MO HealthNet

Application for
Health Home Service Provider Status

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Section 1. Introduction

A. Overview

The Missouri Department of Social Services (DSS) seeks Practice Sites comprised of licensed physicians (internal medicine, general medicine, pediatric, and family practice specialists), collaborating with other licensed health care professionals including nurse practitioners and physician assistants, to serve as Health Homes for MO HealthNet participants. The Health Home is an alternative approach to the delivery of primary care services that promises better patient experience and better results than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home (PCMH) [1], but is customized to meet the specific needs of low-income patients with chronic medical conditions.

The recognized primary care Practice Sites ("Practices") will work individually to continually evolve as a Health Home. Some of the recognized sites may also work with one another collectively to transform their Practices over at least a two-year period by participating in a learning collaborative[2]. DSS will require that all recognized Health Homes participate in Health Home transformation training. DSS will select some Practices to participate in the learning collaborative. Those Practices that DSS does not select for learning collaborative participation and that are part of a multi-site practice organization will be required to participate in practice organization-run training utilizing DSS-prescribed learning collaborative content which the practice organization may choose to supplement. A Practice Site or Practice is defined as the single physical location at which a practice provides Health Home services. Organizations that wish to have multiple Practice Sites recognized as Health Homes may submit one application, but with separate detailed responses for each Practice Site. DSS will consider each Practice Site individually.

If a Practice includes both pediatric and adult specialties (i.e., family, internal, or general medicine), the Practice will be required to operate the entire Practice as a Health Home and must submit one application that covers all primary care specialties at the Practice.

Practices will also be required to obtain National Committee of Quality Assurance (NCQA) Patient Centered Medical Home recognition (see **Section 2.E**).

Practices will be paid for performing certain start-up activities, will be paid per-member-per-month (PMPM) payments for performing various Health Home activities, and may receive incentive payments relating to performance, as more fully described in **Section 3**.

B. Health Home Qualifications

In order to be recognized as a Health Home, primary care practice candidates must, at a minimum, as of the date of application submission:

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[1] For more information on the PCMH, see www.pcpcc.net/files/PCMH_Vision_to_Reality.pdf.

[2] A learning collaborative is a process pioneered by the Institute for Healthcare Improvement whereby clinical teams join clinical teams from other organizations to learn in order to generate performance improvement. Practice teams meet a few times face-to-face over the course of at least 12 months and learn from faculty and from one another.

- have a substantial percentage (not less than twenty-five percent) of the patient panel enrolled in MO HealthNet or uninsured
- provide a Health Home that is capable of overall cost effectiveness;
- have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated by through the application process and agreement to participate in the learning collaborative, including in-person sessions and regularly scheduled telephone calls;
- have patient panels assigned to each primary care clinician;
- actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for MO HealthNet participants;
- utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;
- meet the minimum access requirements of third-next-available appointment within 30 days and same-day urgent care, and
- have completed EMR implementation and been using the EMR as its primary medical record solution, to e-prescribe, and to generate, or support the generation of through a third party such as a data repository, clinical quality measures relevant to improving chronic illness care and prevention for at least six months prior to the beginning of health home services.

C. General Application Requirements

- Applicants must confirm that a substantial proportion of their population served includes MO HealthNet-eligible and/or uninsured patients with chronic conditions.
- Applicants must comply with established timeframes.

D. Application Timetable

Unless otherwise specified, the time of day for the following events shall be between 8:00 a.m. and 4:30 p.m., Central Time (CT).

DSS may adjust this schedule as it deems necessary. Notification of any adjustment to the Application Timetable shall be posted at http://dsspubt/mhd/cs/health-homes/.

1.	Application Issued	June 13, 2011
2.	Deadline for Written Inquiries	July 8, 2011
3.	**Practices' Responses Due**	July 11, 2011
4.	Anticipated Practice Notification Date	September 30, 2011

E. Prospective Applicant Inquiries

Prospective applicants may make written inquiries concerning this application until no later than July 8, 2011 at the address listed in **Section 4.A**, or by e-mail to Clinical.Services@dss.mo.gov.

Inquiries received after the deadline may be disregarded. DSS will review inquiries received before the deadline and at its discretion prepare written responses to questions which it determines to be of general interest and that help to clarify the RFA (Request for Application). Any written response will be posted at- http://dsspubt/mhd/cs/health-homes/. Only written responses will be binding on DSS.

Section 2: Health Home Service Requirements

Practices will work individually, and in some cases with one another collectively, to continually evolve as Health Homes by fulfilling the responsibilities delineated in Section 2. Failure to meet these responsibilities will be cause for suspension of Practice Health Home payments and/or loss of Health Home provider status.

This section describes substantially the activities Practices will be required to engage in and the responsibilities they will fulfill if recognized as a Health Home provider. Health Home status is also subject to change should the CMS or DSS determine that it is necessary to change the requirements of Health Homes or should CMS or DSS action cause for the elimination of the Health Home provider type.

