July/August 2010 Volume 107, Number 4

Colorado Medicine

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Cover story Achieving long-term, issues-based objectives for physicians requires diligent and disciplined doctor participation in election-cycle politics. Like it or not, in policy making you're either at the table or on it and it all starts with meaningful relationships with policy makers. Coverage begins on page 8.

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Editor's note: Articles appearing in Colorado Medicine without a byline represent the collaborative work of CMS leadership and staff.

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president's letter

Mark Laitos, MD, President
Colorado Medical Society

Politics 101

I'm thrilled to tell you that your Colorado Medical Society is great at formulating policy. We are visionary, engaged and focused on crafting approaches that will make Colorado's health care system work better and benefit Colorado's patients.

However, I'm here to tell you that your Colorado Medical Society needs our doctors' help to implement our policy agenda. And I'm sorry to say that doctors don't always provide the support CMS needs to do that.

To illustrate my point, here is a review of what happened with CMS' Patient Safety Act.

Over the course of almost two years, the many brilliant stakeholders of CMS' Ad Hoc Committee on Patient Safety and Professional Accountability crafted visionary CMS policy on patient safety. And CMS began a bold and sweeping offensive to improve the care of our patients, beginning with the introduction of our Patient Safety Act. This year, unlike the previous three years, the discussion at the legislature was not our response to the trial lawyers' incursion into Colorado's stable malpractice environment. Instead, this year we educated legislators that patient safety is an issue of medical care delivery, not of tort law. Patient safety needs to be defined by the people in the exam room, the OR and the ED – the physicians, the nurses and the patients.

Our sophisticated policy formulation team produced a well-written patient safety bill. First it went to the House Health and Human Services Committee. It passed. Next it went to the House Judiciary Committee. It did not pass. When a bill loses in one committee, that bill is done for that session.

We had a superb bill. We had support from caregivers, hospitals and patients. We had great lobbying. Why didn't it pass?

It didn't pass because doctors didn't give CMS the political support we needed. We formulated great policy, but did not succeed at implementing that policy. It didn't pass because doctors are politically naïve.

When you think about it, it's not surprising that doctors don't do politics well. Consider how we conduct our business. We've dedicated our lives to learning the best response to a complex set of circumstances and then issuing a decree to carry out that response. In our exam rooms, we don't suggest—we prescribe. In the hospital, we don't advise—we order. And that approach usually improves our patients' health.

So it isn't surprising that doctors think there is one best legislative answer to complex social problems, and that a good outcome depends on lawmakers listening more carefully to us.

Sorry, folks. It doesn't work that way in politics. The merits of any important bill are usually in dispute. A bill's outcome depends as much on coalition building as on the bill's virtues.

Our legislators are in office because they are skilled campaigners, skilled enough to win an election. And just about every one of them wants to get re-elected. To do that, they need to have good policies. But they also need hard work on the campaign, and they need campaign contributions.

How important are relationships?

State Representative David Balmer (R-Arapahoe County)
"With my consistent opposition to trial-lawyer bills that drive up the cost of health care, I am honored and grateful to earn the continued support of the Colorado Medical Society. I'm bombarded with information at the Capitol; and to sort through it all, I rely on physicians who are focused on optimal patient outcomes."

Cheri Jahn, Democratic candidate for State Senate Seat 20 (Jefferson County)
"I am proud to work with CMS in preserving our strong tort laws, something my primary race opponent doesn't support. CMS' endorsement and generous small donor committee contribution will help me reach more voters and secure their votes."

Legislators, regardless of party, are like elephants: they remember the people who helped them when they needed it. They know who contributed to their campaigns. They know who rang doorbells asking for voters' support. They know who staffed phone banks. They know who wrote letters to the editor supporting them. They know who helped make sure their supporters got to the polls on Election Day.

And when that hard work pays off and the candidate takes (or returns to) office, he or she turns to trusted friends for help understanding the hundreds of complex bills introduced at the legislature. Who are those trusted friends? In large measure, the people who helped that legislator take office.

The Colorado Trial Lawyers Association is well known for their financial support of candidates during their elections. There are many legislators who feel that a lawyer helped get them elected.

In contrast, there are very few legislators who believe a doctor helped get them elected.

Here's what I'd like to see. There are 100 legislative districts in Colorado: 35 senators, 65 representatives. I'd like to see 200 doctors, one Republican and one Democrat in each of those districts, working with the candidate from each party during every election. I'd like those doctors to help elect their legislator, and enlist their medical colleagues to help, too. (Don't worry; CMS is eager to teach you how to help the campaign.)

I'd like that candidate to understand that a doctor helped to get him/her elected. CMS doesn't care if the Democrat or Republican wins. CMS does care that a legislator who believes in our policies and has learned to trust that doctor gets elected. We care that legislators will have a reason to listen carefully to the advice their doctor gives them. ■

executive office update

Alfred Gilchrist, Chief Executive Officer
Colorado Medical Society

Uncircling the wagons

While it didn't necessarily take a comprehensive member survey to confirm it, medicine's general disposition toward the federal "mediquake" and its impending shockwaves can be best characterized as somewhere between Hurricane Katrina and Custer's Last Stand. In my frequent conversations with Colorado physicians and my colleagues across the country, the responses are the same – many physicians feel surrounded, angry and powerless. Wagons are being circled, with rifles pointed both inward and outward. I propose that all those rifles are pointed in the wrong direction, not just the friendly fire. Medicine will need to take careful aim at several moving targets in a target rich environment, but not from a stationary position.

The old political saying: "You're not paranoid when people are in fact after you" may seem to apply in the current environment. However, you are not alone, and some of those people are actually on our side. We'll be convening your colleagues and friends – our statewide community of physicians and advocates – at this crucial Annual Meeting September 9-12 at the Vail Cascade resort. The new realities of our rapidly changing delivery systems will convert some friends to strangers and realign some strange bedfellow friendships.

As we've noted in these pages for more than four years now, we've long anticipated the coming storm, and have been methodically preparing and intervening both in Denver and Washington D.C. When Colorado physicians and their advocates convene next month at the House of Delegates, it won't be with a siege mentality. They will be armed with a well-formed, long-term strategy, and a wide-open forum to gather intelligence, concerns and proactive ideas to incubate, then shake and bake. The resolve and perspective that is drawn from this highly interactive Annual Meeting will be handed off to the Board for a specially called retreat to translate medicine's ideas into real world consequences. We will be uncircling wagons and setting off on this new frontier, but not without our roadmap and the consolidated influence of a fully realized grassroots organization.

I have seen almost every kind of practice-defining confrontation, policy shift and political debate in my three-decades of advocating for the medical profession; however, I have never seen this kind of earth-shaking convergence of powerful, divisive economic forces and a more urgent need for physicians to draw closer together and stay connected as a community of interests. Your medical society will be aggressively coordinating and reaching out through your county and specialty medical societies and other means. I'd like to suggest that you've got my number, this time literally. You can call me on my cell phone at 303-475-0144, if only to hear a friendly (not automated) voice that will be always be on your side.

To mix Timothy Leary with Winston Churchill and John Paul Jones – now is the time to turn on, tune in and not drop out. The mediquake and its aftermath is the end of the beginning, and we've just begun to pick a fight, together, as a grassroots organization. ■

Politics 101: will doctors be at the table or on it?

Lee Morgan, MD, Chair, COMPAC

CMS Political Primer

How politics drives the process that sets policy (and getting mad isn't enough)

As electoral waves of anti-government sentiment crash against incumbents in both primaries, many physicians are likely to dive in and tell their colleagues, "Come on in – the water's fine!" Physicians are justifiably frustrated with a highly regulated practice environment with out-of-whack incentives, delayed and reduced payments and looming uncertainty about future policy changes. Combined with the current volatile political environment, that frustration can and should lead to political engagement.

But how is a physician to engage in a constructive way? At least part of the answer is ongoing, long-term participation in election cycle politics. Driving change through the political and policy process is never just a "one and done" endeavor, and just "throwing the (current) bums out" isn't the answer to physicians' concerns. Few issues that matter to physicians can be addressed in the course of one 120-day legislative session. Most of the issues require years of work; even if we do pass a bill the first time we run it, we frequently need to revise laws as circumstances change, and maintain constant vigilance to ensure that others don't chip away at what we've achieved. Significant, momentous changes can take many years to be realized.

That's why it is so essential for physicians to understand and consistently participate in election-cycle politics. No policy change ever occurs without a political process. And the election cycle begins that process. This article is designed to illustrate why Colorado's house of medicine must embrace a culture of ongoing, active participation in elections; if it does not, CMS will be relegated to the role of an occasional grassroots organization with limited clout and less credibility.

A new way of looking at elections: The start of a beautiful friendship

For an organization like CMS, the art of election-cycle politics is focusing motivated voters on achieving long-term, issues-based objectives, rather than having a short-run tantrum that unhorses (or merely antagonizes) an incumbent. The goal isn't the political assassination of an office holder. It is winning or gaining leverage in an election so that the survivor/winner supports your well-reasoned ideas over your adversaries' equally reasoned ideas.

Legislative ideas arrive at their destinations from a political process. They don't often spring fully formed from the minds of civic minded public servants, like Apollo and Athena emerging from Zeus' head. Rather, legislative proposals take shape from ideas brought to legislators by thoughtful advocates. Not surprisingly, legislators are most receptive to ideas that both sync with their own interests and come from individuals and organizations with which that legislator has a relationship.

In politics, relationships can be as important, if not more so, than issues. And most elected officials' relationships begin with their earliest electoral experiences. A politician rarely forgets or overlooks those who were there during that first, seminal election, or who helped out in a tight re-election campaign. And that long memory translates into access. Who gets to cut in line at a legislator's office?

Will it be the physician who never sent a check, attended a fundraiser or worked on the incumbent's campaign, or the legislator's chiropractor and long-time finance chair? What do you suppose is the predisposition of that legislator on expanded scope of practice for chiropractic? Since most legislators didn't go to medical school, where do you think they go to get some sense on how to vote on these complex and intensely political matters?

There are three types of relationships. All have relative value, and all are readily applied by physicians with an interest in converting their ideas into consequences:

1. Organic: Relationships that preceded a legislator's political career, and are by definition relatively close. These include family members, classmates, physician-patient relationships and neighbors or other community-based relationships involving regular interaction. When managed methodically and ethically, they are by far the most influential.
2. Home grown: These are relationships acquired during an election cycle with people who engaged in the basics of volunteer political action (not just making a contribution, although that remains absolutely essential). This includes signing letters or ads, hosting events, block walking, traveling with the candidate and any in-kind, public, sustained gesture. Deeper than just a commitment to a contributor, these relationships can neutralize even the largest contributors' efforts at bullying your legislator.
3. Artificial turf: These are the en masse responses rallied from your medical organization, where volume, in addition to personal contact, counts. Letters, e-mails, phone calls, and rallies all come under this heading. Lobbyists frequently hear from the uncommitted legislator, "I haven't heard from my docs on this." Such perceived ambivalence gives a legislator cover for a vote physicians may not like, especially if the other side is pounding the office with mail and calls. While en masse outreach does not create personal relationships with legislators, it demonstrates an organization's passion in spades.

Since most legislators didn't go to medical school, where do you suppose they go to get some sense on how to vote on these complex and intensely political matters?

Creating that beautiful relationship and how CMS can help

CMS has a robust process in place that will help you secure this friendship (and trump that chiropractor and trial lawyer).

The Colorado Medical Society Political Action Committee (COMPAC) organizes local physicians to interview candidates running for their local office. These physicians grade the candidates based on their positions on our issues and recommend candidates for COMPAC endorsement. It is in this interview process that candidates make commitments on issues and where you plant the beginnings of a friendship. This process works. Through these interviews we have locked in enough committed "no" votes to defeat legislative attempts to increase pain and suffering caps in medical malpractice cases. And this process has created many a friendship that has led to a legislator asking for our advice prior to casting his/her vote. We all agree that this advice is better dispensed from a physician rather than a chiropractor. ■

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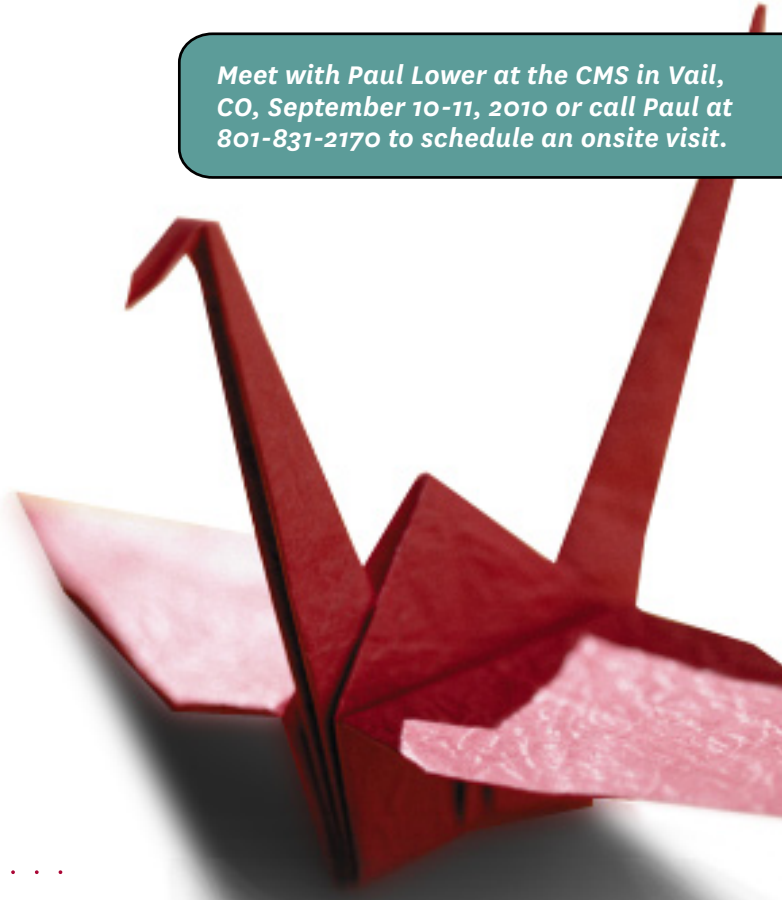

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2010 state primary race endorsements

Diana Protopapa, Director, Political Affairs and Education

COMPAC is the bipartisan political action committee of the Colorado Medical Society and the unified voice of more than 7,000 physicians, medical students and spouses (the CMS Connection) in Colorado. Its goal is to support and elect pro-physician, pro-patient candidates on the state level. On the federal level, COMPAC works in conjunction with the political action committee of the American Medical Association, to represent the interests of physicians and their patients before Congress.

