Demographic Data Call for Applications

Call for Applications

Care Transformation Collaborative of Rhode Island (CTC-RI) is pleased to offer up to fifteen (15) primary care practices the opportunity to apply for funding to conduct a Baseline Needs Assessment and participate in a Train the Trainer Demographic Data Collection Best Practice Webinar Series. Practices will be provided with incentive funding payments of up to $4,100.00 per practice site. Outlined below is the "CTC-RI Demographic Data Collection Pilot Call for Applications" which has been financed by the Rhode Island Department of Health (RIDOH)/Executive Office of Health and Human Services (EOHHS) and the Center for Disease Control and Prevention (CDC).
Review the call for applications here.

Applications are due by Friday August 4th, 2023 5:00 PM EST

For questions please contact: DemoData@ctc-ri.org

If needed, you can close out of the application window and you will be able to return to the spot where your application left off. You must complete the page and select next for it to bring you back to the same spot.

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Practice Information

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* 1. Practice information

Practice Name	
Tax ID Number (TIN)	
Address	
City/Town	
State/Province	
ZIP/Postal Code	
Contact Name	
Email Address	
Phone Number	

* 2. Type of Practice

- ◯ Individual Adult
- ◯ Family
- ◯ FQHC
- ◯ Hospital-Based Clinic
- ◯ System of Care
- ◯ Practice Group
- ◯ Other (please specify)

* 3. Is practice part of System of Care?

- ◯ Yes
- ◯ No

4. If yes, what System of Care?

* 5. Practice intends to apply and participant in Demographic Data Collection Pilot

- Yes
- No

* 6. System of Care intends to participate in Demographic Data Collection Pilot and will implement Train the Trainer plan for completing baseline needs assessment and webinar training program

- Yes
- No

* 7. What Electronic Health Record System do you use?

Name

Version

* 8. What is the percentage of your practice payer mix for: MEDICARE (put N/A if not applicable)

Number of Patients

Percent of total practice

* 9. What is the percentage of your practice payer mix for: MEDICAID (put N/A if not applicable)

Number of Patients

Percent of total practice

* 10. What is the percentage of your practice payer mix for: COMMERCIAL (put N/A if not applicable)

Number of Patients

Percent of total practice

* 11. What is the percentage of your practice payer mix for: SELF-PAY (put N/A if not applicable)

Number of Patients

Percent of total practice

* 12. Do you have an additional practice site that you would like to include in this application?

- ◯ Yes
- ◯ No

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Additional Site Information

Please provide information on the additional practices that would be interested in participating.

* 13. Additional Practice Site information

Practice Name	
Tax ID Number (TIN)	
Address	
City/Town	
State/Province	
ZIP/Postal Code	
Contact Name	
Email Address	
Phone Number	

* 14. Type of Practice

- ◯ Individual Adult
- ◯ Family
- ◯ FQHC
- ◯ Hospital-Based Clinic
- ◯ System of Care
- ◯ Practice Group
- ◯ Other (please specify)

* 15. What is the percentage of your practice payer mix for: MEDICARE (put N/A if not applicable)

Number of Patients	
Percent of total practice	

* 16. What is the percentage of your practice payer mix for: MEDICAID (put N/A if not applicable)

Number of Patients	
Percent of total practice	

* 17. What is the percentage of your practice payer mix for: COMMERCIAL (put N/A if not applicable)

Number of Patients	
Percent of total practice	

* 18. What is the percentage of your practice payer mix for: SELF-PAY (put N/A if not applicable)

Number of Patients	
Percent of total practice	

19. Additional Practice Site information

Practice Name	
Tax ID Number (TIN)	
Address	
City/Town	
State/Province	
ZIP/Postal Code	
Contact Name	
Email Address	
Phone Number	

20. Type of Practice

- ◯ Individual Adult
- ◯ Family
- ◯ FQHC
- ◯ Hospital-Based Clinic
- ◯ System of Care
- ◯ Practice Group
- ◯ Other (please specify)

