NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Care Compass Network PPS

Appendix PPS Narratives

November 2016 **www.health.ny.gov** **Prepared by the DSRIP Independent Assessor**

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DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: Care Compass NetworkCare Compass Network

Highlights and successes of the efforts:
There are many aspects of the DSRIP program and the efforts of Care Compass Network (CCN) we could highlight in this narrative. In this moment of self-reflection that is the Mid-Point Assessment, we would be at a loss to not emphasize and highlight the strong efforts and collaboration that our partners have continually invested into the DSRIP program. The partner engagement at CCN has been universally led by a community of providers and organizations with a passion for their community who have been inspired and motivated to develop, build, and now implement the DSRIP program. Their passion towards provision of quality care in upstate New York has been met and tested by a highly vigorous and demanding program, to which their energy and zeal has not relented. CCN is proud and impressed of its constituency and excited to continue with the momentum forward. For purposes of this narrative, we identified five major areas of highlight based on the year one development of the PPS achieved to date. There are many other areas of success noted throughout the quarterly report and narratives, these items more specifically resonated with the organizational progress achieved by the PPS. **Community Based Organization (CBO) Engagement** Since the beginning of DSRIP Care Compass Network (CCN) has made CBO Engagement a key foundational component to the PPS infrastructure build. The Care Compass Network Board of Directors includes five CBO board members voted from the PPS Stakeholders (via PAC Executive Council) who work alongside the CEOs of the PPS six member organizations. Since the foundation of the PPS, CCN has maintained a monthly PAC/Stakeholders meeting to keep all of our attested and contracted partners apprised of the PPS activity and to effectively communicate all the moving components of DSRIP. As a result of the large geographic area of the PPS (supporting nine counties) four Regional Performing Units (RPUs) were created in an effort to strategically engage all types of organizations comprising the PPS, since all of them will play a key role in the DSRIP initiatives. Leading this development was a CBO Engagement Council which was created by the PPS to create structure and support around the RPUs and further increase the PPS' ability to engage beneficiaries in the respective local communities. The CBO Engagement Council was comprised of staff from organizations from across the PPS representing multiple disciplines of care delivery. The RPUs developed leadership teams led by RPU Leaders and reported updates and progress to the CBO Engagement Council frequent updates regarding the development of strategies and plans at the local level, as well as education and communication of CCN DSRIP plans. Of note, rather than staff the RPU Leaders with FTEs within the PPS, Care Compass obtained the skill of local talent through purchased services to provide direct community input and oversight to the implementation of the RPUs. In addition, CCN developed a function called Provider Relations which helps to maintain and/or build relationships with the stakeholders of CCN. This group is a dedicated workforce positioned to allow the stakeholders of the PPS to have a consistent connection to the PPS that can reply to their questions or needs in a timely manner.

Through combination of dedicated resources such as RPU Lead and Provider Relations staff as well as the local structure and framework of the RPUs, CCN has been able to maintain pace with keeping partners informed of the many moving targets within the DSRIP program.

As a result of these efforts, the Community Based Organizations in the PPS were some of the first to contract with the PPS and implement the newly created workflows associated with project participation. In summary of the CBO contracting and engagement efforts with the PPS,

- CBOs have begun recruiting positions such as LCSW to perform the work of DSRIP, have trained 26 staff members in the role of a Community Health Advocate (CHA) to participate in the Community Navigation program (project 2ci).
- CBOs from across the PPS supported the development of the 2di Patient Activation Measure program in late 2015 by providing 17 of their staff to be trained as PPS PAM Survey Master Trainers.
- In year one contracting, CCN contracted directly with 14 CBOs, out of a total of 55 partners.
- When CCN created the Innovation Fund program, all PPS partners were encouraged to identify opportunities for ground level innovation to promote the maximum impact of DSRIP to the most members of the Medicaid program. In total 19 proposals were received across the PPS as a result of the call to action, including seven from CBO partners representing more than $1.2 million in identified community need for consideration through the CCN Innovation Fund program. We are excited to have the Innovation Fund review committee evaluate these proposals and announce awards in September 2016.

A final indicator of our success with CBO engagement has been the feedback we've received directly from our CBO members. CBOs have recognized the PPS for their efforts around community collaboration, transparency, and inclusion in PPS meetings as well as non-DSRIP related forums. The experience and engagement of our CBOs has been noticed and has led to the PPS being contacted for involvement in thought leadership groups. In one example, a CBO partner leveraged their great experience with Care Compass Network as a platform to participate on a panel discussion with focus on CBO engagement to the New York Association of Psychiatric Rehabilitation Services (NYAPRS) annual Executive Seminar. Most recently, the PPS has been invited to participate in a panel discussion at the Mental Health Association in New York State (MHANYS) Conference to discuss "PPS Integration: Innovative Approaches to Achieve Better Healthcare outcomes with Community Based Organizations". We are excited to share these best practices and continue building on this strength as we move forward into the more challenging and technical years of performance and quality improvement.

Care Compass Network Governance Structure

In soliciting input for the Mid-Point narratives another common theme was the high accolades from the stakeholders for the Care Compass Network (CCN) governance structure. The PPS is comprised of five committees each of which report directly to the Board of Directors. These include the Finance Committee, Clinical Governance Committee, IT Informatics & Data Governance Committee, Compliance & Audit Committee, and the Nominating Committee. When identifying a slate of candidates for each committee, we used a highly transparent and inclusive approach by leveraging existing workgroups, councils, PAC Executive Council and Stakeholder meetings to overview requirements and expectations. Ultimately, solicitation for qualified representatives for each of these committees was seated with skilled members from the community with representation based on factors such as organization type, regional location(s) represented, work experience, and/or professional designation – most of whom have been actively engaged

with DSRIP. Having a well communicated process, the partners have communicated a strong sense of trust and confidence in the governance model.

In the case of the Clinical Governance Committee (CGC), under the direction of the CGC chair each of the four CCN RPUs was advised to establish at minimum three RPU quality subcommittees based on the project requirements of CCN: (1) Onboarding, (2) Disease Management, (3) Behavioral Health. This effort was led dually by the RPU Leads, who are prominent community leaders on service agreements with CCN. The effort of filling the CGC slates in 2015 was a phenomenal showcase of coordination and public service, ending in seating of 13 quality committees each comprised of a total of 133 volunteers. The full slate of the candidates for each of the quality subcommittees went through a vetting process within each RPU to engage the right mix of people of which was ratified by both the Stakeholders and the Board of Directors. These quality committees began meeting in the fall of 2015 and continue to meet today. From an organization perspective, each of the four RPUs nominated three candidates from their respective quality committees to serve on the Clinical Governance Committee. In function this allows for bidirectional communication between the RPUs and the Clinical Governance Committee. The Clinical Governance Committee is seated with many of the best physicians and subject matter experts working within the PPS network. A governance and committee governance structure reporting and monitoring process was created to show all reporting relationships are bi-directional for an effective flow of communication.

Care Compass Network (CCN) has established a very solid IT Informatics & Data Governance structure, starting with a Governance Committee reporting to the CCN Board of Directors and including various subcommittees and workgroups. The Governance committee is active on a monthly basis and includes experts from various clinical settings, IT systems integrations and implementations, and quality reporting from within our PPS. Subcommittees were created to focus on technical advisory needs, change management needs, and data security. By design the Data Security Subcommittee has a dotted line reporting relationship to the Compliance Committee and the IT Informatics & Data Governance Committee. The Technology Advisory Committee is comprised of an IT Workgroup which has technical representation from each of the RHIOs and a Clinical IT Workgroup comprised of staff such as Chief Medical Information Officers, members of the CCN Clinical Governance Committee, primary care providers, and other technical leaders to ensure PPS IT plans are developed with input from clinical professionals. These subcommittees represent the working arms of CCN's IT Governance. The Technology Advisory Subcommittee reviews and provides input into data gathering, IT Vision, needs analysis, and DSRIP goals related to analytics and performance reporting. The IT Workgroup fully participates in the research, design, selection and implementation of IT policies, procedures and key technologies in support of DSRIP goals. Due to this robust structure CCN has been able to complete three of the five IT Systems & Processes milestones. The final two milestones will be completed by the end of DY2, Q3.

This past year the IT groups have seen many successes. CCN was excited to have been awarded more than $14 million through the CRFP grant solely for development of PPS information technology programs. As a result of this award, which was communicated in the spring of 2016, CCN has embarked on a rigorous RFP process to select the most appropriate technology solution in the areas of Population Health / Care Management, Primary Care EMR, Skilled Nursing Facility EMR, Behavioral Health Screening, and Telemedicine / Tele monitoring. In total, CCN received 42 responses and teams are currently in the process of reviewing and scoring the proposals. Teams were set up per RFP based on their expertise with the technology. Trailing the opening comments regarding the commitment of the partners to the PPS, the RFP selection committees (which are comprised of 60 people) were each established on a purely volunteer

basis. Following the RFP review period, vendors will be selected to provide demonstrations of their products. After conducting reference checks, a vendor or vendors of choice will be presented by the evaluation committee to the Technology Advisory Subcommittee. These selections will be vetted through the Clinical Governance Committee, the IT Informatics & Data Governance Committee and obtain final approval by the CCN Board of Directors. This process has commenced in July 2016 and will continue through year end.

Beyond functionality, approach, and efforts of the PPS, the leadership team of CCN pays close attention to utilization and execution of this structure to determine if the governance model as designed remains pertinent to the current business and operations of the PPS. The byproduct of the effective functioning governance model of CCN allows it to properly assist, guide, and provide adequate oversight for the PPS as it moves in rapid tempo towards the 'year six' future of healthcare. To date the Clinical Governance Committee has endorsed 22 clinical guidelines, each of which is now guiding PPS partners as they perform the clinical work of DSRIP. The Compliance and Audit Committee has received an unmodified (e.g., clean) audit opinion from the external auditors following our first year of operations as a new company. The IT Committee has completed a comprehensive IT Roadmap and strategy which successfully guided the PPS to hold significant technology investments and disbursements until a determined date to capitalize on pending CRFP dollars. This decision, partnered with receipt of CRFP dollars, has greatly impacted the CCN funds flow for PPS investments. The Finance Committee has successfully overseen the development of a comprehensive funds flow methodology early in the 2015 timeframe, allowing for focus to shift on acquisition of resources focused on VBP awareness and transition models. The Board of Directors of Care Compass Network led the state as the first PPS in New York to establish the 'NewCo' Lead Entity PPS structure in 2015 and successfully recruited a full time Executive Director for the PPS.

Lastly, the governance of the PPS is impacting and influencing the community of providers within which we serve. The mere composition of the Board of Directors which includes major entity CEOs, commissioners, and executives who would otherwise (and do) compete in the open market makes a clear statement to the community. When coming together to support the development of the PPS in our region, it sent waves throughout the community. In part, this has displayed a top down communication that the needs of the Medicaid community matters. This gesture has become inherent with our work and has been extended many times across the past year. Most recently, the PPS hosted a provider engagement event hosted in May of 2016 which included a panel of leading physicians from four of our major health systems as well as Dr. Doug Fish from the Department of Health. Many in attendance had indicated they had never seen a joint initiative of this magnitude ever in the community.

CCN Contracting Approach

The CCN contracting approach is also emphasized as a best practice. In generation of the contract, the PPS leveraged a Master Services Agreement type model whereby a Partner Agreement would serve as the legal document for related terms and conditions of partnering with a PPS. To prepare this document, CCN leveraged legal counsel services to prepare the general terms which were made available for a thirty-day public review period. All comments and questions were received centrally, documented on the CCN public SharePoint, and reviewed by CCN leadership and legal counsel. FAQs were generated and Partner Agreement related forums held at the CCN Stakeholder meetings to ensure all partners had an opportunity to openly discuss the document prior to it being closed for revision. The final product was an agreement that the hospitals, CBOs, and LGUs were all able to comment on and have feedback incorporated to. Following the release of this document, standardized agreements for the work of the projects, in the form

of agreement Appendices, were publically posted to SharePoint so all partners could have central access and availability to core documents.

In DY1 rather than place the exclusive priority focus on contracting with partners to achieve speed and scale performance targets, CCN placed priority focus on building the partners ability to contract for performance based metrics. Through developing PPS-wide awareness of the DSRIP programmatic requirements our contracting process was surrounded by core principles (1) anyone in the PPS can contract with CCN, (2) All contracts will be supported by guidelines approved by the Clinical Governance Committee and Board of Directors, (3) all contracts will be supported by a defined funds flow model, (4) following an evidenced based model - CCN contracts will require standardized data submissions commensurate to the work performed.

The first principle has proven to be essential to maintaining our partner engagement. We have found that in performing contracting with our partners it is not simply an exercise of document execution between legal teams, but rather an opportunity to build relationships, DSRIP understanding, and promote and develop understanding of the healthcare environment. For example, in reviewing with our partners the requirements for 'year one' contracting, we overview the core principles described above. This exercise is largely an engagement with the network partners that reflects a fee-for-service arrangement. This is critical as it helps the PPS to ensure standard skills across the PPS, especially with PPS partners who are not accustomed to invoicing for services rendered or performance (e.g., as would be the case with an organization primarily funded by grants). In effect, there is an immeasurable workforce development underway simply by Care Compass Networks execution of the contracting strategy. Moreover, as is common with all elements of DSIRP, we encourage our partners to remain flexible as the contracting model will shift from year to year. All CCN contract Appendices have been established on fee-for-service type principals however all have a required termination effective 3/31/17, at which point the CCN contracts will evolve towards a risk based contract with most projects contracted to include upside risk. This methodology resides in all of the CCN DSRIP projects selected by CCN as they are all important steps in developing and implementing a model of care that right sizes, realigns, and integrates the continuum of community based and institutional services to achieve Delivery System Reform Incentive Payment (DSRIP) goals to improve access to care while simultaneously reducing patient Emergency Department visits, re-admissions, and preventable admissions, thereby reducing costs.

