She’s got her mother’s smile, father’s temperament and a hero’s liver.

For 30 years, Porter Transplant has proven itself as one of the leading organ transplant centers in the region. Our board certified physicians have performed more than 2,000 transplants combined. Located at Porter Adventist Hospital in Denver, the Porter Transplant Center has some of the best outcomes in the nation, as recognized by the Scientific Registry of Transplant Recipients. We specialize in kidney, liver and pancreas transplants, along with the latest in surgical technology and expertise. When you visit our center, an experienced multi-disciplinary team will address every aspect of transplantation with you.

Please call 303-715-7008 or visit PorterHospital.org/transplant to learn more!
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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.
Happy New Year! I believe, as I am sure you do as well, that 2016 holds great promise. To be certain, we as family physicians continue to play a major role, if not the most important role, in practice transformation and payment reform. We are continually invited to the table both on a national and state level for expertise regarding primary care and the cost savings and quality it offers our patients. Many of us struggle with the pressures of private practice or the stressors of being an employed physician. Yet we recognize how important our job and careers are to us personally, but more importantly, to our patients. For this reason, it is imperative that we as family physicians push for payment reform to ensure the specialty of family medicine continues to thrive.

With this in mind, I would like to discuss what you can do as a private physician in Colorado. Please let your legislators know how you feel. Visit their offices locally if you are able. Send a letter or email. Believe it or not, it does make a difference when they hear from us. Hopefully, most of you received the email blast in late November from me as president of CAFP asking you to take action to protect primary care funding. We may periodically send similar email blasts this legislative session asking you to give input. Generally, these are very easy action items that do not take much time out of your very busy day. The old adage “strength in numbers” does apply when we as a group give direction to our lawmakers.

A particularly important and Doctor of the Day services are very appreciative.

This brings me to the most important action item this legislative session. The Governor and the state legislature are considering eliminating the “Medicaid bump.” As most of you know, for the last several years, Colorado has continued the reimbursement for Medicaid at Medicare rates. This dramatic reduction is equivalent to 26% cut in primary care rates. As many of you have told us, this rate reduction would have a devastating impact on your ability to continue to see current Medicaid patients or your ability to start seeing new Medicaid patients. Some of you even stated the increased rate helped keep your doors open or allowed care coordination, among other important aspects of practice transformation.

There are various budget constraints including TABOR, K-12 education funding and issues related to the hospital provider fee. This fee as you may know, falls under the state’s spending limit under TABOR. As a result, Colorado will be forced to cut $373 million next year. The estimated 26% primary care Medicaid reduction amounts to about $131 million. Please know that the CAFP is doing everything we can to advance our message about this extremely important issue. Jeff Thormodsgaard and Katie Wolf, the long time CAFP lobbyists, have been busy engaging with the Department of Health Care Policy and Finance, the Governor’s Budget Director and legislators on the Joint Budget Committee (JBC), making them well aware of the CAFP’s position on this issue. As I write this article in late 2015, the JBC has just begun to consider the proposed budget request. We will keep you informed as this budgetary process unfolds. Ryan Biehle, CAFP Director of Policy & Government Relations, is your direct link to this advocacy arm of CAFP.

Thank you for allowing me to serve you as president of CAFP. It is an honor and a privilege. All of us on the CAFP board take this role seriously. We all await the opportunities 2016 holds for primary care and family medicine, in particular during this election year.
Have Hope for Payment Reform (and the Future of Family Medicine)

I was very happy to see a message from The Colorado Health Foundation this fall announcing that they are providing $2.9 million in funding to 20 primary care practices in Colorado, with a goal to improve team-based care. The diverse practices awarded this funding will use it in a number of ways, from integrating behavioral health and dental care to improving patient engagement. This funding adds to the growing list of payment reform and practice enhancement initiatives underway in Colorado, including the State Innovation Model (SIM) Grant, the Comprehensive Primary Care Initiative (CPCI), and others. More than two million Coloradans (that’s 40% of our population) are connected to a medical home.

This is all good news but, of course, we know there are significant challenges. Change is hard, even when it’s good, and even when we want it. Becoming a patient-centered medical home or taking on another model requires a significant shift in thinking for both staff and patients. Change is also a lot of work. Family physicians already face the threat of burnout, and the thought of more tasks and more checkboxes is rarely a pleasant one. Finally, change is costly. There are incentives that help, but they aren’t always enough for every practice.

Given these challenges, why do I have hope for payment reform? For the future of family medicine? Despite the hurdles, I see more and more “aha moments” happening at foundations and universities, and amongst public and private payers. In short: more people are starting to get it. We need to change the way we deliver and pay for primary care. When more people get it, more programs (and money) are made available to practices. When more programs are available, more practices are able to find something that will work for them, be it big or small. When more practices are able to take part in these programs, more is learned about what works, what doesn’t, and what should be done in the future. When more people get it a ball starts rolling, and the effects can be endless.

If you need a little more inspiration, I encourage you to read our first Rural Corner story on page 32 that highlights Dr. Mary Reeves and First Family Health in Salida. They are participating in the Comprehensive Primary Care Initiative, and it has changed not only how the practice operates, but Dr. Reeves’ entire outlook on being a family physician. It’s the perfect example of what can happen when the right practice finds the right program for them.

I hope you too have found something that gives you hope in the future of family medicine. Be it an initiative in your practice, the incredible students choosing family medicine, or just the knowledge that every day, more people are getting it; there is much to be hopeful for.

Endnotes
1 http://www.coloradohealth.org/yellow.aspx?id=7875
2 http://www.coloradohealth.org/SpotlightMedicalHomes/
The second session of the 70th General Assembly will kickoff on Wednesday, January 13th, so we’re gearing up for another busy session in the world of health care. We hope you can join us for CAFP Day at the Capitol on Friday, February 5th to take part in the fun and connect with your state legislators. We’ll be working on a number of important issues this year:

**The Gov’s Budget and Medicaid Primary Care Rates**

It seems counterintuitive that at the same time the Colorado economy has largely bounced back, unemployment is at its lowest level since 2007, and state revenues are robust, we face deep spending cuts in Governor Hickenlooper’s recently proposed state budget. This situation arose – cuts even in relatively good times – due to the interaction between a set of state statutes and constitutional requirements like the TABOR state spending caps. Among the largest proposed cuts are $20 million to higher education and $200 million to the Hospital Provider Fee. Perhaps most significant to Colorado’s family physicians is a proposed $130 million cut to primary care Medicaid rates, reverting to 2012 levels which were 26% lower than Medicare.

In October, we sent out a survey to CAFP members to asses the impact potential cuts would have on you and your patients. Your response was overwhelming. 270 physicians responded with the evidence we needed to show Medicaid, state legislators and the Governor how vital this funding is to Family Physicians. Primary care Medicaid rates have matched Medicare for the last several years. We heard that these enhanced rates have enabled 40% of our members to take more Medicaid patients or begin taking Medicaid. Another 35% could increase their Medicaid appointments for the nearly 450,000 Coloradans who are newly enrolled in Medicaid. For others, the better rates helped keep the doors open, covered the cost of care coordination and more.

The Joint Budget Committee (JBC) began to consider the proposed budget request in November. During the Governor’s presentation to the JBC on November 12th, thanks to the hard work of CAFP’s lobbyists and the coalition of stakeholders we have been building, numerous committee members on both sides of the aisle questioned the primary care cuts at the hearing. We’ve galvanized a coalition of providers, hospitals, clinics and consumer groups that will all be significantly impacted. Many of you took action during a coordinated campaign to contact your legislators to let them know how important these rates are – legislators received hundreds of emails.

The state budget should not be balanced on the backs of the state’s primary care providers and at the expense of primary care, which we know leads to better care and lower costs.

**Tax Credits for Preceptors**

CAFP has also been collaborating with the Colorado Rural Health Centers who are this year leading a bill to establish a tax credit for physicians and some other providers who precept in rural, underserved areas. For years we’ve known about the physician shortages in rural Colorado, and that students who rotate in a rural area are more likely to go back to practice there. Currently there are not enough preceptors to meet the need for medical student rotations. Setting up a credit is one more way to support physicians who would like to be a preceptor or who would like to increase the
number of students they precept. Georgia recently implemented a similar program and has found early success and significant interest from physicians. The details of the bill are being negotiated and CAFP is among those leading a stakeholder process to gain support for the idea. You can look for regular updates as the legislative session ramps up.

**Network Adequacy**

The National Association of Insurance Commissioners (NAIC) recently updated its network adequacy model law for states to adopt. The law sets standards that insurance companies must meet to ensure they have sufficient networks of providers to treat patients who are on their policies. With insurers increasingly narrowing their networks, this development out of NAIC is sure to spur a conversation. The Colorado Division of Insurance is assessing how the updated version of the model law differs from current statute. Depending on the outcome of that analysis, we may see legislation to update Colorado’s laws. However, no bill has yet been drafted.

**ColoradoCare: A Single Payer Possibility?**

In November, ColoradoCareYES, the group behind Colorado’s single payer proposal, turned in enough signatures to make it on the 2016 ballot. Coloradans will be voting on the newly designated Amendment 69 in November. Leading the effort is State Senator and Internal Medicine physician, Irene Aguilar.

Amendment 69 would establish a single payer entity in Colorado, rolling up payments for workers’ compensation, Medicaid, Child Health Plan Plus, and Connect for Health Colorado, in addition to those insured in the commercial market. With a total price tag estimated at $25 billion, the proposal would establish a payroll tax of 6.67% for employers and 3.33% for employees, with employers having the option to pick up the full tab similar to health insurance benefits offered today. ColoradoCare would end deductibles, as well as copays for primary care. However, copays would remain for other types of care.

