MO HealthNet

Application for
Health Home Service Provider Status

Beginning July 1, 2014

Updated Application - 4/16/14

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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, 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), 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. DSS will require that all recognized Health Homes participate in Health Home transformation training (as outlined in Section 2A).

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 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:

- 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, including the medical director and physician champion (can be the same person or not, and does not have to be the health home director) and administration, personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated by the application process and agreement to participate in education and training activities offered.
- have patient panels assigned to each primary care clinician;

- actively utilize MO HealthNet's comprehensive electronic health record (CyberAccess) for care coordination and prescription monitoring for MO HealthNet participants;
- utilize an interoperable patient registry to 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 electronic health record (EHR) implementation and been using the EHR for at least six months prior to the beginning of health home services 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 OR have implemented or plan to implement an EHR system by July 1, 2014 that is currently being used by one or more existing Health Home organizations in Missouri.

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://dss.mo.gov/mhd/cs/health-homes/

1.	Application Issued	April 1, 2014
2.	Deadline for Written Inquiries	April 21, 2014
3.	Informational Webinar	April 22, 2014 - 9 a.m.
4.	**Practices' Responses Due**	**May 8, 2014**
5.	Anticipated Practice Notification Date	May 21, 2014

E. Prospective Applicant Inquiries and Webinar

Prospective applicants may make written inquiries concerning this application until April 21, 2014 at the address listed in **Section 4.A**, or by e-mail to Kathy.Brown@dmh.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. Only written responses will be binding on DSS.

MO HealthNet will offer a **Webinar at 9 a.m. on Tuesday, April 22, 2014** offering further discussion and an opportunity for interested providers to gain additional information.

To access the audio portion, call 877-820-7831 and use pin 35666479#.

To join the visual (computer) webinar: http://stateofmo.adobeconnect.com/pchh042314/

If you have not previously used adobe connect test your connection: http://stateofmo.adobeconnect.com/common/help/en/support/meeting_test.htm

Get a quick overview: http://www.adobe.com/products/adobeconnect.html

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 the elimination of the Health Home provider type.

A. Health Home Staffing

Health Home Practices must maintain staffing positions and ratios as required by DSS. Required staff include:

- Health home director - no specific degree or licensure requirements
- Nurse care manager(s) - must be registered nurse (RN) licensed in Missouri
- Behavioral health consultant(s) - must be a licensed clinical social worker (LCSW) or clinical psychologist (PsyD) with either a current or provisional Missouri license.
- Care coordinator(s) - no specific degree or licensure requirements

B. Health Home Training and Other Activities to Facilitate Practice Transformation

DSS shall require Practice organizations to participate in education and training activities to help implement their Health Home functions and activities, and to help with practice transformation. Training activities will include but not be limited to periodic MO HealthNet provider webinars (held approximately every four to six weeks), care team forums coordinated by the Missouri Primary Care Association, and web-based learning activities. Practices will also be required to participate in practice coaching and other processes offered by MO HealthNet to assist with practice transformation.

C. Internal Practice Team Meetings

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

D. Patient Registries

Practices shall create and maintain patient registries, using 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.

E. Mastery of the Required Health Home Core Competencies[1]

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[2]: 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.[3] 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.

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[1] 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.

[2] "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.

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

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[4] 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.
7. Integrated Clinical Care Management[5] 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.

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

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[6] and 24 hours per day/seven days per week practice coverage.

F. 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 that subsequently results in at least Level 1 recognition as a Patient-Centered Medical Home under the 2011 NCQA standards. More information can be found at: http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx.

G. 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 patients, and intensive monitoring, follow-up, and clinical management of such patients. These activities generally include frequent patient contact in the clinical setting and community environment, 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 Nurse Care Manager(s), responsible for providing Clinical Care Management Services. The Nurse Care Manager shall function as a member of each Health Home Team whenever patients of that Health Home 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.