Flexible Funds Flow Model

The CCN funds flow is being highlighted as a success. The CCN approach for Funds Flow and Distribution planning occurred in two stages. First was a ground-up budget approach, soliciting technical knowledge of CCN leadership and finance team members to identify known costs such as general admin and cost categories by project which was leveraged to build a framework through which information from the project teams and implementation plans could be incorporated. The second stage included the development of a waterfall approach to allow for transparent display of how CCN valuation dollars were allocated to the various cost centers as identified by the bottom-up approach. Care Compass Network's funds flow is shown to be a funds flow and distribution plan that is transparent and incentivizes the providers to meet the various requirements of DSRIP. The funds flow plan allows partners to clearly know what CCN will pay for defined efforts throughout the year one contracting phase. CCN sought a communications roadshow regarding the funds flow framework, completed by the Finance Manager throughout the late summer/early fall of 2015. During this roadshow, presentations on the funds flow methodology and distribution plan were provided to all PPS Network Partners at each the four Regional Performing Unit meetings as well as at the

PPS-wide Stakeholders/PAC. The Stakeholders presentation included a webinar which was recorded and was subsequently placed onto the CCN website for public reference.

The concept of 'flexible' was also intentionally included into the nomenclature of the CCN funds flow process. This serves as a reminder to CCN staff and stakeholders that the DSRIP model will shift and change as we progress through each year – and as a result we will expect the CCN funds flow process to shift and change with it. Initially, changes to the funds flow were more refinement in nature. Initial costs or expenses not identified by a project team would be submitted to the Executive Director, Finance Committee and Board of Directors to provide proper funding for elements critical to program success. At a high level, all of the CCN payments in year one contracted have related to a fee-for-service type model, whereby efforts have a distinct payment associated with them which CCN provides reimbursement for. As part of the flexible funds flow model, payments in year two contracting will shift to performance based metrics, whereby outcomes will reward (e.g., upside risk) partners who have greater quality scores.

As part of managing the funds flow process and to address potential concerns about the financial fragility of the PPS network, the CCN Finance Department created a Network Financial Health Assessment Procedure which has been completed and will be repeated at minimum annually, and more often for providers who are found to be financially fragile. The PPS initially created a Partner Organization database of PPS members based off of information gathered during the DSRIP application period. None were VAPAP or IAAF providers. As time has progressed in DY1, we have been adding to our Partner Organization list as organizations have come forward expressing their interest via letter of attestation to participate with Care Compass Network. These partners have been formally added to the PPS' performance network during the open enrollment period in MAPP, completed in DY1, Q3. As of 9/30, the PPS began developing an assessment tool for partner organization financial sustainability leveraging existing tools such as the toolkit leveraged to determine financial sustainability for PPS Lead Entity Organizations during the initial DSRIP application period. To ensure compliance with the annual financial assessment survey requirement, CCN has made completion of the assessment a component of the Partner Organization contract. The assessment tool was reviewed by the Finance Committee at its regular monthly meeting in October 2015, after which distribution of the survey commenced in November and concluded in December with responses compiled into a complete data set. 40 assessment requests were sent out to organizations who saw at least 1,000 Medicaid recipients in 2014, and 19 were returned (45% response rate). These assessments were sent to a third- party consultant to aggregate and report on to the CCN Finance Committee, ensuring compliance was achieved with regard to anti-trust laws. Based on the received assessments, the PPS analyzed the survey results from the third-party consultant and identified those providers who were determined to be financially fragile and sent out a report of those organizations to the Finance Committee in December with no comments. Based on criteria set forth in the Network Financial Health Assessment Procedure, no organizations were found to be financially fragile as a result of this review. The Network Financial Health Assessment will be completed again in Q3 of each Demonstration Year to ensure Network stability, and more often for providers found to be financially fragile or near the boundary of financial fragility.

A large part of Financial Sustainability has to do with the transformation from fee-for-service to fee-for-value. To that end, the PPS developed a detailed baseline assessment of revenue linked to value-based payment and MCO strategy. The Finance Committee discussed the Value-Based Payment (VBP) planning efforts, including summary of items prepared by HANYS as well as CCN commitment as outlined in the DSRIP application during the August 2015 meeting. The Finance Committee agreed on August 3 to coordinate the establishment of the VBP subcommittee chaired by John Collett, CFO, Cayuga Medical Center which was seated and met later

in August 2015. The VBP subcommittee is comprised of membership representing hospitals, homecare agencies, skilled nursing homes, outpatient services, and CBOs. Throughout Q2 the VBP subcommittee completed three meetings, the outcomes and minutes from which were subsequently presented at the following Finance Committee meeting. Successful completion of the VBP Education and Communication plan was defined as a VBP presentation at each of the RPUs (North/South/East/West) as well as the PAC (Total 5 times), based on the NYS VBP Roadmap. Presentations were completed in the East on 12/09/2015, the PAC on 12/11/2015, the South on 12/16/2015, and the West and North on 12/17/2015. The PAC presentation was a recorded webinar and has been made available on the Care Compass Network website for those who were unable to attend an in-person presentation. The PPS VBP readiness self-assessment survey was developed and sent to 40 organizations, and 25 of them were returned (62.5% response rate). The Finance Manager had collected, assembled, and analyzed results of the surveys received. The VBP baseline assessment was prepared based on the survey results and shared with providers as well as the VBP Sub-Committee, Finance Committee, PAC, and Coordinating Council. All received feedback was incorporated into the baseline, and on 03/08/2016 the CCN Board of Directors approved a resolution regarding their preference for the role of the PPS in VBP contracting to be more of a facilitator or coordinator, especially since current regulations prohibit the PPS from contracting on behalf of network providers or negotiating standard terms with MCOs on behalf of network providers. In addition, the PPS is working on finalizing a plan towards achieving 90% value-based payments across the network by DSRIP year 5 at the latest. To that end, the PPS will work with NYS DOH and the PCG team on getting data related to the risk-adjusted cost of care as well as the potential shared savings at both the population level as per care bundle and subpopulation per the VBP Roadmap, in order to identify the best possible opportunities for PPS providers in their move towards VBP. The PPS is also working with COPE Health Solutions to assist in strategic high-level planning for the VBP transition which will be carried out by a local resource with experience with both local providers as well as our regional MCOs.

The PPS has also taken an approach for an Innovation Fund which is essentially a competitive RFP process to allow for DSRIP incentive dollars to impact the Medicaid recipients outside of the 11 projects which CCN has signed up for. However, it is not necessary that the proposals be for endeavors outside of the 11 projects as they can be enhancements to the DSRIP projects. The applications were due July 31, 2016, with an expectation they are reviewed and approved by our Board of Directors at the September meeting for announcement to the PPS the following day.

In addition to the Innovation Fund, the PPS has set aside $4m dedicated as incentive dollars to recognize infrastructure investments already made by the network. These incentives are intended to recognize and promote the continuation of efforts partners have already made which correlate directly to the requirements of DSRIP project planning and/or CCN implementation efforts. The incentive is based on a per-member model base rate with modifications made to the rate based on infrastructure investments already made by the partner organization, including EHR/EMR, RHIO Connectivity, Project Participation, and PCMH Certification. The modified rate is multiplied by the number of unique Medicaid individuals seen by the organization in the previous 12 months to arrive at a total sign-on bonus dollar amount. Half of this amount is paid with the first invoice from the partner for project work, and the remainder is given after the sixth invoice.

As mentioned previously, through the flexible funds flow methodology the PPS is also looking at changing the payment model of the PPS to one based on value. Similar to the migration of the DSRIP program payments from years 1 through 5, the PPS will migrate funding through each year of the waiver. For example, for contracts effective in DY2 the PPS is essentially paying for effort - do x, receive $y. For DY3 the

PPS plans to add quality measures to payment terms, for example in Care Transitions, a part of the payment for the completion of the discharge plan will be based on whether or not the patient is readmitted prior to its completion. The PPS is doing this as part of the VBP transformation that is a major part of the DSRIP program and it will allow providers in the network to become accustomed to the types of arrangements that will exist in the future.

Care Compass Network Panel

Care Compass Network identified the need to stay connected with the regional stakeholders, including Medicaid members as well as community, CBO, and providers within the PPS. The Community Health Needs Assessment Committee, who had helped to assess the needs of the community and guide the project selection process helped to establish a Panel Management Committee. The Panel Management Committee is comprised of members of the Community Needs Assessment Committee, the Communications Committee, and representatives from the panel management vendor Research & Marketing Strategies, Inc. (RMS). In late 2014 the Panel Management Committee determined that hosting an online community forum would be the most efficient means of meeting the needs of the PPS by (1) eliciting feedback from Medicaid members (2) ensure feedback is consistently received from representatives across the nine county region of the PPS, and (3) elicit feedback from core stakeholder groups including community residents, providers, community organizations, and healthcare workers. The intention was to build a comprehensive panel (the "CCN DSRIP Panel") which would span in duration from the start to finish of the DSRIP program.

After 16 months of implementation, feedback from the CCN DSRIP Panel is fluid and on-going; thus far, CCN has received feedback from a total of 620 active panel members, inclusive of more than 290 Medicaid and uninsured members from across the nine county PPS region. Knowing fluctuation and variability inherently exists as a byproduct of Medicaid enrollment, we have worked with RMS to identify enrollment hot spots to maintain and increase panel participation. Major success has been achieved by housing a panel enroller at targeted DSS locations, Facebook postings, as well as incentive programs which were approved by CCN legal counsel, such as 'refer a friend' which provided modest incentive for panel referrals.

In the pipeline exists an additional 1,338 individuals who have expressed interest in additional engagement strategies that are being vetted for panel participation. The delivery to panel members is simple: touch points every 4-6 weeks comprised of bi-directional feedback with a target of quick (five minutes or less) engagement. This model has proven to allow for CCN to receive feedback and communicate updates while not burdening people with lengthy or heavy time requests. Before engaging the active panel, the process of filling panel membership helped advise the PPS as to how to best communicate and engage with the Medicaid members in our region. We have been able to build on lessons learned by pushing announcements via Facebook account pushes, leverage partner provider locations for intercepts, and advertise refer-a-friend challenges. RMS actively works with CCN to discuss strategies to grow and make use of the patient and provider panel groups based on CCN needs.

Seven survey touch points have been completed so far including CCN Website Perception, Community Health Needs, Communication Preferences, Accessing Healthcare, Cultural Competency, Specialty Care, and Transportation. The Panel Management Committee has done an excellent job at understanding how to engage the community but also how this might better inform CCN in its mission. By design the committee has organized the data gathered from the panel to be organized and usable in a mode conducive to market analysis. One feature imbedded in the panel management tool is the sequencing of questions and data

points to allow for drill down capabilities on each subsequent survey. This allows for comparison of answers from the 'Accessing Healthcare' survey against the 'Transportation' survey.

For the most part, results from the panels completed to date have validated long standing community assumptions and understandings regarding access to care, validation of CNA findings, transportation needs, demographics, etc. For example, the RMS panel has indicated the Medicaid members of the PPS report a 96% with English as a primary language as compared to 93.1% as reported by the CCN Community Needs Assessment completed at the time of application. However, the panel is also helping the PPS to understand fine elements of how the Medicaid member engages the health system across the network. For example, in one survey we learned that 6% of Medicaid or uninsured members reported understanding written materials from their healthcare provider "A little bit". 39% of Medicaid or uninsured members reported they feel they have limited access to healthcare. Of these, 82% responded that Dental care was the most difficult to access. In our most recent panel, 71% of the Medicaid and uninsured respondents indicated they have a relationship with a provider, however 4% indicated they find the local Emergency Department when deciding where to receive care. The panel has proven to be a critical asset to CCN as we move beyond planning and into execution and quality reporting aspects of DSRIP. The panel responses have been received at a high rate (e.g., 29% response rate) which reflects a highly engaged panel group.

There are many additional highlights and successes of CCN such as the DOH applauded Community Health Needs Assessment we completed during the initial DSRIP application, the Care Compass Network staffing model and ability to leverage local talent versus heavy consulting, development of effective Project Management Office in an industry which classically doesn't support project offices, however the areas highlighted within this narrative top the long list of highlights and successes of CCN.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass Network

Project: 2.a.i

Challenges the PPS has encountered in project implementation:
In preparing the midpoint update for project 2ai – the Integrated Delivery System (IDS) – we have realized how far we have come as a PPS, overcoming many logistical challenges while also able to develop and refine future required steps to implement the IDS. In preparing an overview of "challenges the PPS has encountered" thus far, we will not focus on challenges which have been uniformly shared by PPSs at the state level such as timing of CRFP, Opt Out, or administrative requirements associated with managing DSRIP efforts. Rather, our narrative will focus on those challenges encountered by our PPS based on the region, partners, and patients whom we serve. While these may not be solely unique to our PPS, our leadership has found these are the challenges which require ground level innovation, collaboration, mitigation, and continuous assessment to better serve those participants in our network. In developing this midpoint narrative, we have solicited input from PPS partners, stakeholders, and leaders, all of whom were confident that these items would not impact or impede our ability to progress forward into the execution, delivery, and quality stages of the DSRIP program (e.g., years 3, 4, 5). Lastly, it's helpful to note that from working with PPSs across the state this past year we've noticed that not all PPSs are created equally. There are advantages and disadvantages inherent to the landscape, region, partner base and membership of each PPS. For example, some PPSs exist in a single health system environment, which has noticeable advantages when forming and operating a PPS. The single health system environment promotes efficiencies in DSRIP by leveraging synergies in a highly integrated environment where systems, organizational strategic plans, infrastructure, resources, and relationships possess an inherent unification. Comparatively, our PPS is comprised of five competing health systems, which presents challenges when facing development of governance structures, various DSRIP roadmaps (VBP, CC/HL, workforce, population health), and technology integration which leverages to the best of its capacity existing infrastructure. From this perspective we would like to highlight five core challenges the PPS has faced which have been selected for focus during this feedback period. 1. Large Region and Varied Partners The Care Compass Network is a large PPS both geographically as well as by scope of healthcare partners. Geographically, Care Compass Network is comprised of nine counties in upstate NY which represents 12.5% of the landmass of NYS. Across this region, there are five health systems partnered with the PPS which represent nine New York based hospitals. We are fortunate in that these partners have each made significant investments in technology solutions which will greatly impact the PPS. These would include implementation of major systems such as Soarian, Epic, Cerner, Medent, NextGen, and Allscripts. The PPS has also contracted directly with 14 Community Based Organizations

which is a critical element of providing community based patient-centric care. Across our partners, 71% have obtained or are in process of obtaining RHIO connectivity (54% connected, 16% in process) with one of the three established QEs/RHIOs for our PPS; HealthLinkNY, HealtheConnections, and the Rochester RHIO. Across our PPS we have identified approximately 23 safety net providers which will require EMR implementation as part of the IDS requirements. Other partner demographics include health systems who serve as the regional leader, a member of a national Catholic health system, and a member of the Mayo Clinic Care Network. While the advantages to this partner group are many, there are challenges presented with organizing and executing PPS-wide initiatives to multiple partners who are at different starting points and positions. These PPS initiatives range from the PPS VBP Roadmap, CC/HL Strategy, Population Health Roadmap, Workforce Transition Roadmap, and strategic PPS planning regarding functionality of the Integrated Delivery System.