Such a monumental shift in the health care system will inevitably raise a number of questions for physicians and patients. CAFP will be evaluating the proposal in the coming months and reaching out to members for input. Your views will be vital throughout this important conversation.

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**Colorado Health Care:**

**WHERE ARE WE & WHERE DO WE NEED TO GO?**

On June 5, 2015 leaders from across the healthcare landscape gathered with the Colorado Primary Care Collaborative to help answer this question. Many exciting initiatives and ideas were shared.

To help capture the spirit of the day, artist Karina Mullen Branson (www.conversketch.com) sketched the conversations as they were happening. In the past few magazines we have been featuring her artwork and sharing some of the discussions that took place.

To finish out the day, Kate Kiefer from Governor John Hickenlooper’s office spoke on initiatives happening at the state level, and what the vision is for healthcare in Colorado going forward. Jesse Wolff from the Colorado Health Foundation spoke about the huge impact of the private sector on healthcare technology, as well as the goals of the foundation, specifically strengthening primary care delivery and empowering individual health engagement. Finally, Bill Lindsay from Lockton spoke about the future of the insurance marketplace and the health insurance industry.

If you are interested in learning more and getting involved with the Colorado Primary Care Collaborative, contact Raquel Rosen at 303-696-6655 or raquel@coloradoafp.org.
What You Need to Know About MACRA

By Ryan Biehle, Director of Policy & Government Relations

Years of effort and advocacy finally paid off in April 2015, when Congress repealed the flawed Sustainable Growth Rate (SGR) for updating Medicare rates. In its place comes the Medicare Access and CHIP Reauthorization Act (MACRA), which sets Medicare on a path to begin paying for value on a broad scale. It also presents tremendous opportunity for family physicians.

There is a lot packed into MACRA. Through 2019, there will be a 0.5% increase in Medicare payments to physicians. Beginning in 2019 there are two tracks forward:

**Merit-Based Incentive Payment System (MIPS)**

On a basic level, MIPS collapses several existing Medicare programs into a single aligned program. Meaningful Use, the Physician Quality Reporting System, and the Value Based Payment Modifier are consolidated. Practices who choose to take the MIPS track will be assessed in four categories (quality, resource use, meaningful use, and clinical performance improvement activities), and assigned a composite score based on the performance in those categories. Payments are then adjusted using the composite scores.

A signature element of MIPS is that composite scores are used to make payment adjustments on a relative basis. So, payments will be made based on comparisons among physicians who are also on the MIPS track. Adjustments starting in 2019 can range from -4% to +4%. Physicians in the bottom half of composite scores will receive a -4% adjustment to payments for 2019, while those in the top half will receive a +4% adjustment to payments (the highest performing physicians are eligible for three times the positive adjustment, or 12%). Importantly, adjustments will be based on a 2-year look back period, so 2019 payments will be based on 2017 data.

The adjustments change each year until 2022, when negative adjustments for lowest performers will be -9% and positive adjustments will +9% (or as much as +27% for top performers).

MIPS offers a big carrot for practices who can perform in the top quartile. With payments up to 27% higher than the rates set by the Medicare Physician Fee Schedule, this could mean substantial gains for practices. However, it also carries risk for lower performing practices that could be penalized by up to 9% off their Medicare rates.

**Alternative Payment Models (APM)**

The second track is an APM, which offers 5% lump sum incentive payments from 2019-2024 to all practices that are participating APMs. Starting in 2026, those practices will qualify for annual increases of 0.75%.

APM-qualifying practices include:
- Patient-centered medical homes such as those participating in the Comprehensive Primary Care Initiative
- An Accountable Care Organization (ACO) under the Medicare Shared Savings Program
- Practices participating in bundled payment initiatives

MACRA is just getting off the ground, but there will no doubt be many questions along the way. We will be working closely with the American Academy of Family Physicians to provide resources to CAFP members and ensure you have what you need to take full advantage of new opportunities under MACRA.

In a solo or small practice serving a rural or underserved area?

MACRA included $100 million for organizations that can provide technical assistance to practices with 15 or fewer physicians who are participating in MIPS or an APM. Technical assistance can be used to help practices transform and take full advantage of the new payment tracks. Practices in rural, health professional shortage or underserved areas will be given priority for assistance.
Denver hosted the AAFP Congress of Delegates in September 2015. During the Congress, Dr. John Bender of Ft. Collins was elected to the AAFP Board of Directors.

Following the Congress of Delegates, Denver hosted AAFP’s Family Medicine Experience (FMX), a national gathering of family physicians for education and networking. CAFP was represented by both attendees and presenters at the conference.

Health is Primary made its Denver tour stop in conjunction with FMX. Panels were made up of healthcare leaders from across the state. The event was moderated by author and Denver local T.R. Reid and over 120 people were in attendance.

CAFP hosted a reception during FMX for Colorado attendees and their families.

Dr. Steven Wright spoke with University of Colorado students about the legalization of marijuana and the implication for family physicians.

Dr. Steven Wright spoke with Rocky Vista University students about the legalization of marijuana and the implication for family physicians.

Rachel Rosen attended the Colorado Coalition for the Medically Underserved Luncheon.

CAFP staff exhibited at the University of Colorado’s Primary Care Week.

CAFP hosted a medical student and family medicine resident networking event, Nosh & Gather, in RiNo.

Dr. Steven Wright spoke with Rocky Vista University students about the legalization of marijuana and the implication for family physicians.
The 2015 AAFP Congress of Delegates was held in Denver, Colorado this year, and was highlighted by the successful campaign and election of our own Delegate, John L. Bender, MD, to the AAFP Board of Directors.

Activities actually began on Sunday, September 27 with the Meet the Candidates Session, where Dr. Bender was available for Delegates, Alternate Delegates and Chapter Presidents from all states to come and ask questions, in order to get to know him better in preparation for the election which (took place on Wednesday, September 30). We had our usual Western States Forum, where we met in the evening to discuss resolutions that were proposed by the Western State delegations. This was followed by the AAFP Town Hall Meeting where AAFP leaders gave brief summaries of their last year, followed by question and answer sessions. A lot of this time seemed to be devoted to such things as PCMH Certification Criteria, which can create a lot of busywork and wasted time, with similar comments about Meaningful Use Stage 3 Criteria. The AAFP Leadership indicated that they are working with the appropriate organizations to encourage simplification of the processes. With regard to the implementation of ICD-10 on October 1, 2015, while this date is still in effect, CMS announced a one-year grace period for the ICD-10 transition. Medicare claims will not be denied based on which ICD-10 code was selected, as long as the provider submits an ICD-10 code from an appropriate family of codes, allowing physicians and health plans more opportunity to build their coding skills.

The actual Congress began on Monday, September 28, with Monday and Tuesday including speeches by officers, visitors from other organizations, and meetings of the reference committees with debate on the various resolutions. Tuesday included speeches by candidates for the AAFP Board of Directors, and Dr. Bender really rose to the occasion with an excellent speech. Speeches were followed by a Question and Answer session by the candidates, and again Dr. Bender came up with excellent answers, putting himself in a good position for the election which (took place on Wednesday, September 30). There were also speeches and Question and Answer sessions for candidates for the AAFP Officer positions. Monday evening was the Hospitality Night, where each candidate got to answer questions for another two hours in their booth. Dr. Bender had a large supporting cast from his family, staff from his Miramont Clinic, the CAFP staff, CAFP Delegation, and CAFP Board, as well as his dog Tessie the Teacup Yorkie.

The election was held on Wednesday morning with results announced later that morning. Dr. Bender got to speak to the Congress again, thanking all who helped in his campaign.

The AAFP makes its policy through resolutions from the Congress of Delegates. If passed, these policies are sent to the AAFP Commissions, which meet twice a year separate from the Congress. The Commissions determine how to implement the policies, provide advice and recommendations to guide the AAFP Board of Directors in its work. There were 59 Resolutions debated and voted on at their Congress. Only highlights will be discussed here. For those who are interested in understanding more about each of the resolutions, this can be found on the AAFP website under Congress of Delegates.

Reference Committee on Health of the Public and Science:

Substitute Resolution 402 – Where Nutrition and Poverty Meet, was passed:
That the AAFP include reduction of the negative effects of income, education, and nutrition inequality in the AAFP goals, and that the AAFP collaborate with public health agencies to reduce the negative effects of income, education and nutrition inequality in order to improve health outcomes, eg. Obesity.

Substitute Resolution 408 – Driving Safety of Older Adults, was passed:
That the AAFP explore ways to assist members in addressing driving safety in older adults, including tools and education

Substitute Resolution 409 – Electronic Cigarettes, was passed:
That the AAFP communicate its concerns about the ill effects of tobacco products, e-cigarettes and their component products and accoutrements to companies with retail clinics and urge them to cease the sale of these products.

Reference Committee on Practice Enhancement:

Resolution 310 – Remedy the Exclusion of Generic Medication from Pharmacy Benefit Plans, was referred to the board (where it will be further discussed in the commissions and at the board level to come up with a recommendation and plan). There were a number of resolved clauses in this complex issue, but the intent is to protect patient’s access to low cost generic medications without price gouging, price fixing, and with minimal copays.