Those who know medicine govern COMPAC. The voting members of the Board of Directors include 24 physicians, Connection members and medical students who represent the various geographic regions of Colorado. COMPAC functions include physician and Connection grassroots activities, extensive political campaign participation and contributions. To determine the level and type of support for candidates, COMPAC considers the following:

- A candidate's philosophy and positions on medical issues;
- A candidate's medical voting record (if applicable);
- Demographics of the district and a candidate's ability to win; and
- COMPAC and local district physician member recommendations following candidate interviews.

These endorsements only apply to the open seat primary races. COMPAC endorsements may differ for the general elections and we will share those endorsements in the next issue of the magazine. ■

Senate Seats

Republican Primaries

District	Endorsement
2 (Baca, Bent, Crowley, Custer, Fremont, Huerfano, Las Animas, Otero and Pueblo counties)	Matt Heimerich
3 (Pueblo County)	Vera Ortegon

Democratic Primaries

District	Endorsement
20 (Jefferson County)	Cheri Jahn
34 (Denver County)	Lucia Guzman

House Seats

Republican Primaries

District	Endorsement
44 (Douglas County)	Chris Holbert
54 (Mesa County)	Robert Hislop

Democratic Primaries

District	Endorsement
4 (Denver County)	Dan Pabon
5 (Denver County)	Mark Thrun, MD
7 (Denver County)	Angela Williams
12 (Broomfield County)	Neutral

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Election 2010

CMS opposes 2010 ballot initiatives

Amendments 60, 61, Prop. 101; Amendment 62; Initiative 45

Edie Sonn, Senior Director, Public Affairs Division

After deliberations by the CMS Council on Legislation (COL) and Board of Directors, the Medical Society voted to oppose a number of citizen-sponsored initiatives on the 2010 ballot: Amendments 60, 61, 62 and Proposition 101, as well as Initiative 45. (At press time, this measure had not yet qualified for the ballot; if it does, it will likely be listed as Amendment 63.)

CMS does not take positions on many ballot measures. However, when voters will be asked to consider statutory or constitutional changes that could affect the practice of medicine, or when a measure could create a significant change in the business and policy climate of Colorado, our leaders feel it is important that organized medicine's voice is heard. CMS looks especially closely at initiatives that would alter the state's constitution, because it is much harder to change things once they have been written into the constitution than when they are put into statute.

Before recommending a position to the Board, COL reviews information from both sides and, when possible, asks representatives to present their arguments. This was an unusual year, because despite repeated efforts, proponents of 60, 61, 62 or 101 would not agree to make their case in person. COL did not seek formal pro/con presentations on Initiative 45, which would exempt Colorado from the individual mandate to have insurance, because CMS already has policy calling for all Coloradans to have insurance coverage.

Here are snapshots of the initiatives and CMS' reasons for opposing them. Complete text of each measure and additional analysis is available in the Blue Book sent to every Colorado voter prior to the election.

Tax Reform

Amendments 60 and 61 and Proposition 101 are being presented as a package. Each of the three initiatives is complex; the descriptions below are meant to provide a general overview, rather than an exhaustive explanation of every element within them.

Supporters: National Taxpayers Union

Opponents: Chambers of Commerce (CACI, Denver Metro Chamber, others)
Colorado Municipal League
Colorado Counties, Inc.
Banks
Bond underwriters
Colorado Hospital Association
Colorado Healthcare Association
Kaiser Permanente
Colorado Education Association
Colorado Contractors Association
SEIU

Amendment 60, Property Tax Changes (constitutional amendment)

Description

- Enacts several major changes in property tax policy, including:
  - Requires a 50 percent reduction in school district mill levies with a required state backfill.
  - Allows electors to vote on property taxes anywhere in the state where they own real property, whether or not they live in that jurisdiction.
  - Requires enterprises and authorities to pay property taxes.

- Repeals local property tax "de-Brucings."
- Extends expiring property taxes counts as a tax increase.
- Limits future property tax increases to 10 years.

Arguments for

- Property taxes have increased 164 percent since 1992, it is appropriate to reduce them.
- In 2007, the state raised taxes to fund schools without voter approval. The Colorado Supreme Court inappropriately upheld that law.

Arguments against

- Schools would lose more than $1 billion in funding each year and the state would be required to make up the difference from a budget that already lacks the flexibility to fund existing needs adequately.
- The measure would overturn hundreds of local "de-Brucing" elections that have occurred statewide since 1991, in which local voters chose to give greater flexibility to their local school districts, fire departments, library districts, etc. This would allow the state to usurp local control.

Amendment 61, Limit State and Local Government Debt (constitutional amendment)

Description

- Prohibits all levels and divisions of government from bonding, lease-purchase agreements, revenue anticipation notes, etc.
- Limits local voter-approved borrowing to a maximum of 10 years.
- Changes local borrowing limits to a fraction of the currently allowed maximums.
- Requires a tax cut equivalent to the average annual repayment of any loan that is paid off.

Arguments for

- Voters don't realize that politicians borrow money, because they use other names for debt.
- The current economic crisis was caused by reckless borrowing, which needs to be stopped.

Arguments against

- Colorado would be the first state in the nation to severely limit – and in many cases, effectively prohibit – government entities from borrowing money to pay for capital projects, e.g., building/fixing schools, roads, hospitals, college buildings, water and sewer systems, and prisons.
- Colorado is already constitutionally required to balance its budget. Government debt, e.g., in the form of bonds, does not mean Colorado is running a deficit.
- The requirement that local districts repay bonds within 10 years would raise repayment costs to exorbitant levels and effectively prohibit any borrowing for major local projects.
- The state has used tools such as revenue anticipation notes and certificates of participation for decades to even out cash flow throughout the year. Eliminating their use would impede the state's ability to provide services or even meet payroll at times of year when revenue is low.

Proposition 101, Reduce Income Tax and Other Revenue Streams (statutory amendment)

Description

- Reduces state income tax rate over time from current 4.63 percent to 3.5 percent.
- Virtually eliminates "specific ownership" tax on vehicles, to $2 for new vehicles and $1 for old vehicles.
- All registration, license and title charges combined shall total $10 yearly per vehicle.
- Reduces fees on telecommunication services (e.g., telephone, cable, internet, etc.).

Arguments for

- Vehicle, income and phone taxes have never been approved by voters.

Arguments against

- The vehicle registration fee has not been this low since 1919. Vehicle registration fees are a major source of funding for road and bridge construction across the state and are shared with local governments – meaning that this measure would cut funding for both local and state road improvement projects.
- The specific ownership tax on vehicles goes to local governments. A reduction as proposed in the ballot measure would cut local revenue by about $500 million annually.
- The reduction in the state income tax would eliminate a quarter of the state's income tax revenue at a time when the state budget has already been severely affected by the recession and would mean further cuts to state services such as Medicaid and higher education, among others.

Arguments against package (all three measures)

- According to the Colorado Legislative Council's July 8 "Blue Book" draft, "If all of these measures were fully implemented in FY 2010-11, the state would lose $2.1 billion in revenue and would have to increase K-12 education funding by $1.6 billion. The combined impacts mean that K-12 education funding would require about 99 percent of the General Fund budget. A homeowner earning $55,000 per year with a $295,000 home would save approximately $1,800 annually in taxes."

Amendment 62, Personhood (constitutional amendment)

Supporters: Colorado Right to Life

Human Life International
American Life League
Personhood USA

Opponents: Colorado Gyn-OB Society
Colorado Bar Association
Interfaith Alliance
Republican Majority for Choice
National Council of Jewish Women
American Civil Liberties Union
NARAL
Planned Parenthood of Colorado

Description

- The measure is similar to Amendment 48 in 2008, which CMS opposed. It would define the term "person" in the state constitution to include "every human being from the beginning of the biological development of that human being." This definition would apply to the sections of the Colorado constitution that protect the natural and essential rights of persons, allow open access to courts for every person, and ensure that no person has his or her life, liberty or property taken away without due process of law.

Arguments for

- Ensures that all human life is afforded fair and equal treatment. Currently, these rights are not given until birth.
- Gives clear direction to the courts and legislature about who is considered a person, ensuring uniform application of the term "person" under the law.
- Will establish the legal foundation to end the practice of abortion in Colorado.

Arguments against

- The phrase "the beginning of biological development" is not an accepted scientific or medical term and does not refer to any specific point in the process of human reproduction.
- Current medical and scientific practice/procedures that could be banned because of this definition of person include treatment of miscarriage, ectopic and molar pregnancies and infertility; stem cell research; and safe and legal abortion. According to the proponents' Web site, the measure would also prohibit all forms of contraception except barrier methods.
- The amendment represents an unwarranted intrusion into the practice of medicine.
- The term "person" is used thousands of times in Colorado statutes. If this amendment passes, the courts will have to determine how to apply the new definition to a wide variety of laws, including property rights and criminal laws.

Initiative 45, Health Care Choice (constitutional amendment)

Supporters: Independence Institute

Opponents: Colorado Hospital Association
Colorado Community Health Network
Colorado Council of Churches
Colorado Consumer Health Initiative
Colorado Center on Law and Policy
Club 20
SEIU
AFL-CIO

Description

- Adds "health care choice" to the bill of rights in the Colorado Constitution.
- Prohibits the state from requiring or enforcing any requirement that a person participate in a public or private health coverage plan.
- Restricts the state from limiting a person's ability to make or receive direct payments for lawful health care services.

Arguments for

- Provides a basis for Colorado to challenge the federal requirement to have health insurance.
- Ensures that the state cannot enact an individual mandate requirement of its own, if the federal mandate is overturned.
- Protects Coloradans' ability to pay providers directly for their health care, in contrast to systems such as Canada's that prohibit such direct transactions.

Arguments against

- By removing the requirement that all Coloradans be in the insurance pool, Initiative 45 effectively undercuts efforts to end premium differences based on pre-existing conditions. The only way insurers can afford to eliminate pre-existing conditions from premium calculations is by spreading the risk across a large pool of both healthy and sick people. Health insurance doesn't work if people can wait until they are sick to buy and drop coverage when they get better. The idea is for everyone to pay into the program over time so that there is enough money to cover people's needs when they get sick.
- By prohibiting the state from "penalizing the right or ability of a person to make or receive direct payments for lawful health care services," the amendment could hamper the state's ability to discipline health care providers, including guarding against non-physicians practicing medicine.
- It is almost impossible to assess the potential impacts of a constitutionally guaranteed right to a concept as vague as "health care choice." Virtually every health care-related law currently on the books would have to be re-examined, leading to untold court battles and uncertainty. ■

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Wanted:

Physicians to work with advanced practice nurses in new prescribing model

Luke Casias, MD; Steven Holt, MD; Sue Townsend, MD

Rigorous new approach knits together physicians and APNs more closely to enhance safe prescribing

As of July 1, advanced practice nurses (APNs) must follow a new set of rules for prescribing – rules that require physicians to be involved more constructively and systematically than before. Physicians will now act as preceptors and mentors for APNs seeking prescriptive authority, as well as serve as ongoing resources for them once they have achieved that authority. Training requirementrs for APNs to achieve prescriptive authority have been increased as well. It's important that physicians understand and participate in this new arrangement, known as the "articulated plan."

Where did the "articulated plan" come from?

The articulated plan model was originally outlined in 2009 by a multi-specialty group of physicians and APNs as part of negotiations around the sunset of the Nurse Practice Act. As physicians know, Colorado law required APNs to have a "collaborative agreement" with a physician in order to prescribe. The nursing community sought to use the sunset bill to repeal that requirement, saying that most collaborative agreements were meaningless pieces of paper that simply sat in filing cabinets – not the backbone of an ongoing dialogue between nurse and physician about prescribing.

CMS didn't have data on this issue, so the Medical Society surveyed physicians who had collaborative agreements. While not statistically valid, the results indicated that there could be some truth to the nurses' contention. Physicians practicing with APNs in hospital settings and those who employed APNs in their offices tended to have robust, regularly updated collaborative agreements that created a framework for ongoing and effective consultation. However, it seemed that agreements between physicians and independently-practicing APNs were less likely to serve as vehicles for regular consultation, support and quality assurance.

Accordingly, CMS agreed that an alternative to the collaborative agreements was needed. We were not willing to concede to completely independent prescribing, as the nursing community wished. Instead, we suggested that nurses and physicians search together for an alternative.

This alternative was developed through a facilitated workgroup under the aegis of the Department of Regulatory Agencies (DORA). The three of us participated in that group, along with Dave Downs, MD (internist) and Alex Slucky, MD (anesthesiologist) and five APNs. Through more than two months of meetings we developed the outlines of the articulated plan approach and incorporated it into the Nurse Practice Act sunset bill last year.

The bill also created the Nurse-Physician Advisory Task Force for Colorado Healthcare (NPATCH), to advise our respective boards about matters at the intersection of nursing and medicine. (The three of us also sit on the NPATCH, along with internist Christine Gilroy, MD.) The NPATCH's first task has been to develop a model articulated plan.

What are the elements of this approach? What is expected of participating physicians?

This new approach involves three components: a preceptorship period, a mentorship period and the articulated plan. The NPATCH spent many hours refin-

ing the broad outlines of the articulated plan and developed what we believe to be a robust set of recommendations to help APNs and physicians work closely and effectively on safe prescribing.

It is important to recognize that this new approach builds in more "front-end" work on the part of the APN before achieving prescribing authority. Under the old collaborative agreement approach, APNs were required to have 1800 hours of precepted prescribing experience before entering into a collaborative agreement for prescribing. This new model not only retains that 1800-hour preceptorship requirement, but also adds an additional 1800 hours of mentorship before the APN achieves full prescribing authority.

Preceptorship

APNs applying for prescribing authority for the first time, or those who have moved from another state and lack 3600 hours of prescribing experience, and who meet a number of requirements (graduate or post-graduate degree, board certification, liability coverage, successful completion of graduate-level pharmacology and related coursework, etc.) must complete 1800 hours of precepted prescribing in order to obtain "provisional" prescribing authority. Preceptors may be physicians or a team of a physician and APN with prescribing authority (designated as "RXN") and they must be actively practicing in Colorado in an area corresponding with the practice focus of the APN (e.g., pediatrics, women's health, etc.). Preceptors may not require payment or employment from the APN as a condition of the preceptorship, but may request reimbursement of reasonable expenses related to their role.