A. Health Home Transformation Training

1. **Learning Collaborative**

DSS shall select and require some of Health Home-recognized Practices to participate in a Health Home learning collaborative in the following fashion. The Practice shall:

- designate three representatives of each Practice's Core Practice Team to participate in a learning collaborative. Learning collaborative participation shall entail attendance at nine days of learning collaborative meetings, including seven days in the 12 months beginning with the first learning session, and two days in the next twelve months. A senior clinician within the Practice, another clinician, and a non-clinician member (e.g., practice manager or practice administrator) of each Practice's primary care Core Practice Team shall attend the learning collaborative meetings;
- participate with one or more members of each Core Practice Team in monthly one-hour learning collaborative conference calls or webinars;
- submit the data reports specified in **Section 2.H**, below; and
- participate in ad hoc, time-limited topical work groups (e.g., primary care and behavioral health integration) as requested by DSS.

2. Health Home Training

DSS shall require a Practice organization that has more than one of its Practice Sites recognized as Health Homes, but not all of its sites selected by DSS for learning collaborative participation, to designate a trainer to participate in a "train-the-trainer program." The trainer shall attend the learning collaborative as a member of a Practice's Core Practice Team and then train all the organization's other Health Home practices that DSS did not select for learning collaborative participation. DSS, or its designee, shall identify content that the Practice organization trainer will teach to the Health Home Practice Sites that do not participate in the learning collaborative.

B. Internal Practice Team Meetings

Practices shall convene regular internal Practice Team meetings to plan and take steps to support continual Health Home evolution.

C. Patient Registries

Practices shall create and maintain patient registries, using electronic health record (EHR) software, a stand-alone registry or a third-party data repository and measures reporting system. A patient registry is a system for tracking information that DSS deems critical to the management of the health of a primary care practice's patient population, including dates of delivered and needed services, laboratory values needed to track a chronic condition, and other measures of health status. The Practice's registry shall be used for:

- patient tracking;
- patient risk stratification;
- analysis of patient population health status and individual patient needs, and
- reporting, as specified in **Section 2.H**, below.

D. Mastery of the Required Health Home Core Competencies[3]

Practices shall transform how they operate in order to become a Health Home. Transformation entails mastery of 13 Health Home core competencies, to be taught through the learning collaborative, and defined as follows:

1. Patient/family/peer/advocate/caregiver-centeredness[4]: This means that there is a whole patient orientation to care. Longitudinal care is delivered with transparency, individualization, recognition, respect, and an understanding of and respect for cultural and linguistic preferences.[5] Such care also provides patients/families/caregivers with choice in all matters and possesses an ongoing focus on consumer service, with bi-directional feedback. A practice demonstrates a defined structure at the practice level for gaining patient, family, or caretaker advisory input into overall patient satisfaction as well as feedback/suggestions/recommendations specific to operations of the health home.
2. Multi-disciplinary team-based approach to care: A collaborative multi-disciplinary care team in which team members practice to the full extent of their license, education and training with bidirectional, effective team communication, collaboration and clear role definition.
3. Personal patient-primary care clinician relationships: Each patient has a primary care clinician relationship, even if cared for by a care team within the Practice.
4. Planned visits and follow-up care: In contrast to episodic, reactive care, this manner of primary care delivery tracks patients on an ongoing basis so that the practice is informed and ready to address the patient's needs holistically whenever the patient makes contact, and follows up with patients after encounters, as necessary.
5. Population-based tracking and analysis with patient-specific reminders: To support planned visits and follow-up care, a practice needs information tracking capacity in the form of a freestanding or EHR-based patient registry with reporting functionality to proactively identify patient and population gaps in care against evidence-based benchmarks.
6. Care coordination[6] across settings, including referral and transition management: Practices assume responsibility for tracking and assisting patients as they move across care settings, and for coordinating services with other service providers including behavioral health, social service, and long-term support providers.

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[3]Some core competencies lend themselves to condition-specific changes (e.g., self-management support), while others require practice-wide change (e.g., patient-centeredness). For those core competencies requiring condition-specific changes, DSS has adopted the idea that initial learning collaborative sessions would focus on a limited number of common conditions for the practices, with the pediatric practices focusing on different conditions than primary care practices treating an adult population.

[4] "Patient/family/caregiver" recognizes that in pediatric care and in care for some adults, family members and caregivers play a primary role in identifying and communicating the health needs of a patient and in self-management activities.

[5] Berwick DM. "What 'Patient-centered' Should Mean: Confessions of An Extremist". *Health Affairs* 28, no. 4, w555-565, published online May 19, 2009.

[6] See **Appendix A** for definitions of "care coordination" and "Clinical Care Management Services."

