



## Montana PCMH Program Comprehensive Application

### 1st Year Clinics Only - Required with Preliminary Application

This application will enable program administrators to help clinics identify their PCMH focus, strengths, and weaknesses. Clinics who better understand how they are functioning in their PCMH journey can take the necessary steps to improve efficiency and enhance their bottom line. CSI also needs to know PCMHs' current situation technologically and culturally as we explore possibilities for supporting practice transformation through the Montana Department of Public Health and Human Services and potential grant funding from other sources.

You must complete and submit the preliminary application prior to this Comprehensive Application. Your practice must specifically state what PCMH accreditation you have or are pursuing. You can contact Amanda Roccabruna Eby for the preliminary application at 406-444-4328 or [aeby@mt.gov](mailto:aeby@mt.gov).

#### 1. Contact Person Name

#### 2. Address

Name of Practice

Name of Practice Site (if applicable)

Address

City/Town

State/Province

ZIP/Postal Code

Email Address

Phone Number





## Montana PCMH Program Comprehensive Application

### General Practice Information

#### 3. Practice site ownership (check all that apply)

- Individual provider
- Group practice
- Hospital or health system
- Federal, state, local government
- Independent non-profit (not hospital)
- FQHC/Community Health Center
- Other (please specify)

#### 4. Practice type (check all that apply)

- Solo (one provider)
- Single site, single specialty
- Multi-site, single specialty
- Single site, multi-specialty
- Multi-site, multi-specialty
- Residency, academic
- Community health center
- Other (please specify)

5. Primary care specialties (check all that apply)

- Family medicine
- General practice
- Internal medicine
- Obstetrics/Gynecology
- Pediatrics
- Other (please specify)

6. How many years has the practice been in operation?

- 0 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- more than 20

7. If your clinic is qualified, what date did your clinic receive PCMH recognition from NCQA or other approved accreditation agency?

Date

MM	DD	YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

8. If your clinic is provisionally qualified, what date do you anticipate receiving PCMH recognition from NCQA or other approved accreditation agency?

Date / Time

MM	DD	YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

9. How many unique patients were seen by primary care providers in your practice between January and December of 2014?

10. Does your practice integrate the following staff into your care model? Please indicate whether each of the following roles is utilized for any amount of time.

Included in the care team

Primary Care Physician	<input type="checkbox"/>
Primary Care Physician Assistant	<input type="checkbox"/>
Primary Care Nurse Practitioner	<input type="checkbox"/>
Integrated Primary Care related Behavioral Health Services	<input type="checkbox"/>
Care Coordinators/Managers or Patient Navigator	<input type="checkbox"/>
Certified Diabetes Educator	<input type="checkbox"/>
Administrative Staff	<input type="checkbox"/>
Medical Assistant	<input type="checkbox"/>
Nurse (RN, LPN, etc.)	<input type="checkbox"/>
Dietitian	<input type="checkbox"/>
Clinical Pharmacist	<input type="checkbox"/>
Certified Asthma Educator	<input type="checkbox"/>
Certified Lactation Consultant	<input type="checkbox"/>

11. For each role included in your care team, please indicate how many full time equivalent staff (FTE) are currently being used in your clinic. Please enter numbers only.

Primary Care Physician

Primary Care Physician Assistant

Primary Care Nurse Practitioner

Integrated Primary Care Related Behavioral Health Services

Care Coordinators/Managers or Patient Navigator

Certified Diabetes Educator

Administrative Staff

Medical Assistant

Nurse (RN, LPN, etc.)

Dietitian

Clinical Pharmacist

Certified Asthma Educator

Certified Lactation Consultant



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### Enhanced Payment Information

12. Does your practice currently receive enhanced reimbursement from any commercial or public health plan for primary care related services such as a PCMH participation fee, chronic disease management, quality improvement, or other PCMH related components? (This question refers only to payor programs labeled "Medical Home" or "Patient-Centered Medical Home.")

- Yes  
 No

13. Which payor(s) are you receiving the payments from?

- Blue Cross Blue Shield of Montana  
 PacificSource Health Plans  
 Medicaid  
 Allegiance  
 Humana  
 New West Health Plans  
 Montana Health Co-op  
 Other (please specify)

14. If you answered "yes" to Question 12, please indicate the percentage of your practice's total patient population that your clinic receives PCMH compensation for?

- 0 - 10%
- 11 - 25%
- 26 - 50%
- Above 50%

15. What do you feel is the most important work you do for PCMH that you should be reimbursed for in a reformed payment model? Choose your top 3 only.

- Preventive health care services
- Chronic disease management
- Care coordination
- Population management patient outreach
- Community partnerships
- Primary care related integrated behavioral health services
- Primary care related clinical pharmacy services
- Scribes (or equivalent clinical assistant)
- Electronic health record capabilities
- Data registry capabilities
- Patient involvement in quality and planning (e.g. patient advisory council)
- Other (please specify)



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### Current PCMH Status: Transformation, Progress, and Measurement

16. Please select below, your current PCMH practice transformation focus points. Choose your top 3.

- Preventive health care services
- Chronic disease management
- Care coordination
- Population management patient outreach
- Community partnerships
- Primary care related integrated behavioral health services
- Primary care related clinical pharmacy services
- Scribes (or equivalent clinical assistant)
- Electronic health record capabilities
- Data registry capabilities
- Patient involvement in quality and planning (e.g. patient advisory council)
- Other (please specify)

17. In regard to PCMH transformation in your practice, what technical assistance or other support would be most useful at this time?