H. Hospital Care Coordination and Memorandum of Understanding

By the third month, Practices shall develop policies and procedures addressing transitional care planning; addressing notification from local hospitals, MHD, and managed care plans of inpatient admissions of the Practice's patients; notification by MHD of emergency department visits; and maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that might benefit from connection with the Practice, and in addition motivating hospital staff to notify the Practice's designated staff of such opportunities. Health home Practices are encouraged to formalize these policies and procedure in a memorandum of understanding with local hospitals when feasible.

I. Data Reporting

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

[6] Other use of technology, such as to improve medication compliance and provide remote behavior coaching, represents additional means for enhancing access.

- periodic 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;
- other reports, as specified by DSS.

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

K. Notification of Primary Care Practice Changes

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

- the Health Home physician or administrative leadership changes;
- the employment or contract of any Health Home staff member terminates subsequent to the initiation of per-member-per-month payments;
- any substantive changes in Practice ownership or composition, including:
  - the Practice is acquired by another practice;
  - the Practice closes any of its sites or can no longer maintain Health Home services in one or more of its sites;
  - the Practice merges with another practice, and
  - the Practice acquires another practice.

L. 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 periodic 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. **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 (Nurse Care Managers, Behavioral Health Consultants) whose duties are not otherwise reimbursable by MO HealthNet.

B. **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.A and 3.B** will be based on DSS' count of MO HealthNet participants enrolled in the Health Home on the last day of the month, and for whom the Practice attested that a Health Home service was provided during the month . Only those MO HealthNet participants with two or more of the following characteristics for adults can be enrolled in a Health Home and generate a per-member-per-month payment:

   - Asthma
   - Diabetes (defined as both a chronic condition and a risk factor)
   - Cardiovascular disease - including hypertension and hyperlipidemia
   - Obesity (BMI >25)
   - Developmental disabilities
   - Tobacco use (defined as a risk factor)

   Participants, whether managed care of fee for service, will be attributed to the Practice using a standard attribution algorithm adopted by DSS. Participants will, however, be granted the option to change their Health Home, or to opt out of Health Home services, should they so desire.

   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.

Section 4. Application Response Requirements

A. General Submission Instructions

Applications must be submitted by e-mail to Kathy.Brown@dmh.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 the due date for e-mailed responses, and sent by mail or other hand-delivery to:

Kathy Brown
ATTN: Primary Care 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/Site Visit

At its discretion, DSS may elect to interview or visit 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[7])

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.

[7] 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.

