Iowa Healthcare Collaborative

Practice Transformation Network
Participation Charter
Project Dates: May 2015 – April 2019

Practice Name: _____**Practice NPI:** _____
Address: _____
City, State, ZIP: _____

I understand that the Iowa Healthcare Collaborative (IHC), a provider-led, patient-focused healthcare organization, is submitting a proposal to become a Practice Transformation Network (PTN) in our community. The PTN will assist clinicians in transforming their practices to thrive under new payment models and meet quantifiable improvement outcomes.

I understand that this new initiative will support my practice in improving care, increasing satisfaction, and preparing for new payment models. IHC and its PTN partners will provide education, coaching and technical assistance in the areas of leadership, data reporting/analysis and transformation of best practices.

With the PTN's training and coaching assistance, my practice will move through these five transformative stages:

As part of this initiative, I understand that my practice will be expected to:

- Participate in a readiness assessment
- Work with PTN staff to develop strategies and contribute to work plan development to meet practice aims
- Report selected process and outcome metrics monthly via the TCPI PTN Reporting Database
- Commit to engaging patients and communities to improve health outcomes
- Participate in PTN Learning Communities and share best practices with other network participants
- Participate in Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier Programs
- Pursue a culture of safety and accountability at the clinic
- Identify patient safety/quality teams to lead clinic improvement efforts
- Appoint clinic employees to serve as lead contacts for PTN related activities

I am interested in participating in the Transforming Clinical Practice Initiative (TCPI) and the IHC Practice Transformation Network (PTN). Please consider this a **non-binding** letter of our commitment. I understand that eligibility confirmation and formal agreement details will be provided once IHC is awarded funding.

Practice Representative: _____

Date: _____

Printed Name: _____

Please sign and date here and then **complete the next page**

Please list the number of clinicians* expected to participate from your organization in each category:

	Count
Primary Care Clinicians	
Specialty Care Clinicians	

Clinicians include: physicians, nurse practitioners, physician assistants, and clinical pharmacists

Current EHR status (Please check which applies to your practice)

- ☐ We use an electronic health record (EHR). Product name and version: _____
- ☐ We have attested to MU stage 1
- ☐ We have attested to MU stage 2
- ☐ We plan to implement an EHR on ___/___/2015 Product name: _____
- ☐ We do not plan to use an EHR

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

☐ Yes ☐ No ☐ We would like assistance with this

Are you connected with a community-wide health information exchange (HIE)?

☐ Yes ☐ No ☐ We would like assistance with this

Are you sharing electronic data with other clinicians via: *(check all that apply)*

- ☐ Direct (HISP) vendor. Name of vendor: _____
- ☐ Health Information Exchange (HIE). Name of HIE provider: _____
- ☐ Within your network's EHR

Do you currently:

- ☐ Participate in a Medicare, Medicaid, or CHIP value-based payment program?
- ☐ Participate in a payment reform demonstration model such as Pioneer ACO, Medicare Shared Savings Program ACO, or Medicaid ACO

Please send this completed PTN Participation Charter Form with signed Participation Agreement to:

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