. However here is a brief synopsis of what the discussion has been thus far.

The universal vaccine legislative proposal would authorize the state of Colorado to create a vaccine purchase model that would streamline all childhood vaccine purchases and distribution, with the intent of saving the state, providers, insurers, pharmacies and local public health agencies a considerable amount of money. The model would offer vaccines for a significantly reduced cost; additionally it would increase the probability all local providers would offer vaccinations, especially rural providers. The proposal would also eliminate administrative burdens such as multiple billing procedures and requirements to keep vaccines separated based on funding source. This legislation would also repeal the ban on implementing bulk vaccine purchases.

Currently, immunizations for children are funded through private insurance, the state general fund and two federal grant programs. This hodgepodge of systems is unnecessarily difficult and inefficient. Vaccine costs have risen significantly in recent years. The cost to vaccinate a child through age 18 has risen 223 percent to $1,195 for males and 301 percent to $1,483 for females.

The problem is that private providers cannot easily manage the cost or process to purchase vaccines for their patients because they buy small volumes and are forced to keep a costly and confusing separate inventory and system for patients with different insurance statuses. Vaccine purchase is often the highest business expense for pediatricians and Family Physicians. Because of the high cost of vaccines, many smaller providers, especially in rural areas, do not offer vaccines. Consequently, their patients are referred to the county local public health agencies for immunizations, which increases the burden on the local governments.

The solution that universal vaccine purchase suggests is, by pooling funding from private health plans with state and federal sources for the purchase of vaccines through a single source, significant savings can be achieved. Bulk vaccine purchase can decrease the cost of vaccines and create a streamlined, single billing and reimbursement system. Bulk Vaccine Purchase helps to mitigate missed immunization opportunities, and lowers the cost for local public health agencies, local governments, health plans and providers. There are still details that need to be considered such as whether a clearinghouse would distribute the vaccines. And, if so, would the state operate that clearing house, or a private vendor, such as a non-profit? Other considerations include outside competition, and whether or not this legislation would mandate a single purchase point. As this conversation progresses we will continue to send out updates.

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 accept contributions only 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 Political Action Committee 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 interests. 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 candidates, 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 deductible?

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

_____

Email Address Phone

NEW
ICD-10 DEADLINE:
OCT 1, 2014

2014 COMPLIANCE DEADLINE FOR ICD-10

The ICD-10 transition is coming October 1, 2014. The ICD-10 transition will change every part of how you provide care, from software upgrades, to patient registration and referrals, to clinical documentation, and billing. Work with your software vendor, clearinghouse, and billing service now to ensure you are ready when the time comes. ICD-10 is closer than it seems.

CMS can help. Visit the CMS website at **www.cms.gov/ICD10** for resources to get your practice ready.

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Making Sense of the Changing Landscape of Influenza Prevention

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

The Family Physician is always challenged to be fully informed and up to date on an incredible variety of health topics. Keeping up with and interpreting clinical information for the patient can be a difficult task when new research findings are being published frequently and when different authorities are making discrepant claims.

So it is with influenza prevention. Beginning in 2010, the Advisory Committee on Immunization Practices, or ACIP, of the Centers for Disease Control and Prevention has recommended flu vaccination for virtually the entire U.S. population 6 months of age and older.[1] This recommendation was not made before 2010 primarily because vaccine supplies had been inadequate to support it.

In January 2012, a rigorous meta-analysis of the 31 most methodologically sound studies that documented the efficacy, effectiveness and cost-effectiveness of influenza vaccines concluded that adequate evidence for protection was demonstrated in only two situations[2]:

- Using the intranasal flu vaccine in children 6 months to 7 years and
- Using the injected flu vaccine in adults age 18 through 64.

The authors of the meta-analysis held that the remaining ACIP recommendations have been extrapolated either across age group lines or from studies that were believed to be informative although not entirely rigorous.

Nonetheless, the authors concluded that the current ACIP recommendations are appropriate given our limited arsenal of prevention strategies and ended by issuing a clarion call for "game-changing influenza vaccines" based on antigens of the influenza virus expected to yield more robust immunity than the HA antigen used currently.

Two other issues have recently surfaced. First, what is the ideal timing for the flu shot each season? Recently, it has been thought that the need for annual vaccination has mostly to do with antigenic drift of the flu virus from year to year, and that one should receive the flu shot as soon as it is available in the fall so that antibody develops before the flu season starts (which can be unpredictable).[3] However, as yet unpublished research is now suggesting that the duration of immunity from the vaccine is shorter than previously thought. This could require a revisit of the timing issue during the fall of 2013.

Secondly, it has been thought that if the antigenic match between the vaccine and the circulating virus were exact, vaccine efficacy should be much higher than is seen in most flu seasons. Surprisingly, however, during the 2009 H1N1 flu pandemic, a vaccine exactly matched to the pandemic strain demonstrated an efficacy of only 56 percent against that strain.[4]

So what do we do with this information?

First, one still clearly ought to administer flu vaccine to one's patients each year, beginning immediately before the start of flu season as best one can predict – ideally in October but certainly continuing so long as influenza circulates in the community.

Tips from Prescriber's Letter for the 2012-2013 Flu Vaccines:

- When patients ask about Fluzone Intradermal, explain that it works as well as the IM version ... but it causes more local reactions.
- And tell seniors there's still no proof that Fluzone High-Dose works better than the standard-dose vaccine to prevent flu.
- Don't delay vaccination for a mild acute illness. Consider waiting for a moderate or severe acute illness ... to avoid confusing symptoms of the illness with possible adverse effects of the vaccine.
- Kids 8 years and younger usually get two doses of flu vaccine just the first year they're vaccinated. But some kids will need TWO doses again this year ... to ensure adequate protection against H1N1. Give TWO doses at least four weeks apart if they haven't had at least two doses of seasonal flu vaccine during any previous season ... and at least one dose of a vaccine with H1N1.

Second, the Family Physician should recommend:

- The nasal flu vaccine for children 2 through 7 years, and
- The injectable flu vaccine for:
  - o Children 6 to 24 months and
  - o Adults age 18 and older.

Finally, one should not forget the other important aspects of influenza prevention – hand washing, not coughing or sneezing into one's hands, and avoiding crowds if one has respiratory symptoms. In the meantime, we strongly hope that better influenza vaccines that are being developed will be available quickly.

Reginald Finger, MD, MPH, is a public health expert and researcher, as well as a former member of the CDC's Advisory Committee on Immunization Practices (ACIP). Walt Larimore, MD, DABFP, FAAFP, is the medical director of Mission Medical Clinic in Colorado Springs (www.MissionMedicalClinic.org).

1. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6132a3.htm (last accessed November 21, 2012).
2. Osterholm MT, Kelley NS, Sommer A, et al. Efficacy and effectiveness of influenza vaccines: a systematic review and meta-analysis. *Lancet Infect Dis* 2012;12(1):36-44.
3. http://www.cdc.gov/flu/protect/keyfacts.htm (last accessed November 21, 2012).
4. Griffin MR, Monto AS, Belongia EA, et al. Effectiveness of non-adjuvanted pandemic influenza A vaccines for preventing pandemic influenza acute respiratory illness visits in 4 U.S. communities. *PLoS One* 2011;6(8):e23085.
5. Flu Vaccines. Prescriber's Letter; October 2012; Vol: 28.

New Consumer Health Information Area Launched on CAFP Website

The Colorado Academy of Family Physicians has extended its reach to consumers through a newly launched landing page on our website. The landing page, titled Family Health, is accessed by clicking on the Family Health icon that is located under the main CAFP website navigation bar. The new landing page supports the CAFP initiative to further reach out and connect with the community and continue to foster a better understanding of Family Medicine Physicians and their vital role in the health care system.

The consumer area was created as a public service and was launched Oct. 1 in conjunction with the CAFP *On Call for Colorado* television show, which aired October through December on Comcast Entertainment Television. Following its run on Comcast, the program is being distributed to several local access channels statewide for airing throughout 2013. The program will also be offered to health clubs, hospitals and physician offices. CAFP member physicians on the program are also featured on the site to acquaint viewers with their professional backgrounds.

CAFP members provided initial content for two of the site's sections - *Health Care Myths and Facts*, and *Living Healthy in Colorado*, which shares information specific to Colorado health issues such as high altitude illness. *The Helpful*

continued on next page >>

GREAT NEWS FOR MEMBERS:
20% DISCOUNT ON NCQA PCMH FEE

The Colorado Academy of Family Physicians has negotiated a discount for all members to use when applying to the National Committee for Quality Assurance for recognition as a Patient Centered Medical Home.

Please note that this code can be issued to all sites that have not been approved as a "multi-site" practice for Patient Centered Medical Homes 2011. Practices with three or more independent sites are eligible for a 50 percent discount off of the per-clinician application fees and are not eligible for an additional discount through this sponsorship. Practices that have thee or more sites and share the same electronic medical record or practice registry (that tracks patient and billing data the same) and can submit under the same program agreement are eligible for the multi-site discount. **Single sites and those with just two site locations will now be eligible for the 20 percent sponsor discount through CAFP.**

The "discount code" field will be found in the online application and can be added any time prior to submission of the application. It is under the "Practice Site" tab, where you will then click on your site name and enter the code in the "discount code" field.