We have found that despite the significant investment in technologies, their communities, and commitment to the PPS not all partners have fully defined nor publicly released their VBP or population health management strategic plans. These are critical elements to the Integrated Delivery System which has required the PPS to both push a progressive DSRIP program while concurrently maintaining the need to adapt and respond to partner needs as they define and refine their own future. As the mitigation plan overview will detail further, strong partner engagement, governance, transparency, education, and communication has helped our PPS build adequate structures to support our region while allowing for achievement of traction and success amidst the competitive and vast environment.

2. Mismatch of Pace

The health systems which comprise the Care Compass Network provide healthcare services to all payer types, however the PPSs are required to implement a comprehensive program with fixed timetables and roadmaps specific to a single payer environment – the regional Medicaid member base. A 'mismatch of pace' exists whereby DSRIP requires fast action and organizational changes for delivery of care to the Medicaid population, however many partners of the PPS need to consider how the delivery system reform programs will also impact the tools, interventions, and techniques for all patients regardless of payer category. This larger, more comprehensive transformation of the healthcare delivery system presents a 'mismatch of pace' when considering that across the Care Compass Network, the average Medicaid volume from an inpatient medical surgical perspective only represents 17% of overall services provided.

This reality presents the PPS with a logistical challenge – how does the PPS encourage stakeholders who participate with multiple payers to place adequate focus on the DSRIP program amidst their competing priorities for the remaining 83% of their constituency.

Furthermore, the ability for cross-PPS collaboration is not consistently available since some PPSs will not encounter this issue. Many CBO partners have a larger percentage of their patient population represented by Medicaid members, and they may have less barriers to consider when participating in the DSRIP program. In the case of Care Compass Network, we have found this to be true in isolated pockets of providers who have a narrower scope of work or mission, making it easier for them to align and quickly adapt to the DSRIP program requirements. The early success of the PPS on this regard has been the ability to quickly connect with those service providers with a narrower scope of service (e.g., most closely aligned missions with the Medicaid member population).

3. Workforce Staff Crisis

During the planning stages of DSRIP and the development of the Care Compass Network project plans there were expectations that major staff impacts would be realized as a byproduct of a successful DSRIP implementation of the integrated delivery system. At a high level, we had anticipated the need to develop workforce plans to allow for the proper redistribution of staff as a result of the shift from acute care facilities to the primary care and community based organizations who would provide care at the lower cost setting. Through our work to date with the workforce initiative we have found that this will likely not be the case. While there will be an increased need for workforce development at the community level, it is unlikely that this workforce will be largely redeployed from the acute care settings as originally expected. Over the past two years, vacancy rates for nurses and other professional staff have increased and as a result of those increases, the number of RNs and other professional patient care staff to be redeployed are not available.

Additionally, we may face compounding issues such as workforce competition scenarios for skilled workers. For example, the vacancy rate for Certified Home Health Aides in our PPS is 17%. This is potentially the same pool of candidates who would also be considered for titles such as peer support workers (9% vacancy), health coach (0% vacancy), or community health workers (4% vacancy).

4. Alignment of State Programs

From a stakeholder identification and engagement perspective there was a year one challenge of identifying and fully engaging all of the respective state programs and initiatives as well as their respective geographic territories. Ranging from RHIOs, Offices of Mental Health, OASAS, Department of Health locations, coalitions and programs (PHIP, AHC), etc. there was a massive effort undertaken to understand regional barriers and overlap with adjacent PPSs.

A RHIO snapshot: Care Compass Network is the only PPS in the state engaged with three RHIOs. PPS partners either have an existing relationship with one of the RHIOs or is pursuing a relationship. One critical element of the Integrated Delivery System is access to live, real time data, which can inform provision of quality care. A second critical element is the PPSs ability to leverage existing infrastructure so as to not use DSRIP dollar to duplicate investments which have already been made. There is a huge benefit to the PPSs ability to collaborate with the local RHIOs and leverage infrastructure developed by the community, however this will require more comprehensive plans and analysis to ensure systems and connectivity plans developed are achievable and realistic in the timeframe of the DSRIP waiver.

5. Understanding Data Sharing Associated Requirements

A backbone for the operations of the Integrated Delivery System is a sound footing on agreements in the form of contracts, Business Associate Agreements (BAA), and consents which clearly afford and define the proper controls, relationships, and expectations associated with working in a collaborative environment to attain CCN's DSRIP goals. Since the beginning of the waiver, consenting requirements associated with DSRIP have been under continuous refinement as PPSs, DOH, and partner organizations strive to understand the consent and BAA requirements necessary for data sharing. An additional complexity is added with the need to understand how PPS consents and BAAs differ from DOH's DEAA document, "Opt-Out" program, and the RHIO/QE consenting process. The PPS has had to maintain effective and clear communications with our partners explaining the data sharing

environment, as this subject has caused frequent confusion and concern. This continues to be a challenging area given that regulations imposed by New York State for data sharing are sometimes more stringent than the federal HIPAA guidelines. The population health initiatives required within the DSRIP program are at times in conflict with the restrictions on data sharing without patient consent. Obtaining and managing patient consents on a PPS-wide level presents myriad challenges that could limit the PPS' ability to thoroughly collect the data required to properly manage the intended population.

6. Slow Pace of MCO Involvement

As the DSRIP program developed significant traction in 2015 there was mixed reaction and response from the managed care organizations in the Care Compass Network region. Reactions ranged from lack of response or unwillingness to establishment of recurring touchpoint meetings. We have found it helpful to host very generic ground setting discussions to review high level topics such as "What are the short and long term goals of the PPS?" "How are the PPSs gathering data and what data needs are expected for the future?" "How do goals of the PPS potentially align with MCO goals?" "What is the relationship between the PPS and the providers and CBOs in the region and how does this impact or require MCO collaboration?" In addition, the discussions have revolved around the Value-Based Payment (VBP) plans of the MCOs going forward as the PPS looks to define the Financial Stability milestones six, seven, and eight. Based on discussions with the four largest MCOs in the PPS, there seems to be a focus on arrangements with upside risk only. None of the four largest MCOs are discussing bundled payments or other types of VBP arrangements. The lack of progression to more advanced VBP models in these discussions presents a host of issues for the PPS in advancing a strong VBP agenda.

Efforts to mitigate challenges identified above:

1. Large Region and Varied Partners

The challenge of geography and partner variety has been present since day one of the PPS. Forming a cohesive Community Needs Assessment was critical to focusing the partners and plans of the PPS centrally around the needs of the patient population, which ultimately guided the project selection process at the time of valuation. This step was proven to be helpful again when the Southern Tier PPS (STPPS) merged with the Rural Integrated PPS (RIPPS) to form the Southern Tier Rural Integrated PPS (STRIPPS) during the application stage – keeping the focus on our vision "to improve the health and life of Medicaid beneficiaries who engage in coordinated, culturally sensitive services that utilize the most appropriate, effective setting given medical, behavioral, social, and health literacy needs."

Care Compass Network leadership team has been actively mitigating the challenges associated with a large geographical region to ensure the PPS is engaging the right partners for project implementation through strategic planning sessions. Collaboration and transparency has greatly benefited our ability to engage partners in the network. In operationalizing our governance model we leveraged detailed skills matrices to ensure adequate representation by region, skillset, practice, education/professional designations, and employer types. As a result, we have maintained a presence by each of the three RHIOs, clinicians, CBOs, LGUs, health systems, and agencies. We have also developed and maintained an active panel of more than 100 Medicaid members to advise the PPS on the development of our work.

In May 2015 a workgroup called the CBO Engagement Council was formed and helped to properly identify and connect the PPS with CBOs from across the region. As a result, new CBOs attested to the

PPS and were added to the Partner Network in MAPP during the fall 2015. The group achieved the mission of its charter and was disbanded in December of 2015, after which we began to place a stronger emphasis on local Regional Performance Units (RPU) meetings to engage partners at the community level. The local RPUs are supported by an RPU Leader and Partner Relations staff to provide the communities with a consistent team and contact for DSRIP related questions. Additionally, the CCN funds flow has allocated administrative dollars to the RPUs to allow the RPU Leads to endorse and incent grass roots efforts to support DSRIP implementation at the local level. In the North RPU, the RPU budget was leveraged to support the Healthy Cortland County IRT event, a free no cost medical event sponsored by the US Military providing primary care, dental, optometry, and veterinary services to underserved communities. The RPU Budgets were also leveraged to host provider awareness and engagement events in the fall of 2015 and spring of 2016 which included PCPs from the community as guest speakers with keynote speakers Jason Helgerson and Dr. Doug Fish. Upcoming in the fall of 2016, we are pleased to announce that Dr. Fish will be returning to the CCN region for a CBO engagement event.

The CCN finance team has utilized thought leaders like COPE Health Solutions to provide broader VBP perspective from a national, state, and PPS perspective to the Care Compass Network VBP Sub-Committee. We have also leveraged local content experts to provide VBP education to each of the CCN RPUs as well as the PAC Advisory Council. To promote availability of information we have also recorded presentations and made them available via our website and created a Care Compass Network YouTube channel, LinkedIn page, and cross-pollinated postings between the CCN website and partner websites.

2. Mismatch of Pace

   In conjunction with efforts noted above, the PPS strategic planning process will help to mitigate any mismatch of pace with regards to how partners prioritize the work of DSIRP amidst competing priorities which comprise the larger percentage of their community involvement. On this front, the PPS has acquired the services of a talented Strategic Advisor to oversee the development of a strategic planning program for the PPS which aligns the efforts of the Integrated Delivery System team with that of the year six requirements of the PPS.

3. Workforce Staff Crisis

   CCN is focusing on educating more professionals to work at the top of their license and not have them perform duties which can be done by other employees. This includes the solicitation of LCSWs for integration of Primary Care and Behavioral Health as well as pursuing opportunities for leveraging non-RN services for home visits following a patient discharge.

   To secure needed workers the CCN workforce transition roadmap and training strategy, which are both due for completion later in 2016, are being constructed based on the following foundational guidelines:

   1. Comprehensive, strategic plan for recruiting of new hires
   2. Creativity in utilizing alternative providers
   3. Flexibility in degree requirements
   4. Utilization of licensed workers to the fullest extent of their scope of practice

4. Alignment of State Programs

CCN works with our Partners to align state programs where possible and not duplicate work and takes into account other activities our Partners are participating in. Additionally, CCN has been in communication with the RHIOs in our network to align activities where possible. From a governance perspective, we have included multiple LGUs on the Board of Directors which has been helpful to ensure prior, current, or upcoming initiatives are in the perspective of the PPS. Each of the three RHIOs participates in the CCN IT Committee structure. CCN is fortunate to have received an award as part of the CRFP program, which coincided with attainment of consulting services to provide deeper analysis of stakeholder readiness and begin to work through the ground level details associated with implementation of technical strategies across a large region with varied stakeholders.

5. Understanding Data Sharing Associated Requirements
   CCN is actively working internally with other PPSs and DOH teams to understand approaches being considered regarding PPS consent requirements. A grass roots effort created an all-PPS Compliance Professionals group that meets biweekly to discuss compliance issues and concerns encountered in the DSRIP program. CCN's Compliance Officer is actively involved in this group and provides formal reports to both the CCN Compliance Committee as well as the IT Committee. Currently, this group is working on a joint effort with the DSRIP CIO Steering Committee, which the CCN Compliance Officer and IT leaders participate in, to create a consolidated document that explains the concerns and confusion regarding data sharing for PPSs. This collective group has assembled a meeting with DOH representatives on September 27th in Albany to discuss the aforementioned challenges with the ambiguous consent requirements for data sharing in the PPS environment. The goal being pursued by the PPSs is for the DOH to provide additional specific guidance to the PPSs that addresses and support models for data sharing relationships which have been created as a part of DSRIP. Additional guidance in this area is essential for PPSs to institute their population health initiatives and associated necessary data sharing without additional consent requirements.

6. MCO Involvement
   Through this reporting cycle Care Compass Network (CCN) has been able to develop active relationships with each of the MCOs in the region minus one. Through recent collaboration with a group of upstate PPSs, convened through UNYHealth in Syracuse, CCN was able to secure a regional style meeting with Fidelis, the most difficult MCO to contact to date. Through this effort Fidelis has agreed to a meeting with the upstate PPSs who comprise the UNYHealth collaborative. This is a positive indicator, as Fidelis, the largest MCO in the six PPSs, has been very difficult to get involved up to this point as they have indicated meeting with each PPS individually is a large administrative burden. Regular meetings are established with Excellus which operates in Broome County, and United HealthCare which operates across the PPS. Discussions with Total Care, which operates in three of the nine PPS counties, are ongoing. CCN is hosting payer forums so that partners across the network can further learn how they can play a role in the Value-Based Payment contracting arrangements. As previously mentioned, the four largest MCOs are looking at a Total Care for Total Population (Shared Savings Only) arrangement for 2017, and this presents an opportunity for our CBO partners to engage with the hospitals (which have the covered lives necessary to engage in this type of arrangement) to do outreach and engagement with the Medicaid Member for services not currently provided by the hospitals but have an impact on the health outcomes through addressing the social determinants of health.