7. Integrated Clinical Care Management[7] services focused on high-risk patients: For the most clinically at-risk patients in a practice, a care manager is either a) based in the practice or b) residing outside of the practice but otherwise tightly integrated with the Practice Team.
8. Patient and family education: The Practice Team educates patients and family members both on primary preventive care, and on self-management of chronic illness (i.e., secondary preventive care).
9. Self-management support by members of the Practice Team: Extending beyond education, self-management support assists the patient and/or family/peer/advocate/caregiver with the challenges of ongoing self-management, directly and/or through referral.
10. Involvement of the patient in goal setting, action planning, problem solving and follow-up: Patient-centered primary care requires care planning and related activities focused on a patient's specific circumstances, wishes and needs involving two-way communications and active patient involvement.
11. Evidence-based care delivery, including stepped care protocols: Care should be evidence-based wherever evidence exists, and follow stepped protocols for treatment of illness.
12. Integration of quality improvement strategies and techniques: Practices should utilize the improvement model emphasized by the Institute for Healthcare Improvement to measure performance, identify opportunities for improvement including those identified during and after the Health Home application process, test interventions, and reassess performance.
13. Enhanced access: Another hallmark of patient-centered primary care is the availability of easy and flexible access to the Practice Team, including alternatives to face-to-face visits, such as e-mail and telephone[8] and 24 hours per day/seven days per week practice coverage.

E. National Committee for Quality Assurance (NCQA) Recognition

By the eighteenth month following the receipt of the first Health Home payment, Practices shall submit to DSS evidence that the Practice has submitted an application to NCQA and obtained NCQA PCMH recognition at "Level 1 Plus." Level 1 Plus recognition is defined for these purposes as meeting 2011 NCQA Level 1 standards, plus recognition for achieving the following 2011 NCQA PCMH standard at the specified level of performance: Standard 3C at 100% or 75% with an acceptable plan of correction.

F. Clinical Care Management Services

Practices shall provide Clinical Care Management Services, as further defined in **Appendix A**. Clinical Care Management entails the identification of highest-risk

[7] See **Appendix A** for definitions of "care coordination" and "Clinical Care Management Services."
[8] Other use of technology, such as to improve medication compliance and provide remote behavior coaching, represents additional means for enhancing access.

patients, and intensive monitoring, follow-up, and clinical management of such patients. These activities generally include frequent patient contact, clinical assessment, medication review and reconciliation, communication with treating clinicians, and medication adjustment by protocol.

Practice shall employ or contract with licensed nurse(s) as the Practice's Clinical Care Manager(s), responsible for providing Clinical Care Management Services. The Clinical Care Manager shall function as a member of each Practice Team whenever patients of that Practice Team are receiving Clinical Care Management Services.

Practices shall ensure and document that Clinical Care Management Services funding is used exclusively to provide Clinical Care Management Services. Recognized Health Home Practices may collaborate in provision of Clinical Care Management Services.

G. Hospital Memorandum of Understanding

By the third month, Practices shall develop a contract or memorandum of understanding (MOU) with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of the Practice's patients, as well as maintain a mutual awareness and collaboration to identify individuals seeking emergency department services that might benefit from connection with the Practice, and in addition motivate hospital staff to notify the Practice's designated staff of such opportunities.

H. Data Reporting

Practices shall submit to DSS or its designee the following reports, as further specified by DSS or it designee, within the time frames specified below:

- monthly narrative practice reports that describe the Practice's efforts and progress to implement Health Home practices;
- monthly clinical quality indicator reports utilizing clinical data contained within the Practice's patient registry or a third-party data repository;
- periodic submission of Health Home Implementation Quotient (MHIQ) survey[9] scores, as specified by DSS, and
- other reports, as specified by DSS.

I. Demonstrated Evidence of Health Home Transformation

Practices are required to demonstrate evidence of Health Home Transformation on an ongoing basis using measures and standards established by DSS and communicated to the Practices. As of the publication date of this application, DSS defines evidence of Health Home transformation as follows:

- demonstrated development of fundamental health home functionality at 6 months and 12 months based on an assessment process to be applied by DSS or its designee, and

[9] The MHIQ 2.0 evaluation tool is accessible at: www.transformed.com/MHIQ/welcome.cfm.

- demonstrated significant improvement on clinical indicators specified by and reported to DSS or its designee.

J. Notification of Primary Care Practice Changes

Practices are required to notify DSS within five working days of the following changes:

- the employment or contract of a Clinical Care Manager terminates subsequent to the initiation of Clinical Care Management payments;
- any substantive changes in Practice ownership or composition, including:
  - the Practice is acquired by another practice;
  - the Practice merges with another practice, and
  - the Practice acquires another practice.

K. Participation in Evaluation

Practices shall participate in an evaluation, to be performed by a DSS-designated evaluator. Participation may entail submission of monthly clinical indicator reports, submission of monthly narrative reports describing the Practice's transformation process, responding to surveys and requests for interviews of Practice staff and patients. Practices shall provide all requested information to the evaluator in a timely fashion.

