



# CAFP NEWS

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**BOLD CHAMPION FOR COLORADO FAMILY PHYSICIANS**

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Fit Family Challenge!***

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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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# PRESIDENT'S REPORT

By: Candace Murbach, DO



## Happy New Year – Dive In

As we plunge forward in to the New Year, many of us have a lot we'd like to accomplish in 2015. The year begins anew and we may embrace this with eager optimism. We may start off with New Year's resolutions and goal setting. Perhaps we learned things in 2014 we need to incorporate throughout the New Year. As with most people, the average length of time we stick to a resolution is 10 to 30 days, so although setting New Year's resolutions is common, succeeding with the resolution is not. We are all familiar with the list topping resolutions, and the raised brow of skepticism we feel when we hear them. The lifestyle changes: lose weight, quit smoking, drink less, exercise, spend less, save more, waste less, and recycle. Of course, we must include the self-help changes: learn something new, travel, learn to cope with stress, get a new job, volunteer, take a class on eating healthy, express gratitude, etc. By the time you read this many of us will have already forgotten our new year's resolution. For those who plan to persevere, however, there are some keys to success. People oftentimes make their goals too big and too general – making them seem less achievable within the timeframes set. The more specific you can make your goal, such as: "exercise 4 times a week through the month of March," the easier it will be to reach your goal.

As family doctors, our list of goals and resolutions could be daunting with just the required tasks: the additional HIPPA changes and compliance in a digital age; meaningful use 1; meaningful use 2; NCQA certification, ICD-10 and its implementation; the moving target of reimbursement related to the ACA; patient satisfaction; staff satisfaction; MOC. These are just the ones with huge changes this year that we can knowingly anticipate. These must happen. They may involve goals and resolutions, but we as

individuals have no real control over any of them, so not a worthy candidate for our New Year's list.

What I propose as a respectable list for us as family docs is as follows:

1. Be grateful for the privilege of being a family physician and each day express gratitude to someone at work for their contribution;
2. Clearly define your priorities and construct and live your life to reflect them;
3. Make time for the people you love (and don't compromise on this);
4. Be a living example of the lifestyle you prescribe - exercise regularly; eat a reasonably healthy diet, get enough sleep;
5. Limit exposure to technology (cell phones, laptops, television, video games) for a specific period each week to benefit relationships and enhance personal peace;
6. Meditate, practice yoga, or follow some spiritual practice;

## Be grateful for the privilege of being a family physician and each day express gratitude to someone at work for their contribution

7. Stay current on your documentation and do not deviate. (if not, this ever so slowly depletes your energy);
8. Choose to be happy and guard against letting skepticism and sarcasm rob you of it; Attitude, attitude, attitude.
9. Manage your stress and ask for help if you cannot; (this will likely involve the word "no" and some focused time management.)
10. Donate to a worthy cause – time if you choose and certainly money. On that note, I will close with a brief pitch for the CAFP. Remember you can donate money or time or both to the organization. Donate money to the CAFP, its political action committee, any of its programs, volunteer for Doctor of the Day, join a committee, or become an active board member. There is much to be done, do something.

Have a satisfying and joy filled 2015.

# CEO's Report

By: Raquel J. Rosen, MA, CAE



## YEAR IN REVIEW: HEALTH IS PRIMARY

Your CAFP board of directors and staff worked very hard over the 2014 year to further the mission of the CAFP: To serve as the bold champion for Colorado's Family Physicians, patients, and communities through advocacy and education. Some of the accomplishments and news of 2014 were:

### Colorado Primary Care Collaborative

Our team organized the successful convening events for the Colorado Primary Care Collaborative (CPCC) and continued to raise funds for CPCC to advocate for medical homes and payment reform. CPCC leaders met with the medical directors of health plans to advocate for CPCC.

### Patient Centered Primary Care Collaborative (PCPCC) Western Regional Conference

CAFP staff team collaborated with PCPCC and HTW and put on a successful PCPCC western regional conference on June 9 & 10, and a very good convening event for CPCC on June 10. CAFP received revenue sharing.

### Payment Reform

We organized the Payment Reform workgroup meetings with representatives from the Colorado Association of Health Plans, pediatricians, internal medicine and the CAFP. The group made excellent progress. We have now incorporated this into the CPCC.

### Capitol Events

We coordinated students and residents checking blood pressure at the Capitol.

### Pain Symposium

We partnered with North Colorado Health Alliance to put on the North Colorado Pain Symposium.

### Non-Dues Revenue

At the direction of the CAFP board, staff created non-dues revenue projects which netted \$45,000.

### Relationship building

The board and staff continued to build relationships with many other organizations including the Colorado Nurses Association.

### Fit Family Challenge

CAFP's Fit Family Challenge pediatric obesity intervention for primary care practices won the AAFP Foundation's 2014 Outstanding Program Award. A

training program is scheduled for June 1 and 2, 2015 for anyone interested in learning how to implement this in their practice. Go to [www.ourfitfamily.org](http://www.ourfitfamily.org) for more information.

We also successfully negotiated with Colorado Health Op to get funding for practices implementing Fit Family Challenge.

### National Committee for Quality Assurance (NCQA)

Raquel Rosen was invited to participate on NCQA's Customer Advisory Board and accepted.

### Technology Supported Health Confidence

CAFP was awarded \$50,000 from the Physician's Foundation for the Technology Supported Health Confidence grant. Practices are invited to apply for these grant funds to implement this valuable resource.

### Family Medicine for America's Health

Family Medicine for America's Health is a new collaboration between the nation's eight family medicine organizations to improve the U.S. health care system and demonstrate the value of true primary care and drive patient engagement. They created a five year strategic plan and a three year communications campaign to advocate for primary care. The campaign is called Health is Primary and will consist of paid advertising, news media outreach, partnerships, and stakeholder.

The eight Family Medicine organizations are:

- American Academy of Family Physicians
- American Academy of Family Physicians Foundation
- American Board of Family Medicine
- American College of Osteopathic Family Physicians
- Association of Departments of Family Medicine
- Association of Family Medicine Residency Directors
- North American Primary Care Research Group
- Society of Teachers of Family Medicine

Goals of Family Medicine for America's Health

- Furthering the evolution of the patient-centered medical home;
- Advancing the use of technology;
- Ensuring a strong primary care workforce; and,
- Shifting to comprehensive primary care payment.

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7 Core Strategies:

1. Show the value and benefits of primary care;
2. Ensure every person will have a personal relationship with a trusted family physician or other primary care professional in the context of a medical home;
3. Increase the value of primary care;
4. Reduce health care disparities;
5. Lead the continued evolution of the patient-centered medical home;
6. Ensure a well-trained primary care workforce; and,
7. Improve payment for primary care by moving away from fee-for-service and toward comprehensive primary care payment.

**Get Involved**

AAFP is organizing a volunteer workforce in six major areas: Practice, Payment, Workforce Education and Development, Technology, Research, and Engagement.

Learn more about how you can

get involved at [fmahealth.org](http://fmahealth.org).

For more detailed information please read this article: *Health is Primary: Family Medicine for America's Health*, Annals of Family Medicine, 12 1, 2014

**Family Medicine for America's Health Identifies City Tour Locations**

Family Medicine for America's Health ([fmahealth.org](http://fmahealth.org)) has selected locations for its Health is Primary ([www.healthisprimary.org](http://www.healthisprimary.org)) 2015 City Tour. The campaign will travel to cities across the United States to showcase examples of where and how true primary care works. In each city, the campaign will host a panel discussion in coordination with AAFP chapters and bring together local stakeholders – employers, policymakers and health advocates – to look at community level interventions that are enhancing and improving primary care. Year one will be a pilot year, with the goal of expanding to a broader set of cities in future years of the campaign. Year one events are:

- February – Raleigh
- March – Seattle
- May – Chicago
- September – Denver
- October – Detroit

**Health is Primary**

Family medicine wants to ensure that America is a place where *Health is Primary*.

A place where:

- Doctors and patients work together in true partnership;
- Doctors have long-term relationships with their patients and see and treat the whole person;
- Technology supports and fosters the connection between doctors and patients;
- Everyone has access to a primary care home where most, if not all, of their health needs can be met and a coordinated medical neighborhood that provides additional care when needed;
- Prevention and health promotion are as important as treating disease;
- Doctors are working in partnership with community leaders to address individual and population health;
- Health disparities are reduced by increasing access to primary care; and,
- Financial incentives line up with good care and better health outcomes.

To learn more, go to [healthisprimary.org](http://healthisprimary.org).

## 2015 CAFPP Annual Scientific Conference

The April 23-26, 2015 Annual Scientific Conference will have more CME choices than ever before with timely topics and excellent speakers. I hope you will take advantage of the early registration discounts and register now at <http://coloradoafp.org/2015asc/>.

## Major Collaborative Efforts in Colorado to Advance Medical Homes & Payment Reform

I hope all of you are on a path to transforming your practices. But if you don't have the resources, help is on the way!

One resource possibility is a new federal CMS opportunity called Transforming Clinical Practice Initiative (TCPI) and the other is the State Innovation Model (SIM). Colorado has been awarded \$65 million from the SIM Project.

Both are being run out of the Governor's office with strong support from the Governor and direction and leadership from his staff.

SIM will have much broader implications regarding helping practices to transform to medical homes and advocating for payment reform.

The CAFPP's name was submitted as a collaborating organization on the new TCPI grant under the Support & Assistance Network (SAN). This would be broader than SIM. Its goal is to get a large number of all primary care and specialty care clinicians to start on the path of transformation. CDPHE would be the organization coordinating the SAN efforts. HCPF is the coordinator for the Practice Transformation part of the grant.

There is much talk about continuing the great work of the Comprehensive Primary Care Initiative (CPCI) and specifically the payment reform that all the payers are participating in including Medicare, Medicaid, and private plans.

It is very exciting to see all players talking about PCMH and payment reform!

## MEDICAID REPORT

This is information that was included in Colorado's Medicaid report to the Joint Budget Committee.