Implementation approaches that the PPS considers a best practice:

1. Regional Structure
   Recognizing the vast nine county region of Care Compass Network (CCN) which comprises 12.5% of the landmass of New York State, CCN developed a regional approach towards operationalizing the DSRIP program. These four hubs, called Regional Performing Units, were developed based around identified trends in care delivery and service models existent within the PPS. Leveraging the existing infrastructure as a framework enabled CCN to more easily establish the related governance framework throughout the 2015 building stage of the PPS.

   Each RPU is supported by an RPU Lead, a local content expert contracted by the PPS to maintain connectivity to the work of the PPS and organize local community outreach events called RPU Operating Meetings. These micro-Stakeholder meetings 'bring the PPS to each community' to ensure that efforts coordinated centrally from Binghamton are effectively spread across the region. Similarly, questions and concerns raised at the local level from CCN partners can be escalated via RPU Leads to the PAC Executive Council where they provide recurring reports. Furthermore, the RPUs were used in supporting the identification of qualified candidates for several CCN governing bodies in 2015. The RPU Operating Groups also helped to aid in the CBO engagement effort by reviewing the CCN attested partner lists to ensure all stakeholders from their community had been identified and contacted by the CCN Provider Relations team.

   Having regional approaches to implementation that take into account the varying dynamic makeup of the RPUs is highlighted as a best practice which will assist in driving success within Population Health, Performance Evaluating, Sub Committee implementation, as well as committee interactions and cross continuum teams. As part of getting each RPU operationalized last year, the CCN office has provided extensive knowledge transfer regarding the DSRIP program to help orient the partners to the program – but also disseminated concepts and principles behind DSRIP.

2. Non Hospital Organization Engagement (CBO)
   In addition to leveraging the RPU structure, fully engaging the non-hospital organizations (CBOs) from the CCN region has been a tremendous success. To support the administrative requirement of supporting the PPS through the application, program development, and the associated subsequent program management aspects CCN has contracted directly with several CBOs for the services provided by their staff to the PPS. The simple act of acknowledging the value of their time has greatly benefited the PPS as evident by a highly engaged, highly talented workforce which has a longstanding understanding of the community being served. This includes purchased services for roles such as RPU Leader and project leaders for programs such as Navigation (project 2ci), Crisis Stabilization (project 3aii), Chronic Disease Management (Project 3bi - CVD), Palliative Care (project 3gi), and Increasing Access to High Quality Chronic Disease Preventative Care & Management (project 4bii – COPD). We have also recently leveraged the local Visiting Nurse Service to develop a training program and materials which will be leveraged by the PPS for organizations who are participating in the home visit component of the Care Transitions program (project 2biv). To date, CCN has reimbursed more than $367,196 to non-hospital partners for contracted work related to support administrative time related to program development and implementation. In year DY1/DY2 contracting, CCN contracted directly with 47 non-hospital organizations, out of a total of 55 partners resulting in an estimated $2,058,471 to be paid out to non-hospital organizations for work performed through March 31, 2017. In DY1 rather than place the exclusive priority focus on contracting with partners to achieve speed and scale

performance targets, CCN placed priority focus on building the partners ability to contract for performance based metrics. Through developing PPS-wide awareness of the DSRIP programmatic requirements our contracting process was surrounded by core principles (1) anyone in the PPS can contract with CCN, (2) All contracts will be supported by guidelines approved by the Clinical Governance Committee and Board of Directors, (3) all contracts will be supported by a defined funds flow model, (4) following an evidenced based model - CCN contracts will require standardized data submissions commensurate to the work performed.

Through use of regional RPU Operating Meetings and frequent Stakeholder meetings, the CBOs of CCN have been immersed in the discussion and dialogue of healthcare transformation in real-time. This includes the utilization of the RPU model to receive education on Value Based Payments, requirements of compliance functions for organizations who are not currently required to maintain a compliance program, education and awareness building regarding anti-trust, and Medicaid Health Home Overview including a deep dive on how operations work in a Per Member Per Month (PMPM) environment. In follow-up, CCN leadership has been invited and participated in CBO board meetings to discuss the DSRIP program and how their organization may have a larger role in the delivery of care in the new healthcare environment. Through building an awareness of current and upcoming needs of the PPS, some CBOs have signed up to be service providers for new services within the community, such as crisis mobile service teams or providers of home visits for patients post discharge. This active role in participating with the PPS will remain critical as functions of the Integrated Delivery System are activated in the upcoming year, such as Care Coordination platforms, development of consent management programs, and continued outreach and engagement programs.

3. PPS Innovation Fund

The Care Compass Network leadership team identified the need to stimulate innovation within the PPS to ensure the partners did not solely rely on the PPS and the 'eleven projects' to successfully transform the delivery system in our region. Through development of the Innovation Fund, the PPS has enabled the stakeholders of the region to develop proposals for how to transform and deliver quality care above and beyond what the scope of the eleven projects may achieve. The program is funded across the last four years of the waiver, with years two – four focusing on development of innovation programs and year five focused exclusively on sustainability. Fixed funding was allocated to each fiscal year, requiring a competitive bid and review process be created and implemented by the PPS. The CCN Provider Relations team advertised and promoted the solicitation for proposals, an enrollment period which ended on Sunday July 31. As of this report, 19 submissions have been received for roughly six million dollars. The CCN leadership team is excited by the large interest from across the PPS and will work with the selection team to identify and announce awards by September 2016.

4. Incentive Bonus

Care Compass Network recognized that each of its partners has maintained a commitment to the community which can be evidenced either by their investments in infrastructure and systems or simply by their heavy involvement in developing the PPS. Regardless of investments or mode of delivery all partners are critical to the work of DSRIP in our region. To promote activity CCN has created a Partner sign-on bonus to be distributed in demonstration year 2 (DY2) taking into account the number of unique Medicaid members served, existing RHIO connectivity, the number of projects a Partner contracts for, existing use of an EHR and existing PCMH certification.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

CCN had the pleasure of participating in the IT TOM (Target Operating Model) series in the spring/summer of 2016. This process brought many partner groups together during the KPMG facilitated sessions and the CCN hosted workshops. This exercise was instrumental in laying the foundation for the Integrated Delivery System project and it highlighted the cross-PPS needs for care management and data sharing. CCN staff members gained valuable skill sets in process flow development and mapping through a collaborative exercise with peers from across the PPS. One of the indirect benefits proved to be the networking component inherent with the IT TOM process. As a result of IT TOM, we have developed an engaged group of specialists who are now shifting focus from IT TOM discussions, which tended to be more theory in format, to practical CCN issues of today or the future. The IT TOM effort required moderate investment from the CCN staff, however was well benefited by the PPS on various fronts. This would not classically be reported as part of a report since there is no milestone or speed/scale associated with IT TOM, however we would like to highlight the direct and indirect benefits realized as part of this program.

CCN distributed an RFP for the development of an interim data warehouse. Following a successful bid, CCN contracted with the Business Intelligence Department of a partner organization (UHS) who is currently in process of building the interim data warehouse for CCN. This action reflects Phase 1 of the CCN Population Health and Analytics Initiative. This warehouse will be used to receive and process standardized monthly reporting files from CCN partner organizations, securely store Medicaid claims data received from NYS DOH, house data acquired from other sources, and run analytics and performance measures. The warehouse is nearing the go-live stage (August 2016) and will also provide the PPS PMO deduplication services related to compiling the DY2, Q2 report. In future periods, the Phase 2 of the data warehouse will allow aggregation of data from the three RHIOs in our PPS. CCN is excited and proud to leverage the local talent of upstate New York to develop the requisite infrastructure and tools required to track, monitor, manage, report, and implement the DSRIP program.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The population demographics and trends as identified by the initial community needs assessment which drove PPS attribution and project selection remain consistent within our PPS today. Across the nine counties of Care Compass Network, distribution of attribution for Medicaid beneficiaries remains largely consistent. Broome County and the corresponding City of Binghamton remains as the Medicaid population density for the PPS, followed by Tompkins County. From a PPS infrastructure perspective, this member attribution is reflected by our four Regional Performing Units (RPUs). Based on a blend of county and salient data, South RPU initial Medicaid attribution reflected 46% of the Medicaid members in the PPS, compared to 50% (+4%) as of May 2016. Similarly, the North RPU currently represents 24% of the PPS Medicaid members (-4%), the East RPU 14% (+1%) and the West RPU 10% (-1%).

The overall Medicaid enrollment volume has maintained a consistent increase in both Fee-for-Service and managed care Medicaid – largely a byproduct of the Affordable Care Act. We believe this is the predominant influencer to the minor attribution fluctuation noted above. In terms of delivery of enrollment, there has been a noticeable shift away from in-person visits with the local Departments of Social Services as supplemented by increased online, application manager utilization, and utilization of licensed enrollment facilities to get people connected to insurances including Medicaid.

From a delivery of care perspective, the community needs also remain the same. As with other PPSs, we placed a heavy emphasis on behavioral and mental health by means of projects which specifically focus on the behavioral health needs of the community: 3ai Model 1 and Model 2 (Integration of Primary Care and Behavioral Health), 3aii (Crisis Stabilization), and 4aiii (Strengthening the Mental Health Infrastructure). As validated by a recent workforce survey conducted by Iroquois Health Alliance, there exists a shortage in PPS behavioral health and substance abuse professionals including Psychiatrist (24% vacancy) and Psychiatric Nurse Practitioner (10% vacancy rate). These shortages continue to reinforce and highlight the needs of the community and the benefits the DSRIP program is supplying across the region.

We would like to leverage a section of this report on the Integrated Delivery System to also comment on factors which impact the delivery system population beyond attribution and projects and more closely at disparities of health such as rurality, women/children/seniors, socioeconomic classes, etc. We believe the PPSs ability to consider the broader impacts facing the communities of the PPS are foundational towards achieving accountable communities of health in the Integrated Delivery System. For reporting purposes, we will provide snapshot on the two largest Medicaid member counties in the PPS, Broome and Tompkins.

Broome County: Housing and Socioeconomic Snapshot

The PPS maintains a local operating team in the South RPU which includes leadership from Broome County. This involvement aids our PPS in the ability to stay connected with direct impacts the DSRIP program is making as well as understanding outside forces which may impact the implementation of CCN related effort. For perspective on the community, over the past thirty years the city of Binghamton has lost about half of its population, roughly decreasing from 85K to 45K residents. Of the people that are left there is a much denser group of lower socioeconomic residents. Based on studies from Cornell University and the Community Foundation of South-Central New York, one in five Southern Tier children live in poverty. The Broome County overall poverty rate of 17% is higher than the state average of 15%, whereas the City of Binghamton (47%) is higher than the boroughs of NYC. The population turnover in Broome County represents an out flux of middle class residents coincided by an influx of lower socioeconomic residents. Over the past 30 years, one of the attractions in Binghamton has been affordable housing, however over the

same 30-year period there has been a decline in homes that are owned by families and an increase in rental properties. The shift to renting is one thing that causes an increase in a poorer community.

Additional community figures According to the NYS Community Action Poverty Reports these trends vary by demographic, such as families with female heads of household and children present, a statewide average of 38.4% live in poverty whereas the CCN counties average 42.5%, with a Broome County rate of 44.6%.

In May 2016 the United Way of Broome County was awarded $1.5 million in funding as part of the Empire State Poverty Reduction Initiative (ESPRI) with a focus to develop objectives to "improve social mobility through public-private strategies." In phase I, an anti-poverty task force will be working to understand contributors to poverty in both urban and rural areas of Broome County. Binghamton University will be leveraged to support data analytics to ensure outcomes are evidenced based. The Care Compass Network is also partnered with the United Way for provision of 211 services to help provide navigation services for members of the community as part of project 2ci. The United Way has also been one of many pivotal partners in the development of the CCN comprehensive community resource guide.

Tompkins County: Housing & Socioeconomic Snapshot

The Tompkins County population is experiencing growth primarily driven by Cornell University, Ithaca College, and Tompkins County Community College. This growth presents a growing gap between lower socio economic status and others. As a result of high and growing student populations there is a developing housing problem whereby high housing demand influences higher rental costs. Community members who rely on rental units are faced with higher percentages of income being used to support housing costs. To combat the issue, the City of Ithaca is developing plans to create housing targeted for student and university populations – which will free up existing housing for community members.

Similar to Broome, female heads of household with children present average almost 39% poverty in Tompkins County, greatly above the US and NYS average of 15.6%. In July 2016, the Cayuga Addiction Recovery Services announced the awarding of $1M in funding from NYS OASAS to address residents with substance abuse disorders. The program will support the addition of 25 new beds, including women specific and residential treatments.

Tompkins County represents a rural and urban landscape reliant on transportation services. Locally, shifts in reimbursement towards cab services has forced bus routes to be redefined. In Tioga County, a more drastic impact has been the entire loss of the public transportation system. Cognizant of this landscape the PPS has and will continue to imbed staffing resources to community development teams, such as mobility management and transportation forums to further promote alignment of community collaborations underway.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass NetworkCare Compass Network

Project: 2.b.iv2.b.iv

Challenges the PPS has encountered in project implementation:

1. Provider and Community Engagement
   Care Compass Network (CCN) encountered predictable start-up challenges centered around introducing and communicating the Care Transition Intervention Model to Reduce 30-Day Readmissions. The Providers as defined in 2. b.iv are safety net PCP and Non-PCP providers, hospitals, Health Homes/Care Management Organizations and all others from across our PPS totaled 261 partners. The task of provider and community engagement included lining up key representatives from the hospital settings as well as community settings to distribute a unified message across their Regional Performance Unit (RPU) to ensure a consistent message is communicated regarding the CTI project and its potential impact on reducing readmissions.

