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*New specialties as of fall 2013

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Physicians are faculty of the University of Colorado School of Medicine.
## CAFP Board of Directors

**Officers 2013-2014**

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## Vision Statement:

**Thriving Family Physicians creating a healthier Colorado.**

## Mission Statement:

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

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**Contact Information for the CAFP**

Colorado Academy of Family Physicians
2224 S. Fraser St., Unit 1
Aurora, CO 80014
Phone: 303-696-8655 or 1-800-468-8615
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PRESIDENT’S REPORT
Rick Budensiek, DO, FAAFP

Your 2000 Member Strong ‘Clique’

I was recently surprised to receive a letter from a former Colorado Academy of Family Physician (CAFP) member who felt that the CAFP leadership was a clique and she didn’t see much value in her membership. To those of you who hold similar views, I invite you to read on. The rest of those reading this piece will be better informed about recent activities of the CAFP.

My perspective on the value of the CAFP has changed greatly over the past 7 years I have been involved in its leadership. Our dues make up a substantial portion of the operating budget of the CAFP. These dues, however, are highly leveraged through our organization. Through the excellent management and representation of our members by our CEO, Raquel Rosen, careful watchfulness of our treasurer, Ryan Flint, DO and the CAFP board of directors, and our lobbyist, Jeff Thormodsgaard and the leadership of the CAFP the effect of your dues is multiplied. Your organization uses its resources for advocacy, education, enhancement of our practices and practice environment, and promoting the health of the public. Your organization is involved in so many venues, it would take up too much space here to name them all, and so I will mention a few.

Our first objective is advocacy for our patients, our members, and our communities. We aim to shape health care policy through interactions with government, the public, businesses, and the healthcare industry.

An exciting development of advocacy for our practices and our quality of care is the formation of the Colorado Primary Care Collaborative (CPCC). The CAFP, under the vision of our immediate past president, the late Robert Brockmann, MD, has been forming this team by bringing together representatives from business, health care entities and organizations, health plans, and others to build the public will for medical homes to improve health care in Colorado. On January 9th, we brought these partners together to talk about the Patient Centered Medical Home (PCMH) model, building the public will for Medical Homes, and building the case for payment reform in primary care. Our venue was the Warwick Hotel in downtown Denver. Paul Grundy, MD, Chief Medical Officer from IBM and the founder of the Patient Centered Primary Care Collaborative (PCPCC) gave a keynote address. Since it correlates with the first week of the state’s legislative bodies, we invited our legislators for a luncheon at the Warwick, to hear him talk about the PCMH. In June, the CPCC with the help of Health Team Works will be putting on a regional meeting of the PCPCC to further promote primary care.

The “market” of health plans, businesses, and the newly insured need to know about the value of primary care and the medical home has the best data for arguing the value of payment reform. Under the present payment structure of fee for service, compensation for increased value of the PCMH is inadequate to support the work that needs to be done. PCMH support is spotty, and unlike the farmer who inherits a million dollars, the PCMH practices can’t continue to “farm” until they go bankrupt. We haven’t inherited that “million dollars.” We are advocating for all of family medicine in this time of many changes knowing that we all want to provide the right care at the right time and at the right place. Making changes in our practices is costly and takes resources. Vulnerable practices can ill afford increasing costs of transforming their services without the resources to do so.

There are new models of payment and delivery that may answer the problems of poor alignment of our pay structure with the needs of our patients. Direct Primary Care seems to be gaining traction in our state. From the Multipayor PCMH Pilot, Regional Care Collaborative Organizations (RCCO’s), to PC2 program of Anthem, to the Pilot Accountable Care Organizations, and to 74 Comprehensive Primary Care Initiative practices across the state, payment reform is happening.

To those who wonder about the value of our organization, I challenge you to get involved. We constantly receive requests for family physicians to be a part of the conversation of where health care is going and the role of family medicine. From the State Innovation Models Initiative, to serving on boards with health plans, our CAFP legislative committee, to volunteering for Doctor of the Day, to talking to medical students about primary care, to representing family medicine to the business community, we need you. There are many who mistakenly believe our role as family medicine physicians is fading in the future of health care. The CAFP relies on the voice and expertise of its members to the story about the value of primary care and family medicine in the public and political arena.

How do you get involved? Read your excellent CAFP publications. Respond to requests in those publications for participation. There are spots you can fill for Doctor of the Day and other services. Contact your Board of Directors representatives and express your interest in leadership.

Yes, the CAFP is a clique! A clique that is 2000 members strong! Please help me in this critical time in our profession in advocating for our patients, our profession, and leveraging our organization’s excellent reputation and representation across the state to promote the triple aim of improving quality, lowering costs and improving the patient experience.
2013: **YEAR IN REVIEW**

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

**CAFP STAFF VISION/GOAL:** Creating a dynamic organization forwarding the goals of CAFP.

**COLORADO PCPCC:** Bob Brockmann, MD, past president of the CAFP, had the vision to create a Colorado organization similar to the national Patient Centered Primary Care Collaborative (PCPCC). Rick Budensiek, DO, and I arranged meetings with potential supporters of the Colorado Primary Care Collaborative including Colorado Institute of Family Medicine, CAFP Foundation, Paul Grundy, MD, and Colorado Business Group on Health. The Jan. 9, 2014 Convening Meeting of this new initiative will have over 100 attendees and there are close to 200 people and organization who are interested in the vision and mission of this project.

**VISION:** Patient-centered comprehensive and coordinated primary care services sustained through practice transformation and payment reform resulting in improved health for individuals and communities.

**MISSION:** The Colorado Primary Care Collaborative (CPCC) is dedicated to advancing primary care via the patient-centered medical home (PCMH) by focusing on delivery reform, payment reform, patient engagement, workforce training, and benefit redesign.

**REGIONAL PCPCC CONFERENCE:** The CAFP has the wonderful opportunity to help plan and organize the first western regional conference of the PCPCC here in Colorado. We are working with HealthTeamWorks to hold this meeting in Colorado on June 9 & 10, 2014. We expect 300 to 400 attendees.

**PAYMENT REFORM:** This has been at the top of the list for strategic goals for the CAFP. Our new Colorado Primary Care Collaborative will help build the momentum for primary care medical homes and payment reform. In addition, CAFP leaders have been meeting with representatives of the Colorado Association of Health Plans to advocate for medical home support and payment.

**LOSS:** The death of our CAFP president, Dr. Brockmann, was very hard on all of us. There were many pieces that had to be picked up and put back together because of the huge void that was created. The CAFP worked with his family to create the CAFP Foundation Medical Student and Resident scholarship fund and with the CAFP education committee to create a physician health and wellness talk at the ASC. The CAFP is stronger because of Bob’s work but we miss him.

**PR:** The PR Branding project continued with the distribution of the CAFP’s TV show to all members, media, and legislators, and an excellent annual report. We designed a new CAFP exhibit to be displayed at various meetings.

