



STATEWIDE HEALTHCARE INNOVATION PLAN (SHIP) Final PCMH Application for Cohort 2

Version 1.0 FINAL (September 2016)

A Final Application **must be completed online** for each individual clinic site **by Friday, October 28, 2016**, to be considered for SHIP participation. If you encounter content or technical issues, please contact the Office of Healthcare Policy Initiatives at OHPI@dhw.idaho.gov or call 208-334-0600.

Introduction: The Idaho SHIP seeks to transform the healthcare system through use of a state developed model test design based on the patient centered medical home. Continuing the healthcare reform process Idaho initiated in 2007, the Idaho Healthcare Coalition (IHC) was created by executive order 2014-02 to lead this process and guide Idaho's SHIP. As part of the grant, Idaho has the ability to support practice transformation with a variety of resources and tools (e.g. technical assistance, data analytics tool, incentive payments). Idaho's transformation plan is based on our experience and success with the patient centered medical home model.

This final PCMH application will be used to evaluate and determine the second cohort of clinics selected for SHIP participation. As guided by the IHC, selection criteria are based on key transformation standards and elements thought to increase the chance of successful PCMH implementation and potential recognition. These criteria in no specific order include: physician/ provider champion engagement, geographic location (within each of the seven Public Health Districts), rural vs. urban/suburban service area, electronic health record utilization and connectivity, and PMCH familiarity. The criteria selected have been based on previous experience implementing the PCMH model within the state of Idaho and our desire to select clinics able to make the transformation successfully while helping other clinics prepare for participation in Cohort 2 and 3.

Previous experience with clinic recruitment has also taught us to collect selection criteria items as well as readiness assessment information during the application process. This permits readiness information to be shared with the SHIP PCMH technical assistance contractor after final cohort selection, allowing them to enter into work with this cohort better informed of the current structure. **Selection criteria question text will appear in BOLD**, while readiness assessment questions will remain in plain text format. Questions contained within this application are logic driven; meaning that depending on how questions are answered, additional questions will appear seeking further details. Please respond to all questions honestly and as accurately as possible; answers provided to readiness assessment questions will not be viewed or considered by the Department evaluation team. The selection committee will receive de-identified responses when reviewing applications for participation.

Finally, SHIP is a multi-year plan for Idaho that includes three cohorts of clinic selection. Cohort 1 spanned from 2/1/2016 to 1/31/2017; Cohort 2 will begin 2/1/2017 and end 1/31/2018. Cohort 3 will span 2/1/2018 to 1/31/2019. Final notification of clinic selection for Cohort 2 is anticipated to occur during the month of December 2016; additional instruction and next steps will be provided at time of notification.

If not selected for the second cohort, feedback will be provided to help your clinic(s) prepare to apply for the third cohort in the fall of 2017. The number of clinics selected is directly tied to grant resources, funding and current change capacity.

Additional information on SHIP including a FAQ page can be found on our website at:

www.SHIP.idaho.gov.

Section 1: Clinic Profile

Rationale:

Your clinic contact information, make-up and descriptive characteristics will assist in follow-up efforts and does include several selection criteria (**BOLD** items)

Please provide the following information for each individual clinic site to be considered for SHIP participation:

1.	Clinic Name	
2.	Clinic's Physical Address	
3.	City	
4.	State	
5.	County	
6.	Zip Code	
7.	Phone Number	
8.	Fax Number	
9.	Main Contact First Name	
10.	Main Contact Last Name	
11.	Main Contact Email Address	
12.	Corporate Ownership or Healthcare System Name (if applicable)	
13. Organization Type	<input type="checkbox"/> Private Practice <input type="checkbox"/> Community Health Center (CHC) <input type="checkbox"/> Rural Health Center (RHC) <input type="checkbox"/> Hospital/ Health System Owned Clinic <input type="checkbox"/> Other:	
14. Predominant Specialty	<input type="checkbox"/> Family Medicine <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Multi-Specialty <input type="checkbox"/> Other:	
15. Please complete the Clinic Staff List	a. Physicians	
	Name:	Credentials: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time

	b. Physician Assistants, Nurse Practitioners		
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	c. Clinic Staff (i.e. other professional licensed staff)		
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	d. Administrative and Support Staff		
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Name:	Credentials:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time

