

Project RedDE! Practice Application

Practice Information

Thank you for completing this online application to participate in the Reducing Diagnostic Errors in Primary Care Pediatrics (Project RedDE!) Quality Improvement Collaborative.

Priority will be given to applications completed by June 3, 2015.

Up to 35 teams will be included in the community of learners and will collaborate over 31 months to make improvements in pediatric care. Please note: You will identify the members of your core improvement team in this application.

Project staff and leadership will be in touch with you with any follow-up questions about your application.

Sincerely,
Michael L Rinke, MD, PhD, FAAP, Project RedDE! PI
Liz Rice-Conboy, Project RedDE! Manager
Email: ericeconboy@aap.org

* 1. Practice Information

Practice Name:	<input type="text"/>
Address:	<input type="text"/>
City/Town:	<input type="text"/>
State:	<input type="text"/>
ZIP/Postal code:	<input type="text"/>
Main Phone:	<input type="text"/>
Email Address:	<input type="text"/>
Alternative Phone:	<input type="text"/>

Core Improvement Team Contact Information

Please provide information on the 3 Team Members within your practice/medical home.

Note: We strongly recommend an interdisciplinary team with physicians (primary care pediatricians), nurses and non-clinicians (front office staff, IT staff person, patient coordinator, etc.) and potentially a subspecialist, mental health professional or counselor with whom the practice refers patients on a frequent basis.

* 2. Team Member #1 (Lead Physician)

Name (include designations):	<input type="text"/>
Position in practice:	<input type="text"/>
Department:	<input type="text"/>
Phone:	<input type="text"/>
Email:	<input type="text"/>

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*3. Team Member #2

Name (include designations):	<input type="text"/>
Position in practice:	<input type="text"/>
Department:	<input type="text"/>
Phone:	<input type="text"/>
Email:	<input type="text"/>

*4. Team Member #3

Name (include designations):	<input type="text"/>
Position in practice:	<input type="text"/>
Department:	<input type="text"/>
Phone:	<input type="text"/>
Email:	<input type="text"/>

5. There is a max of 5 members on the core improvement team, please use the space below to include the name, title and email of core improvement member 4 & 5.

Team Member #4:	<input type="text"/>
Team Member 4 Title & Email:	<input type="text"/>
Team Member #5:	<input type="text"/>
Team Member 5 Title & Email:	<input type="text"/>

*6. Group Administrator.

Please assign one member of your identified team to be designated to enter data for your hospital. 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. It is helpful for the group administrator to serve as the champion for chart review, data pulls and responsible for interface with the EHR (as applicable).

The designated person from our identified team (one of the 3-5 individuals included as part of this application) is:

Practice Demographics

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*7. Please choose the description that BEST DESCRIBES your practice.

- ☐ Independent Practice
- ☐ Hospital affiliated practice (no university or medical school affiliation)
- ☐ Practice affiliated with a University or Medical School
- ☐ County public health department/clinic
- ☐ Federally Qualified Health Center (FQHC) or Community Health Center
- ☐ Other, please specify:

*8. How many annual visits (all patient encounters in the office) does your practice see across all primary care providers?

*9. How many unique patients do you have in your practice across all primary care providers?

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

Family physician	<input type="text"/>
Pediatrician	<input type="text"/>
Physician Assistant	<input type="text"/>
Social Worker	<input type="text"/>
RN	<input type="text"/>
Family Nurse Practitioner (FNP)	<input type="text"/>
Pediatric Nurse Practitioner (PNP)	<input type="text"/>
Licensed Vocational Nurse (LVN)/ Licensed Practical Nurse (LPN)	<input type="text"/>
Nursing Assistant	<input type="text"/>
Medical Assistant	<input type="text"/>
Residents	<input type="text"/>
Case Manager/Care Coordinator	<input type="text"/>
Other	<input type="text"/>

*11. Are there residents/trainees that ever see patients in your practice?

- ☐ Yes
- ☐ No

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***12. Please enter the right PERCENTAGE (%) breakdown of the number of years experience post-training that your physician/s have below. The three percentages below should add up to 100%.**

0-3 years out of training

4-9 years out of training

10 and more years out of training

***13. Please enter the right PERCENTAGE (%) breakdown of the number of years experience post-training that your nurse practitioner/s have below. The three percentages below should add up to 100%.**

0-3 years out of training

4-9 years out of training

10 and more years out of training

***14. How would you describe the area surrounding your practice?**

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

Practice Characteristics

***15. Please rate the amount of work your practice has previously put into improving:**

	A lot	A little	None
Screening adolescents for depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnosing adolescents with depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Measuring blood pressure in all patients age 3 and over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnosing patients with elevated blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tracking received laboratory results	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acting on abnormal laboratory results	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