If you would like to receive the code please contact raquel@coloradoafp.org or 303-696-6655, ext. 10.

Resources section provides visitors with background on the Patient Centered Medical Home and links to FamilyDoctor.org and interactive health tools. Content for these areas of the website will be continually updated throughout the year.

The landing page also features a central copy block with rotating messages to update visitors on new information, communicate key messages and motivate visitors to return for updates and news relating to CAFP and Family Medicine.

To further promote the brand of Family Medicine Physicians, the *Family Medicine Physicians at a Glance* section provides facts everyone should know about Family Medicine Physicians and an overview of primary care in the 21st century that describes care provision issues and the Patient Centered Medical Home solution.

Visitors to the page also have access to a downloadable Know Card, a tool for families to record important individual health histories and conditions. The consumer area and the Know Card are both promoted via a new public service announcement, which was produced and distributed to broadcast stations and local access channels statewide as a public service of CAFP. This is an excellent resource for your patients.

Any CAFP member who would like to be a contributor and author a topic for *Myths and Facts or Living Healthy in Colorado* may contact the CAFP office at 303-696-6655. Members' professional input will ensure that the site continue to provide relevant, fresh and beneficial information to visitors of all ages.

Information on obtaining DVDs of *Family Physicians On Call for Colorado* to run in members' offices is available by contacting Raquel Rosen at 303-696-6655.

AAFP State Legislation Meeting Nov. 1-3, 2012

By Rick Budensiek, DO, FAAFP, President-Elect, CAFP, Co-Chair, CAFP Legislative Committee

Dateline: Memphis, site of the American Academy of Family Physicians State Legislation Meeting. Elvis was in the House (looking a lot like our own Jeff Cain, M.D., AAFP President) singing "I'm all shook up!" Dr. Cain was talking about changes in the climate in which we practice while acknowledging the award winning accomplishments of grass root efforts in Iowa, Mississippi and Virginia.

Co-chairs of the CAFP Legislative Committee Candace Murbach, DO, and Rick Budensiek, DO, learned about legislative issues in other state chapters. All politics are local and the way Family Docs are approaching Medicaid expansion, insurance exchanges, workforce issues and patient advocacy have that local flavor. Having said that, it was apparent that the Family Docs around the country are passionate about what they do, no matter their geography or party affiliation.

We look forward to serving you this coming legislative session. We are pleased that so many of you have expressed interest in the legislative committee and have signed up to participate.

Top Left: State Legislative Conference - Jeff Cain, MD.

Left: Rick Budensiek, DO, Laura Makaroff, DO, and Candance Murbach, DO.

CAFP ON THE GO

Denver Post highlights John Bender, MD, and His Practice

Miramont Family Medicine shows value of reform

Colorado AFP group at AAFP Congress of Delegates

Following is an excerpt of a Sept. 12 article by The Denver Post reporter Michael Booth. The article was posted Sept. 12 on denverpost.com under the headline "Key Medicaid reform effort in Colorado shows promising savings."

"Miramont Family Medicine has about 430 of its 1,700 Medicaid patients in the new Colorado program, receiving $3 a month extra per patient. The practice, with offices in northern Colorado and Parker, can earn back an extra $1 the state withholds until quality and usage goals are met.

Contractors bid to oversee the patient medical homes in seven regions of Colorado. They help train medical offices to make needed changes and, for smaller, less-modernized practices, can handle coordination of patient cases.

"The regional contractors receive $12 per patient, with another $1 withheld for quality and cost goals.

"Bender's practice combines its state payments with private insurance reform efforts — and soon, Medicare reform bonuses — to buy data analysis, and hire nurses for case management and even an in-house dietician.

"Data reviews found a Medicaid patient who had been to the ER 32 times in the year before joining Miramont. In the next year, that patient had one ER visit, in part because of care coordination, and in part because of Miramont's extended evening

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and weekend hours.

In a prereform group of 1,000 Medicaid patients nationally, the average was 800 ER visits in a year, Bender said. In measurements the practice keeps separately from the state's, Miramont's rate of ER use is only 300 visits per 1,000 patients in a year.

"A nutritionist will cost his practice $90,000 a year, and in the first year, that brought in only $45,000 in billings, he said. With per-patient, per-month fees added to that pool of resources, the nutritionist will be justified, even while doing hour-long diet consultations that don't have a billing code."

Right: Jeff Thormodsgaard, Rick Budensiek, DO, Bob Brockmann, MD, and Raquel Rosen met with Judy Zerzan, MD, Chief Medical Office for Medicaid HCPF.

CAFMR Student & Resident Dinner - CU Residents

CAFMR Student & Resident Dinner - Kim Marvel addresses the group.

Dr. Brockmann and Representative-Elect Tracy Kraft-Tharp

Austin Bailey, MD, addresses attendees at the 35th Anniversary of the Commission on Family Medicine.

Dave Gaspar, MD, and Bob Brockmann, MD, at Student Resident Dinner

Dr. Voorhees and Dr. Budensiek with Jan Spooner and Representative-Elect Lois Landgraf

Dr. Budensiek with Senator Mary Hodge

Mary Fairbanks, MD, and Ed Perlmutter.

Dr. Budensiek presented information on Family Medicine and the Patient Centered Medical Home to the legislative candidates at the CAFP reception.

Commission on Family Medicine 35th Anniversary.

WE NEVER SAY NEVER.®

At National Jewish Health, we never say never. That's one of the reasons we've been named the **nation's number one respiratory hospital** for the 15th year in a row. 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.**

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Jeffrey Cain, MD, FAAFP, Installed as AAFP President

Tennessee physician will succeed him

Coloradoan Jeffrey Cain, MD, FAAFP, was recently installed as president of the American Academy of Family Physicians, having completed a year a president-elect. Reid Blackwelder, MD, FAAFP, from Kingsport, Tenn., was elected to serve as president-elect.

Alabaman John S. Meigs Jr., MD, FAAFP, and Illinois doctor Javette Orgain, MD, MPH, FAAFP, were elected as speaker and vice speaker, respectively.

New members of the AAFP board of directors are Carlos Gonzales, MD, FAAFP, from Arizona; Rebecca Jaffe, MD, MPH, FAAFP, from Delaware; H. Clifton Knight, MD, FAAFP, from Indiana; and Lloyd Van Winkel, MD, FAAFP, from Texas. Dr. Jaffe will serve out the remaining two years left vacant by after Kansan Julie Wood, MD, FAAFP, resigned to assume the position of AAFP vice president for interprofessional activities and health of the public.

The Colorado Academy of Family Physicians was successful in getting a resolution passed. The resolution states that "the American Academy of Family Physicians develop and actively support a plan for model legislation that supports the right of primary care physicians to collectively negotiate with health insurers and grants them immunity from anti-trust statutes when they do so.'

The reference committee recommended that the second resolved clause of Resolution No. 509 be referred to the board of directors and presented a board report at the 2013 Congress of Delegates.

The complete report on AAFP resolutions passed at the Congress of Delegates is available at www.aafp.org/congress.

Colorado Delegation Achieves Rules Change, HELP FOR INDEPENDENTS

AAFP Congress of Delegates Report

By Kern Low, MD, CAFP Delegate

Greetings from the City of Brotherly Love, Philadelphia, where the American Academy of Family Physicians Congress of Delegates debated several issues. Numerous resolutions were brought to the various reference committees. Topics of some of the more lively discussions included developing a collaborative relationship with certified nurse midwives, emergency contraception and same-gender civil marriage. Results of the resolution votes can be found by going to www.aafp.org/congress and clicking on Reference Committee Reports on the left.

In regard to Colorado's resolutions, the Colorado delegation was successful in modifying the campaign rules to allow candidates to speak at regional state meetings held at the Congress of Delegates. As some may know when Jeffrey Cain, MD, the recently installed AAFP president, was running for president-elect last year, he was not allowed to speak at regional meetings. The western states meet the evening prior to the start of Congress of Delegates. Now the candidates, who are generally informed leaders, are able to comment on pertinent issues.

Our resolution on Survival of Independent Primary Care Practice was successfully modified to ask the AAFP to develop and actively support legislation that supports the right of primary care physicians to collectively negotiate with health insurers and grants them immunity from anti-trust statutes when they do so. In the past, the AAFP has agreed with this but has not been active. The Congress of Delegates has requested that there will be a board report next year stating what the AAFP has done on behalf of this issue.

