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2012

COLORADO PCMH *Best Practice* OF THE YEAR

AWARD Application

Submitted on behalf of

Primary Care Partners, PC

By Carol Schlageck, Managing Associate

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NCQA certification



COLORADO ACADEMY OF FAMILY PHYSICIANS

2224 S. Fraser St., Unit 1, Aurora, CO 80014
Phone: 303-696-6655 Toll-Free: 800-468-8615 Fax: 303-696-7224

June 1, 2011

Dear Primary Care Colleague:

The Colorado Academy of Family Physicians congratulates you as a physician leader of one of the **First One Hundred** NCQA recognized Patient Centered Medical Homes in Colorado. As one of the “early adopters” of the Joint Principles of the PCMH, we admire your commitment to your patients and your profession. CAFFP also recognizes the contributions of Advance Practice Nurses and Physician Assistants as leaders and essential team members of this model.

The CAFFP has embraced the concepts of the PCMH as the best model for the transformation of primary care practices to meet the health care needs of Coloradoans in the 21st century. We have developed a wide variety of resources, initiatives and partnerships to help primary care physicians learn about and become leaders of Medical Home teams. We recognize your example as a powerful inspiration for other physicians and primary care clinicians to become part of the medical home movement.

Our patients deserve a reformed and sustainable health care system that provides higher quality care at lower cost with higher patient satisfaction. Such a system inevitably will provide higher satisfaction for the providers of care as well. Primary care practices like yours, functioning as Medical Homes, will be the foundation of that reformed system. We look forward to supporting your maturation as a Medical Home in the years to come.

Sincerely,

Tracy Hofeditz MD, FFAFP
Chair, PMCH Committee
Colorado Academy of Family Physicians
Physician leader, Belmar Family Medicine, Level 3 PCMH

The Colorado Academy of Family Physicians

Recognizes

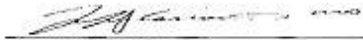
PCP - Family Physicians of Western Colorado

For Achieving

**NCQA PATIENT CENTERED
MEDICAL HOME RECOGNITION**

*In acknowledgement that PCP - Family Physicians of Western Colorado was one of
the first 100 Colorado practices to achieve NCQA PCMH Recognition.*

PRESENTED ON JUNE 1, 2011


Lake Coats, MD, President

6-1-2011

Date


Raquel Alexander, MA, CAE, CEO

6-1-2011

Date



PHYSICIAN PRACTICE CONNECTIONS
PATIENT-CENTERED MEDICAL HOME

Certificate of Recognition

National Committee for Quality Assurance commends

Primary Care Partners, PC

Western Colorado Physician's Group

Recognized – Level 3

on Achievement of Recognition for Systematic use
of Patient-Centered, Coordinated Care Management Processes

Awarded from: September 10, 2010 to: September 10, 2013




Margaret E. O'Kane
President

Patient Satisfaction Surveys

Family Physicians of Western Colorado

How would you rate your experience with our front office staff?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
0%	2%	5%	33%	60%

How would you rate your experience with our nurses?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
0%	0%	10%	34%	56%

How satisfied were you with your care during this visit?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
0%	0%	10%	34%	56%

How would you rate communication between you and your physician?

(re: addressing concerns, listening, diagnosis, treatment/follow-up)

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
0%	0%	4%	22%	74%

Was your appointment scheduled in a timely manner? Yes No

How would you rate our phone service?

100 %

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
2%	8%	24%	33%	33%

Are you confident that you are provided resources/information to self-manage your care? Yes No

96%	4 %
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Do you feel you and your family are partners with your physician regarding the management of your health care? Yes

No	98%	*See comment
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****One patient gave no answer to this question***

Total number of surveys

50

July, 2011

Western Colorado Physicians Group

How would you rate your experience with our front office staff?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
		4%	30%	66%

How would you rate your experience with our nurses?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
		3%	23%	74%

How satisfied were you with your care during this visit?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
			20%	80%

How would you rate communication between you and your physician?
(re: addressing concerns, listening, diagnosis, treatment/follow-up)

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
			26%	74%

Was your appointment scheduled in a timely manner? Yes No
 How would you rate our phone service?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
	3%	23%	40%	34%

100 %	
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Are you confident that you are provided resources/information to self-manage your care? Yes
 No

100%	
------	--

Do you feel you and your family are partners with your physician regarding the management of your health care? Yes No

100%	
------	--

*Total number of surveys
 Survey completed: July, 2011*

30

Western Colorado Pediatric Associates

How would you rate your experience with our front office staff?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
0	5%	9%	38%	48%

How would you rate your experience with our nurses?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
0%	2%	10%	25%	63%

How satisfied were you with your care during this visit?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
0%	1%	10%	26%	63.%

How would you rate communication between you and your physician?
(re: addressing concerns, listening, diagnosis, treatment/follow-up)

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
1%	2%	9%	25%	63%

Was your appointment scheduled in a timely manner?

99 %	1%
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How would you rate our phone service?

Comments varied, but averaged "very good". Nine of the 60 commented waits were often long, but most accepted it as a fact of life for a busy practice.

Are you confident you are given the resources/information to self manage care for you or your child?

Yes 99%	No 1%
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Do you feel you and your family are partners with your physician regarding the management of your health care?

Yes 97%	No 3%
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Total number surveys

60

May 2011

DOCS ON CALL

How would you rate your experience with our front office staff?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
		11%	37%	52%

How would you rate your experience with our nurses?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
		2%	41%	57%

How satisfied were you with your care during this visit?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
	11%	9%	48%	32%

How would you rate communication between you and your physician?

Re: addressing concerns, listening, diagnosis, treatment/follow-up)

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
5%	5%	15%	43%	32%

Was your appointment scheduled in a timely manner? Yes 100 % No

How would you rate our phone service?