2013 was my 26th year and every year has brought new challenges and new opportunities.

**MEMBERSHIP:** CAFP staff and concentrated on membership development, recruitment, and retention. We attended meetings with representatives at both medical schools with the intention of increasing student membership. We developed new marketing materials for member recruitment and welcome packets for new members and those are being sent out regularly.

**RESIDENCY PRESENTATIONS:** I have begun to do these presentations again. These give the CAFP the opportunity to let Family Medicine residents know about the CAFP’s work, the strength of Family Medicine in Colorado, and how they can get involved.

**MEDICAID EXPANSION:** CAFP met with representatives of Medicaid to figure out how to recruit more Family Medicine Physicians to participate in Medicaid.

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

**NON-DUES REVENUE:** We signed up with MultiView to have advertisers on the CAFP web site and receive revenue. We are working on other avenues of non-dues revenue.

**CAFP ANNUAL SCIENTIFIC CONFERENCE (ASC)** – The 2013 CAFP ASC budget was in the black because of strong income

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from exhibits, grants, and registrations. An exciting new format is being planned for the April 2014 Annual Scientific Conference.

**BETTER REGISTRATION SYSTEM:** We signed up with Reg On Line to improve email blasts and conference registration systems.

**SOCIAL MEDIA:** The CAFP’s Facebook and Twitter accounts have been improved and have expanded reach.

**TAR WARS:** New life has been breathed into the Tar Wars program with the hiring of the new Tar Wars coordinator, Karol Groswold. Her experience as an elementary school teacher will be very helpful in increasing the program’s reach. Our Colorado poster won third place nationally. Karol has already exceeded the number of school/presenter matches from last year.

**WEB SITE:** The new web site is being developed and will look more modern and be more user friendly.

**AUDIT:** The CAFP has a financial review for two years and an audit done on the third year. 2012 was the audit year and our financials were found to be acceptable.

**AAFP CONGRESS OF DELEGATES:** The CAFP delegates, Kent Voorhees, MD, and John Bender, MD, and alternate delegates, Brian Bacak, MD, and Rick Budensiek, DO, did a fabulous job representing our Colorado members during the discussions and debates. Here are some important messages from the AAFP leaders:

- **Doug Henley, MD, AAFP EVP:** If we are to make progress, I would suggest that health care delivery has to be transformed in several ways:
  - Significant entitlement reform for Medicare and Medicaid.
  - Major reform in how we pay for care.
  - Continued primary care transformation to the Patient Centered Medical Home (PCMH).
  - Physician leadership and accountability for stewardship of our health care resources.

- **Glen Stream, AAFP outgoing board chair:**
  - AAFP membership is now 110,600
  - Advocacy agenda:
  - Seek repeal of SGR
  - Expand student scholarship and loan forgiveness
  - Reform funding of Graduate Medical Education
  - Improve primary care payment

- **Jeff Cain, MD, AAFP outgoing president:**
  - Merritt Hawkins reports that today Family Physicians are the number one recruited specialty.
  - Spent 190 days on the road
  - At WONCA, Dr. Margaret Chen, director of the World Health Organization, said that the world has changed, where infectious disease is being overtaken by chronic disease as the number one cause of death. In this new world, Family Physicians are the new superheroes of medicine worldwide.

2013 was my 26th year and every year has brought new challenges and new opportunities. But this year was especially exciting because of the new staff team that we created and the new health care initiatives that are so supportive of Family Medicine Physicians. We continue to have a strong board and strong leaders who continually put Family Medicine and the CAFP in the limelight. I am so proud to be a part of it.

It is a pleasure to serve you.

Sincerely,

Raquel J. Rosen, MA, CAE
CAFP CEO

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**Congratulations to the Newly Elected Members of the BOARD OF TRUSTEES!**

COLORADO ACADEMY OF FAMILY PHYSICIANS

TERM JAN. 2014 – DEC. 2014

Cissy Kraft, MD, President
John Bender, MD, Vice President
Raquel Rosen, Secretary
Ryan Flint, DO, Treasurer
Brian Bacak, MD, Trustee
Rick Budensiek, DO, Trustee
Luke Casias, MD, Trustee
Kajsa Harris, MD, Trustee
Michelle Jimmerson, MD, Trustee
Kent Voorhees, MD, Trustee
By Jeff Thormsodsgaard, Vice President, Mendez Consulting Inc., CAFP Director of Public Policy

MEDICAID PRIMARY CARE BUMP

Health care is still a very popular and relevant topic at the State Capitol. With the implementation of the Affordable Care Act off the ground, one of the biggest concerns is making sure that providers are reimbursed properly for primary care services. The Incentive Payment Program for Primary Care Services: Section 5501(a) of the Patient Protection and Affordable Care Act brings Medicaid payments for certain primary care services and some preventive health services up to parity with Medicare levels for the 2013 and 2014 calendar years. The Act specifies that physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine qualify as primary care providers for the purpose of this increased payment. The primary care fee increase is fully federally funded up to the difference between each state’s Medicaid fees in effect as of July 1, 2009 and Medicare fees effective in 2013 and 2014.

The Medicaid program is the primary source of health care funding for low-income individuals, providing health insurance for roughly 400,000 low-income children in Colorado. Low Medicaid payment rates place an unfair burden on Medicaid providers, resulting in the restriction of low-income Colorado residents’ access to care. Through the Incentive Payment Program for Primary Care Services, the federal government has taken a large step in an effort to alleviate this burden. It is critical that Colorado begin to match the federal government’s payment increase beyond 2014 to protect access to health care for thousands of low-income Colorado residents.

Medicaid Payments are Low – Medicaid Pays Only 66% of Medicare Fees on Average

In 2012, Medicaid physician fees were 66% of Medicare fees and close to half of the states paid no more than 75% of Medicare fees.[1] Medicaid is a critical health care program for millions of low-income children and for children with special health care needs, covering 32 million children nationwide.[2] Half of all Medicaid enrollees across the country are children.[3]

In Colorado, Medicaid physician fees for primary care services

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[3] Id.
were 75% of Medicare fees in 2012. Colorado pays lower physician fees than many of its neighboring states including Kansas, New Mexico and Wyoming, which have Medicaid to Medicare ratios up to 21 points higher than Colorado’s ratio. 28.4% of Colorado’s children are enrolled in Medicaid. In Colorado, a physician providing primary care treatment to a child who is on Medicaid receives only 75% of what would be paid to treat a senior on Medicare for the same illness.

Access to Care is Poor – Low Payments are a Primary Factor

According to the Medicaid and CHIP Payment and Access Commission (MACPAC) the rate of physician participation in Medicaid has historically been considered an indicator of access to care.[4][9] A large body of research has shown that low provider rates are a primary factor affecting provider participation in Medicaid and access to services for Medicaid beneficiaries.”[5] According to the American Academy of Pediatrics, low and inconsistent Medicaid payment rates result in fewer physicians being able to participate in Medicaid, threatening access to quality health care for Medicaid enrollees.