Substitute Resolution 313 – Assisting Family Physicians in Eliminating Hurdles to Appropriate Medications for Medicare Patients, was passed:
That the AAFP work with CMS to modify the Medicare Part D plans, so patients have adequate and affordable choices for their physicians to treat their chronic conditions and:
That the AAFP advocate for CMS to have Medicare Part D plans cover a broader choice of medications with less paperwork
and fewer hindrances that can delay the provision of timely, quality medical care.

**Reference Committee on Advocacy:**

Substitute Resolution 503 – Legalization of Marijuana for Personal Use, was passed:
That the AAFP support decriminalizing the possession of marijuana for personal use and
That the AAFP encourage NIH to conduct appropriate research on the health effects of marijuana use.

Substitute Resolution 505 and 506 – Generic Medications, was passed:
That the AAFP request Congress and/or appropriate federal agencies to investigate current policies that result in unreasonable pharmaceutical price increases and that create barriers to accessing low-cost, generic medications.

Substitute Resolution 510 – Affordable Health Care for All Americans, was passed:
That the AAFP support the inclusion of the territories and the Commonwealth of Puerto Rico in all aspects of the Patient Protection and Affordable Care Act, including appropriate funding mechanisms, as it would for any state.

**Reference Committee on Education:**

Substitute Resolution 604 – Medical Education Support for Practice in Rural and Underserved Areas was Amended as Adopted: RESOLVED, That the American Academy of Family Physicians identify and disseminate model elements of medical school curricula and admission practices that prepare medical students for rural practice, which have been shown to increase their student likelihood to practice in rural and underserved areas.

Resolution 608 – Providing Resources for Debt Relief on the AAFP Website, was passed:
That the AAFP provide a description of, and links to, national resources available for practicing physicians to decrease debt burden change and as new national programs emerge, that the AAFP website be updated to include this new information, and
That the AAFP provide information and assistance to chapters to advocate for effective state-level debt relief programs that are present in other states.

**Reference Committee on Organization and Finance:**

Resolution 207 – Supporting Rural Hospitals, was passed:
That the AAFP advocate for and support federal legislation which provides for multiple means of funding to help save our rural hospitals.

Substitute Resolution 206 – ISTOP Exclusions, was passed:
That the AAFP request that the Veterans Administration participate in any and all state prescription drug monitoring programs.

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**The Colorado Department of Public Health and Environment**

**Retail Marijuana Education Program introduces:**

**Marijuana Pediatric Exposure Prevention and Pregnancy and Breastfeeding Clinical Guidance**

**Evidence-based guidance for Colorado health care providers to talk with patients about marijuana exposure.**

Visit Colorado.gov/CDPHE/marijuana-clinical-guidelines for:
- Marijuana Pregnancy and Breastfeeding and Pediatric Exposure Prevention Clinical Guidance
- Marijuana Factsheets for Patients
- Marijuana Clinical Guidelines Educational Webcast
- Additional resources for health care professionals
This quarter we’d like to give a recap of our 2015 SNOCAP Convocation which was again combined with the CCTS1 Community Engagement Research Exchange Poster Session. The event was two half-day sessions and was full of exciting research updates, engaging speakers, and lots of quality brainstorming time for future projects.

**Friday, September 25, 2015**

Friday began with a round of five “rapid fire” research project updates; one from each of SNOCAP’s five Practice-Based Research Networks (PBRNs).

- Douglas Fernald, BIGHORN director, shared the Connection to Health project, with 36 primary care practices in Colorado and California studying how best to engage practices in patient self-management support. **Findings**: strategies need to be put into place to prepare an office for such work, to allow for technology issues that arise, and to engage the whole office redesign thinking.

- Don Nease spoke on INSTTEPP, a Self-Management Support, Boot Camp Translation project with 16 practices in 4 PBRN’s in Colorado, Oregon, Iowa, and Wisconsin. This project involved each PBRN creating and implementing their own Self-Management Support Tool. **Findings**: significant improvements resulted in practices’ self-management support and patients’ health status, both as reported by patients.

- Christopher Stille from the COCONet pediatric PBRN shared the first outcomes data for P3RC: Parent-Provider Partnerships for Referral Communication project in Colorado and Oklahoma. P3RC sought to determine if enhancing parent-primary care-specialist-parent communication can improve interactions, the communication process, value of specialty referrals, and referral outcomes. **Findings**: parent experience proved to be excellent. Emergency department visits and admissions were uncommon and there was fairly high agreement on referral activities.

- Melanie Whittington reported on behalf of the COPHPBRN Public Health PBRN, on Calculating the Cost of Communicable Disease Surveillance for Local Public Health Agencies, a project that used focus groups, key informant interviews, and micro-costing approaches. **Findings**: there is possible cost savings if smaller agencies were to coordinate together.

- Christin Sutter from High Plains Research Network, serving rural, Eastern Colorado. Christin presented on the iSurvive Cancer Survivorship project. Through site visits, webinars, online discussion boards, and patient manuals, primary care practices learn about cancer survivorship to better serve their populations. **Findings**: from baseline to post-intervention, knowledge surrounding cancer survivorship is increasing.

**Saturday, September 26, 2015**

Convocation closed out with an interactive discussion on:

*What does mental health look like from your perspective? What does it look like during your day? And what would you put on your “wish list” to address this problem?*

**What mental health looks like:**
- Mental health diminishes patients quality of life
- There is a gap between those not sick enough and those really severe
- There are long waits for help
- There is a lack of continuity of care

**“Wish list” items:**
- To have a whole societal approach, because it is a cultural issue
- Being able to get patients in for same-day appointments
- Want a bigger, more responsible mental health system
- Want providers to have more time with me to talk

Through these discussions, the issue of **mental health and health care interfacing with the judicial system** arose:
- Often, the mental health issue is revealed only after a person is incarcerated or in jail
- The judicial system is set up to fail with their health care
- Rules of confidentiality need to be visited
- Need to have intensive enough help before they are in the judicial system

We are working on developing one or more projects to dig into this topic within our SNOCAP practices. Stay tuned!

Finally, please **Save The Date** for next year’s Engaging Communities in Education and Research (ECER) Conference in Breckenridge! This will take place on Friday, October 14-Sunday, October 16, 2016!

Don, Jodi and Mary
Established in 2011, the American Board of Obesity Medicine offers a pathway for doctors interested in earning certification as an obesity medicine specialist. Currently, there are nearly 1,200 ABOM diplomates throughout the United States and Canada. Nearly 30 percent of diplomates are family physicians.

“We see tremendous interest from family physicians because of the prevalence of the obesity epidemic across the age spectrum,” says ABOM Executive Director Dana Brittan. “More than any other field of medicine, family physicians are in a tremendous position to help all patients affected by obesity and overweight.”

The ABOM certification exam is developed in cooperation with the National Board of Medical Examiners and is offered annually each December at Prometric computer-based testing centers. Physicians must meet the following requirements:

• Proof of an active medical license in the U.S. or Canada.
• Proof of completion of U.S. or Canadian medical residency.
• Active board certification in an American Board of Medical Specialties (“ABMS”) member board or osteopathic medicine equivalent.

• Completion of a minimum of sixty (60) credit hours of continuing medical education (CME) recognized by the American Medical Association Physician Recognition Award (AMA PRA) Category 1 Credits on the topic of obesity. At least thirty (30) credit hours must be obtained by participation and attendance at a conference. The other thirty (30) credit hours may be obtained by at-home CME activity. The sixty (60) credit hours can be completed within the thirty-six (36) months preceding the final application deadline (August 30, 2013 – August 30, 2016).

The Colorado Academy of Family Physicians 2016 Annual Summit will feature a daylong Fit Family Challenge Dissemination that will count toward the ABOM CME requirement.

Visit www.abom.org or email info@abom.org for more information about becoming board certified in obesity medicine.

ABOM Dates to Remember:

July 12, 2016 Early Registration Deadline
August 30, 2016 Final Application Deadline

Seeking Direct Primary Care Physicians for Pueblo, CO

Patient-centered primary care, through an Employer-Sponsored Direct Primary Care, is an innovative approach enabling physicians to transform their careers. This is an exciting opportunity for a primary care career where you can truly have it all: a smaller panel where you spend as much time as you want with your patients... without financial risk. Welcome to Paladina Health™, the leader in bringing this transformative model to healthcare!

Our Employer-Sponsored Direct Primary Care model offers many benefits to both physicians and their patients:

• Enhanced Relationships: Limited Patients, without patient time constrictions
• Aligned Incentives: Focus on improving health outcomes, driving patient engagement, and creating an atmosphere where patients are highly satisfied
• Focus on Preventive Care: Our physicians provide health care, not sick care
• Flexible Practice Approach with Improved Quality of Life for You and Your Family
• Competitive Salary: We offer a competitive base salary with significant upside potential resulting from a quality and satisfaction-based bonus program... no production incentives.

To Apply Contact:
Jenna Blusiewicz
480-290-6997
Jenna.Blusiewicz@PaladinaHealth.com
Influenza Part 2 – Diagnosis and Treatment

Influenza Testing

In general, influenza tests should be ordered only if positive or negative results will influence clinical management or influence the clinical practice for other patients.

Testing platforms available for influenza diagnosis include influenza-specific polymerase chain reaction (PCR), respiratory pathogen PCR (which detect multiple respiratory viruses and bacteria) direct fluorescent antibody (DFA) tests, and rapid influenza detection tests that rely on enzyme immunoassay technology. PCRs are significantly more sensitive than rapid influenza antigen detection tests (>95% vs. 10-70%, respectively). Recently, the Alere I Influenza A & B Test (Alere Inc), a new point of care influenza test was approved by the US Food and Drug Administration (FDA). It is available for use in office practice, with results available in less than 15 minutes. Using a similar platform to PCR-tests, this nucleic acid-based test detects viral RNA, and has a sensitivity over 90%, even when used by healthcare personnel without specific laboratory training. This may prove to be a valuable new tool in diagnosing influenza for the primary care provider.