FOR REFERENCE ONLY

Section 2: Transformation Plan, History and Experience

Rationale:

Through various pilot projects, we have learned engaged leadership and an effective transformation team are critical to the success of implementing and sustaining the PCMH model. Questions appearing in **BOLD** will be considered as selection criteria.

16. Please list your current or proposed Transformation Team members	Physician/ Provider Champion Name:	Title:	Role in Transformation:	email:
	Clinic Administration Name: (if applicable)	Title:	Role in Transformation:	email:
	Office Manager Name:	Title:	Role in Transformation:	email:
	Other Key Leaders Name:	Title:	Role in Transformation:	email:
	Other Key Leaders Name:	Title:	Role in Transformation:	email:
17. Has your clinic ever participated in any of the following? (Please check all that apply)	<input type="checkbox"/> Safety Net Medical Home Initiative <input type="checkbox"/> Idaho Medical Home Collaborative (IMHC) Pilot <input type="checkbox"/> Other PCMH Programs (CHIC, etc.); Please list: <input type="checkbox"/> None			
18. Has your clinic achieved national PCMH recognition or accreditation? <i>Recognition is encouraged, but not required to apply or to participate in the SHIP.</i>	<input type="checkbox"/> Yes [if yes, proceed to 19, skip 20-21] <input type="checkbox"/> No [if no, proceed to 20]			
19. Please indicate, the organization(s) the national PCMH recognition or accreditation was received from, and level of recognition (if from NCQA). <i>Recognition is encouraged, but not required to apply or to participate in the SHIP.</i>	<input type="checkbox"/> AAAHC	Date Accredited:		
	<input type="checkbox"/> Joint Commission	Date Accredited:		
	<input type="checkbox"/> NCQA	Date Recognized: Level of Recognition:		
	<input type="checkbox"/> URAC	Date Certified:		
20. Are you currently in the process of applying for recognition or accreditation with AAAHC, The Joint Commission, NCQA, or URAC?	<input type="checkbox"/> Yes [if yes, proceed to 21] <input type="checkbox"/> No [if no, proceed to 22]			

21. Please provide information on the current status of your application process for national recognition or accreditation, with which organization you are applying, and to what level, if applicable, you are attesting to?	
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FOR REFERENCE ONLY

Section 3: Health Information Technology (HIT) Capabilities

Rationale:

We understand that every clinic in Idaho has a different level of experience and may use one of several platforms (i.e. EHR). Access to data, in a timely and consistent manner is essential for effective practice transformation. Additionally, federal grant reporting requirements necessitate practice connectivity to the Idaho Health Data Exchange (IHDE) and Health Tech Solutions. Many of the questions included in this section are readiness related and will assist the IHDE once the first wave selection has been completed. Only questions appearing in **BOLD** will be considered as selection criteria. The questions in this section should be answered by or through consultation with your clinic's IT Administrator/ Manager.