In terms of the leadership of the AAFP, Dr. Cain was installed as the 65th president of the national organization. He gave a motivating speech and we are proud of him

Jeff Cain, MD, and Colorado supporters the evening of his installation as President of AAFP

and look forward to his leadership and "flight plan." Reid Blackwelder, MD, FAAFP, of Tennessee was elected as the president-elect. Carlos Gonzales, MD, FAAFP, from Arizona, Lloyd VanWinkle, MD. FAAFP, from Texas, and Clifton Knight, MD, FAAFP, from Indiana were elected to the board of directors. Rebecca Jaffe, MD, MPH, FAAFP, from Delaware was elected to complete a vacated two-year term. Kent Voorhees, MD, was selected to chair the Commission on Education.

Overall, Colorado was well represented by John Bender, MD, Kern Low, MD, Dr. Voorhees, Brian Bacak, MD, Bob Brockmann, MD, and Tamaan Osbourne-Roberts, MD. Of course, this wouldn't be possible without the coordination and leadership from Raquel Rosen, chief executive officer.

John Bender, MD, on Reference Committee at Congress

Jeff Cain, MD, president of AAFP gives talk to 4,000 attendees of AAFP Scientific Assembly in Philadelphia

Brian Bacak, MD, testifies during reference committee at AAFP Congres

CAFP Delegates Kern Low, MD, and John Bender, MD

CAFP Delegation enjoy dinner in Philadelphia

Kent Voorhees, MD, and Brian Bacak, MD, CAFP Alternate Delegates

Glenn Stream, MD, installs Jeff Cain, as AAFP President

Kent Voorhees, MD, testifies during Congress of Delegates Reference Committee

Jeff Cain, MD, installed as AAFP president by Glen Stream, MD, chair of the board

Concepts in Outpatient Pediatric Antibiotic Use

Practitioners have an Important Role in Stewardship

By Michelle Mitchell, MD, and Sarah Parker, MD

With 80 million prescriptions for more than 12,000 tons of antibiotics filled in the United States annually, the extensive use of antibiotics drives microbial resistance on a patient and community level. In pediatrics, studies show 60 percent of hospitalized patients are prescribed antibiotics, and reviews of prescriptions demonstrate 50 percent of these are suboptimal. Antimicrobial stewardship refers to the practice of carefully choosing whom to treat, with what, and for how long, with the goal of the best outcome, best safety, least resistance and least cost. Thus, stewardship concepts are applicable to all who prescribe antimicrobials because making informed decisions in antimicrobial use will help maintain the effectiveness of currently available drugs for years to come, not to mention keep patients safer.

Did you know that 9 in 10 "human" cells are microbes, adding up to 3 lbs. of an adult human? Most of our microbes are good, or even essential; antibiotics change our microbes to more pathogenic and resistant species. Caring for our friendly microbes through judicious antibiotic use is antimicrobial stewardship.

Concept 1: Recognize the Pollyanna phenomenon.

This term refers to the false optimism that a minimally active drug is as effective as an active drug (see Merchant et al, *J. Peds*, 1998). The most common reasons antibiotics are used in pediatric outpatient practice include community-acquired pneumonia, otitis media and rhinosinusitis, all diseases with high spontaneous remission rates. Many antibiotics used for treatment of these diagnoses gained favor based on non-inferiority trials, a suboptimal study design for these entities in which an antibiotic may be deemed "non-inferior" to another without comparing it to a placebo. This often has no relationship with drug efficacy. However, these trials are often erroneously interpreted as drug "equivalence," or worse yet, "effectiveness." Searching for higher quality study designs that build in other components such as bacterial eradication or supportive pharmacokinetics helps to more critically evaluate antibiotic choices.

Concept 2: Oral cephalosporins: reconsider if you are enamored

While the oral cephalosporins can be very important drugs in your antibiotic armamentarium, they should be confined to very specific uses due to their inferior pharmacokinetics/dynamics, as explained in detail by Dalhoff et al, *Infection*, 2009. Oral cephalosporins, though tasty, are generally poorly absorbed, highly protein bound (only unbound drug will exhibit pharmacologic effects), and have short half-lives. Thus, they rarely maintain the required serum levels for the length of time necessary to eradicate common pediatric bacterial pathogens (i.e. the serum drug level is not over the concentration needed to inhibit the organism for more than 40 percent of the day). This is particularly true when dosed infrequently.

Even more alarming, because they are present at sub-inhibitory levels for much of the day, they strongly encourage the emergence of resistant pathogens. The evidence for this is demonstrated on a societal scale in countries that restrict cephalosporin use and subsequently have very low MRSA rates, such as the Netherlands. Reasonable uses include treatment of urinary tract infections, treatment of skin/soft tissue/musculoskeletal infections, and treatment of truly penicillin allergic children. Because these drugs are less preferred, it is important to sort out if a child is truly penicillin allergic with referral to an allergist, to prevent suboptimal treatment the rest of his or her life. If an oral cephalosporin is prescribed, it is best pharmacokinetically supported if used at the highest allowable dose divided as many times per day as possible. Even the "best" oral cephalosporins are pharmacokinetically inferior to amoxicillin for susceptible pathogens, though cephalexin has a reasonable profile for MSSA.

Concept 3: When you need to prescribe, consider the workhorse, amoxicillin.

In contrast, amoxicillin and its combination (amoxicillin/clavulanic acid) are well absorbed and not highly protein bound. However, they still suffer from shorter half-lives. As a result, high-dose twice daily dosing is not enough to treat intermediately resistant *S. pneumoniae*, unless it is in the middle ear (the drug half-life is longer in the middle ear). For maximal killing time, use high dose (90-100mg/kg/day), divided three times daily. If clavulanic acid is added, this expands the coverage to most common gram negative pathogens. However, because this is very broad coverage, it should not be used unless expanded coverage is clearly necessary.

Concept 4: Resist the temptation for azithromycin.

Unfortunately the seduction of its once daily dosing and short course has made azithromycin a favorite for common outpatient pediatric diagnoses. It does not achieve serum levels sufficient to kill for most common pediatric bacterial pathogens. Though it does concentrate in some tissues, this is not enough for bacteriologic success. For example, in the middle ear it is bacteriologically and clinically inferior (see Dagan, Int. J. Antimicrobial Agents, 2007). Though omitted from pediatric clinical care guidelines for sinusitis, otitis media, streptococcal pharyngitis and community acquired pneumonia (except in severe penicillin allergic patients or treatment of atypical pathogens), this drug is still popular. Moreover, it is even unclear if pediatric patients with atypical

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Changing Kid's Lives One Bike at a Time

Bikes For Life

With nearly a quarter of Colorado kids overweight or obese, childhood obesity is a serious concern to health care providers. As providers and parents, we know children need 60 minutes or more of physical activity a day in order to maintain a healthy lifestyle. But for many families, that is not as simple as it sounds. The Bikes For Life program was established in 2011 as a means to help connect children with some basic tools and information to help kids be active.

Bikes For Life is a partnership between Children's Hospital Colorado and UnitedHealthcare, which encourages Colorado youth to develop healthy habits and a lifelong commitment to wellness through bicycling. Over the next three years, Bikes For Life will provide 1,000 bicycles and helmets to qualifying children in the Boys and Girls Clubs of Metro Denver and Children's Hospital Colorado clinics.

Children enrolled in the program will attend a two-hour bicycle education clinic. At the clinic, they will be educated on rules of the road, how to properly wear a helmet, how to perform a quick check of a bicycle before riding, and other bicycle safety information. Once they have been fitted with their helmets and to their bicycles, they will have the opportunity to ride their bicycles and practice important balance and large motor skills on an obstacle course. For many of the children in the program, this will be the first time they are on a bicycle. These children will be taught separately how to balance on a bicycle and then how to pedal. During the half-hour skills course, children are able to learn how to ride a bicycle for the first time.

Bicycles will serve as an incentive to encourage increased physical activity and develop long-term lifestyle habits. In return for a free bicycle, participating youth commit to bicycling on a regular basis and will be provided with ongoing support and evaluation. For one year, participants will report activity levels and height/weight measurements at key intervals to track their progress. Ultimately, researchers at Children's Hospital Colorado will be able to report on how bicycling can improve health status as a result of engaging in physical activity.

Bicycling safely is a priority, and participants and their families will be invited to participate in community events focused on improving skills and encouraging safe bicycling. Through these events, Bikes For Life will promote bicycling as a safe and healthy activity for Colorado's youth.

Information on how to get involved is available at www.childrenscolorado.org/BikesForLife.

Children's Hospital Colorado
Affiliated with School of Medicine University of Colorado Anschutz Medical Campus

kids corner

Keeping Colorado's family physicians up-to-date on children's health topics

WHY WE VACCINATE KIDS

By Robert Brayden, MD

In the winter of 1964-65, the United States sustained an epidemic of rubella, also known as German measles or three-day measles. More than 12 million Americans came down with the disease, and essentially all of them recovered.