The physician preceptor or physician/RXN preceptor team must design a written plan with the APN applying for prescriptive authority that assures regular interaction between the preceptor(s) and the APN. We don't expect the time commitment for physicians to be onerous. If a physician is the sole preceptor, weekly meetings with the APN would be expected and would not likely require more than 30-60 minutes/week. Physicians preceptoring as part of a team must participate in a minimum of one meeting per month. During the preceptorship all medication or prescriptions must be signed or otherwise legally authorized by a preceptor or another person with prescriptive authority.

The APN applicant and preceptor(s) must provide documentation of completion of the 1800-hour preceptorship in order for the APN to receive provisional prescriptive authority. This provisional authority is limited to the patients and prescriptions appropriate to the APN's role and population focus. The APN then has five years in which to complete an additional 1800 hours of mentorship and develop an articulated plan in order to receive full prescribing authority.

Mentorship

Like the preceptorship, the mentorship must be mutually structured between the APN and either a physician or a team of a physician and RXN. The other requirements (actively practicing in similar specialty, reimbursement for expenses but not payment, etc.) also apply to the mentorship.

The mentorship plan must be documented in writing and signed by the APN and the mentor(s). This document outlines a process and frequency for ongoing interaction and discussion of prescriptive practice throughout the mentorship process between the APN and the mentor(s) to provide for patient safety. There is no defined time requirement for the interaction between APN and mentor(s). The time commitment will be dependent on the progress the APN is making toward safe prescribing. The APN is able to write prescriptions within the APN's population focus independently during the mentorship period and the physician mentor is not required to sign off. Upon successful completion of the 1800-hour mentorship the mentor(s) will verify this completion in writing. The mentorship document must be retained for a period of three years by the APN and mentor(s) and should be available to the Medical Board from the physician mentor upon request.

Articulated plan

During the mentorship period, the APN and his/her mentor(s) must develop an articulated plan for safe prescribing. By law this document must include considerably more information than the collaborative agreement about how the APN will safely prescribe. At a minimum, the articulated plan must detail:

- A mechanism for consultation and referral with physicians and other health care providers for issues regarding prescribing. Such resources could include designated physicians or APNs (employer or otherwise, primary care or specialty), medical facility director, pharmacists, local or state health department, poison control centers, etc.
- A quality assurance plan for evaluating the efficacy and quality of the APN's prescribing practices. Potential approaches to the quality assurance plan include peer review, periodic chart audits, prescription audits, use of an electronic decision support system and utilization review. The NPATCH developed a lengthy list of resources for additional support, including P&T committees, poly-pharmacy committees, hospital QI initiatives and guidelines from state and national organizations.
- Decision support tools that will help the APN make (in the words of the rule defining the plans) "appropriate judgments regarding safe prescribing." Examples include electronic prescribing databases, evidenced-based guidelines, antimicrobial reference guides, professional journals and textbooks. Again, NPATCH members have identified a number of specific resources for consultation, some specific to certain specialties (e.g., pediatrics, mental health) and others of a more general nature.
- Documentation of ongoing continuing education in pharmacology

and safe prescribing in programs with content relevant to the APN's prescribing practice.

APNs must review and update their articulated plans annually. Physicians are not required to participate in this review, although we strongly encourage our colleagues who help to develop the articulated plans and serve as resources to their APN colleagues to offer their insight and suggestions for this annual review.

Physicians need to participate

The articulated plan approach creates new opportunities for physicians to train and guide advanced practice nurses who prescribe. We strongly encourage all of our colleagues to participate. APNs relocating to Colorado and those just completing their graduate training need physicians to act as preceptors and mentors and help develop their articulated plans. Physicians must offer their services in order for this new and improved model to work.

CMS will create a database of physicians willing to participate in articulated plans. If you'd like to be included, please contact Edie Sonn, senior director of public affairs, at (720) 858-6327 or edie_sonn@cms.org.

If you have questions about the articulated plan model or the NPATCH, please feel free to contact any of us: Luke Casias, MD, lmcasias@hotmail.com, Steve Holt, MD, steven.holt@healthonecares.com, or Sue Townsend, MD, sue_townsend@pediatrix.com.

Luke Casias, MD is a family physician from Hesperus. Steven Holt, MD is an OB-GYN from Denver. Sue Townsend, MD is a neonatologist from Colorado Springs. These three physicians sit on the Nurse-Physician Advisory Task Force for Colorado Health Care and also participated in the DORA Workgroup that developed the articulated plan model. ■

Reviewing peer review

Physicians have opportunity to reinvent peer review in Colorado

Edie Sonn, Senior Director, Public Affairs Division

A key component of this year's Medical Practice Act sunset bill was a provision requiring a "sunset" review of Colorado's peer review statute. CMS advocated for updates to the statute, and we will recommend a variety of changes to lawmakers.

It's important to recognize that, despite its connotations, "sunset" does not mean that a law will be taken off the books, although that does occasionally happen. The purpose of a sunset review is to determine if a given statute still meets the need for which it was developed. If the need and circumstances have changed, then how should the law be adapted to this new environment?

Accordingly, the Department of Regulatory Agencies (DORA) will spend the next year interviewing stakeholders for input on whether and how the peer review statute should be modified. DORA will report its recommendations to lawmakers in the fall of 2011, and legislative changes will be offered in 2012.

The CMS Ad Hoc Workgroup on Patient Safety and Professional Accountability has created a multi-specialty subcommittee to develop physician recommendations on peer review. A logical starting point for their work will be: If we were to create a professional accountability structure from scratch, what would it look like? How could it better serve both physicians and patients?

The subcommittee will take into account the recommendations we provided to DORA last year. These include standardizing processes and definitions, exploring the creation of independent peer review structures rather than relying solely on in-house committees, enhancing protections for peer review records, harmonizing state and federal peer/quality review laws, and more. We expect the subcommittee will also analyze other ideas that have been floated. For example, some institutions in other states include patient advocates on peer review committees. Is there interest in doing that in Colorado? What other changes are necessary before we could take that step?

The subcommittee's recommendations will be vetted through the entire Ad Hoc Workgroup, the Council on Legislation and the CMS Board. We will ensure ample opportunity for input from members and will keep you updated in these pages and through your component and specialty societies.

If you have questions or comments as we embark on this journey, please contact Edie Sonn, senior director, Division of Public Affairs, (720) 858-6327, edie_sonn@cms.org. ■

Continued competency requirements for maintenance of licensure:

A cornerstone of CMS' patient safety initiatives

Mark Laitos, MD, CMS President

Professional accountability is an indispensable piece of CMS' efforts to make Colorado the safest state in the country for patients. As we seek new ways to address adverse medical events – instead of relying on the broken litigation system – it is imperative that we physicians demonstrate our own commitment to continuous improvement.

As a result, CMS is working to develop a meaningful approach to assessing physician proficiency as part of state licensure. Our Ad Hoc Workgroup on Patient Safety and Professional Accountability has established a subcommittee on "maintenance of licensure" (MOL). This committee will craft recommendations for a program that would likely take effect with your 2015 license renewal.

Our vision for "maintenance of licensure" (MOL) standards is not to simply record continuing medical education (CME) credits. Indeed, Colorado's medical board determined years ago that simply obtaining CME hours does not demonstrate competency, or necessarily improve the quality of care to patients. As a result, the board eliminated the earlier CME requirement for license renewals. Colorado is now one of only five states with no such requirement.

Instead, CMS envisions a system in which physicians will be required to document their participation in ongoing professional development activities for license renewal or reinstatement.

The majority of Colorado physicians are board certified. We expect that those physicians would, for the most part, be deemed to have met MOL requirements by virtue of maintaining current certification by their specialty board. Those of you who regularly renew your board certification certainly know the time-consuming, rigorous and comprehensive nature of those renewals!

A number of board-certified physicians have lifetime certification and our MOL subcommittee will explore appropriate ways for those physicians to demonstrate their ongoing commitment to professional development.

We will also identify performance assessment options for physicians who are not board certified. These may include relevant CME, self-assessment, assessment by clinical peers (e.g., chart reviews) and performance improvement activities as necessary. We'll also explore appropriate options for physicians in administrative practice.

As the subcommittee develops its recommendations, its members will work with staff from the Colorado Department of Regulatory Agencies (DORA), which oversees the Medical Board. We'll also refer to a framework developed over the last seven years by the Federation of State Medical Boards (FSMB). Colorado's chief medical officer, Ned Calonge, MD, participated in that process.

The FSMB's guiding principles for MOL dovetail with CMS' view and approach. For example, FSMB concludes that MOL should facilitate improvement in physician practice and balance transparency with privacy protections; they recommend that an MOL infrastructure must be flexible and offer choices for meeting requirements.

Along with the FSMB, medical organizations including the American Board of Medical Specialties, the Accreditation Council for CME, the American Osteopathic Association, the Accreditation Council for Graduate Medical Education and the AMA have been working diligently and collaboratively to develop professional standards, educational programs and practice improvement strategies to ensure ongoing physician competence in a way that makes a difference in patient care and safety. CMS' efforts to develop an MOL structure that works for Colorado's patients and physicians will test-drive those concepts.

Our MOL subcommittee will seek member input throughout its work and educate physicians about the new expectations we will be asked to meet. You can expect to read more details in upcoming issues of *Colorado Medicine*, and also hear directly from us in meetings and presentations. We intend to promote quality health care and improve patient safety through a licensing framework that will enhance the profession of medicine and build public trust. ■

CMSOnline
www.cms.org

HIT: The time is now

Federal incentives for electronic health records, CO-REC free assistance program and statewide health information exchange plan are ready: Are you?

Sara Burnett, CMS Health Care Research/Project Specialist

Last month, the federal government released final rules for its electronic health record (EHR) incentive program, spelling out just what physicians must do to receive payments in 2011 and 2012. The Colorado Regional Extension Center (CO-REC) officially began assisting qualifying practices to achieve "meaningful use" of health information technology (HIT). And local and national health care leaders called on physicians to act.

"The time is right to do things differently," Joan Henneberry, executive director of Colorado's Department of Health Care Policy and Finance, told a group of more than 200 at a summit organized by CORHIO, the state-designated entity for health information exchange (HIE). David Blumenthal, the national coordinator for health information technology at the Department of Health and Human Services, called widespread use of EHRs and HIE inevitable, and urged physicians to take advantage of the federal incentive money while it's available.

"There is up to $27 billion (in federal incentive funds) on the table, ready to help physicians that have come to the conclusion that their future is electronic," said Blumenthal, who appeared at the CORHIO event via live video feed from Washington, D.C. "Who's going to help you pay for this in 10 years?" he asked.

It won't be the government. Incentive funds of up to $44,000 or $63,500 per physician, depending on the program, are available only for the next few years.

To qualify for the full amount, a physician must demonstrate meaningful use by Oct. 1, 2012. After that date, the maximum payment gets smaller each year. Physicians who can't demonstrate meaningful use of HIT by 2015 will lose a portion of their Medicare payments, and that penalty will increase each year.

Meaningful use

The EHR incentive fund program was part of the federal stimulus bill signed into law in early 2009. The program provides money to physicians and other eligible providers who demonstrate "meaningful use" of a certified EHR.

The final rule released last month states that physicians and other eligible providers may begin signing up for the program in January 2011. The first payments, for the Medicare incentive program, will be issued to qualifying physicians in mid-May 2011.

To get that first payment, physicians must demonstrate meaningful use for 90 days. (To receive a payment in 2012, physicians must demonstrate meaningful use for a full 12 months).

The rule released in July makes clear that just implementing an EHR isn't enough. Physicians must also attest or otherwise demonstrate that they are using the EHR to improve quality, safety and efficiency. The rule requires physicians to meet a series of 20 objectives, and to report at least six clinical quality measures, in order to demonstrate meaningful use.

For 2011 and 2012, there is a "core set" of 15 objectives that all physicians must meet. In addition, physicians may

Additional HIT Resources

CMS/Component Societies' HIT Web site:
http://cms.org/HIT/1HITHome.html

CO-REC:
720-285-3245
www.co-rec.org

CORHIO:
www.corhio.org

choose five additional objectives from a list of 10 "menu set" objectives. For the clinical quality measures, all physicians must report three core measures. They must also report three additional measures of their choosing.

A full list of the objectives and clinical quality measures is available on the CMS/Component Societies' HIT Web site: http://cms.org/HIT/1HITHome.html.

Help has arrived

Colorado Medical Society and the component medical societies are working closely with CORHIO and the CO-REC to help physicians prepare for and make decisions about HIT and HIE.

CO-REC received federal grant funding to help physicians and other eligible providers reach meaningful use. Their services include free project management provided by staff from several CO-REC partners, including the Colorado Foundation for Medical Care, Health TeamWorks and Physician Health Partners (PHP). These providers work with practices to determine if they are ready for HIT, to select an EHR if they do not have one, and to work with them to reach meaningful use.

Last month Suman Morarka, MD, became one of the first Colorado physicians to take advantage of CO-REC services.

"(HIT) is coming," said Morarka, a member of the CMS Board of Directors. "I think (the EHR) will be more efficient. It will reduce errors and questions about prescriptions. I think it will save me time."

Dr. Morarka had been eagerly awaiting the final rule on meaningful use so she could begin working with CO-REC to select and implement an EHR. Because she is a member of PHP's Colorado Pediatric Partners IPA, a PHP staff member is serving as her CO-REC provider.

