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**COMMUNITY HEALTH TEAM PROJECT**

**MEMORANDUM OF AGREEMENT (MOA)**

**BETWEEN COMMUNITY HEALTH TEAM ENTITY AND CTC-RI PRIMARY CARE PRACTICE**

1. **Introduction**:

This Memorandum of Agreement (MOA) is a cooperative agreement between the Community Health Team Entity and the CTC-RI primary care practice site which indicates an agreement to work together to achieve the mutual goals and objectives and assist in the implementation of the plan and scope of work described for the Community Health Team Project and defined in this document.

1. **Definitions:**
2. Community Health Team (CHT): Locally based care coordination team comprising multidisciplinary staff (community health resource specialists and social workers) that work in partnership with the primary care practice. The CHT connects patients, caregivers, providers and systems through care coordination, collaborative work and direct patient engagement.
3. Care Transformation Collaborative of Rhode Island (CTC-RI): Non-profit organization that works under the auspices of the Rhode Island Office of the Health Insurance Commissioner and is a multi-payer primary care initiative focused on improving quality, customer experience and reducing cost of care. The CTC-RI Board of Directors has approved the funding of the CHT through funds received from the Rhode Island health plans (Tufts Health Plan, United Healthcare, Neighborhood Health Plan and Blue Cross and Blue Shield of Rhode Island).
4. Community Health Team (CHT) Entity: Organization that receives the funding through a contract with CTC based on the budget approved by the CTC-RI Board of Directors. The CHT Entity has the overall clinical, fiscal and administrative responsibility for the CHT Project, and is charged with fulfilling the goals and purposes of the CHT Project. The Community Health Team Entity is responsible for executing the Memoranda of Agreement (MOA) with CTC-RI primary care practice sites that are interested in participating in the CHT project in the Pawtucket and Central Falls area. Note: the geographic area may extend to neighboring communities but would not include patients that reside more than 10 miles beyond the primary locations).
5. Multi-payer Initiative: All of the Rhode Island based health plans (United Healthcare: Managed Medicaid and Commercial, Blue Cross and Blue Shield of Rhode Island, Tufts Health Plan and Neighborhood Health Plan of Rhode Island) provide financial support for the Community Health Team project; The health plans generate high risk patient lists for the primary care practices to review and select patients for CHT referral (with the exception of United Healthcare Commercial).
6. Memorandum of Agreement: MOA establishes criteria for CTC-RI practice sites and the CHT entity consistent with the objectives established by the CTC-RI Board of Directors.
7. Primary Care Practice: The primary care practice resides in the CHT geographic vicinity, is part of the CTC initiative and provides patients with patient centered medical home services. Health plans provide the primary care practice with information on patient risk and cost. Primary care practices are responsible for analyzing this information and selecting patients for CHT participation based on referral criteria.
8. Registry: CHT entity panel of high risk patients which includes patients referred to the CHT by the CTC-RI primary care practices together with their engagement status.
9. **Purpose:**

The purpose of the Community Health Team (CHT) Project is to develop, implement and evaluate the impact of the Community Health Team model which works together with CTC-RI Patient Centered Medical Home primary care practices. The CHT staff will serve as practice “extenders” for CTC-RI primary care practices and will focus on patients who are identified as high risk, high cost and high impact with the goals of: improving patient engagement, and health literacy; improving access to community based services and supports; improving health outcomes; reducing unnecessary utilization of emergency and inpatient hospital services; and demonstrating directional improvement in health and total cost outcomes of patients in the CTC primary care practice that are engaged by the CHT.

Health Plans additionally participate in the CHT pilot project and are responsible for generating lists of patients that they identify to be “high risk/high cost” and tracking cost of care for the high risk patients that are selected and agree to been engaged with CHT staff.