Treatment

Clinical trials and observational data show that early antiviral treatment can shorten the duration of fever and illness symptoms, and may reduce the risk of complications from influenza (e.g., otitis media in young children, pneumonia, respiratory failure) and death, and shorten the duration of hospitalization. Clinical benefit is greatest when antiviral treatment is administered early, especially within 48 hours of influenza illness onset. Treatment should not wait for laboratory confirmation of influenza but, when clinically indicated, should be started as soon as possible.

a. Antiviral treatment is recommended regardless of the day of illness for any patient with confirmed or suspected influenza who:

1) is hospitalized;

2) has severe, complicated, or progressive illness; or

3) is an outpatient who is at higher risk for influenza complications on the basis of their age or underlying medical conditions. Clinical judgment, based on the patient’s disease severity and progression, age, underlying medical conditions, likelihood of influenza, and time since onset of symptoms, is important when making antiviral treatment decisions for high-risk outpatients.

b. Antiviral treatment should be considered for any outpatient with confirmed or suspected influenza who is otherwise healthy for whom a decrease in duration of clinical symptoms is felt to be warranted by his or her treating provider, if treatment can be initiated within 48 hours of illness onset.

Neuraminidase Inhibitors

Oseltamivir (Tamiflu®) and zanamivir (Relenza®) are the antiviral medications still recommended for treatment and chemoprophylaxis of influenza A and influenza B virus infections, as virtually all US influenza viruses characterized from last winter demonstrated in vitro susceptibility. They are classified as neuraminidase inhibitors (NAIs) because they inhibit the viral neuraminidase enzyme that helps progeny escape from infected cells. NAIs may also have efficacy against the novel influenza viruses.

Oseltamivir (Tamiflu®) is given orally for five days with dose adjustments required for renal impairment and weight. Longer treatment courses (i.e. 10-14 days) can be considered for patients who remain severely ill after five days of treatment. The most common side effects of oseltamivir are nausea or vomiting. Transient neuropsychiatric events (self-injury or delirium) have been reported, mainly among Japanese adolescents and adults. Dosing regimens for oseltamivir treatment and prophylaxis are listed in Table 4.

a Although not part of the FDA-approved indications, use of oral oseltamivir for treatment of influenza in infants less than 14 days old, and for chemoprophylaxis in infants 3 months to 1 year of age, is recommended by the CDC and the American Academy of Pediatrics.

b The American Academy of Pediatrics has recommended an oseltamivir treatment dose of 3.5 mg/kg orally twice daily for infants aged 9-11 months for the 2013-14 season, on the basis of data which indicated that a higher dose of 3.5 mg/kg was needed to achieve the protocol-
defined targeted exposure for this cohort as defined in a recent study. It is unknown whether this higher dose will improve efficacy or prevent the development of antiviral resistance. However, there is no evidence that the 3.5 mg/kg dose is harmful or causes more adverse events to infants in this age group.

Zanamivir (Relenza®) is a dry powder administered via oral inhalation. It is not FDA-cleared for treatment in children under 7 years of age. The dose is two breath-activated inhalations twice daily for 5 days. The prophylaxis dose is two inhalations once daily for 5 yrs of age and older. It is not recommended for patients with underlying airway disease including asthma or COPD due to lack of safety and efficacy data in these individuals. Serious adverse events include bronchospasm and decline in lung function, most commonly in patients with underlying airway disease. (If zanamivir is used in patients with underlying airway disease, they should be instructed to have a fast-acting bronchodilator available). Allergic reactions including rashes and oropharyngeal or facial edema are reported. Side effects include diarrhea, nausea, sinusitis, runny or stuffy nose, bronchitis, cough, headache, dizziness, and ear, nose and throat complaints.

Amantadine/Rimantadine: These are not currently recommended for antiviral treatment of chemoprophylaxis, since most circulating influenza A strains have developed resistance to these drugs.

Chemoprophylaxis

Neuraminidase inhibitors are 70-90% effective in preventing influenza. Yet the CDC does not recommend widespread or routine use of chemoprophylaxis due to the possibility that resistant viruses could emerge, thus limiting the usefulness of these medications for high-risk or severely ill persons.

Oseltamivir can be used for chemoprophylaxis of influenza among infants aged <1 year when indicated although children less than 3 months of age should not receive prophylaxis unless the situation is judged critical, due to limited data in this age group.

Chemoprophylaxis is not usually recommended if more than 48 hours have elapsed since the last exposure to an infected person. For effective prophylaxis, an antiviral medication must be taken each day for the duration of potential exposure to a person with influenza, and continued for 7 days after the last known exposure.

Post exposure prophylaxis should be considered for family members and close contacts of infected patients if they are at high risk of complications from influenza.

Kids Corner is a regular feature of the Colorado Family Physician 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. Laura Pickler, the Chief of Family Medicine at Children’s Colorado, through One Call at (720) 777-3999 or (800) 525-4871.

Table 4. Recommended dosing for oseltamivir treatment or prophylaxis

<table>
<thead>
<tr>
<th>AGE</th>
<th>TREATMENT DOSE</th>
<th>PROPHYLAXIS DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 weeks - 3 months*</td>
<td>3 mg/kg/dose twice a day</td>
<td>Not recommended unless situation judged critical</td>
</tr>
<tr>
<td>Children 3-11 months*</td>
<td>3 mg/kg/dose twice a day</td>
<td>3 mg/kg/dose once daily</td>
</tr>
<tr>
<td>Children 1-12 years old and weighing:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 15 kg</td>
<td>30 mg/dose twice a day</td>
<td>30 mg once daily</td>
</tr>
<tr>
<td>&gt; 15-23 kg</td>
<td>45 mg/dose twice a day</td>
<td>45 mg once daily</td>
</tr>
<tr>
<td>&gt;23-40 kg</td>
<td>60 mg/dose twice a day</td>
<td>60 mg once daily</td>
</tr>
<tr>
<td>&gt;40 kg</td>
<td>75 mg/dose twice a day</td>
<td>75 mg once daily</td>
</tr>
<tr>
<td>Children &gt; 13 years of age and adults</td>
<td>75 mg/dose twice a day</td>
<td>75 mg once daily</td>
</tr>
</tbody>
</table>
Considerations for Providers when Authorizing Patient Access to Disabled Parking

By Gina Robinson, Colorado Department of Health Care Policy and Financing

Did you know that nearly two-thirds of people with disabilities believe there isn’t enough access to parking in Colorado? A 2015 survey of Colorado residents found a disconnect between able-bodied drivers and those with disabilities: while most able-bodied drivers felt enough disabled parking spaces existed, 62% of those surveyed who qualified for disabled parking said there wasn’t enough.

Focus groups helped further explain the disconnect. Most drivers who aren’t actively seeking disabled parking spaces identify them by the wheelchair logo painted on the ground and on the sign in front. When the space is occupied, the vehicle covers the paint and sign. So, unless you’re actively attempting to park in a disabled parking space, you only see them when they’re empty.

Medical professionals are the first line of protection for those who qualify for disabled parking spaces. While many medical professionals are judicious when authorizing access to disabled parking spaces, there’s a minority who unfortunately create a negative image for the community. A 2010 Colorado Statesman article states “[a]n estimated 186,000 Coloradans have physical disabilities that make them medically eligible to receive placards .... Yet, at least 1.2 million placards are in circulation suggesting abuse.”

Another report discusses how the reporter obtained a placard for his dog because one doctor had signed, blank placard applications available in the waiting room.

As a provider, we have an important consideration to make when authorizing access to disabled parking for our patients. Of course we should authorize those who qualify for disabled parking access. However, Federal law only requires a limited number of disabled parking spaces be designed, built, and maintained - 2% is the current requirement. Despite Federal law, not all spaces are actually properly maintained. With each authorization, we certify one more person the legal right to park in those limited spaces. With each authorization, that means more space will be occupied and therefore one less space available for others who might need it. While the applicant may be our patient (and maybe even our friend), we must consider how we are potentially offsetting our other patients with each additional authorization.

One way we can help is to be sure we’re authorizing access only to those who qualify based on federal and state requirements. Another way is to give the best placard for the patient’s condition. If the mobility impairment will probably only last a few months, consider issuing a 90 day placard instead of a 3 year placard. And, if the impairment continues beyond 90 days, the patient can receive another 90 day placard. Many DMV offices offer expedited service to those with disabilities.

Thank you for all you do. As State Representative Jerry Frangas says in that Statesman article: “[b]locking someone’s access to a building or facility is serious. It is denying someone equal rights.” With your help, we can maximize equal access by appropriately allowing the correct people access to disabled parking spaces for the right amount of time.

---

Find Resources and Funding to Advance Your Practice

The Colorado Health Extension System has released a catalog designed to help primary care practices find programs designed to help with advancement. This comprehensive guide will help practices identify which programs fit their specific needs, and how their practice can prepare for long-term advancement.

Access the catalogue at www.coloradoafp.org/ptocatalogue.
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.

