

**INFORMATION FOR 2012 QUALITY IMPROVEMENT IN HEALTH CENTERS SUPPLEMENTAL FUNDING OPPORTUNITY**

Status: **NOT COMPLETE**

**Grantee Information**

**Note:** The information listed in cell 1 and 2 is the grantee name and grant number maintained for your organization in the Electronic Handbook (EHB).

1. Grantee Name

2. H80 Grant Number

**Purpose of FY 12 Supplemental Funding**

3. My health center received FY 2011 Supplemental Funding for Quality Improvement and Patient-Centered Medical Home Development in Health Centers award.

Yes     No

If 'Yes', describe how the activities proposed under this supplement will not duplicate what has been accomplished under the previous award.

(Maximum 4000 characters)

**PCMH Notice of Intent (NOI) and Proof of Recognition Information (select only one)**

4. My health center is not currently recognized or accredited as a PCMH and will use the funds to achieve PCMH recognition.

<p>If so, upload NOI.</p>	
<p>5. My health center is not currently recognized or accredited as a PCMH from a recognizing organization but has already submitted an NOI. If so, upload copy of NOI.</p>	<input type="checkbox"/>
<p>6. My health center has already received recognition for at least one of its sites and will use the funds to achieve PCMH recognition at an additional site(s).   A. Submit proof of your site(s) recognition with this application. If multiple sites are recognized, please consolidate proof of recognition into 1 document and;  B. Submit an NOI with the names of the additional site(s) for which you are seeking recognition.  If so, upload NOI and Proof of Recognition.</p>	<input type="checkbox"/>
<p>7. My health center is recognized as a Level 1 or 2 PCMH at all of its eligible sites and will use the funds to increase our recognition Level (from Level 1 to 2 or Level 2 to 3).   A. Submit proof of your site(s) recognition and level with this application. If multiple sites are recognized, please consolidate proof of recognition into 1 document and;  B. Submit an NOI requesting an add-on survey (the survey that practices must complete to increase recognition level).  If so, upload NOI and Proof of Recognition.</p>	<input type="checkbox"/>
<p>8. My health center is accredited as a PCMH or recognized as a Level 3 PCMH for all eligible sites and will increase quality improvement activities to maintain our PCMH recognition   A. Submit proof of your PCMH recognition with this application.  If so, upload Proof of Recognition.</p>	<input type="checkbox"/>

**Note:** If you have multiple documents, please consolidate these documents to upload one attachment for NOI and Proof of Recognition items below – if applicable. You can consolidate multiple documents by scanning and combining them together.

Notice Of Intent (Maximum One (1) Attachment)				
Select	Purpose	Document Name	Size	Uploaded By
No attached document exists.				
<input type="button" value="Attach"/>				

Proof Of Recognition (Maximum One (1) Attachment)				
Select	Purpose	Document Name	Size	Uploaded By
No attached document exists.				
<input type="button" value="Attach"/>				

Budget Justification (Maximum One (1) Attachment)				
Select	Purpose	Document Name	Size	Uploaded By
No attached document exists.				
<input type="button" value="Attach"/>				

**Identify at least one of the domains (by selecting 'Yes') for using supplemental funds to achieve, enhance, or maintain PCMH recognition and improve cervical cancer screening rates. Under each domain choose one or more of the sub-topics by providing a brief narrative (maximum 1000 characters) in the adjacent white space/cell that describes how the proposed activities will improve cervical cancer screening rates.**

<b>PCMH Domain 1: Enhance Access &amp; Continuity</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
1a. Access During Office Hours		1e. Medical Home Responsibilities	
1b. After-Hours Access		1f. Culturally and Linguistically	

		Appropriate Services	
1c. Electronic Access		1g. The Practice Team	
1d. Continuity			
<b>PCMH Domain 2: Identify &amp; Manage Patient Populations</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2a. Patient Information		2c. Comprehensive Health Assessment	
2b. Clinical Data		2d. Use of Data for Population Management	
<b>PCMH Domain 3: Plan and Manage Care</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
3a. Implement Evidence-Based Guidelines		3d. Medication Management	
3b. Identify High Risk Patients		3e. Use Electronic Prescribing	
3c. Care Management			
<b>PCMH Domain 4: Provide Self – Care Support and Community Resources</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
4a. Support Self-Care Process		4b. Provide Referrals to Community Resources	
<b>PCMH Domain 5: Track &amp; Coordinate Care</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
5a. Test Tracking and Follow-up		5c. Coordinate with Facilities and Care Transitions	
5b. Referral Tracking and Follow-up			

<b>PCMH Domain 6: Measure and Improve Performance</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
6a. Measure Performance		6e. Report Performance	
6b. Measure Patient/Family Experience		6f. Report Data Externally	
6c. Implement Continuous Quality Improvement		6g. Use Certified EHR Technology	
6d. Demonstrate Continuous Quality Improvement			
<b>Cervical Cancer Screening Goal:</b> Increase the number of female patients 24-64 years of age receiving one or more Pap tests during the measurement year or during the two years prior to the measurement year.			
Baseline Data (Refer to 2011 UDS Measure)	<input type="text"/> %	Goal proposed for FY12 Supplemental Funding	<input type="text"/> %