22. Does your clinic have an electronic health record?	<input type="checkbox"/> Yes [if yes, proceed to 23] <input type="checkbox"/> No [if no, proceed to 36]										
23. Do you have any EHR conversion planned or being considered between 2/1/2017 and 1/31/2018? (For example: Will you be changing EHR vendors or software between 2/1/2017 and 1/31/2018?)	<input type="checkbox"/> Yes <input type="checkbox"/> No										
24. Please identify your clinic's IT Administrator/ Manager or anyone in your clinic who is involved in the daily operational management with your EHR vendor and the person completing the questions in this section of the application.	<table border="1"> <tr> <td data-bbox="824 877 1036 919">IT Contact Name</td> <td data-bbox="1036 877 1443 919"></td> </tr> <tr> <td data-bbox="824 919 1036 961">Title</td> <td data-bbox="1036 919 1443 961"></td> </tr> <tr> <td data-bbox="824 961 1036 1066">Organization (if not employee of applying clinic)</td> <td data-bbox="1036 961 1443 1066"></td> </tr> <tr> <td data-bbox="824 1066 1036 1108">Email</td> <td data-bbox="1036 1066 1443 1108"></td> </tr> <tr> <td data-bbox="824 1108 1036 1140">Phone</td> <td data-bbox="1036 1108 1443 1140"></td> </tr> </table>	IT Contact Name		Title		Organization (if not employee of applying clinic)		Email		Phone	
IT Contact Name											
Title											
Organization (if not employee of applying clinic)											
Email											
Phone											
25. Did the person listed in Question 24 complete this section of the application?	<input type="checkbox"/> Yes [if yes, proceed to 27] <input type="checkbox"/> No [if no, proceed to 26]										
26. If No, please identify the person completing this section of the application	<table border="1"> <tr> <td data-bbox="824 1213 1036 1255">Name</td> <td data-bbox="1036 1213 1443 1255"></td> </tr> <tr> <td data-bbox="824 1255 1036 1297">Title</td> <td data-bbox="1036 1255 1443 1297"></td> </tr> <tr> <td data-bbox="824 1297 1036 1339">Email</td> <td data-bbox="1036 1297 1443 1339"></td> </tr> <tr> <td data-bbox="824 1339 1036 1371">Phone</td> <td data-bbox="1036 1339 1443 1371"></td> </tr> </table>	Name		Title		Email		Phone			
Name											
Title											
Email											
Phone											
27. What is the size, make-up, and availability of your clinic's IT office staff?											
28. What brand of EHR are you using?	<input type="checkbox"/> Allscripts Professional <input type="checkbox"/> athenaClinicals <input type="checkbox"/> Centricity <input type="checkbox"/> Cerner <input type="checkbox"/> e-MDs <input type="checkbox"/> eClinicalWorks <input type="checkbox"/> Epic <input type="checkbox"/> Greenway (PrimeSuite, SuccessEHS, Intergy) <input type="checkbox"/> NextGen <input type="checkbox"/> McKesson (Practice Partner) <input type="checkbox"/> Meditech <input type="checkbox"/> Other (please specify):										

29. What version of the EHR is currently deployed to production? (This can often be located on the splash screen of the program when launched)	
30. How many months has the clinic been using its current EHR system?	
31. Does your EHR support Health Information Exchange (HIE) connectivity? (This functionality may need to be activated by your vendor, not all EHR products even support this. You may need to contact your EHR vendor for assistance in answering this question)	<input type="checkbox"/> Yes <input type="checkbox"/> No
32. Can your certified EHR produce a CCD (transition of care document) in the .xml format using the CCD template structure? (You may need to contact your EHR vendor for assistance in answering this question)	<input type="checkbox"/> Yes [if yes, proceed to 33] <input type="checkbox"/> No [if no, proceed to 34]
33. If yes, can your EHR automate the production of the CCDs, as opposed to having to manually create them? (You may need to contact your EHR vendor for assistance in answering this question)	<input type="checkbox"/> Yes <input type="checkbox"/> No
34. Do you have access to vendor product support? (Often referred to as 'Level 2' support - troubleshooting, configuration, database administration, and repair for server, network, infrastructure, Data Center, email, file shares, and other infrastructure issues)	<input type="checkbox"/> Yes <input type="checkbox"/> No
35. Do you have access to helpdesk support when you have questions about your EHR? (Often referred to as 'Level 1' support – device support, breaks/fixes, configuration issues, software installations, trouble shooting)	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. How does your clinic or organization support your EHR product?	
37. Is your EHR connected to the Idaho Health Data Exchange (IHDE)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4: Primary Care/ Behavioral Health Integration

Rationale:

Idaho is a 100% designated shortage area for mental health professional services. As clinics transform to PCMH practices support the client, integration and access to behavioral health care will be essential elements to achieving patient wellness. Part of the SHIP plan includes goals and metrics related to increasing patient wellness and this will be support in part by behavioral health integration efforts with PMCH clinics.