Many hands, one heart.
Non-Surgical Care for Infantile Scoliosis

Infantile scoliosis is a relatively common diagnosis, but the true incidence is unknown. 80-90% of cases resolve spontaneously with normal growth and most mild cases are likely undiagnosed. Infantile scoliosis can be identified with an observant physical examination. Children should be fully disrobed prior to examination of the back. Identifying scoliosis is easier if the child is held in a seated position if they are unable to sit independently. Signs of infantile scoliosis include asymmetric appearance of the shoulder blades, shoulder height difference, and unilateral prominence of the rib cage (Figure 1). The examiner should palpate the spinous processes in the midline and trace them from superior to inferior to evaluate spinal alignment. Skin should be examined for dimples and hairy patches.

Radiographs are recommended for children with suspected scoliosis. If the infant is able to sit independently the radiographs should be done in the upright position, otherwise they should be supine. Radiographs should always be two views, frontal and lateral. If your radiology site is not accustomed to doing spinal radiographs on infants it is recommended to defer these until an evaluation is done by a pediatric orthopedist. If there is a hairy patch or a sacral dimple that does not have a visible floor, evaluation of the spinal axis by ultrasound or MRI is recommended to evaluate for neural tube defect. Ultrasound can be done without sedation, but generally only before the age of 3-6 months. After this time, the posterior spine elements have mineralized which distorts the ultrasound image. MRI generally requires sedation in this population, but in some cases can be “feed and sleep” sedation where a child is given a bottle or breastfed, settles in for a nap, and the MRI can be done while they are sleeping. If you are ordering the test, check with your MRI provider regarding sedation options.

Treatment options for infantile scoliosis are most often non-surgical. In most cases, the scoliosis will resolve with normal muscular development of the paraspinal musculature. Serial observation and radiographs will be done by the orthopedic team until resolution of the scoliosis occurs. Tummy time is encouraged for infants to stimulate development of these powerful trunk stabilizing muscles. Radiographs can help identify patients at risk for progression of their scoliosis based on the magnitude of the scoliosis and the amount of chest rotation associated with the scoliosis. Resolving infantile scoliosis generally has little chest rotation while progressive infantile scoliosis has a greater amount of chest rotation. This is clinically seen as more asymmetry of the rib cage and on radiographs as asymmetric angulation of the ribs as they take off from the spine (Figure 2).

For cases that fail observation or have high risk of progression based on exam and radiographs, the mainstay of treatment is serial spine casting. Casting has been used for infantile scoliosis for many decades, but was largely abandoned in the late 1900s due to enthusiasm for early surgical correction with spinal fusion. Unfortunately, children having early spinal fusion often develop significant respiratory compromise as adults due to restrictive lung disease from an abnormally short trunk caused by early spinal fusion. Casting has seen resurgence in popularity because it is a safe and effective technique for controlling scoliosis in infants while allowing growth. In up to 30-40% of cases it may even fully straighten scoliosis so that no further treatment is needed. In the remainder it is usually effective at controlling curvature and allowing for growth so that any surgeries can be delayed. The older a child is the better safety profile for the surgery. MRI is also indicated for children with progressive infantile scoliosis due to 10-15% incidence of associated spinal axis abnormalities (e.g. chiari malformation, syrinx, spinal cord tumor, tethered spinal cord).

Spine casting is done under general anesthesia in the operating room or procedure center. It requires a skilled team with experience in proper casting technique. Improper casting can be ineffective at controlling scoliosis, and in worst cases cause further chest wall restriction and skin pressure sores. Casting does not try to “squeeze” the chest, but rather de-rotate the chest cage. This preserves chest volume while molding the rotational asymmetry. An analogy is
tying a crooked plant to a stake to “guide” growth in the desired alignment. After proper molding of the cast, windows are cut to allow room for chest and belly expansion for breathing and feeding (Figure 3). Often a posterior window is cut to allow better de-rotation of the rib cage. Some surgeons place shoulder straps on the cast; others will leave the cast underneath the axilla. Casting is not painful, and children are free to continue normal play and activities after cast application. In most cases, the only activity prohibited in cast is water activities. Some surgeons are trying waterproof casting, but these are not widely available currently. The effectiveness of waterproof casts is not well studied.

Casts are typically changed every 2-4 months based on the child’s age (older children require less frequent cast changes since they are growing more slowly). The number of casts required for each child is variable based on their response to casting. In cases where casting is not fully straightening the scoliosis children may have a “summer holiday” from casting with resumption in the fall. These children are still having successful treatment in delaying need for surgical interventions. In the past, casting was mainly done only for children with idiopathic scoliosis (no known cause for scoliosis). More pediatric orthopedists are now using casting for non-idiopathic cases for children with congenital spinal malformations to delay the need for surgery. Casting has been shown to be more effective for infantile scoliosis than bracing.

Casting should be done only at centers with expertise in the treatment of infantile scoliosis to maximize effectiveness of casting and minimize risks of treatment.

For more information, please visit www.childrenscolorado.org/ortho.
Patients Recording Interactions With Their Physicians

If you don’t have something nice to say...

By COPIC’s Patient Safety and Risk Management and Legal Departments

In 2013, a Virginia man prepared for his colonoscopy by pressing record on his phone to capture the post-op instructions from his doctor. After the procedure, he started to listen to the recording and found that he recorded the entire examination. He also discovered that the surgical team had mocked and insulted him as soon as he drifted off.

A Washington Post article noted the conversation that occurred. In the recording, the anesthesiologist told the sedated patient “After five minutes of talking to you in pre-op, I wanted to punch you in the face and man you up a little bit.” When a medical assistant noted the man had a rash, the anesthesiologist warned her not to touch it, saying she might get “some syphilis on your arm or something,” then added, “It’s probably tuberculosis in the penis, so you’ll be all right.”

At the trial, the jury awarded the patient with a payment of $500,000—$100,000 for defamation ($50,000 each for the comments about the man having syphilis and tuberculosis), and $200,000 for medical malpractice, as well as the $200,000 in punitive damages.

“There’s really no excuse,” said J. P. Abenstein, MD, president of the American Society of Anesthesiologists (ASA), in a Medscape Medical News article. “If you don’t have anything good to say, just keep your mouth shut.” Dr. Abenstein said that even if the physicians were frustrated or annoyed, they were duty bound to treat the patient with dignity.

DISCUSSION

Medicine has a long tradition of gallows humor. Perhaps this humor allows us to deal with long hours, human loss, and suffering. However, there is a growing call for physicians to be more resilient and professional in their dealings with patients. We don’t have to like every patient, but we need to do what is best for them, and that never involves insults and belittling patients.

Then there is the issue of recording conversations. The question of “can I record this conversation?” was never asked in this situation. Colorado, similar to Virginia, is a state that allows “one party” consent, meaning that only one person involved in a conversation needs to consent to recording it. Smartphones have made it all too easy for patients to secretly record conversations with their health care providers.

The recording may, in the physician’s mind, change the nature of the physician-patient relationship. It makes the patient a potential adversary. If physicians are aware of a recording, they may act as if they are in front of a jury and cannot speak frankly. In other words, physicians do not like being recorded because they assume that the person recording them has negative motivations and it erodes the trust that is so important with patients.

But let’s pause for a moment and look at this in a different way. What if they don’t have negative motivations? What if I am consoling a woman about her new diagnosis of cancer, and she is struggling to understand her treatment options? Or, she wants to go over the discussion afterwards with her out-of-state daughter. Recording might be a fine way to increase understanding and adherence.

To that end, Cullman Regional Medical Center in Alabama instituted a plan that created audio recordings of the instructions that patients received at the time of discharge from the hospital. The audio was a verbatim recording of what the patient was told as part of their discharge, which was administered by a nurse or case manager. The recordings were uploaded to a “cloud,” where they could be accessed by calling in, or via a website. The hope was that the recording could help clarify any confusion that patients or their families may have about the numerous questions that often arise after leaving a medical facility. They called the program, appropriately enough, “Good To Go.” It turned out to be a great success, improving patient satisfaction scores, and surprisingly, it reduced 30-day readmissions by 15 percent.

https://www.washingtonpost.com/local/anesthesiologist-trashessed-patient-jury-orders-hebtopay-500000/2015/06/23/cae05c00-18f3-11e5-ab92-e75ae6ab94b5_story.html
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Ready

Family Emergency Plan

EMERGENCY CONTACT NAME: TELEPHONE: OUT-OF-TOWN CONTACT NAME: TELEPHONE: NEIGHBORHOOD MEETING PLACE: TELEPHONE: OTHER IMPORTANT INFORMATION: DIAL 911 FOR EMERGENCIES

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THE GAME CHANGERS IN MEDICINE ARE AT UCHEALTH.
In the Summer 2015 issue of *Colorado Family Physician*, we discussed a 49-year-old-man with GERD, depression, hypertension, and obesity who complained of snoring and excessive daytime sleepiness. Suspicion for obstructive sleep apnea (OSA) was high, and the authors reviewed indicators of and screening for the disorder. This article discusses OSA treatment options.

**Case continued:** The patient undergoes a home sleep study which shows an apnea-hypopnea index (AHI) of 26 respiratory events per hour. Before revisiting his sleep specialist, he discusses treatment options with his family physician.

An AHI of 26 events/hr indicates moderate OSA. The decision to treat his sleep disorder depends on many factors, including OSA severity, medical comorbidities, and associated symptoms (e.g., daytime sleepiness). Treatment of severe OSA, with or without symptoms, has been associated with cardiovascular event reduction. Anyone with OSA and daytime sleepiness (“OSA syndrome”) should be offered treatment. Our patient’s history of depression and hypertension are also indications for definitive treatment, regardless of OSA severity. Weight loss counseling is an essential first step; weight management decreases OSA severity and associated symptoms.