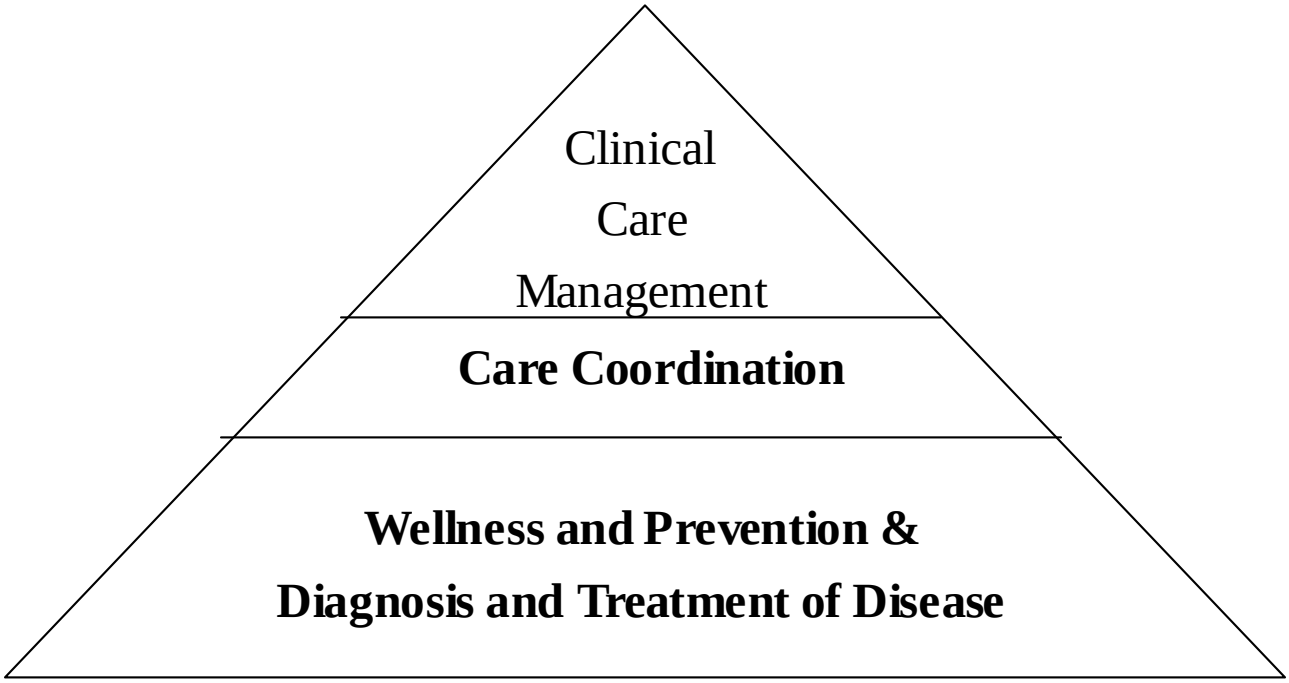
Note: The terms "Case Management" and "Disease Management" were consciously not used, because both terms are so closely linked to payer-based functions and as such differ from the practice-based functions described here. In addition, Case Management is a term that has specific meanings within several 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

1. General Information on the Practice(s)	
Name and title of person completing application:	Email and Telephone:
Name of applicant organization (or parent, if applying for more than one Practice Site):	Federal Tax Identification Number (of parent):
If parent organization exists, list name of person responsible for overseeing Health Homes:	Email and Telephone:
Name and title of person who will be physician champion/provide physician leadership for Health Home:	Email and Telephone
Name and title of person who will be medical director for Health Home:	Email and Telephone

1.A Name and Primary Contact Information for Practice Site(s) Applying for Participation				
Name of Practice Site and Federal Tax ID	**Address of Practice Site:**	**Person overseeing practice transformation (at local Practice Site) (Name and Title):**	**Email :**	**Phone:**
Sample Practice Site Name 12-123456	*45 South Main Street Kansas City, MO 64147*	*Joe Smith Practice Administrator*	*Joe.Smith@practice.com*	888-898-8999
[insert more rows for additional Practice Sites]				

1.B Provider Detail for Practice Site(s) Applying for Participation		
Name of Practice Site	**Name of Clinicians at Practice Site**	**NPI of Clinicians**
Sample Practice Site Name	*Dr. Mary Smith* *Dr. Susan Jones*	*1902049000* *1912409000*

[insert more rows for additional Practice Sites]		

2. Payer Detail for Practice Site(s) Applying for Participation

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.

- HealthCare USA (Aetna)
- Home State Health Plan (Centene)
- Missouri Care Health Plan (Wellcare)
- MO HealthNet

Name of Practice Site	**Insurers**	**Provider Number**
Sample Practice Site Name	*Home State Health Plan* *MO HealthNet*	*8934567890* *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 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. 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]					

6. 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 currently use an EHR, what plans does the Practice Site have to implement an EHR in 2014?	*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*				
daily by all providers?	*Yes*				
Is practice productivity level at least within 10% of productivity prior to EHR adoption?	*No*				
Name of EHR vendor and system.	*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 (CyberAccess) for care coordination and prescription monitoring for MO HealthNet participants?	*Yes*				

Section B: Health Home Transformation

7. 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.

8. 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."

9. 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.

10. 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 ensuring all Health Home staff are adequately trained.

11. 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 rows for additional Practice Sites]		