***16. Are you and your practice's leadership able to accept being randomized to a group that will be asked to initially work on one of the 3 diagnostic errors of interest? (Note: You can continue ongoing work on the other diagnostic errors)**

- ☐ Yes
- ☐ No

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***17. PER MONTH, how many well child encounters/healthcare maintenance visits/annual physicals does your practice with patients AGE 3 years old and ABOVE?**

- ☐ Less than 30
- ☐ 31-100
- ☐ 101 and over

***18. PER MONTH, how many well child encounters/healthcare maintenance visits/annual physicals does your practice have with patients AGE 11 year old and ABOVE?**

- ☐ Less than 17
- ☐ 17-30
- ☐ 31-60
- ☐ 61 and over

Electronic Health Record capability

19. Does your practice use an electronic medical record (EMR) or electronic health record (EHR) system (not limited to billing records)?

- ☐ Yes
- ☐ No

20. If your practice does not have an EHR, is your practice able to query your billing system for patient charts of certain ages or codes?

- ☐ Yes
- ☐ No

***21. Does your practice plan on beginning to use an EHR in the next 3 years?**

- ☐ Yes
- ☐ No

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***22. The ability to query your EHR and/or billing system for specific patient charts or specific patient data is essential to this project that focuses on missed opportunities in diagnosis. In order to facilitate the necessary steps to ensure you can successfully work with your IT staff and/or EHR vendor, we are requesting additional information:**

As part of this application process, do you or your practice's IT staff or EHR liaison commit to discussing the needs of this project in the next 4 weeks?

Please see "Conversation with your EHR vendor for Project RedDE! document.

☐ Yes

☐ No

☐ Other (please specify):

Please contact Liz Rice-Conboy, ericeconboy@aap.org, for a tool to discuss the needed information from your EHR vendor.

***23. What EHR or EMR vendor does your practice use?**

***24. Is your current EHR or EMR system (select one choice):**

☐ BASIC: defined as demographics, problem lists, prescription orders, laboratory and imaging result viewing, clinical notes, and medication lists

☐ FULL: defined as Basic plus drug interactions warnings, e-Prescribing, ordering and electronic transmission of laboratory and radiology tests, age-specific laboratory ranges, electronic images returned, medical history, and guideline reminders.

☐ LESS THAN BASIC

Institutional Review Board (IRB)

***25. No PHI will be obtained in any of the data collection tools. AAP IRB approval has been obtained to provide human subjects protections for the core improvement team and the de-identified patient data for Project RedDE! The project leaders determine whether local IRB approval or review, or other agreements will be necessary for participation in this project.**

In light of what is mentioned above, have you inquired with your affiliated health system, practice manager, university system, etc., about the local IRB or other requirements (if necessary) to participate in this project?

☐ Yes

☐ No

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26. Will you need to seek local IRB or go through another internal 'approval' process at your practice to participate in this project?

- ☐ Yes, and we commit to submitting an IRB in the next 8 weeks.
- ☐ No
- ☐ Unknown, but we commit to finding out in the next 4 weeks and submitting an IRB in the next 8 weeks as necessary.

***27. Do you need documentation (other than the project recruitment materials) in order to gain leadership buy-in for your practices participation in this project?**

- ☐ Yes
- ☐ No
- ☐ Maybe

28. What other documentation (other than the project recruitment materials) do you NEED in order to gain leadership buy-in for your practices' participation in this project?

***29. Are you a QulIN member? Information on QulIN is available at <http://quiin.aap.org>**

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

***30. How did you hear about Reducing Diagnostic Errors in Primary Care Pediatrics (Project RedDE!)?
(Select all that apply).**

- ☐ Quality Improvement Innovation Networks (QulIN) listserv
- ☐ AAP Quality Connections Newsletter
- ☐ AAP Chapter Connections Newsletter
- ☐ AAP News OnCall
- ☐ Colleague
- ☐ AHRQ PSNet Patient Safety Network Newsletter
- ☐ National Patient Safety Foundation
- ☐ Other, please describe:

Confirmation of submitted application & thank you!

Please select DONE to submit your project application.

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We appreciate your interest in Project RedDE! Please feel free to contact Ms Rice-Conboy or Dr Michael Rinke (mrinke@montefiore.org) if you have further questions.

Thank you,

Liz Rice-Conboy, ericeconboy@aap.org

Project RedDE! Manager

Phone: 1-800-433-9016 ext 7103