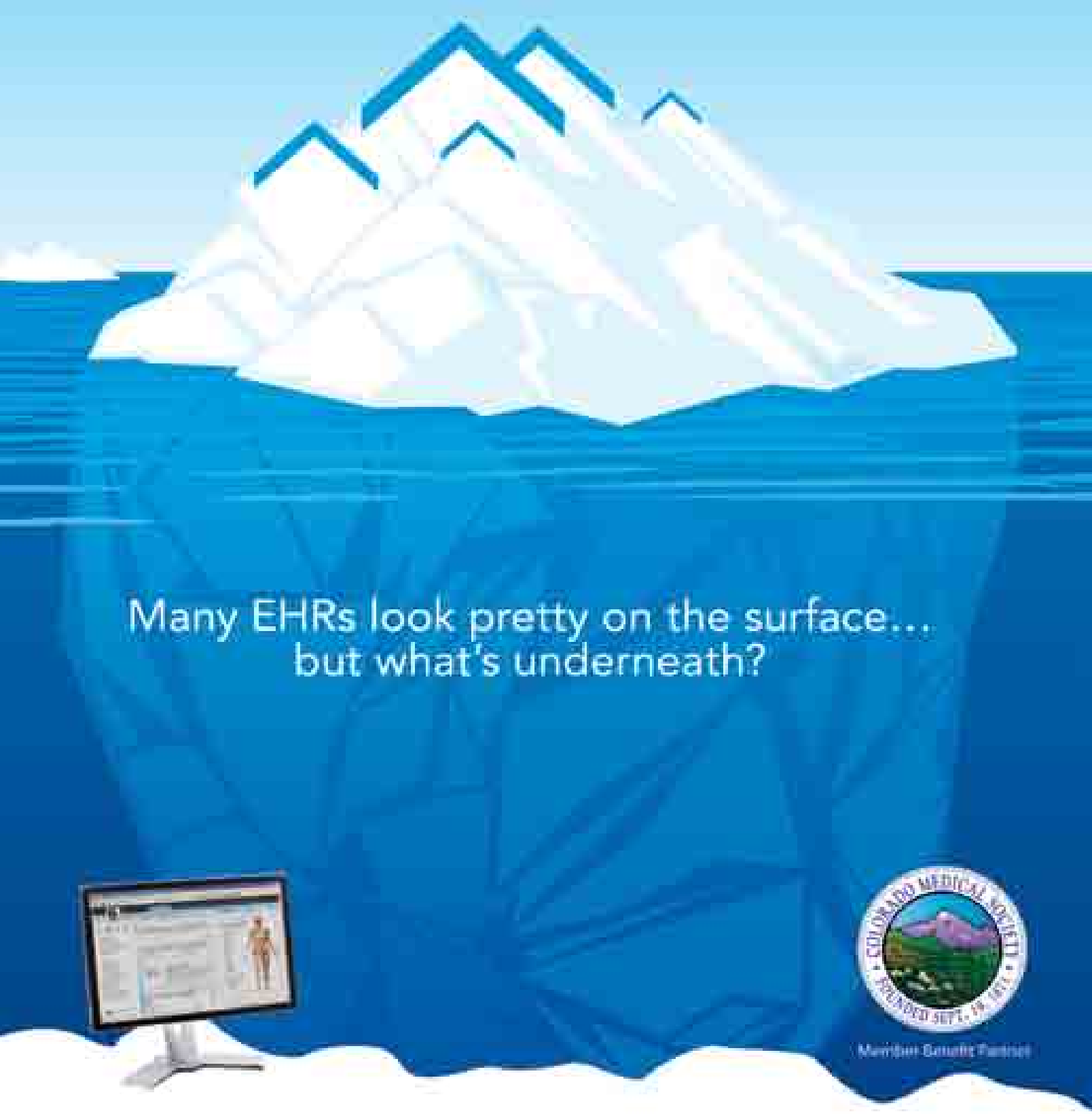
"I need somebody who is an expert in this technology and who can be on my side," Morarka added. "They are doing it at no cost. There is no downside."

At this point, CO-REC services are free for "priority primary care providers," or primary care physicians (including OB-GYN) in small practices. They are striving to assist 2,295 primary care providers to achieve meaningful use by February 2012. CO-REC hopes to have the capacity to work with specialists and larger primary care providers around the middle of 2011.

Suman Morarka, MD, (center), and her staff members Yanet Calzontzi and Julie MacDonnell (left) are working with PHP staff Glenn Smith and Britta Fuglevand (right) to implement HIT.

"CO-REC and its six partner organizations provide the needed hands-on, field support for primary care providers in Colorado to advance the rapid adoption and use of health IT," said Robyn Leone, director of CO-REC. "CO-REC services launched last month and having the final rule for meaningful use will help us assist small, primary care practices to achieve meaningful use and access federal stimulus funds as soon as possible. Colorado health care providers are poised to make rapid advancements in the adoption of electronic health records and health information exchange, and we are excited to be part of helping them improve patient care and get to meaningful use."

Meanwhile CMS and the component societies continue to work with CO-REC and CORHIO to provide tools for physicians and their staff, regardless of practice type. Look for more information online and in future issues of *Colorado Medicine*. ■



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CTN working to fix frustrating communication difficulties in rural communities

Sara Burnett, CMS Health Care Research/Project Specialist

At one rural Colorado hospital, sending an X-ray to a specialist electronically is an all-staff endeavor.

Because the radiology data is sent over a shared fiber-optic line, the speed at which it can be transported ebbs and flows depending on how many people are using the system, and what they're doing. So before an X-ray can be sent, everyone in the hospital must disconnect from the Internet.

"Even then, it takes 45 minutes to send that data 40 miles," said Steve Ward, executive director of the Colorado Telehealth Network.

It's not exactly the kind of value and efficiency we envision in the new world of health information technology. But particularly in rural communities where technology infrastructure is still catching up to the rest of the state, it's often the reality.

Colorado Telehealth Network (CTN) is working to fix that.

CTN is a high-speed, virtual private network that is a faster, more secure alternative to the commodity Internet, or the Internet used by the general public. Because it is dedicated exclusively to use by its members, it will facilitate innovations such as high-definition virtual consults and around-the-clock video conferencing between rural health care professionals and others across Colorado.

"CTN will enable Coloradans to receive top quality care no matter where they are in the state," said Steven J. Summer, president and CEO of the Colorado Hospital Association (CHA). "Geography becomes irrelevant as physicians will be able to interact face-to-face."

CTN also has benefits for physicians, health care facilities and patients in urban and suburban areas, Ward said.

How it works

CTN is managed by the Colorado Hospital Association and is a collaborative venture between CHA and Colorado Behavioral Healthcare Council. The $34 million project is funded in part by awards from the Federal Communications Commission (FCC). In 2007, both CHA and CBHC received awards worth a combined $9.8 million to expand broadband and telemedicine/telehealth access to rural areas. Earlier this year, CTN received another $10 million grant from the FCC's Rural Health Care Pilot Program.

CTN is not a health information exchange (HIE). In Colorado, HIE is being facilitated by CORHIO, the Colorado Regional Health Information Organization. CORHIO is working with Medicity, a Salt Lake City-based technology company, to connect local practices, hospitals, labs and other providers at the community level to the statewide HIE.

It is technology from CORHIO and Medicity that will enable the transfer of information from one physician's electronic health record (EHR) system to an EHR at a hospital, another physician's office, or other health care facility on the HIE.

It is up to physicians to determine if they want to send that information using the practice's existing Internet connection, or using CTN.

This summer, CTN began deployment to connect 200 "anchor" facilities – largely hospitals and clinics – and another approximately 180 health care provider facilities across Colorado. When fully deployed, it will be among the largest health care information networks in the United States.

Benefit to physicians

Private physician practices may choose to use CTN to transmit information for several reasons, Ward said.

CTN will provide physician offices with the same quality of service it is now establishing in facilities. Because it is a virtual private network, it is more secure than commodity Internet, he said.

Also, CTN allows users to prioritize bandwidth. For example on commodity Internet, if a physician is sending an image electronically, the speed at which it is sent and the quality of the image may be affected based on the number of users on the system. On a medical-grade virtual private network such as CTN, the physician could assign that critical task a "priority one," meaning the bandwidth to send the image would be reserved and anyone else using the connection would not affect it.

Ward said the annual or monthly fee to use CTN has not yet been determined, but should be similar to a cable TV bill.

CTN also is working to offer additional services that still are in development. Questions? Email steve.ward@cha.com. ■

Connecting Care in Colorado

New Connected Care program brings advanced telehealth technology to rural parts of Colorado

Christopher Stanley, MD, and Gary S. Campbell, FACHE

Residents in four rural counties in Colorado are now among the first in the nation to experience a groundbreaking telehealth initiative called Connected Care. The program improves access to health care in Colorado by connecting patients in rural areas with primary and specialty physicians in suburban and urban locations hundreds of miles away via high-definition virtual visits.

Connected Care was launched this spring as a result of a unique collaboration between UnitedHealthcare, Centura Health and the state of Colorado. Nonprofit organizations Colorado Rural Health Center and Colorado Community Health Network also assisted in helping choose the best locations to start this exciting program. In addition, the services provided are among the first available through the Colorado Telehealth Network, a statewide fiber-optic network that will eventually connect more than 400 hospitals, clinics and other health care providers in Colorado.

Together, our goal is to improve access to quality health care regardless of geography, and to advance the efficiency and effectiveness of health care throughout the state. Connected Care eliminates the need for patients or doctors to travel long distances for in-person visits. The program also helps health care providers in rural areas and participating specialists to expand their practices, engage new patients and enhance their revenue stream.

As many as 4,800 patient visits are expected to be made each year in Colorado via Connected Care, which has been installed at the following locations: Buena Vista Family Practice in Buena Vista; High Plains Community Health Center in Lamar; St. Vincent General Hospital in Leadville; and Rio Grande Hospital in Del Norte. Each of these facilities has been outfitted with sophisticated audio and video equipment, including high-definition TV screens, plus an array of medical instruments such as digital scopes, cameras and monitors. The sites are staffed by an in-person health care professional such as a nurse or medical attendant who help to ensure coordinated and personal care for visiting patients.

Connected Care is open to anyone. Many health insurers, including UnitedHealthcare, offer coverage for telehealth services such as those offered by Connected Care. Medicaid and Medicare health plans also cover some telehealth services such as follow-up care after an in-patient hospital stay or on-going consultations after a cardiac procedure.

Patients in these rural locations will be connected to Centura Health's medical specialists located at three Front Range medical facilities: St. Anthony Central in Denver, Littleton Adventist Hospital in Littleton and St. Mary Corwin Medical Center in Pueblo. Like the rural sites, these provider facilities also have been equipped with the Connected Care audio and video technology.

Patients can schedule an exam by phone or in person at one of the rural Connected Care locations. During the exam, the Centura Health physician can see and interact with the patient much the same way as an in-person visit. While the doctor and the patient may be hundreds of miles apart, they can both see each other as well as have access to live patient data such as vital signs, images from exam cameras and scopes, and hearing audio from the stethoscope.

Currently, Connected Care offers access to several specialty areas including ear/nose/throat (ENT), gastroenterology, cardiology, critical care/pulmonology, neurosurgery, and pre- and post-surgery consultations.

In addition to expanding access to specialist care for residents of rural communities, Connected Care also has begun to unlock new possibilities for how physicians and medical staff interact with patients. For instance, Connected Care allows patients to have simultaneous group video consultations with multiple physicians who are in different locations. This can eliminate the need for the patient to set up multiple appointments or follow up exams to see more than one physician. Furthermore, it allows for more collaborative diagnostic exams that can reduce time and expense for both physicians and patients.

Through various collaborations, UnitedHealthcare is seeking to develop a national Connected Care network that will connect scores of physicians and hospitals with patients in rural and underserved areas. Furthermore, while telehealth clinics have already begun to be available in the workplace and retail locations, we believe similar technology can make in-home telehealth doctor visits a reality in the near future.

More details on Connected Care and the Colorado program can be found at www.Centura.org or www.ConnectedCareAmerica.com.

Christopher Stanley, MD, is senior medical director for UnitedHealthcare of Colorado. Gary S. Campbell, FACHE, is president and CEO of Centura Health. ■

A NEW CONVERSATION ABOUT LACTOSE INTOLERANCE

Help Your Patients Enjoy Dairy Again

Most people with lactose intolerance say they are open to dairy solutions as long as they can avoid the discomfort associated with consuming them.[7]

And research shows that people like lactose-free milk more than non-dairy alternatives.[8]

Many health authorities agree that low-fat and fat-free milk and milk products are an important and practical source of key nutrients for all people – including those who are lactose intolerant.[1,2,3,4,5,6]

It's valuable for health and nutrition professionals to encourage and educate individuals with lactose intolerance to consume dairy foods first, before non-dairy options, to help meet key nutrient recommendations.

A Solutions-Focused Approach

People who are lactose intolerant should know that when it comes to dairy foods, practical solutions can help them enjoy the recommended three servings of low-fat and fat-free dairy foods every day*, without experiencing discomfort or embarrassment:

- *Gradually reintroducing milk back into the diet by trying small amounts of it with food or cooking with it.*
- *Try drinking lactose-free milk, which is real milk just without the lactose, tastes great and has all the nutrients you'd expect from milk.*
- *Eating natural cheeses, which are generally low in lactose, and yogurt with live and active cultures, which can help the body digest lactose.*

Visit *nationaldairycouncil.org* for more information, management strategies and patient education materials.

NATIONAL DAIRY COUNCIL®

These health and nutrition organizations support 3-Every-Day™ of Dairy, a science-based education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products, to help improve overall health.

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STRONG MEDICINE FOR AMERICA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

eat right. American Dietetic Association

NHMA National Hispanic Medical Association

National Medical Association

1 U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2005. 6th Edition, Washington, DC: U.S. Government Printing Office, January 2005.

2 National Institutes of Health Consensus Development Conference Statement. NIH Consensus Development Conference: Lactose Intolerance and Health. Draft statement, issued at 7:47 p.m. ET on February 24, 2010. http://consensus.nih.gov/2010/images/lactose/lactose_draftstatement.pdf

3 American Academy of Pediatrics, Lactose intolerance in infants, children, and adolescents. Pediatrics. 2006; 118 (3):1279-1286.

4 USDA, FNS. Special Supplemental Nutrition Program for Women, Infants and Children: Revisions in the WIC Food Package, Interim Rule; 7 CFR, Part 246.

5 National Medical Association. Lactose Intolerance and African Americans: Implications for the Consumption of Appropriate Intake Levels of Key Nutrients. Journal of the National Medical Association. Supplement to October 2009; Volume 101, No. 10.

6 Wooten, WJ and Price, W. Consensus Report of the Nationals Medical Association: The Role of Dairy and Dairy Nutrients in the Diet of African Americans. Journal of the National Medical Association 2004; 96:1S-31S.

7 NPD Group. Fluid Milk Concept Test for Dairy Management Inc. November, 2007.

8 Palacios OM, et al. Consumer Acceptance of Cow's Milk Versus Soy Beverages: Impact of Ethnicity, Lactose Tolerance And Sensory Preference Segmentation. Journal of Sensory Studies, 2009; 24:5.

* The *2005 Dietary Guidelines for Americans* recommend 3 servings for individuals 9 years and older, and 2 servings for children 2-8 yrs.

PROMETHEUS PROJECT Payment Reform

HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE INC

Janet Seeley, MD, Larimer County Medical Society and Robert J. Smith, MBA, Colorado Business Group on Health

Time to be involved in payment reform: Reinforcing the patient-physician relationship

Against the backdrop of national reform and continuing concerns over the quality and cost of U.S. health care, a question is being raised: Should physicians consider embracing – perhaps even promoting – payment reform? In particular, should they embrace "bundled episodes of care" or "case-rates," the dominant model being nationally evaluated by numerous payers including the Centers for Medicare and Medicaid?