Unfortunately, rubella virus injures a fetus. Twenty thousand of those infected turned out to be pregnant women who would go on to give birth to children affected by the virus. The children were born with birth defects, known collectively as congenital rubella syndrome. The virus affects many body organs, but the most serious influences on a growing fetus are on the brain, the eyes and the heart. Thousands were diagnosed with mental retardation. The estimated cost of taking care of these 20,000 affected children was $840,000,000. You can imagine the consequences in terms of heartache and loss.

In 1969, the first rubella vaccine was approved in the United States. In 2007, there were 12 cases of rubella in the entire country. Rubella had been reduced by a million fold. There was not a single case of congenital rubella syndrome reported.

Taken from this perspective, the reason we vaccinate is enormously clear. We improve our quality of life and save medical costs with a safe and effective vaccine. The same story can, to various extents, be told for every vaccine.

Vaccines, however, have become a victim of their own success. Many young parents today have never seen the 16 diseases against which we now routinely vaccinate. Diphtheria, tetanus, measles, mumps, rubella, and polio—these diseases are virtually gone. Hepatitis A and B, and Haemophilus influenzae type B are fading away. Many medical students—much less parents—have not seen these diseases.

But there is still much to do. Preventing pertussis, chickenpox and Streptococcus pneumoniae can still be improved upon. In the first six months of 2012 in Colorado, there were 484 cases of whooping cough reported, 302 of chickenpox and 244 of invasive Streptococcus pneumoniae. Meningococcal-borne diseases and influenza are being reduced with vaccines, but we remain in the early stages of benefiting from their prevention. Perhaps someday in the future, cervical cancers triggered by human papillomavirus infections will be eliminated.

Colorado 's vaccination rate—a proxy measure for vulnerability to disease—has risen into the middle of the rates for all of the states in the past five years. More than 91 percent of all vaccine series have been completed by American children and thus we should be able to prevent most cases of vaccine-preventable diseases.

Parents, however, remain concerned. One of the biggest concerns is the number of shots that kids get. At many doctor visits, kids will get three, four or even five or more injections. Parents are rightly concerned about the emotional consequences of these painful procedures. Without the reminders of disease, parents do not see the converse benefit of vaccination. The diseases however, will return without high levels of vaccination, thus creating a paradox.

The way out of this paradox contains many small steps. First, when a vaccine can be administered via nasal inhalation as opposed to injection, it should be done that way. The availability of nasal influenza vaccine needs to be improved and it must continue to be affordable.

Second, improvements in the way in which vaccines are combined into a single injection need to be made. In Europe, a six-valent vaccine combination is helping to reduce the number of injections. More combinations will likely be coming to the U.S.

Thirdly, bio-technology needs to discover new ways of administering vaccines that are currently given by injection. Skin patches administer many medications; perhaps vaccine antigens could also be delivered in this way. Perhaps antigens could pass through the stomach without being digested and later be absorbed in immunizing amounts from the gastrointestinal tract. These issues are complex and will take time to resolve.

Finally, some (but not all) of the diseases against which we vaccinate can be eradicated. Just like smallpox, the first disease to be eradicated intentionally from the globe, perhaps someday soon we will be able to declare victory over one or more vaccine-preventable diseases of humans and be able to cease vaccination entirely. Perhaps polio. Perhaps other diseases someday.

In the meantime, we need to maintain high levels of vaccination.

There are several actions we can take

- Access to a medical home for children is one of the most important ways of helping ensure timely vaccination. Medical homes are where the majority of medical care is, and should be, provided.
- We need to get the word out about the improvements

in the quality of life and health as a result of vaccination. Funding and support of communications efforts will cost money, but think how much money we have saved as a result of vaccines. A fraction of this should support vaccination education efforts.

• Providers must have access to reliable and accurate information about vaccine preventable disease. As with communications efforts, we should spend some of the money we have saved on ensuring that we don't have the diseases return.

Robert Brayden, MD, is the president of the board of directors of the Colorado Children's Immunization Coalition, professor of Pediatrics at the University of Colorado Denver and an active instructor for Family Medicine residents at the Children's Health Clinic.

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

"Some (but not all) of the diseases against which we vaccinate can be eradicated. Just like smallpox, the first disease to be eradicated intentionally from the globe, perhaps someday soon we will be able to declare victory over one or more vaccine-preventable diseases of humans and be able to cease vaccination entirely."

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pneumonias benefit from treatment.

Concept 5: Don't get too broad or too fancy.

Because bacteria really don't like their DNA replication systems messed with, they try very hard to develop resistance. Thus, the fluoroquinolones arguably drive resistance and selection of Clostridium difficile more than any other class of drugs. Also, though the significance of fluoroquinolone arthropathy in pediatrics is not clear, it is real (Noel et al, Ped Infect Diseases, 2007). Linezolid and daptomycin have MRSA coverage, but there is rarely reason to use them over older MRSA drugs. Drainage is the most important aspect of therapy in soft tissue abscesses, and culturing can help avoid the need for these drugs. Patients may also be put at risk if not monitored for the serious side effects of these less familiar drugs.

Michelle Mitchell, MD, is currently a third-year fellow in Pediatric Infectious Diseases with an interest in antimicrobial stewardship.

Sarah Parker, MD, is an associate professor in Pediatric Infectious Diseases and medical director of Antimicrobial Stewardship at Children's Hospital Colorado. Her background is in microbial genetics.

Concept 6: Perhaps your practice needs to elect a steward! A practice steward reviews current literature and helps design guidelines for antimicrobial use for your practice; if your steward would like to discuss antibiotics, contact us!

Reviewing the Necessity of Common Medical Tests and Procedures

By COPIC's Patient Safety and Risk Management Department

In 2012, the ABIM Foundation, a not-for-profit foundation established by the American Board of Internal Medicine, launched a project called "Choosing Wisely," which seeks to encourage physicians and patients to follow evidence-based guidelines in managing health problems and avoiding medical procedures that are unlikely to be of real benefit.

Recognizing that physicians often struggle with decisions about prescribing tests and procedures as a way of covering all possible bases, the ABIM Foundation joined with nine leading medical specialty societies[1] to develop lists as guidelines. A master list of "45 Things Physicians and Patients Should Question" was developed as evidence-based suggestions that should be considered in the way you practice. These recommendations from the ABIM Foundation are guidelines and do not establish a standard of care. They also are not comprehensive for all clinical conditions. Reasonable care that is different from each of these selected guidelines is defensible with a carefully documented and comprehensive history, physical and thought process of clinical judgment.

The following are selected excerpts from the master list:

1. Don't order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis. Viral infections cause the majority of acute rhinosinusitis and only 0.5 percent to 2 percent progress to bacterial infections. Most acute rhinosinusitis resolves without treatment in two weeks. Uncomplicated acute rhinosinusitis is generally diagnosed clinically and does not require a sinus CT scan or other imaging. Antibiotics are not recommended for patients with uncomplicated acute rhinosinusitis who have mild illness and assurance of follow-up. If a decision is made to treat, amoxicillin should be the first-line antibiotic treatment for most acute rhinosinsutis.

2. Don't diagnose/manage asthma without spirometry. Clinicians often rely solely upon symptoms when diagnosing and managing asthma, but these symptoms may be misleading and be from alternate causes. Therefore, spirometry is essential to confirm the diagnosis in those patients who can perform this procedure. Recent guidelines highlight spirometry's value in stratifying disease severity and monitoring control. History and physical exam alone may over- or under-estimate asthma control. Beyond the increased costs of care, repercussions of misdiagnosing asthma include delaying a correct diagnosis and treatment.

3. Don't perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients. Performing stress cardiac imaging or advanced noninvasive imaging in patients without symptoms on a serial or scheduled pattern (e.g., every one to two years or at a heart procedure anniversary) rarely results in any meaningful change in patient management. This practice may, in fact, lead to unnecessary invasive procedures and excess radiation exposure without any proven impact on patients' outcomes. An exception to this rule would be for patients more than five years after a bypass operation.

4. In patients with low pretest probability of venous thromboembolism (VTE), obtain a high-sensitive Ddimer measurement as the initial diagnostic test; don't obtain imaging studies as the initial diagnostic test. In patients with low pretest probability of VTE as defined by the Wells prediction rules, a negative high-sensitivity D-dimer measurement effectively excludes VTE and the need for further imaging studies.

5. Avoid nonsteroidal anti-inflammatory drugs (NSAIDS) in individuals with

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AND THEY'RE OFF!

Colorado CPCi Practices Start Quality Improvement Work Nov. 1

By Marjie Grazi Harbrecht, MD

What lies ahead for the 73 Colorado primary care practices chosen to participate in the Comprehensive Primary Care Initiative referred to as CPCi?

Changes in care will be delivered using new practice processes, care management and data to drive improvements, particularly for high-risk patients. CPCi participants will essentially adopt the health care model tested in the Colorado Multi-Payer Patient Centered Medical Home Pilot — which demonstrated improvements in quality, satisfaction and reductions in cost trends to help establish patient-centered care as the new norm for primary care providers.