2. Lack of Provider awareness/readiness for training and the ability to consistently deploy care transitions interventions/solutions.
   Early in the project development stage CCN adopted a Coleman-like model for the Care Transition Intervention including the four core pillars of the Coleman model. As part of this plan, the CCN CTI project plans for the intervention included participating with community based organizations and allowing the pivotal role of transition health coach be performed by people other than a nurse professional. A major influencer for adoption of this approach was the staffing shortage of nurses present across our region. Based on recent workforce surveys conducted by the PPS Workforce initiative, the vacancy rate for registered nurses is 6%, or 185 workers. Although the impact of DSRIP is likely to reduce avoidable services, this reduction is not likely sufficient to offset the need of FTEs required to deploy the CTI model across the region. As a result, the approach adopted by CCN presents a less traditional model for the standing medical practices in our region and requires an intentional shift in thinking. The CTI intervention developed by the Care Transitions Project Team and approved by CCN's Clinical Governance Committee and Board of Directors was a departure of the traditional model where community health nurses almost exclusively serves the role of the health coach. In general, the overall challenge was to build both understanding of the CTI model and trust in those carrying it out.

3. System modification to support the technical requirements of the program requires enhanced support by the PPS. We are fortunate in that the discharging hospitals have existing EMR systems including Soarian, Epic, Cerner, Medent, NextGen, and All scripts. Following the development of the project plan for CTI, the PPS has had to work with each discharging hospital to understand their

system requirements and capabilities as related to the data tracking and reporting elements required to support DOH reports, as well as those data elements CCN has requested to track and manage population health management and data analytics. Through implementation most systems have required modification and/or customization. The challenge presented was an insufficient capacity for providers to easily expand access or add complexity to existing workflows and engage community partners due to lack of IT and other technologies to support patient engagement and comprehensive care coordination. Due to the operational challenges, working out the mechanism of partnering is further complicated when coordinating multiple provider networks to a community of CBO's which are connected with further variation in systems. Even in instances where hospitals and home health agencies are part of the same system the system integration has required additional work to meet the project needs. Despite the challenge, we are excited to invest in this development which will greatly benefit connectivity within the PPS as part of the Integrated Delivery System through shared platforms and connectivity to RHIO for organizations.

Efforts to mitigate challenges identified above:

1. Our efforts to mitigate challenges identified above was a multi-pronged strategy of engaging hospital and community based leaders and subject matter experts early and often. The engagement was key to imparting knowledge and understanding of the CTI model among our partners across our nine county PPS region. In light of the key role health providers and CBO's are playing every day in care transitions, CCN formed a 2biv Care Transition Project Team to address the challenges discussed in part one and to define and establish a model for care transitions. The Project Team, a 40 -member team is composed of representatives from 27 organizations with at least one representative from each of the 5 hospital systems. The Project Team members represent acute, post-acute, and community based providers, and other service agencies and includes: discharge planners, nurse managers, social workers Hospice Staff, CEO and RN's from Certified Home Health Agencies, and numerous community partners. The active engagement of the Project Team resulted in a robust review of existing care transition models. The Project Team identified common elements of CTI and jointly selected four elements that reflected best practice in transitional care and developed nine guidelines to ensure a successful transition. This effort has greatly benefited the project implementation effort twofold (1) providers from across the PPS had buy-in on care transition models prior to the execution of implementation efforts and (2) although slight variation in implementation may exist based on systems functionality and provider networks across the nine counties, the project implementation promotes a level of continuity of provision of care across the PPS. Furthermore, many organizations are looking at how to implement the CTI principles for all discharged patients. This program includes the four-week Care Transition program is modeled on the four pillars of the Eric Coleman like Care Transitions program. The program includes standardized visits and telephone outreach for patients discharged from acute-care. The Project Team recommended the CTI protocols and identified a procedure to identify and recruit patients who could benefit from the intervention and establish mechanisms for collaboration between the hospital (the sender) and the outpatient services (receiver). Secondly, the Project Team raised and discussed key issues related to ensuring adequate "competencies" for carrying out effective care transitions and shared best practices on how to integrate an effective Care Transition. The Project Team also identified necessary resources to support the CTI. In defining the role of the Care Transition Intervention, the Project Team assessed workforce's ability to manage patient care transitions and developed and adopted training which will develop the core competencies required

for effective care transitions. To further embed the intervention components, the Project Team identified a CTI program champion at each hospital located within the PPS. The CTI champion ensure adequate competencies for carrying out CTI are achieved. The role of the program champion was to identify gaps in existing Care Transition Plan in use at each hospital as compared to the PPS adopted Care Transition Intervention Model. Secondly, The CTI Champion is responsible for training and making others in their institutions aware of the CTI model, clarifying how the model works, and provide CCN approved training.

The Project Teams protocols are then brought to the Clinical Governance Committee (CGC), the clinical practice governing body of the PPS for review, input and approval. The CGC is supported by the Cross Continuum Teams (CCT)/QA Subcommittees, which exist within each of the 4 CCN RPUs. Each RPU has 3 core CCT/ QA Subcommittees; Onboarding, Disease Management and Behavioral Health/Substance Abuse. Each of the 4 Regional Performance Units has three representatives who are seated on the 12 member PPS wide Clinical Governance Committee. The Care Transition project falls within the Disease Management Subcommittee. CCT/QA Subcommittees across the four RPU's consists of a total of 144 representatives engaged at the local levels. The CCT/QA Subcommittees have representation from organizations from across the continuum of care -including those within acute care, community care, residential care, social service agencies, mental health, and substance use, and primary care. Membership includes frontline clinicians who manage patients across settings, including: physician leaders, skilled nursing administrators, hospital discharge planners and directors of nursing. The CGC meets monthly to review proposed care practices and guidelines The goals of developing a standardized 30-day care transition plan for the PPS have been achieved with the cross-continuum action, close collaboration with physicians, and numerous community partners through our Clinical Governance Committee framework.

As of this report we have executed contracts with three out of the five hospitals systems to implement the CGC approved Care Transition protocol. Two hospital systems have successfully submitted speed and scale for the month of June documenting a discharge plan accompanied with a care transition plan containing the four pillars. CCN has executed a total of seven contracts with community based organizations to perform the post discharge 30-day follow-up plan for items such as home visits, phone follow-up, and pre-discharge warm handoff meetings.

2. Training approach on the Clinical Governance Committee approved CTI. CTI project team members including facility champions and community-based organizations, collaborate on training approach, content, and frequency. CTI Project Team participants share their best approaches to making staff and others aware of CTI protocols and are able to offer clarifying information on the best resources to use and the most effective methods to disseminate/train employees on the CTI. Currently, CCN has developed the CTI training content. The Inpatient Training will take the format of a webinar and Transition Health Coach Training will be an in-classroom training and associated learning tools. Both curriculums and associated tools focus on the four conceptual areas referred to as pillars. Curriculum reflects and incorporates CCN's Clinical Governance Committee approved Care Transition Protocol. All training materials are reviewed by the RPU Disease Management Subcommittee and the Project Team. In addition to the Care Transition Protocol training includes sections on motivational interviewing, health literacy and cultural competence and the nine Care Transition guidelines. Both curriculums are in final review with the CGC and expected to be offered in late

August.

3. Through continuing work with hospital Facility Champions, protocols are being developed to allow Care Transition providers access to beneficiary admission information from the hospitals IT/EMR database. Depending on the capabilities of both the hospital and the Care Transition provider, this information will be shared either through direct access to the hospitals database, or through ADT reports generated by the hospital provided to the Care Transition provider. The Project Management Office (PMO) and the 2. b. iv project team has been actively working with the CCN IT team throughout the IT plan development to discuss technical requirements of the 2.b.iv project as well as factors and challenges on the utilization of care coordination software and an integrated electronic health record with connectivity to RHIO.

Implementation approaches that the PPS considers a best practice:

1. Care Transition goals are achievable with the Clinical Governance Committee (CGC) framework. Recommendations on protocols and training made by the CTI Project Team are brought to the CGC the clinical practice governing body of the PPS for review, input, and approval. Cross continuum Teams (CCT)/QA Subcommittees exist within each of the four RPUs. Each RPU has a local composite of three core CCT/QA Subcommittees, one of which being the Disease Management committee where efforts of CTI implementation are reviewed at the local RPU level. This allows for each of the hospitals/CBOs at the local region to discuss implementation efforts locally and share feedback bi-directionally to the CGC governing body. Each of the 4 Regional Performance Units has selected three representatives who are seated on the 12 member PPS wide CGC governing body. Each of the CCT/QA Disease Management Subcommittee have representation from front line clinicians who manage patients across care settings. The RPU Disease Management Subcommittee's in each RPU review and provide oversight and direction on all proposed Care Transition protocols and procedures. Subsequently all materials go to the CGC for final review and ratification. This process ensures all sites/partners function similarly in their commitment to employ CTI model. In one instance, an RPU Disease Management committee identified the use of the LACE tool (a scoring tool for risk assessment of hospital readmissions) to determine a level of acuity for patient discharges. Implementing a tool to assess patients who are at a high risk for readmission will better enable discharge planners to provide the patient population with a comprehensive discharge/ transition plan that will promote attainment of community resources to support the patient in the most appropriate health setting and avoid preventable readmissions. The CGC approved the LACE tool for utilization during the discharge process in January 2016. To date, two of the largest health systems in the PPS are actively using the LACE tool in their associated inpatient facilities.
2. Monitor Cross Continuum Team/Individual Provider Effectiveness. Quality oversight of CTP Cross Continuum Teams will fall under the Clinical Domain of the PPS. Identified metrics specific to provider engagement and effectiveness have been established and monitored through monthly reports. The PPS Data Warehouse which provides standard reports is in the testing stage and will be able to feed quality reports to the CTP Cross Continuum Teams in the DY2, Q2 timeframe. A Continues Quality Improvement process will ensure best practices are regularly followed.

3. The PPS has adopted Hybrid Care Transitions Protocol coupled with nine elements to ensure effective Care Transitions. The Project Team adopted a model which includes four pillars for coordinated care, which reference an Eric Coleman-like based model for an evidenced based process for Care Transitions. The four components or pillars of coordinated care have been endorsed by the CGC and are as follows: 1. Medication Management using tools from the Eric

Coleman model, 2. Ensuring follow up appointment with PCP after hospital discharge, 3. Patient Understanding of "red flag" indicators of worsening condition and appropriate next steps 4. Use of a patient-centered health record that helps guide patients through the care process. The Clinical Governance Committee approved nine additional policies and procedures to ensure a 30-day transition of care period. The nine elements are: 1. Outreach and Engagement - Prior to discharge the Care Transition nurse will identify what each beneficiary requires for a smooth and safe transition from the acute care hospital. This includes but is not limited to: gain knowledge of social and physical factors that affect functional status at discharge (transportation, medication, specialized medical equipment, financial ability to sustain independent living and their feasibility to acquire what is needed). 2. Health Literacy - Assessment of the beneficiary's and caregivers level of engagement and empowerment is key to developing a safe discharge to home. Assessment of the beneficiary and caregiver's knowledge of the disease process must take place during the hospital stay as limited health literacy has been shown to undermine beneficiary follow up with primary care provider, decreased adherence to treatment protocols and their own engagement in their care. 3. Meet Patients Physically Where They Are - The Care Transition nurse or appropriate healthcare representative (e.g. Community Health Advocate, Home Care agencies, etc.) will visit beneficiary while in inpatient setting and then visit the patient at home. Home visit(s) will emphasize best practices in care transitions including: medication reconciliation, follow-up with primary care physician and/or mental health clinician, awareness of worsening symptoms of a person's health condition, home safety, and connections to home and community-based supports. 4. Family/Caregiver Involvement - Family caregivers play a significant role in keeping loved ones living at home and in the community. The Care Transition nurse will engage with caregivers wherever possible and appropriate. Following the wishes of the beneficiary, family caregivers will be included in education about symptom management and medication management. Caregivers will be informed about support services and respite care to enable them to care for themselves while providing care. 5. Create Warm Hand Offs/ Minimize Hand Offs - Wherever possible, beneficiaries will be connected with CBOs where they have a preexisting relationship. 6. Community Navigation - Identified as a vital component of an effective 30-day transition of care plan, all beneficiaries will be introduced to the array of Community Navigation services within the PPS tailored to each beneficiary's unique profile. 7. Provide Incentives - Care Compass Network will develop guidelines and policy to incentivize beneficiaries for engagement and achievement of personal milestones. The Care Transition nurse will work within this framework. 8. Create Virtual Support Groups/ RMS Panel - Beneficiaries will be offered the option to participate with their peers in diagnosis specific, social support groups, or as a member on the CHNA Panel. 9. Maximize Physician Support - Physician recommendation is a key contributor to patient's acceptance as well as the initial presentation of the programs to beneficiaries and caregivers. Discuss all standards of care being utilized to insure understanding.

4. We are very proud of the diverse composition of high level of activity and engagement with the Project Team members. The CCN project team coordinating CTI efforts totals 40 members representing 27 organizations. The Project Team members are comprised of industry leaders and front line providers form acute, post-acute, and community based organizations and service organizations who have expertise in improving quality of care and knowledge on culturally competent services in the community and conduct appropriate referrals to existing services.