<p>38. Please indicate the level of primary care/ behavioral health integration occurring in your office?</p>	<p> <input type="checkbox"/> Full collaboration in a merged integrated practice for all patients <input type="checkbox"/> Close collaboration with several aspects of integrated practice <input type="checkbox"/> Co-located with close collaboration on-site with some system integration <input type="checkbox"/> Co-located with basic collaboration on-site <input type="checkbox"/> Basic collaboration off-site <input type="checkbox"/> Minimal collaboration/ coordination </p>
<p>39. Is your clinic completing behavioral health screenings (i.e. a PHQ 2, PHQ 9, or other universal screening)?</p>	<p> <input type="checkbox"/> Yes [If Yes, proceed to 40] <input type="checkbox"/> No [If No, proceed to 41] </p>
<p>40. If yes, are behavioral health screenings conducted only during wellness visits?</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>
<p>41. Please describe how your clinic interfaces with behavioral health services and providers in your community. It can include efforts to meet patients' needs not previously captured.</p>	

Section 5: Quality Improvement (QI) Activities

Rationale:

Quality improvement is a hallmark of high performing patient centered medical homes. Learning more about current practices will assist the PCMH contractor in offering technical assistance.

42. Does the clinic use performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
43. Do you have a formal quality improvement policy in place?	<input type="checkbox"/> Yes [If Yes, proceed to 45] <input type="checkbox"/> No [If No, proceed to 44]		
44. If No, do you have a plan to implement QI policies and procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
45. Please indicate frequency of QI meetings			
46. Please list clinic role of QI committee members (e.g. RN, patients, office manager)	Name	Title	Role
	Name	Title	Role
	Name	Title	Role
	Name	Title	Role
47. Please specify the QI tool(s) being used by your clinic (e.g. Six Sigma, Lean, PDSA cycles).			
48. Please indicate what you track and measure. (Check all that apply)	<input type="checkbox"/> Clinical Quality measures <input type="checkbox"/> Preventive care <input type="checkbox"/> Care Coordination <input type="checkbox"/> Patient Experience <input type="checkbox"/> Provider Experience <input type="checkbox"/> Overall clinic efficiencies affecting healthcare costs (e.g., reduction readmissions, ER visits, redundant labs)		

Section 6: Clinic Vision and Intentions

Rationale:

An engaged physician/ provider leadership champion, clinic administration engagement and a dedicated transformation team is imperative for successful transformation and sustainability of the PCMH model. A physician (recommended), or other provider leadership champion, should be instrumental in implementing long-term changes/vision and continually encourages other physicians/providers who might be unsure if they want to participate.

49. How does your clinic’s strategic plan align with the SHIP goals to improve health outcomes, reduce healthcare costs and improve provider and patient experience?	
50. Please tell us about your identified physician/ provider champion [answered in Section 2; Question 16] and what your transformation team hopes to accomplish within the Cohort 2 timeframe (February 1, 2017 to January 31, 2018) and beyond.	
51. As the physician/ provider champion for this clinic, what will your commitment to this PCMH work look like over the next year (i.e., attending meetings, leading communications, breaking down barriers, troubleshooting challenges, etc.)?	
52. As the physician/ provider champion for this clinic, please describe: <ul style="list-style-type: none"> • One or more successful change or transformation projects you have championed within the clinic. • How did you champion that change? 	

Section 7: Completion & Submission

By electronically submitting this application, I attest the answers provided are complete and accurate to the best of my ability at the time of submission.

Further, I attest that I am the authorized representative of the business entity permitted to submit this application for consideration.

Name of person completing application	
Job Title	
Email address	
Phone number	