Positive airway pressure (PAP) is first-line therapy for all patients with moderate to severe OSA, those with mild OSA syndrome, and any patients with significant comorbidities (e.g., depression, diabetes, hypertension). PAP works as a pneumatic splint, relieving upper airway obstruction during sleep. A small, quiet device sends pressurized room air through flexible tubing into a facial interface. Available interfaces include “full face” masks delivering air through the nose and mouth, nasal masks and “pillows” providing air intranasally, and rarer “oral masks” delivering air only through the mouth.

Mandibular advancement devices (MADs) offer another effective treatment option for patients with mild to moderate OSA who decline or are intolerant to PAP. Generally supplied by dentists, these oral appliances increase upper airway caliber by bringing forward the jaw, tongue, and other soft tissues. While viable treatment alternatives, MADs are not as effective as PAP in normalizing AHI and are not indicated for severe OSA. Dental and medical insurance infrequently cover them.

Various surgical options are available, including uvulopalatopharyngoplasty (UPPP) and maxillomandibular advancement (MMA). These procedures can reduce the AHI, but less effectively than PAP. They carry significant risk of side effects and are reserved for patients intolerant to PAP or MADs, and those with significant cranio-facial abnormalities (e.g., mandibular hypoplasia). Tracheostomy remains a viable option for PAP-intolerant patients with severe OSA; the procedure is nearly 100% effective in eliminating obstructive apneic events, but associated social stigma and lifestyle modifications limit patient acceptance. Tonsillectomy/adenoidectomy is considered first-line therapy for pediatric OSA but is less effective in adults.

An array of other OSA treatments have emerged. Positional therapy, accomplished by sewing tennis balls into the back of a night shirt, sleeping laterally against a full body pillow, or wearing an anti-supine belt, is available for supine-predominant OSA. It can be effective but not to the extent of PAP. Patients with mild to moderate OSA can also trial nasal inspiratory positive airway pressure (EPAP) generated by a one-way valve adhered to the base of the nostrils. Although early data shows modest benefit, direct comparisons to PAP in treatment-naive patients are lacking. Emerging methods of hypoglossal nerve stimulation may also improve daytime patency through genioglossus muscle contraction.

**Case conclusion:** The patient and his physician agree that he should begin PAP therapy. His sleep specialist prescribes autotitrating PAP (APAP) at a range of 5–20 cm H2O. Over the next several months his excessive daytime sleepiness improves, he no longer snores, and he has more energy to use his fitness center.

Although specially-trained primary care clinicians can manage uncomplicated OSA successfully, sleep specialist consultation is typically advised. That specialist’s decision to start APAP versus fixed-setting, continuous PAP (CPAP) is increasingly common. APAP units adjust PAP based on airflow limitation, apneas, and snoring. They are as effective as CPAP and, given reduced need for in-laboratory CPAP titration, can lead to significant cost savings. APAP- or CPAP-intolerant patients and individuals requiring more advanced nocturnal ventilation may use bilevel PAP (BPAP).

Whichever PAP mode is utilized—APAP, BPAP, or CPAP—adherence is essential. A dose-response relationship exists between increasing PAP use and improved sleepiness, blood pressure, and quality of life.

Although the Centers for Medicare and Medicaid Services (CMS) and many private insurers require ≥4 hours of use on ≥70% of nights to document adherence, PAP use should be encouraged with all sleep. Family physicians can dovetail their efforts with those of sleep specialists to improve PAP adherence by promoting positive initial experiences with PAP, providing anticipatory support for future troubleshooting, and involving bed partners and other family members in OSA treatment.

**References**


This article was developed through the National Healthy Sleep Awareness Project, a joint effort of the Centers for Disease Control and Prevention (CDC), American Academy of Sleep Medicine (AASM) and the Sleep Research Society (SRS). Visit www.sleeppeducation.org for more information.

This article was supported by the cooperative agreement number U50DP004930-01 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.
Opening the Door to Vaccination Conversations

By Meredith Kersten, Communications Director, Colorado Children's Immunization Coalition

The Colorado Chapter of the American Academy of Pediatrics and the Colorado Children’s Immunization Coalition introduced a new tool for communicating providers’ firm stance on the childhood vaccination schedule and their commitment to protecting patients and their families from vaccine-preventable disease.

According to findings published online Nov. 2 in the journal Pediatrics and based on research by faculty from the University of Colorado School of Medicine on the Anschutz Medical Campus, one in every five U.S. pediatricians dismisses families who refuse vaccination for their children. The survey of 800 physicians, led by Sean O’Leary, MD, MPH, a pediatric infectious disease specialist at Children’s Hospital Colorado, aimed to assess characteristics of physicians who were more likely to dismiss a family for vaccine refusal and the factors leading to dismissal.

“Pediatricians who dismiss families for vaccine refusal are more likely to practice in a private setting, to be from the South, and to be in states without philosophical exemption laws and/or without more difficult exemption policies,” O’Leary wrote in the article for Pediatrics.

The study authors also stated that the American Academy of Pediatrics and the U.S. Centers for Disease Control and Prevention (CDC) both discourage the practice, instead urging physicians to build a relationship of trust with parents. While the issue of refusing families for their vaccine beliefs is hotly debated among physicians, many agree that doing so closes an opportunity to have meaningful conversations about the importance and safety of vaccination. Still, physicians find it difficult to balance the need to provide education and care with the desire to create a safe community and clinical environment for all families in their practice.

In October, the AAFP took a stand alongside groups such as the American Medical Association and a growing number of state governments that have said immunization exemptions are detrimental to society unless given for medical reasons. The new policy reasserts the AAFP’s longstanding support for immunization of infants, children, adolescents and adults as defined by recommendations from the CDC’s Advisory Committee on Immunization Practices and approved by the AAFP.

Understanding the need to facilitate dialogue while demonstrating unwavering confidence in the efficacy and safety of the CDC-recommended vaccine schedule, the Colorado Chapter of the American Academy of Pediatrics and the Colorado Children’s Immunization Coalition (CCIC) have teamed up to create an office poster that addresses the importance of immunization for both the children receiving vaccines and their communities, as well as for office staff. The poster, available in both English and Spanish, communicates health care providers’ strong recommendations regarding childhood vaccination and their commitment to protecting patients and their families from vaccine-preventable disease.

The printed posters may also be customized to include an office staff photo.

Together, we can reaffirm that we all want what’s best for kids, families, and the community at large.

To order the free posters for your practice, visit childrensimmunization.org.

About the Colorado Children’s Immunization Coalition:
The Colorado Children’s Immunization Coalition (CCIC) is a statewide, independent 501(c)(3) nonprofit. Its mission is to strategically mobilize diverse partners and families to advance children’s health through immunizations. CCIC does not accept funding from vaccine manufacturers or distributors. To learn more, visit www.childrensimmunization.org and connect with CCIC on Facebook and Twitter.
The Latest Liver News

By Beth Bernard, Patient Services Coordinator, Liver Health Connection

Liver-related cirrhosis, cancer, and death are increasing in the U.S. and expected to peak by 2030. Living a healthy lifestyle by eating nutritious food, limiting alcohol and tobacco use, and exercising regularly are important factors that can help prevent cancer. However, incorporating regular screening for hepatitis C and other liver diseases into primary care practices is imperative for early detection and prevention of primary liver cancer (including intrahepatic bile duct cancer).

In order to address the steady increase in liver cancer rates across Colorado, the Colorado Department of Public Health and Environment added liver cancer to the 2016-2020 Colorado Cancer Plan. Nationally, almost all cases of liver cancer occur in people who have a chronic hepatitis B or hepatitis C infection. The Centers for Disease Control and Prevention (CDC) estimate that over 3 million Americans are living with chronic hepatitis C or hepatitis B but are unaware that they are infected. In fact, fewer than 200,000 cases of both these chronic diseases were reported to the CDC in 2013. In addition to viral hepatitis, other risk factors for liver cancer include drinking large amounts of alcohol for many years, having a metabolic syndrome, having a long-lasting liver injury, having hemochromatosis, or eating foods that contain aflatoxin, a poisonous fungus. Although incidence rates are increasing in people of all races and both sexes, men are about three times as likely as women to develop liver and intrahepatic bile duct cancers. Additionally, Asians/Pacific Islanders and American Indians/Alaskan Natives have higher incidence rates of these cancers than people of other races/ethnicities. Being familiar with these risk factors and educating patients can help detect this illness sooner and prevent unnecessary death.

According to the World Health Organization, over 350,000 people die each year of liver-related diseases from hepatitis C. Data from the Surveillance, Epidemiology, and End Results Program (SEER) shows that liver cancer is diagnosed most often among people between the ages of 55-64 (born between 1951-1960). The rate of deaths due to liver cancer is also highest among this group. Effective screening for hepatitis C can dramatically decrease cases of decompensated cirrhosis, hepatocellular carcinoma, and liver transplantation, especially for people born between 1945 and 1965 (baby boomers) or for those who have specific risks including a history of injecting illicit drugs. The CDC, United States Preventive Services Task Force, Medicare, and the State of Colorado also recommend screening baby boomers for hepatitis C at least once in their lifetime. Participating in hepatitis C screening is just one example of how liver cancer can be prevented if screening is a routine part of primary care.

Liver Health Connection (formerly Hep C Connection) is a Colorado nonprofit that can offer resources for your practice. Given the steadily increasing rates of liver disease diagnoses, they identified a need to transform their existing patient advocacy model to address more diseases of the liver, including hepatitis B virus, fatty liver disease (NASH), and liver cancer. Staffing a Liver Disease helpline, providing free, hepatitis C antibody testing, and offering educational classes for patients and providers are the main services that will be offered.