<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>
		22%	45%	33%

Completed August 2011

Examples of completed and current QI programs

Policy Title:	Vaccine Registry Workflow
Depts. Affected:	
Approval Date:	7-7-11
Written by:	Mary McCrum, D.O.
Approved by:	QIS Task Force
Revised:	N/A



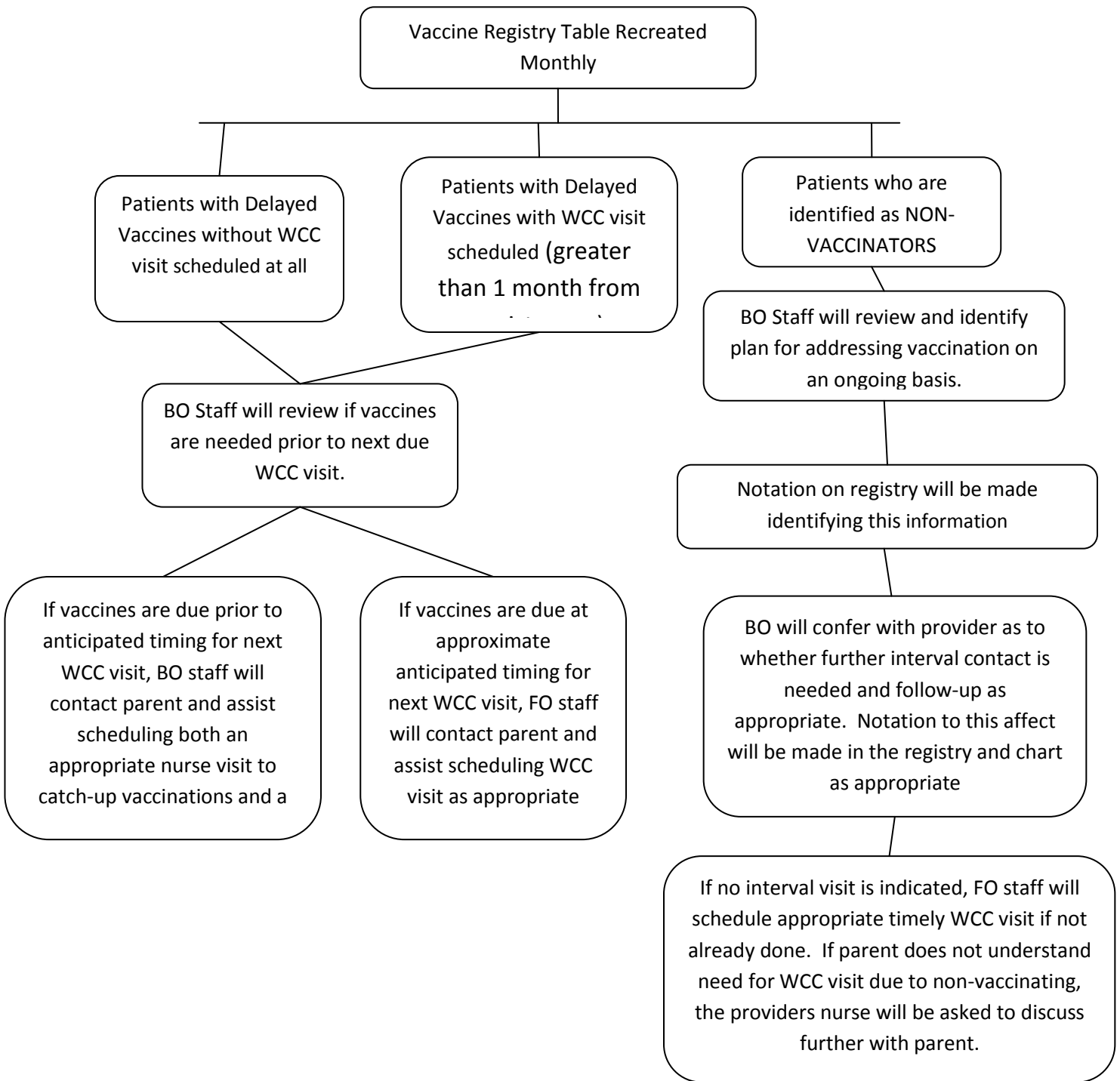
POLICY: National guidelines for childhood vaccination require completion of the initial vaccine series by each child's 2nd birthday. In order to meet these guidelines and provide appropriate disease prevention for our patients Primary Care Partners, PC has developed a vaccine registry to actively manage those patients not vaccinated according to our office's current vaccine schedule. This schedule is updated routinely as new guidelines are released by ACIP, AAP, and AAFP. Patients who are not up to date are to be reviewed monthly and recalled as appropriate on a routine basis. Back office staff will review the patient's vaccine history and develop a "catch-up plan" in conjunction with national guidelines. They will contact parents of children who are not up to date for their scheduled vaccines and assist the family in scheduling an appropriate timely nurse visit or offer a visit with the child's primary care provider to further discuss appropriate vaccination. NOTE: Children who are behind for Well Child Care Visits and vaccines will be notified by the front office to schedule a Well Child Care visit and will not be addressed by this registry workflow unless family is resistant to scheduling a Well Child Care visit.

PURPOSE: Maintain up to date vaccination for all children in order to provide appropriate disease prevention

Steps:

- (1) Children are seen routinely for Well Child Care Visits at 3 & 10 days of life, 2 mos, 4 mos, 6 mos, 9 mos, 12 mos, 15 mos, 18 mos and 24 mos. Ideally, each child will receive the recommended vaccinations at the time of these visits. (see attached table) NOTE: a separate registry and recall system assist in recalling children in need of routine well child care visits.
- (2) Dan Norman in IT will populate vaccine registry reports for patients 3 yrs of age and younger for all physicians of each pod monthly.
 - a. The report will list all pediatric patients in this target age group who have are deficient in any of the following vaccines: DTaP, HiB, IPV, Prevnar, Hepatitis B, Varicella and MMR.
 - i. Each report will **exclude** those patients
 1. who already have a well child care visit scheduled in the future; in order to best facilitate workflow and avoid duplicating appointment. NOTE: summer 2011 Touchworks EHR will have an upgrade with dashboard reminder of vaccine within the chart screen of each individual patient. In addition, each chart maintains the vaccine history for each individual patient. These tools will allow providers to appropriately address vaccine needs at each Well Child Care visit.
 2. who have been identified as having a medical contraindication for the deficient vaccine (to be added to registry in future)
 - b. The report will be broken down into 3 sections:

- i. Those overdue for vaccination of 1 or more of the targeted vaccines and are not scheduled for a WCC visit in the future. (this population will be addressed by the WCC registry workflow)
 - ii. Those overdue for vaccination of 1 or more of the targeted vaccines and are identified as NON-VACCINATORS due to parental choice.
 - iii. Those overdue for vaccination of 1 or more of the targeted vaccines and are scheduled for a WCC visit more than 1 month in the future. NOTE: This population will be reviewed as well to determine those needing a nurse visit in the interval leading up to their next WCC visit in order to ensure appropriate vaccine catch-up for those with delayed vaccines.
 - c. The report includes:
 - i. patient name,
 - ii. DOB,
 - iii. age,
 - iv. parent's name,
 - v. phone number,
 - vi. most recent well child care visit date, and
 - vii. which provider the most recent well child care visit was with.
 - d. The report also includes the following columns for staff to "track" their attempts to contact:
 - i. Date of appointment scheduled
 - ii. L/M (left message)
 - iii. N/A (no answer)
 - iv. Moved
 - v. Refused
- (3) Each respective Pod back office staff (BO) will work in teams made up of the MOA, LPN, or RN (referred to as BO in this document) assigned to a given provider and the given provider:
- a. BO will review their given provider's registry worklist on a monthly basis.
 - i. Identify appropriate timely plan for next set of vaccinations in order to ensure a timely vaccination.
 - ii. Contact patient's parent/guardian by the following means notifying them of need updating delayed vaccines and offering to schedule an appropriate visit (maybe a nurse visit or WCC visit depending on the child's vaccine needs) to do so at the time they are speaking with the patient's parent/guardian:
 - 1. Phone call
 - 2. A letter or Portal message may be sent to the family if there have been 2 unsuccessful attempts to reach the family
 - iii. Note: some parents may need a visit scheduled to specifically discuss vaccination needs of their child and significant questions/concerns they may have regarding vaccination. In this case, a 20 minute visit may be scheduled to better assist the family in addressing these concerns.
 - b. Document on the registry the following:
 - i. Date of appointment scheduled
 - ii. L/M (left message), date message left
 - iii. N/A (no answer), date attempted to call
 - iv. Moved
 - v. Refused
 - vi. Letter/Portal Message sent and date message sent
 - c. BO will confer with the specified provider or Janelle, RN (PCP Immunization Program oversight nurse) as needed to assist in determining an appropriate catch-up schedule.



Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind—United States • 2011

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age

PERSONS AGED 4 MONTHS THROUGH 6 YEARS					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B ¹	Birth	4 weeks	4 weeks (and at least 16 weeks after first dose)		
Rotavirus ²	6 wks	4 weeks	4 weeks ³		
Diphtheria, Tetanus, Pertussis ³	6 wks	4 weeks	4 weeks	6 months	6 months ³
Haemophilus influenzae type b ⁴	6 wks	If first dose administered at younger than age 12 months 4 weeks 8 weeks (as final dose) If first dose administered at age 12–14 months No further doses needed If first dose administered at age 15 months or older	If current age is younger than 12 months 4 weeks 8 weeks (as final dose) ⁴ If current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed If previous dose administered at age 15 months or older	8 weeks (as final dose) ⁴ This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal ⁵	6 wks	4 weeks If first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) If first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks If current age is younger than 12 months 8 weeks (as final dose for healthy children) If current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) ⁴ This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	6 months ⁶	
Mumps, Measles, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months			
Hepatitis A ⁹	12 mos	6 months			
PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria, Pertussis ³	7 yrs ¹⁰	4 weeks	4 weeks If first dose administered at younger than age 12 months 6 months If first dose administered at 12 months or older	6 months If first dose administered at younger than age 12 months	
Human Papillomavirus ¹¹	9 yrs		Routine dosing intervals are recommended (females) ¹¹		
Hepatitis A ⁹	12 mos	6 months			
Hepatitis B ¹	Birth	4 weeks	4 weeks (and at least 16 weeks after first dose)	6 months ⁶	
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	6 months ⁶	
Mumps, Measles, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months If person is younger than age 13 years 4 weeks If person is aged 13 years or older			

- Hepatitis B vaccine (HepB).**
 - Administer the 3-dose series to those not previously vaccinated.
 - The minimum age for the third dose of HepB is 24 weeks.
 - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
- Rotavirus vaccine (RV).**
 - The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
 - The maximum age for the final dose in the series is 8 months 0 days.
 - If Rotarix was administered for the first and second doses, a third dose is not indicated.
- Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).**
 - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
- Haemophilus influenzae type b conjugate vaccine (Hib).**
 - 1 dose of Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy.
 - If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
 - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.
- Pneumococcal vaccine.**
 - Administer 1 dose of 13-valent pneumococcal conjugate vaccine (PCV13) to all healthy children aged 24 through 59 months with any incomplete PCV schedule (PCV7 or PCV13).
 - For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV13 if 3 doses of PCV were received previously or administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
 - A single dose of PCV13 is recommended for certain children with underlying medical conditions through 18 years of age. See age-specific schedules for details.
 - Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant, at least 8 weeks after the last dose of PCV. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See MMWR 2010;59(No. RR-11).
- Inactivated poliovirus vaccine (IPV).**
 - The final doses in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
 - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months following the previous dose.
 - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
- Measles, mumps, and rubella vaccine (MMR).**
 - Administer the second dose routinely at age 4 through 6 years. The minimum interval between the 2 doses of MMR is 4 weeks.
- Varicella vaccine.**
 - Administer the second dose routinely at age 4 through 6 years.
 - If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- Hepatitis A vaccine (HepA).**
 - HepA is recommended for children aged older than age 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
- Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).**
 - Doses of DTaP are counted as part of the Td/Tdap series.
 - Tdap should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years or as a booster for children aged 11 through 18 years; use Td for other doses.
- Human papillomavirus vaccine (HPV).**
 - Administer the series to females at age 13 through 18 years if not previously vaccinated or have not completed the vaccine series.
 - Quadrivalent HPV vaccine (HPV4) may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
 - Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 1 to 2 and 6 months after the first dose). The minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be administered at least 24 weeks after the first dose.

Information about reporting reactions after immunization is available online at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at <http://www.cdc.gov/vaccines> or telephone, 800-CDC-INFO (800-232-4636).

Department of Health and Human Services • Centers for Disease Control and Prevention

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2011

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹		HepB	HepB			HepB						
Rotavirus ²				RV	RV	RV ²						
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP	^{see footnote 7}	DTaP				DTaP
<i>Haemophilus influenzae</i> type b ⁴				Hib	Hib	Hib ⁴	Hib					
Pneumococcal ⁵				PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus ⁶				IPV	IPV	IPV						
Influenza ⁷						Influenza (Yearly)						
Measles, Mumps, Rubella ⁸						MMR			^{see footnote 9}			MMR
Varicella ⁹						Varicella			^{see footnote 9}			Varicella
Hepatitis A ¹⁰						HepA (2 doses)					HepA Series	
Meningococcal ¹¹												MCV4

Range of recommended ages for all children

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations at <http://www.cdc.gov/vaccines/pubs/adip-list.html>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967. Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

- Hepatitis B vaccine (HepB).** (Minimum age: birth)
 - At birth:**
 - Administer monovalent HepB to all newborns before hospital discharge.
 - If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
 - If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).
 - Doses following the birth dose:**
 - The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
 - Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
 - Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
 - Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
 - The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.
- Rotavirus vaccine (RV).** (Minimum age: 6 weeks)
 - Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
 - The maximum age for the final dose in the series is 8 months 0 days.
 - If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
- Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** (Minimum age: 6 weeks)
 - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Haemophilus influenzae* type b conjugate vaccine (Hib).** (Minimum age: 6 weeks)
 - If PRP-OMP (Pedvax-Hib or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
 - Hibertix should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.
- Pneumococcal vaccine.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
 - PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
 - A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
 - A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
 - A single supplemental dose of PCV13 is recommended for all children aged 60 through 71 months with underlying medical conditions who have received an age-appropriate series of PCV7.
- Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
 - If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
 - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- Influenza vaccine (seasonal).** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
 - For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
 - Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
 - Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-9):93–94.
- Measles, mumps, and rubella vaccine (MMR).** (Minimum age: 12 months)
 - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
- Varicella vaccine.** (Minimum age: 12 months)
 - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
 - For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- Hepatitis A vaccine (HepA).** (Minimum age: 12 months)
 - Administer 2 doses at least 6 months apart.
 - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
- Meningococcal conjugate vaccine, quadrivalent (MCV4).** (Minimum age: 2 years)
 - Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
 - Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
 - Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
 - Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip/>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