Section 3. Payment

Subject to all required federal approvals, DSS has developed the following payment structure for recognized Health Home Practices. All payments are contingent on the Practice meeting the requirements set forth in this application, as determined by DSS. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments specified within this application.

The anticipated payment methodology for Practices is in addition to existing fee-for-service payments and is described as follows:

A. **Quarterly start-up, training, and infrastructure cost reimbursement.** Using a methodology developed by DSS, DSS will reimburse Practice Sites for start-up costs and lost productivity due to collaboration demands on staff not covered by other streams of payment.

B. **Clinical Care Management per member per month (PMPM) payment.** Using a methodology developed by DSS, DSS will make payment for reimbursement of the cost of staff primarily responsible for delivery of services not covered by other reimbursement (Primary Care Nurses, Behavioral Health Consultants) whose duties are not reimbursable otherwise by MO HealthNet.

C. **Performance incentive payment.** DSS will make payment to Practices for 50% of the value of the reduction in total health care PMPM cost, including payments A and B above, for the Practice Site's attributed MO HealthNet fee-for-service patients, relative to prior year experience. Savings will be distributed on a sliding scale up to 50% of net

savings based on performance relative to a set of Practice Site-specific clinical preventive and chronic care measures generated and reported by the practice and subject to DSS audit.

Payments described in **Sections 3.B** and **3.C** will be based on DSS' count of MO HealthNet participants assigned to or attributed to the Practice on a date certain each month. During Year 1, payments shall be made for only those participants over five years of age with two or more of the following characteristics:

- Serious Mental Health Conditions;
- Substance Abuse Disorders;
- Asthma;
- Diabetes;
- Cardiovascular Disease, including Hypertension;
- Overweight (BMI> 25);
- Developmental Disabilities;

or, one of the previous chronic conditions and either tobacco use or diabetes as "at risk of" triggers.

Participants not enrolled in a MO HealthNet Medicaid managed care plan will be attributed to the practice using a standard patient attribution algorithm adopted by DSS. Participants will, however, be granted the option to change their Health Home should they so desire. Participants enrolled in a MO HealthNet Medicaid managed care plan will be attributed to the practice which the participant has selected or to which the participant has been assigned by the plan.

Should experience reveal to DSS that elements of the payment methodology will not function, or are not functioning, as DSS intended, DSS reserves the right to make changes to the payment methodology after consultation with recognized Health Homes and receipt of any and all required federal approvals.

DSS is currently in the process of reviewing its proposed State Plan Amendment with CMS. CMS is generally supportive regarding the proposed rate structure and payment methodology. DSS understands the challenge providers face in submitting applications not knowing the final, agreed upon payment rate and will share final details as soon as possible. Should a practice site find the final rate unacceptable and determine that it no longer wishes to apply, it may withdraw its application with written notice to DSS without penalty.

Section 4. Application Response Requirements

A. General Submission Instructions

Applications must be submitted by e-mail to Clinical.Services@dss.mo.gov by the date and time listed in the Procurement Timetable, **Section 1.D**. A follow-up hard copy of the responses must be postmarked by due date for the e-mailed responses, and sent by mail or other hand-delivery to:

Clinical Services
ATTN: Health Home Services
PO Box 6500
Jefferson City, MO 65102

B. Contents of the Submission

The applicant must submit:

- a completed application form, found in **Appendix B**, attached to this application, and
- **a cover letter** that clearly states the name of the applicant organization and the name of the applicant's contact person. The letter must be signed by an individual authorized to bind the applicant.

Section 5. Application Evaluation Process

A. Application Review and Evaluation

1. Compliance with Application Instructions

All responses will be reviewed by DSS to determine compliance with the response submission instructions described in **Section 4**. For those responses that comply with the response submission instructions, including meeting the pre-qualification requirements defined in **Section 1.B** and the submission of a complete response to the application contained in **Appendix B**, an Evaluation Committee designated by DSS will review the applications.

2. Applicant Interview

At its discretion, DSS may elect to interview some or all applicants to assess their qualifications to serve as a Health Home.

3. Evaluation Criteria for Health Homes

a. The following identifies the criteria by which DSS will evaluate written responses and interview findings, if any, from each applicant practice:

- the Practice demonstrates that it meets the practice pre-qualifications identified in **Section 1.B**;
- the quality of the responses to the questions in **Appendix B** in accordance with the following criteria: comprehensiveness, feasibility, appropriateness,

clarity, effectiveness, innovation, and responsiveness to the needs the core competency requirements of a Health Home, and

- the extent to which the practice demonstrates leadership commitment and basic capabilities that will allow it to effectively operate as a Health Home and continually evolve as such through practice transformation activity;

Finally, DSS may consider any relevant information about the practice known to DSS.

4. Qualifying Applications

DSS reserves the right to reject a practice's application at any time during the evaluation process if the applicant:

- fails to demonstrate to DSS' satisfaction that it meets all application requirements, or
- fails to submit all required information or otherwise satisfy all application requirements in **Section 4**.

