ChiroCare Centers of Excellence

Clinic Application

Instructions: Complete this application in its entirety. All questions should be responded to considering the standard practices of the clinic or group practice. ***If additional space is needed for any portion of this application, please feel free to respond using a separate, typed document and attach to this application.***

CCoE Self-Assessment Score ____/22

1. Name of clinic / group practice applying for designation:

   _____

   a. Clinic Tax ID Number: _____ b. Clinic NPI Number: _____

2. Person within the clinic for Fulcrum to contact regarding the ChiroCare Centers of Excellence program:

   Name: _____ ***Title***: _____

   Phone: _____ ***E-Mail***: _____

3. List the physical address(es) for each office where patients are treated.

Location 1:	Street	_____		Suite # _____
	City	_____	State _____	ZIP _____
Location 2:	Street	_____		Suite # _____
	City	_____	State _____	ZIP _____
Location 3:	Street	_____		Suite # _____
	City	_____	State _____	ZIP _____
Location 4:	Street	_____		Suite # _____
	City	_____	State _____	ZIP _____

Please list all DC's in the clinic and their years of *overall* clinical experience below:

Name of DC (*Please Print*)	**Sees Patients at which locations?** ***(Use location #s from above)***	**Years of Clinical Experience** ***(MM/YYYY – MM/YYYY)***	**Acupuncture Certification?**	
1. _____	_____	_____	___Yes	___No
2. _____	_____	_____	___Yes	___No
3. _____	_____	_____	___Yes	___No
4. _____	_____	_____	___Yes	___No
5. _____	_____	_____	___Yes	___No

4. Please tell us which Electronic Health Record system the clinic is currently using:

   _____

5. Describe how your patient assessment process aligns with the *Patient Intake and Assessment* description given in the "**Attributes of Excellence in Chiropractic Care Management**" document. ***Please attach samples of the assessment and evaluation tools utilized in your clinic.***

   _____

   _____

   _____

   _____

   _____

6. Which outcome tools are currently being used in your clinic(s)?

   ___ Oswestry

   ___*Version 2.1a* ___ *PCLBDQ* ____ *Other*

   ___Roland-Morris Questionnaire

   ___Bournemouth Questionnaire

   ___Orebro Musculoskeletal Pain Screen Questionnaire

   ___PROMIS Global Health 10 instrument

   ___Other(s) _____

7. When and how do you incorporate Cognitive Behavioral Therapy into your patient assessment and care planning process?

_____

_____

_____

_____

8. Describe your clinic's approach to Shared Decision Making and how it is incorporated into the care planning process. A***ttach sample tools / forms offered to your patients to support this process***.

_____

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_____

9. Provide a detailed description of your treatment / care planning process, including how it aligns with the elements provided in the *Patient-Centered Care Planning* section of the "**Attributes of Excellence in Chiropractic Care Management**" document.

_____

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_____

_____

10. ***Attach three (3) DE-IDENTIFIED samples of recent treatment plans developed by providers in your clinic***.

11. Do you refer patients to other health care providers? ☐ Yes ☐ No

    a. If Yes, list the specialties / types of providers you commonly refer:

___Neurologists ___Physical Therapists

___Orthopedics ___Primary Care Providers

___Acupuncturists ___Other: _____

___Other: _____

12. Please attach a copy of your clinic's documented referral process – include samples of letters or forms used.

13. Describe the Case Management and Care Coordination processes utilized in your clinic(s).

_____

_____

_____

_____

14. ***Attach a sample copy of the Patient Consent Form.***

15. How do you incorporate active care instruction and education into your care plans? Please describe your approach to active care use and the patient's involvement in their recovery.

_____

_____

_____

_____

16. List the most common patient education materials used by your clinic and ***attach samples***.

_____

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_____

_____

17. Do you provide your patients with information / resources for smoking cessation?

☐ Yes ☐ No

18. What preventative care tools and/or education (i.e., wellness, injury prevention, etc.) do you offer your patients?

_____

_____

_____

_____

Submission Instructions:

1. Review, sign and date the ChiroCare Centers of Excellence *Attestation to Clinic Application* page

2. Gather examples of:
    a. 3 De-identified treatment plans
    b. Samples of clinic referral letters
    c. Samples of informed consent form
    d. Assessment and evaluation forms
    e. Patient education materials
    f. Preventative care education
    g. Active Care instructions

3. Completed applications including the signed Attestation, supporting examples and **de-identified** treatment plans (question 10) can be submitted by any of the following methods:

    A. **Mail** to:

    Fulcrum
    Attn: Dr. Vivi-Ann Fischer, CCO
    1000 County Road E, Suite 230
    Shoreview, MN 55126

    B. **Fax** to (651) 389-2009

Please note that missing information can result in delays in your application. If you have any questions please contact Dr. Vivi-Ann Fischer at 651-389-0143, toll free at (866)-714-0524, or by email at v.fischer@fulcrumhealthinc.org.