For more information about the Liver Health Connection, please visit www.liverhealthconnection.org or call 800-522-4372.

CDPHE Colorado Cancer Plan https://www.colorado.gov/pacific/cdphe/cancer-get-involved
National Cancer Institute – Liver Cancer Overview http://www.cancer.gov/types/liver
Oral health is essential for healthy development, yet nationwide there is an unacceptably high burden of oral disease. Delivering preventive oral healthcare in the primary care setting will improve access to early detection and preventive interventions, particularly for high-risk and vulnerable patients. In Colorado, dental caries is the leading chronic childhood disease. In the 2011-2012 school year, 39.7 percent of kindergarten children had experienced dental caries; 13.8 percent had untreated decay, and 1.5 percent were in urgent need of dental care due to pain or infection.

Recent scientific research suggests a very strong correlation between chronic oral infections from periodontal disease and systemic health. Treatment for numerous medical conditions such as cardiovascular disease, pulmonary disease, diabetes, orthopedic replacement, kidney disease, cancer, rheumatoid arthritis, and pregnancy may be complicated by bacteria from the mouth.

A June 15, 2015 article by Qualis Health asserts that primary care teams have the skills necessary to understand and intervene in the oral disease process; the relationships needed to engage patients and families in oral health self-care; and a structure for coordinating referrals to dentistry and supporting patients during transitions of care. They have developed an Oral Health Delivery Framework, which delineates activities for which a primary care team can take accountability to protect and promote oral health.

As a result of the advocacy efforts of Oral Health Colorado and its partner organizations, Medicaid now reimburses eligible medical providers for certain dental services for children up through the age of 18. We encourage family physicians to add this option to their practice by becoming a Cavity Free at Three provider.

The Delta Dental of Colorado Foundation is leading the way with its Colorado Medical-Dental Integration Project (CMDI) which supports grantees as they integrate dental services into medical facilities by adding a dental hygienist as part of the health care team. Nine clinics are delivering patient care and, as of August 1, 2015, CO MDI practices have reached 1,319 children and adults in pediatric and family practice medical settings. As the project progresses, Delta Dental will be sharing best practices for integrating oral health in a variety of practice settings.

Oral Health Colorado advocates strongly for the delivery of preventive oral healthcare in primary care settings across the state and our current efforts include weaving oral health into many of Colorado’s health system change efforts. We hope family practitioners will welcome this change and help us to put the mouth back in the body!

About Oral Health Colorado

Oral Health Colorado is a non-profit network of advocates that represent a wide range of public, private and non-profit organizations committed to advancing oral health, and ensuring health equity throughout Colorado. OHCO creates strategic connections with individuals, organizations, and partners to achieve collective impact for improved health.

About Delta Dental Foundation of Colorado

The Delta Dental Colorado Foundation is the philanthropic arm of Delta Dental of Colorado – the state’s largest dental insurance provider. The mission of the Delta Dental Foundation of Colorado is improving Colorado’s oral health by eradicating childhood tooth decay.

About Qualis Health

Qualis Health is one of the nation’s leading population health management organizations, and a leader in improving care delivery and patient outcomes, working with clients throughout the public and private sector to advance the quality, efficiency, and value of healthcare for millions of Americans every day.
Another measles outbreak may be just around the corner

Researchers from Emory University in Atlanta state that almost 25% of U.S. children 3 or younger are vulnerable to measles because of low vaccination rates. In addition, they found almost 9 million of 70 million children younger than 17 lack immunity to measles and would likely become sick if exposed to the virus. Although the “herd immunity” to measles is very close to the 92% threshold, meaning that the U.S. currently has the overall immunity needed to protect against sustained measles transmission, there is still the potential for large outbreaks in areas where there are clusters of unvaccinated children. We should note that these findings should be considered preliminary because they have not appeared in a peer-reviewed journal. (tinyurl.com/nud88f8)

Immunization rates for seniors fall short

Kaiser Health reports that although vaccination rates for children are rising overall, most people older than 60 are behind on their shots. Federal data indicate that three out of four do not get the shingles vaccine, while “nearly half” are not immunized for tetanus, four in 10 are not vaccinated for pneumonia, and “one in three seniors each year skips the flu vaccine.” One reason for the low adult participation is lack of patient education. “Many adults don’t know what vaccines they should have,” says Dr. Bruce Gellin, the nation’s top vaccine official. Although the Affordable Care Act requires private insurers to pay 100% for all preventive services including vaccines, Medicare patients don’t get the same deal. Flu and pneumonia shots are free because they are covered under Medicare Part B, but vaccinations for shingles and tetanus are covered under Medicare Part D and often require co-payments of $100 or more. (tinyurl.com/osup653)

Americans traveling abroad without key vaccinations

Dr. Emily Hyle, an infectious disease specialist and instructor at Harvard Medical School and Massachusetts General Hospital, and her team reported at an infectious disease conference that of the nearly 41,000 international U.S. fliers they studied, 16% needed the MMR vaccine – but only about half of them actually got it. Health experts note this is dangerous “because most measles outbreaks in the US are caused by unvaccinated people who are infected overseas.” Dr. Hyle added, “Measles is one of the most contagious diseases in the world and even brief exposure can lead to infection.” Although measles has been eliminated in the U.S., several imported cases occur each year and can spread if people are not fully immunized. According to Hyle’s study, over half of known U.S. importations of measles originate “not from foreign visitors, but from unvaccinated or undervaccinated U.S. travelers bringing the virus back.” Again, these findings should be considered preliminary because they have not appeared in a peer-reviewed journal. (tinyurl.com/nvbssoqa and tinyurl.com/o2hbpag)

Flu shots less effective in seniors taking statins

Two studies published last fall in The Journal of Infectious Diseases suggest the flu vaccine may be less effective in older adults who are taking statins. One study found that patients who took statins had 38% to 67% lower levels of antibodies to flu, depending on the strain, three weeks after vaccination. A second study found statins dampened the protective effect of the flu vaccine, possibly because they reduce inflammation in the body, which is good for cardiac health, but which may lower the effectiveness of vaccinations that use inflammation to prime the body against pathogens. The researchers suggested that older people on statins may need higher doses of flu vaccines or vaccine boosters to better arm their immune system. A high-dose flu vaccine is approved and available for adults aged 65 and older in the United States, they added. (tinyurl.com/pm465wr)

Flu shots reduce hospital admissions for pneumonia

An estimated 57% of hospital admissions for influenza pneumonia may be prevented if patients get vaccinated against the flu, researchers reported in the Journal of the American Medical Association. Marc Siegel, M.D., at New York University Langone Medical Center said pneumonia is a leading cause of hospitalization and death and that the flu enables pneumonia and other diseases and illnesses. Siegel properly points out, “The study didn’t prove that getting a flu shot also prevents pneumonia, but only shows that most people who had flu-related pneumonia hadn’t been vaccinated.” (tinyurl.com/ogwln32)

Chickenpox cases have declined dramatically due to vaccination

A CDC study found a 78% decline in hospitalizations and outpatient visits for chickenpox following the introduction of the varicella vaccine in 1995. The report in the Journal of the Pediatric Infectious Diseases Society found the biggest decreases were seen in patients ages 1 to 19. One of us (RF) reported in 1994 that rates of chickenpox peaked during the preschool and kindergarten years (ages 3-6), but that approximately 20% of children remained susceptible to chickenpox after age 8. Since then, the routine two-dose varicella vaccination program launched in 2007 has been even more dramatically effective. (tinyurl.com/oz37y4w and tinyurl.com/ozw5kf7)

Walt Larimore is an award-winning family physician and best-selling author who lives in Monument. Reg Finger is a public health physician, a former member of CDC’s ACIP, and an assistant professor at Indiana Wesleyan University in Indiana.
As Much as Possible for the Patient. As Little as Possible to the Patient

By Lynlee Espeseth

Primary care is at the center of helping our most underserved patients. The next generation of healthcare leaders who envisioned and now operate the DAWN Clinic in Aurora are proof of that.

The DAWN Clinic (Dedicated to Aurora’s Wellness and Needs) started as a collaboration between the Colorado Chapter of Primary Care Progress and the Fields Foundation. The vision was to create a primary care clinic setting that would both help health professions students improve their interprofessional collaboration skills, and deliver a much needed service in an urban, underserved community.

To move the clinic from idea to reality took a tremendous amount of work and support from many parties. Much of the early effort was spearheaded by Dr. Joseph Johnson, Medical Director of the DAWN Clinic, and Dr. Kari Mader, his partner in the project.

One of the first goals Drs. Johnson and Mader had was to recruit 10-15 student leaders from disciplines across the University of Colorado’s Anschutz Medical Campus. A key part of the clinic’s success would be developing it as a truly interprofessional project, so having a variety of student voices was vital. Once the initial students were identified, Drs. Johnson and Mader focused on building leadership skills among the group. Those students then led the effort to recruit an additional 50-75 dedicated and diverse student leaders, and collected 800 signatures on a petition asking the University of Colorado administration to support the clinic.

Support was also built off campus, thanks to the help of Representative Rhonda Fields, D-42, her daughter Maisha Fields, FNP, and Pastor Reid Hettich of Mosaic Church of Aurora; along with Aurora Health Access and the Community-Campus Partnership. With critical mass reached both on and off campus, leaders including former Dean Krugman, the Deans of each school, the Anschutz Executive Committee, Children’s Hospital, and Governor John Hickenlooper were engaged.

