ADVANCING INTEGRATED HEALTHCARE

CALL FOR APPLICATIONS: RI MomsPRN Cohort 3 New Practices

The Rhode Island Department of Health (RIDOH) and the Care Transformation Collaborative of Rhode Island (CTC-RI) are pleased to offer prenatal care practices a funding opportunity to help support perinatal behavioral health screening, treatment, and referral workflows.

The goal of the RI MomsPRN Perinatal Behavioral Health Learning Collaborative is to help practices increase the identification, early intervention, and treatment of depression, anxiety, and substance use among their pregnant and postpartum patients. Up to three practices and/or locations will be selected. Applications are due by May 25, 2022 Project activities will begin in June 2022 and will continue for 15 months.

Please review the full call for applications which outlines program objectives, expectations, structure, and the selection process.

Please note that a completed application package includes:

- **this survey monkey application (one copy can be submitted for multiple practice sites)**
- **letter of commitment from the practice team (template found here)**
- **letter of support from the practice system of care if applicable (template found here).**

If you need to pause before finishing your application, you can resume your where you left off by accessing the application from the same computer. If you have any issues with the Survey Monkey application, or if you would like to fill out a different application for each of your practice sites, please email jarruda@ctc-ri.org.

To see all of the questions in the application before filling it out, click here.

RI MomsPRN
Maternal Psychiatry Resource Network

RHODE ISLAND DEPARTMENT OF HEALTH

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND — pcmh kids patient-centered medical home
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Practice Information

* 1. Practice Information

Name of Practice

Address

Address 2

City/Town

State/Province

ZIP/Postal Code

Phone Number

Perinatal Patient Panel Size

* 2. Practice Tax ID Number

* 3. Type of Practice

- OBGYN
- Adult
- Family
- FQHC
- Hospital Based Clinic
- Other (please specify)

* 4. Is your practice part of a system of care (e.g., owned, managed, overseen by a hospital or other health care organization)?

- ◯ No
- ◯ Yes (please specify):

* 5. Are you applying for more than one site (is this a multisite practice)?

- ◯ Yes
- ◯ No

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Additional Practice Site Location Information

Please identify all other practice site locations and indicate white site(s) will be participating.

6. Are these sites applying as one entity or separately? *If separately, you will need to provide an application for each site that includes data specific to just that location.*

- ○ One entity
- ○ Separately

7. Additional Practice Information

Name of Practice Site	
Address	
City/Town	
Indicate Participation (yes/no)	

8. Additional Practice Information

Name of Practice Site	
Address	
City/Town	
Indicate Participation (yes/no)	

9. Additional Practice Information

Name of Practice Site	
Address	
City/Town	
Indicate Participation (yes/no)	

10. Additional Practice Information

Name of Practice Site	
Address	
City/Town	
Indicate Participation (yes/no)	

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Team Contact Information

* 11. Provider Champion Contact

Name

Site Name

Title

Professional Credential (MD, DO, etc.)

Email Address

Phone Number

* 12. Practice Lead Contact

Name

Site Name

Title

Email Address

Phone Number

* 13. IT/EHR Staff Member

Name

Site Name

Title

Email Address

Phone Number

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Practitioners Information (MDs, DOs, NPs, and PAs)

* 14. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

15. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

16. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

17. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

18. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

19. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

20. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

21. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

22. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

23. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

24. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

25. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

26. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

27. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

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Name

NPI #

Professional Credential (MD, DO, etc.)

29. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

30. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

31. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

32. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

33. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

34. Enter the name and NPI # for all practitioners (MDs, DOs, NPs, PAs)

Name

NPI #

Professional Credential (MD, DO, etc.)

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Approximate Payer Mix of Deliveries for the Past Calendar Year

* 35. #of Deliveries covered by respective payer (enter 0 if none for a category)

BCBSRI	
NHP-RI Commercial	
Tufts Commercial	
United Commercial	
Insured Other	
Medicaid FFS	
NHP-RI Medicaid	
Tufts Medicaid	
United Medicaid	
Uninsured	
Total	

* 36. % of All Deliveries covered by respective payer (enter 0 if none for a category)

BCBSRI	
NHP-RI Commercial	
Tufts Commercial	
United Commercial	
Insured Other	
Medicaid FFS	
NHP-RI Medicaid	
Tufts Medicaid	
United Medicaid	
Uninsured	
Total	

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Application Questions

* 37. Please indicate if your practice or site location is anticipating undergoing any major planned changes to operations (e.g., change in clinical leadership, office location, or other consolidation/merger) within the next 15 months.

- ◯ No
- ◯ Yes (please indicate)

____

* 38. Please provide the name of the electronic health record system your practice currently uses.

____

* 39. Please indicate if your practice is anticipating changing its electronic health record within the next 15 months.

- ◯ Yes
- ◯ No

* 40. Does your practice serve a meaningful number of rural patients (generally defined as select communities in Washington County, Newport County, or northern Rhode Island) where transportation and health care access may be limited?

- ◯ Yes
- ◯ No

* 41. When treating pregnant and postpartum patients currently, does your practice routinely and universally screen for **Depression**?

- ◯ No
- ◯ Unsure
- ◯ Yes (please specify the evidence-based screening tool, if any, your practice utilizes)

____

* 42. When treating pregnant and postpartum patients currently, does your practice routinely and universally screen for **Anxiety**?

- No
- Unsure
- Yes (please specify the evidence-based screening tool, if any, your practice utilizes)

* 43. When treating pregnant and postpartum patients currently, does your practice routinely and universally screen for **Substance Use**?

- No
- Unsure
- Yes (please specify the evidence-based screening tool, if any, your practice utilizes)

* 44. If your practice does routinely screen, how are screening results documented?

- Paper records only
- Electronic health record only
- Both electronic health record or paper records
- Unsure
- Not applicable (my practice does not screen)
- Other (please specify)

* 45. Does your practice generate screening reports or review screening rate performance about:

	Generate reports?	Meet to review screening rates?
Depression		
Anxiety		
Substance Use		

* 46. Does your practice provide on-site counseling for the treatment of Depression?

	Provide on-site counseling?
Depression	
Anxiety	
Substance Use	

47. If your practice provides on-site counseling for the treatment of Depression, Anxiety, or Substance Use, who provides the counseling? (Select all that apply)

- [ ] Psychiatrist
- [ ] Psychologist
- [ ] Psychiatric Clinical Nurse Specialists (PCNS)
- [ ] Licensed Clinical Social Worker (LCSW)
- [ ] Licensed Mental Health Counselor (LMHC)
- [ ] Licensed Marriage and Family Therapist (LMFT)
- [ ] Advanced Chemical Dependency Professional (ACDP, LCDP)
- [ ] Peer Recovery Specialist
- [ ] NA
- [ ] Other (please specify)

* 48. Does your practice have experience utilizing quality improvement concepts and tools to enhance standard of care and/or practice protocols?

- No
- Yes (please indicate the focus areas of any completed/ongoing initiatives):

* 49. Please indicate briefly why your team is interested in participating in the RI MOMSPRN program.

* 50. Please indicate if your practice team is interested in optional practice reporting payment option (providing age, race, ethnicity, health coverage/plan, and pregnancy status info with quarterly de-identified screening reports) for an additional $1,500 of practice payments?

- No
- Yes (Please describe practice/system of care IT/practice reporting capabilities and/or available support):