Through implementation we have learned by the project team that some patients will need further transitional support after the CTI is completed above and beyond what may be required directly by the project implementation plan we had previously established. Alignment with additional efforts underway within the PPS, such as the navigation program could allow for additional services to fill the gap where the more narrowly defined CTI leaves off. For example, as part of our Health Coach training, coaches will be instructed to assess adequacy of support systems and need for ongoing navigation/case management. The Health Coach will do a warm hand-off to navigation services assisting the patient to further develop navigation skills.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

1. The Care Transition Project is planning to utilize Telehealth capability in managing the 30-day post-acute care. In late May the PPS sent out a request for proposal for a Telemedicine platform. The IT Technical Advisory Subcommittee has created evaluation and selection committees to proposals of vendors to and participate in system demonstrations, and select the ideal vendors. This work will start in July and continue through December 2016. Following vendor reviews and demonstrations CCN will commence implementation of technology with partners beginning during DY2, Q3 and DY2, Q4. The Care Transition Project Lead and members of the Project Team are on the selection committee to ensure continuity of project plan and community needs assessment knowledge is considered in the selection process.
2. Active participation of project team members has been consistent in the PPSs IT TOM efforts with KPMG. Through this initiative, important decision points were identified throughout work streams that are directly related to the CT implementation. The team provided input on topics including:
   i. How to identify high-risk patients, when do we engage MCOs to assist
   ii. Care Coordination = Key Factor
   iii. How best to incorporate care manager/coordinator/navigator with TOM
   iv. Bundle payment contracts with MCOs
   v. Collaboration with CBOs
   vi. Effective service to patients
   vii. CBOs were an important part of the IT TOM team

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

To address gaps in care for vulnerable populations and to encourage accurate assessments of informal and social determinants in all discharge plans our target population is all Medicaid patients admitted to an inpatient setting. CCN's model is not intended to be condition-specific, but instead focuses on capturing the clinical best practices necessary to achieve a successful transition from the acute hospital setting to the post-acute care provided in the home.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass Network

Project: 2.b.vii

Challenges the PPS has encountered in project implementation:

1. Engagement of SNFs in the INTERACT project and program speed and scale. When the initial speed and scale calculations were performed by the project team in late 2014, an incorrect assumption was made that the program only applied to straight Medicaid patients. Once the project team understood that duel eligible were allowable for engagement as per program definitions, the speed and scale numbers has already been 'locked in' and could not be edited or revised. As a result, speed and scale estimates are low for the INTERACT program and will require additional modeling by the PPS to develop a program that can truly meet the need of the entire community.

2. Coordinating INTERACT Training due to the large geographic area of CCN

3. Reimbursement for 3-day hospital stay
   - The goal of INTERACT is to reduce potentially avoidable nursing home to hospital transfers. In the current nursing home reimbursement environment there is a potential financial incentive to transfer a Medicaid resident to the hospital rather than to "treat in place" A day's stay for a Medicaid resident is typically reimbursed almost one have the rate of a Medicare resident. If a Medicaid resident is transferred to a hospital for treatment such as dehydration or CHF, and is in the hospital for 3 days, the facility would be reimbursed the bed hold rate for that resident who is in the hospital and then when the resident is returned typically they would be covered by Medicare for at least a short time. Sending a resident to the hospital would potentially increase the reimbursement to the facility.
4. EHR meets Meaningful Use stage 1/2 CMS requirements

5. EHR Connectivity - Varying capabilities of SNFs with EHR or no EHR at all

Efforts to mitigate challenges identified above:

(1) Engagement of SNFs in the INTERACT project and (2) Coordinating INTERACT Training due to the large geographic area of CCN

The CCN office placed an emphasis on building relationships with each of the SNFs located in the PPS, since doing so would be critical for the success of the INTERACT project and DSRIP initiatives. CCN identified a best practice to building the relationships would be to host more individual based one-on-one time with key leadership at each SNF, versus distribution of a letter as per the original implementation plan. The CCN team began formal road show with leadership from all of the SNFs from across the PPS in December 2015. The purpose of these meetings was to discuss more directly and intimately the PPS program for SNFs, how to work with overlapping PPSs (when applicable), and provide an overview of CCN operations including areas such as contracting, funds flow, and clinical governance. Based off the initial success we plan to continue this effort to engage the SNFs located in the PPS. Care Compass Network has also begun to offer the Certified INTERACT 4.0 Champion class in each of the 4 Regional Performing Units (RPUs) to encourage participation as well as offering reimbursement for Champion and Co-Champion to attend the 2-day training. Two training sessions have been held, one in the North RPU and one in the South RPU with a third session lined up in the East RPU in early September 2016.

The CCN project team also performed an assessment of Medicaid members (including dual eligible) who could be engaged across the PPS over the waiver period. As a result of this review, additional funding dollars were created as part of the PPSs 'flexible funds flow' methodology. The PPS is now adequately funded for the INTERACT program and has begun to achieve actively engaged requires for multiple reporting cycles.

(3) Reimbursement for 3-day hospital stay

As part of participation in the INTERACT project, CCN has developed a reimbursement model which provides incentive to Partners to perform interventions in the Skilled Nursing Facilities. The reimbursement model accounts for various components of applying the INTERACT principles and has prompted strong response from the partners.

(4) EHR meets Meaningful Use stage 1/2 CMS requirements

The Meaningful Use requirement initially caused hesitancy from the SNFs during the pre-contracting meeting as this was an unreasonable requirement. Per IA guidance received in June 2016 "The requirement to use a Meaningful Use certified EHR within SNFs has been removed." However, CCN is ensuring communication of the removal of the requirement to all the SNFs in the PPS.

(5) EHR Connectivity - Varying capabilities of SNFs with EHR or no EHR at all

In late May the PPS sent out an RFP for a Skilled Nursing Electronic Medical Record with several proposals submitted in June. The IT Technical Advisory Subcommittee has created evaluation and selection committees to review each set of responses, select a smaller subset of vendors to provide system demonstrations, and select the ideal vendors. This work will start in July and continue through December 2016. Implementations will begin during Q3 and Q4 of DY2. The approved EMR systems would be offered to SNFs within the PPS.

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Implementation approaches that the PPS considers a best practice:

1. **Incentive Bonus**
   Care Compass Network recognized that each of its partners has maintained a commitment to the community which can be evidenced either by their investments in infrastructure and systems or simply by their heavy involvement in developing the PPS. Regardless of investments or mode of delivery all partners are critical to the work of DSRIP in our region. To promote activity with CCN has created a Partner sign-on bonus to be distributed in demonstration year 2 (DY2) taking into account the number of unique Medicaid members served, existing RHIO connectivity, the number of projects a Partner contracts for, existing use of an EHR and existing PCMH certification.

2. **Certification potential in INTERACT (through participation in Certified INTERACT 4.0 Champion class)**
   With the use of INTERACT T.E.A.M Strategies, LLC for training the SNF INTERACT Champion and Co-Champion in the Certified INTERACT 4.0 Champion (CIC) program, the Champion and Co-Champion have the opportunity to become a Certified INTERACT 4.0 Champion by taking an online test after completing the two-day training. With the two CIC sessions held in late June 40 people had attended the 2-day sessions and are eligible to become Certified INTERACT 4.0 Champions. The 40 people are from 17 different Skilled Nursing Facilities located in the PPS.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

None to report – our PPS Quarterly Reports are rather comprehensive.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to the population served by the project.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass Network

Project: 2.c.i

Challenges the PPS has encountered in project implementation:
The Care Compass Network (CCN) project team and coordinating council who oversees the implementation efforts of each project has identified challenges the PPS has encountered in the project implementation of the Community Based Navigation project (2ci) across the Performing Provider System (PPS) nine county region. Those challenges include: 1.) Tracking of Patients Engaged; There are many partners critical to the success of navigation work who have found the tracking requirements associated with patient navigation to be cumbersome, difficult, and at times in opposition to their organization's mission. In one example, EMRs in place by the hospital systems in our region have required modifications to allow for tracking of engaged patients to meet the attestation requirements associated with the waiver. In another, the 211 call centers, who provide a great asset to navigation services, are organizations who have existed under the premise of anonymity. The concept of needing to track patients engaged proved to be a challenge both technically, but also ethically as to whether or not this concept conflicted with their organizations missions and values. These have proven to be new risks and challenges to mitigate which have impacted the PPSs ability to execute speed and scale projections. 2.) Bridging the gap between Healthcare Systems and Community Based Organizations (CBO's); Healthcare systems and CBO's are still in the mindset of competing with each other. This has caused tension and competition between partners, focusing on the dollar amount, not the help and overall impact of the patient. The goal of 2ci is not only to reduce or eliminate barriers patients face that hinder their access to care, but to bridge the gap and create a relationship between the healthcare systems and CBOs. 3.) Program Education and Contracting; The speed and scale projection that CCN adopted was prepared based on estimates derived by the project teams leveraging the Community Needs Assessment. CCN has identified two challenges that are hindering the performance; first, Community Based Partners are projecting low speed and scale numbers due to DSRIP being completely new and unknown. Educating partners on DSRIP and how they can participate takes at least three pre-contracting meetings unless the partner is well versed in DSRIP. Second, each organization's internal contracting approval process is different and requires different timelines for when a contract is fully executed. CCN is experiencing that although larger organizations will provide the most speed and scale, and ultimately the most impact on implementation, it is taking weeks or months before we have a fully executed contract due to

multiple layers to the process. Smaller organizations are able to present a fully executed contract sooner; however, they are projecting very low speed and scale metrics due to low-staffing, capacity of adding duties to staff and overall budget of the organization.

Efforts to mitigate challenges identified above:

The efforts Care Compass Network (CCN) is doing to mitigate the challenges identified above are as follows:

1.) CCN continues to work towards the projected speed and scale set for the PPS, as this data will be critical for the overall success of the project. To help mitigate this challenge, the project manager along with the project team, and provider relations coordinators continue to strategize and focus on organizations to contract with identified in the "hot spot" patient mapping and data we receive. Additionally, considering the ambiguity with regards to partner contract estimates and to promote CCN's success in achievement of speed and scale, we will be seeking partner contracts well in excess of speed and scale requirements in year one. We will continue this contracting model through the end of contracting year one, which concludes March 31, 2017. Following a completed contracting cycle with partners of the PPS, we will be able to validate assumptions with regards to hot spots and more clearly refine contracting targets.

2.) In order to continue to work on bridging the gap between health care organizations and CBOs, CCN creates a community of trust. The community of trust brings value to the PPS by inviting contracted partners and interested partners to contribute and collaborate in meetings alongside their known competitor.

3.) As for contracting, CCN continues to work along with the organizations to help educate, process and implement the 2ci project. CCN also implemented a new sign-on bonus for organizations to receive upon signing a contract to participate in any of the 11 projects. The Care Compass Network leadership team identified the need to stimulate innovation within the PPS to ensure the partners did not solely rely on the PPS and the 'eleven projects' to successfully transform the delivery system in our region. Through development of the Innovation Fund, the PPS has enabled the stakeholders of the region to develop proposals for how to transform and deliver quality care above and beyond what the scope of the eleven projects may achieve. The program is funded across the last four years of the waiver, with years two – four focusing on development of innovation programs and year five focused exclusively on sustainability. Fixed funding was allocated to each fiscal year, requiring a competitive bid and review process be created and implemented by the PPS. The CCN Provider Relations team advertised and promoted the solicitation for proposals, an enrollment period which ended on Sunday July 31. As of this report, 19 submissions have been received for roughly six million dollars. The CCN leadership team is excited by the large interest from across the PPS and will work with the selection team to identify and announce awards by September 2016. CCN also recognizes the partnership with other PPSs across New York State (NYS) is important for questions, feedback and also to share strategies on how to mitigate the challenges.

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Implementation approaches that the PPS considers a best practice:

Implementation approaches that Care Compass Network (CCN) considers a best practice for the Community Based Navigation project (2ci) are as follows:

1.) In order to reach diversity and number of patients in the community that are needed for this project, CCN developed a best practice by establishing two types of navigation. Type 1 was modeled after the 2-1-1 call systems who help mitigate social determinate barriers that would limit their access to healthcare and potential admission to the Emergency Department. This Type 1 navigation is predominantly a 'lower acuity' navigation that would be performed telephonically. A more comprehensive Type 2 navigation was developed for the in-person Community Health Advocate (CHA) navigation services with the Medicaid patient who has more than one identified social barrier and may also have a clinical need which would require the navigator to follow-up with the patient. The Type 2 navigation would follow a longitudinal path and eventually transition the patient out of the navigation services (e.g., navigation discharge) into a long term care coordination or Medicaid health home if eligible. Through implementing the Type 1 and Type 2 navigation programs, the CCN project team for navigation identified a best practice whereby each provider agency can develop their own screening, orientation, and training for staff that will be providing the CHA assistance. The common element is that each provider agency be given standardized guidance from the PPS and be asked to develop written criteria for inclusion with the contract process with CCN. This grass roots approach has been well received by the CCN partners who know their respective communities the best and are engaged to meet the needs of patients in the communities where they are served with modest diversity in approach to maximize effectiveness.

2.) CCN, along with the 2ci project team and oversight group, continue to work and collaborate on the Community Resource Guide. The Community Resource Guide oversight group decided to partner with what the current 2-1-1 systems use for their database called iCarol, instead of creating a new community resource guide. iCarol is an electronic platform that CCN would make available to its partners. The iCarol system has two major advantages: first, the system allows for creation of a public community resource guide of integrated resource data from each the three participating 2-1-1s in our PPS. This would allow CCN to leverage existing content already present within the PPS to create the Resource Guide. In execution, the aggregated materials would be implemented and launched on our CCN website for the navigators to use and for the public to use. The second component of the iCarol system is the database which can be used for tracking and reporting purposes (tracking of engaged members). This provides a huge benefit to the community, in particular those agencies who do not currently have an electronic system to track telephonic engagements and/or in person engagements. The system allows for the CCN project team to extract reports of the referrals made by the navigators from the resource guide, track most frequent resources used per county, track the amount of calls a client makes, and finally, would provide CCN reports of met and unmet social determinate needs which would be used for performance, quality, and overall impact of the navigation project.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The additional details on the project implementation efforts beyond what is detailed in PPS Quarterly reports is as follows;

1.) Care Compass Network (CCN) recognizes the importance of health and community events our partners contribute and participate in throughout our PPS. Currently, the partners contracted to do the 2ci project, have taken the opportunity to utilize the navigation services at their standard workflow as well as at community events. This approach has helped market the navigation project, and implement the project in a public community setting to get aggregate data which will be used for the impact of the navigation project. It has also helped to align the organizations who provide navigation services through the CCN navigation team meeting to promote collaboration at these events so a coordinated approach is provided to the community.