### Enrollment

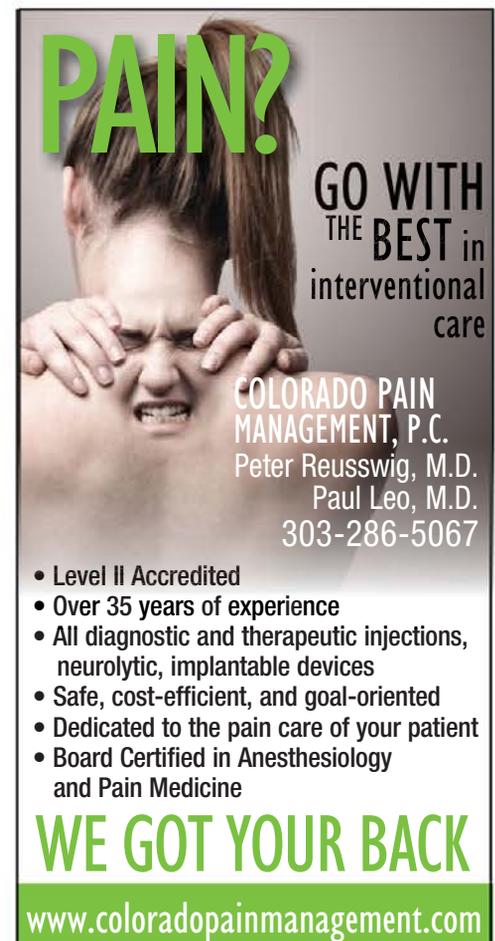
As of June 2014, there were 609,051 members enrolled in the ACC (nearly 60% of all Colorado Medicaid clients). Enrollment includes 328,958 non-disabled children, 242,468 non-disabled adults, and 37,625 individuals with a disability. This is a 73% increase in membership since June 2013.

During FY 2013-14, the ACC generated savings that exceeded all administrative costs. In FY 2013-14, the ACC achieved gross savings in medical costs between \$98,433,017 and \$102,100,305, with net savings totaling \$29,330,495 to \$32,997,329 after accounting for administrative expenses.

### Program Performance Highlights

- Reduction in emergency room (ER) visits: Children and adults who were enrolled in the ACC for more than six months had a lower rate of ER visits than children and adults who were not enrolled, or had been in the ACC for less than six months.
- Reduction in high cost imaging: Consistently lower utilization of these services for all members who have been enrolled in the ACC for six months or longer as compared to those not enrolled and those enrolled for less than six months. Performance on this metric has been so strong for the Program that the Department will no longer include it as a pay-for-performance metric.
- Reduction in 30 day, all-cause hospital readmissions: Hospital readmissions rates were lower for all children and adults who had been in the ACC for six months or longer,

- Switch from ER visits to professional visits for children with disabilities: Since 2012 there has been a 6% increase in the rate of professional visits for children with disabilities and a 7% decrease in emergency room visits.
- Health care delivery system transformation: Regional Care Collaborative Organizations across the state have improved communication, referrals and relationships among both medical and non-medical providers. In some areas, they have even taken steps towards integrating physical and behavioral health care.



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by Jeff Thormodsgaard, CAFP Lobbyist

# Election Overview

## Statewide Races- US Senate, Governor

- Sen-elect Cory Gardner's defeated incumbent Sen. Mark Udall 48.69% to 45.85%
- Gov. Hickenlooper's defeated former Congressman Bob Beauprez 48.93% to 46.42%.
- The GOP swept the offices of Secretary of State (which conducts elections), State Treasurer, and Attorney General.
- Amendment 67 defining Personhood failed 65% to 35%.
- Amendment 68 expanding gambling failed 71% to 29%.
- Proposition 104 regarding open meetings for school boards passed 70% to 30%.
- Proposition 105 requiring labelling for GMO food failed 66% to 34%.

## Colorado State Senate

The State Senate currently is now a 18-17 split, with the Republicans in control for the first time since 2006. There were many very close races, and a handful that were not determined until a week after the election. The main seat that the switch was hinging on was the race to replace Sen. Lois Tochtrop (D-Thornton) in Adams County. Ultimately, Beth Humenick won that seat, defeating former Representative Judy Solano by a slim margin. Other notable races include:

- Sen. Jeanne Nicholson (D-Gilpin County) officially lost to former Sen. Tim Neville (R-Littleton) by 2,280 votes, 48% to 52%. As a former public health nurse she was a prominent and dynamic voice for the healthcare in the Senate. Her successor is Tim Neville,
- Sen. Rachel Zenzinger (D-Arvida), who replaced Senator Evie Hudak last January, lost to her opponent Laura Woods Waters (no relation) by 841 votes, 46.4% to 47.8%.
- Sen. Cheri Jahn (D-Lakewood) barely beat her opponent Larry Queen, 196 votes to be precise, however it was just over .05% therefore she was able to avoid a recount.
- Senate Education Chairman Andy Kerr (D-Lakewood) survived by 1,047 votes against newcomer Tony Sanchez, 51% to 49%, also barely avoiding a recount.
- Vail City Councilwoman Kerry Donovan (D) officially won over Orchard Springs Mayor Don Suppes (R) for Senate District 5 on the Western Slope 49%-47%.
- Former Representative Leroy Garcia

(D-Pueblo) soundly defeated Sen. George Rivera (R-Pueblo) to take back the seat lost in the 2013 recall elections 55% to 45%.

- Sen. Bernie Herpin (R-Colorado Springs) lost to former Rep. Mike Merrifield (D-Manitou Springs) 42% to 52%, regaining another seat lost in the 2013 recall elections.

## State House

In the State House the Democrats barely held onto their majority, despite their 9 seat advantage going into the election. Ultimately, the final numbers are 34-31, with the Democrats in control. Some of the highlighted races were:

- Representative Joe Salazar (D-Thornton) barely barely beat his opponent Carol Beckler, 49.66% to 50.34%, which translates to less than 150 votes. This was not a race that was expected to be close.
- Rep. Jenise May (D-Aurora), House member on the JBC lost to her opponent by 435 votes or 48.57% to 51.43% This also was not expected to be a close race.
- House Judiciary Chairman Rep. Daniel Kagan (D-Cherry Hills Village) also barely pulled off his win against Republican Candice Bengé by 416 votes, or 50.69% to 49.31%.
- Rep. Tony Exum (D-Fountain) sadly lost to his opponent Kit Roupe by 294 votes, or 45% to 47%. This seat has gone back and forth between Democrat and Republican in every election since 2006 and I don't anticipate this pattern to change.
- Rep. Mike McLachlan (D-Durango) lost to former Rep. J. Paul Brown (R-Ignacio) in a rematch of 2012 by 229 votes, or 49.66% to 50.34%.

With the new composition in mind, Mendez Consulting has been working closely with the CAFP Legislative Committee since mid-November to evaluate our steps moving forward in this new environment.

Of course, that is not the only thing going on under the Dome. In the first two weeks of December, the Joint Budget Committee meet with the Department of Health Care Policy and Financing (HCPF), to discuss their budget requests for fiscal year 2015-16 and evaluate their performance from fiscal year 2014-15. Although these requests still have a long way to go before they are approved, here are the highlights for family medicine.

## HCPF Budget Overview

- 25.4% of all state General Funds (GF) go to HCPF
- The total requested appropriation for HCPF for FY15-16 is \$7,782,578.
  - Of this \$7.9 billion, approximately \$4.7 billion is federal funding.
  - The request represents an increase of 9.6% over the FY14-15 budget.
- 72.7% of the total funds appropriated in FY14-15 were for the Medical Services Premium line items which include payments made under Medicaid state plan benefits and HCBS Medicaid waiver benefits.
  - Behavioral health (a capitated—not fee for service—system) amounted to 7.1%
  - 7.1% for indigent care
  - 6.2% for the Office of Community Living
  - 3.0% for the Executive Director's Office
  - the remainder is appropriated for other medical services and DHS programs funded by HCPF
- Medicaid enrollment has increased significantly in recent years because of increasing population, economic conditions and changes in state and federal eligibility policies. Under the Affordable Care Act, the federal government covers 100% of the cost for newly eligible adults.
  - That amount decreases beginning in 2017 until it reaches 90% in 2020.
- In Colorado, those persons eligible for coverage under Medicaid expansion includes parents and caretakers with incomes up to 138% of the Federal Poverty Level (FPL) and adults without dependent children with incomes up to 138% of FPL.
- Medicaid is the largest health insurer in Colorado covering approximately 20% of residents.
  - Covered population ranges from 7% in Pitkin and Douglas Counties to almost 47% in Costilla County.
- HCPF has estimated that expenditures for the current fiscal year will be about 2.5% higher than the appropriation approved by the General Assembly. It is not unusual for the Medicaid budget to

*continued on page 10 >>*

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**Our services include:** Comprehensive food allergy testing/challenge, exercise physiology and lung function testing, genetic and immune function testing for immunodeficiency, neuropsychological testing, sleep disturbance evaluations.

<< continued from page 8

be revised; the reasons for the revision in FY14-15 include:

- “welcome mat” effect—outreach efforts for Medicaid expansion resulted in enrollment that was greater than anticipated;
- the per capita costs of new enrollees into Medicaid was under-estimated; and
- the effect of “continuous eligibility” decisions made by the General Assembly was underestimated.
  - In 2011, the Legislature addressed the problem of children losing eligibility from month to month because of fluctuations in family income by using funds from the Hospital Provider Fee.
  - In FY15-16, the presumption is that continuous eligibility would be covered by the General Fund. The Legislature will have to enact new laws to accommodate this.
- Per capita Medicaid expenses in the FY14-15 appropriation for persons with disabilities and the elderly have increased more dramatically in past years than for expenses for children and adults not included in those categories:
  - the per capita expenditure for persons with disabilities in 96-97 was about \$7,200—in 14-15, the expenditure in FY14-15 is \$18,393.
  - For children covered under Medicaid, the per capita expense in FY96-97 was about \$1,800; in FY14-15 the

budgeted expenditure is \$2,059.

- Colorado’s Federal Matching Assistance Percentage (FMAP) will see a slight percentage decrease in FY15-16 because the state’s per capita income has increased.
  - FMAP is calculated each year for each state based on the state’s per capita income compared to national averages.
  - Federal matching percentages range from 83% for the poorest states to a maximum of 50%.
  - Prior to the recession, Colorado’s FMAP was at 50%; in The FMAP in FY15-16 will be 50.72%--down from 51.01 in FY 14-15.