Department of Health and Human Services • Centers for Disease Control and Prevention

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2011

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, Diphtheria, Pertussis ¹			Tdap	Tdap	Range of recommended ages for all children
Human Papillomavirus ²	see footnote ²		HPV (3 doses)(females)	HPV Series	
Meningococcal ²		MCV4	MCV4	MCV4	Range of recommended ages for catch-up immunization
Influenza ⁴		Influenza (Yearly)			
Pneumococcal ²		Pneumococcal			Range of recommended ages for catch-up immunization
Hepatitis A ⁴		HepA Series			
Hepatitis B ⁷		Hep B Series			Range of recommended ages for certain high-risk groups
Inactivated Poliovirus ⁸		IPV Series			
Measles, Mumps, Rubella ⁹		MMR Series			
Varicella ¹⁰		Varicella Series			

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

- Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
 - Persons aged 11 through 18 years who have not received Tdap should receive a dose followed by Td booster doses every 10 years thereafter.
 - Persons aged 7 through 10 years who are not fully immunized against pertussis (including those never vaccinated or with unknown pertussis vaccination status) should receive a single dose of Tdap. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid-containing vaccine are needed.
 - Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Human papillomavirus vaccine (HPV).** (Minimum age: 9 years)
 - Quadrivalent HPV vaccine (HPV4) or bivalent HPV vaccine (HPV2) is recommended for the prevention of cervical precancers and cancers in females.
 - HPV4 is recommended for prevention of cervical precancers, cancers, and genital warts in females.
 - HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
 - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
- Meningococcal conjugate vaccine, quadrivalent (MCV4).** (Minimum age: 2 years)
 - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
 - Administer 1 dose at age 13 through 18 years if not previously vaccinated.
 - Persons who received their first dose at age 13 through 15 years should receive a booster dose at age 16 through 18 years.
 - Administer 1 dose to previously unvaccinated college freshmen living in a dormitory.
 - Administer 2 doses at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
 - Persons with HIV infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
 - Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
 - Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older).
- Influenza vaccine (seasonal).**
 - For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
 - Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
 - Children 6 months through 8 years of age who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.
- Pneumococcal vaccines.**
 - A single dose of 13-valent pneumococcal conjugate vaccine (PCV13) may be administered to children aged 6 through 18 years who have functional or anatomic asplenia, HIV infection or other immunocompromising condition, cochlear implant or CSF leak. See *MMWR* 2010;59(No. RR-11).
 - The dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7.
 - Administer pneumococcal polysaccharide vaccine at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition.
- Hepatitis A vaccine (HepA).**
 - Administer 2 doses at least 6 months apart.
 - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
- Hepatitis B vaccine (HepB).**
 - Administer the 3-dose series to those not previously vaccinated. For those with incomplete vaccination, follow the catch-up schedule.
 - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
- Inactivated poliovirus vaccine (IPV).**
 - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
- Measles, mumps, and rubella vaccine (MMR).**
 - The minimum interval between the 2 doses of MMR is 4 weeks.
- Varicella vaccine.**
 - For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
 - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
 - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).
 Department of Health and Human Services • Centers for Disease Control and Prevention

Policy Title:	Diabetic Registry
Depts. Affected:	
Approval Date:	7-7-11
Written by:	Stephanie Shrago
Approved by:	QIS Task Force
Revised:	N/A



POLICY: Monitor performance of the management of PCP’s diabetic patients

PURPOSE: Document the workflow and utilization of PCP’s diabetic registry

Steps:

1. Dan Norman in IT will populate diabetic registry reports for all physicians of FPWC and WCPG monthly. The report will list diabetic patients ranked from highest A1C to lowest A1C. The report includes patient name, DOB, age, phone number, recent blood pressure, recent A1C and date, LDL and date, and notes if a diabetic patient is taking aspirin and has h/o hypertension. If a patient has a future appointment scheduled, they will not be included in the report to help facilitate flow and avoid duplicating appointments.

2. Individual physicians review the reports to see which diabetic patients are “exception patients” meaning those who are followed by endocrinology, hospice, in nursing home, etc. These are designated with an “E” or a comment.

3. A front office staff or MOA has been trained to review each diabetic report and schedule appropriate appointments based on the following criteria:

- Patients that have an A1C > 7.0-9.0 that have not been tested in over 3 months and who do not have a future appointment, will be scheduled with their PCP
- Patients that have an A1C > 9.0 that have not been tested in over 3 months may be referred directly to a diabetic educator.
- Patients that have any A1C < 7.0 and have not been seen in a year, will be scheduled with their PCP
- Patients that have a BP >140/90 and have not been seen in over 3 months and who do not have a future appointment, will be scheduled with their PCP
- It will note if patient scheduled, refused, left voice mail, or other.
- 2 contacts will be attempted and then a letter will be sent.

4. The reports are generated monthly. A comparison report of the registry will be provided to each physician quarterly. This will allow physicians the ability to monitor the number of uncontrolled diabetics, progress made, and relative reduction in the number of higher risk diabetics behind on routine diabetic appointments.

Policy Title:	Hypertension Registry
Depts. Affected:	
Approval Date:	7-7-11
Written by:	Patrick Page
Approved by:	QIS Task Force
Revised:	N/A



POLICY: Monitor performance of the management of PCP hypertension patients;

PURPOSE: Document workflow and utilization of PCP hypertension registry

Steps:

1. Dan Norman in IT will populate the hypertension registry for all physicians of FPWC and WCPG monthly. The report will list patients with hypertension diagnoses, using ICD codes that start with 401. The report will include patient name, DOB, age, phone number, most recent systolic and diastolic BP. Systolic readings above or equal to 140 and diastolic readings above or equal to 90 will be highlighted in patients whose last appointment was equal or greater than 90 days prior. If a patient has a future appointment scheduled, they will not be included in the report to help facilitate flow and avoid duplicating appointments.
2. A front office staff member or MOA in a clinical team t has been trained to review the HTN report and schedule appointments on the following criteria:
 - a. Patients with a systolic BP \geq 140 or diastolic BP \geq 90 will be contacted by phone, letter or patient portal email to arrange for a doctor office visit to address non-adherence.
3. The reports will be generated monthly. A quarterly quality report will be generated for physicians for review and comparison to peers.
4. Two contacts will be attempted and then a letter will be sent.