2.) CCN also recognizes the importance of engagement. CCN will be hosting a Community-Based Organization (CBO) event this summer. This event will target the CBOs in our PPS to come for an evening of learning and engagement of the DSRIP projects. CCN will partner with CBOs who have successfully implemented the 2ci project in their organization, share their experience, and the importance of the 2ci project for the organization, Medicaid patient and our community. A large component of 2ci contracted partners are CBO members. At the event we look forward to CBO agencies sharing with fellow CBOs their experience in doing the work of DSRIP.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There are currently no changes to the populations that were proposed to be served through the 2ci project.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass Network

Project: 2.d.i

Challenges the PPS has encountered in project implementation:
The Care Compass Network (CCN) project team and coordinating council who oversees the implementation efforts of each project has identified challenges the PPS has encountered in the project implementation of the Patient Activation project (2di) across the Performing Provider System (PPS) nine county region. Those challenges include: 1.) Actively Engaged Projection; The 2di project actively engaged (speed and scale) projection for Care Compass Network is the highest speed and scale projection of any PPS across New York State. In the upcoming reporting cycle ending 9/30 CCN has a requirement to achieve 7,560 PAM surveys. Towards this effort, CCN has contracted with partners for the completion of 7,298 PAM surveys. Although CCN believes it is achievable to meet the speed and scale targets for DY2, the numbers climb aggressively each year, ultimately ending with approximately 90K required engaged patients by DY4. The CCN project team is aware of this requirement and closely monitors comparable risks, such as success in identifying uninsured members via hot spot analysis. One compounding issue for speed and scale is our partners general lack of information with regards to the low / non utilizing Medicaid population as well as the uninsured. While statics on Medicaid services are tracked electronically, systems do not commonly record whether a Medicaid member is low or non-utilizing. Furthermore, many of the community based organizations who provide services in hot spot areas to the uninsured have not classically documented these services in a standardized manner, if at all. These factors have impacted the partner's ability to prepare accurate estimates for contracting with CCN for performance of PAM survey work. 2.) Training Organizations in the PAM Survey; Another challenge is the development and roll-out of training for scheduling and in-take staff administering the PAM survey. For training, we had established a group of Master Trainers comprised of partner organizations from each Regional Performance Unit (RPU) who could be paid by the PPS to execute a train the trainer model to newly contracted organizations. This model was intended to allow CCN to reinvest DSRIP dollars to the training faculties already existent within the PPS, versus leveraging external consulting. Through delivery of this model, several new barriers have risen including (1) conflicting schedules between organizations has not allowed for timely delivery of training to newly contracted partners, (2) as partners sign agreements with CCN, their focus shifts to their own entity's implementation efforts, resulting in less Master Trainers available than had been anticipated, (3) based on feedback received from training delivered, our PPS partners have expressed concerns with the Insignia provided materials and approach which requires the survey be

administered without assistance to help coach the patient or guide them through the survey. According to the vendor this would be viewed as persuading results. From an application standpoint, our partners have seen a lack of response and/or inability of eligible surveyed members to answer to the best of his/her ability.

3.) Managed Care Organization (MCO) Engagement;
There are several steps and milestones in the implementation plan which focus on PPS alignment and engagement with MCOs. MCO engagement has been difficult and all PPSs CCN has been in contact with have communicated similar issues, especially with regards to receiving lists of low and non-utilizers. Others have communicated being able to do this via their lead agency but Care Compass Network, as a New Co., is presented with a unique challenge in that this is not as simple as asking for a list from the MCO as a major healthcare system (a list of patients that are seen at the company's facility, for example). Instead, Care Compass Network is faced with managing this relationship without direct access to patient data and pre-existing payer relationships.

Efforts to mitigate challenges identified above:

Care Compass Network's (CCN) efforts to mitigate the challenges identified above are as follows:

1.) CCN continues to work towards the projected speed and scale set for the PPS, as this data will be critical for the overall success of the project. Considering the ambiguity with regards to partner contract estimates and to promote CCN's success in achievement of speed and scale, we will be seeking partner contracts well in excess of speed and scale requirements in year one. As of this report the PPS has contracted for 120% of the speed and scale requirements for the period ending DY2, Q2. We will continue this contracting model through the end of contracting year one, which concludes March 31, 2017. Following a completed contracting cycle with partners of the PPS, we will be able to validate assumptions with regards to hot spots and more clearly refine contracting targets. Some partners who contracted in year one for 100 PAM surveys per month may find their organization only encounters an average of 50 per month. Conversely, other partners may find they were too conservative in their estimates and be afforded the opportunity to increase contracted amounts effective April 1. This process will be informed from the standardized data of CCN as our Partners do not have full awareness of how many of the eligible populations they will be able to connect with. However, the project manager along with the project team, and provider relations coordinators continue to strategize, and focus on organizations to contract with identified in the "hot spot" mapping and data we receive. From a funds flow perspective, the leadership team has made efforts to equip the project teams with adequate funding to react to such situations. According to the CCN funds flow process, each project is funded with dollars to achieve speed and scale targets plus a 20% contingency to allow for high performance. Above and beyond speed and scale, overall project budgets (inclusive of training and system requirements) have an overall project contingency of 15% allocated. These reserves were implemented to allow project teams to have flexibility to react to CCN or DOH program changes. One example where this has already been put to use was the recent introduction of the Palliative Care POS form from the DOH, which was introduced subsequent to the approval of the funds flow process and impacted how speed and scale was required to be tracked and managed by the PPSs and partners. Having the adequate reserves allocated at the project level allowed the project team to quickly shift focus and create the associated partner agreements for project level work. This example has reinforced our funds flow methodology and validated the CCN Governance model as being quickly able to react to changes in the program to keep projects moving forward with only minor delay.

2.) In executing the projects Care Compass Network has noted the significant time investment required to adequately train staff. To supplement the Master Training team CCN has sent the CCN 2di Project Manager to attend a super user training for the PAM Survey hosted by Insignia Health. This two day, 8-hour session training will provide the Project Manager with program updates from the vendor and also provide a more in-depth overview on the PAM Survey. As a result of the training, the CCN Project Manager is now able to provide trainings more real-time to newly contracted partners and provide technical guidance on PAM survey techniques. In line with prior plans we will also continue to leverage available partners to perform training as available.

Additionally, the Project Manager has leveraged the 2di Project Team, comprised of 20 members with a combination of Community Based Organizations and Healthcare Systems to review implementation efforts. One deliverable from these monthly workshops are questions for the vendor which can be communicated by the Project Manager. We were excited to learn about the vendor's response to the DSRIP program by modifying the approach for concluding a valid survey as including those instances where a participant select "Agree" for all answers. This update shows that the vendor (Insignia) is listening to the lessons learned from the PPSs and applying to how their survey applies to a highly niche market.

3.) The CCN efforts for MCO engagement are spearheaded by the Finance Department as part of the VBP milestones associated with financial reporting. Project related requirements for MCO collaboration have been gathered and shared with this team so they have a comprehensive knowledge of all PPS MCO requirements which is leveraged in current MCO discussions.

Through this reporting cycle Care Compass Network (CCN) has been able to develop active relationships with each of the MCOs in the region minus one. Through recent collaboration with a group of upstate PPSs, convened through UNYHealth in Syracuse, CCN was able to secure a regional style meeting with Fidelis, the most difficult MCO to contact to date. Through this effort Fidelis has agreed to a meeting with the upstate PPSs who comprise the UNYHealth collaborative. This is a positive indicator, as Fidelis, the largest MCO in the six PPSs, has been very difficult to get involved up to this point as they have indicated meeting with each PPS individually is a large administrative burden. Regular meetings are established with Excellus, which operates in Broome County, and United HealthCare which operates across the PPS. Discussions with Total Care, which operates in three of the nine PPS counties, are ongoing. CCN is hosting payer forums so that partners across the network can further learn how they can play a role in the Value-Based Payment contracting arrangements. Through our discussions to date we understand that the four largest MCOs are looking at a Total Care for Total Population (Shared Savings Only) arrangement for 2017, and this may present opportunities for our CBO partners to engage with the hospitals (which have the covered lives necessary to engage in this type of arrangement) to do outreach and engagement with the Medicaid Member for services not currently provided by the hospitals but have an impact on the health outcomes through addressing the social determinants of health.

Implementation approaches that the PPS considers a best practice:

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Implementation approaches that Care Compass Network (CCN) considers a best practice for the Patient Activation project (2di) are as follows:

1.) CCN has recognized the strength and collaboration of the Community Based Navigation project (2ci) and 2di project working in a dual role is a best practice approach for the PPS. This combination was advertised as part of the "CBO Bundle" of projects at various stakeholder meetings and contracting fairs throughout 2015 and 2016. Utilizing the PAM survey to see what level of engagement of the patient, and then transitioning that score and patient to the navigator to follow-up with insurance enrollment, social determinants, and clinical needs that the patient will need help with.

2.) Very early in the implementation efforts CCN developed multiple assistive materials for the project. In one example, CCN was the only PPS to complete Milestone 12 before commencing speed and scale efforts. This milestone required that the PPS "Develop a process for Medicaid recipients and project participants to report complaints and receive customer service" and was a necessity of the project before speed and scale achievement was ever required. The screening tool used to identify the eligible population has served as a template for most, if not all, existing screening questionnaires used by PPSs to-date. Additionally, the PPS has created a mechanism for requesting training and has developed supplemental materials to help explain the relevance of the project activity to DSRIP goals. This has served to operationalize this project more efficiently than had we developed these parallel to achievement. Most Milestones for this project come due years in advance of other PPS', yet this has served CCN well with regards to positioning itself to perform project activities.

3.) Alignment of community navigation (project 2ci) and the patient activation measure (project 2di) workflows. When establishing the Clinical Governance Committee (CGC) of the PPS, quality sub committees were established in each of the four Regional Performing Units (RPUs). The framework developed by the chair of the CGC included the establishment of an Onboarding subcommittee at each RPU. The Onboarding subcommittee, among other things, would provide regional focus on the implementation efforts of the Community Navigation project (2ci) and Patient Activation project (2di). The design of dually reviewing the performance of these programs together has helped to ensure a consistent outreach and engagement approach is leveraged at each RPU and across the PPS. Additionally, in May 2016, CCN reorganized project assignments amongst the PMO staff to take advantage of synergies between projects. This included the assignment of project 2ci and 2di to a single project manager. The alignment of these programs has resulted in decreased volunteer time by the stakeholders realized through the combination of 2ci and 2di project teams. The alignment of 2ci and 2di workloads has also benefited the PMO by more closely connecting the various implementation efforts underway by both projects, since efforts for both of these programs will predominantly impact the same partner base.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The additional details on the project implementation efforts beyond what is detailed in PPS Quarterly reports is as follows:

1.) Care Compass Network (CCN) recognizes the importance of health and community events our partners contribute and participate in throughout our PPS. Currently, the partners contracted to do the 2di project, have taken the opportunity to utilize the PAM Survey at community events. This approach has helped implement the project in a public community setting to get aggregate data which will be used for the impact of the PAM Survey and population we are targeting.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There are currently no changes to the populations that were proposed to be served through the 2di project.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass Network

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

Challenges identified are:

1. Limited provider engagement and buy in to integration
2. Shortage of appropriately trained and licensed behavioral health providers – Integration limited due to shortage. Shortage of psychiatry providers to assist PCP in managing higher level need patient cases and those who are not responding to treatment or medication.
3. Financial Sustainability – VBP for DY6. Lack of clarity for how to bill for tele psychiatry services and services that partners can bill to Medicaid. Lack of clarity regarding the License Threshold application versus the Integrated License.
4. Actively Engaged Targets for 3ai

Efforts to mitigate challenges identified above:

1. **Provider and CBO Engagement Activities** – The 3ai Project Team is hosting an event on A Collaborative Model of Care: Integrating Behavioral Health into the Primary Care Setting with Cornell University's Gannett Health Services. Cornell University is nationally recognized for its cohesive, innovative public health approach to student's health and wellness. The Cornell clinical team will share: • Rationale for integrating this approach • Examples of provider collaboration • Benefits and challenges • Lessons learned. CCN is taking a proactive approach by offering PPS wide initiative to bring awareness to mental health issues and substance abuse in our region. The 3ai Project Team also extended the invitation to the 8 PPS who are participating in the MAX workshop on integration.
2. **Incentivizing Co-location and Collaboration -** CCN developed financial assistance through Appendix C Start Up funding for co-locating services where they are not already in place, as approved by the Finance Committee and Board of Directors. The primary challenge and barrier to implementing Model 1 is the shortage of appropriately trained and licensed behavioral health providers which was confirmed through the Compensation & Benefits Analysis Workforce completed by Iroquois Health Association. For example, CCN has a signed contract with a hospital system with 12 primary care clinics for the integration project however we are only able to roll out one site due to a lack of appropriately trained and licensed behavioral health providers currently employed by the organization. CCN has initiated and supported communications among primary care clinics and counseling centers to collaborate and partner up their resources to make Model 1 integration come to fruition. The project team is working with Workforce to identify and explore options to support the PPS's workforce shortage in primary care providers, licensed behavioral health specialists and care coordinators. The 3ai and 4aiii project team in conjunction with IT have developed an IT roadmap, submitted RFPs for tele psych/telemedicine IT platforms and an RFP evaluation/selection timeline to help bridge the gap in care due to the shortage of psychiatry providers in the PPS. PCPs who struggle prescribing psychotropic medication and side effects for patients will have the support and resource readily available.

CCN will be looking to obtain clarification for how to bill for tele psychiatry services in order for the services to be sustainable and effective for DY6. The state needs to revisit how these services are reimbursed with MCOs as many lives will be impacted with the psych shortages which the providers are having challenges in recruiting due to our area and pay scale.

