Maryland Practice Transformation Network Application Form

Return to MCMS via email to kmiller@montgomerymedicine.org, or fax to 301.921.4368.

Please fill out the following information to complete the application:

Name of Practice: _____ ____Primary Care ____Specialty Care

Practice Representative Name: _____Email: _____

Practice Representative Phone Number: _____Number of Physicians in Practice: _____

1. Current Electronic Health Record (EHR) Status: (Please check which applies to your practice)

_____We use an EHR. Product Name and version: _____

_____We have attested to Meaningful Use (MU) Stage 1

_____We have attested to MU Stage 2

_____We plan to implement an EHR on:

Product Name: _____

_____We do not plan to use an EHR

2. Can you run data reports from your EHR to assist with quality improvement efforts?

_____Yes

_____No

_____We would like assistance with this

3. Are you connected with a community-wide health information exchange (HIE) (For example, CRISP)?

_____Yes

_____No

_____We would like assistance with this

4. Are you sharing electronic data with other clinicians via: (Check all that apply)

_____Direct Health Information Service Provider (HISP) vendor.

Name of vendor: _____

_____Health Information Exchange. Name of HIE provider: _____

_____Within your network's EHR

_____None of these apply

5. Do you currently: (Check all that apply)

_____Participate in a Medicare, Medicaid, or Children's Health Insurance Program (CHIP) value-based payment program?

_____Participate in a payment reform demonstration model such as Pioneer Accountable Care Organization (ACO), Medicare Shared Savings Program ACO, Comprehensive Primary Care Initiative (CPCI), or Medicaid ACO?

_____Participate in another Practice Transformation Network or other CMS initiative?

If yes, please list: _____

_____ None of these apply