**Official Department Budget Requests**

- *R7 Participant Directed Programs:* Request of \$816,000 GF to manage the Colorado First Choice implementation process and to allow individuals receiving services on the Supported Living Services (SLS) waiver to utilize Consumer Directed Attendant Support Services (CDASS).
- *R9 Personal Health Records:* HCPF proposes creating a secure, centralized web portal through which Medicaid clients could access online health education materials and view their personal health records and communicate securely with their providers. Access to health records and communication with providers would be through the Health Information Exchange (HIE) managed

by CORHIO. This item gets a 90% federal match, so the request for GF is less than \$500,000.

- *R11 Public Health and Medicaid Alignment:* HCPF proposes a total fund of \$1.4M (\$495,000 GF) to create a grant program for Local Public Health Agencies (LPHAs) to be administered through Medicaid’s Regional Care Collaborative Organizations (RCCO). The goal would be to utilize the expertise of LPHAs to address population health issues impacting the Medicaid population, such as diabetes management or obesity intervention. JBC members had several questions about this proposal that will be addressed by HCPF at their hearing.
- *R13 ACC Reprourement Preparation:* HCPF requests \$250,000 total funds (\$125,000 GF) for consulting services associated with the procurement process for the Accountable Care Collaborative (ACC) to assist with stakeholder engagement, financial analysis, and program/policy assessment. Senator Lambert asked why current HCPF budget could not be used to cover this.
- *R17 School-based Early Intervention and Prevention:* HCPF requests continued funding to pay Behavioral Health Organizations (BHOs) for school-based substance abuse prevention and intervention programs authorized through SB14-215 and paid for with marijuana sales tax revenue.
- *R19 Public School Health Services:* HCPF

# Super Heroes in Family Medicine

## 2015 Annual Scientific Conference

Cheyenne Mountain Conference Center, Colorado Springs

April 23 - 26

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- 60+ Hours of CME Available
- Innovative learning opportunities on the latest and greatest medical information and an office procedural workshop
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requests an increase in spending authority for public school health services passed on projected increases in enrollment and school district participation. This program certifies funds spent by school districts for health services for Medicaid children as state matching funds. Those certified public expenditures are then used to draw down federal matching funds, effectively doubling the funds available for school health services. The JBC members had several questions about this program and requested that HCPF provide more information at their hearing.

### Issue: Forecast Trends

This Issue Brief presents a summary of the trends impacting the medical services premiums (Medicaid) budget. Of note:

- Medicaid covers an estimated 1 in 5 Colorado residents; the proportion of the population covered by Medicaid varies significantly by county (see map page 21)
- Medicaid covers 41% of births in Colorado
- 20% of utilizers account for 80% of costs in FY2013-14 and the top 1% accounted for 25% of expenditures; HCPF spent \$1.5M on hemophilia drugs for one patient in FY2013-14
- The “welcome mat” effect resulted in greater enrollment than anticipated
- Per capita costs have been adjusted in the HCPF request based on experience with a \$55 increase for children, but a \$370 decrease for parents/caretakers

### Issue: Affordable Care Act Expansion

This Issue Brief discusses the ACA implementation impact on the state and some of the effects on the Department’s workload, including the HCPF request for new FTE to address call center volume.

Summary:

- For FY14-15, HCPF significantly underestimated the “newly eligible” population that would enroll in Medicaid, but due to an overestimate of the per capita cost, the revised forecast of expenditures is almost unchanged.
- If the state had to pay 10% of the share of the costs for the “newly eligible” in FY2015-16, the projected cost would be \$151.1 million. According to state law, this 10% will come from the Hospital Provider Fee.
- Interesting maps and charts regarding demographics of the “newly eligible” population can be found on pages 29-34.
- An increase in call volume has led to the request for 25.0 FTE for the Call Center. A more detailed analysis of this budget request is on pages 35-36.

### Issue: R12 Provider Rate Setting Process

This Issue Brief discusses HCPF’s request for provider rate increases and a plan the Department submitted for how an annual rate review process could be implemented for future years. This was a point of contention between many members of the JBC, and therefore discussed at length. Some of the highlights are below, but this will more than likely also be a significant conversation at the hearing on Tuesday.

- HCPF proposes a 1.0% increase, for a 0.5% across-the-board increase and

targeted rate increases.

- Regarding the targeted increases, JBC staff expressed several concerns about the criteria for prioritizing rates, limited evidence that proposed rates would address the access issues, the rationale for choosing some and not other reimbursement increases, and the late submission of the information relative to the budget process timeline.
- JBC staff specifically discussed anesthesiologist reimbursement rates, indicating that their business practice is to provide services to all hospital patients regardless of payer source, yet they are losing money for each Medicaid patient due to their low reimbursement rates. In this case, there is not an access issue, but there are incentives for anesthesiologists to change their business practices to serve fewer or no Medicaid patients. This is an example of where access alone may not be a good measure for determining reimbursement rates.
- Senator Aguilar requested information from HCPF on which specialties have the longest wait for Medicaid patient appointments, indicating she has heard that dermatology, neurology and orthopedics are the worst.
- Representative May asked for the Department to comment on having rate increases effective January of each year rather than July 1. Options were discussed.
- Senator Lambert indicated strong support for anesthesiologist and other provider reimbursement increases, a lack of confidence in the Department’s process and recommendations, and frustration with the timeline as it relates to the budget process.

## CAFP SEEKS TAX INCENTIVES FOR MEDICAL PRECEPTORS

During the 2015 legislative session, the Colorado Academy of Family Physicians will bring our very own bill regarding tax incentives for physician preceptors. As you may know, Colorado’s primary care shortage is well documented and it is imperative that the training of medical students, physician assistant students, and nurse practitioner students be secured in the state as these three disciplines form the core of our primary care workforce. The Colorado Academy of Family Physicians and Colorado’s Area Health Education Center Program would like to invite you to join us for the second stakeholder interest meeting on bringing legislation that would provide tax incentives for preceptors of medical students, physician assistant students, and nurse practitioner students. If you are interested in joining the committee, please email the CAFP’s Public Policy Director Manthan Bhatt at [manthan@coloradoafp.org](mailto:manthan@coloradoafp.org)

# Report from the AAFP Congress of Delegates in Washington, DC October 20 – 23, 2014

By Kent Voorhees, MD, CAFP Delegate

This report will not discuss every resolution but primarily the ones that may be of interest. Wording is paraphrased.

## Reference Committee on Education

Resolution 602, Adopted: That the AAFP work with the ABFM to develop a process whereby AAFP members who participate in a Self-Assessment Module (SAM) group study workshop registered with the ABFM can obtain the appropriate number of “live” CME credits and AAFP to report back to the 2015 Congress of Delegates.

Resolution 603, Adopted that the AAFP advocate for nursing pumping rooms at commercial transportation hubs, in a non-restroom space that has at a minimum a chair, counter, sink and power for equipment use.

Resolution 604, Referred to the Board of Directors That the AAFP advocate with the federal government to eliminate the mandatory 30 day waiting period for Medicaid sterilization procedures.

Resolution 605, Adopted that the AAFP advocate that HHS amend the list of preventive services provided under the Affordable Care Act to include all contraceptive services for patients, regardless of gender, including vasectomies.

## Reference Committee on Organization and Finance

Resolution 202, Not Adopted that the AAFP not renew the alliance with Coca Cola After lengthy debate on the floor, it was felt that there were positive aspects of this relationship, and that the AAFP may be having some positive influence on educational material, and products that Coca Cola is involved with. The \$1Million yearly amount is financially important. Relationships with other companies may have some products that we do not necessarily endorse, but do not dissect as much as this one.

## Reference Committee on Health of the Public & Science

Resolution 401, from Colorado – Vaccination Personal Belief Exemption Policy, Referred to the Board of Directors That the AAFP adopt as its policy requirement for students and parents to see a licensed health care provider for education and/or counseling prior to claiming a person belief exemption for immunizations for school. Testimony was primarily in support of this resolution, where personal belief exemption is often used as a convenient way to get children enrolled in school. There was concern of details – edict to see a physician other than provider, consider other options, such as giving parents the option of online training. Felt it required additional investigation.

Resolution 405, Referred to the Board That the AAFP develop patient centered educational materials regarding the use of recreational marijuana based on scientific evidence. Testimony agreed that this was important, however with lack of research – referred to the Board until additional evidence based research is available.

## Reference Committee on Practice Enhancement

Resolution 304, Referred to the Board That AAFP, the AMA, CMS and Medicaid work together to require all health care plans cover insulin delivery devices at the same tier as vial and syringe insulin injections. Testimony changed this to insulin pens, but it was still referred to the Board.

Resolution 308, Adopted that the AAFP encourage CMS to begin covering the cost of the recommended one-time dose of Tdap booster vaccine and its administration as Medicare Part B benefit.

## Reference Committee on Advocacy

Resolution 508, Not Adopted that the AAFP support “Single

Payer National Health Insurance” Testimony included that our system has changed to exploring alternative payment systems other than just fee for service, including ACO’s and that these should be allowed to declare how they do before they are abandoned and changed to a single payer system, which still rely more on a fee for service model.

509: Direct AAFP to include in advocacy efforts dissemination of Model State Legislation

After lengthy discussion, the COD voted to refer a substitute resolution to the board for study on both dissemination and development of model legislation ...many small chapters who do not have the administrative or staff support to develop their own legislation really were hoping that the AAFP BOD would take this on, but various people testified about both the potential cost of developing individual pieces of legislation that would be appropriate for individual states and the difficulty of coordinating this among the different states.

511: Electronic prescriptions of controlled substances

The COD voted to adopt this resolution, asking for the AAFP to communicate with the DEA to simplify the rules for electronic prescribing, as the complicated EMR rules around electronic prescribing now cause many EMR’s to default to paper systems, which increases problems with diversion.