The CPCi is a nationwide, multipayer project from the Centers for Medicare and Medicaid Services Innovation Center providing enhanced compensation for high-quality, coordinated, patient-centered care to patients in selected practices. Starting Nov. 1, the centers began using a blended payment model combining traditional fee- for-service reimbursement with a $20 per-member, per-month fee to promote enhanced functions such as care coordination. The model also provides the opportunity to share in cost savings.

Participating commercial insurers, state health plans and other carriers also make enhanced payments to CPCi practices to support high-quality primary care. Payers in the Colorado market are Anthem Blue Cross Blue Shield of Colorado, Cigna, Colorado Access, Colorado Choice Health Plans, Colorado Medicaid, Humana, Rocky Mountain Health Plans, and UnitedHealthcare.

CPCI LAUNCH IN COLORADO DRAWS MORE THAN 200

More than 200 members from Colorado's selected practices attended the Oct. 26 kick-off event hosted by HealthTeamWorks and Rocky Mountain Health Plans (RMHP) at the Doubletree Hotel in Greenwood Village. HealthTeamWorks will provide onsite coaching to facilitate patient-centered care in Front Range practices; RMHP will support those on the Western Slope.

Asaf Bitton, MD, MPH, FACP, an instructor in medicine and health care policy at Harvard Medical School and Brigham and Women's Hospital in Boston, and special adviser to the CPCi, outlined the nine milestones that CPCi practices must meet by the end of Year 1:

- Create a budget forecast showing where CPCi money is reinvested.
- Demonstrate the provision of case management services for high-risk patients.
- Establish provider access to patient data 24/7 so providers can participate in care decisions with their patients anytime, and allow patients access to the care team 24/7.
- Demonstrate improved patient experiences using the CAHPS* survey or a patient advisory council that meets at least quarterly.
- Demonstrate use of data to guide patient care at the care team level via use of quality management projects.
- Demonstrate active engagement across the medical neighborhood.
- Improve shared decision-making with patients.
- Participate in regular learning sessions and market-based learning collaboratives.
- Meet requirements for EHR** Meaningful Use Stage 1.

Key elements that will assist practices in meeting initiative goals include health plan consistency on project parameters, clinical measures, and data sharing with practices on utilization issues. All CPCi practices will participate in shared learning opportunities including webinars, day-long learning sessions, and online resources.

IT TAKES A TEAM

David Nuhfer, MD, described the work that lies ahead. He is one of four providers with Family Practice Associates in Louisville, which participated in the PCMH Multi-Payer Pilot. "This is hard work, but I realized, 'I can do this,'" he told the audience. "It takes a team … We learned that data make a difference — if you measure it, it will improve."

Nuhfer endorses the PCMH model. "We are a better practice. We have to keep this work going. It's a privilege to be a part of this [the CPCi]."

500 PRACTICES PARTICIPATING NATIONWIDE

Nationwide, 500 primary care practices are participating in the CPCi. They represent 2,144 providers serving an estimated 313,000 Medicare beneficiaries. The 73 Colorado clinics comprise 335 providers with an estimated 41,000 Medicare patients plus many others covered by commercial insurers.

The Innovation Center chose practices based on:

- Commitment to quality improvement,
- Use of technology,
- Recognition of advanced primary care delivery,
- Service to patients covered by participating payers,
- Experience with practice transformation and improvement activities, and
- Diversity of geography, practice size and ownership structure.

CPCi will provide an incredible opportunity to build on the tremendous work started in the Colorado multi-payer pilot. By spreading to more practices, engaging Medicare and several commercial plans and further redesigning how primary care is delivered and paid for, this initiative will take us to the next level in reaching Triple Aim Goals: improving individual and population health, at an affordable cost, with increased satisfaction for patients and their healthcare teams.

** Consumer Assessment of Healthcare Providers and Systems*

***Electronic health record*

COPIC Donates $10,000 to Support Prescription Drug Monitoring Program

COPIC, a leading medical liability insurance provider that focuses on patient safety initiatives, recently made a $10,000 donation to support Colorado's Prescription Drug Monitoring Program. The PDMP, which is overseen by the Colorado State Board of Pharmacy, provides a database of controlled substance prescriptions that have been dispensed by registered Colorado pharmacies and it serves as a resource for medical practitioners and pharmacists.

The PDMP enables medical practitioners and pharmacists to gather information about their patients and ensure that their prescribing and dispensing are appropriate for the circumstances presented. For instance, if a patient is taking OxyContin, the prescriber would be able to review when the patient was first prescribed the drug, how many providers have prescribed for the patient, how often, and from what pharmacies the patient has received controlled drugs.

COPIC's donation will support the maintenance of the PDMP, which was established in 2005 and reauthorized in 2011. According to a recent report by the Congressional Research Service, "Nearly all prescription drugs involved in overdoses are originally prescribed by a physician." The report also noted that prescription drug abuse has been identified as the United States' fastest growing drug problem with seven million individuals (aged 12 or older) being current nonmedical users of prescription—or psychotherapeutic—drugs in 2010.

"The PDMP is a key tool in addressing the issue of prescription drug abuse and we have worked closely with the health care professionals we insure to reinforce this and how it assists their efforts to provide quality care," said Ted Clarke, MD, chairman and chief executive officer of COPIC. "We are proud to support the ongoing initiatives of this program, as it improves health care services and overall treatment for all patients in Colorado."

The information collected by the PDMP is accessible online only by licensed, authorized medical practitioners and pharmacists. Patients may receive their own personal data by contacting the PDMP. Law enforcement officials may contact the PDMP to obtain prescriber or patient data (a court order or subpoena is required for such release).

"Having strong support from leaders in Colorado health care, such as COPIC, enables us to keep the PDMP a solid and reliable resource designed to empower the health care community in the prevention of prescription drug abuse," said Tia Johnson, PDMP administrator. "We are grateful for not only COPIC's financial support, but also for its role as an important advocate for this program and the benefits it provides."

Founded by physicians in 1981, COPIC is a leading medical liability insurance provider that focuses on patient safety initiatives that reduce medical errors and improve outcomes. Its mission is to improve medicine in the communities served. COPIC partners with physicians, health care facilities, and hospitals to provide patient safety and risk management educational resources that reinforce the practice of good medicine. COPIC alsoå serves as a strong advocate for medical professionals on important policy issues and maintaining a stable medical liability environment that has a direct impact on accessible, affordable health care. COPIC consists of COPIC Insurance Company, COPIC Financial Service Group, Ltd., and COPIC Medical Foundation—all of which work together to collaborate with key stakeholders and the broader health care community. The web site is www.callcopic.com.

The Prescription Drug Monitoring Program is overseen by the Colorado State Board of Pharmacy within the Department of Regulatory Agencies (DORA). DORA is dedicated to preserving the integrity of the marketplace and is committed to promoting a fair and competitive business environment in Colorado. The web site is www.dora.state.co.us/pharmacy.

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hypertension or heart failure or chronic kidney disease (CKD) of all causes, including diabetes. The use of NSAIDS, including cyclo-oxygenase type 2 (COX-2) inhibitors, for the pharmacological treatment of musculoskeletal pain can elevate blood pressure, make antihypertensive drugs less effective, cause fluid retention and worsen kidney function in these individuals. Other agents such as acetaminophen, tramadol or short-term use of narcotic analgesics may be safer than and as effective as NSAIDs.

The goal of the "Choosing Wisely" campaign is to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources in the United States. It is hoped that this will promote wise choices by clinicians in order to improve health care outcomes, provide patient-centered care that avoids unnecessary and even harmful interventions, and reduce the rapidly expanding costs of the health care system. Additional information is available at the ABIM Foundation's "Choosing Wisely" website at www.choosingwisely.org.

[1] **Medical specialty societies that helped develop guidelines: American Academy of Allergy, Asthma & Immunology, American Academy of Family Physicians, American College of Cardiology, American College of Physicians, American College of Radiology, American Gastroenterological Association, American Society of Clinical Oncology, American Society of Nephrology and American Society of Nuclear Cardiology.*

The goal of the "Choosing Wisely" campaign is to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources in the United States. It is hoped that this will promote wise choices by clinicians in order to improve health care outcomes, provide patient-centered care that avoids unnecessary and even harmful interventions, and reduce the rapidly expanding costs of the health care system.

Moving Forward in the New Year: *A Fit Family Challenge Update*

By Sarah Roth, Program Manager

The Fit Family Challenge project continues to meet success as we work to combat pediatric obesity in the state of Colorado. The 12-month data from the initial pilot demonstrates the powerful impact the intervention has had so far. Body mass index and blood pressure measures have slightly decreased while measures of healthy behaviors centered on the 5-2-1-0 message have mostly improved. Daily fruit and vegetable intake has increased by an entire serving per day. In this issue of the CAFP News, Bonnie Jortberg, PhD, RD, CDE, further details the 12-month data.