1. **Community Health Team Entity Responsibilities:**

Blackstone Valley Community Health Center, as the Community Health Team Entity, is responsible for:

1. Serving as the fiscal intermediary for the project in Pawtucket and Central Falls. As such, the Entity is responsible for receiving and accounting for the funds for the project, hiring, training and supervising the staff that is deployed to work with the CTC-RI practice sites, providing intensive care management of the high risk patients, and for accessing achievement of the goals of the CHT project;
2. Providing leadership and direction for the Blackstone Valley Community Health Team (CHT) pilot project with overall clinical, fiscal and administrative responsibility for the CHT Pilot project;
3. Collaborating with the CTC-RI practice site staff at the practice site and when providing services in the community;
4. Determining if patients referred meet the referral criteria (as identified in ATTACHMENT A) ; outreaching and engaging with selected high risk patients based on referral criteria and with patient consent, implementing screening tools and formulating comprehensive assessments of patent/caregiver needs and priorities
5. Executing a mutually agreed upon plan of care based on the patient needs;
6. Providing patients and caregivers with extended services (such as community resource specialist and behavioral health services) in other locations based on patient needs (i.e. home visits, hospital rounding, SNF care team meetings );
7. In collaboration with the practice site, establishing , utilizing and maintaining compacts with specialists that can meet the needs of patients with more serous behavioral health and substance use disorder needs;
8. Documenting screening assessments, care plans, services provided, including level of patient engagement and outcomes and sharing documentation with the practice site;
9. Maintaining an active case load of 50-60 patients per CHT FTE with the anticipation that 120-150 patients will be served in a twelve (12) month time frame;
10. Establishing and maintaining a “real time” high risk patient registry with information on the updated patient registry communicated to the health plans and the practice site;
11. Rounding with clinical staff on at least a monthly basis at the practice site to effectively problem solve and coordinate care coordination services;
12. Monitoring and reporting on effectiveness of interventions and strategies based upon agreed upon measures of success with the intended outcome of improving population health, improving access to care for behavioral health conditions, and addressing patient barriers to obtaining cost effective, quality health care services;
13. Reporting to CHT-RI (inclusive of Board of Directors) project implementation results.

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1. **CTC-RI Primary Care Practice Site Responsibilities:**

The CTC-RI primary care practice site is responsible for:

1. Ensuring appropriate practice site leadership and staff participation in the CHT pilot project including staff participation in monthly care conferencing;
2. Clinically reviewing health plan identified high risk referred patients and identifying patients based on referral criteria who may benefit from CHT intervention;
3. Outreaching to potential CHT patients to describe potential patient/caregiver benefits and conducting a “warm hand off” to the CHT staff; Such communication can be done on site at the practice site with the patient through telephone contact and/or written exchange of information;
4. With patient agreement, providing referral information, input and direction for the care that is provided to the high risk patients in the CHT Project;
5. Collaborating with health plan staff to assist with locating hard to reach high risk patients;
6. Notifying CHT staff members when there are significant changes in patient conditions and needs;
7. Participating in care conferring on high risk patients with the goal of meeting the triple aim: improving clinical outcomes, patient experience and reducing cost of care;
8. Supporting the policies and procedures and reporting requirements that are agreed to based on being part of the CHT pilot program;

1. **Mutual Responsibilities**:
2. The CHT entity, working with the practice site, shall update the high risk patient registry on at least a quarterly basis with information on the updated patient registry communicated to the health plan.
3. Monitor and report on the effectiveness of interventions and strategies based on project objectives with periodic reports provided to CTC-RI Board of Directors/CTC stakeholders.
4. Ensure appropriate practice site leadership and CHT staff participation in monthly CHT meetings
5. Improve the overall health and functioning of the patients that are involved with this project through establishing, implementing and monitoring the shared plan of care.
6. **Expected Outcomes, measures and benefits:**
7. Demonstration of an effective partnership between CHT Entity and CTC-RI Practice Site with improved community resource linkages and shared services that result in:

* Improved health care for the identified high risk/high cost/high impact patient as a result of intensive care management, and the integrated team communicating regularly about patient care
* Enhanced care management services for high risk patients that are more vulnerable based on social determinants of health;
* Enhanced care management services for the high risk patients with behavioral health needs;
* Expanded on-site and in-home services for the vulnerable population
* Intentional population management for the high risk population with a reduction in health care disparities in quality measures
* Reduction in total cost of care

1. Specific clinical outcomes include:

* Improved ability by the practice team to screen for depression, alcohol and drug use and improved patient access to mental health and substance abuse services
* Improved health by increasing medication adherence via pharmaceutical support and psychosocial interventions
* Improved patient functioning as a result of patient engagement strategies
* Improvement in quality outcomes, customer experience and patient risk status