## Other items of interest

Reference Committee Chairs Reference Committee on Finance – Dr. John Bender

Candidacy Announced Candidacy of Dr. John Bender was announced to be running for the Board of Directors of the AAFP in the 2015 election

Assembly Announcement for 2015 To be held in Denver Colorado September 29 – October 3, 2015



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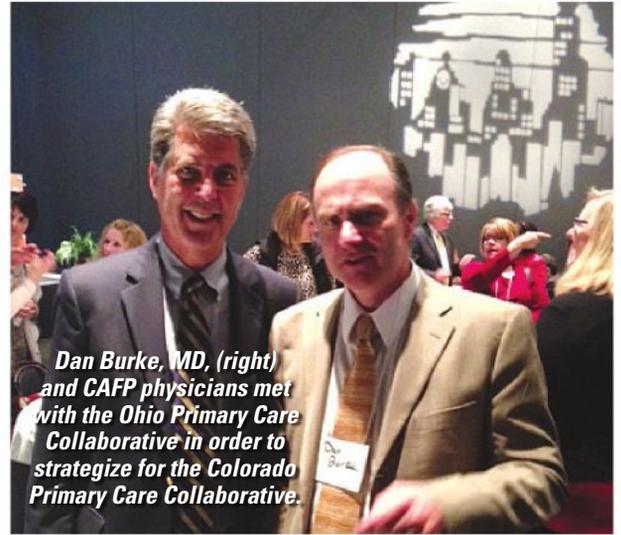
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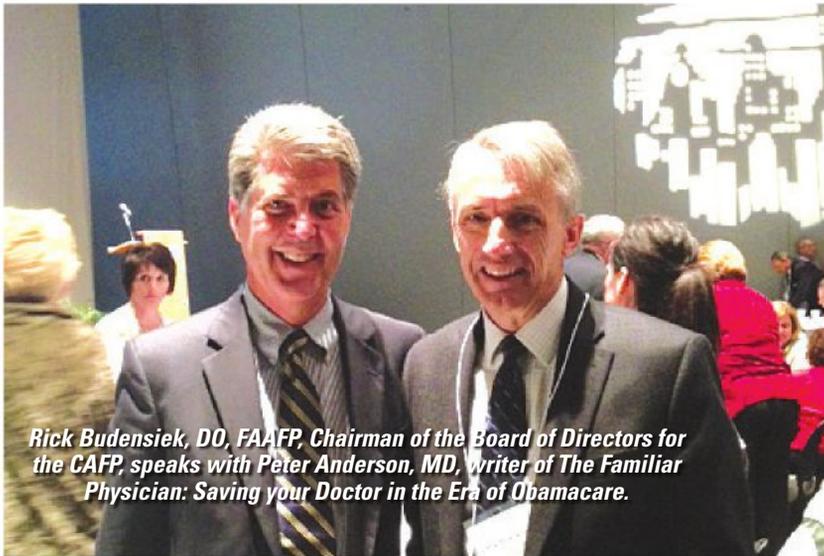
# CAFP ON THE GO



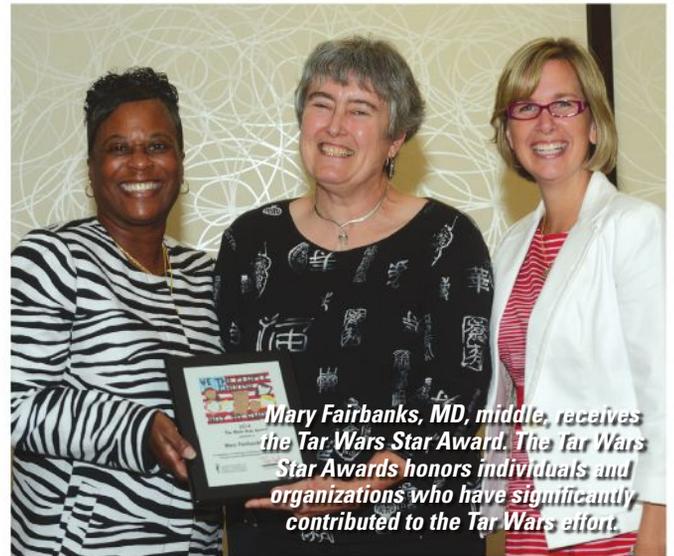
*The CAFP delegation to the annual AAFP's Congress of Delegates was successful in accomplishing Colorado's agenda.*



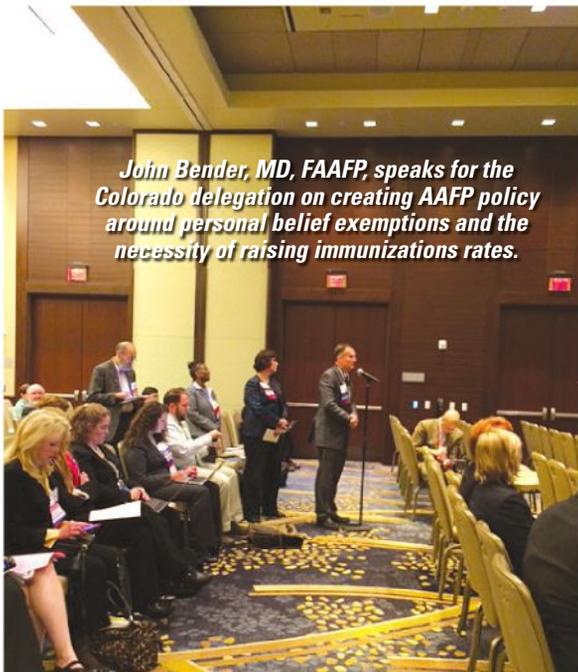
*Dan Burke, MD, (right) and CAFP physicians met with the Ohio Primary Care Collaborative in order to strategize for the Colorado Primary Care Collaborative.*



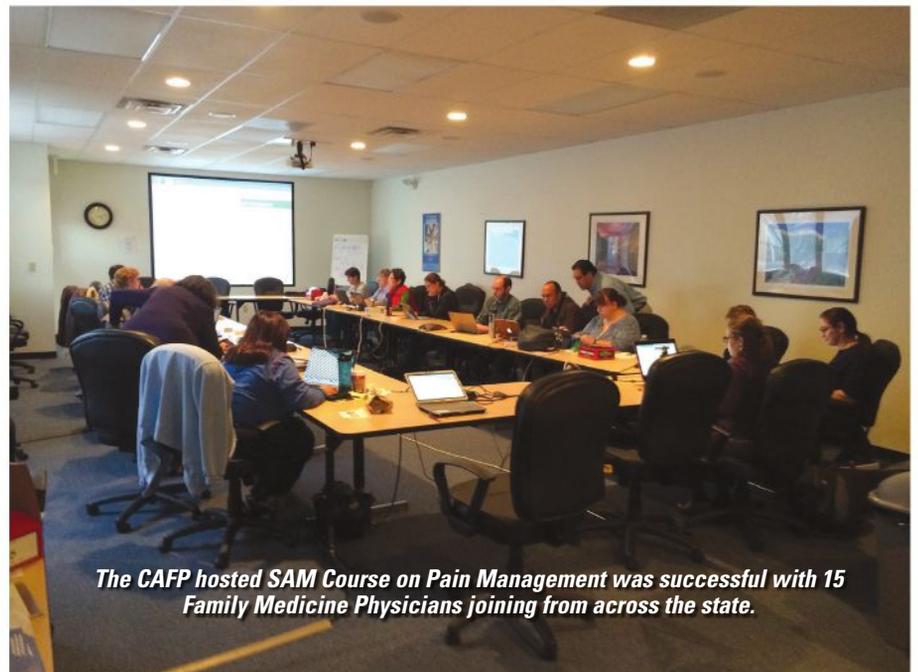
*Rick Budensiek, DO, FAAFP, Chairman of the Board of Directors for the CAFP, speaks with Peter Anderson, MD, writer of The Familiar Physician: Saving your Doctor in the Era of Obamacare.*



*Mary Fairbanks, MD, middle, receives the Tar Wars Star Award. The Tar Wars Star Awards honors individuals and organizations who have significantly contributed to the Tar Wars effort.*



*John Bender, MD, FAAFP, speaks for the Colorado delegation on creating AAFP policy around personal belief exemptions and the necessity of raising immunizations rates.*



*The CAFP hosted SAM Course on Pain Management was successful with 15 Family Medicine Physicians joining from across the state.*



## Working together to provide the **best care for kids.**

Sleep problems can occur at any age, but when they occur in infants, children or young adults, they can have a big impact on the entire family. Twenty percent of all children suffer from some type of sleeping problem, and the causes range from poor sleep habits and behavioral problems to primary sleep disorders such as obstructive sleep apnea and insomnia. Whatever the cause, the impact can be disruptive to children and their families.

Children's Hospital Colorado Sleep Center provides a comprehensive service for evaluating, diagnosing and treating any sleep disorder. Our physicians, nurse practitioners, sleep psychologists and surgeons work to improve sleeping problems so that the entire family can return to an optimal night of sleep. Our team maintains close contact with the referring primary care provider to develop an individualized plan that best serves the patient and gives support to the family to continue that plan at home.

For more information about our multidisciplinary sleep program, please visit [childrenscolorado.org/sleep](http://childrenscolorado.org/sleep).

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**Children's Hospital Colorado**

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## Food Protein-Induced Enterocolitis Syndrome (FPIES): *An Often Overlooked Item on the Food Allergy Menu*

Dan Atkins, MD  
Allergy Section Chief, Children's Hospital Colorado  
Associate Professor, University of Colorado School of Medicine

Children with immunoglobulin-E (IgE)-mediated food allergy present with symptoms typically associated with allergic reactions that occur reproducibly within minutes to a couple of hours after ingestion of the culprit food and have a positive skin test to the offending food. In contrast, children with non-IgE-mediated food allergies often present with symptoms isolated primarily to the gastrointestinal tract such as abdominal pain, nausea, vomiting, diarrhea, food refusal and failure to thrive.

The diagnosis of non-IgE-mediated food allergy early in life is often missed or delayed due to the overlap of symptoms with other GI disorders, a longer delay between food ingestion and symptom onset, a lack of biomarkers (prick skin tests are usually negative) and poor awareness of these conditions by some care providers.

Food protein-induced enterocolitis syndrome (FPIES) is a perfect example of a non-IgE-mediated food allergy that is often misdiagnosed or not diagnosed in a timely fashion. FPIES presents during infancy in both acute and chronic forms. The acute form of FPIES occurs either after initial food introduction or upon reintroduction following removal of a culprit food from the diet. Symptom onset is typically within two to four hours of food ingestion and consists of repetitive, profuse vomiting in addition to pallor and lethargy, often followed hours later by diarrhea. Severe reactions result in acute dehydration, hypotension and/or bloody, mucousy stools filled with eosinophils and leukocytes. Peripheral



blood neutrophil counts are increased and often accompanied by thrombocytosis.