On Oct. 4 and 5 we hosted in Denver the dynamic group of participating practices for the Fit Family Challenge Training and Biannual Learning Collaborative. Twenty-one primary care practices across the state have agreed to participate in the second phase of the pilot project. During the two day training, the project team covered several key topics, including the HealthTeamWorks pediatric obesity guidelines, motivational interviewing, data collection, and the HeartSmartKids System, as well as billing and reimbursement. On the first day, we provided the 14 new practices with an overview of the project and outlined project expectations. The second day allowed an opportunity for new and continuing sites to engage in rich discussion concerning best practices, successes, challenges and much more.

Following the Learning Collaborative we scheduled on-site rapid improvement activities for each of the 14 new practices joining the pilot. Each 90-minute session includes a review of the HealthTeamWorks pediatric obesity guidelines with the entire practice staff and support in developing a work flow that incorporates the Fit Family Challenge pilot into the practice.

As always we are thankful for the contributions of the Fit Family Challenge project team and pilot sites whose commitment to pediatric obesity and endless energy underpin the project's success. Find out more about how our project partners address pediatric obesity at www.heartsmartkidslive.com and www.healthteamworks.org/guidelines/childhood-obesity.html.

Holiday Healthy Living Tip:

Start a family tradition that involves moving. Who says that holiday stress and cooler temps have to keep you indoors?! Physical activity can help relieve stress, regulate appetite and burn up extra calories. Participate in local Turkey Trots and Jingle Bell Runs, or try winter sport activities such as hiking, snow shoeing and skiing. You just might start a great family tradition! More healthy living tips are available on our Facebook page at www.facebook.com/Colorado5210

To find out more about the Fit Family Challenge visit our website, http://coloradoafp.org/pobesity, or contact Sarah Roth, program manager for Fit Family Challenge, 2224 S. Fraser St., Unit 1; Aurora, CO 80014; by phone at 303-696-6655x16 or by email at sarah@coloradoafp.org.

Kent Voorhees, MD, appointed as Chair of the AAFP Commission on Education

Congratulations to Kent Voorhees, MD, on his appointment to chair the American Academy of Family Physicians Commission on Education for 2012-2013. The quality of his prior service on the Commission on Education was noted by the Subcommittee on Screening and the AAFP board. It is through dedicated efforts of Family Physicians such as Dr. Voorhees that the AAFP can be strong and healthy to better serve its members.

Dr. Voorhees is a past president of the Colorado Academy of Family Physicians and currently serves as alternate delegate to the AAFP Congress of Delegates.

The Fit Family Challenge Project 12-Month Data Report

By Bonnie T. Jortberg, PhD, RD, CDE, Assistant Professor,
Department of Family Medicine, University of Colorado School of Medicine

We are pleased to provide the 12-month report on the deliverables for the Fit Family Challenge, or FFC, for behavior change data and clinical outcomes. The overall goal of this project is to reduce childhood obesity in Colorado through the use of integrated childhood obesity guidelines and implementation of a family-based intervention into clinical settings across the state, with a focus on rural and underserved populations. The project team and pilot practices participating have made significant progress towards our measureable results and achieving grant milestones.

Building on the report in the CAFP June issue, we continue to see decreases for body mass index (or BMI), systolic and diastolic blood pressure, and improvements for lifestyle factors related to the 5-2-1-0 message (five servings of fruits and vegetables per day; two or fewer hours of screen time per day; one hour or more of physical activity per day; and zero servings of sugar-sweetened beverages per day) for children enrolled in the Fit Family Challenge.

Summary of Results

- All clinical outcomes continue to slightly decrease:
  - o BMI percent decreased by .21 (from 96.9 percent to 96.5 percent)
  - o Systolic blood pressure decreased by .3
  - o Diastolic blood pressure decreased by .2

HeartSmartKids (HSK) Questionnaire Results (Pre/6-mo/12-mo)

- All measures related to the 5-2-1-0 message improved. Some measures not related to 5-2-1-0 did not change (i.e. dairy consumption) and this may be related to a lack of emphasis of the Fit Family Challenge program on these measures.
- Dietary results:
  - o Fruit and vegetable intake increased from 2.8 to 3.9 servings/day (+1.1 and an additional increase of .8 serving per day from 4-6 month data). This result was statistically significant (p less than .001).

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Fit Family Challenge Clinical Outcomes

Clinical Outcome	Baseline N= 181	4-6 Months (N=156)	12 Months N=112	Change (+/-)	
				4-6 months	12 months
BMI (percentile)	97.0	96.7	96.5	-.3	-.5
Systolic BP (mm Hg)	104.8	104.6	104.5	-.2	-.3
Diastolic BP (mm Hg)	65.4	65.3	65.2	-.1	-.2

HSK Question	Baseline	4-6 Months N=156	12 Months N=112	Change (+/-)	
				4-6 months	12 months
Each day, about how many fruits & vegetables does your child eat?	2.8 servings/day	3.6 servings/day	3.9 servings/day	+.8 servings/day	+1.1 servings/day**
Each day, about how many times does your child drink soda, juice, or other sweet beverages?	1.6 times/day	1.3 times/day	0.9 times/day	-.3 times/day	-.7 times/day
Each day, about how many glasses of milk, cups of yogurt, or servings of cheese does your child eat or drink?	2.5 servings/day	2.9 servings/day	2.6 servings/day	+.4 servings/day	+.1 servings/day
How many days per week is your child physically active, outside of school time, for at least 60 minutes? (walking, running, biking, swimming, playing outside, dancing, etc.)	4.0 days/week	4.4 days/week	4.9 days/week	+.4 days/ week	+.9 days/week
How many times per week does your family do something active together?	2.3 times/week	2.7 times/week	2.4 times/week	+.5 times/week	+.1 times/week
In total, how many hours per day does your child watch TV or movies, or play video or computer games?	2.5 hours/day	2.2 hours/day	2.1 hours/day	-.3 hours/day	-.4 hours/day

**p<.001

OUR CHILDREN NEED YOU!

In order to duplicate last year's success, Tar Wars needs your support!

The mission and goal of Tar Wars is to educate fourth and fifth grade students about being tobacco free, provide them with the tools to make positive decisions regarding their health, and promote personal responsibility for their well-being. By utilizing a community-based approach to mobilize family physicians, educators, and other health care professionals, Tar Wars can accomplish its mission. Goals of the program are to:

- Educate and motivate students to be tobacco free
- Mobilize health care professionals to become proactive in their community's health education
- Encourage community involvement in support of the Tar Wars program

Please join us in participating to bring this life-saving program to the kids of Colorado. In order to get to the Tar Wars website, please go to www.coloradoafp.org and click on CAFP Programs, then Tobacco Education/Cessation, and finally Tar Wars. You may then fill out the Presenter Participation form and submit or request a form by email and I will send it directly to you.

Join us, for the health of it!

Carrie Wilhelm
CAFP
Colorado Tar Wars Coordinator
2224 S. Fraser St., Unit #1
Aurora, Colorado 80014
303-696-6655 ext. 17
Carrie@coloradoafp.org
www.tarwars.org

Tar Wars®

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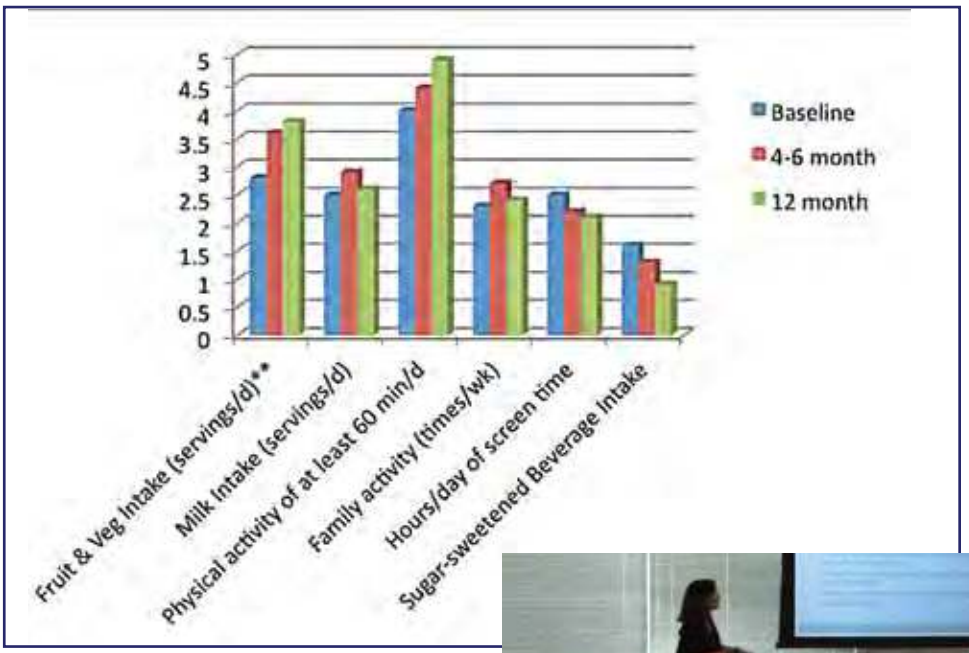
FFC HeartSmartKids Questionnaire Outcomes (Baseline/4-6 Mo/12 Mo)



Bonnie Jortberg, PhD, teaching about FFC history, research, and program guide

o Sugar sweetened beverage intake decreased from 1.6 servings per day at baseline to .9 serving per day at 12 months (-.7 serving per day; decreasing daily calorie consumption by approximately 50 kcals).

o Dairy consumption stayed relatively the same, a difference from the increase by almost one-half serving/day (+.4) seen with the 4-6 month data.