Results of Practice measures as relate to important medical conditions

Report Period	Count of patients 18 or older	Adult Weight Screening age 65 and older			Count of Patients 18 to 64 with a BMI in range PLUS count with a BMI not in range but have a follow-up plan documented	Diabetes Blood Pressure and A1c Measurements		
		Count of Patients 65 or Older with a visit in 6 months	Count of Patients 65 or older with a BMI in range PLUS count with a BMI not in range but have a follow-up plan documented	Count of patients 18 to 64 year of age with a visit in 6 months		Count of DM patients 18-75 yo	Count of DM patients with most recent BP in MY <140/90	Count of DM patients with most recent A1c in MY > 9.0%
5/1/2011	2054	137	43	336	80	144	108	13
6/1/2011	2058	146	47	348	86	143	103	14
7/1/2011	2050	152	48	350	91	140	102	15
8/1/2011	2049	146	48	350	97	141	105	14
9/1/2011	2040	150	47	340	102	143	96	14

Report Period	IVD LDL Screening and LDL Value <100			Tobacco Use Assessment, Part A	
	Count of IVD patients 18 years or older	Count of IVD patients with an LDL-C test done in MY	Count of IVD patients who have LDL < 100mg/dL	Count of patients 18 and older with 2 visits in 24 months	Count of patients 18 and older with 2 visits in 24 months queried about tobacco use one or more times
5/1/2011	60	34	15	703	639
6/1/2011	60	35	14	705	649
7/1/2011	58	36	16	699	652
8/1/2011	57	36	16	691	650
9/1/2011	57	35	16	699	661

Demonstration of planned team care

Medical Home Services Provider by Primary Care Partners, PC

The following is a list of services and activities provided by Primary Care Partners. These services allow us to provide quality patient care, to efficiently manage patients in a cost-effective manner and to encourage appropriate utilization of their health care resources.

Medical Care:

There are three medical practices in Primary Care Partners—Family Physicians of Western Colorado, Western Colorado Pediatric Associates and Western Colorado Physicians Group. Each practice is staffed with physicians (family physicians and pediatricians), physician assistants, nurse practitioners, nursing, clerical and support personnel. There are over 247 employees with an annual payroll of over \$12 million and revenue over \$20 million.

Scope and Coordination of Care: Our physicians care for 85% of the medical problems that present in our offices (respiratory, obstetrical, diabetic, cardiovascular and dermatologic). We arrange care with a panel of outstanding specialists for those medical problems we do not manage internally. We manage patients in both local hospitals. Our pediatricians treat complicated cases (chemotherapy, metabolic disorders, infectious diseases, premature infants) locally in consultation with specialists in the local area and the state.

Electronic Health Records: We have used an EHR for 12 years. Currently we use Allscripts brand. Our offices are paperless and wireless. Patient records are available at all sites, in the local hospitals, emergency rooms and assisted living facilities.

Medical Neighborhood: We have developed solid relationships with local specialists over the past 35 years. We are linked to them and all local health facilities electronically through the Quality Health Network (QHN). We minimize miscommunication and duplication of testing and services while we maximize excellent care. Through our Stentor connection, local radiologists and specialists can access our x-rays instantly, and we can access hospital imaging studies as well as those done in specialists' offices.

Continuity of Care: 40 primary care physicians and eight physician assistants and nurse practitioners provide care through Primary Care Partners. In 2009, there were 145,000 patient visits to our facilities. We provide primary care for over 30% of Mesa County residents. Every effort is made to have the patients seen in the office by the patient's personal physician. We have an elaborate system of notifying and educating patients when to use DOCS ON CALL, our on-site after hours clinic. At all the practices, the physicians coordinate care with other health care agencies (e.g. home health and hospice). Representatives from these agencies periodically attend meetings of the physicians and talk with individual physicians to assure coordination of care. Our physicians work closely with specialists and other health care providers when they are involved in the patient's care before, during and after the patient's care provided by that specialist. This communication is important to the continuity and quality of patient care as the primary care physician helps to keep the expectations of the patient in perspective with the anticipated results of a specialist's care.

House Calls and Nursing Home Visits: House calls are made as needed and nursing home visits are made regularly. Both are done to reduce the need or potential for hospitalization. We staff clinics in two local assisted living facilities.

Telephone Care: Many contacts occur with patients via telephone. All telephone conferences with patients where advice is given or treatment prescribed are documented in the patient record.

Telephone Triage: Qualified nursing personnel, using protocols and with the supervision of a physician, respond to patient questions, provide feedback on tests and procedures and do patient follow up every day. They provide physician directed case management. This service is available daily, including weekends and holidays, from 8:00 A.M. to 10:00 P.M. Between 10 pm and 8 am, the on-call physician takes all calls.

Disease State Management: Primary Care Partners participates in many disease state management programs such as high risk OB, diabetes, cardiovascular disease, asthma and depression. Health surveillance is monitored and encouraged through recall letters for mammograms, pap smears, physicals and other follow up care.

Uncomplicated Urinary Tract Infection (UTI) Management: Females 18-65 years of age with complaint of a possible UTI are screened in accordance with office protocol. If the complaint is only frequency, urgency or dysuria, the call is triaged by a nurse and authorization is obtained for appropriate medication. There is no office visit unless the symptoms are more serious (hematuria). Also, there is no Urinalysis or Culture and Sensitivity testing cost. This is an efficient, effective way to care for these patients.

Strep Culture Program: Patients can come directly to the office and receive a Strep culture with treatment if the test is positive without the expense of a regular office visit.

Patient Satisfaction: Patients are surveyed in all divisions at least twice a year. Some surveys are focused, some are random. Results are distributed to appropriate providers and management for continued improvement. This process over 30 years has enhanced our patients' loyalty and satisfaction with our service.

Hospital Utilization Management: In an effort to lower the length of stay for hospitalized patients, our physicians take an active involvement in the care of the hospitalized patient. Communication occurs with the patient and specialist physician(s) prior to a non-emergent hospitalization and during any hospitalization. Each month our physicians do case review of hospitalized patients to assure cost-effective and appropriate utilization of the hospital.

Drug Utilization Management: In an effort to control the cost of prescribed drugs, the drug management program has been established. A formulary has been developed of 'sample medications' that will be accepted by the practice. Presentations are made to the physicians about generic drugs that are less expensive, and on ways to prescribe medications that will reduce overall cost. Pharmaceutical representatives are not seen and no amenities are accepted from them. We have a monthly meeting (Pharma-Suitables) to discuss pharmacy cost and quality issues. All providers utilize Epocrates and receive a monthly pharmacy newsletter that promotes appropriate prescribing. Our physicians excel in generic prescribing.