DSS may determine non-compliance with an application requirement is insubstantial.

Appendix A

General Functional Definitions of
Care Coordination and Clinical Care Management Services

(adapted from definitions developed by Ed Wagner, MD[10])

Care Coordination

A core function of primary care and Health Homes is the delivery of a set of care coordination activities, assuring that patients receive timely, high quality and efficient health care and support services within and outside of the health home through the development and implementation of a care plan and development of patient self-management skills. Services may be identified either by the practice by referral or by the patient or other providers to maintain or improve the well being of the patient and includes clinical services, clinical and non-clinical support services available within the community, and facility-based services. To coordinate care effectively, this role involves activities to:

- identify available community resources;
- assure that referrals made by the practice for external services result in timely appointments, timely two-way transmission of useful patient information, and address patient and practice concerns without duplication of services or provision of inappropriate services;
- obtain reliable and timely information about external services not initiated by the practice such as emergency, patient-initiated, or other provider-initiated care, as well as case management in order to provide and receive patient information, and to assure safe and effective transitions;
- interface with case management or disease management staff functioning on behalf of insurers, disease management companies, publicly funded programs, state agencies, including schools, etc. to assure that services are consistent with the Health Home's care plan, and
- provide patient education and self-management support.

Clinical Care Management

The Clinical Care Manager has several unique functions, some of which can only be performed by a licensed nurse. The unique activities of the clinical care management role are the identification of high-risk patients, and their more intensive monitoring, follow-up, and clinical management. These activities generally include:

- frequent patient contact;
- clinical assessment;
- medication review and reconciliation;
- communication with treating clinicians, and
- medication adjustment by protocol.

[10] Judith Schaefer, MacColl Institute

Self-management support is also a critical element in this role. While Clinical Care Managers often take on some of the activities described in the care coordination role, especially related to transitions, their role is primarily clinical rather than administrative. The Clinical Care Manager can reside within the practice setting or be contracted through a community-based agency. In either situation, the Clinical Care Manager must be closely integrated within the practice primary care team.

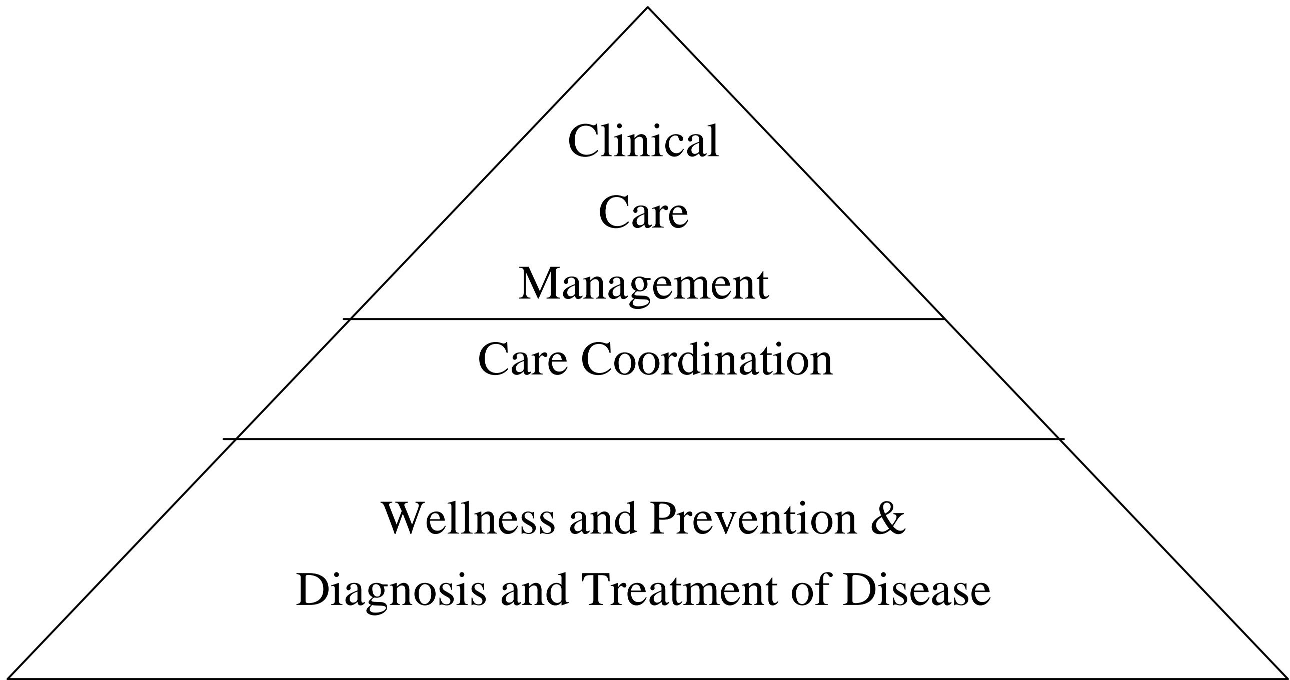
Note: The terms "Case Management" and "Disease Management" were consciously not used, because both terms are so closely linked to payer-based functions and as such differ from the practice-based functions described here. In addition, Case Management is a term that has specific meanings within several publicly funded health and human service programs. If successfully implemented and operated within the practice setting, Care Coordination and Care Management have the potential for eliminating the need for at least some public and private payer-based Case Management and Disease Management functions once practices are capable of assuming some or all of these responsibilities.