• Physical activity/decrease in sedentary behavior results:

o Days of physical activity of at least 60 minutes increased from baseline of 4.0 days per week to 4.9 days per week, an increase from the 4-6 months of almost one-half of a day (+.4) to almost a full day per week.

o Amount of family doing something active together increased slightly from baseline but decreased from 4-6 months (+.5).

o Sedentary behavior (watching TV or movies or playing video or computer games) continued to decrease for the 12-month data, decreasing by an additional .1 hour per day from the six-month data to 2.1 hours per day (-.4 hour from baseline).

These results indicate that our project is having a positive impact on reducing the burden of pediatric obesity in Colorado. We recently received funding for an additional three years for this project and enrolled 14 more primary care practices across Colorado. We look forward to continuing to track changes for the participants enrolled in the Fit Family Challenge.

This project was made possible through the support of The Colorado Health Foundation and the dedicated work and efforts of the physicians and staff at the participating pilot practices.

Additional information is available by contacting Sarah Roth at sarah@coloradoafp.org or 303.696.6655 ext. 16.

What Does the Reach Out and Read Colorado Coalition Do?

By Robert Brayden, MD

This article is part two of a series. The first article appeared in a previous edition of this publication.

The Reach Out and Read Colorado coalition provides a communication and networking structure, evaluation and quality assurance, training and technical assistance, advocacy and visibility, as well as funding to purchase books. Maintaining quality is an important focus for the coalition. The coalition would like to ensure that all clinics are providing families with high quality books and developmentally and culturally appropriate messaging. Each clinic is evaluated yearly to make sure that the process of handing out books is efficient and easy and to help providers improve their messaging to families. There are a number of opportunities that the coalition has created for Reach Out and Read providers:

Every two years we host a Reach Out and Read Colorado conference to promote different topics around early childhood literacy. We also have a quarterly provider e-newsletter and coordinator newsletter to keep in touch with our large network of providers and clinics. Reach Out and Read National has created an online training program that all new providers need to complete for a clinic to be approved as a Reach Out and Read site. This online training is a great source of information on how to effectively practice Reach Out and Read and can provide a good refresher for any practitioner who feels the need. The national organization also provides webinars throughout the year on various topics including "Train the Trainer", and "Leyendo Juntos."

"Train the Trainer" is specifically designed for folks who will be teaching Reach Out and Read to other providers, like residents and students. Leyendo Juntos is one of Reach Out and Read's initiatives to improve the messaging providers give to their Spanish speaking patients and families. The initiative began with webinairs and is currently moving toward an online continuing medical education training for Reach Out and Read providers regarding not only how to optimize the promotion of early literacy development with Spanish speaking families, but also encouraging and applauding bilingualism.

Finally the coalition is involved in training through Colorado's pediatric and multiple Family Medicine residency training programs. Most programs have their own trainers, enthusiastic Reach Out and Read champions who are in charge of training the new faces of Reach Out and Read.

WHAT IS COMING UP? Reach Out and Read Colorado has two initiatives this coming year.

BILINGUAL FAMILIES

The first initiative is supporting bilingual families: Many children in Colorado grow up in families where English is not the primary language. In the fall of 2010, 13.9 percent of all K-12 pupils enrolled were English Language Learners (ELLs). Within Denver public schools, 35.1 percent are ELL.1 On the 2010 third-grade reading standardized tests, 69 percent of ELLs did not score proficient. According to the Colorado Children's Campaign, only 5 percent of fourth-graders who are non-native English speakers could read at grade level. Bilingualism can increase brain plasticity. Benefits include: increased language ability (increased phonemic awareness and vocabulary), increased academic benefits (understanding how languages work, math) and improved abstract thinking, creativity and cognitive flexibility. Cultural benefits include feeling proud of their heritage and nurturing better relationships among family members. For children living in poverty and with a litany of disadvantages, promoting bilingualism is a powerful gift from parents to help counteract detrimental exposures. As health care providers for young children, we should be encouraging parents to speak their heritage language (Spanish, Amharic etc.) at home and we should be giving them ideas as to how to provide quality exposure of this language, for instance by reading together. 3

With this data in mind, Reach Out and Read Colorado wants to educate, celebrate and improve the messaging around bilingualism by partnering with and promoting Leyendo Juntos as well as educating Reach Out and Read providers in the benefits and best practices for promotion of bilingualism. Among Spanish-speaking families, parents' perspectives of Reach Out and Read in Colorado were very positive.4 Spanish-speaking families also reported low availability of books and high enthusiasm about receiving the books. Reach Out and Read Colorado would like to ensure that these families are not only receiving the Reach Out and Read intervention at their medical home but also

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CU Recruiting Practices for NIH-Funded Study of Self-Management Support

Self-management support is a critical part of the Patient Centered Medical Home framework for health system redesign – but effective self-management support can be very challenging for primary care practices to implement. The University of Colorado Department of Family Medicine recently received funds from the National Institutes of Health-National Institute of Diabetes and Digestive and Kidney Diseases to implement Connection to Health, a project to compare three interventions to assist practices with implementation and sustainability of self-management support over time. This project particularly focuses on patients with diabetes, but other patients may be included at the practice's discretion. Practices will be randomized to receive one of three implementation assistance interventions. Family Medicine and internal medicine practices in Colorado and the San Francisco Bay area will be included in the project.

The Connection to Health system is a collection of web-based tools designed to support practices in providing self-management support for their patients. Key features include the following.

- Patients complete a structured, evidence-based, automated assessment of disease-related lifestyle activities and psychosocial factors known to affect clinical outcomes.
- A summary report is generated with specific recommendations for action.
- The patient then can prioritize from the recommendations one or two primary issues for discussion with his or her clinician during the visit.
- A report of the results of the assessment and prioritization, with suggestions for clinical intervention based on the assessment, is then provided for both patient and clinician.
- This is designed to prompt a clinical conversation during the visit about key self-management support problems.
- The project helps to focus and simplify the self-management support process.

Practice recruitment will begin in February 2013, with 18 primary care practices participating in Colorado. Practices must have a minimum of 80 patients with type 2 diabetes; have the majority of clinicians within the practice willing to participate; be able to participate for 18 months; be willing to accept random assignment to one of three interventions; have internet access in the practice; have a functional electronic health record for at least 12 months; and be willing to complete study questionnaires and participate in data collection.

Practices that are interested in more information or would like to participate should contact Randa Kniceley at RANDA.KNICELEY@UCDENVER.EDU

UCD Medical Student Program Aims to Grow Pool of Rural Physicians

By Rick Budensiek, DO

A recent article in the U.S. Today quoted American Academy of Family Physicians statistics that the number of medical students going into primary care has dropped 51.8 percent since 1997. It went on to report that the AAFP statistic indicates that there will be a shortage of 40,000 Family Physicians in 2020. The current environment is attracting only half the number needed to meet the demand.

One reason for the shortage is a rapidly increasing demand, fueled by several factors. These include the aging of the baby boomer generation, the expansion of Medicaid programs and the growth in the number of people insured due to the Affordable Care Act. This demand for more primary care services translates into and the need for a larger primary care workforce.

Also contributing to the shortage are factors that make other careers appear more attractive than medicine and other specialties appear more attractive than Family Medicine. These include the high cost of medical education and the disparity of earnings between primary care and specialties.

One effort to increase the primary care workforce, especially for rural Colorado communities, is a program the University of Colorado Denver has introduced. UCD is recruiting highly qualified high school students from rural communities to join a program that funds their undergraduate education and guarantees them a spot in CU medical school upon successful completion their undergraduate degrees and maintenance of a 3.5 grade point average. These students are placed in dorms with other students in the program, allowing for mentoring and support among students with similar goals. Students are more likely to practice in communities similar in size to the communities in which they have been reared so pre-selection of students from rural communities increases the pool of doctors likely to practice in rural communities. In addition, advocates of the program hope it will create a source of future physician leaders of Patient Centered Medical Homes.