A local pilot project funded by the Colorado Health Foundation, administered by the Health Care Incentives Improvement Institute and supported by a coalition of physicians, businesses, health care organizations, Colorado Medical Society and the Center for Improving Value in Health Care, intends to find out how such a system might work in Colorado.

Standard for weighing options

To consider this question, let's remember that payment mechanisms represent tools. As with any other tools, they should be selected based on the objective at hand – on the purpose that is to be served. What purpose should a health care payment mechanism serve?

We propose that mechanism should constructively support what we believe to be the very nexus of the health care system: the patient-physician relationship. No other focus seems more central to the ideals of medicine.

Considering the alternatives

Let's begin with what we know. Over the last several decades, private-practice physicians have had painful experiences with the two major reimbursement systems.

- Fee-for-service: In terms of its tendency to generate quality waste – the overuse of some services, the underuse of other services, and the misuse of yet other services – fee-for-service reimbursement is proving to be toxic. It is particularly damaging as purchasers rely on discounting fees schedules to compensate for the ineffectiveness of third-party medical management.

- Capitation: We consider capitation inappropriate for two reasons. First, it unreasonably foists insurance risk upon physicians. Second, it completely ignores the standards of effective, evidence-informed standards. (Capitation's standards are actuarially – not clinically – based and meant to serve the insurer, not the patient.)

Patient-centered payment

As an alternative to the above, a mechanism for organizing care around patients and their specific needs is being actively evaluated by representative employers, payers, physicians and governmental groups. "Evidence-informed case rates" or ECRs, developed by the Prometheus payment project, would make a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings.

Case rates clearly delineate and disassociate the roles of payers and providers by assuming that insurers should bear probability risk (likelihood of the patient developing a medical problem) and providers should bear the technical risk (likelihood of adverse event) of delivering care. When properly constructed along clinical guidelines based on the best available evidence, case rates can inform the patient care process both with regard to efficacy and efficiency of care.

Potential advantages

What advantages accrue when we delineate and separate insurance risk from the financial risk of organizing and delivering care? Although there are others, we think these are the top three:

1. Autonomy/Integrity of practice: Once physicians assume technical risk through global fees for patient-centered episodes of care, the reasons evaporate for insurers to meddle in the provision of care. The design and content of patient care plans will become the absolute purview of the medical community in partnership with their patients. Alternatively, if providers, hospitals and doctors don't

learn how to do this, insurers and the government have no alternative but to impose external bureaucratic management and regulations.

2. Quality of care: The feedback loops needed to allow physicians to pursue their mission of providing the highest quality of care are universally lacking in either the fee-for-service or capitated environment. When providers report the best practice measures they are tracking on their patients, the episodes of care system reports the results of the care plan back to providers. This closes the loop, providing data that providers need to continuously improve patient care.

3. Savings capture/managing margins: Case rates would allow potentially significant savings associated with the efficient management of episodes of care and reduction of potentially avoidable complications to be shared with provider organizations. For insured commercial populations, various studies have estimated the waste associated with such complications to be 25-40 percent of the medical expense.

Universal standard, not elixir

Pending further analysis of actual PAC rates for the state of Colorado, which are forthcoming this autumn, case rates seem more promising for more physicians than either fee-for-service or capitation. While no payment mechanism is likely to benefit all physicians, ECRs do hold promise for universally reinforcing the patient-physician relationship overall – particularly for high cost or ongoing cases.

We should have the opportunity to learn more in the near future since there are several medical communities in Colorado interested in "test driving" an ECR bundled case rate system. If you would like to learn more about or participate in this project please visit www.hci3.org. ■

[1] Smith, Robert. "Health Care Incentive Payment Pilot Seeks Savings Through Payment Reform," Colorado Medicine, March/April 2010, page 28-29.

[2] See "Bundled Payment: What is it?" published on RAND Health COMPARE (http://www.randcom-

LEGAL UPDATE

Kari M. Hershey
Hershey Skinner, LLC
legal counsel to the Colorado Medical Society

Timely articles of medically-related news of immediate interest to the physician community

This just isn't working out: discharging a patient of the practice

It happens every now and then, physicians find themselves providing care to a patient and it's just not working out. The reasons vary from non-compliance, abusiveness to staff, non-payment of bills, or insurance coverage that the practice no longer wishes to accept. Regardless of the reason, the end result is the same – the relationship must terminate. When, why, and how the relationship ends can make the difference between an amicable separation and the potential for legal or regulatory action.

When should physicians terminate the physician-patient relationship?

Conflicts

The physician-patient relationship must terminate whenever a conflict arises that is likely to impact the provision of care. The difficulty is determining when such a conflict arises – in other words, when the relationship has passed the point of no return.

Certainly, some days are better than others in all relationships and physician-patient relationships are no exception. Physicians regularly talk to patients about unpleasant realities and each patient responds to such information differently. More often than not, these difficult conversations lead to a focused plan for dealing with a patient's health needs. Sometimes, however, a patient refuses to acknowledge information provided, responds in an abusive manner to the physician or staff, or is simply non-compliant. An isolated incident is one thing, an ongoing pattern is another.

One key consideration is deterioration of trust. For example, when a physician suspects a patient is malingering or drug seeking; or the patient lacks confidence in the physician.

Perhaps most difficult, is assessing the impact of outside factors. A physician may have a difficult time providing objective care to a patient who is covered by the insurance carrier who is investigating him, the friend of a patient who is suing him, or a close personal friend or family member. The bottom line is that if a physician's personal or professional feelings interfere with objective assessment or treatment of the patient, the relationship must terminate.

Payor issues

Additionally, physician decisions about accepting assignment from certain payors can trigger the need to review appropriate discharge of patients from a practice. Third party payors are increasingly making material changes to provider participation agreements. Such changes affect reimbursement rates, the types of providers who can provide services, and the care that will be covered. These changes have led some physicians to consider limiting the payor plans with which they will participate or limiting the number of patients they will accept from various payors.

Although most providers simply close their practice to new patients who have the insurance at issue, some providers may decide not to care for patients with a particular insurance plan altogether. In that case proper discharge processes for existing patients must be followed.

Severing the relationship

Deciding that any given patient or payor relationship is no longer productive is only the beginning. Prohibitions on patient "abandonment" restrict a physician's ability to immediately terminate a physician-patient relationship.

Additionally, physicians may not refuse to treat a patient for a discriminatory reason. For example, federal and state law prohibits discrimination based on race, religion, sex, national origin, disability, and age. Moreover, some states prohibit discrimination based on sexual orientation. So, while a

physician may decide that she does not want to treat lawyers (not a protected class), she may not be able to refuse to treat someone because they are a particular religion. Moreover, physicians are generally not permitted to terminate a patient if the physician knows that no other health care provider is able to provide the patient care.

In Colorado, the Board of Medicine has outlined guidelines for proper termination of patients, including that the physician provide patients written notice delivered via certified mail that states:

- The intent to terminate the relationship and the length of time the physician will provide provisional coverage (15-30 days) to allow the patient time to find a new physician;
- Notification that the patient's records will be sent to the patient's new physician upon receipt of written authorization from the patient; and
- Referral information, if possible.[1]

The Board requires physicians to provide fifteen to thirty days of provisional coverage to discharged patients. During this time the physician must provide appropriate care, including refilling medications, attending to emergent health needs, and making appropriate referrals.

In providing referral information, physicians may want to refer to "find a doctor" resources on local hospital and payor We sites. Medicare also maintains a list of participating physicians on its Web site at www.medicare.gov.

In addition to Board guidelines, provider contracts may have added requirements, including contract termination and patient notice provisions. Accordingly, physicians should review any applicable contracts and should consider discussing the intent to discharge patients with the health plan administrator, to determine if special conditions apply. For example, Medicare providers typically have signed a Medicare Participating Physician or Supplier Agreement. Such agreements automatically renew each January 1 unless written notice of the intent to terminate at the end of the current term is mailed or delivered during the enrollment period provided near the end of any calendar year to TrailBlazer Health Enterprises, LLC. Medicare participating physicians seeking to terminate the agreement before year-end must file a written notice of intention to terminate the agreement with the Secretary, who may accept the termination date or may set a different date within six months from the date the provider's notice is filed.

Notifying staff

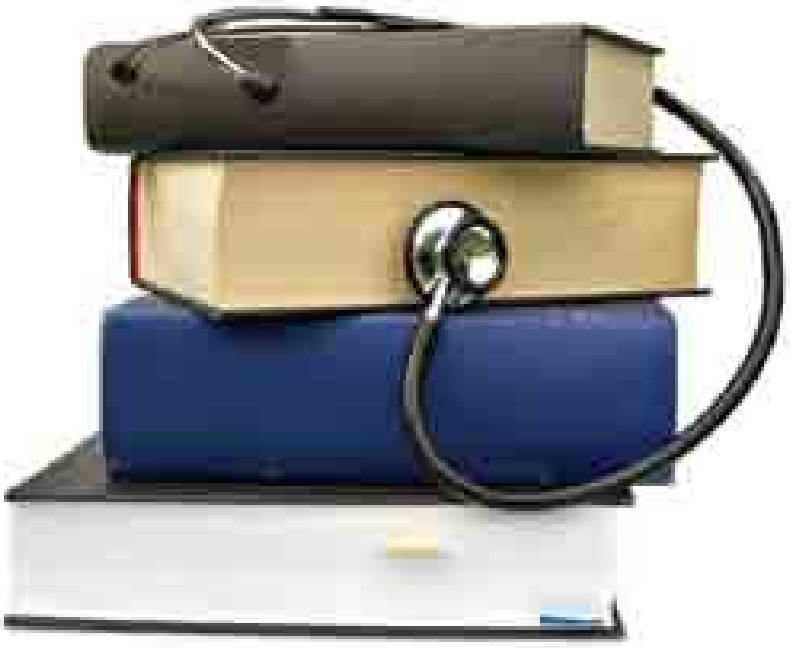
Because scheduling an appointment for a discharged patient may reestablish a physician-patient relationship, physicians must also notify key staff of all patient discharges. This will help prevent inadvertent scheduling of a discharged patient after the termination date.

Conclusion

The key to the proper discharge of a patient from a medical practice is adequate notice. This article summarizes basic steps to discharging a patient; however, individual contract requirements or unique patient situations may require additional precautions. Accordingly, if you have a question about whether discharge is appropriate in a specific situation, consult an attorney. ■

[1]*Board of Medicine Policy 40-2*

Changes in the medical student component



Tyler Miller, MS and Sarah Michael, MS

The Colorado Medical Society is in the middle of a growth spurt. The Medical Student Component, which makes up about twelve percent of the total CMS membership, is in the process of doubling in size, thanks to the addition of Rocky Vista University College of Osteopathic Medicine. The first class at RVU matriculated in the fall of 2008 and immediately formed a group of committed students eager to be involved with CMS, AMA and the world of organized medicine. Over the next two years, the institution will grow to enroll the same number of students as the University of Colorado School of Medicine. As CMS has traditionally granted membership and waived dues to every medical student in the state, this change will result in a doubling of student membership in our medical society.

Perhaps more important than the increase in membership is the fact that the activity and involvement of the student component as a whole has grown substantially over the past few years as well. At both CU and RVU, the number of students serving in chapter leadership positions has increased during each of the past three years. Students have become a regular and welcome voice on the Board of Directors and within the Council on Legislation. We have been increasingly politically active on medical and higher education issues within the state, writing letters to our representatives and actively lobbying with CMS's legislative team at the Capitol. We are improving our community outreach with the student component's third annual Health Action Conference planned for this fall. In addition, any CMS member who has attended a recent Annual Meeting has likely noticed the high turnout and enthusiasm brought by the student section to these gatherings.

In addition to these positive changes, the students and CMS leadership have been having an ongoing discussion about how to optimize the student component's role within CMS. These conversations have focused on two main areas: 1) How to effectively balance student representation in CMS and 2) How to further strengthen involvement of students, as well as residents and young physicians, within CMS. The student component in conjunction with Dr. Laitos and other CMS leaders have drafted a resolution to be brought forth at the House of Delegates this fall that addresses these two areas:

First, because medical students are automatically enrolled in CMS, our membership rate is 100 percent, far higher than that of most component societies. Automatic enrollment has been critical in fostering student involvement in the organization in the past years and should undoubtedly continue. Yet in the context of the Annual Meeting's House of Delegates it gives us disproportionately high representation compared to other component societies and thus a disproportionately powerful voice in deciding CMS policy, especially now that our numbers are doubling. To address this issue, we have decided to voluntarily restrict our number of votes in the House of Delegates to not exceed that of the largest non-student component – a measure that will effectively hold our representation near current levels. Given the inherently delicate nature of any discussion involving political representation, a variety of perspectives have been taken into consideration in coming up with this compromise. On one hand, students recognize that we often have less experience dealing with the realities of managing a practice. On the other hand, CMS leadership has often pointed out that students have the most practice-years ahead of us and thus the most at stake when the greater membership of CMS comes to a particular decision. The physicians of CMS have an exceptional track record of fostering student involvement in organized medicine and will no doubt continue to do so, but it is important to us that all CMS physicians feel we have an equitable and appreciated voice within the organization.

The second, more substantive, change we are hoping to make is the forma-

tion of an advisory board for the student component. As the number of student leaders in CMS continues to grow with each class, we are hoping to further increase interaction between students, residents and practicing physicians. We are also hoping to provide a role for older students and residents with past experience in CMS to work with the first and second year students who comprise the lion's share of active members in the student component. Ideally, members of this board would be comprised of CMS leadership, physicians, residents and senior medical students, as well as a faculty advisor, all interested in working closely with students and furthering the goals of the student section. The board would help plan and participate in the events organized by the student section, such as our regular lunch lecture series on health policy issues, our annual Health Action Conference and immunization drive, lobbying activities, or just our informal beer and pizza get-togethers with CMS leadership and staff.

It has been an exhilarating experience to see our organization grow and mature over the past several years. Student involvement in organized medicine is perhaps stronger in Colorado than in any other state and helps provide medical students with a critical aspect of professional development not taught in the classroom. As we move forward, it is our sincere hope that the enthusiasm and strength of the student component continues to grow, further enriching the training and practice of medicine within our state.

If you are interested in being involved with the Student Advisory Board or the Medical Student Component, please contact tyler.miller@ucdenver.edu or CMS staff at genni_pearman@cms.org.

