MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between One Health Quality CTO (Adventist), a care transformation organization (the "CTO"), and [Name of the Practice], (the "Practice") (each a "Party," and collectively the "Parties").

The CTO has been selected by the Centers for Medicare and Medicaid Services ("CMS"), Center for Medicare and Medicaid Innovation ("CMMI"), to serve as a care transformation organization in the Maryland Primary Care Program ("MDPCP"). The Practice is a primary care practice that provides health care services to Medicare beneficiaries, among others, in the State of Maryland.

This Arrangement sets forth the terms and conditions under which the CTO will provide to the Practice certain care transformation services and resources consistent with MDPCP requirements.

1. *Participation Agreements*. Prior to the Effective Date of this Arrangement, the CTO must sign an MDPCP Participation Agreement with CMMI (the "CTO Participation Agreement"). Prior to the Effective Date of this Arrangement, the Practice must sign an MDPCP Participation Agreement with CMMI (the "Practice Participation Agreement"). If either Party does not sign a Participation Agreement with CMMI prior to the Effective Date of this Arrangement, then this Arrangement shall be deemed null ab initio.

2. *Effective Date*. The Effective Date of this Arrangement is the later of January 1, 2019, or January 1 of the year following the date this Arrangement is signed by the last Party to sign it (as indicated by the date associated with that Party's signature). A Party's performance obligations under this Arrangement shall not begin prior to the Effective Date.

3. *Term of Arrangement*. This Arrangement is effective for a minimum of one full Performance Year, which consists of a 12-month period beginning on January 1 of each year, and will renew automatically on January 1 of each year, until terminated by either party in accordance with Section 12 of this Arrangement. This Arrangement is subject to early termination by either Party only if: (1) CMS terminates either the CTO Participation Agreement or the Practice Participation Agreement, or (2) if CMS authorizes, in writing, such early termination of this Arrangement.

4. *Offer and Selection of CTO Services*. The Practice is responsible for meeting the Care Transformation Requirements as listed in Appendix A. The CTO will support the Practice in meeting those requirements including any support specified in the either the CTO or Practice Participation Agreements. The CTO has offered to provide any and all of the CTO Services to the Practice, as listed in the package selected in Appendix B. The CTO offers these same CTO Services to all participating practices within the same service option level and Track.

5. *Care Management Fees*. CMS will calculate the Practice's Care Management Fees ("CMF") according to the CTO Participation Agreement, the Practice Participation Agreement, and the methodologies described therein. In accordance with CTO Option Selection Form A, the CTO will receive **30/50%** of the practice's CMF payment amount calculated by CMS, and the remaining **70/50%** of such CMF payment amount will be paid to the Practice.

6. *Lead Care Manager*. For practices choosing the 50% option, the CTO will provide the Practice with one or more individuals who are fully dedicated to care management functions of the Practice (the "Lead Care Manager"), and additional services selected in accordance with Section 4. For practices choosing the 30% option, the practice will have its own care manager(s) to work in conjunction with the CTO and the CTO's offerings in accordance with Section 4.

7. *Data Sharing and Privacy*. The Practice authorizes the CTO to have access to all clinical data available in the electronic medical records or shared through the State-Designated Health Information Exchange ("HIE"), including personal health information, of MDPCP Beneficiaries attributed to the Practice. The Practice authorizes the CTO to have access via CRISP to quality and utilization reports available to the Practice. The CTO will include a Business Associate Agreement ("BAA") for the Practice to approve. The BAA will govern their data sharing, use, and confidentiality, a copy of which is in Appendix B. Each Party will comply with HIE policies and regulations, including patient education requirements, and will execute any separate agreement that may be required by CRISP.

8. *Notification of Changes in Medicare Enrollment*. The Practice will notify the CTO of any changes to the Practice's Medicare beneficiary enrollment information within thirty (30) days after such changes occur.

9. *No Remuneration Provided*. Neither the CTO nor the Practice has offered, given, or received remuneration in return for, or to induce business other than the business covered under this CTO Arrangement.