Patients Who May Be in Need of Care Coordination and Clinical Care Management

	Patients Who May Be in Need of Care Coordination	**Patients Who May Be in Need of Clinical Care Management**
Description	Patient or family with low to moderate level of self-actualization who has a current medical condition and/or risk factors needing services or is healthy, but in need of services to prevent diminution of health status.	Patient with complex condition or multiple co-morbidities that places him or her at high risk for a future inpatient medical or behavioral health admission.
Duration of Services	Temporary, intermittent, or on-going, depending on nature of need	On-going until sufficient reduction in risk
Examples	8-year old recently diagnosed with autism who needs educational, social, behavioral health and family support	Patient with uncontrolled diabetes
Provider Type	May be provided by trained layperson (parent, family advocate, community health worker), or a health care provider	Must be provided by a licensed nurse
Goal of Services	Goal: to take action to assist the patient to remain as healthy as possible by accessing culturally appropriate and necessary care and community-based services and by using services appropriately.	Goal: to take action to keep the person safely cared for within the patient-centered health home or across a system of care within the community, preventing ER visits, hospitalization, reduce unnecessary facility admissions, and minimize nursing facility lengths of stay.

	Patients Who May Be in Need of Care Coordination	Patients Who May Be in Need of Clinical Care Management
Focus of Services	Broadly focusing on medical, psychosocial, educational needs and providing linkage to community services	Primarily a medical focus
Relationship to Health home	Physically or virtually located within the practice. Care Coordinator is a member of the Health Home care team.*	Physically or virtually located within the practice. Clinical Care Manager is a member of the Health Home care team.*
Key Service Functions	o Care Coordination and follow-up o Development of multi-disciplinary care plan, created jointly by the individual or family and the care team, and which the individual or family has access to at all times o Support/facilitate care transitions o Provides linkages to needed community-based services, e.g., behavioral health services o Maintain continuous communication and documentation to assure care team's knowledge of activities/decisions/issues o Manage/track tests, referrals and outcomes o Assist patient/family with identifying barriers and problem solving solutions o Function as system navigator o Coach patients/families on self-management skills o Participate in QI activities at the level of the Health Home or broader system of care	o Coordinates care among providers and across continuum of care o Population Management – identifies high risk patients in need of care management and pro-active outreach o Intense medical and medication management o Intense transition management o Care review and planning: o Complete/analyze medical, biopsychosocial support and self-management support assessments; o Update as necessary o Develops and maintains care plan o Provides Care Coordination services to patients receiving Clinical Care Management o Oversees care coordination activities delegated to other team members o Trains team members in care coordination and self-management support

*Practices might share resources, which could be either dedicated resources or contracted resources from a community agency, such as Independent Living and Recovery Learning Centers for Care Coordination and/or a home health agency or home care agency for Clinical Care Management.



Application of Care Management and Care Coordination
by Population

Appendix B

Application to be Recognized as a Health Home

Section A: Practice Site Information

<table>
<tr><th colspan="6">1. General Information on the Practice(s)</th></tr>
<tr><td colspan="4">Name and title of person completing application:</td><td colspan="2">Email and Telephone:</td></tr>
<tr><td colspan="4">Name of applicant organization (or parent, if applying for more than one Practice Site):</td><td colspan="2">Federal Tax Identification Number (of parent):</td></tr>
<tr><td colspan="4">If parent organization exists, list name of person responsible for overseeing Health Homes:</td><td colspan="2">Email and Telephone:</td></tr>
<tr><th colspan="6">1.A Name and Primary Contact Information for Practice Site(s) Applying for Recognition</th></tr>
<tr><th>Name of Practice Site and Federal Tax ID</th><th colspan="2">Address of Practice Site:</th><th>Person overseeing practice transformation (at local Practice Site)
(Name and Title):</th><th>Email :</th><th>Phone:</th></tr>
<tr><td>Sample Practice Site Name
12-123456</td><td colspan="2">45 South Main Street
Kansas City, MO 64147</td><td>Joe Smith
Practice Administrator</td><td>Joe.Smith@practice.com</td><td>888-898-8999</td></tr>
<tr><td>[insert more rows for additional Practice Sites]</td><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><th colspan="6">1.B Provider Detail for Practice Site(s) Applying for Recognition</th></tr>
<tr><th>Name of Practice Site</th><th colspan="3">Name of Clinicians at Practice Site</th><th colspan="2">NPI of Clinicians</th></tr>
<tr><td>Sample Practice Site Name</td><td colspan="3">Dr. Mary Smith
Dr. Susan Jones</td><td colspan="2">1902049000
1912409000</td></tr>
<tr><td>[insert more rows for additional Practice Sites]</td><td colspan="3"></td><td colspan="2"></td></tr>
<tr><td></td><td colspan="3"></td><td colspan="2"></td></tr>
</table>