Tyler Miller is past Co-President of the CU Chapter of the CMS Medical Student Component and Sarah Michael is past Co-President of the Rocky Vista University College of Osteopathic Medicine Chapter. Both are third-year medical students. ■

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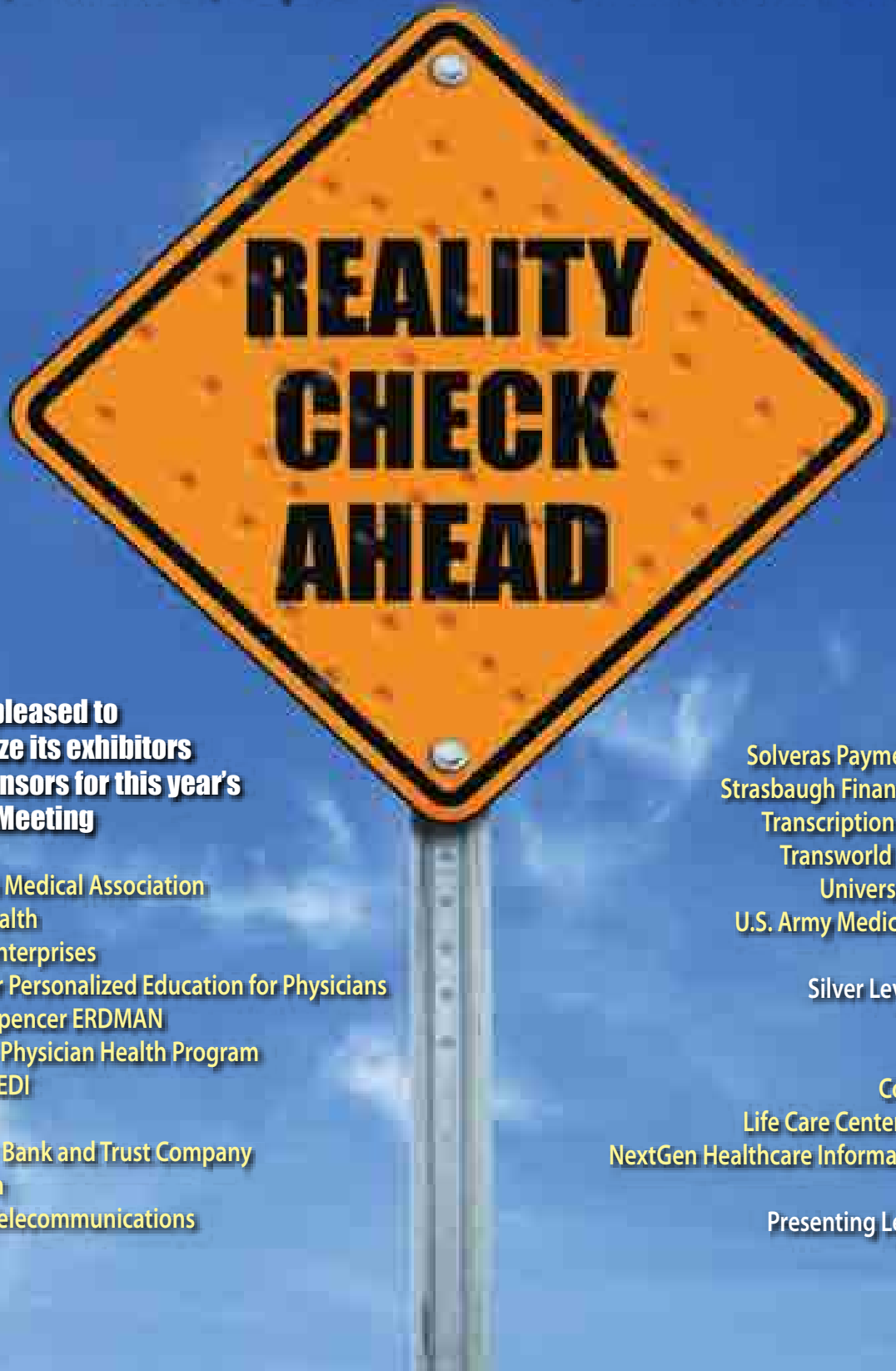
2010 CMS Annual Meeting

Vail, Colorado, September 9 –12, Vail Cascade Resort



CMS is pleased to recognize its exhibitors and sponsors for this year's Annual Meeting

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2010 CMS Annual Meeting agenda

Thursday, Sept. 9		Location
10:00 AM – 1:00 PM	Medical Executives Meeting	Blue Spruce
12:00 PM – 1:00 PM	Finance Committee	Aspen Boardroom
1:00 PM – 5:00 PM	Board of Directors	Rocky Mountain Boardroom
5:30 PM – 7:30 PM	Dinner on your own – Save dessert for the Welcome Reception	
7:00 PM – 9:00 PM	Registration Open	Cascade Foyer
7:30 PM – 9:00 PM	Welcome Reception (desserts, etc)	Cascade Ballroom

Friday, Sept. 10		Location
7:00 AM – 5:00 PM	Registration	Centennial Foyer
7:00 AM –11:00 AM	Exhibits open	Centennial Foyer
7:00 AM – 7:45 AM	New Delegate Orientation	Blue Spruce
7:00 AM – 7:45 AM	Reference Committees Breakfast/Credentials Committee	Juniper
7:00 AM – 7:45 AM	COMPAC Board	Primrose
8:00 AM – 8:50 AM	House of Delegates Opening Session • Opening of House • President's Speech • Nominees for Office (3 minutes each)	Centennial Ballroom
8:50 AM – 9:00 AM	Environmental Scan–Mike Pramenko, MD	Centennial Ballroom
9:00 AM –10:00 AM	CORHIO HIE/HIT–Mark Wallace, MD	Centennial Ballroom
10:00 AM –10:50 AM	Meet and Greet with Exhibitors	Centennial Foyer
10:50 AM –11:50 AM	Payment Reform: Center for Improving Value in Health Care Jay Want, MD, Chairman,, CVHC and Phil Kalin, CEO, CVHC	Centennial Ballroom
12:00 PM – 1:15 PM	AMA Luncheon: Colorado U.S. Senate Candidates (invited)	Cascade Ballroom
12:00 PM– 12:10 PM	Welcome/Introductions–Ray Painter, MD	
12:10 PM – 12:15 PM	Overview–Jeremy Lazarus, MD	
12:15 PM – 1:15 PM	Senate candidates	
1:20 PM – 3:10 PM	Reference Committee on Health Affairs	Centennial ABC
3:10 PM – 3:30 PM	Meet and Greet with Exhibitors	Centennial Foyer
3:30 PM – 5:30 PM	Reference Committee on Board of Directors	Centennial EF
6:00 PM – 7:30 PM	Reception with Exhibitors	Centennial Foyer
6:00 PM – 7:30 PM	Colorado Academy of Family Physicians	Blue Spruce
6:00 PM – 7:30 PM	Colorado Chapter of American College of Physicians	Juniper

Saturday, Sept. 11		Location
6:45 AM –12:00 PM	Registration open	Centennial Foyer
6:45 AM – 7:30 AM	Breakfast buffet	Centennial Foyer
6:45 AM – 8:00 AM	Past Presidents Forum	Blue Spruce
6:45 AM – 8:00 AM	Meet the Candidates Forum	Primrose

2010 CMS Annual Meeting agenda

Saturday, Sept. 11

		Location
6:45 AM – 8:00 AM	Patient Engagement Tools: A Patient Safety Focus Group	Juniper
8:00 AM – 8:30 AM	HealthTeamWorks (previously CCGC): The Importance of Tracking Quality– Marjorie Harbrecht, MD, Medical/Executive Director	Centennial Ballroom
8:30 AM – 9:00 AM	Primary Care Workforce in Crisis: How will Colorado address today's shortages and plan for the future? – Lou Ann Wilroy, CEO, Colorado Rural Health Center	Centennial Ballroom
9:00 AM –10:00 AM	Health Care Reform Reality Check Open Forum	Centennial Ballroom
10:00 AM –10:50 AM	Meet and Greet with Exhibitors	Centennial Foyer
10:00 AM –12:00 PM	Connection Membership & Board Meeting • 10:00–11:00–Pat Kletke, AMA Alliance National Director • 11:00–12:00–Membership & Board Meeting	Mountain View
11:00 AM – 12:00 PM	Patient Safety: Tim McDonald	Centennial Ballroom
12:00 PM – 12:15 PM	COMPAC Lunch: Welcome/Introductions–Alethia "Lee" Morgan, MD	Cascade Ballroom
12:15 PM – 1:25 PM	Gubernatorial candidates (invited)	
1:25 PM – 1:55 PM	Q&A/Wrap up	
2:00 PM – 5:00 PM	Medical Students	Mountain View
2:00 PM – 3:00 PM	COPIC Seminar	Primrose
3:00 PM – 4:00 PM	COPIC Seminar	Juniper
4:00 PM – 5:00 PM	COPIC Seminar	Larkspur
5:30 PM – 6:00 PM	The Inaugural Warm Up: Meet The Candidates	Centennial Foyer
6:00 PM –10:00 PM	Inaugural Gala	Centennial Ballroom
8:00 PM – 9:00 PM	COPIC Dessert Reception	Centennial Foyer

Sunday, Sept. 12

		Location
8:00 AM – 8:30 AM	Component Caucuses	
	ADEMS	Juniper
	Aurora-Adams	Rocky B
	Boulder	Rocky C
	Clear Creek Valley	Larkspur
	Denver	Rocky A
	El Paso County	Blue Spruce
	Larimer/Weld	Primrose
	Medical Students	Mountain View Room
	Pueblo/Western Slope	Rocky D
8:15 AM – 8:30 AM	Credentials Committee	Back of Centennial Ballroom
8:30 AM –12:00 PM	Closing Session HOD	Centennial Ballroom
9:00 AM –10:00 AM	Connection Walk for Health	Meet in hotel lobby

Annual Meeting Registration

Annual Meeting of the Colorado Medical Society/Connection
Vail Cascade & Conference Center, Vail • September 9-12, 2010

Name (please print) _____

Component Society _____

Name of Spouse/Guest(s)_____

CMS Connection Member ❑ **Yes** ❑ **No** ❑ **My physician spouse will not attend, please send handbook to my attention**

If you are not a member of CMS, please provide the following information and $125 for registration fees:

Company/Organization _____ **Title** _____

Registration deadline is August 26, 2010. Registrations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, **Connection members and staff of county medical societies are considered members**. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

Complimentary Events for CMS or Connection Member & Spouse/Guest

Except for the COMPAC Luncheon, you and one guest are entitled to attend all events at no charge.
To confirm your reservation, use the boxes below for yourself and one guest and the shaded area for additional guests.

Thursday, September 9		member	spouse/guest
7:30 pm	Welcome Reception	❑	❑

Friday, September 10		member	spouse/guest
12:00 pm	AMA Forum Lunch	❑	❑
		Meat ❑	Vegetarian ❑
6:00 pm	Exhibitor Reception	❑	❑

Saturday, September 11 (Complimentary for member & one guest only)

				CHARGES FOR ADDITIONAL GUESTS
7:00 am	Breakfast Buffett	❑	❑	#_____ @ $35/each_____
8:00 am	Education Program	❑	❑	
5:30 pm	Candidate Reception	❑	❑	
6:00 pm	Inaugural Gala			
	Meat Dinner	❑	❑	#_____ @ $105/each_____
	Vegetarian Dinner	❑	❑	#_____ @ $105/each_____
	Vegan Dinner	❑	❑	#_____ @ $105/each_____

Non-complimentary events Saturday, September 11

12:00 pm COMPAC Luncheon* Meat ❑ Vegetarian ❑

* CHARGE PER PERSON FOR ALL MEMBERS AND GUESTS #_____@ $40/each

TOTAL amount enclosed for non-members, additional guests and COMPAC Luncheon. **$** _____

Please make check payable to: **Colorado Medical Society** and mail this form,
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phone it to us at 720-859-1001 or 1-800-654-5653 or fax it to us at 720-859-7509

CMS 2010 Annual Meeting
Accommodations Reservation Form

Vail Cascade Resort & Conference Center, Vail • Sept. 9-12, 2010

ACCOMMODATIONS

Please indicate your first (1) and second (2) choice: (please use this form for one room only)

ROOM TYPE	NIGHTLY ROOM RATE
Main Lodge	$149
Deluxe Room	$169
Mountain Grand Fireplace	$179
Cascade Suite	$269-$299
Presidential Suite	$500

The above rates do not include resort lodging fee and sales tax which total 15.8%. Check-in time is 4:00 PM and check-out time is Noon. Children 17 and under stay for free in parent's room with existing bedding. Valet $20 per day – Self park $15 per day

-

NOTE: RESERVATIONS MUST BE RECEIVED BY AUGUST 8, 2010 TO BE GUARANTEED SPECIAL **COLORADO MEDICAL SOCIETY** RATES.

REGISTRATION INFORMATION

Arrival Date_____ Departure Date_____

Name(s) _____

Address_____

City_____ State_____ Zip_____ Phone_____

Any Special Needs/Requests?_____

E-mail Address:_____

DEPOSIT AND CANCELLATION INFORMATION

A one night deposit is due with registration with remaining balance due upon arrival. Personal check or major credit card may be used for the deposit. Cancellations made **after September 1st** are subject to a one night cancellation fee. No shows, late arrivals and early departures will be assessed the total payment for the full length of stay as originally booked unless room is resold.

Card Type_____ Card #_____ Expiration_____

Name of Cardholder_____

I authorize Vail Cascade Resort to charge my credit card for the deposit for accommodations listed above.

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Signature Date

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Mediquake aftershocks

Lynn Parry, MD, Chair, Physicians' Congress for Health Care Reform

Positioning new realities

The reverberations from the passage of the federal health care reform bill continue to be felt, and September is stacking up to be an important month for Colorado physicians. The Physicians' Congress for Health Care Reform completed its analysis of the Patient Protection and Affordable Care Act (PPACA) and developed a report with recommendations for next steps that will be considered by the CMS House of Delegates at the 2010 Annual Meeting later this fall.

The report and the political and policy discussions it provokes will serve as another opportunity for physicians to come together, to have the difficult discussions and to develop a plan to position the profession for the next stage of the health system reform in Colorado as the bill is implemented or amended.

Taking temperatures

Last spring the CMS Board of Directors commissioned a member survey to assess physician attitudes about the enacted bill. This online flash poll effectively took the temperature of CMS members on the bill and the results reinforce how important health care reform is to physicians. The survey shows that CMS members are broadly concerned about the impact of the PPACA. While a majority agree that access for the uninsured will improve and almost half report that health information technology will improve, physicians are generally pessimistic that the legislation will improve other aspects of the system, such as fiscal sustainability and affordability, advancing medical innovation, or defragmenting care.