A study published in the New England Journal of Medicine found that Medicaid-enrolled children were denied appointments at a significantly higher rate than privately insured children. The study also found that when children did receive appointments the average wait time for Medicaid-enrolled children was considerably longer than the wait time for privately insured children.[6] The study concluded that, “Policy interventions that encourage providers to accept patients with public insurance are needed to improve access to care.”[7]

The rate of Medicaid reimbursement has been shown to affect a physician’s willingness to begin to accept new Medicaid patients.[8] Only 50% of physicians are willing to accept new Medicaid patients, while 70% of physicians are willing to accept new Medicare or private insurance patients.[9]

The Two Year Policy is Not Long Enough – States Ought to Pay the Increased Rates

“A consistent theme from MACPAC’s interviews [with policy officials from six states] was a concern that the effect of the provision on provider participation may be limited because it is set to expire after 2014.”[10] Officials “voiced concern that rolling back rates in 2015 to pre-2013 levels would be perceived as a rate reduction rather than a discontinuation of the rate increase and could negatively affect provider recruitment efforts.”[11]

According to MACPAC, some state officials “reported concerns that because the rate increase is temporary, it will not provide enough incentive for non-participating physicians to become Medicaid providers.”[12] The state officials’ concerns were validated in an article published by The Advisory Board Company.[13] The article informed primary care physicians about the Medicaid rate increase and warned them “to carefully consider their ability to effectively manage Medicaid patients [after the increase expires] before rushing to add them to their panels or signing new Medicaid managed care contracts.”[14]

The Advisory Board Company advised physicians that if they decide to take on Medicaid patients, because of the limited length of the increased payments, they should plan a strategy for how to deal with Medicaid patients once rates drop in 2015. This raises concerns that physicians will no longer provide services to Medicaid patients once the rate increase ends. As a result, it is crucial that Colorado begins to pay the increased rates once the subsidy from the federal government expires.

Due to the importance of this issue to the Colorado Academy of Family Physicians, Mendez Consulting will be working with the Colorado State Legislature in the 2014 session to find a funding solution for this to continue. We will send updates on our progress, as necessary.

[7] Id.
[12] Id.
[13] The Advisory Board Company is a publically traded, global research, technology and consulting firm.
[14] Id.
The Department of Family Medicine at the University of Colorado Denver School of Medicine is seeking an outstanding Family Physician and Clinician Educator to serve as Medical Director for our residency practice located at Rose Medical Center.

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

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

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

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

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

Salary is commensurate with skills and experience. The University of Colorado offers a full benefits package. Information on University benefits programs, including eligibility, is located at [http://www.cu.edu/pbs/](http://www.cu.edu/pbs/) Applications are accepted electronically at [www.jobsatcu.com](http://www.jobsatcu.com).

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

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

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

“"The University of Colorado Denver and Health Sciences Center requires background investigations for employment.”
“The University of Colorado is committed to diversity and equality in education and employment.”
Less than Whole Patient Care is INCOMPLETE CARE

by Lesley Brooks, MD

In Colorado, there are over 3,200 primary care physicians and nearly 1,800 primary care nurse practitioners and physician assistants, and we all serve the 5.2 million people who live in our state. We work hard every day to care for our patients, and we want to see each of them achieve good health and thrive, but many of them simply cannot escape the life circumstances that keep them in poor health. It’s an age-old struggle that often presents as non-compliance—a patient not following doctor’s orders and continuing to suffer in spite of our best medical interventions. As providers, how we choose to respond is of the utmost importance.

Research has shown that providers who have empathy for their patients’ life circumstances also have better clinical outcomes. It is our responsibility to recognize and acknowledge the social factors that are interfering with our patients’ abilities to maximize their health, and to work with them to more successfully address their needs. These social determinants of health, such as a patient’s income, education, access to quality food and housing, race or ethnicity, and many more, are barriers to health care for many Coloradans. Many patients face issues accessing care without insurance, filling prescriptions they cannot afford, finding stable transportation to get them to and from appointments on time, or communicating in their non-native language. What we may perceive as noncompliance could be a result of factors outside our patients’ control.

It is ultimately the responsibility of our communities and our government to work together to reduce or eliminate the impact of these social factors on health and health care. However, health care providers have an important role in this work, too. We can strive to understand the whole of our patients’ lives. We can think creatively to provide care that is respectful of limited resources and leverages broader community assets. We can educate ourselves, and challenge ourselves to confront these issues. To this end, the Colorado Coalition for the Medically Underserved (CCMU) created a new video (http://www.ccmu.org/sdoh), on which I advised. Whether it is brand new information or an important reminder for you, I invite you to watch it and share it broadly.

It is my hope, as well as CCMU’s goal, to start a conversation within the health care community about how to better equip ourselves to address the social determinants of health. I believe we can expand our definition of health care beyond the four walls of our exam room, empower patients to be involved in their own care, form innovative partnerships within our communities, implement new solutions, and redefine our personal concepts of patient care and compliance. We can be leaders for a new kind of whole patient care in our community, and across our state.

Dr. Brooks serves as a family physician at Sunrise Monfort Family Clinic and as associate medical director for the North Colorado Health Alliance (NCHA) in Greeley, Colorado.

permanent doc-fix is on the horizon

by Rick Budensiek, MD, FAAFP

As you must already know, every year for the last decade Republicans and Democrats have patched the sustainable growth rate (SGR) formula that Medicare uses to calculate provider rate. This, commonly known as the “doc-fix”, happens every year because the SGR is flawed in the way that it connects physician reimbursements to erroneous economic indicators. For instance, without the yearly patch, we face an estimated 24.7 percent cut to Medicare reimbursements in 2014. YIKES!

For the first time in the last decade, we have a real chance of passing a permanent doc-fix and finally ending the yearly self-imposed ritual of patching the SGR. We need your help on this.

On July 31, 2013, the House Energy and Commerce Committee unanimously supported HR 2810, a bill to permanently fix to the SGR. On October 30, 2013, the Senate Finance and House Ways and Means committees released a joint proposal that would repeal the SGR and replace it with a better way to pay physicians and support the Medicare program. This bipartisan proposal not only repeals the SGR but establishes a period of stability in Medicare payments, while providing pathways for practices with alternative models of payment (such as the PCMH) to receive higher payments for practice improvements.

I urge you to contact Colorado’s delegation to the 113th Congress to support the repeal of the SGR and the bipartisan, bicameral, legislation passing through Congress. I certainly hope that we can finally stop worrying about the SGR and move our focus to other pressing issues like ensuring an adequate primary care workforce, payment reform, and addressing access issues.

Please visit the CAFP website to learn about how you can contact your congressman.
The newly installed Chair of the Board of Directors at the American Academy of Family Physicians (AAFP), Jeffrey Cain, MD, FAAFP, embraces the newly installed President of the AAFP.