If you know of capable students from rural communities who have aspirations to practice medicine, please refer them to:

Trishia Vasquez
BA/BS-MD Program Coordinator
University of Colorado Denver
Department of Integrative Biology
303 352 3557
trishia.vasquez@ucdenver.edu

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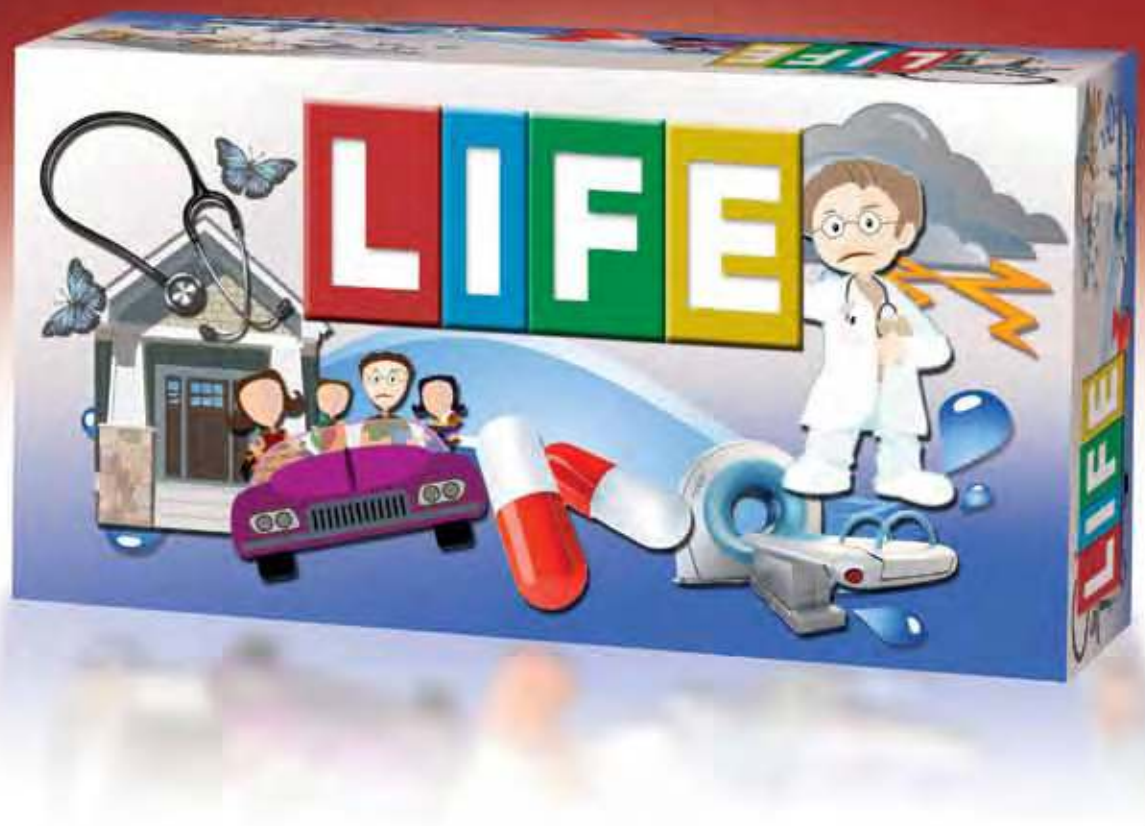

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The Adjudication of PHYSICIAN DISPENSING *for Colorado Medicaid Beneficiaries*

By John Bender, MD

John Bender, MD, staff, and patients meet with Board of Pharmacy

A small delegation of patients and Miramont Family Medicine pharmacy techs and managers met with senior staff at the Board of Pharmacy/Colorado Department of Regulatory Agencies Aug. 22.

We visited for an hour with Wendy Anderson and Chris Gassen, who have been with DORA for 16 and 11 years respectively. They were clear that there is nothing in statute or rule-making from DORA that prevents the comptroller for the Department of Health Care Policy and Financing from paying physicians for in-house dispensing and adjudicating our claims. Although the Board of Pharmacy regulates Colorado pharmacies, Anderson and Gassen reiterated that physician dispensing is regulated solely by the Board of Medicine, that the Board of Pharmacy has no jurisdiction over physician dispensing, and therefore the "other outlet" rules do not apply. (The relationship is analogous to the Board of Nursing overseeing the advanced practice nurses, a matter in which the Board of Medicine has no jurisdiction.)

In closing, physician dispensing offers the prospect of lower costs to the taxpayer, better population compliance and outcomes, and better patient experience of care (triple aim). The current policy of the Department of Health Care Policy and Financing is not in line with federal policy (e.g. Medicare and Tricare adjudicate with physician dispensing) or with with many other states (my software vendor for the adjudication says Colorado is the only state where they do business but cannot get a contract). The policy is protectionist with the main beneficiaries being large box store corporate pharmacies, such as Walgreens, Wal-Mart, at the expense of private sector small business owners who live, collect and pay Medicaid taxes in Colorado. The result is tantamount to restraint of trade with little to no benefit to the public.

I respectfully request that physician claims for dispensing be adjudicated by the Department of Health Care Policy and Financing for Medicaid beneficiaries via standard contracting with software vendors doing business in Colorado who are able to do so without any undue burden to the state for implementation (as the technology and licensing already exists and is in widespread use in the public and private sector).

Tamaan Osbourne-Roberts, MD, seeks CMS High Office

Focus is on high-quality care for all

Tamaan K. Osbourne-Roberts, MD, recently announced his candidacy for president-elect of the Colorado Medical Society. If elected, he would serve in the position for one year starting in September 2013 and then serve the subsequent year as president.

"My practice philosophy revolves around delivering high-quality care for every patient, regardless of economic, national or ethnic background," Dr. Osbourne-Roberts stated.

To help advance that philosophy, Dr. Osbourne-Roberts plans to take steps to assure "all physicians have a viable atmosphere in which to provide care," he said. He wants to be certain that doctors in both the public and private sectors are able to receive fair pay for services that allow them to provide high quality care to all.

Dr. Osbourne-Roberts also plans to take steps to make certain the Colorado Medical Society is supporting all doctors, whether they are in small or large private practices or working as employees of hospitals or large groups. He noted that practice demographics are changing as more physicians go to work as employees and fewer are in small private practices.

Dr. Osbourne-Roberts is the son of two immigrants from the Caribbean nation of the Republic of Trinidad and Tobago. When he was young, his father was in the U.S. Air Force and the family moved often. Places Dr. Osbourne-Roberts lived while his father was in the military included Guam, Florida, New York and Mississippi, as well as Denver. The cultural awareness and language skills he developed through these moves have often served as an asset in communicating with patients. He is fluent in English and Spanish and has limited ability to converse in French and Portuguese.

After earning his bachelor's degree at Williams College in Massachusetts, Dr. Osbourne-Roberts completed both his medical degree and his residency in Family Medicine at the University of Colorado.

He currently works at Salud Family Health Centers, a nine-clinic system that cares for underserved patients in northeastern Colorado.

On the state and local levels, Dr. Osbourne-Roberts serves on the boards of the Denver Medical Society, the Colorado Academy of Family Physicians and the Colorado Medical Society. On the national level, he is active in the American Academy of Family Physicians and the American Medical Association, where he serves on the Colorado delegation to the AMA House of Delegates. His candidacy is endorsed by the Colorado Academy of Family Physicians board of directors.

Dr. Osbourne-Roberts lives in Denver with his wife, Camille, and his two children, Keston and Noelle. When he's not working, he enjoys hiking, cooking, reading, scuba diving and traveling.

If he is elected he will succeed CAFP member John Bender, MD, who became president-elect in September 2012 and will become president in 2013. CMS leaders are elected by approximately 300 delegates representing the society's constituent organizations.

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hearing high quality messaging about the importance of reading out loud to their children and the importance of retaining a child's heritage language.

INCREASED VISIBILITY

The second initiative is increasing visibility. Reach Out and Read Colorado is well known within the Colorado medical community. We have consistently achieved our goal of providing funding for books to all of the clinics that participate in Reach Out and Read. Reach Out and Read Colorado serves nearly half of all low-income children under age 6 in Colorado, yet the general public is generally unfamiliar with this evidence-based program. In 2012, Reach Out and Read will celebrate 15 years of program provision in Colorado. Throughout the year, a public awareness campaign will be launched to increase

program visibility. As part of this effort, we are collecting stories from providers on their experience doing Reach Out and Read or how the program has benefited a families. Providers who have stories to share may send them to megan@reachoutandreadco.org.

More than 950 doctors and primary care providers provide Reach Out and Read to children each year in Colorado. We thank them for bringing literacy and anticipatory guidance into the exam room, and for all they do to support the program. Those who are interested in learning more about the program may visit www.reachoutandreadco.org or call: 303-623-3800.

REFERENCES

1. *2011 KIDS COUNT in Colorado*
2. *CSAP results 2010: http://www.schoolview.org/schoolperformance/csapinfo.asp*
3. *Lecture, Reach out and Read Colorado Conference 2010: Dr Naoim Steiner, Developmental-Behavioral Pediatrician, Floating Hospital for Children, Tufts University*
4. *Survey conducted by Reach Out and Read Colorado and Augenblick, Palaich and Associates in 2010.*

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