CALL FOR APPLICATIONS: RI MomsPRN Cohort 3 Continuing Practices

The Rhode Island Department of Health (RIDOH) and the Care Transformation Collaborative of Rhode Island (CTC-RI) are pleased to offer select practices a continuation funding opportunity to further support perinatal behavioral health screening, treatment, and referral to care performance improvement efforts. This extended collaboration can help practices further strengthen select protocols and/or reporting processes as well as address ongoing professional education needs.

The goal of this RI MomsPRN Perinatal Behavioral Health Learning Collaborative is to help practices increase and strengthen the identification, early intervention, and treatment of depression, anxiety, and substance use among their pregnant and postpartum patients. Up to three practices will be selected for this extended funding opportunity which will start in June and continue for 12 months.

Who can apply: Practices that have completed an initial RI MomsPRN Behavioral Health Learning Collaborative:
- **Cohort 1 Collaboration: Practices participating between October 2019-December 2020**
- **Cohort 2 Collaboration: Practices participating between February 2021-April 2022**

Applications are due by May 25, 2022. Project activities will begin in June 2022 and will continue for 12 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 logo] ![Rhode Island Department of Health logo] ![Care Transformation Collaborative Rhode Island / pcmh kids logo — ADVANCING INTEGRATED HEALTHCARE]

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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	
Address 2	
Email Address	
Phone Number	

* 13. IT/EHR Staff Member

Name	
Site Name	
Title	
Email Address	
Phone Number	

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Previous Cohort Participation

14. Please indicate which previous RI MomsPRN learning collaborative your practice participated in.

☐ Cohort 1: October 2019- December 2020

☐ Cohort 2: February 2021-April 2022

RI MomsPRN
Maternal Psychiatry Resource Network

ADVANCING INTEGRATED HEALTHCARE

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Baseline Data

* 15. If your practice participated in Cohort 1(October 2019- December 2020) of the RI MomsPRN program, please indicate if you will re-run your baseline data report or if you will use last quarter data from cohort 1:

◯ Our practice will re-run our baseline report

◯ Our practice will use cohort 1 last quarter data

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

Update this list with any changes in the last 12 months. Please email jarruda@ctc-ri.org if you need your previous cohort application responses sent to you. Skip this page if no significant changes have occurred in the last 12 months.

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 #

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

Name

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

Name

NPI #

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

Name

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

Name

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

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

Name

NPI #

Professional Credential
(MD, DO, etc.)

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

Name

NPI #

Professional Credential
(MD, DO, etc.)

36. 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

If your practice participated in cohort 1 only: please fill out this page.
If your practice participated in cohort 2: please fill out this page if there have been significant changes in the last 12 months. If no significant changes have occurred in the last 12 months, please skip this page. if you would like your previous cohort application responses, please email jarruda@ctc-ri.org.

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

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

38. % of All Deliveries covered by respective payer (enter 0 if none for 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

* 39. 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 12 months.

◯ No

◯ Yes (please indicate)

[ ]

* 40. Please indicate if your practice is anticipating changing its electronic health record within the next 12 months.

◯ Yes

◯ No

* 41. Please identify your practice's intended area of improvement in this next cohort: (select all that apply)

☐ Increase referrals to treatment

☐ Increase Depression screening rates (improvement by >10% between first and last data report)

☐ Increase Anxiety screening rates (improvement by >10% between first and last data report)

☐ Increase SUD screening rates (improvement by >10% between first and last data report)

☐ Increase screening rates at a particular visit type

☐ Increase utilization of the RI MomsPRN teleconsultation line

☐ Increase staff competency and staff capacity

☐ Improve medication management

☐ Enhance EHR for more streamlined referral to treatment

☐ Other (please specify)

[ ]

* 42. Please describe rationale for selecting this area of improvement and steps that your practice may take to implement this change

* 43. Please reflect on practice self-efficacy results provided and identify an area on improvement in regards to staff capacity and competency.