GPCI-QIP Primary Care Practice Site Application

Practice Information

*1. Primary Care Practice Site Information

Practice Name:

Address:

City/Town:

State:

ZIP:

Main Phone:

Alternative Phone:

Fax:

*2. Practice Size

- ◯ Solo Provider (if solo, not eligible)
- ◯ Small group practice (3 or less primary care providers)
- ◯ Large group practice (more than 3 primary care providers)

*3. Does your practice have at least 5,000 patients age 0-21?

- ◯ Yes
- ◯ No (if not, not eligible)

If yes, how many?

Practice Team Contact Information

Please provide information on the 3 Team Members within your practice that would lead the efforts, attend the face-to-face Learning Sessions, etc (your core improvement team).

Note: We suggest the team consist of 3 members, including a lead physician, clinical support staff (e.g. nurse), and an administrative or office staff person.

*4. Team Member #1 (Lead Physician)

Name:

Position (specify pediatrician or family physician):

Phone:

Fax:

Email:

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***5. Team Member #2**

Name:

Position:

Phone:

Fax:

Email:

***6. Team Member #3**

Name:

Position:

Phone:

Fax:

Email:

***7. Please assign one member of your identified team to be designated to enter data for your practice. If your practice is selected to participate in this Quality Improvement Project, this person will be given rights in our data collection system to enter data. Other team members will still be able to view and analyze data, but will not be able to enter data. The designated person from our identified team (one of the 3 individuals included as part of this application) is:**

Practice Characteristics

***8. How many physicians are in your practice?**

***9. Will nurse practitioners or physician assistants be involved in the care of patients with genetic conditions in your practice?**

◯ Yes

◯ No

If yes, how many are in your practice?

***10. How many providers (physicians, nurse practitioners, or physician assistants) are willing to participate in this project (by using tools and strategies to improve care and providing patient carts for review by the core improvement team)?**

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***11. Does your practice use an electronic health record?**

- ◯ Yes
- ◯ No
- ◯ In the process of obtaining

If yes, which vendor?

***12. Do you plan to make any changes to your EHR system within the next year (implement a system or change systems)?**

- ◯ Yes
- ◯ No

If yes, describe

13. Does your practice use a practice registry?

- ◯ Yes
- ◯ No

If yes, describe the registry (is it part of the EHR or separate, which patients are included, how was the registry built?)

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*14. Please indicate the number of Full Time Equivalent (FTE) employees at your practice.

Family Physician	
Pediatrician	
FNP	
PNP	
NP	
Physician Assistant	
Nursing Assistant	
RN	
Medical Assistant	
LVN/LPN	
Social Worker	
Case Manager/Care Coordinator	
Office Administrator	
Residents	

*15. Please choose the best description of your practice type that is applying to participate in the project:

- ◯ Independent Practice
- ◯ Hospital Affiliated Practice
- ◯ Affiliated with a University or Medical School
- ◯ County Public Health Department/Clinic
- ◯ Federally Qualified Health Center (FQHC) or Community Health Center
- ◯ Other

If "Other" please specify

*16. How would you describe your primary practice/position area?

- ◯ Urban (inner city)
- ◯ Urban (non-inner city)
- ◯ Suburban
- ◯ Rural

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***17. The 50 states are divided into 7 Regional Genetics and Newborn Screening Collborative Regions. Which region is your practice located in? (Select your state from the list below)**

- ◯ New England Genetics Collaborative (NEGC) - Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island and Vermont
- ◯ New York-Mid-Atlantic Consortium for Genetics and Newborn Screening Services (NYMAC) - Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Virginia, and West Virginia
- ◯ Southeast NBS & Genetics Collaborative (SERC) - Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, Puerto Rico, South Carolina, Tennessee, and the Virgin Islands
- ◯ The Region 4 Genetic Collaborative (Region 4) - Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin
- ◯ Heartland Genetics and Newborn Screening Collaborative (Heartland) - Arkansas, Iowa, Kansas, Missouri, Nebraska, North Dakota, Oklahoma, and South Dakota
- ◯ Mountain States Genetic Regional Collaborative Center (MSGRCC) - Arizona, Colorado, Montana, Nevada, New Mexico, Texas, Utah, and Wyoming
- ◯ Western State Genetic Services Collaborative (WSGSC) - Alaska, California, Guam, Hawaii, Idaho, Oregon, and Washington

***18. What percentage of your patients would you estimate to be in the following ethnic or cultural groups? If you have no patients in a specific group, please place a "0" in that space. (Note: Percents should add up to 100.)**

White, non-Hispanic/Latino	
Hispanic/Latino origin	
Black/African American	
Asian	
Native Hawaiian/other Pacific Islander	
American Indian/Alaska Native	
Other (specify)	

***19. What percentage of your patients would you estimate to be in the following payment category?**

Private Insurance	
Public Insurance	
Uninsured	

20. Do you have an idea of how many patients in your practice have genetic conditions?

- ◯ Yes
- ◯ No

If yes, approximately how many?

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***21. How would you describe your level of knowledge regarding the Model for Improvement quality improvement methodology?**

- ◯ Very Knowledgeable
- ◯ Knowledgeable
- ◯ Somewhat knowledgeable
- ◯ Not knowledgeable

***22. Does your practice have a system in place for:**

	Yes	No	N/A
Making referrals?	◯	◯	◯
Tracking those referrals?	◯	◯	◯

If yes to either, please describe.

***23. What is the approximate distance from your practice to the closest geneticist?**

- ◯ 5 miles or less
- ◯ 6-10 miles
- ◯ 11-30 miles
- ◯ 31-50 miles
- ◯ 50 or > miles
- ◯ Do not know

***24. When referring a patient to a geneticist, check the response that represents the nearest available location for both standing or outreach clinics:**

	Primary Hospital	Community	State	Other	Do not know
Standing Clinic	☐	☐	☐	☐	☐
Outreach/Satellite Clinic	☐	☐	☐	☐	☐

25. Describe a Quality Improvement (QI) project you have participated in, including your experience with using data to make improvements.

***26. Does your practice have a system in place to obtain regular feedback from parents/families?**

- ◯ Yes
- ◯ No

27. If yes, what does this system include (check all that apply):

- ☐ Parent/Family Surveys
- ☐ Parent/Family Focus Groups
- ☐ Parent/Family Advisory Committee
- ☐ Ask families for informal feedback at visits
- ☐ Other, please specify:

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***28. Please describe the attributes or strengths of your team that would make it a good choice for this project.**

***29. What does your practice want to accomplish as a participant in this project?**

***30. Are you a QuIIN member? Information on QuIIN is available at http://quiin.aap.org**

- ◯ Yes
- ◯ No
- ◯ No, but am willing to join this free quality improvement network

***31. We have discussed this project with the senior leadership at the organization and they are supportive of our involvement.**

- ◯ Yes
- ◯ No

***32. Will your practice require local IRB Approval?**

- ◯ Yes
- ◯ No
- ◯ Not sure

The GPCI-QIP has received approval from the AAP Institutional Review Board. No identifiable protected health information is being collected for this project; therefore, HIPAA authorization will not be needed from patients in order for your practice to participate. Often, the information supplied in the AAP IRB Application will be applicable to your own local or hospital IRB application. A copy of the AAP IRB is available upon request.

Confirmation

Your application is now complete! Please click "Done" to submit now.

If you have any questions, feel free to contact Jill Healy at the information below.

Jill Healy, MS
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