10. *Practice of Medicine or Professional Services Not Limited by this Arrangement*. The Arrangement does not limit or restrict in any way the ability of the Practice and its clinician(s) to make medical decisions that they consider in their professional judgment to be in the best interest of a MDPCP Beneficiary.

11. *Compliance with All Applicable Laws*. This Arrangement does not alter or amend the Parties' being bound to comply with all relevant federal and State laws, including, but not limited to, health care fraud and abuse laws, HIPAA, and the Maryland Medical Practice Act. The CTO will continue to be bound by the terms of the CTO Participation Agreement, and the Practice will continue to be bound by the terms of the Practice Participation Agreement.

12. *Termination*. Either Party may terminate this Arrangement annually or earlier by providing written notice of termination to the other Party, CMS and the Program Management Office. If the Practice or CTO decides to terminate this Arrangement for any reason, it must provide written notice in accordance with the notification and termination requirements stated in the applicable MDPCP Participation Agreements. This Arrangement automatically terminates on the Effective Date of the termination of either the CTO Participation Agreement or the Practice Participation Agreement.

13. *Copies and Retention of Arrangement*. The Practice will provide a copy of this Arrangement to the CTO and the Maryland Department of Health, Program Management Office, within thirty (30) days of execution. The CTO will retain copies of this Arrangement for a period of ten (10) years following expiration or termination of the CTO Participation Agreement. The CTO will, upon request, provide copies of this Arrangement to the federal government, including, but not limited to, CMS, the HHS Office of the Inspector General, or the Comptroller General.

14. *Amendments*. The Parties may amend this Arrangement including, but not limited to, the CTO Services offered and provided, at any time upon mutual written consent. The CTO must continue to offer the same CTO Services to all participating practices within the same service option level and Track, as specified in Section 4 of this Arrangement.

IN WITNESS THEREOF, and in acknowledgement of the aforementioned, the authorized representatives of the CTO and the Practice do hereby indicate their approval and consent:

FOR THE CARE TRANSFORMATION ORGANIZATION:

_SAMPLE Only – Do NOT Complete Now__
Signature

_SAMPLE Only – Do NOT Complete Now__
Printed Name

_SAMPLE Only – Do NOT Complete Now__
MDPCP CTO ID

_SAMPLE Only – Do NOT Complete Now__
Title

_SAMPLE Only – Do NOT Complete Now__
Date Signed

FOR THE PRACTICE:

_SAMPLE Only – Do NOT Complete Now__
Signature

_SAMPLE Only – Do NOT Complete Now__
Printed Name

_SAMPLE Only – Do NOT Complete Now__
MDPCP Practice ID

_SAMPLE Only – Do NOT Complete Now__
Title

_SAMPLE Only – Do NOT Complete Now__
Date Signed

Appendix A:

Care Transformation Requirements

Comprehensive Primary Care Functions of Advanced Primary Care	Care Transformation Requirement	Practice Track Requirement
Access and Continuity	1.1 Empanel attributed beneficiaries to practitioner or care team.	Track 1 + 2
	1.2 Ensure attributed beneficiaries have 24/7 access to a care team or practitioner with real-time access to the EHR.	Track 1 + 2
	1.3 Ensure attributed beneficiaries have regular access to the care team or practitioner through at least one alternative care strategy.	Track 2 only
Care Management	2.1 Ensure all empaneled, attributed beneficiaries are risk stratified.	Track 1 + 2
	2.2 Ensure all attributed beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management.	Track 1 + 2
	2.3 Ensure attributed beneficiaries receive a follow-up interaction from your practice within one week for ED discharges and two business days for hospital discharges.	Track 1 + 2
	2.4 Ensure targeted, attributed beneficiaries who have received follow-up after ED, hospital discharge, or other triggering events receive short-term (episodic) care management.	Track 1 + 2
	2.5 Ensure attributed beneficiaries in longitudinal care management are engaged in a personalized care planning process, which includes at least their goals, needs, and self-management activities.	Track 2 only
	2.6 Ensure attributed beneficiaries in longitudinal care management have access to comprehensive medication management.	Track 2 only
Comprehensiveness and Coordination across the Continuum of Care	3.1 Ensure coordinated referral management for attributed beneficiaries seeking care from high-volume and/or high-cost specialists as well as EDs and hospitals.	Track 1 + 2
	3.2 Ensure attributed beneficiaries with behavioral health needs have access to care consistent with at least one option from a menu of options for integrated behavioral health supplied to attributed beneficiaries by the Practice	Track 1 + 2
	3.3 Facilitate access to resources that are available in your community for beneficiaries with identified health-related social needs	Track 2 only
Beneficiary & Caregiver Experience	4.1 Convene a Patient-Family/ Caregiver Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities.	Track 1 + 2
	4.2 Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning	Track 2 only
Planned Care for Health Outcomes	5.1 Continuously improve your performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures.	Track 1 + 2