Current President of the CAFP, Rick Bodenstine, DO, FAAFP, observes a reference committee meeting at the annual AAFP Congress of Delegates.

Raquel Rosen, MA, CAE, observes the education reference committee at the 2013 Congress of Delegates.

Current President of the CMS and Delegate for the CAFP, John Bender, MD, FAAFP, sits as a Liaison on a reference committee.

CEO of the AAFP, Raquel Rosen, MA, CAE, and CAFP Lobbyist, Jeff Thormodsgaard, speak with Ben Price, the CEO of the Colorado Health Plans Association, about the current paths towards payment reform.

Board of Director Member and Alternative Delegate, Brian Bacak, MD, sits as an official observer to the education committee.
What are the benefits of being a PRIMARY CARE MEDICAL PROVIDER (PCMP) in the Accountable Care Collaborative (ACC)?

The Accountable Care Collaborative (ACC) program is Colorado Medicaid’s premier reform effort and the predominant services delivery system for physical health care services. Regional Care Collaborative Organizations (RCCOs) are responsible for provider support, care coordination, and accountability of care in each region.

Per Member per Month Payment
PCMPs receive $3 per member per month reimbursement for providing medical home level services.

FFS Reimbursement
PCMPs receive FFS reimbursement for medical services.
- In July 2013, provider rates increase by 2%.
- Beginning January 1, 2013, physician reimbursement for Medicaid services increased to 100% of Medicare reimbursement for evaluation & management codes.

Incentive Payment
The Department has paid out over $1 million to providers for two quarters of performance. Every participating ACC provider has received an incentive payment.

$1 per member per month Incentive Payment may be paid based on four regional key performance indicators:
- Hospital All Cause Thirty (30) Day Readmissions
- Emergency Room (ER) Visits
- High Cost Imaging Services
- Well Child Visits

Shared Savings
All ACC providers will be eligible to receive a percentage share of medical cost savings generated by the program.

Patient Panel Limits
Providers can set limits on their patient panels.

Data Analytics and Reporting Capabilities
Through the Statewide Data and Analytics Contractor (SDAC), PCMPs will receive client level utilization and risk data on the clients in their panel. The SDAC provides a web-portal dashboard for each practice that physicians can use to manage, coordinate and integrate care.

Care Coordination and Medical Management
Regional Care Collaborative Organizations (RCCOs) coordinate the services provided to clients, which may include behavioral health, long term services and supports, and government social services. Care coordinators may also link clients to non-medical community services, such as adoption and advocacy services, youth programs, housing programs, and emergency financial assistance.

Practice Support
RCCOs supply providers with practical tools and resources to fulfill the basic elements of a Medical Home. Practice support may include clinical tools, client materials, operational practice support, data, reports and other resources.

Technical Support
The RCCOs assist providers in navigating Medicaid administrative systems.

*Contact your RCCO today to get signed up.
Visit www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675 to find out what RCCO Region you are in

RCCO Contact Information

Region 1: Rocky Mountain Health Plans  ◆  Jenny Nate  ◆  303.967.2082  ◆  Jenny.nate@rmhp.org
Region 2: Colorado Access  ◆  Dave Rastatter  ◆  970.350.4665  ◆  Dave.rastatter@coaccess.com
Region 3: Colorado Access  ◆  Molly Markert  ◆  720.744.5415  ◆  Molly.markert@coaccess.com
Region 4: Integrated Community Health Partners  ◆  Donna Mills  ◆  719.543.1344  ◆  Donna.mills@ichpcolorado.com
Region 5: Colorado Access  ◆  Julie Holtz  ◆  720.744.5427  ◆  Julie.holtz@coaccess.com
Region 6: Colorado Community Health Alliance  ◆  Adam Bean  ◆  720.315.6626  ◆  Adam.bean@phpmcs.com
Region 7: Community Care of Central Colorado  ◆  Kelley Vivian  ◆  719.632.5094  ◆  Kelley@ppchp.org
A Patient’s Story

“Cecelia” is a preschooler who suffered from refractory constipation since eight months of age. As a toddler, her symptoms worsened with abdominal distension and pain. Because of these problems, her appetite decreased, and she became nutritionally compromised. Cecelia was ultimately referred to a GI Motility Clinic where after her consultation she underwent colonic manometry to measure the pressures generated by her colon.

Cecelia’s colon showed poor contractions in its lower third. Based on these findings, she had surgery to place a cecostomy tube in her colon to allow her to receive enemas from the beginning of her colon. Working together with nurses, psychologists and social workers, the family was able to

Electrogastrogram (EGG) showing the normal electrical waves of the stomach

continued on next page >>
to successfully learn how to use this tube at home. In time, Cecelia participated in giving herself the enema flushes. Her symptoms improved after her surgery. With the help of a multi-disciplinary feeding team, her appetite and nutrition increased. Over time, Cecelia was able to successfully potty train. Her quality of life as well as that of her parents improved tremendously. Her mother remarked at the end of her treatment that “she was a typical little girl now.”

Cecelia’s case exemplifies how a comprehensive “team approach” can make a significant difference with a complex GI mobility disorder for the life of a child and also for their family.

**What are GI Motility Disorders in children?**

Children with motility disorders are increasingly seen by primary care providers and pediatric gastroenterologists, and the complexity of their needs requires specialized care. Children suffering from motility issues have trouble with normal digestion, which can result in symptoms such as dysphagia, abdominal pain and bloating, constipation, nausea, vomiting and refractory gastroesophageal reflux. These disorders can be devastating and in some circumstances effectively result in “paralysis” of any or all parts of the GI tract, including the esophagus, stomach, small bowel and colon. These conditions can also affect appetite, resulting in feeding problems and malnutrition. Unfortunately, many children with complex motility needs often do not receive the comprehensive care required for treatment of their particular condition because of the very limited number of pediatric motility centers in the United States.

**Neuro-gastroenterology and Motility Centers**

The goal of a Neuro-gastroenterology and Motility Center is to evaluate and treat children and adolescents with motility problems from “mouth to bottom.” This includes patients with swallowing problems due to esophageal dysfunction as seen in conditions such as achalasia or those secondary to congenital abnormalities. Children are evaluated for symptoms of gastroparesis, chronic nausea, as well as those with small bowel failure and symptoms of pseudo-obstruction. Motility Centers can also evaluate and care for patients with refractory constipation and incontinence and work in close collaboration with pediatric surgery staff in the care of children with Hirschsprung’s disease. Most importantly, the Motility team aims to establish a strong partnership with both local primary care providers and pediatric gastroenterologists to serve as a resource for consultation and a location for direct patient care.

**Tools Used to Assess Motility Problems**

Pediatric GI Motility Centers utilize diagnostic tools such as manometry to assess the strength and propagation of intestinal pressure waves necessary to coordinate mixing and propulsion of GI luminal contents. The GI tract has its own nervous system – the enteric nervous system – with nearly as many neurons as are found in the spinal cord. Instruments such as the electrogastrogram (EGG) – the “EKG of the stomach” – are utilized to measure the electrical waves of the stomach.