Because of the acute onset of symptoms, children with FPIES are often seen urgently in their doctor's office or in the emergency department where they are frequently misdiagnosed with suspected sepsis, acute viral gastroenteritis, or surgical conditions, further delaying the correct diagnosis. In contrast, chronic FPIES occurs when the culprit food is introduced early in life and fed regularly, such as milk or soy formula. Symptom onset is usually within the first three months of life and between one to four weeks of formula introduction. Onset can occur later if formula introduction is delayed, but rarely occurs after a year of age.

Classic symptoms include persistent

irritability, abdominal distention, lethargy, failure to thrive, and bloody diarrhea accompanied by laboratory findings of metabolic acidosis, neutrophilia, eosinophilia, anemia and hypoalbuminemia. Methemoglobinemia and acidosis have been reported in up to a third of infants with severe reactions. Removal of the offending food from the diet results in significant improvement over the following 24 to 48 hours, although symptoms return acutely following subsequent exposures.

Milk and soy formulas are the most common causes of FPIES and in the United States about half of the children who react to one also react to the other. The foods that often trigger solid food FPIES include several that rarely cause IgE-mediated reactions and are commonly

the first foods introduced into the infant diet, which is another reason that food allergy is rarely considered the cause. For example, rice is the most common cause of solid food FPIES while other common triggers include oat, barley, avian meats, sweet potato, white potato and corn. A relatively common scenario for FPIES is the infant who is fed rice cereal for the first or second time and develops classical FPIES symptoms two to four hours later. Because rice is not considered a common food allergen, the diagnosis of a food allergy is not considered or is even discounted if suggested by a parent. About a third of the children with FPIES to milk and/or soy subsequently develop FPIES to solid foods, whereas about 80 percent of infants with solid food FPIES react to more than one food. High-risk food groups in the first year of life include grains, legumes and poultry. Fortunately, most children outgrow milk and soy FPIES by three years of age, although resolution of solid food FPIES may take longer. Interestingly, FPIES to fish and shellfish has been described in older children and adults.

Knowledge of the common food triggers, typical symptoms, timing of symptom onset following food exposure and the different forms of FPIES (acute and chronic) is critical to making the diagnosis. Allergen skin testing is usually negative although recent evidence suggests that those with positive skin tests take longer to outgrow FPIES and may subsequently develop IgE-mediated food allergy. Occasionally, oral food challenge to the suspected food after a period of avoidance is necessary to confirm the diagnosis. Oral food challenges are also considered after 12 to 18 months without a reaction to determine whether the FPIES to the incriminated food has been outgrown.

Because approximately half of positive challenges result in repetitive vomiting and acute dehydration, experienced personnel should perform these challenges in a medical setting with intravenous access and the ability to provide rapid fluid resuscitation. Treatment with a single dose of methylprednisolone is recommended for severe reactions. Routine treatment with antihistamines or epinephrine is not recommended as they do not reduce emesis or lethargy, but a recent report demonstrated a prompt response to

treatment with ondansetron in patients with acute FPIES. Accidental ingestions resulting in a reaction often require trips to the emergency room for fluid resuscitation. Providing families with a letter to give to urgent care personnel describing the presentation and management of FPIES helps avoid misdiagnosis and reduces the time to provision of optimal therapy.

Management of the infant with multiple food FPIES often presents a challenge best addressed with assistance from other care providers such as an allergist, a gastroenterologist, a dietician, a feeding therapist and occasionally a psychologist. Input from these specialists

aids in insuring optimal nutrition while on the required elimination diet and overcoming feeding difficulties resulting from unpleasant feeding experiences through the provision of strategies that reinforce the feeding and oral skills these infants and children require. Fortunately, the prognosis is excellent as most children outgrow their FPIES within several years. Hopefully, as knowledge about FPIES is gained and disseminated, delays in diagnosis and misdiagnoses will be substantially reduced, resulting in better nutrition and improved quality of life for these patients and their families.

## Upcoming Events: for more information visit: [coloradoafp.org/events](http://coloradoafp.org/events)

### February 2015

#### Brew and Chew: 7th Annual Medical Student Dinner

**February 7 @ 6:00 pm - 8:00 pm**

Dry Dock Brewery, 15120 E. Hampden Ave., Aurora, CO 80014, United States  
Students, meet & visit with Family Medicine Physicians from clinical and academic settings in both urban & rural environments. Learn more about this diverse speciality.

### April 2015

#### 2015 CAFP Annual Scientific Conference

**April 23-26**

Cheyenne Mountain Conference Center, 3225 Broadmoor Valley Rd, Colorado Springs, CO 80906 United States

Join us for the 2015 CAFP Annual Scientific Conference! We hope to bring fun and exciting CME and networking events with some of the best exhibitors from all across the country!

### June 2015

#### National Conference: Fit Family Challenge Pediatric Obesity Training

**June 1-2**

What is the Fit Family Challenge? This pilot project aims to integrate childhood obesity guidelines into clinical primary care and community settings across Colorado, with a focus on rural and underserved populations so physicians have the tools they need to diagnose and treat children struggling with obesity. The loose frameworks provided to primary care physicians to date are still heavily theoretical leaving primary care physicians without a truly relevant methodology for applying these ideas to clinical practice for young patients...

#### CPOCC Convening Event

**June 5th**

More information to come soon. Contact Manthan at [Manthan@coloradoafp.org](mailto:Manthan@coloradoafp.org) for more information.

# Eating Disorders in Children and Adolescents

By Amy Sass, MD, MPH; Jennifer Hagman, MD; Jim Masterson, LCSW; and Pat Kokora, RD, Children's Hospital Eating Disorder Program



"ANOREXIA DESTROYED MY LIFE. IT TOOK AWAY EVERYTHING THAT I CARED ABOUT, REPLACING IT WITH WHAT I THOUGHT WAS CONTROL, INDEPENDENCE AND SUCCESS. THE IRONY IS THAT AT THE HEIGHT OF THE DISEASE I WAS THE ONE BEING CONTROLLED."

## What is the typical path to onset of an eating disorder?

Children or teens who present with eating disorder symptoms may have been teased about their body shape or weight, or have become unhappy with their body size and are comparing themselves to their peers. They are often achievement-oriented and perfectionistic. Body dissatisfaction contributes to the decision to change their body shape or weight and kids try to limit certain foods, such as desserts, fats, carbs and portion sizes. They often increase their exercise to hasten weight loss. Other behaviors can include skipping meals, lying about what they have eaten, purging and using laxatives. Family members and friends often notice an increasing preoccupation with weight and appearance and avoidance of eating with others.

The early phase of an eating disorder is often silent or hidden. By the time the family becomes aware of the significance of the symptoms, the changes in thoughts and behaviors can be profound. Although most individuals with an eating disorder are female, up to 20 percent are male.

Table 1

### What are the different eating disorders?

DSM V defines five different eating disorders:

- **Anorexia Nervosa (AN):** Significantly low body weight, less than minimally expected, an intense fear of gaining weight, distorted body image and persistent behavior that interferes with weight gain.
- **Bulimia Nervosa (BN):** Patterns of binge eating followed by behaviors to avoid weight gain, such as purging, using laxatives, fasting or excessive exercise.
- **Binge Eating Disorder (BED):** A new diagnosis, characterized by bingeing without purging. People with BED are often overweight.
- **Avoidant/ Restrictive Food Intake Disorder (ARFID):** Another new diagnosis, which is characterized by children who show little interest in food, accept only a limited diet due to issues with sensory concerns or who have food refusal related to an aversive experience such as choking or vomiting fears.
- **Eating Disorder Not Elsewhere Classified (EDNEC):** Deregulated eating affecting daily functioning that does not fit the above criteria.

## What are medical complications of having an eating disorder during childhood/adolescence?

Medical complications associated with eating disorders are listed in Table 2. Most of the medical complications of eating disorders resolve with weight restoration and/or resolution

Table 2

### Medical Complications that result from Eating Disorders

#### General

- Dehydration
- Hypokalemia
- Hypomagnesemia
- Hyponatremia
- Amenorrhea and menstrual irregularities
- Low bone mineral density; osteoporosis
- Cognitive deficits

#### Caloric restriction and weight loss

- Inability to maintain body temperature
- Prolonged QTc interval or increased QT dispersion
- Dysrhythmias and other electrocardiographic abnormalities
- Mitral valve prolapse
- Pericardial effusions
- Delayed gastric emptying and impaired gastrointestinal tract motility
- Constipation
- Hypoglycemia
- Hypercholesterolemia
- Abnormal liver function test results
- Sterile pyuria
- Anemia, leukopenia; thrombocytopenia
- Sick-euthyroid syndrome
- Growth retardation

continued on 20 >>

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<< continued from 18

Cortical atrophy  
 Vomiting-related  
 Hypochloremic metabolic alkalosis  
 Gastroesophageal reflux  
 Esophagitis  
 Dental erosions  
 Mallory-Weiss tears

### When should a patient with an eating disorder be medically hospitalized?

Children and adolescents have the best prognosis when their disease is diagnosed early in the illness course and treatment is started quickly to avoid medical morbidities. Unfortunately, hospitalization may be necessary. Table 3 lists the major medical guidelines for hospitalization of children and adolescents with eating disorders.

Table 3  
 Medical Guidelines for Hospitalization of Children and Adolescents with Eating Disorders

- <75% IBW, or ongoing weight loss despite intensive management
- Heart rate <50 bpm daytime; <45 bpm nighttime
- SBP <90 mmHg
- Orthostatic changes in pulse (>20 bpm) or blood pressure (>10 mmHg)
- Hypothermia T<96°F
- Arrhythmia including prolonged QTc
- Electrolyte abnormalities (K<3.2, Cl<88)
- Intractable vomiting

### How do you manage barriers to the family accepting evaluation results and treatment recommendations?

Parents may come to an initial evaluation with heightened awareness and readiness to act, but some parents resist recommendations for treatment. The physician should convey clinical information and concerns while developing a level of rapport essential to facilitate the acceptance of treatment recommendations. Encourage the parent to elaborate on their concerns to improve rapport and diminish resistance. Parents are the primary agents of change given the substantial level of resistance typically displayed by the patient. The patient frequently views the changes in eating patterns and weight loss as a solution rather than a serious medical illness. He or she is in a “precontemplative” stage of change, indicating a denial of any problem. Motivational interviewing with emphasis on active listening and reflecting back concerns in a collaborative manner are very effective.