While this support was building the group also had to manage the logistics of opening a new clinic. They had to obtain supplies, develop testing capabilities, organize primary care volunteers and a specialty network, design the clinic blueprints, and raise the $110,000 that was needed for the clinic space. Thanks to the dedication of the students and other medical professionals, and support of the wider community, the clinic was launched in March, 2015.

The DAWN Clinic is open on Tuesday and Wednesday evenings, providing a walk-in clinic setting on Tuesdays and an outpatient physical therapy clinic on Wednesdays. Because the DAWN Clinic was built with an interdisciplinary approach in mind, patients have access to an incredibly varied scope of services, including medical, dental, mental health, physical therapy and pharmacy. There are also interpretive services available at the clinic for as many patients as possible.

“Our visits are very team-oriented and collaborative, with typically 2 or more providers working with a patient to evaluate and develop a plan of care for their needs. We try to get a big picture of each patient’s needs and then coordinate to follow-up with relevant services, such as dental, physical therapy, behavioral health, or other medical needs,” says Megan Davis, a student in the Doctoral of Physical Therapy program at the University of Colorado and one of the student leaders involved with the clinic.

The DAWN Clinic is designed to see uninsured patients 18 and over, however, insured patients are able to see volunteers at the clinic for an initial visit to get connected to primary care and specialty care in the community. The clinic also provides non-medical services, thanks to collaborations with other community resources. Patients can get help accessing housing, food, education, long-term care, transportation, religious resources and support groups. The clinic also offers health education classes and assistance applying for Medicaid and other social services.

The demand for the clinic, and its effect on the community, has proven to be exceptional.

“We open on Tuesday nights from six to eight, but because we are a walk-in clinic that operates as first come first serve, many patients show up at five. We also do not close the clinic until the last patient is seen, which can be eleven on some nights if it was a complex patient,” says Tuong Phan, a medical student and co-leader of the Research Workgroup and Clinic Manager at DAWN. “We have never gone a night without new patients, and I think it will just continue to be a positive trend as more people find out about us.”

Initial data collected at the clinic has also proven what a need it was in the Aurora community. 91% of clinic patients have no insurance, and 92% have no primary care provider. 75% report their overall health as average or
worse, 45.3% report their mental health as average or worse, and 81.4% rate their dental health as average or worse. Of the patients visiting the DAWN Clinic, 34% had been to the ED in the last year, 27% would have gone if they didn’t come to the clinic, and 55% would have opted to stay home and not receive care.

The clinic has also had a positive effect on the students involved, strengthening their interest and dedication to both primary care and the importance of collaborative care.

“One of the most inspiring things about the DAWN clinic is the way it brings people together. As health professional students, we are often quite isolated from other professions as we pursue our degrees and training,” says Davis. “Even more so, our campus environment isolates us from the community we live in, as many of our buildings and resources are not available to the general public. The DAWN Clinic seeks to change that model, by bringing different types of students together with the residents of our community. We are all united by a common goal: to provide care to those who need it most. With every patient we work with, we are slowly building a reputation as a place that was not just built for the community but with the community.”

Each night, before clinic begins, students and clinic managers gather to discuss how the evening will go. Each of these huddles ends with a reminder of the DAWN Clinic’s motto: “As much as possible for the patient. As little as possible to the patient.” This motto, and the lasting impact the clinic has on its volunteers, is close to the hearts of DAWN’s founders.

“We are able to nurture the values that originally brought many students to health professional school and keep those virtuous caring sentiments alive through grueling years trapped in classrooms and behind books,” says Dr. Johnson. “I know from personal experience that it can be difficult to keep one’s values alive through those difficult years, even before launching our career. In the end, we hope to have a lasting impact by inspiring students to enter into the field of primary care.”

If you would like to get involved with the DAWN Clinic, physician volunteers are needed to serve on Tuesday evenings to teach and provide care to patients. The clinic is located at 1445 Dayton St., Aurora, CO 80010. Many volunteers participate on a monthly or every other month basis. Malpractice coverage is obtainable through COPIC’s volunteer physician program free of charge, and the clinic’s onboarding team can help volunteers navigate the process and become oriented to clinic flow and the Practice Fusion EMR. Email Dr. Joseph Johnson at JDJohnson18@gmail.com for more information.

Thank you to Dr. Joseph Johnson, Dr. Frank Barry, Sarah Wood, Megan Davis, Tuong Phan, Marielle Galanto, and Ani Reddy for their contributions to this story.
Dr. John Bender, AAFP Board of Directors

Congratulations to Dr. John Bender of Fort Collins, who was elected to the AAFP Board of Directors at the 2015 Congress of Delegates in Denver.
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By Lynlee Espeseth

“It is always good when you feel like you are supported in doing the kind of quality work you want to do.”

Perhaps no sentiment could better sum up how many family physicians in Colorado feel. Dr. Mary Reeves, a recently retired (after 22 years) partner at First Street Family Health (FSFH) in Salida, Colorado, is one of them. In an effort to achieve that sentiment she, along with partners Matt Burkley, MD, Joel Schaler, MD, Meggan Grant-Nierman, DO and Dan Lombardo, MD, embraced practice transformation supported by the Comprehensive Primary Care Initiative, or CPCI.

CPCI was launched by the Centers for Medicare and Medicaid Services in 2012 in seven US regions, including Colorado. The focus of CPCI is to offer population-based care management fees and shared savings opportunities to support five core functions: risk-stratified care management, access and continuity, planned care for chronic conditions and preventative care, patient and caregiver engagement, and coordination of care across the medical neighborhood.

Why did First Street Family Health choose to participate in CPCI, and what has the program actually meant for them?

Like most practices (large and small), FSFH was busy taking care of patients and “just trying to keep the lights on.” They had tried other reimbursement programs before, and while they liked the opportunities these programs offered, some didn’t translate to worthwhile reimbursement, some didn’t translate to real improvement in practice, and some were simply too much hassle for a small practice to take on.

After reading about CPCI, First Street Family Health finally found an option that fit. Because the program was focused on Medicare patients, and Medicare patients are 25% of FSFH’s patients, there was a large financial benefit to the practice. That additional income allowed the practice to invest in the infrastructure needed to change in the ways they wanted to change. The materials provided through CPCI were helpful, including the 9 milestones the practice was required to hit that helped to steer it in the right direction. Additionally, Medicare’s contract with HealthTeamWorks meant there were local consultants to help FSFH do the work of transformation.

The practice has been able to focus on bringing better care to patients through care coordination, population care, preventative care, and better planned care for chronic disease patients. They have changed from the traditional doctor/nurse unit to a team based model with an emphasis on all providers involved in care practicing to the top of their license. The practice uses data to monitor care and drive improvement. They have empaneled and risk stratified their patients to begin to deliver population care for chronic diseases and planned preventative services.

FSFH has also been able to integrate more people into their team based approach. The practice now includes services around behavioral health, pharmacy, diet and exercise, disease support, and care coordination. They have also started a patient and family advisory council (PFAC) to make patients a partner in their care.

While the transformation has proven valuable to the practice and to patients, it has also revitalized how Dr. Reeves and her partners feel about being family doctors. In the old style of practice, Dr. Reeves says that sometimes providing care could feel like a battle.

“I sometimes felt like I was the only one really interested in solving my patients’ problems, or getting my patients the kind of care they want, need and deserve. Sometimes, it was a battle with the patients,” she says.

However, after CPCI, and because of the emphasis on patient-centered care, the work the entire care team at FSFH does is aligned with the goals and care wishes that their patients have. A big part of achieving that has been working with the PFAC. Staff and patients meet regularly and collaborate on practice improvement. Dr. Reeves sees it as a major “low tech/high touch” driver of practice transformation.

For Dr. Reeves, it has also been rewarding to witness daily
examples that prove why exceptional, high quality care matters. For patients who are frequent users of the ER, there are resources to help them reduce those trips. For patients on many medications, there are resources to help them find the most affordable options. They can also help patients who struggle with issues outside of their own health. For example, a patient who came in for a physical and admitted to struggling to care for a spouse with dementia is given the resources and help needed to manage that care, even if it is totally outside the scope of the original appointment.

While CPCI is a temporary program, First Street Family Health will not have to end their new process of care when it is over. Indeed, participating in CPCI has set them up to succeed in the new healthcare landscape. As Medicare and other payers move toward value based payments, the practice is ready to take advantage of new billing codes and data collection and submission requirements, without the stress so many other practices are feeling. Additionally, their patients have become accustomed to what care management is all about, and will be both willing and happy to see these different kinds of care continued.

“CPCI represents an opportunity for our small practice to transform into a modern, advanced primary care practice,” says Dr. Reeves.

She encourages other practices to explore practice transformation like this, but recognizes that, just as FSFH found, not every program will fit the needs of every practice. One exciting opportunity for practices is the Transforming Clinical Practices Initiative, or TCPI, recently launched by CMS. This program takes the lessons learned from CPCI and makes them available to small practices who have not done transformation work before, so they can begin to work towards becoming eligible for value based payments.

For as physicians find ways of transforming their practices to provide the quality care that is their calling, they will re-discover that “it is always good,” and when more physicians truly love primary care, the better all care will be.

Congratulations to Paige Bennett, a 4th-year medical student at the University of Colorado for being selected as one of six 2015 Pisacano scholars.

Do you have exciting news about yourself or a colleague that should be recognized?
Email Lynlee Espeseth at lynlee@coloradoafp.org

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