For me the poll reinforces not only the complexity of the issue but also the sophistication of Colorado physicians. The PPACA was a mediquake that has been building for decades. It brings with it the toppling of rapacious insurance practices, the opportunity for more equitable coverage for a larger number of American citizens, greater transparency and administrative simplification – all of which are important for the goals of our profession. But there is also real fear that the rapid and sweeping changes will flatten physicians' practices and threaten their relationships with their patients – the personal part of medicine that is equally as important as the quality of systems of care.

The bad and the good

I am mindful and appreciative of these very real and sometimes raw feelings as a backdrop to the upcoming House of Delegates deliberations on the work of the Physicians' Congress. The report details CMS policy consistencies and inconsistencies within the bill. It makes a series of recommendations covering issues that range from components of the law that require more work to pilot projects within the bill that should be

Calling All Comments

The Physicians' Congress report to the CMS House of Delegates is available for review under the Physicians' Congress section at www.cms.org.

Whether you love or loathe the bill, please take a moment to see how it lines up with existing CMS policy.

Review the recommendations for next steps and make some of your own, but don't forget to share your feedback with CMS and your component societies in advance of the upcoming Annual Meeting.

Your opinion is important, so make sure we hear it. Then plan on attending the Annual Meeting to participate in the process.

aggressively pursued in Colorado. Highlights are below.

- SGR: The lack of a comprehensive fix to the Medicare payment formula endangers access to care and compromises meaningful reform.
- IPAB: The current scope and authority of the Independent Payment Advisory Board raises concerns about transparency, equity and ability to make reform meaningful.
- Limited alternatives for liability reform: The $50 million allocated for grants to develop alternatives to tort reform falls far short of what is really needed to evolve the system into one that increases transparency, improves safety and appropriately holds providers accountable and underscores the need to create alternatives at a state level.
- Comparative effectiveness research: A focus on using research to evaluate clinical effectiveness is commendable, but limiting its application dulls the promotion of quality care.
- Value-based payment: While CMS supports changes to the payment system that rewards value not volume, Colorado physicians will need to work with HHS during rulemaking to ensure that methodologies for assessing value in medical services are transparent and equitable.
- Innovative care models: The bill promotes care models like patient-centered medical homes and accountable care organizations that should be piloted in Colorado.

Over the years the Physicians' Congress has worked hard to use an inclusive process to gather feedback and build consensus for policy areas on which physicians agree. We are not stopping now. Please share your thoughts on the report and help to set a path forward for our patients and our profession. ■

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Creating Medical Home Communities

Primary care/specialist physician compact

Scott Hammond, MD, SOC/PCMH Initiative Medical Director

In the last issue of *Colorado Medicine* physicians were introduced to the concept of a care compact and how the Systems of Care (SOC)/Patient-centered Medical Home (PCMH) initiative is using it to improve patient care through better coordination and communication and grow trusted networks of physicians called medical neighborhoods. This article will share what a compact can do for patients, medical practices and physicians.

The average primary care physician coordinates patient care with 217 specialists in 117 practices. The average Medicare patient sees seven different physicians per year from whom they receive an average of 20 different prescriptions (Pham et al. Annals of Internal Medicine, 2009). Add in ever-changing regulations and requirements by payers and government and it's a wonder that any patient-centered care is ever delivered. Patients bounce from physician to physician and precious time, resources and patient health are squandered. We can do better, but we have to start with small, practical steps.

Testing, testing

Our three-physician practice became a PCMH in 2009 and, after getting our house in order, the next obvious step was to improve care coordination by extending our home to a neighborhood. We started to work with the SOC/PCMH Initiative to create the primary care-specialist physician compact as another way to bring order to the chaos and reduce our daily struggles. The core elements of medical information for bi-directional communication between PCP and specialist were identified (see sidebar) and a means to measure accountability was created. The documents were vetted through numerous specialists and PCPs and then piloted through our practice with 11 specialty groups.

We invited our key specialists to join our medical neighborhood. All but one specialty practice agreed and became a medical neighbor. We reviewed the compact, the transition record and mutual expectations. After three months of dialog and clarification, we have seven specialty practices actively transforming their practice and four more beginning the process.

Outcomes

So how are we doing? The specialist groups were given scorecards to measure our performance and we created scorecards specific to the expectations outlined for the specialty groups. When we looked at results, it was no surprise that there was room for improvement. Like most physicians, we thought we were accomplishing more. We needed to correct some system flaws in our transition records, and our specialty groups needed to work on returning timely and complete transition reports and include us in secondary referrals.

Work continues, and the compact has served as a nexus to keep us on track to improve our communication and coordination. Our specialist teammates are pleased with how our professional relationship has been redefined and with

Anatomy of a Compact

The purpose of the Primary Care-Specialist Compact is to provide optimal health care for patients and provide a framework for better communication and safe transition of care between providers.

The compact is composed of four basic areas that outline mutual agreements and expectations between primary care and specialty care physicians including:

- Transition of care—maintaining accurate and up-to-date clinical records;
- Access—ensuring availability;
- Collaborative care management—clarifying responsibilities between PCP, specialist and patient; and
- Patient communication—honoring patient choices and providing informed consent.

Learn more about the compact at http://www.cms.org/SOC-PCMHI/MedicalHomeCommunities.html. Tell us what you think! You can also obtain assistance from SOC/PCMH experts to explore how the compact might work for your practice and your neighborhood by contacting Karen Frederick Gallegos at Karen_frederick-gallegos@cms.org or at 720-858-6323.

the timely and complete records they receive with each referral. I am happy that I'm included in patient care decisions and am more connected with my patients as they navigate across the health care system. Most importantly, our patients have been surveyed and their experiences in the practices have also received high marks.

This work can also be leveraged as more electronic health information exchange systems come on line to ensure that the right information is available at the point of care.

While the compact has required some challenging work to implement, it has ultimately helped me stay focused on my patients and on the team members on whom I rely both inside and outside of my practice. The strength of the tool is in its simplicity and its function as a constructive first step that physicians can take to partner with patients and accelerate the journey to change the way care is provided at both an individual and community level. I can now say that our patients receive well-coordinated and high quality care across the complex health care system. ■

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F. Brent Keeler, MD, Chair of COPE
Marilyn Rissmiller, Senior Director, Health Care Financing Division

Specialists and the medical neighborhood

How does the specialist fit in? How does this new concept affect the viability of the specialist practice? (I use the word new with the understanding that the terms are new but many of the operational concepts are not. Specialists and PCP's have engaged in shared patient care for a long time.) Let me begin with a couple of definitions. Think of the Medical Home as a practice of one or more primary care physicians (PCP's) – on steroids. Add a complement of specialist practices, do a little upgrading, and you have a Medical Neighborhood. The medical home movement is thriving in our state, there are two, complementary paths to becoming a medical home. SB-130 was passed several years ago encouraging, and rewarding, practices that are interesting in becoming a medical homes for Medicaid kids. There is a broader movement nationally to qualify practices using the NCQA Patient Centered Medical Home criteria in one of three levels and, with the recent addition of Kaiser clinics, we now have over 300 NCQA PCMH recognized physicians are already practicing here in Colorado.

Upgrading from our traditional ways is necessitated by a few dysfunctions that have cropped up along the way. These dysfunctions are mainly centered on issues of communication. What workup has already been done? Does the specialist report to the PCP about what the plan is? The patient (and sometimes even the physicians) may not know clearly which physician is in charge. When is the patient to return to the PCP? Will the specialist assume ongoing management of the particular condition – or even of the entire spectrum of the patient's care? Which physician prescribes medications? Does the other physician know about medication changes? Did the specialist clearly "release" the patient back to the PCP? And, if needed, with what ongoing plan of care? Obviously, the more clearly these questions are answered, the better the quality – and the safety – of the care received by the patient.

Viewed from the Medical Home, the Neighborhood is two-dimensional, as with spokes in a wheel. From the specialist viewpoint, the Medical Neighborhood is multi-dimensional. The typical specialist provides care for patients referred by more than one PCP, for patients who have "self-referred," and sometimes upon referral from another specialist. Specialists will need to be "neighbors" with more than one Medical Home.

The specialist who is a "good neighbor" will have the more viable practice than the specialist who is not. Some specialists are inherently good "neighbors" – new terminology notwithstanding. Other specialists who don't communicate as well – who aren't as "neighborly" – will see practice viability drop. As the Medical Home movement gains ground, specialists will need to be involved with PCP colleagues to be sure the Neighborhood is fully functional.

Right now, we still have a lot of reliance on letters, faxes, phone calls, and even coincidental verbal communication amongst colleagues. Although I would argue that the fax is a very efficient method, each of these nevertheless has barriers and issues. Someday soon, we will be using electronic record keeping, one element of which will be a "neural net" type of communication among medical neighbors. Yet, even in that ideal world, there will still be barriers if there is not a basic commitment for effective communication.

That commitment might occur at various levels, from the informal "handshake" all the way up to a more "formal "compact." Some Medical Homes are seeking affiliation with specialists who are willing to engage in a compact. (A compact is not a contract, and it carries no legal baggage. It does endeavor to provide a document that outlines how physicians are expected to communicate.)

It's all about communication. Let the PCP know what's going on. Do send the letter or fax. Might be best to restrict the phone call to truly urgent/emergent matters. When it's up and running, post it on the electronic network. By being thoughtful and deliberative about our communication, we can enhance the abilities of our practice to provide high quality, accessible and patient-centered care.

Learn more about the compact at http://www.cms.org/SOC-PCMHI/MedicalHomeCommunities.html. Tell us what you think! You can also obtain assistance from SOC/PCMH experts to explore how the compact might work for your practice and your neighborhood by contacting Karen Frederick Gallegos at Karen_frederick-gallegos@cms.org or at 720-858-6323. ■

Reflections
FROM OUR MEDICAL STUDENTS

Reflective writing is now a regular portion of the CU School of Medicine curriculum, beginning in the first semester. All medical students participate by writing essays or poems that reflect what they have seen, heard and felt. This column is selected and edited by Henry N. Claman, MD, and Steven R. Lowenstein, MD, MPH, from the new Medical Humanities Program

Jeunesse Grenoble

Jeunesse Grenoble is a fourth year medical student from Durango, Colorado. She enjoys the mountains, traveling and singing. She plans to pursue a career in ophthalmology.

Don't drop the baby

I was returning to the pediatric workroom at 10:30 p.m., after checking on a patient, when there was suddenly a heightened sense of energy in the room. The resident hung up the phone, catching my eye as I walked in. She pulled an extra pair of green scrubs out of her bag. "Here, put these on," she said. "They need extra hands upstairs – 33-week twins are about to be born." I rushed off to change and then joined the resident and intern to hurry up the stairs. As we walked, the resident briskly explained what was about to take place. Should we have to do chest compressions, it was "push, push, push, breathe… push, push, push, breathe." Then there was something about intubation, tapping out the heartbeat, at what pressure the oxygen should be set and Apgar scores. I glanced at the intern, hoping she was more prepared than I was, hoping she knew what the resident was actually talking about.

"Can you catch the baby?" the resident suddenly asked me. "They will put a drape over your arms to catch it. Do whatever you have to do to keep it in your arms. These babies can be slippery, so if you have to grab a leg or a head or whatever, just do what you need to do not to drop it." She looked at me. "Don't Drop the Baby." Giddy and terrified at the importance of my task, I nodded agreement. I would catch it.

At the door to the OR we pulled on booties over our shoes, as if we might go moon walking. We tucked our hair under netted caps and tied yellow masks, complete with clear plastic eye covers, around our heads. Blue latex gloves were the final touch. We entered the OR, covered head to toe, as if ready for combat. White lights and white walls peered down on a Betadine-yellowed abdomen. The soon-to-be mother was on the operating table, belly up, covered with sterile drapes from the waist down. Nurses and physicians dressed in the standard blue and green bustled around the room arranging equipment, drapes and surgical instruments. The mother's head disappeared behind a sterile blue drape strung between IV poles. I hurried out of the way to allow the operating team to enter. Freshly scrubbed, they held bare forearms at perfect 45-degree angles, water dripping cleanly off their elbows without contaminating their hands. Someone handed them each a sterile towel and began the careful process of tying them into their papery blue sterile gowns.

Moments later a nurse asked, "Who is catching Baby B?" I

realized I was that person. I held out my arms as the nurse carefully covered my arms and chest in a sterile blue drape that fastened around my neck. She motioned for me to stand to one side of the operating table. I stood with my arms in front of me, like a pilgrim holding an offering, silent and humbled by the profundity of what was unfolding. I stood there, praying that I was up to the task and that I would not drop the baby. Suddenly the nurse motioned me forward. There was a pause in the surgical bustling at the table; the doctor turned, and into my arms went a tiny, reddish-blue baby, squirming and crying and covered in bits of white, like a lint-covered shirt pulled from the drier. A jelly white cord protruded from his abdomen. For a moment, the universe stood still. Then, as quickly and as carefully as I could, I walked the six steps from the operating table to the warming bed and placed the baby under the lamps. The pediatricians took over, rubbing and stimulating the baby to ensure normal perfusion. I stood there in awe. I had just received a baby, in its first shocking moments of life. What did life have in store for this baby? I looked at him on the table, crying and turning a reassuring shade of pink, no chest compressions required. My stomach began to un-knot, and I thought to myself, *I did it. I didn't drop the baby.* ■

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there is a better way

COPIC COMMENT

Ted J. Clarke, MD,
Chairman & CEO
COPIC Insurance Company

A COPIC connection to AHRQ demonstration projects

In September 2009, President Obama authorized the U.S. Department of Health and Human Services' Agency for Health Care Research and Quality (AHRQ) to set aside $25 million for demonstration projects, awarding grants of up to three years and $3 million each on a competitive basis to states and health systems. Applications had to address one or more of the following goals: (1) put patient safety first and work to reduce preventable injuries; (2) foster better communication between doctors and their patients; (3) ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and (4) reduce liability premiums.

In June, AHRQ announced its selection of seven demonstration grants for a total funding amount of $19.7 million. We're proud to say that COPIC's Patient Safety and Risk Management department has a connection to two of these multimillion-dollar projects.

The first project is headed by Thomas Gallagher, MD, of the University of Washington in Seattle. Funded at $2,972,209, the project creates a statewide initiative involving communication training for health care workers and a collaboration between hospitals and a medical liability insurer to improve adverse event analysis, disclosure, and compensation. The goal is to enhance the culture of health care communication in order to improve patient safety and decrease medical malpractice liability.

The second project is headed by Timothy McDonald, MD, J.D., of the University of Illinois at Chicago. Funded at $2,998,083, the project is designed to fill the evidence gap regarding the impact on patient safety and litigation rates of programs that feature improved communication with patients, transparency, disclosure of adverse events, early offers of compensation, and learning from mistakes. It will evaluate the impact on medical liability reform and patient safety outcomes of extending an existing disclosure program from an academic hospital setting to a group of diverse hospitals in the greater Chicago area.