21. What is the percentage of your practice payer mix for: MEDICARE (put N/A if not applicable)

Number of Patients	
Percent of total practice	

22. What is the percentage of your practice payer mix for: MEDICAID (put N/A if not applicable)

Number of Patients	
Percent of total practice	

23. What is the percentage of your practice payer mix for: COMMERCIAL (put N/A if not applicable)

Number of Patients	
Percent of total practice	

24. What is the percentage of your practice payer mix for: SELF-PAY (put N/A if not applicable)

Number of Patients	
Percent of total practice	

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Practice Provider Information

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PLEASE NOTE:
The webinar series will be open to any practice staff who wish to attend in addition to the identified trainer.
The stipend will be paid only for the Trainer to attend.

All trainers will be asked to sign the practice participative agreements post selection.

* 25. Practice Staff Member Identified to act as Trainer to complete Baseline Needs Assessment

Name	
Position	
Practice Site	
Email Address	
Phone Number	

26. Practice Staff Member Identified as Trainer to attend Train the Trainer Webinar Series (if different from above)

Name	
Position	
Practice Site	
Email Address	
Phone Number	

27. If you are applying for more than one practice site, please provide the Practice Staff Member Identified to act as Trainer to complete Baseline Needs Assessment

Name	
Position	
Practice Site	
Email Address	
Phone Number	

28. If you are applying for more than one practice site, Practice Staff Member Identified as Trainer to attend Train the Trainer Webinar Series (if different from above)

Name	
Position	
Practice Site	
Email Address	
Phone Number	

29. If you are applying for more than one practice site, please provide the Practice Staff Member Identified to act as Trainer to complete Baseline Needs Assessment

Name	
Position	
Practice Site	
Email Address	
Phone Number	

30. If you are applying for more than one practice site, Practice Staff Member Identified as Trainer to attend Train the Trainer Webinar Series (if different from above)

Name	
Position	
Practice Site	
Email Address	
Phone Number	

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Appendix A

Conducting a Baseline Needs Assessment is a way for practices to evaluate current demographic data collection processes and identify opportunities for improvement. The Train the Trainer Webinar Series will provide opportunities to learn more about how to improve demographic data collection and reporting based on baseline needs assessment findings. Practices will need to demonstrate capacity and availability of staff time to participate in this pilot program. Practices can use the comment section to provide more detail on the practice's plan and capacity to conduct the Baseline Needs Assessment and participate in the Webinar Series.

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* 31. **Practice/Organizational Readiness and Capacity:** Has there been discussion within your practice/organization regarding: The need for staff education on collection and use of demographic data collection?

- ◯ Yes
- ◯ No
- ◯ N/A

* 32. **Practice/Organizational Readiness and Capacity:** Has there been discussion within your practice/organization regarding: The need for patient education on collection and use of demographic data?

- ◯ Yes
- ◯ No
- ◯ N/A

* 33. **Practice/Organizational Readiness and Capacity:** Has there been discussion within your practice/organization regarding: Demographic data collection policies and processes?

- ◯ Yes
- ◯ No
- ◯ N/A

* 34. **Practice/Organizational Readiness and Capacity:** Has there been discussion within your practice/organization regarding: The need for expanded staff training on structural racism, health equity and/or cultural competency?

- ◯ Yes
- ◯ No
- ◯ N/A

* 35. **Practice/Organizational Readiness and Capacity:** Has there been discussion within your practice/organization regarding: The need to improve electronic health record reporting capacity?

- ◯ Yes
- ◯ No
- ◯ N/A

* 36. **Practice/Organizational Readiness and Capacity:** Has there been discussion within your practice/organization regarding: The opportunity to reduce health disparities by improving the collection and use of demographic data?

- ◯ Yes
- ◯ No
- ◯ N/A

* 37. **Practice/Organizational Readiness and Capacity:** Has there been discussion within your practice/organization regarding: Interest in using staff and patient feedback and leveraging data to improve care?