### How should parents approach the challenge of feeding their child?

Parents have a central role in the child’s recovery from an eating disorder. They will need to take control temporarily of all aspects of daily nutrition; planning, preparing and supervising all meals and snacks. A helpful strategy is to have the family and patient think of food as medicine and as “fuel to run the

body.” Eating will need to be the priority of the day. You can remind the patient that “health is not negotiable” and “eating is essence to health.” Just as you would prescribe a medicine and recommended how many a times a day to take it, the nutrition “prescription” for a patient with an eating disorder is a minimum of three meals and two to three snacks a day, as the medicine. Normal eating and weight restoration takes time, patience and practice.

### How many calories does a child or adolescent need to restore weight?

The American Psychiatric Association (APA) Practice guideline (2006) advises beginning with 200 to 300 calories above the patient’s usual calorie intake. Most patients will need to work up to at least 3000 calories to gain weight and will need to limit their activity until they reach their target weight. The use of regular foods is important versus diet, low calorie or low fat foods during weight restoration. Patients with eating disorders usually have distorted beliefs about foods and tend to label foods as “good” and “bad.”

**Are there any medications that can be used to treat someone with an eating disorder?** Fluoxetine is approved for the treatment of bulimia nervosa, but there are not other medications approved for the treatment of AN, ARFID or BED. Medication, such as SSRIs, can be helpful for co-morbid conditions, such as depression, anxiety and obsessive compulsive disorder.

### How are eating disorders treated? Does anyone get well?

Most families will need a therapist who specializes in Family Based Therapy (FBT), an outpatient approach to treating eating disorders in youth. Consultation with a dietician can also be helpful, and medical monitoring by their family physician is critical. In cases of medical instability or severe eating disorder behaviors, a higher level of care may be recommended. With strong family support and effective professional interventions, patients can fully recover from an eating disorder. Early, effective intervention and normalization of body weight and eating patterns is critical.

Amy Sass, MD, MPH, is an adolescent medicine physician at Children’s Hospital Colorado and an associate professor of pediatrics at the University of Colorado Denver School of Medicine. Jennifer Hagman, MD, is a child psychiatrist at Children’s Colorado and an associate professor of psychiatry at the University of Colorado Denver School of Medicine. Jim Masterson, LCSW, is a therapist in the program, and Pat Kokora, MS, RD, is a dietician who works closely with families in the Eating Disorder Program at Children’s Colorado.

For questions, call the program directly at 720-777-6452 or toll free through One Call at 800-525-4871, or e-mail [jennifer.hagman@childrenscolorado.org](mailto:jennifer.hagman@childrenscolorado.org).

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

# Nutrition Basket of Services for Family Medicine

Bonnie T. Jortberg, PhD, RDN, CDE

Department of Family Medicine, University of Colorado School of Medicine

Over 70% of patients that present in family medicine clinics everyday have one or more chronic diseases. Evidence-based guidelines from the US Preventive Services Task Force, The American Diabetes Association, The American Heart Association, and others, recommend intensive self-management support for these patients to engage them in self-care activities. However, most family medicine practices lack the time, staff, and resources to fully provide self-management support services to their patients. This is reflected in a recent report from the Centers for Disease Control (MMWR 2014;63:1045-9), which found that only 6.8% of insured patients with a new diagnosis of diabetes participated in self-management education within the first year of diagnosis.

Several of the new payment models and primary care initiatives are emphasizing the need for robust self-management support services that are provided within

in providing Medical Nutrition Therapy (MNT) and patient self-management support. Nutrition counseling provided by a RDN has been shown to improve health outcomes for type 2 diabetes, weight management, disorders of lipid metabolism, and hypertension. Primary care physicians report seeing the benefit of including RDNs on their health care teams to provide MNT and patient self-management support, yet typical fee-for-service has limited the ability to fully integrate RDNs into family medicine. The good news is through the Affordable Car Act, there is a renewed emphasis on prevention and wellness services making it easier for RDNs to provide comprehensive MNT and patient self-management support within a family medicine practice. For example, Medicare considers RDNs a “qualified medical professional” for performing the Annual Wellness Visit, the Subsequent Annual Wellness Visit,

education; and she is also a member of the integrated health team, which includes behavioral health professionals, care managers, and volunteer health coaches. Janette also has a defined role for population management within the practice, specifically managing the diabetes registry. She assists the health coaches in identifying high-risk patients for outreach, and data from the registry is also used by their integrated team and the clinic’s Diabetes Quality Improvement Team to identify gaps in care and opportunities for improvement.

Janette experiences first-hand how RDNs can enhance the work of family medicine practices, and states, “I think dietitians are well-suited to working in a PCMH. RDNs have excellent clinical training and patient-engagement skills that are an ideal fit for this model of care. PCMH emphasizes disease prevention, self-management support, and collaborative population management, and RDNs have been addressing these aims for many years. Our training underscores the importance of whole-person and patient-centered care and we are invested in helping patients attain positive health outcomes. Rather than accepting referrals as an outside consultant, being physically located in the primary care clinic is ideal for patient access, provides the RDN with full access to the patients’ medical records, and allows for immediate communication amongst the team members.”

To find a RDN in your area, check out the following resources:

- Colorado Academy of Nutrition and Dietetics LinkedIn Group page: [https://www.linkedin.com/groups?home=&gid=4784920&trk=an\\_et Ug\\_hm](https://www.linkedin.com/groups?home=&gid=4784920&trk=an_et Ug_hm)
- Academy of Nutrition and Dietetics “Find a Registered Dietitian”: [www.eatright.org](http://www.eatright.org)
- Contact Kristy Bates, RDN: [bateskri@gmail.com](mailto:bateskri@gmail.com)

*Nutrition counseling provided by a RDN has been shown to improve health outcomes for type 2 diabetes, weight management, disorders of lipid metabolism, and hypertension.*

the family medicine practice. For example, the Patient-Centered Medical Home (PCMH) has as one of the primary tenants to engage patients and families into their care. The new strategic effort from the family medicine community, “Health is Primary: Family Medicine for America’s Health” will focus the first year of its campaign on actionable information about how to improve health through exercise, nutrition, prevention, and chronic disease management. Payment initiatives, such as Meaningful Use, Pay 4 Performance, and value-based-purchasing are tying payments to practices based on improvements in quality metrics, including demonstration of coordinated patient care plans.

Registered Dietitians Nutritionists (RDNs) are one of the recognized experts

the Initial Personal Prevention Exam, Chronic Care Management, and Intensive Behavioral Therapy for Obesity. Providing these services, in addition to MNT for patients throughout the life cycle including pediatrics, can make it financially feasible for family medicine practices to hire RDNs as integrated members of their health care team.

The PCMH and Per-Member-Per-Month payments are also mechanisms for family medicine practices to provide nutrition and self-management support to their patients. For example, meet Janette Neel, MS, RDN, CDE, who works at the St. Anthony Family Medicine Residency Practice in Westminster, Colorado. Janette provides traditional nutrition services, such as nutrition counseling and diabetes

# Colorado HealthOp Offers the Fit Family Challenge as Member Benefit

The Colorado HealthOp recently announced that it now will cover the Fit Family Challenge program as a reimbursable benefit to its members. This marks an important step towards value-based payment to support practices offering comprehensive primary care. This announcement also represents an important step in the coverage of pediatric obesity treatment in Colorado.

The Academy applauds the Colorado HealthOp's willingness to invest in the long-term health of its members. Childhood obesity comes with an estimated price tag of \$19,000 per child when comparing lifetime medical costs to those of a normal weight child, according to an analysis led by researchers at the Duke Global Health Institute and Duke-NUS Graduate Medical School in Singapore.<sup>1</sup> Innovative programs like the Fit Family Challenge exemplify what's possible under the medical home model where preventative measures today decrease future health risks along with the associated price tag. Accordingly, payment must follow suit to support family medicine physicians to implement programs like the FFC in their practices.

Over the last five years the CAFP, has piloted the Fit Family Challenge across the state of Colorado. The project has shown statistically significant decrease in BMI and statistically significant increase in health behaviors related to 5-2-1-0 (more than five servings of fruit and vegetables, less than two hours of screen time, more than one hour of physical activity, and zero sugar-sweetened beverages each day). The project team has developed 15 shelf ready modules for children ages 6-12 and their families.

In order to receive payment for participation in the Fit Family Challenge, practices must participate in a Fit Family Challenge Dissemination training. After completing the training, practices can implement the intervention at their offices. For each Colorado Health Op patient active



in the Fit Family Challenge program, providers will receive \$75 per child after the first visit, after the sixth visit, and after the tenth visit.

The next FFC training will be held

June 1-2, 2015. Contact Sarah Roth at Sarah@coloradoafp.org for more information.

<sup>1</sup> Lifetime Direct Medical Costs of Childhood Obesity, Eric Andrew Finkelstein, Wan Chen Kang Graham, and Rahul Malhotra Pediatrics peds.2014-0063; published ahead of print April 7, 2014, doi:10.1542/peds.2014-0063

**The Colorado Academy of Family Physicians invites you to participate at our 7th Annual Medical Student Dinner!**

## BREW & CHEW

**WHEN**  
February 7th, 2015  
6pm - 8pm

**WHERE**  
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Brewery  
15120 E Hampden Ave.  
Aurora, CO, 80014



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# Engaging Patients in New Way

*SNOCAP Recap - Dec. 2014*

As I write this, we're just ending our Thanksgiving holiday weekend, which on Sunday featured an abrupt transition from glorious warm Fall weather to more wintery temperatures. Transitions are a frequent occurrence in life!

Within SNOCAP we've just experienced one of those transitions with the departure of our fantastic Coordinator, Tabria Winer. Tabria leaves us for new horizons in Portland, Oregon with her fiancée. We send her off with enormous appreciation for all of her contributions to SNOCAP over the past 14 months.

A project progressing towards completion this spring is INSTTEPP, which stands for Implementing Networks' Self-management Tools Through Engaging Patients and Practices. INSTTEPP involves four practices each in Colorado, Oregon, Wisconsin and Iowa. The focus of the project is to learn more about how tools for chronic disease self-management support can be implemented in primary care. A key feature of this project that is unique is the involvement of patients. We have been bringing patients to the table to include their expertise as those who have to actually DO the self-management. We are using an engagement method pioneered by the eastern Colorado High Plains Research Network called Boot Camp Translation. Boot Camp Translation involves patients in a series of ongoing conversations so that research findings are implemented in

meaningful ways in practice. These conversations have been very enlightening! Patients are telling us that they want to be held accountable. They understand providers can't carry the entire load. They are eager to give their input!