2. Payer Detail for Practice Site(s) Applying for Recognition		
For the Practice Site(s) identified above and from the list of payers below, please include the provider number for any insurer with which the Practice(s) has a primary care contract. If the applicant has multiple Practice Sites that all have the same provider number with a payer, indicate as such. • Blue-Advantage Plus of Kansas City • Children's Mercy Family Health Partners • Harmony Health Plan of Missouri • HealthCare USA • Missouri Care Health Plan (Aetna) • MO HealthNet • Molina HealthCare		
Name of Practice Site	**Insurers**	**Provider Number**
Sample Practice Site Name	*Blue-Advantage Plan of Kansas City* *Children's Mercy Family Health Partners* *MO HealthNet*	*8934567890* *2334567890* *4634567890*
[insert more rows for additional Practice Sites]		

3. Practice Site Characteristics		
Name of Practice Site Note: If the applicant has multiple sites with the same status (FQHC or RHC) and same specialty mix, they can be grouped in one row.	**FQHC or Rural Health Clinic?**	**Specialty (include all that apply)** • **Pediatrics** • **Family Medicine** • **Internal Medicine** • **General Practice**
Sample Practice Site Name	*Rural Health ~~Center~~Clinic*	*Pediatrics, Family Medicine*
[insert more rows for additional Practice Sites]		

4. Practice Site Clinicians with Patient Panels			
Please provide totals in full-time equivalences (FTEs) and subtotals by category of clinician in number of people filling those positions, to the extent that the practice has such personnel and whether the positions are staffed or vacant:			
Name of Practice Site	**Total Physician FTEs with patient panels** • Total physician FTEs with patient panels • # of staffed full time physicians • # of staffed part-time physicians • # of vacant full-time physicians • # of vacant part-time physicians	**Total Nurse Practitioner (NP) FTEs with patient panels** • Total NP FTEs with patient panels • # of staffed full time NPs • # of staffed part-time NPs • # of vacant full-time NPs • # of vacant part-time NPs	**Do individual Practice primary care clinicians each have defined panels of patients?** ***(Yes or No)***
Sample Practice Site Name	• *3 physician FTEs with patient panels* • *2 of staffed full time physicians* • *0 of staffed part-time physicians* • *1 of vacant full-time physicians* • *0 of vacant part-time physicians*	• *4 NP FTEs with patient panels* • *2.5 of staffed full time NPs* • *1.5 of staffed part-time NPs* • *0 of vacant full-time NPs* • *0 of vacant part-time NPs*	*Yes*
[insert more rows for additional Practice Sites]			

5. Payer Mix Characteristics			
Please provide the information requested in the table below for each source of patients by payer and source of site revenue. Exclude grant revenue.			
Practice Site Name	**Payer Name**	**Total Number of Patients in Calendar Year 2010**	**Total Payments Received for Calendar Year 2010**
Sample Practice Site Name	Aetna		
	Anthem Blue Cross Blue Shield		
	Blue-Advantage Plus of Kansas City		
	Blue Cross Blue Shield of KC		
	Children's Mercy Family Health Partners		
	CIGNA Health Care		
	Coventry/Group Health		
	Harmony Health Plan of Missouri		
	HealthCare USA		
	Humana		
	Medicare		
	Mercy Health Plan		
	Missouri Care Health Plan (Aetna)		
	MO Health Net		
	Molina HealthCare		
	UnitedHealthcare		
	Private Pay		
	Uncompensated Care		
	Other[11] (please identify):		
	TOTAL		

[11] Identify only payers who accounted for 5% or more of practice revenue in 2010.

Practice Site Name	**Payer Name**	**Total Number of Patients in Calendar Year 2010**	**Total Payments Received for Calendar Year 2010**
[insert more rows for additional Practice Sites]	Aetna		
	Anthem Blue Cross Blue Shield		
	Blue-Advantage Plus of Kansas City		
	Blue Cross Blue Shield of KC		
	Children's Mercy Family Health Partners		
	CIGNA Health Care		
	Coventry/Group Health		
	Harmony Health Plan of Missouri		
	HealthCare USA		
	Humana		
	Medicare		
	Mercy Health Plan		
	Missouri Care Health Plan (Aetna)		
	MO Health Net		
	Molina HealthCare		
	UnitedHealthcare		
	Private Pay		
	Uncompensated Care		
	Other (please identify):		
	TOTAL		