**Care for Functional Disorders of the GI Tract**

GI Motility Centers also are prepared to care for children with functional disorders of the GI tract which may co-exist with motility problems. These conditions can be very difficult to diagnose and treat, often due to vague and poorly defined symptoms as well as the absence of tangible or objective structural pathology. Examples include: cyclic vomiting syndrome, chronic idiopathic nausea, ruminations, dyspepsia, irritable bowel syndrome and abdominal migraines. The mechanisms underlying these conditions remain poorly understood. The impact of these conditions on a child and family’s wellbeing can be tremendous. Persistence of symptoms can be associated with both social and psychological consequences, resulting in decreased school attendance.

continued on page 16 >>
DOES YOUR CHILD HAVE ALLERGIES OR ASTHMA?
WE CAN HELP.

WE NEVER SAY NEVER.®
Whether your child has mild or severe eczema, allergies or asthma, coming to National Jewish Health as early as possible can lead to better outcomes. Our Pediatric Specialists use innovative approaches that address each child’s individual needs, helping them (and you) breathe easier.
Make an appointment now by calling 1.800.621.0505 or visit njhealth.org.

National Jewish Health
Science Transforming Life®
and loss of quality of life for both patients and families. GI Motility teams are prepared to handle these challenges by providing a multi-disciplinary approach to the care of these patients and families and exploring cutting edge new approaches to treatment. **A Multi-disciplinary Approach to Motility and Functional GI Disorders**

The Neuro-gastroenterology and Motility Center at Children’s Hospital Colorado integrates a diverse team for its clinical and research endeavors, to include pediatric psychology, cardiology and neurology. We collaborate routinely with members of the surgery, radiology and pathology departments who are key participants in the care of these patients. Lastly, the team actively engages in a family-centered approach in the care of patients. While we learn a great deal from diagnostic testing, often some of the most valuable information comes from the parent and child.

The first step in evaluating a child with the possibility of a GI motility disorder is referral to a pediatric gastroenterologist to address any GI conditions that may not be motility related, The Neuro-gastroenterology and Motility Center works in close collaboration with local and national pediatric gastroenterologists. For those circumstances when a direct referral to the Motility Center is warranted, especially for children demonstrating orthostatic symptoms along with their GI problems, staff is always prepared to answer any questions and referrals and can be contacted at 720-777-1335.

For more information about the Neuro-Gastroenterology and GI Motility Center at the Digestive Health Institute, please call (720) 777-6669 or visit www.childrenscolorado.org/gastroenterology.

**John Fortunato, MD** is an Associate Professor of Pediatrics at the University of Colorado School of Medicine and the Director of the Neuro-gastroenterology and Motility Center.

**Kids Corner** is a regular feature of the CAFP News brought to you by the Department of Family Medicine at Children’s Hospital Colorado. For questions about this article or suggestions for future topics you may contact the author or Dr. Jeffrey Cain, Chief of Family Medicine through One Call at (720) 777-3999 or (800) 525-4871.

“MOST IMPORTANTLY, THE MOTILITY TEAM AIMS TO ESTABLISH A STRONG PARTNERSHIP WITH BOTH LOCAL PRIMARY CARE PROVIDERS AND PEDIATRIC GASTROENTEROLOGISTS TO SERVE AS A RESOURCE FOR CONSULTATION AND A LOCATION FOR DIRECT PATIENT CARE.”

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**CAFP to Offer Training on New DOT Medical Examiner Certification**

Effective May 21, 2014, all healthcare professionals who perform physical examinations and issue medical certificates for interstate commercial motor vehicle (CMV) drivers will be required to complete an accredited certification training course and pass an examination. Only those professionals who have fulfilled these requirements by this date will be included in the National Registry of Certified Medical Examiner (National Registry) online directory. This is imperative as only those included in this database will be able to provide a legally recognized examination for CMV drivers.

To help you meet these qualifications, the CAFP is offering an in-person training session in conjunction with our upcoming CAFP Annual Scientific Conference. This training will be held Thursday, April 24 at the Cheyenne Mountain Conference Center in Colorado Springs, members and non-members can participate in this intensive 7-8 hour course that has been designed to meet the core curriculum for the medical examiner training in accordance with the National Registry Federal Motor Carrier Safety Administration (FMCSA) examination.

After taking our course, you will be eligible to sit for the exam. Please visit www.coloradoafp.org/ASCattendee to register for the DOT Medical Examiner Training course.
A comprehensive collection of evidence-based tools and resources to improve the assessment and management of chronic pain, and particularly, the long-term use of opioids is now available on the website of the University of Colorado School of Public Health at: coloradoafp.org/painkit

This is the first time we have seen all these tools and their links collected into one user-friendly website. Examples of links to tools on this website include:

- **Opioid Risk Tool**
- **CAGE-AID**—Screen for alcohol and drug problems
- **Patient Health Questionnaire (PHQ-9)**—Screen for depression
- **Sample Patient Contract**
- **Pain Assessment Documentation Tool (PDT)**
- **Screener and Opioid Assessor for Patients in Pain (SOAPP)**—Assessment of risk of prescription opioid abuse
- **Diagnosis, Intractability, Risk, Efficacy (D.I.R.E.) Score**—Predict outcomes of opioid prescribing in chronic pain patients
- **Graded Chronic Pain Scale**—Assess severity of chronic pain
- **Brief Pain Inventory (BPI) (short form)**—Patient self-assessment of pain
- **Aberrant Behavior Checklist (ABC)**—Assess problem behaviors in developmentally-challenged patients

Tools for managing chronic pain patients:
- **Opioid Dose Calculator**
- **SAMHSA TAP32: Clinical Drug Testing in Primary Care Manual**
- **Web-Based Opioid Dose Calculator**
- **Opioid Conversion Tips and Charts**
- **Pain Management Log (for patients)**
- **Daily Pain Diary (for patients)**
- **Functional Assessment Questionnaire**
- **Prescription Drug Monitoring Program (PDMP) Links:**
- **Alliance of States with Prescription Monitoring Programs**
- **Colorado PDMP**
- **Colorado PDMP Training Guide for Practitioners and Pharmacists**
- **Guidelines Links:**
  - **FDA Blueprint for Prescriber Education**
  - **Colorado Guidelines for Chronic Pain Treatment**
  - **Interagency Guidelines on Opioid Dosing for Chronic Non-Cancer Pain**

Other Useful Links and Handouts:
- **Urine Drug Testing In Chronic Pain**
- **The 4 As of Pain Treatment Outcomes**
- **Physicians for Responsible Opioid Prescribing (PROP)**
- **PROP “Cautious Evidence-Based Opioid Prescribing”**
- **The American Chronic Pain Association (for patients)**
- **National Institute on Drug Abuse (NIDA)**
- **The Substance Abuse and Mental Health Services Administration (SAMHSA)**

Of further interest is the ability to complete a CME course “The Opioid Crisis Guidelines and Tools to Improve Chronic Pain Management.” Completion of this course earns CME and COPIC points. The course is available at: www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/maperc/online/Pages/Pain-Management-CME.aspx.