Why am I calling this to your attention? It's because I believe one of the big things for SNOCAP in the coming years is helping our practices with engagement of patients and stakeholders. Engagement is nothing new. Many of us have at various times sought to develop a partnership with our patients, however, now we have practical and effective methods to work with practices to truly do this. Many of the INSTTEPP practices have been inspired through their participation to take a new look at how to bring patients to the table. Boot Camp Translation provides a practical method for engaging patients to help us improve how we provide care to them and inform them about their healthcare. Please contact us if you would like to know more about Boot Camp Translation, or ways to engage patients in your community or setting.

In the coming months, we will be sharing more about how we are working to bring the worlds of patient and community engagement and practice-based research together.

Don Nease and Jodi Holtrop  
SNOCAP Director and Co-Director



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**RURAL OUTPATIENT CLINIC**

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- Annual bonus - Starting at 7% of annual salary
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Seth Lidren – 907-543-6094  
Seth\_Lidren@ykhc.org

**www.ykhc.org**

# 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:

- o Hospital All Cause Thirty (30) Day Readmissions
- o Emergency Room (ER) Visits
- o High Cost Imaging Services
- o 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](http://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@pmpmc.com

**Region 7:** Community Care of Central Colorado ❖ **Kelley Vivian** ❖ 719.632.5094 ❖ Kelley@ppchp.org

# Fit Family Receives AAFP Award, Study Shows Dramatic Changes

This October the AAFP Foundation awarded the Fit Family Challenge Pilot Project the 2014 Outstanding Program Award. The AAFP Foundation established the Outstanding Program Award in 2010 to nationally recognize outstanding philanthropic activities of AAFP Chapters and Chapter Foundations. The AAFP Foundation selected the Fit Family Challenge Pilot project based on the following criteria: content, presentation, creativity, measurable outcomes, and relationship of the project to the mission of the AAFP Foundation.

The award was presented at this year's AAFP Scientific Assembly in Washington D.C. Luke Casias, MD, Fit Family Challenge Medical Director, accepted the award on behalf of the Colorado Academy of Family Physicians. In his acceptance speech Dr. Casias highlighted the importance of the program, "the FFC, since its inception, has focused on providing primary care providers with the tools to identify and treat the obese pediatric patients in practices. It utilizes relationships Family Medicine Physicians have with families, and optimizes the knowledge, caring and

compassion of our staff. It is this relationship that allows the FFC to have such dramatic impacts on not only physical markers such as BMI, but also on the behavioral actions that impact healthy eating and lifestyle choices, which change lifestyles and thus change lives."

Fit Family Challenge, a pediatric obesity pilot program started in Colorado, released data outcomes showing statistically significant results in reducing body mass index, increasing physical activity and changing lifestyles of children. The program, currently in 15 primary care practices in Colorado, coaches and empowers physicians to address pediatric obesity and can be easily replicated in any primary care office.

"From Durango to Lamar, Pueblo to Fort Collins, the Fit Family Challenge pilot project has worked with primary care practices that serve rural and underserved Colorado," said Sarah Roth, MA, who works as the program director for the pilot. "The Fit Family Challenge is a body positive program focused on improving families' daily health habits versus kids losing weight."

**REGISTER NOW**



## Fit Family Challenge Dissemination Training

**Cost:** \$295

**When:** June 1<sup>st</sup> and 2<sup>nd</sup>, 2015

**Where:** Marriott Denver Airport at Gateway 16455 E. 40<sup>th</sup> Circle  
Aurora, CO 80011

**Register now at** <https://www.regonline.com/ffcdisseminatortraining>

Questions? Contact Sarah Roth e: [Sarah@coloradoaafp.org](mailto:Sarah@coloradoaafp.org) or p: (303) 696-6655X16

A physician and their team coach children on ideal lifestyles that revolve around the 5-2-1-0 recommendation of 5 fruits and vegetables a day, 2 hours or less of recreational screen time, 1 hour or more of physical activity and ZERO sugary drinks. Unlike most obesity programs, the coaching continues in group visits with the physician and her/his team. In these group visits, children and their parents within the program meet on a monthly basis to track results, share ideas and talk about sustaining lifestyle changes.

“Fit Family Challenge provides the tools needed to address and treat pediatric obesity in the clinical setting,” said Luke Casias, MD, FAAFP, a Family Medicine Physician in Durango, Colo. “No longer will there be apprehension of how we as Family Physicians can provide evidence based therapy for this illness.”

Fit Family Challenge’s concept was engineered with the idea that the program could be easily replicated in any practice.

“FFC was designed and tested as a treatment that could be used in the clinical setting of any practice regardless of size, socioeconomic panel, or urban/rural location,” said Dr. Casias. “One of its greatest strengths is its flexibility, all the tools are included and have been supported by evidence to show they are effective.”

Childhood obesity has become a major problem in the United States with 18% of children aged 6-11 and 21% of adolescents aged 12-19 currently suffering with obesity. Childhood obesity has both long-term and short-term health effects. Short-term effects range from prediabetes, high cholesterol, and high blood pressure to bullying, sleep apnea, social and psychological problems and low self-esteem. Children and adolescents who are obese, according to the Center for Disease Control, are more likely to be obese as adults.

“The results from the Fit Family Challenge show that a primary care-based pediatric obesity program can effectively decrease BMI percentile and BMI Z scores for children ages 6-12 years and with BMI % >85th percentile,” said Bonnie T. Jortberg, PhD, RD, CDE and Professor at the University of Colorado School of Medicine. “Our results also indicate that other pediatric obesity lifestyle risk factors can be significantly improved,



including fruit and vegetable intake, physical activity, sedentary time, and number of times of weekly dining out. This project is the first one to demonstrate the effectiveness of a primary care-based program.”

The Fit Family Challenge is currently in the 6th year of its pilot program and is funded by a grant from the Colorado Health Foundation. The University of Colorado School of Medicine, the Colorado Academy of Family Physicians, HealthTeamWorks and HeartSmartKids have partnered to build this program’s curriculum and to administer the program.

*Fit Family Challenge aims to integrate childhood obesity guidelines into clinical primary care and community settings across Colorado, with a focus on rural and underserved populations so physicians have the tools they need to diagnose and treat children struggling with obesity. The loose frameworks provided to primary care physicians to date are still heavily theoretical leaving primary care physicians without a truly relevant methodology for applying these ideas to clinical practice for young patients and their families. As a response to this gap, this project brings obesity-related clinical guidelines from “theory into practice,” first in the primary care practice setting; and second, in the home and community, by creating diagnostic tools for physicians to utilize in clinical practice. This user-friendly, relevant template can be readily implemented at the clinical level and will result in an integrated, replicable obesity prevention and intervention model for Colorado youth and families.*

*Integration of prevention and management in the primary care setting for pediatric obesity will be completed through quality improvement strategies, the Health TeamWorks Childhood Obesity Guideline, and the Fit Family Challenge intervention model. New recommendations from the U.S. Preventive Services Task Force, or USPSTE, regarding screening for childhood and adolescent obesity call for moderate- to high-intensity interventions for obese patients. Our project requires hard-work, consistency, and dedication to achieve the desirable results of more healthy and active children and their families.*

# VACCINES IN THE NEWS

## Implementing the New Pneumococcal Vaccine Recommendation for Older Adults

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

In August, 2014, the Advisory Committee on Immunization Practices (ACIP) recommended that one dose of the 13-valent conjugate pneumococcal vaccine be given to persons over 65 (regardless of previous pneumococcal vaccination, so long as it has been a year or more), followed six to twelve months later by the “old” 23-valent polysaccharide vaccine if the individual has not received that vaccine before.

There are more than 90 types of pneumococcal bacteria. The pneumococcal conjugate vaccine protects against 13 of the most common severe pneumococcal infections among children, while the pneumococcal polysaccharide vaccine protects against 23 types of pneumococcal bacteria, including those most likely to cause serious disease in adults, which is one reason both are recommended for older adults.

A second reason is the distinction between a polysaccharide vaccine and a conjugate vaccine, and how the latter induces superior immunity.

A more detailed immunologic rationale behind the new recommendation, based on the recent “CAPiTA” trial,<sup>1</sup> is thoroughly reviewed in CDC’s Morbidity and Mortality Weekly Report.<sup>2</sup>

However, the family physician may still need to explain to patients: (1) vaccine A protects against 13 kinds of pneumonia, but gives you better protection than vaccine B; (2) you still need vaccine B to protect against additional kinds of pneumonia; and (3) the vaccines have to be given at least six months apart, and trust me as to why that is.”

The explanation is complicated enough in and of itself, but it becomes more difficult if the patient says, “Before my previous pneumonia shot, you told me that (in contrast to the flu shot, which you said I get every year) that I wouldn’t have to have another one.”

There is no way around the reality that new clinical research findings are published all the time, and that some degree of confusion and misunderstanding is probably unavoidable. The trick is to keep the confusion from hardening into mistrust and hostility. Sometimes it takes extra time to explain, listen, and re-explain to a patient. With some patients, it may work to ask the question “Would it be responsible for me, as your physician, to treat you based on science from ten years ago?” You could also remind the patient that not so long ago, there was nothing medicine could do to prevent a stroke once the symptoms started, but that it is completely different now.

It is also important to remember that in terms of communication strategy with the patient, “one size does not fit all.” There are some elderly patients who have professional experience in technical fields (even if not in medicine) and would appreciate a little more complete explanation.

The bottom line is that family physicians need to have a good understanding of the various vaccine recommendations and the basic reasons for them, and also a good sense of how much each particular patient needs and wants to understand. This, after all, is family medicine.

However currently, Medicare only pays for one dose of pneumococcal vaccine for patients older than 65. According to the AAFP representative to ACIP, “January 1, 2016, is the earliest the Medicare representative at the ACIP meeting thought Medicare might be able to take the ACIP recommendation into account and approve coverage for two pneumococcal vaccines for those 65 or older. ... The upshot? There will be patients who turn down the second vaccine because it is expensive.”<sup>3</sup>

If a patient has not enrolled in Medicare and still carries insurance from a traditional insurance provider, a second pneumococcal vaccine should be more easily covered, because these insurers are required to follow ACIP guidance and they have to do so more quickly than Medicare.