Emergency Room Utilization Management: To reduce unnecessary hospital emergency room utilization, we have an aggressive program to educate our patients before and after emergency

room visits. Our staff contacts every patient that uses the emergency room when another resource would have been more appropriate and conducts education for future responses to urgent medical issues.

Coding Quality: Our “Accuracy in Coding Education Committee” does both focused and random chart reviews, gives feedback to providers, and conducts educational sessions to ensure accurate coding.

Outside Clinics: Facilities are provided for physicians from outside the area for specialty clinics.

DOCS ON CALL: This after hours-medical service is staffed by our physicians, nurses, technologists and receptionists daily. It is open from 5:00 — 10:00 P.M. weekdays and from 9:00 A.M. — 10:00 P.M. on Saturday and 10:00 A.M. to 10:00 P.M. on Sunday, and variable hours on holidays. It is a cost-effective and convenient alternative to the hospital emergency room for non-life threatening medical care. A visit for an ear infection costs 1/4th of the cost of the same visit at our local emergency room. A visit for abdominal pain costs 1/9th of an ER visit.

Grand Junction Diagnostics: The ancillary services provided by this division of Primary Care Partners include: X-ray, mammography, laboratory, bone densitometry (Osteoporosis) scanning and nocturnal oximetry. X-ray and laboratory services are available daily during office hours and DOCS ON CALL hours. 73,000 tests were performed in 2009.

Registered Dietitians and Certified Diabetic Educators: Our program is AADE accredited for diabetes education. A registered dietitian and three registered nurses, all certified diabetes educators, provide extensive counseling for our diabetic patients. Our bilingual dietitian provides nutritional education for patients with hyperlipidemia, obesity and their metabolic illnesses. These services have proven to reduce hospitalizations for patients (e.g., a newly diagnosed diabetic). Classes are offered on Type 2 Diabetes and healthy eating habits.

Other Services Offered to Our Patients:

Billing Information Services: We provide a help-desk for patient questions about insurance coverage and payments. This desk is staffed for 8 hours, Monday through Friday by 0.5 FTE's from our billing and collecting department at a cost to the organization of \$30,000 annually.

Healthy Steps: Our pediatricians participate in this nationally recognized program. Parents-to-be who meet eligibility criteria are seen by a licensed social worker at the time of their prenatal visits with their physician. Input, direction, support and encouragement on all aspects of childcare are given. On subsequent well child visits, additional support and advice are provided by the social worker. Support groups meet on a regular schedule for follow up and exchange of information.

Translation Service: This is a telephone interpreting service available 24 hours per day, 365 days per year through Language Link Enterprises. Interpretation for hundreds of languages is available from Albanian to Zulu.

Patient Education: A wide variety of educational materials are available. A library of books, audio-visuals, computer-generated handouts, pamphlets and brochures are provided to patients. 12 of our staff are fluent in Spanish.

Emergency Room Utilization Data: For 2009, our ER visits/1000, commercial business, was 112/1000. A regional comparison would be 216/1000.

Hospital Utilization Data: For 2008, our commercial business adult hospital days were 116/1000. A national comparison would be 260/1000.

Grand Valley Transit: Patients without transportation during the day are able to ride Grand Valley Transit to PCPPC doctor's office and back home at no cost to them. If they need to get medications or have a test or procedure, patients can get to these locations at no cost if the travel is on the same day.

Summary of outreach activities



News Release

University of Colorado Denver | Anschutz Medical Campus

Advancing Care Together (ACTT) aims to combine physical and mental health treatment

111 new sites create ACT portfolio

AURRORA, Colo. (Aug. 10, 2011) – A new and collaborative program led by medical experts at the University of Colorado Anschutz Medical Campus aims to bring together local, state and national leaders focused on improving primary care, mental health care and substance abuse treatment. The Advancing Care Together (ACTT) program will tap the expertise of clinicians on the front line and work with them to change their practices by addressing the fragmentation that has led to the separate treatment of physical and mental health problems. This three-year program is funded by the Colorado Health Foundation and will be housed at the CU School of Medicine Department of Family Medicine. “It is time to move beyond the separate histories of physical and mental health, and to achieve whole-person care for everyone,” said ACT Director, Larry A. Green, MD, professor of family medicine at the University of Colorado School of Medicine.

In July 2011, state and national leaders on the ACT Steering Committee selected 11 Colorado practice sites that comprise the ACT portfolio. These Colorado innovators are people who work tirelessly in primary care practices and community mental health centers in different types of communities serving diverse populations under varied business models. These awardees offered their best ideas about how to redesign their systems of care, and proposed practical solutions to better integrate the care of their patients and clients. Colorado and other states stand to learn a great deal from these innovators about how to work together to improve care.

ACT has a strong evaluation team led by Dr. Deborah Cohen of Oregon Health Sciences University who will assess the effects of the proposed strategies and help learn how to make sustainable changes.

“The ACTT program findings will be invaluable for other community partners and their integration efforts,” said Kelly Dunkin, vice-president of philanthropy for the Colorado Health Foundation. “We also hope that ACTT will continue to encourage the integration movement in Colorado, which falls in line with the Foundation’s mission to make us the healthiest state in the nation.” The formal launch of this program takes place September 16-18 at Cheyenne Mountain Resort in Colorado Springs.

The 11 Sites that Make Up the ACT Portfolio

Axis Health System, Durango Practice: Cortez Clinic Project: *Using a Personal Health Profile to Facilitate Integrated Care* Principal Investigator: Pamela Wise-Romero, PhD

Bender Medical Group, Inc., Fort Collins Practice: Miramont Family Medicine Project: *AIMS: Automation of Mental Health Services* Principal Investigator: John Bender, MD

Denver Health and Hospital, Denver Practice: Lowry Family Health Center Project: *Meeting Patient Preferences for Behavioral Health Screening and Treatment* Principal Investigator: Rob Keeley, MD

Jefferson Center for Mental Health, Wheat Ridge Practices: Independence Outpatient Services, West Colfax Outpatient Services, Cedar Adult Intensive Services Project: *Healthcare Homes without Walls* Principal Investigator: Donald Bechtold, MD

Kaiser Permanente Colorado, Denver Practice: TBN Project: *Practical Approaches to Integrating Mental and Physical Healthcare* Principal Investigator: Arne Beck, PhD

MidValley Family Practice, PC, Basalt Practice: MidValley Family Practice, PC Project: *Optimizing Healthy Lifestyle Management* Principal Investigator: Glenn Kotz, MD

Plan de Salud del Valle, Inc. Practice: Salud Family Health Center, Brighton Project: *Integrated Primary Care Workforce Development in the Medical Home* Principal Investigator: Andrea Auxier, PhD