As COPIC does not own the rights to this course, a subscription fee may be required for participants in this course.

2014 Annual Scientific Conference

We invite you to join us at the beautiful Cheyenne Mountain Conference Center in Colorado Springs for our Annual Scientific Conference. This is your once-a-year local opportunity to expand and refresh your medical knowledge base while connecting with fellow Family Physicians who share the promises and challenges unique to practicing in Colorado.

We would like to see all Colorado Family Physicians, Residents, and Students attend. Please contact Erin Watwood at erin@coloradoafp.org or 303-696-6655 ext. 14 to see if you might qualify for the Residents and Students scholarships.

Please join us for another fantastic weekend of medical education, legislative updates, chapter business, and practical pointers for running a successful practice; along with plenty of time for fun and family. Come refresh your enthusiasm for patient care and reinvigorate your confidence in successfully practicing the art and science of Family Medicine in Colorado at the 2014 ASC!

We’ve planned a new and innovative conference format with expanded optional workshop sessions and infoPOEMS updates with Mark Ebell, MD, and John Hickner, MD. Don’t worry, you’ll still see traditional lecture style presentations too. Your ASC conference will be more family friendly with activities for all ages and optional child care available. Our Friday reception this year will be a circus theme and will be appropriate for “kids” of all ages. This year bring your kids, spouses and guests to the informal barbeque Colorado style on Saturday!

Chandra Hartman, MD
Conference Committee
Co-Chair

Anna Wegleitner, MD
Conference Committee
Co-Chair

Register by going to: coloradoafp.org/ASCattendee
How Much Do You Need to Retire? Let’s Calculate

Calculating a retirement savings goal is one of the most important steps investors can take to help determine if they are on pace to meet that goal. However, most American workers haven’t tried to figure out how much money they will need to accumulate for retirement. What about you?

Planning Matters

What’s important to realize is that the exercise of calculating a retirement savings goal does more than simply provide you with a dollars and cents estimate of how much you’ll need for the future. It also requires you to visualize the specific details of your retirement dreams and to assess whether your current financial plans are realistic, comprehensive, and up-to-date.

Action Plans

The following four strategies will help you do a better job of identifying and pursuing your retirement savings goals.

1. Double-check your assumptions. Before you do anything else, answer these important questions: When do you plan to retire? How much money will you need each year? Where and when do you plan to get your retirement income? Are your investment expectations in line with the performance potential of the investments you own?

2. Use a proper “calculator.” The best way to calculate your goal is by using one of the many interactive worksheets now available free of charge online and in print. Each type features questions about your financial situation as well as blank spaces for you to provide answers. An online version will perform the calculation automatically and respond almost instantly with an estimate of how much you may need for retirement and how much more you should try to save to pursue that goal. If you do the calculation on a paper worksheet, however, you might want to have a traditional calculator on hand to help with the math. Remember that your ultimate goal is to save as much money as possible for retirement regardless of what any calculator might suggest.

3. Contribute more. Do you think you could manage to save another $10 or $20 extra each pay period? If so, here’s some motivation to actually do it: Contributing an extra $20 each week to your plan could provide you with an additional $130,237 after 30 years, assuming 8% annual investment returns. At the very least, you should try to contribute at least enough to receive the full amount of your employer’s matching contribution (if offered). It’s also a good idea to increase contributions annually, such as after a pay raise.

4. Meet with an advisor. A financial professional can help you determine a strategy – and help you stick to it. Retirement will likely be one of the biggest expenses in your life, so it’s important to maintain an accurate price estimate and financial plan. Make it a priority to calculate your savings goal at least once a year.

Retirement Calculator example can be found at:

http://www.summitwealthadv.com/new/mysummitadvisor/content.asp?contentid=2017671441

The result shown is for illustrative purposes only. The hypothetical returns used do not reflect the deduction of fees and charges inherent to investing. Taxes are due upon withdrawal. Your results will vary.

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Article provided by Michael Dambeck, Financial Advisor, Summit Wealth Advisors, LLC
According to a report from MedScape News, the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP) unanimously approved the 2014 Child/Adolescent Immunization Schedule in late October. The recommendations include some significant changes to the current schedule of which family physicians should be aware.

The 2014 guidelines include the following changes:

- **Influenza vaccine:** The guidelines added information about the recombinant influenza vaccine (RIV), and now address the use of RIV and the inactivated influenza vaccine (IIV) in patients with egg allergy.

- **Pneumococcal vaccine:** A section in the footnotes separates various risk groups by age (ages 24 – 71 months and 6 – 18 years) and provides recommendations regarding 13-valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine. There are separate guidelines for children aged 6 to 18 years who are immunocompromised and for those with chronic conditions who are not immunocompromised. A vaccine catch-up table is also included.

- **Hepatitis A vaccine:** The guidelines now include:
  - individuals who travel to or work in countries with high or intermediate endemicity of infection,
  - men who have sex with men,
  - those who use injection or noninjection illicit drugs,
  - those who work with hepatitis A virus (HAV)-infected primates or with HAV in a research laboratory,
  - those with clotting-factor disorders, and
  - those with chronic liver disease.

- **Human papillomavirus vaccine:** The guidelines have been changed to add that the third dose should be administered “at least 12 weeks after the second dose AND at least 24 weeks after the first dose.”

- **Meningococcal vaccines:** The guidelines now recommend that the MenACWY-CRM (Menevo, Novartis Vaccines) vaccine may be given as early as 2 months of age for those with high risk for meningococcal disease. The guidelines include detailed instructions for use of the vaccines, as well as catch-up recommendations.

- **Tdap vaccine:** Those aged 11 years and older who have received no Tdap vaccine should have a Tdap followed by tetanus and diphtheria toxoids booster doses every 10 years.
after that. The committee does not recommend repeat doses of Tdap, except for pregnant adolescents (aged 11-18 years), during each pregnancy. The guidelines also advise that adolescents who inadvertently receive a pediatric DTaP, that dose should be considered the adolescent Tdap booster.

- **Varicella vaccine:** Explains that immunocompromised adults born in the United States prior to 1980 may not have immunity to varicella. However, the ACIP’s herpes zoster workgroup will continue to recommend that the minimum age at which adults receive the herpes zoster vaccine remains 60 (for the reasons outlined below).

According to one news report, several members discussed the possibility of making this information available electronically so that it would be more accessible to those who use computers, tablets, and smart phones — although it was agreed that the guidelines need to be available on paper as well. We think most family physicians would be in full agreement with this recommendation.