Appendix B:

CTO Services/Personnel Offered and Practice Selection

Package A (50%)

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2, NQF 0004	The CTO will work with all practices to ensure that they have access to resources for comprehensive behavioral health services: Education of practices on a behavioral health triage tool to ensure access to right level of care.; Care Management of behavioral health conditions by RN Case Managers and Community health workers.; Integration of an electronic resources list into the practices which will include access to the Adventist HealthCare Community Link Search Engine so that beneficiaries have access to urgent as well as longer term behavioral health programs.; Regular education of physicians and practices on behavioral health management by a CTO Psychiatrist using a case study framework similar to the ECHO Diabetes project.; Free support groups on common behavioral health diagnosis led by licensed clinical social workers and therapists.; The CTO will also work with the practices to design practice specific solutions to behavioral health access needs.	Psychiatrist Licensed Clinical Social workers Behavioral Health liaison Care Managers Community health workers	1 to 20 1 to 25 1 to 20 1 to 5 1 to 5
Medication Management	Care Management 2.6	Provision of care management services integrated within the practice and care transition services to the practices' Medicare beneficiaries based upon risk stratification, targeting efforts towards those with high needs, rising risk, chronic conditions, and multiple co-morbidities.; Care Management Medication Management services may include but not limited to: in-home assessment of drug compliance regime, medication education, Medication reconciliation, consultation with pharmacists regarding comprehensive medical review to identify allergies and cross reactions and opportunities for alternative drug therapies., Counseling is also available for polypharmacy coordination of medical information among primary care and specialists.	Pharmacists (PharmD) Care Managers Community health workers	1 to 25 1 to 5 1 to 5
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Overall Care Managers and Community Health workers from the CTO will identify social needs of the patients and work along aside the practices to coordinate needed services based on a screening tool. Services: We will provide practices a list of enabling community services including but not limited to insurance eligibility assistance, youth development programs, nutrition education and health education and other social services.; We will also work to enable a social determinants screening tool into the EMR that takes into account the following categories: Connectedness, Stress, Transportation, Demographics, Safety, Housing and income security	Care Managers Community Health Workers Behavioral Health Liaison	1 to 5 1 to 5 1 to 20
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Overall the CTO will work with the practices on individualized basis to implement alternative access workflows for patients. The services will include but not limited to: Patient education on how to contact patient care team electronically and telephonically including education of the practices on the optimized use of the patient portal to facility optimize two-way communication.; Facilitate the implementation in all practices of telemedicine services integrated in to the practice's EMR; Also facilitate the deployment of remote patient monitoring tools in appropriate patient homes in One Health Quality CTO Vivify platform.; Implementation of secure text messaging modality between the PCPs and hospital-based specialists to optimize doctor to doctor communication.	IT Staff Operations staff Care Management staff Project Manager	1 to 20 1 to 20 1 to 5 1 to 20
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Provision of care management services integrated within the practice and care transition services to the practices' Medicare beneficiaries based upon risk stratification, targeting efforts towards those with high needs, rising risk, chronic conditions, and multiple co-morbidities. Care Management services may include but are not limited to in-home assessment, medication education and reconciliation, coordination of medical information among primary care and specialists, coordination of appointments, outreach calls, and telehealth services. Services: The CTO offers comprehensive care management services to rising and high-risk patients in the hospital, in transition and at home; Outpatient Care Management: Lead care manager partners with practices to identify rising risk and high-risk beneficiaries to develop plan to maximize health and prevent breakdown; Transitional Care Management: Coordinate care for patients upon hospital discharge to ensure that they have the resources required to recover safely at home**;** Available Support: Home safety assessment; Assess access to safe housing, sufficient food, medication, housing, and transportation; Remote biometric monitoring for Diabetes, HTN, CHF, and COPD; Medication reconciliation; Disease education; Coordination of appointments and referrals; Connection to transportation resources; Free Diabetic and prediabetes classes are offered to CTO practices through services of a certified diabetic educator; Free Tobacco Cessation medication and counseling services are offered to CTO patients through certified Tobacco Cessation specialists.; Navigation and Triage services are offered to CTO practices for patients with Behavioral health patients on urgent, emergent and or routine bases.**;** Additional care management support will include the CTO helping the practice create an automated ENS reporting tool for the practice specific beneficiaries that will identify patients with ED and IP discharges and admissions daily. This CRISP report will identify ED and hospital discharges in a practice specific report daily. The CTO will partner with the practice to ensure a timely outreach process to successfully follow up for post ED or inpatient discharge.	Care Managers Community Health Workers Certified Diabetic Educator Certified Tobacco Cessation Counselor IT Integration staff Operations staff Behavioral Health Liaison	1 to 5 1 to 5 1 to 20 1 to 20 1 to 20 1 to 20 1 to 10

Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	The CTO has an infrastructure offering data analytics, patient risk stratification, care planning and care management/care transitions and additionally self-management educational opportunities. Services: The CTO uses a powerful data analytics platform to aggregate and normalize clinical data from multiple sources (including the Maryland CRISP HIE, and associated hospital and ED data) and risk-stratify personalized patient data.; The CTO will work with practice their data to identify patterns of morbidity, estimate resource utilization and reveal chronic condition cohorts by practice and suggested interventions for either prestation or management.; The CTO has an associated community health and wellness division which provides community-based health education programs and self-management programs. The CTO also has clinical pathways available for chronic disease conditions across the care continuum.; Based on the data described above, the CTO's care managers will engage with the primary care physicians to facilitate a personalized care planning process for the beneficiaries.; The final care plan will be documented in both the practices EMR as well as CTOs data analytical platform and progress on these care plans will be reviewed on a regular basis.; The CTO and its associated palliative care team and pastoral care resources will work with the practices' to educate the practice teams on the importance of advanced directives as well as its best approaches.; We will assist practices with the design and implementation of comprehensive approach to advanced care planning. The CTO will use evidence based research to train and support practices in advance care planning.	Palliative Care Team Resources Pastoral Care Team Resources Care Managers Community Health Workers IT Staff	1 to 50 1to 50 1 to 5 1 to 5 1 to 20
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	The CTO IT and Clinical Care Management Team will be actively engaged in this initiative. We will provide each practice with relevant eCQM quality measures, utilization measures, cost profile and risk stratification measures on a regular basis. The CTO Care Management team will provide coaching on consistent workflows to achieve clinical best practices on the identified MDPCP measures. Services: The CTO will provide the practice with quarterly hospital and ED utilization scores and also identify patient specific intervention for patient specific populations.; The CTO will organize data integration between the practice's EMR and the CTO's powerful data analytics engine. This population health tool will risk stratify the practices patients on an ongoing basis.; The CTO's population health data analytics engine will also provide practices with high risk and high cost member identification through a secured SFTP site in order to proactively help the members to reduce the cost of care.; The CTO's care managers will be working with each of the CTO practices' high risk high cost members in conjunction with the PCP.; The CTO staff will also assist the practices in meeting the eCQM metrics by providing member specific gaps in care report on an ongoing basis.	Care Managers IT and Data Analytics staff Community health workers Operations Staff	1 to 5 1 to 20 1 to 5 1 to 10
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Overall the CTO will provide Risk Stratification of all empaneled beneficiaries on a continual basis using the One Health Quality Phillips Wellcentive data analytics tool and its risk scoring tool. Services will include but not limited to the following: Practices will receive their beneficiaries' risk scores quarterly. Details include risk utilization scores, frailty scores, calculated chances of readmissions and ED usage. The CTO will utilize population health data analytics tool Wellcentive Phillips in order to provide practices with patient specific risk scores based on real time EMR and claim data through Johns Hopkins risk stratification algorithm.; The CTO will supply practice specific care managers who will review the Wellcentive Data on regular basis and screen for high risk beneficiaries.; The Care Managers will meet regularly with the practices physicians to share these high-risk beneficiary details and enroll physician – selected high risk beneficiaries into the CTOs care management program.; The CTO IT staff will work with each practice to ensure that the ENS CRISP Link is enabled in the practice. The CTO practice transformation staff will ensure that the practice has a workflow for reviewing the ENS hospital and ED discharge list daily and appointing those patients rapid follow up visits.; The Care Managers and Community Health Workers who are care managing these patients will perform care management duties such as: in-home visits, medication reconciliation, in-home monitoring set up, telephonic outreach and social services linkages.	Care Management Community Health Workers IT and Data Analytics staff Practice Transformation Performance Excellence staff consultants	1 to 5 1 to 5 1 to 20 1 to 20
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	The One Health Quality CTO administrative support team will deliver logistical and administrative support for the Patient Family Advisory Council meeting at the practice including facilitation, minute taking, meeting notifications and follow up support. Services: The CTO will help identify patients in the practice from the community who are interested in serving on the council and providing health care team with constructive advice and feedback to improve our patients' experiences.; The goals of the PFAC are to improve patient satisfaction, to provide patient-centered care, to bring patients' needs and concerns to the healthcare team and leadership to guide our priorities and planning for the future to further enhance our relationship between the practice and our community.; The CTO will provide your PFAC with patient discussion questions and relevant CG/CAHPS consumer topics to drive the discussion in the PFAC. The CTO will help practice leader to organize the meeting, facilitate and follow up with practice optimization based on the feedback of the customer.	CTO Operations Staff Patient Experience Specialist	1 to 10 1 to 20

Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	The CTO IT and Clinical Care Management Team will be actively engaged in this initiative. We will provide each practice with relevant eCQM quality measures, utilization measures, cost profile and risk stratification measures on a regular basis. The CTO Care Management team will provide coaching on consistent workflows to achieve clinical best practices on the identified MDPCP measures. Services: The CTO will provide the practice with quarterly hospital and ED utilization scores and also identify patient specific intervention for patient specific populations.; The CTO will organize data integration between the practice's EMR and the CTO powerful data analytics engine. This population health tool will risk stratify the practices patients on an ongoing basis.; The CTO population health data analytics engine will also provide practices with high risk and high cost member identification through a secured SFTP site in order to proactively help the members to reduce the cost of care.; The CTO's care managers will be working with each of the CTO practices' high risk high cost members in conjunction with the PCP.; The CTO staff will also assist the practices in meeting the eCQM metrics by providing member specific gaps in care report on an ongoing.	Care Managers IT and Data Analytics staff Community health workers Operations Staff	1 to 5 1 to 20 1 to 5 1 to 10
24/7 Access	Access & Continuity 1.2	The CTO will provide education on the clinical relevance and importance of "PCP match" and electronic auditing of designated beneficiaries to ensure PCP attribution. Monthly feedback and training for practices. Goal is 95% of beneficiaries are empaneled with a PCP and seeing that PCP regularly. Clinical support will be provided to encourage establishment and ongoing engagement of beneficiaries with PCP team. From an IT perspective our CTO team will ensure that practices have a 24/7 real time link to their practice EMR. Services: Assistance with patient education on how to contact patient care team electronically and telephonically.; IT Assistance to practices and their beneficiaries on optimizing EMR portal access for real time communication with providers and care managers on 24/7 basis; Facilitate data analytics (including CRISP) that documents the process of 24/7 access exists in the practice.; Facilitate practice use of CRISP Care Alerts to support care coordination and management for the providers' patients.; Implementation of secure text messaging modality between the PCPs, the CTO's care managers and hospital-based specialists to optimize real time doctor to doctor and doctor to care manager communication.	Care Managers IT and Data Analytics staff Community health workers Operations Staff	1 to 5 1 to 20 1 to 5 1 to 10
Referral Management	Comprehensiveness & Coordination 3.1	Education of the participating practices on distribution of high cost specialists and high cost hospitals and EDs based on CMS portal claims reports. Services: Creation of a quarterly report per practice that details out the practices' referral patterns and associatd costs to hospitals and ED's provider specialty groups.; From the CRISP data, the CTO will create a list of the practices high cost beneficiaries and the associated referral hospital or specialist and send these updated lists to practices on a quarterly basis.; The CTO's care managers assigned to practices will co-manage these lists and put in place strategies to improve the cost profile.; The CTO also has access to a set of nursing home data called the point right system which identifies nursing homes quality and cost profile. The care managers will also work with the practices with these data to influence referral patterns to high quality, cost effective facilities.; Through the implementation of secure text messaging modality between the PCPs, the CTO's care managers and hospital-based specialists will optimize real time doctor to doctor and doctor to care manager communication. This communication will help ensure that timely follow up with the ED and hospital visits occur which will lower the costs of care.	Care Managers IT and Data Analytics staff Community health workers Operations Staff	1 to 5 1 to 20 1 to 5 1 to 10