18. Does your practice have a formal quality improvement strategy or use standardized quality improvement methodologies?

Yes

No

19. Are you using one of the following standardized methods/strategies? Check all that apply.

Lean management principles

Six Sigma

Plan-Do-Study-Act (PDSA) cycles

Institute for Health Improvement's (IHI) model for improvement

Other (please specify)

20. Does your practice have a staff person who has dedicated quality improvement responsibilities?

Yes

No

21. If yes, please provide the contact information for the quality improvement staff person.

**Name**

**Title**

**Email Address**

**Phone Number**

22. Please enter the approximate number of hours your staff person spends on QI per week.

23. Does your practice utilize the following? Check all that apply.

Patient advisory council

Patient surveys

Other (please specify)

24. Has your practice enhanced access to care for patients?

Yes

No

25. Please select the ways in which your practice has enhanced access to care. Check all that apply.

Electronic communication/e-mail

Expanded office hours

Same day appointments

Clinical advice system available when office is not open

Patient portal

Telephonic or electronic visits

Other (please specify)

26. Has your practice incorporated care coordination and/or disease management into care delivery?

Yes

No

27. What elements of care coordination/disease management are parts of your care delivery? Check all that apply.

- Collaborate and assist patients in personal goals for their improved health (self-management and goal setting)
- Patients receive paper or electronic copy of their Care Plan specific to their chronic disease
- Your clinic electronically generates lists of patients needing care and contracts these patients
- Your clinic has some system for the team to do pre-visit planning or huddles
- Your clinic does additional coordination of care for complex, high use patients (referrals, labs, tests)
- System in place to follow-up pro-actively with patients having recent ER visit and/or hospitalization
- Other (please specify)



## Montana PCMH Program Comprehensive Application

### EHR/EMR Use

28. Does your practice currently have an electronic health record (EHR) system (other than for billing)?

- Yes, an EHR system is installed and available to all providers in the practice.
- Yes, the EHR is currently installed but only available to some providers in the practice.
- No, but we plan to implement an EHR system within the next 12 months.
- No, and we do not plan to implement an EHR system within the next 12 months.

29. What is the name of the EHR system (or vendor) your practice currently uses?

- Allscripts
- Amazing Charts
- Cerner Powerchart
- CPRS
- Chart Logic
- Dairyland
- Digichart
- Docsite
- eClinical Works
- eHealthcare Systems
- E-MD's
- eMeds: MedNet
- EPIC

- GE Centricity
- HealthCare Systems
- HMS
- Inservio-Medical Office Sol
- Integreat IC-Chart
- Lavender & Wyatt
- MediNotes
- Medicat
- Meditech
- Meditech/Health Partner
- NextGen
- Practice Partner
- PrognoCis
- RPMS HR
- Soapware
- techtime
- Vista
- Other (please specify)

30. What version of your EHR system is your clinic currently using?

31. When did your clinic initiate use of the current EHR system?

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 to 3 years ago
- 3 to 5 years ago
- More than 5 years ago

32. For each EHR system function listed below, please check whether it is available in your practice's EHR system.

	Available	Unavailable	Unknown
Chronic Disease Registry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Decision Support System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient Portal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to document patient referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to document patient reminder or follow-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to pull custom reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to provide electronic data exchange (HL7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. For each EHR system function that is available in your practice's EHR, please check whether it has been used by your staff.

	Used	Unused	Unknown
Chronic Disease Registry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Decision Support System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient Portal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to document patient referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to document patient reminder or follow-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to pull custom reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to provide electronic data exchange (HL7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. Do you have an EHR technical lead or professional IT support person on staff?

- Yes
- No

35. If yes, please enter their contact information below.

**Name**

**Title**

**Email Address**

**Phone Number**



## Montana PCMH Program Comprehensive Application

### Depression Screening

36. Does your practice use a standardized depression screening tool (such as PHQ-2, PHQ-9)?

- Yes  
 No

37. If yes, which standardized depression screening tool(s) do you use for adolescents (12-17 years)?  
Check all that apply.

- Patient Health Questionnaire for Adolescents (PHQ-A)  
 Beck Depression Inventory-Primary Care Version (BDI-PC)  
 Mood Feeling Questionnaire (MFQ)  
 Center for Epidemiologic Studies Depression Scale (CES-D)  
 PRIME MD-PHQ-2  
 Other (please specify)

38. If yes to question 29, which standardized depression screening tool(s) do you use for adults (18 years and older)?

- Patient Health Questionnaire (PHQ-9)
- Beck Depression Inventory (BDI or BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Duke Anxiety-Depression Scale (DADS)
- Geriatric Depression Scale (GDS)
- Cornell Scale Screening
- PRIME MD-PHQ-2
- Other (please specify)

39. The CSI partners with the Montana Department of Public Health and Human Services (DPHHS) in regard to collecting and analyzing quality metric data from PCMHs. Are you interested in receiving information from the DPHHS about potential opportunities to support quality improvement initiatives in your office (e.g. technical assistance, funding opportunities for quality improvement and health information technology)?

- Yes
- No

40. Please enter any questions or comments for CSI regarding the Montana PCMH Program here.