What's the COPIC connection? COPIC is working with Dr. Gallagher on a separate three-year study funded by AHRQ to evaluate the effectiveness of disclosure training on several outcomes measures. We also collaborated in a Robert Wood Johnson Foundation grant that looked at the leading disclosure and early offer-type programs such as COPIC's 3Rs Program. We provided disclosure coaching to Colorado residents in collaboration with a program Dr. McDonald conducted on disclosure in residency programs. In addition, Dr. Gallagher helped to develop the post-case surveys that COPIC uses with 3Rs Program physicians, patients, and program administrators. An additional study analyzing what has been learned through the 360 degree feedback process is also in progress.

Additional AHRQ demonstration grant recipients and projects include:

- Stanley Davis, MD, Fairview Health Services, Minneapolis, MN, $2,982,690—The objective of this project is to improve perinatal patient safety and demonstrate the relationship between improved patient safety and a reduction in the number of malpractice claims. The project will implement and evaluate the use of perinatal best practices in 16 hospitals to assess the impact on patient safety and the level of malpractice activity. This initiative builds on the institution's prior efforts as part of a nationwide collaborative to eliminate preventable perinatal harm.
- Eric Thomas, MD, M.P.H., University of Texas Health Science Center, Houston, TX, $1,796,575—The project will review the use of a disclosure and compensation model, which informs injured patients and families promptly and makes efforts to provide prompt compensation. The project will investigate disclosure and compensation in the UT system over a three-year period, identify best practices for using disclosure to improve patient safety, and disseminate best practices with a focus on incorporating patient and family input into efforts to understand why errors occur.
- Ann Hendrich, M.S., RN, F.A.A.N., Ascension Health System, St. Louis, MO, $2,990,612—This project will focus on ways of improving both the quality of perinatal patient care delivery and the way adverse perinatal events are managed in five geographically dispersed hospitals. The project will establish a uniform, evidence-based obstetrics practice model based on the idea that eliminating variation in obstetrics practice will translate to improved patient safety.
- Judy Kluger, J.D., New York State Unified Court System, New York, NY, $2,999,787—This project aims to protect obstetrical and/or surgery patients from injuries caused by providers' mistakes and reduce the cost of medical malpractice through the use of an expanded and

enhanced judge-directed negotiation program currently used in New York's courts, coupled with a new hospital early disclosure and settlement model.

- Alice Bonner, M.S., APRN, BC, Massachusetts State Department of Public Health, Boston, MA, $2,912,566—The project proposes to engage clinicians, patients, malpractice insurers, and the state public health agency to ensure more timely resolution of medical errors that occur in outpatient practices and improve communication in all aspects of care. The project will identify key areas contributing to ambulatory medical errors and malpractice suits in order to redesign systems and care processes to prevent, minimize, and mitigate such errors in a group of Massachusetts primary care practices. The project will also transform communication culture, processes, and outcomes in these practices so that they are more patient and family-centered, particularly with respect to proactively seeking out, handling, and learning from patients' safety experiences, concerns, and complaints.

Our business model is to find ways to increase patient safety and decrease medical liability claims, which is at the heart of each of these demonstration projects. We'll be watching them closely for lessons we can pass along to our insured physicians. ■

Ten ways to improve cash flow from self-pay patients

Patient accounts not paid on time can severely affect the practice's cash flow. A clearly defined and carefully communicated payment policy can help prevent difficult collections. Here are ten simple steps that can dramatically improve a practice's cash flow and help retain valuable patient relationships.

1. Have a defined credit policy

Let patients know exactly when payment is expected. Give them a statement at the time of the visit and let them know up-front that while the office is filing their insurance claim as a professional courtesy, they are ultimately responsible for their visit.

2. Invoice promptly and send statements regularly

Establish a systematic invoicing and billing process. Just as early medical treatment can forestall a potentially serious illness, prompt billing can prevent an account from becoming a collections problem. Send an invoice immediately should you receive notice the patient owes a co-pay or deductible. Send statements at regular intervals. Consistency and early recovery is paramount for successful collections.

3. Use 'Address Service Requested'

It's difficult to collect from a patient who has moved without informing you of his/her new address. Deal with this possibility by using the U.S. Postal Service's "address service requested" procedure. Print these words on the envelope of all correspondence, just below your return address. If the addressee has left a forwarding address, the post office will send you a form with the correct address for a nominal fee.

4. Contact patients with overdue accounts more frequently

The old adage "the squeaky wheel gets the grease" has some merit when it comes to collecting past-due accounts. Contact late payers every 10-14 days but, to avoid becoming a broken record, limit follow-up to not more than twice. From that point on a fixed-cost, diplomatic written contact from a third party will efficiently recover more, maintain your patient relationship and put your staff in the driver's seat to negotiate any payment plans which may be needed in these economic times.

5. Use your aging sheet, not your feelings

Many a provider or their well-intentioned staff has let an account age beyond the point of collection because they "hoped" the patient would pay. While this may happen occasionally, it's the exception rather than the rule. Stick to your systematic follow-up plan. You'll soon know who intends to pay and who doesn't.

6. Train your staff

While patients must be treated courteously, yet firmly, ultimately it's the owner's responsibility to determine when the major steps of an accounts receivable process should take place. Office managers and staff may benefit from participating in professional groups sponsored by the Colorado Medical Society.

7. Admit and correct your mistakes

Sometimes patients don't pay because they believe you've made a billing error. If you have made a mistake, quickly admit it and correct it. Denying an error only heightens a patient's resentment.

8. Follow state collection laws

Certain collection practices, such as calling patients at odd hours or disclosing to a third party that someone owes you money, can have serious repercussions. If you're not sure, contact the Secretary of State's Collection Practices Division. Be aware of Colorado HB 04-1285 which requires providers give a written notice 30 days prior to moving patients accounts to a 3rd party.

9. Use a third party sooner

If you've systematically pursued a past-due account for more than 60 days from the due date, the patient is sending a clear message. A Flat Fee collection service will allow you to re-establish communications with your patients and effectively identify those who can and will resolve their account. For the residue of stubborn debtors you can elect to use a contingency collection agency, go to small-claims court, or hire an attorney.

10. Keep more of your profit

The purpose of a carefully designed and administered collection plan is to help speed cash flow and improve your profit margin. Use a third party collection agency to identify problem accounts early to save your practice time and profit.

Developing and implementing a sound collections policy is a vital part of running a successful business.

For a free accounts receivable consultation, contact your current collection agency or Nancy Peters with Transworld Systems/GreenFlag Profit Recovery, a CMS Member Benefit Partner. 720.962.4462; nancy.peters@transworldsystems.com. ■

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medical news

Brent Keeler, MD running for CMS President-elect

Thanksgiving is my favorite holiday. President Abraham Lincoln set aside the last Thursday in November as a national day of Thanksgiving in 1863. It was permanently established as a national holiday by FDR in 1941. We have been blessed with so much and, in my opinion; Americans are still the envy of the world. Remember the lyrics of Neil Diamond: Coming to America. No, we are not perfect. Yet the beauty of our way of life is that we are empowered.

Some major reforms enacted in the 20th century include, Women's Suffrage, the Civil Rights Act, the Clean Air Act, and the Clean Water Act. These reforms addressed some of society's major shortcomings, and each was initially met with considerable resistance. Today we accept them as part of the fabric of our society, AND we can alter/amend them as needed!

Health care is another shortcoming. But let's not trash everything. We have a lot to be thankful for when it comes to health care. We are blessed with the best of just about everything: doctors, nurses, state-of-the-art facilities and hospitals, education and training, CME, high-technology devices and equipment, research, designer pharmaceuticals, vaccines and more. I would even argue that the compassion and empathy of our health care professionals are unrivaled.

However, as a society, we fall short in the thoughtful and equitable utilization of our vast array of health care assets. We have many blessings, but we don't always use them appropriately. Some individuals receive too much care, while others cannot gain access to even the very basics. As physicians, we own a significant chunk of this failure. It is our responsibility, our challenge and our mission to be part of the solution-- the reform.

Organized medicine has a central role in this mission. At the national and state level, physicians are at the table and hopefully not on the menu! Health care reform will fail without physician involvement. We bring a unique and invaluable perspective.

The physician's perspective encompasses much more than first meets the eye. We must ensure that reform enables our care to be accessible, evidence-based, safe and appropriate. We must be accountable for the quality of our services. Yet I submit that these are not enough! We MUST also take the conversation down to the individual level, where it's about ONE doctor rendering care to ONE patient.

One-on-one, there are two critical concepts in play. First, there is the autonomy of both the physician and the patient. When exercised reasonably, this is at the very heart of the physician-patient relationship. We destroy or seriously degrade these autonomies at our peril.

Second, the physician must function in a viable and sustainable environment. As chair of the CMS Council on Practice Environment, I have witnessed first-hand how desperately we need to keep this at the forefront. Simply put, if physician practices are not sustainable, then we are not rendering care to anyone. The environment must be both economically and personally sustainable. Yes, the conversation also needs to be about physicians!

I would be grateful for your support of my candidacy for president-elect of your Colorado Medical Society. ■

medical news

Colorado Medical Board seeks physicians to serve

The Colorado Medical Board is seeking new physician members. Interested doctors should contact Susan Miller at susan.miller@dora.state.co.us or 303-894-7714.

By law, the Board is comprised of eight MDs, three DOs, one PA and four public members. Physician members of the Board must have been actively practicing medicine in Colorado for three years to qualify for appointment. The term of appointment is four years and members are appointed by the Governor. The Board is divided into two Inquiry Panels of six members each for purposes of reviewing and acting on complaints filed with the Board and there is one Panel of three members responsible for reviewing applications for licensure that have potential issues and also reviewing and acting on complaints involving unlicensed practice.

Each Panel of the Board meets monthly and the entire board also meets quarterly to handle those functions that, by law, must be done by the entire board. The Inquiry Panels typically meet on the second and third Thursday of the month except for those months when the full board meets. Panel meetings last approximately four to six hours with about six to eight hours of preparation required. The quarterly full board meetings typically last no more than six hours with two to three hours of preparation required. Licensing Panel meetings will last approximately two hours with three to four hours of preparation required. Board and Panel meetings are held at the Board offices located at 1560 Broadway, Denver.

Board service is truly public service. Board members receive a $50 per diem for each meeting attended and are reimbursed for actual and necessary travel expenses, such as mileage, parking, etc. ■

AMA/MGMA offer toolkit to assist in practice management software selection

The upcoming transition to the government's modified electronic transaction standards, coupled with the Medicare and Medicaid electronic health record incentive program, will require physician practices to upgrade or replace their current practice management software. To help you select and purchase the most appropriate software for your practice, the American Medical Association (AMA) and the Medical Group Management Association (MGMA) collaborated to develop a new online toolkit. Free to members of the AMA and the MGMA, the new "Selecting a Practice Management System" toolkit (http://www.ama-assn.org/go/pmsoftware) provides a road map to make this process easier for your practice. You can use this information to establish your practice needs and take advantage of recent improvements in automation. ■

Proposed 2111 Medicare rules

The American Medical Association has issued this summary and analysis of the proposed Medicare 2011 physician payment policies. The document includes a table listing the estimated impact on total allowed charges, by specialty.

The Centers for Medicare and Medicaid Services issued the 1,250-page rule last month. The comment period is open until Aug. 24. To read the AMA summary and analysis in its entirety, visit the CMS Web site at http://cms.org/livewire/071510/ama2011analysis.pdf. ■

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the final word

EHR: A patient's perspective

Editor's note: During CORHIO's recent health information exchange summit at The Children's Hospital, Jason and Heather Bottone described how electronic health records have made all the difference in the care of their five-year-old son, Jacob. This is an edited transcript.

Our son Jacob was born at 31 weeks, an emergency C-section at Exempla St. Joseph Hospital. He weighed just shy of three pounds.

After a few weeks in the NICU, we discovered his kidneys hadn't really formed. He was diagnosed with end-stage renal disease. He went home on hospice care, and the doctors estimated he'd live a few weeks – maybe a few months. But months went by, and he continued to thrive. We called our neonatologist at Kaiser, who took us in for labs, and we got Jacob into the kidney clinic at Children's.

He was put on dialysis for 12 to 14 hours a night, six nights at week at home. When he got to 15 kilos, he weighed enough to receive a kidney from Heather. This month, it will have been two years since the kidney transplant.

The Bottone family, who has years of experience with Colorado's health care system, calls the recent addition of electronic health records a "blessing."

Through all of that, in a matter of a very short time, we were working with the kidney center, cardiology, urology, gastroenterology, physical therapy, nephrology, surgery and genetics at Children's. Then we saw his primary pediatrician over at Kaiser.

Which leads us to the wonderful new realm of electronic records sharing.

We had started carrying around an accordion file that we called "Jacob's bible." It had different areas for his medication lists, referrals from Kaiser, and all the various other things we would always need to rattle off at the start of his doctor appointments. Usually the med list itself was a 10-minute affair.

When we came here, they had the med list in front of them (on the electronic health record) when we arrived, and they were ready for us. That was a nice change.

Prior to the electronic sharing, when a doctor authorized care here at Children's from Kaiser, every procedure essentially had to get a referral generated and delivered here. There were good people on the Kaiser end, but it still took a little time to get it generated and delivered.

Once, Heather had Jacob here for a test. By the time they got to the parking lot afterward, Children's called and wanted to do a follow-up X-ray. Heather had to sit and wait three or four hours for the referral to be delivered. These were all the issues pre-electronic information exchange. Now, it takes a quick phone call. Sometimes we don't even have to be involved in the request because hey can generate those electronically. Sometimes when they order different tests it's in the file before we get here.

Jason, Heather and Jacob Bottone

Jacob (child), Heather (standing background), and Jason Bottone (sitting right) watch as Jacob has blood drawn at hospital.

It's been quite nice, not having to lug the "bible" around, or have double tests done, and we think our care from our providers has been heightened. They're aware of everything before we go into the appointment. We're not spending time on the med lists, or updating them on everything.

We can still spend a half hour, but they're going over the next step for him and the care for him, and not just repeating what we've been through for the past five years. It seems like time better spent. It's more of him playing and engaging the caregivers. There's more time for patient contact and Q&A and that sort of thing, for making sure the care is there and more precise.

As a parent you can just focus on your child. As we have always said with Jacob, "Keep your eye on the baby, eye on the kiddo."

It's been quite a blessing. ■

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