Loehr said the ACIP also heard a presentation on the efficacy of the herpes zoster vaccine that we believe most family physicians will find instructive. Currently, the FDA has approved the vaccine for use in adults ages 50 and older, and the ACIP recommends it be given starting at age 60.3

Information presented during the meeting showed a 50 percent decrease in shingles incidence and a 67 percent decrease in post-herpetic neuralgia (PHN) incidence at three years after vaccination. Results also indicated some continued protection against shingles and PHN as long as seven years after vaccination.

“(The vaccine’s efficacy) seems to wane after eight to 10 years, and, unfortunately, there’s no indication that there will be a study on booster doses,” Loehr said. “So if you’ve no evidence on booster doses – working or not working – and you’ve got to pick one date to give this, you probably wouldn’t want to give it at age 50 because (the vaccine’s protective effects) would wane before the highest risk period, which is in the 60s and 70s. So, the workgroup reaffirmed that age 60 appears to offer the best balance of cost and benefits.”3

Walt Larimore, MD, DABFP, FAAFP, a well-known author and medical journalist, who works with Concentra Medical Clinics in Denver and Colorado Springs and volunteers at Mission Medical Clinic in Colorado Springs. His web site and medical news blog can be found at www.DrWalt.com. Reginald Finger, MD, MPH, serves on the faculty of the School of Health Sciences at Indiana Wesleyan University, and is a former member of the CDC’s Advisory Committee on Immunization Practices (ACIP) and of the Colorado Children’s Immunization Coalition.

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A Heart Healthy Diet: Should We Be Updating Our Recommendations?

Two webinars offered for Continuing Medical Education credit through February 2015
Each webinar is approved for 1 Prescribed credit by the American Academy of Family Physicians
There is no cost to participate. Credit certificates will be issued to participants.

This one-hour web presentation offers new information to consider when advising patients who are adopting a heart-healthy diet and lifestyle as a preventative or risk reduction strategy for cardiovascular disease. Comparative data from several diet studies are presented regarding observed effects on cholesterol and reduction of CVD risk factors. Current research regarding the role of lean beef in a heart-healthy diet and lifestyle offers new findings and links to dietary adherence which is relevant as we explore more effective ways to combat our nation's #1 killer, cardiovascular disease.

This one-hour web presentation describes the Beef in an Optimal Lean Diet study (BOLD), previously published in the American Journal of Clinical Nutrition, and the observed impacts on patient health and cardiovascular disease risk factors. Content includes practical information and strategies for physicians helping patients make dietary changes aimed at a reduction in cardiovascular risk factors. Strategies included address enhancing adherence to a heart-healthy diet by including lean protein sources, and working with patients’ taste preferences, familial eating patterns, and social/economic constraints.

Web-based presentations for Colorado family physicians and other healthcare professionals offered by our affiliate chapter, the Oklahoma Academy of Family Physicians.

www.heart-healthynutrition.com

This educational opportunity is offered by the Oklahoma Academy of Family Physicians, a state chapter of the American Academy of Family Physicians (AAFP) which represents over 105,000 physicians, residents and medical students in the United States
Educational grant support for the program provided by the Oklahoma Beef Council and supported by the Colorado Beef Council.
Checking in with the Fit Family Challenge
By Sarah Roth, MA and Bonnie T. Jortberg, PhD, RD, CDEAdvisors, LLC

The Fit Family Challenge pediatric obesity pilot project continues to make progress towards its goals. Since the pilot's inception in 2012 we have enrolled more 300 children in the pilot. The pilot data continues to trend in the right direction showing statistically significant results for health behavior change. Importantly, the FFC pilot practices have screened more than 25,000 for cardiovascular risk! As a result of continued progress, the project team has begun to look ahead towards dissemination and expansion of the project to family medicine physicians statewide.

Recent pilot highlights
• In October, we hosted the pilot practices at the Biannual Learning Collaborative. Representatives from CIVHC, HealthTeamWorks, Rocky Mountain Hospital for Children presented on a number of topics including Meaningful Use, the State Innovation Model, and Cultural Impacts on Obesity.

The AAFP Foundation awarded the FFC a 2013 Family Medicine Philanthropic Consortium (FMPC) Grant Award in the amount of $7000

Fit Family Challenge (FFC) Data
Baseline, 6 Month, 12 Month, 15 Month, 18 Month, > 21 Months
BMI, Blood Pressure & HeartSmartKids Questionnaire
October 22, 2013
Summary of Data:

• Summary of Results
  o 307 children plus their families have enrolled in the FFC since September 2011
  o 145 children plus their families are currently enrolled in the FFC
  o Clinical outcomes continue to decrease:
    • BMI% decreased from baseline to >21 months by .4%
    • Systolic blood pressure decreased slightly by .3 mm Hg
    • Diastolic blood pressure decreased slightly by .5 mm Hg
  All measures related to the 5-2-1-0 message improved.

• Dietary results:
  o Fruit & vegetable intake increased from baseline of 3.03 to 4.21 servings/day at > 21 months (+1.2 ). This is a statistically significant result.
  o Sugar sweetened beverage intake decreased from 1.4 servings/day at baseline to .9 serving/day at >21 months (−.5 servings/day; decreasing daily calorie consumption by ~75 kcals/day).

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<td>2.12</td>
<td>2.11</td>
<td>2.10</td>
<td>2.09</td>
<td>0</td>
<td>0.7523</td>
</tr>
<tr>
<td>Sugar-sweetened Beverage Intake (servings/d)</td>
<td>1.36</td>
<td>1.3</td>
<td>1.23</td>
<td>1.17</td>
<td>1.10</td>
<td>1.04</td>
<td>0.97</td>
<td>0.91</td>
<td>-0.5</td>
<td>0.055</td>
</tr>
</tbody>
</table>

*Statistically significant change
o Milk type change from whole milk to skim milk decreased from 1.6 servings at baseline to .1.2 servings/day at >21 months (decreasing daily calorie consumption by ~51 kcals/day). This is a statistically significant result.

o Amount of family activity increased from baseline of 2.3 days/week to 3.5 days/week at >21 months. This is a statistically significant result.

o Sedentary behavior (watching TV or movies or playing video or computer games) continued to decrease for the >21 month data, to 2.1 hours/week. This is almost at goal of < 2 hours of screen time/day.
Hello everyone. This is Jodi Holtrop, new to SNOCAP. I look forward to meeting and working with you in the future. Don asked that I write an update for this month’s newsletter.

As with primary care in general, a lot of exciting things are happening with our practices in SNOCAP. We completed a successful SNOCAP convocation at the end of September. We say successful because we: 1) had the opportunity to reflect on what we have learned over the past year in terms of what works with caring for our patients in primary care (see below for a couple resources); 2) partnered with stakeholders in the community to learn about working together and resources they bring; and 3) were able to hear from our physicians, other providers and practice members about issues that are challenging that hopefully we can begin to address (see below for key areas identified).