- ◯ Yes
- ◯ No
- ◯ N/A

38. Please provide any comments about the about Practice/Organizational Readiness & Capacity questions.

* 39. **Equipment/Platform:** Indicate if your practice has the following technical capabilities: Ability to participate in Zoom Webinar Platform?

- ◯ Yes
- ◯ No
- ◯ N/A

* 40. **Equipment/Platform:** Indicate if your practice has the following technical capabilities: Access to and ability to use the Survey Monkey platform for conducting and completing surveys?

- ◯ Yes
- ◯ No
- ◯ N/A

* 41. **Equipment/Platform:** Indicate if your practice has the following technical capabilities: Ability to aggregate patient survey data collected via multiple sources such as electronically on Survey Monkey, over the phone and on paper?

- ◯ Yes
- ◯ No
- ◯ N/A

42. Please provide any comments about the about Equipment/platform questions.

* 43. **Staffing:** Indicate if your practice/organization is: Willing and able to identify a qualified “improvement” champion who will be the practice “Trainer”

- ◯ Yes
- ◯ No
- ◯ N/A

* 44. **Staffing:** Indicate if your practice/organization is: Willing to provide protected time for identified staff to complete Baseline Needs Assessment surveys and participate in the 6 session Webinar Series

- ◯ Yes
- ◯ No
- ◯ N/A

* 45. **Staffing:** Indicate if your practice/organization is: Able to gather and report data on practice demographic data collection performance

- ◯ Yes
- ◯ No
- ◯ N/A

46. Please provide any comments about the about Staffing questions.

* 47. **Performance Improvement:** Is your practice interested in participating in a demographic data performance improvement initiative if that was available in the future to further apply learning gained in this pilot project?

- ◯ Yes
- ◯ No
- ◯ N/A

48. Please provide any comments about the about Performance Improvement questions.

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Questions:

Please provide a response to each question (limit responses to a maximum of 300 words

The goal of this CTC-RI opportunity is to provide primary care practices with financial and technical support that will enable your practice to assess current demographic data collection processes and performance, identify opportunities for improvement and participate in a webinar series to support practice improvement of REAL demographic data collection with the goal of reducing health disparities.

* 49. What are your organization/practice goals for participating in this program?

* 50. Please identify the qualifications of the person or persons who will be designated as “Trainer” to complete the Baseline Needs Assessment and attend the Webinar Series.

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Questions:

Please provide a response to each question (limit responses to a maximum of 300 words

* 51. How will your practice benefit from participating in the CTC-RI Demographic Data Collection Pilot?

* 52. What do you see as the challenges of participation?

* 53. How do you anticipate addressing those challenges?

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Questions:

Please provide a response to each question (limit responses to a maximum of 300 words

* 54. Outline your plan for the Trainer to disseminate learning from this program

* 55. Who will receive the training? Please provide the number of staff members to be trained and their roles.

* 56. When will the training be conducted? Please provide a timeline for completing the training.

* 57. How will the training be conducted? Please describe details on the method or setting of the training.

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Questions:

Please provide a response to each question (limit responses to a maximum of 300 words

This question only needs to be answered if the System of Care is applying on behalf of a group of practices.

The "Call for Applications" is intended to provide practices with the opportunity to identify strategies to improve demographic data performance. If a System of Care wants to apply for this opportunity on behalf of their practices, indicate a plan for:

58. Identifying a trainer

59. Completing the baseline needs assessment

60. Webinar participation

61. Staff training plan

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Practice & System Letter of Support

For sample templates, please see below:

Sample Practice Cover Letter
System of Care Letter of Support Template

62. Please upload your practice cover letter here. (Sample Practice Cover Letter Here)

Choose File Choose File No file chosen

63. Please upload your system of care letter of support here. (System of Care Letter of Support Template)

Choose File Choose File No file chosen