Package D (30%)*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2, NQF 0004	Support BH care management for identified mental health condition with specific attention to care management for mental health conditions based on patient's needs.	Support MH Care Manager / Medical Assistant	1 per 5 practices
Medication Management	Care Management 2.6	Support review of complex and high-risk patients' medication lists and identify intervention in coordination with Primary Care Physician (PCP)	Support Care Manager / Medical Assistant	1 per 5 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Identification and establishment of social service resources and ongoing updating of these resources. Maintaining a social service resource list and contact for point of care referrals	Lead Community Health Worker (CHW)	1 per 5 practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Provide CHW for home visits	CHW	1 per 5 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Support identification of patients needing episodic / transitional care.	Support Care Manager / Medical Assistant	1 per 5 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Support identifying patients for longitudinal care management. Support with targeted, proactive care management inclusive of patient's goals, needs, self-management, annual wellness visits.	Support Care Manager / Medical Assistant	1 per 5 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Target and track performance on required key outcomes monthly, quarterly, annually	Quality Improvement (QI) Specialist Data Analyst (DA)	1 per 15 practices 1 per 15 practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Target and track performance compliance for episodic care, longitudinal care, behavioral health, eCQMs, utilization monthly, quarterly, annually	QI DA Support Care Manager / Medical Assistant	1 per 15 practices 1 per 15 practices I per 5 practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Identify beneficiaries and care givers. Establish PFAC	Program Director Support Care Manager / Medical Assistant	1 per 15 practices 1 per 5 practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Target and track performance on required key outcomes. Initiate QI corrective action based on verified reliable monthly, quarterly data	QI DA Support Care Manager / Medical Assistant	1 per 15 practices 1 per 15 practices 1 per 5 practices
24/7 Access	Access & Continuity 1.2	Ensure Care Team 24/7 access to Practice's EHR.	IT Manager Program Director	1 per 15 practices 1 per 15 practices
Referral Management	Comprehensiveness & Coordination 3.1	Identify high volume, high cost specialist and ED usage. Target patients for care management coordinating referrals geared to reduce utilization	QI DA Support Care Manager / Medical Assistant	1 per 15 practices 1 per 15 practices 1 per 5 practices

*Practice will have its own care manager to work in conjunction with the CTO and the CTO's offerings.

Final Practice Selection

- ☐ Package A (50%)
- ☐ Package D (30%)

Practice Signature SAMPLE Only – Do NOT Complete Now CTO Signature SAMPLE Only – Do NOT Complete Now

<u>Appendix C</u>:

Business Associate Agreement
between the CTO and the Practice

[Attached hereto]