### Three Excellent Practices to Increase Immunization Coverage

The following suggestions were made by our colleague, Wilson Pace, MD.<sup>4</sup> We have adapted them for this publication. None of these ideas are new, but each needs to be more widely and consistently implemented by family physicians;

1) Consider setting up standing orders for the various vaccines. Immunizations, when due, can be given much more efficiently when the nursing staff does not have to find the clinician for a separate signed order to give the vaccine. Systems can be set up to check for contraindications – which are uncommon compared to those for many medications. Be sure that your medical assistants know how to document in the medical record which vaccines were offered and whether they were given or refused. Consider having your staff notify you of all refusals.

2) Consider having your front office establish a reminder/recall system. Patients, when enrolling in a practice, can be asked if they would be willing to receive e-mail, text, or post-card reminders when a vaccine (or other item of preventive care) is due. These systems are routine in dental and optometry practices, and should be used throughout primary care as well.

3) Consider setting up electronic “flags” of immunizations due. Many electronic medical records (EMRs) have a system to remind the clinician of the immunizations that are due. This system can also be set up manually for offices with paper charts (and included as standing orders). These reminders can be quite helpful for us when we are busy caring for so many other pressing clinical problems for which our patients present.

## Childhood Pneumococcal Vaccine Cuts ‘Superbug’ Infection Rate

The childhood pneumococcal vaccine helps children avoid the suffering and danger of ear infections, meningitis, and pneumonia. A new study<sup>5</sup> suggests it may provide an added bonus: cutting down on infections from antibiotic-resistant “superbugs.”

First used in children in 2010, the pneumococcal vaccine has been linked to a 62 percent reduction between 2009 and 2013 of drug-resistant infections of bacterial pneumonia, meningitis, and bloodstream infections for children under five.

## Interesting Vaccine Developments

### Do-it-yourself flu vaccine may be a possibility in the future

A recent study sponsored by the US Military Vaccine Agency, with results presented at a recent meeting of the Infectious Diseases Society of America, has found that “military folks who squirted [MedImmune’s FluMist] vaccine up their noses were as well-protected as others who got it from health workers.”

The study suggests that parents could safely and effectively administer it to their children. The government says the mist is “the preferred method for healthy kids ages 2 to 8 if it is available; it is approved for ages 2 through 49.”<sup>6</sup> As of now, only health professionals are permitted to administer the vaccine nasal spray.

### Flu shot requirement for preschools and preschools reporting vaccination rates to parents both gaining steam

The Wall Street Journal reports that more preschools around the country are beginning to require flu vaccinations prior to enrollment, with New York City being the latest to mandate this requirement.<sup>7</sup> The CDC recommends that all healthy children older than six months get a flu shot, and last year 70% of all children aged six months to four years old were vaccinated.

Furthermore, in a recent editorial, the Los Angeles Times suggests, “It would help if schools were required to report their annual vaccination rates to parents, along with information about herd immunity. Parents have a right to know the dangers at their schools when immunization rates fall too low. Maybe peer pressure from alarmed parents will persuade vaccine doubters to join in what is a community, not just an individual, concern.”<sup>8</sup>

And, in fact, 74% of parents agree (52% strongly agree) that all children in daycare centers should be vaccinated, and that daycare providers should be checking vaccine records every year, according to the University of Michigan C.S. Mott Children’s Hospital recent National Poll on Children’s Health.<sup>9</sup>

“Results of this poll indicate that most parents want strong policies around making sure children in daycare are up-to-date on vaccines,” says Sarah J. Clark, MPH, associate director of the National Poll on Children’s Health and associate research scientist in the University of Michigan Department of Pediatrics.

“Checking vaccination records every year is beyond the scope of many state requirements, and may represent a significant change in practice at many daycares. The bottom line is this poll shows that parents of young children have real concerns about whether vaccination standards are upheld in the daycare setting. Parents should feel empowered to ask about daycare vaccination policies, such as how the daycare handles the situation of children who are not up-to-date, and whether they check children’s vaccination status every year.”

## Endnotes

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# The Flight of My Life

## *Reflecting on Six Years of Service*

Jeffrey Cain, MD, FAAFP, Board Chair of the American Academy of Family Physicians

In its more than 40 years, my little Hatz biplane has had quite a life. In the two decades we have shared the sky, we have introduced more than 400 kids to the thrill of flying and traveled all the way across the country. It has brought me immeasurable joy.

But like all things physical, wear and age were beginning to show. So six years ago, we started the long process of restoration from the ground up. We replaced fabric covering, installed new instruments and a wood propeller, and finished with an updated paint job.

Today, she looks like a beautiful new airplane that's ready for new adventures. When you fly as a pilot and when you restore a plane, you keep a record -- a logbook -- that lists every flight and every improvement you make.

Coincidentally, it was six years ago that I joined the AAFP's Board of Directors. In many ways, looking back over those six years is like opening my Academy logbook.

Just like for my plane, there was a lot of work to be done in family medicine. The specialty was in crisis. Payment was woefully inadequate. AAFP membership was down. Student interest was low. Forty-seven million Americans were uninsured. As a candidate running for the AAFP Board, I asked the Congress of Delegates, rhetorically, if we were actually witnessing the collapse of primary care.

*Today, the patient-centered medical home model has shown that improving primary care is the key to meeting the triple aim for health care: higher quality, lower costs and improved care for patients.*

Fast forward to today, and the outlook for family medicine has changed. Day to day, our work in the trenches continues to be challenging, but the forecast for the future from the 10,000-foot level of the Board chair is now encouraging.

Six years ago, we knew family medicine was valued by our patients -- we could see it every day in our offices. Barbara Starfield, M.D., M.P.H., had showcased the value of primary care in her research. Still, recognition of those truths -- and support for primary care -- from payers, employers and government was lacking.

Today, the patient-centered medical home model has shown that improving primary care is the key to meeting the triple aim for health care: higher quality, lower costs and improved care for patients. The Comprehensive Primary Care Initiative launched by CMS' Center for



Medicare and Medicaid Innovation is changing the way our government pays for primary care -- paying for value over volume -- and it is expanding. A growing number of employers, health plans and government agencies are beginning to demonstrate that they really value what we do. When it comes to payment reform, we haven't arrived at our destination, but we are on the way.

On Capitol Hill, we no longer have to explain to legislators and congressional staff what we family physicians do and why we matter. Federal agencies seek the Academy's input on important health care issues, and legislators are actively looking for ways to train more family physicians to address our country's primary care shortage.

But what about access to care? Today, there are 10 million newly insured Americans thanks to the Patient Protection and Affordable Care Act (ACA). Our uninsured rate now stands at 13 percent -- 5 percent lower than it was six years ago and the lowest it has been since 2000. Americans may be split on the ACA, but there is overwhelming support for some of the basic tenets of the law: getting more people covered by insurance and reforming unfair insurance rules, including no longer allowing denial of coverage based on pre-existing conditions, caps on coverage, or retroactive canceling of coverage after someone becomes sick.

However, there is still much work to be done. We need restraints on rising health care costs, malpractice reform and a path to creating the primary care

workforce our country deserves. And we still have millions of uninsured. We haven't arrived at our Academy's ultimate goal of health care for all, but we are on the way.

Interest in family medicine is up nationally. AAFP membership reached a record high this year at 115,900. And for the fifth consecutive year, the number of medical students choosing family medicine climbed higher than the previous year. Twenty-five percent of all U.S. medical students are now Academy members.

To meet the needs of our nation's health care system, those numbers must continue to grow; this year, the AAFP took steps to proactively ensure that they can. Last month, the Academy unveiled a proposal that would significantly change the way graduate medical education is financed. Our proposal would bring transparency and accountability to a system that invests \$15 billion a year on physician training but is unable to produce a workforce that

aligns with the needs of the nation.

I'm also proud of the work the Academy is doing in public health. Last year, we included the social determinants of health in our strategic plan. And this year, we began the process of reimagining Tar Wars -- a program I helped develop more than 25 years ago -- as part of a comprehensive tobacco and nicotine prevention and control program that will include new tools for family physicians, community programs and advocacy.

We've talked about where the Academy has been, but where are we going? During the AAFP Assembly in Washington next week, the AAFP -- along with seven other national family medicine organizations -- will launch a national campaign that is the culmination of the Family Medicine for America's Health initiative and the biggest thing to happen in family medicine since the Future of Family Medicine project in 2004. This campaign will speak not only to family physicians but also to patients, payers and

others, defining what we do as family physicians and why primary care is the vital foundation of our health care system.

Now when I climb in my biplane, I can tell she is still the same plane I have known and loved all these years, yet with new energy and new life -- the way she climbs, handles and how her paint flashes in the sun. She has come a long way.

Today, we are all part of a rebirth of family medicine. Our voice is being heard, our contributions are being valued, and we, too, have come a long way. Our country is counting on us to continue to be "bold champions" for America's health, transforming health care for optimal health for everyone.

As for me, my Academy logbook is now full. It's time to open up a new logbook and start my next adventure. Thank you for granting me the privilege of serving you. It has been the flight of a lifetime.

**Congratulations Dr. Colleen Conry, MD, FAAFP** for being selected as a nominee for the ABFM Board of Directors during the December 8-12, 2014 AAFP Board of Directors meeting! The ABFM Board of Directors will review the nominations and will determine the final selection at their April 2015 meeting.



## John Bender, MD, FAAFP, Named Chair of AAFP Finance and Insurance Commission

John Bender, MD, FAAFP, of Fort Collins, Colorado was named the Chair of AAFP Finance and Insurance at the AAFP's Congress of Delegates. Dr. Bender, CEO of Miramont Family Medicine, will be serving as the Chair of the Committee for the 2015 AAFP Congress of Delegates in Denver, Colorado. Dr. Bender will also be running for the AAFP Board of Directors at the 2015 Congress of Delegates.

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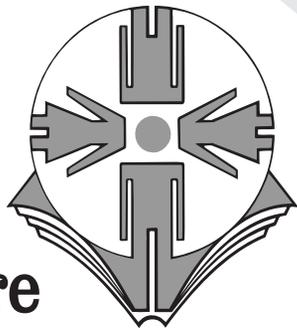
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