1. Review:
   1. The Community Health Team Entity, CHT team members, representatives from the CTC practice sites, CTC-RI management and other stakeholders (e.g., representatives from the health plans) will meet regularly (e.g., monthly) to review progress towards goals and performance improvement action plans based on data and team discussion.
2. **Financial Plan**
3. Funding:

* CHT Entity shall be responsible for receiving funding that has been approved by the CTC-RI Board of Directors and other funding for which they may have successfully applied. CHT Entity will apply this funding to support IT support and project reporting, and the expense for the shared service staff; the CHT entity is not allowed to bill for clinical services provided by CHT staff members that are part of the CHT entity as health plans have provided financial support to cover the cost of the clinical services. The CHT entity is responsible for submitting invoices to CTC-RI on expenditures and activities.

1. Billing:
   1. CTC-RI Practice sites may continue billing and collecting payments from carriers for services rendered to patients who are attributed to the CTC practice site and identified as patients who are part of the CHT program. Billing by the CTC practice site would not occur for CHT shared services that have been paid for through the CHT funding (e.g. CHT entity Community health worker, licensed social worker, pharmacist, etc.). The CHT entity will be responsible for invoicing CTC-RI for these expenditures and activities as outlined in the CHT entity contract with CTC-RI.
2. Reporting:
   1. CHT Entity is responsible for reporting to CTC-RI Board of Directors on a regular basis. CTC-RI practice sites are responsible for reporting to the CHT Entity on agreed upon metrics.
3. **Policies and Procedures:**

CTC Practice agrees to follow the policies and procedures and reporting requirements that are agreed to as being part of the CHT pilot project. CHT Entity shall advise CTC Practice of any applicable modifications which will need to be agreed to by the CHT program. CHT Entity will expressly acknowledge receipt of and approval of such changes.

1. **HIPPA Compliance and Confidentiality**

The parties shall execute and maintain a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability ACto fo 1996 (HIPPA).

CHT Entity shall be in compliance with all applicable aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Administrative Simplification Section, Title II, Subtitle F, regarding standards for privacy and security of PHI (protected health information) as outlined in this Act.

CHT Entity, as a business associate of CTC Practice, must agree to appropriately safeguard any protected health information received from or created or received by CHT Entity on behalf of CTC-RI Practice in accordance with CHT Entity policies and applicable state and federal laws.

CHT Entity will not use or further disclose the information other than as permitted or required by this Agreement, or as required by law. Any other use or disclosure of protected health information must be made pursuant to a properly executed Release of Information.

1. **Notice**

Any notice substantially affecting the terms or conditions of this Agreement shall be directed to:

CHT Entity: Christine Hansen, COO

At: Blackstone Valley Community Health Center

39 East Ave.   
Pawtucket, RI 02860

CTC-RI Practice: Principle Owner/CEO

At:

1. **Termination**

Termination without Cause: Either party may terminate this agreement by giving thirty (30) days written notice to the other party. With MOU termination, both parties would work together to assure a safe transition of care for the high risk patients.

Termination Effective Immediately Upon Delivery of Note: The above notwithstanding, either party may immediately terminate this agreement if upon reasonable investigation if concludes:

1. That the other party’s Board of Directors, President/CEO or other officer or employee has engaged in malfeasance;
2. Failure to perform obligations under the project;
3. That the other party lost its state licensing (if applicable);
4. That the other party lost its eligibility to receive federal funds;
5. That the other party cannot maintain fiscal solvency
6. Discontinuation from the CTC-RI initiative
7. **Authority to Sign**

The signing of this MOA implies that the signatories will strive to reach, to the best of their ability, the goals and objectives stated in this MOA.

The persons signing below certify by their signatures that they are authorized to sign this Agreement on behalf of the party they represent, and that this Agreement has been authorized by said party.

On behalf of the organization I represent, I wish to sign this MOU and contribute to its further development.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written below.

CHT Entity CTC-RI Practice

President/CEO: Principle Owner/CEO

This agreement has an effective date of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and will be renewed on a annual basis subject to continued funding.