Primary Care Partners, PC, Grand Junction Practices: Western Colorado Pediatric Associates, Family Physicians of Colorado, Behavioral Health and Wellness Project: *Expanding the Patient Centered Medical Home* Principal Investigator: Patrice Whistler, MD

Southeast Mental Health Services, La Junta Practice: High Plains Community Health Center Project: *Lamar REACT: Rural Excellence in Advancing Care Together* Principal Investigator: Jay Brooke, LCSW

Univ. of CO, Colorado Springs/CU Aging Center, Colorado Springs Practice: Peak Vista Community Health Centers

Project: *Cognitive and Psychological Screening to Enhance Integrated Care for Seniors*
Principal Investigator: Michael Kenny, PsyD

Westminster Medical Clinic, Westminster Practice:
Westminster Medical Clinic Project: *Behavioral Health-A Shared Service Model* Principal Investigator: Scott Hammond, MD

Faculty at the University of Colorado's [School of Medicine](#) work to advance science and improve care. These faculty members include physicians, educators and scientists at University of Colorado Hospital, Children's Hospital of Colorado, Denver Health, National Jewish Health, and the Denver Veterans Affairs Medical Center. Degrees offered by the University of Colorado School of Medicine include doctor of medicine, doctor of physical therapy, and masters of physician assistant studies. The School is located on the University of Colorado's Anschutz Medical Campus, one of four campuses in the University of Colorado system. For additional news and information, please visit the [University of Colorado Denver newsroom](#) online.

About the Colorado Health Foundation

The Colorado Health Foundation works to make Colorado the healthiest state in the nation by investing in grants and initiatives to health-related nonprofits that focus on increasing the number of Coloradans with health insurance, ensuring they have access to quality, coordinated care, and encouraging healthy living. For more information, visit www.coloradohealth.org.

Our Providers

Amy Bratteli, MD

Practice Experience:

Amy has been a family medicine physician for Family Physicians of Western Colorado since 2004. From 2000-2004, she practiced at Holy Family Memorial Hospital in Manitowoc, Wisconsin.

Residency:

Genesys Regional Medical Center, Grand Blanc, MI

Medical School:

University of North Dakota School of Medicine

College:

University of Mary

Certifications, Honors & Affiliations:

Board Certified – Family Medicine
Colorado Medical Society
Mesa County Medical Society
Board Certified - American Board of Family Medicine
Advanced Cardiac Life Support
Basic Life Support
Advanced Life Support in Obstetrics

Hospital Affiliations:

St. Mary's Hospital & Medical Center
Community Hospital



John Bratteli, MD

Practice Experience:

John has been a family medicine physician for Family Physicians of Western Colorado since 2004. From 2000-2004, he practiced at Holy Family Memorial Hospital in Manitowoc, Wisconsin.

Residency:

Genesys Regional Medical Center, Grand Blanc, MI

Medical School:

University of North Dakota School of Medicine

College:

University of North Dakota

Certifications, Honors & Affiliations:

Colorado Medical Society

Mesa County Medical Society

Board Certified – Family Medicine

Hospital Affiliations:

St. Mary's Hospital & Regional Medical Center

Community Hospital



Joshua Campbell, MD

Practice Experience:

Dr. Campbell joined Family Physicians of Western Colorado in August, 2009. Special interests include preventive and adult medicine, pediatrics and adolescent care.

Residency:

St. Mary's Family Medicine Residency

Medical School:

Loyola University in Chicago

College:

University of Colorado

Certifications, Honors & Affiliations:

Board Certified in Family Medicine

Hospital Affiliations:

St. Mary's Regional Hospital & Medical Center



David Dirks, MD

Practice Experience:

Dr. Dirks joined Family Physicians of Western Colorado in 1978. He has worked in the full arena of family medicine, including obstetrical, pediatrics, prevention medicine, and geriatrics.

Residency:

University of Utah McKay Dee Hospital

Medical School:

University of Colorado Medical center

College:

Princeton University

Certifications, Honors & Affiliations:

Board Certified – Family Medicine
American Academy of Family Physicians
Colorado Medical Society
Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center
Community Hospital



Jill Hilty, MD

Practice Experience:

Dr. Hilty joined Family Physicians of Western Colorado in 1997. She is also the Medical Director for Advanced Skin Care & Laser Center. She provides the full range of family medicine.

Residency:

University of California at Davis

Medical School:

University of Colorado School of Medicine

College:

Michigan State University

Certifications, Honors & Affiliations:

Medical Director, Physician Education for St. Mary's Hospital since 2004

Board Certified – Family Medicine

American Academy of Family Physicians

Colorado Medical Society

Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center



John P. Flanagan, MD

Practice Experience:

Dr. Flanagan joined our practice in January, 2009. Previously, he had practiced family medicine in Ft. Collins, CO for eight years. His special interests include pediatrics, prevention and adult medicine, and sports medicine.

Residency:

St. Joseph's Hospital Family Practice Residency; Denver, CO

Medical School:

University of Connecticut School of Medicine

College:

Fairfield University

Certifications, Honors & Affiliations:

Board Certified - Family Medicine

American Board of Family Medicine

Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center



Lynn Holliday, MD

Practice Experience:

Joined Western Colorado Physicians Group in 2010

Residency:

St. Mary's Hospital Family Medicine

Medical School:

Vanderbilt University Medical School; Nashville, Tennessee

College:

Vanderbilt University College

Certifications, Honors & Affiliations:

Summer Medical Institute Medical Missions Experience; Manila 2006



Glenn Madrid, MD

Practice Experience:

Dr. Madrid joined Western Colorado Physicians Group in 1989. He specializes in all aspects of family practice, with a strong interest in obstetrics.

Residency:

St. Mary's Family Practice Residency

Medical School:

University of Colorado Medical School

Certifications, Honors & Affiliations:

Board Certified – Family Medicine

American Academy of Family Physicians

Colorado Medical Society

Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center

Community Hospital



Rebecca Mashburn, MD

Practice Experience:

Dr. Mashburn joined Western Colorado Physicians Group in 2000. She specializes in all aspects of family practice. Prior to joining Primary Care Partners, she was the Regional Medical Director for five years for Nepal Okhaldhunda Hospital. She also worked at Haxtun Community Hospital in Haxtun, Colorado

Residency:

Northern Colorado Medical Center

Medical School:

Medical University of South Carolina

Certifications, Honors & Affiliations:

Board Certified – Family Medicine
American Academy of Family Physicians
Colorado Medical Society
Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center
Community Hospital



Andy Mohler, MD

Practice Experience:

Andy has practiced family medicine at Family Physicians of Western Colorado since 2002. He served as Chief Resident at Good Samaritan Family Medicine from 1999 – 2000, and was a Junior Faculty Member from 2000-2001.