6. Additional Practice Site Information					
Please answer the following questions with information as of the date of completing this application.					
Practice Site Name	When a patient calls for an acute visit, when is the third-next-available appointment at the Practice Site?	When a patient calls for urgent care, what is availability for an appointment at the Practice Site?	Please list the hospital(s) to which your Practice Site primarily admits patients, and answer the two questions to the right.	Does the hospital provide 24 hour notification of inpatient admission? (Yes or No)	Does the hospital provide 24 hour notification of ED visit? (Yes or No)
Practice Site Name	*4 days*	*Within 24 hours*	*Jefferson City General Hospital*	*Yes*	*No*
[insert more rows for additional Practice Sites]					

7. Medical Records Please complete the following table for each practice. Please include additional tables if this application is for more than 5 Practice Sites.					
	Sample Practice Site Name	*Practice Site Name*	*Practice Site Name*	*Practice Site Name*	*Practice Site Name*
If the Practice Site uses an electronic health record (EHR), when was it implemented?	*2008*				
Are the eligible providers at the Practice Site qualified for Meaningful Use Stage One?	*Yes*				
- If not, when is the Practice Site expected to do so?	*N/A*				
If the Practice Site does not use an EHR, does the Practice Site have plans to implement an EHR in 2011 or 2012 (please indicate year).	*N/A*				
Is the EHR used:					
-in the exam room during patient visits	*Yes*				
-to exchange data with external systems (e.g., lab, referral providers)	*Lab only*				
-for 100% of patient record keeping	*Yes*				
All providers use the EHR daily	*Yes*				
Practice productivity level is at least within 10% of productivity prior to EHR adoption.	*No*				
Name of EHR vendor.	*EpicCare*				
With or without an EHR, does the Practice utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning?	*Yes*				
Does the Practice actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for MO HealthNet participants?	*Yes*				

8. If the applicant has more than one Practice Site, please list in ranked order the Practice Sites that the applicant wishes to have selected for the learning collaborative, with the applicant's first choice listed at the top.

9. Should DSS select a Practice Site(s) to participate in a learning collaborative, please indicate which learning collaborative which Practice Sites would prefer to attend (only select one learning collaborative for each Practice Site):			
Practice Site Name	**St. Louis, commencing in December 2011:**	**Kansas City, commencing in February 2012:**	**Columbia, commencing in March 2012:**
Sample Practice Site		*X*	
[insert more rows for additional Practice Sites]			

Section B: Health Home Transformation

10. Describe in one page or less the experience of the individual(s) who provides Practice Site leadership at each applicant Practice Site for Health Home transformation, what he or she will do to ensure successful Health Home evolution, and his or her understanding of the challenges inherent in practice transformation.

11. In one page or less, describe and provide examples of how the Practice Site will involve patients, families and/or caregivers in the process of defining the elements of a "patient-centered practice."

12. In one page or less, describe and provide examples of how the Practice Site, working as a team, has developed and implemented innovative or creative solutions to better meet patient needs, solve operational issues, or improve clinical outcomes.

13. How often does the Practice Site hold regular meetings to discuss clinical issues?		
Practice Site Name	Frequency of Meetings (e.g., weekly, monthly, quarterly, annually, never, other.)	Who Attends (please include all participants) (e.g., physicians, nurse practitioners, physician assistants, medical support staff, office staff, other.)
Sample Practice Site Name	*Bi-weekly (Tuesdays and Thursdays)*	*Physician, nurse, medical assistant*
[insert more rows for additional Practice Sites]		

14. Those Practice Sites selected by DSS for learning collaborative participation must identify an adult or child patient population for the purpose of initial training on Health Home transformation processes. List the names and titles of the members of each applicant Practice Site's proposed Core Practice Team(s), including one primary care physician or nurse practitioner holding a senior leadership position, another clinician and a non-clinician member of the primary care Core Practice Team (e.g., practice manager or practice administrator). A Practice may designate a pediatric-focused Core Practice Team (pediatric or family practice specialties) or an adult (internal or general medicine or family practice) - focused Core Practice Team to possibly attend the Learning Collaborative sessions. Please identify the name, title and specialty of the Practice's Core Practice Team.			
Practice Site Name	**Core Practice Team Members**	**Title/Position**	**Specialty focus of Core Practice Team**
Sample Practice Site	*Mary Smith* *John Jones* *Jill Matthews*	*Medical Director* *Practice Administrator* *Nurse Practitioner*	*Child* __x__ *Adult* ____
[insert more rows for additional Practice Sites]			

15. In one page or less, if the applicant is other than an independent, single-site practice, describe in detail the manner in which the larger corporate entity will support the Practice Site(s) functioning as a Health Home, including:

a. ensuring that supplemental payments made available from DSS will be directly used to support the provision of Health Home services at the Practice Site;

b. provision of staff or other resources (including at a minimum, information technology staff for activities such as EHR programming, data analysis);

c. provision of resources to ensure spread of Health Home functionality to other care teams that are not part of a the Practice Team, and

d. identifying the name of the person who would be responsible for training Practice Sites, not responsible for the learning collaborative.