**Studies that have turned into resources**

Health Assessments (Doug Fernald) – Congratulations to Doug and his team on developing this guide with thanks and appreciation from those who participated. Here is how to access it and training information. The guide, Health Assessments in Primary Care: A How-to Guide for Clinicians and Staff [link](http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/health-assessments/) employs the best current evidence for successful implementation of health assessments in the primary care setting. On January 15, 2014 at 12:30pm – 2pm ET, the PBRN Resource Center is sponsoring a webinar about this guide – go to [https://www1.gotomeeting.com/register/842052801](https://www1.gotomeeting.com/register/842052801) to register for this webinar!

Just Check It (Linda Zittleman) is a resource available to primary care patients and their providers to help patients with home monitoring of blood pressure. Go to [http://justcheckit.org](http://justcheckit.org) to access the registry and get more information.

**Convocation key topics**

These topics were discussed and will be explored for future research. They include -

**Chronic pain management**
- Understanding of types and stages of pain, including relative perception of pain, from the patient perspective
- Understanding the consequences of prescription patterns for people with a history of drug or alcohol misuse from the patient and family perspective
- Research on connection of systems that help identify drug seeking behavior

**We are always interested in coming to visit practices. If you’d like to have us swing by when we’re on the road, let us know!**

- Physician or pharmacist communication/discussions with patients (timing, duration, content, etc.)
- Integrating behavioral/mental health with primary care
  - Standards for follow-up and ongoing treatment (similar to physical therapy)
  - Comparison of referral processes with efficiency and appropriateness for different populations
  - Understanding the ideal patient load for behavioral health providers including varying license/practice levels and complexity of patient diagnosis and need
  - Care guidelines and level of required care
  - Impact of education and awareness initiatives at the practice and community level
  - Influence of trauma informed care approach

Also discussed was the Affordable Care Act and addressing the volume and needs of newly insured patients; specific ideas were not generated.

**Studies that are still open for practice involvement**

Connection to Health – Perry Dickinson and Bonnie Jortberg are still looking for practices that might be interested in this project focused on helping practices improve the care of their diabetic patients. Core to the project is the use of an innovative, web-based tool that allows patients to prioritize what they would like to focus on improving. If you are interested please contact Tabria.

Medical Marijuana Communication – Tabria, Don and Elin Kondrad, are still looking for practices to participate for 3-5 days in this card study focused on the communication between patients and their usual medical providers when they are using medical marijuana. The burden on practices is low and we are in and out of your practice very quickly. We are learning lots from this already. Again, please contact Tabria if you are interested.

That’s it for this quarter. We are always interested in coming to visit practices. If you’d like to have us swing by when we’re on the road, let us know!

Until next time!

Jodi Holtrop; Jodi.holtrop@ucdenver.edu
Donald Nease; Donald.nease@ucdenver.edu
Tabria Winer; tabria.winer@ucdenver.edu
Please volunteer for the 2013-2014 school year!

Volunteer as a Tar Wars presenter and help educate 4th and 5th grade students about the harmful effects of tobacco use! As a Tar Wars presenter you will be teaching young children about tobacco use awareness and prevention.

This year, medical students who present the Tar Wars Program to the most students between September 1, 2013 and April 1, 2014 have the opportunity to win up to $500 for their FMIG (Family Medicine Interest Group). Tar Wars will grants three award to the FMIGs with the most outstanding community service effects of presenting Tar Wars on May 1, 2014.

• First Prize: $500
• Second Prize: $300
• Third Prize: $200

To apply for the award, a medical student must complete the AAFP Tar Wars Feedback for Presenters on behalf of your FMIG by April 1, 2014.

If you need further information or assistance with signing up to be a Tar Wars volunteer presenter, please contact Karol Ann Groswold at the CAFP office.

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Phone: 303-696-6655 ext. 15

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   - No → 4. Do you want to proceed toward Patient-Centered Recognition?

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3. Submit online application.

4. Attend FREE Standards & Guidelines training.

5. Order FREE online application.

6. Do you have 3 or more practice sites?
   - Yes → 7. STOP! Obtain multi-site approval.

7. Prepare and submit ISS Survey tool to NCQA.

8. NCQA reviews ISS Survey tool (30–60 days).

10. Attend FREE software training (at least 30 days before submitting ISS Survey Tool).


12. Submit online application.

13. Prepare and submit ISS Survey Tool to NCQA.

14. NCQA reviews ISS Survey Tool (30–60 days).

15. Receive decision (results in ISS).

16. Promote your NCQA Recognition status.

17. Upgrade your NCQA Recognition status.

18. Maintain your NCQA Recognition status.

**DUring EARN IT**

**AFTER KEEP IT**
Small Donor COMMITTEE

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

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

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________________________________________________________________________________________________________________________________
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Veteran Family Physician and author, Glenn M. Cosh, D.O., F.A.A.F.P., a past president of the Colorado Academy of Family Physicians in 1985-1986, has written a book called “Is There a Doctor in the House?” Filled with common sense medical insights and anecdotes, Dr. Cosh examines the history of Family Medicine, identifies current problems with the system, and provides everyday ways the Family Physicians can create solutions for the future.

“Is There a Doctor in the House?” revolves around the famous painting by Sir Luke Fildes’, “The Doctor (1891)” The image, pictured above, depicts the character and bearing of physicians during anxious moments and their professional devotion to their patients. Dr. Cosh looks to the painting as the bearing for not only his professional career but an attitude for all physicians.

“We, as physicians are in the business of helping people,” said Dr. Cosh. “And that’s where empathy is so important, and at times I find it missing in today’s overregulated and business-focused medical environment.

In one harrowing story, Dr. Cosh tells about the time when a young mother carried her SIDS (Sudden Infant Death Syndrome) baby to his office. Because their priest was unavailable to perform the last rites, he instructed Dr. Cosh, a non-Catholic, to give them. His personal dedication in caring for his patients, are reflected by the anecdotal stories throughout the book.

Although Dr. Cosh realizes every generation of physicians have their unique challenges, he believes their core value system should always be focused on an unconditional commitment to serving their patients with dignity, respect, and empathy. Towards the end of the book, Dr. Cosh examines what he calls “Alphabet Soup Medicine,” a guide to answering some of the most frequently asked questions in Family Medicine with skill and empathy. One example, under the letter ‘I’, Inconvenient,” he answers a common complaint of patients, “Doc, I don’t have time for this.” With “It’s not an option for you,” followed with an anecdote about a mother canceling her sick daughter’s appointment because she found it inconvenient to cancel her own hair appointment.

Dr. Cosh’s common sense suggestion for patients, as well as fellow physicians, is to maintain a daily balanced approach to their lives, including physical, mental, emotional and spiritual health. Most important, he says, is to set realistic limits and balance of what we expect of ourselves.

“We, as physicians are in the business of helping people. And that’s where empathy is so important, and at times I find it missing in today’s overregulated and business-focused medical environment.”
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