Residency:

Good Samaritan Family Medicine - Phoenix, AZ – Family Medicine

Medical School:

University of Colorado Health Sciences

College:

Pomona College – Bachelor of Arts

Certifications, Honors & Affiliations:

Board Certified – Family Medicine
Colorado Medical Society
Mesa County Medical Society
American Academy of Family Physicians
Alpha Omega Alpha, Phi Beta Kappa

Hospital Affiliations:

St. Mary's Hospital & Medical Center
Community Hospital



Gregg Omura, MD

Practice Experience:

Dr. Omura joined Western Colorado Physicians Group in 1981. He specializes in all aspects of family medicine and has a strong interest in depression and chronic care management.

Residency:

St Mary's Family Practice Residency

Medical School:

University of Colorado School of Medicine

Certifications, Honors & Affiliations:

American Academy of Family Physicians

Colorado Medical Society

Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center

Community Hospital



Pat Page, MD

Practice Experience:

Dr. Page joined Western Colorado Physicians Group in 1983. He specializes in all aspects of family medicine, including obstetrics.

Residency:

Lutheran Medical Center – Brooklyn, NY

Medical School:

University of Colorado School of Medicine

Certifications, Honors & Affiliations:

Board Certified – Family Medicine

American Academy of Family Practice

Colorado Medical Society

Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center

Community Hospital



Mike Pramenko, MD

Practice Experience:

Mike joined Family Physicians of Western Colorado in 1998. He has worked in the full arena of family medicine, including obstetrics, pediatrics, prevention medicine and geriatrics.

Residency:

St. Mary's Family Practice Residency Program

Medical School:

Dartmouth College Medical School

College:

University of Colorado

Certifications, Honors & Affiliations:

Board Certified – Family Medicine

American Academy of Family Physicians

Colorado Medical Society

Mesa County Medical Society

President – Mesa County Medical Society

Physicians Health Care Congress (Health Care Reform)

Medical Column – Grand Junction Free Press (bi-weekly)

Hospital Affiliations:

St. Mary's Hospital & Medical Center

Community Hospital



James Quackenbush, MD

Practice Experience:

Dr. Quackenbush joined Family Physicians of Western Colorado in 1996. He is currently the Medical Director of our after-hours clinic, DOCS ON CALL.

Residency:

St. Mary's Family Practice Residency Program

Medical School:

University of Colorado School of Medicine

College:

University of Colorado

Certifications, Honors & Affiliations:

Board Certified – Family Medicine
American Academy of Family Physicians
Mesa County Medical Society
Colorado Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center
Community Hospital



Susan Sayers, MD

Practice Experience:

Susan joined Family Physicians of Western Colorado in 1998. She has worked in the full arena of family practice, including obstetrics, pediatrics, prevention medicine and geriatrics. She worked as a research assistant at the Arizona Cancer Center from 1986-91, and worked in malaria control as a Peace Corps volunteer in Thailand from 1984-86.

Residency:

St. Mary's Family Practice Residency Program

Medical School:

University of Arizona Medical School

College:

University of Arizona

Certifications, Honors & Affiliations:

Board Certified – Family Medicine
American Academy of Family Physicians
Mesa County Medical Society
Colorado Medical Society
Advanced Cardiac Life Support
Advanced Life Support in Obstetrics
Mesa County Independent Physicians Association

Hospital Affiliations:

St. Mary's Hospital & Medical Center
Community Hospital



Britta Seppi, MD

Practice Experience:

Dr. Seppi joined Family Physicians of Western Colorado in 2007 after completing her residency. She also offers obstetrical services through this practice.

Residency:

St. Mary's Family Practice Residency; Grand Junction, CO

Medical School:

University of Colorado School of Medicine

Certifications, Honors & Affiliations:

Board eligible in Family Medicine

Hospital Affiliations:

St. Mary's Hospital & Regional Medical Center
Community Hospital



Stephanie Shrago, MD

Practice Experience:

Dr. Shrago joined Family Physicians of Western Colorado in July, 2007 after completing her residency.

Residency:

St. Mary's Family Practice Residency; Grand Junction, CO

Medical School:

University of Colorado School of Medicine

Certifications, Honors & Affiliations:

Board eligible in Family Medicine

Hospital Affiliations:

St. Mary's Hospital & Regional Medical Center
Community Hospital



Marshall Steel, MD

Practice Experience:

Dr. Steel joined Western Colorado Physicians Group in 1989. He specializes in all aspects of family medicine.

Residency:

St. Mary's Family Practice Residency

Medical School:

Loyola University, Stritch School of Medicine

College:

Occidental College, Los Angeles, CA

Certifications, Honors & Affiliations:

Board Certified – Family Medicine
American Academy of Family Physicians
Colorado Medical Society
Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center
Community Hospital



Paul Sturges, MD

Practice Experience:

Dr. Sturges joined Family Physicians of Western Colorado in 2005. His special interest is preventative and adult medicine. He practiced in California for 15 years before returning to his home state of Colorado.

Residency:

Loma Linda University School of Medicine

Medical School:

Loma Linda University School of Medicine

College:

Union College – Lincoln, Nebraska

Certifications, Honors & Affiliations:

Board Certified - Family Medicine

American Academy of Family Physicians

Colorado Medical Society

Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center

Community Hospital



Dan Sullivan, MD

Practice Experience:

Dr. Sullivan joined Family Physicians of Western Colorado in 1992. His special interests are pediatric and adult preventive care, and computer applications in medicine.

Residency:

University of Washington

Medical School:

University of Colorado Health Sciences Center

College:

University of Colorado

Certifications, Honors & Affiliations:

Board Certified – Family Medicine

Colorado Medical Society

Mesa County Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center

Community Hospital



Christopher Weaver, MD

Practice Experience:

Chris joined Family Physicians of Western Colorado in 1989. Prior to that, he was the Clinical Director of Ft. Duchene Indian Health Clinic from 1985-88.

Residency:

St. Mary's Family Practice Residency Program

Medical School:

University of Colorado School of Medicine

College:

University of Colorado

Certifications, Honors & Affiliations:

Board Certified – Family Medicine

Fellow - American Academy of Family Physicians

Faculty of St. Mary's Family Practice Residency Program

Asst. Clinical Professor, University of Colorado Schools of Medicine

Mesa County Medical Society

Colorado Medical Society

Hospital Affiliations:

St. Mary's Hospital & Medical Center

Community Hospital



Peggy Wrich, DO

Practice Experience:

Dr. Wrich joined Family Physicians of Western Colorado in August, 2011 after completing her residency program.

Residency:

St. Mary's Family Practice

Medical School:

Des Moines University

College:

Des Moines University

Certifications/Honors:

Board Certified in Family Medicine

Hospital Affiliations:

St. Mary's Hospital
Community Hospital