3. **Financial Sustainability and VBP –** CCN is working with our partners by offering DSRIP funding through Project 3ai Start Up funding, creation of sign on bonus and innovation fund. Our focus has been to build a strong infrastructure in order for us to support the 4 Regional Performing Units and partners. CCN's intent is to assist the partners to best position their organization to negotiate MCO contracts through data such as effectively managing patients assigned to their panel through reduction in ED/inpatient admissions, avoidable readmission, patient outcomes and medical expenses. The project team will be exploring options to reimburse for LCSW/LMSW services for ages 21 and older under Article 28 with DSRIP funding that is currently a non-covered service. This will help partners to slowly migrate towards VBP. **Lack of clarity regarding billing**—CCN is working with its partners and billing experts to understand which preventive care/behavioral health services can be billed. This is an act of faith on the part of CCN partners to be asked to begin to provide services (and make all the requisite changes in staff and physical space) for which they are unsure of the payment rates. Lack of clarity for how to bill for tele psychiatry services. **Lack of clarity regarding License Threshold and Integrated License** – CCN is working with partners and our PCG support team to support applications. CCN continues to hear from partners that their OMH representatives provide conflicting information. The 3ai project team is serving as the primary liaison to address and support our partners as questions arise.
4. **Actively Engaged Targets for 3ai** – The integration of primary care and behavioral health is being programmatically implemented by CCN based on a true integration model. PPS partners are being encouraged and incented to integrate a behavioral health consultant into the primary care practice through Model 1 or integrate a primary care provider to the behavioral health location via Model 2. As part of this implementation, the focus has been on 'standing up the project' and not the raw delivery of screens – otherwise seen as a 'check the box' approach to DSRIP. As we have learned from our MAX program, locations with full attention of the CCN office and consultants from KPMG have had a quick ramp up in the level of impact to the community as they solve challenges related to integration such as supporting an integrated treatment plan, provider engagement/buy-in and streamline process communications between the BH and PCP. In order to deliver these services, confidentiality regulations remain under scrutiny as OMH requirements inhibit the sharing of information when a PCP patient is admitted to an OMH licensed facility. The CCN implementation model did not initially plan on this high level of support, and will need to react to ensure participating partners receive adequate level of PPS support as they transform their practices. Providers on multiple EHR platforms are posing as a huge barrier especially in supporting an integrated treatment plan which is to incorporate medical and behavioral health in one individual patient EHR. The 3ai and 4aiii Project team is planning to pilot a tablet solution under the Integrating Behavioral Health and Primary Care project. The BH IT solution will also meet the needs of project 3aii – Crisis Stabilization and project 4aiii Strengthening Mental Health and Substance Abuse Infrastructure. We anticipate this BH IT solution to be selected and contract to be signed by the end of DY2, Q3. The BH IT solution will assist BH and primary care providers to efficiently screen/identify, treat, refer, and track patients with behavioral and mental health issues. We anticipate this collection of these data will help us to facilitate and evaluate treatment protocols based on the members' outcomes and frequency of ED visits. Furthermore, we have a Behavioral Health quality subcommittee in place at each Regional Performance Unit (RPU) who will evaluate the program functions, efficacy and report results to the PPS level Clinical Governance Committee.

Implementation approaches that the PPS considers a best practice:

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MAX – Lourdes Primary Care @ Robinson Street

In late 2015, Care Compass Network (CCN) was presented with the opportunity to participate in a MAX program in a variety of fast paced pilot programs hosted by the DOH through vendor KPMG. The CCN Coordinating Council, who serves as the project oversight group, reviewed the eligible programs and had provided resounding support for the integration of primary care and behavioral health program. After review of potential sites, the Coordinating Council and Our Lady of Lourdes hospital agreed to perform the MAX program at the Robinson Street clinic, one of the top Medicaid volume PCP locations in the PPS. In this effort, CCN is one of eight PPSs participating in the MAX program for integration of primary care and behavioral health. MAX is an 8-month intensive learning collaborative focusing on the development of an efficient processes and outcome metrics.

Location Background: At the time of implementation, the Robinson Street practice had an awareness of integration concepts however had not yet started the process. Location was chosen due to its significant Medicaid population served among seven primary care providers. There was not yet a behavioral health consultant (BHC) on site, however shortly after the practice was able to bring the behavioral health consultant on-site for one day per week and eventually on a full time status in the month of May. With this co-location level of integration, there were logistical and cultural challenges the office needed to consider, such as workflow, patient management, EMR systems, communication between the BHC and PCP, licensure/billing requirements, provider engagement and referral management. The sponsoring organization, Our Lady of Lourdes Memorial Hospital Inc., stepped up to the plate and provided a strong model for how to support an integration effort of this magnitude. Senior leadership provided heavy support for the program and dedicated a core team to oversee the implementation effort including the Director of Clinical Services, Director of Youth Services – LCSW-R, Nurse Manager, Operations Manager and Project Manager.

Early Results of MAX

Currently, Lourdes Robinson Primary Care is in its 5th month out of an 8th month intensive learning collaborative. Even after this short period of time, the investment in the MAX program has begun to show significant results. The PPS has begun to advertise and showcase these results in an effort to engage the partners of the PPS in Fact Based Optimism. This includes a recent overview and presentation of results and discussion with the engagement team at the PPS Stakeholder meeting. The work of DSRIP, although challenging, is possible and is making a difference. A summary of achievements to date are highlighted below:

(1) Embedding a behavioral health consultant on site five days a week at the practice.
(2) Successfully completed 495 PHQ-9 screenings for all patients between the ages of 20-50 age range since May
(3) 61 referrals made to BH for all PHQ-9 scores over 15 since May.
(4) Screenings and warm hand offs allow the team to refer patients for appropriate treatment and intervention
(5) Successfully implemented 50 mini huddles across seven PCPs since May.
(6) Tracking 5 core performance metrics to monitor their progress and outcomes.

Description	Before (Mar'16 – Apr '16)	After (May '16 – Jun '16)	% Change (From Baseline)
Total Screening Rates	66.5 average / month	310 average / month	366%
Warm Handoffs	4.5 average / month	15 average / month	233%

Follow-up (for PHQ-9 score 15-27)	8 average / month	32.3 average / month	303%

Moving Forward
CCN and Lourdes continues to participate in MAX Program which is scheduled for 'official' completion in September, however will formally continue as part of the PPS efforts for the 3ai project. Lourdes is looking to extend the work of 3ai to 12 additional locations in the upcoming year. This program has provided a valuable lesson to the PPS as to how much effort, coordination, and collaboration is required to properly implement meaningful change. We are excited to continue to share these best practices within the CCN network as well as with fellow PPSs from across the state. CCN's 3ai Project Manager will be sharing lessons learned and challenges at the All PPS Learning Symposium in Syracuse in September. The Project Manager will be supporting the contracted partners to facilitate and oversee project implementation process at their clinics.

CCN would also applaud the DOH on sponsoring this initiative and would encourage the DOH to continue hosting additional MAX programs on similar topics (e.g., super-utilizers or integration of care) or new topics in upcoming years.

CO-location of BH in primary care and meeting PCMH 2014 NCQA level 3 2014
Care Compass Network (CCN) dedicated its manpower and resources to creating the infrastructure and behavioral health guidelines to stimulate an impact and deliver on early detection and early intervention for patients with behavioral health and substance abuse issues. We also realized that performing the screenings are good, but we need to be able to support our providers and patients if the screens are positive. The 3ai and 4aiii project team are working with partners to facilitate communications between primary care, behavioral health providers, and community based organizations to collaborate in the spirit of DSRIP. One way this is being reinforced is through the funding of incentives by CCN to support and stimulate achievement of PCMH designation. The alignment of the various programs of DSRIP has greatly benefited the partners as they see the comprehensive approach DSRIP is taking to support the patient, the providers, and the underlying infrastructure associated with delivery of care in the community.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

"Mini Provider Huddle" – While implementing the 3ai program at the Robinson Street, the action team noted the importance of daily interoffice communications, especially with the behavioral health consultant and the providers. The establishment of 'mini provider huddles' is intended to improve communications about upcoming patients, prior notes, and align treatment orders and changes. In execution, the model of the mini huddle is to "BRING" the huddle to the providers. This proactive action was implemented following a persistent conflict in schedules and availability. By implementing this plan, the behavioral health consultant and providers are compelled to interact and collaborate on patient care in order to work towards he integrated treatment plan. Huddles is one of the major requirements in achieving NCQA PCMH 2014 Level 3 which encourages care coordination among the collaborative team.

MAX pilot team – Following the establishment of protocol adoption and implementation of the 3ai program at the Robinson Street clinic, the action team is pursuing the incorporation of substance use disorder screening with evidence based tools such as the CAGE-AID, DAST 10, or AUDIT as needed. This is in addition to screening for

Depression with the PHQ-9. The lessons learned are being shared with the CCN project team so best practices can be shared with organizations across the region.

Partner Education Events – With learnings from the MAX program the CCN office has recognized the tremendous organization lift associated with implementing the program. As a result, we have organized several learning platforms for partners to share and collaborate best practices. First, we coordinated with an existing integrated service team within the PPS, Gannett Health from Cornell University, to provide insights and perspectives in an interactive workshop with providers and professionals from across the PPS. This workshop was completed in July 2016 and among many topics, included deep dialogue with the providers regarding the valuable services a behavioral health consultant could provide to their practice despite the BHCs lack of prescribing authority. Additionally, as noted above the project team from the Lourdes MAX program gave an overview to the CCN stakeholders about their experience with integration of care and more broadly, how they approached change within their organization and what tools/tricks helped to facilitate the process. We look forward to continuing to engage the partners of the PPS with forums where they can promote sharing of best practices, through additional panels with Gannett and potential outside vendors such as Cherokee health. We will also be working with the independent assessor facilitator team to understand whether the DOH will be making available additional MAX series programs.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to report as project 3ai is targeted for the Medicaid population.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass Network

Project: 3.a.ii

Challenges the PPS has encountered in project implementation:

1. Development of Successful Mobile Crisis Services – it has been a challenge to develop a service that is financially sustainable within the DSRIP timeframe and beyond. Mobile services are an expensive service to provide and where billable, reimbursement does not necessarily correspond to the cost of providing. Moreover, revenue is unpredictable (whereas the service requires staff dedicated to provide the service needs to be available at all times, and beyond normal business hours). In addition, wrapping around OMH reinvestment dollars to use DSRIP funds to expand services in ways that meet local needs has been challenging. In addition, crisis teams must be able to respond to behavioral health crises regardless of insurance status; Medicaid reimbursement and DSRIP funds are only for Medicaid members.

2. Overlap with other PPSs—close coordination with overlapping PPS makes the most sense. It has been challenging to coordinate. CCN does not currently have an agreement for cross-PPS de-duplication of actively engaged lists.

3. Shortage of LCSW to provide mobile crisis services—difficult to staff new teams or expand existing teams.

4. Community-based Crisis Respite – it has been a challenge to develop a service that is financially sustainable within the DSRIP timeframe and beyond. Crisis Respite is not a billable service currently.

5. Long Term Sustainability—CBOs have been concerned about the long-term sustainability of crisis services after DSRIP as there are no local dollars for the foreseeable future.

Efforts to mitigate challenges identified above:

1. CCN funds flow model for mobile services includes start-up funds for new teams. Reimbursement for mobile crisis services is comparable to reimbursement for offsite crisis intervention services performed by a mental health clinic (and is less restrictive in terms of what qualifies for reimbursement). The CCN Project Management Office is offering assistance to find complementary DSRIP project work that can help even out unpredictable revenue (Care Transitions- 30 day supported period following psychiatric discharge).

2. Overlap with other PPSs—CCN has remained engaged in solution finding for coordination and de-duplication strategies. CCN has been working in tandem with the Director of Community Services from the Chemung County Department of Mental Hygiene, who is a FLPPS project lead in Chemung

and Steuben counties (where CCN overlaps with FLPPS). Leadership from the two PPSs have discussed potential solutions. CCN remains open to new potential solutions.

3. Shortage of LCSWs—CCN has developed a robust crisis stabilization program which recommends using a mix of clinical and non-clinical skills to provide services, rather than rely heavily on clinicians. We recommend using one licensed clinician, typically an LCSW, and one or more non-licensed personnel, including peers and case managers.

4. Community-based Crisis Respite—this service is included in the Home and Community Based Services waiver, and CCN has aligned our program with the HCBS waiver program; however, relatively few Medicaid Members will qualify for these services and it appears they must have previously elected to add a Health and Recovery Plan for those services to be billable, even by organizations approved to provide crisis respite services.

5. Long Term Sustainability – CCN has aligned the need for long term sustainability in the development of year six modeling of the PPS, functionality of the Integrated Delivery System, and VBP Roadmap planning. In this effort, CCN has begun working with local Managed Care Organizations to understand scenarios for establishment of structures and population health initiatives which would allow for creation of managed care reimbursement to fund these services. This work is in its infancy.

Implementation approaches that the PPS considers a best practice:

1. Crisis Stabilization Definition and Community-Wide Protocol. This is a clinical guideline that outlines the project—defines a behavioral health crisis (low, medium, high acuity), defines crisis services included in the Care Compass Network project including service deliverables, recommends assessment tools, and outlines how people in crisis can access the services. This document is a living document that will develop for each county separately (our geographical focus for coverage) and will outline the triage process and referral streams. Writing and presenting this document has helped the 3ai Project Team envision how these different services will interact and stand on their own. It has helped develop a multi-year vision of the project.

2. Regional planning of services. CCN has met with the stakeholders to discuss local needs and challenges. CCN is flexible in meeting local needs to improve access to community-based crisis services. Behavioral Health Quality Committees have played a significant role in shaping how the project will roll out in each Regional Performance Unit.

3. CCN has spent extensive time developing understanding and awareness with the healthcare community and CCN stakeholders regarding crisis stabilization services. Through a multi-month planning effort, the CCN project team was able to coordinate the development of a community wide approach to crisis stabilization in the South RPU, the region in the PPS that represents 50% of the attributed Medicaid lives and 77% of the medical surgical discharge activity. This effort concluded with a collaborative between the local police department, suicide prevention hotline, Crisis Intervention Teams (CIT), MCAT(mobile team serving Chenango and Delaware counties), health systems, and a local CBO the Mental Health Association of the Southern Tier to provide mobile crisis services in instances where emergency department or CPEP services have the potential for avoidance. The local CBO MHAST has received CCN incentive funding for the recruitment of a dedicated LCSW as well as funding for provision of mobile service visits and post-incident care coordination to promote the successful de-escalation event remains stable.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
1. In the planning for crisis stabilization services CCN has been working with local law enforcement units to develop capacity to address behavioral health calls/crises with sensitivity. This effort allows our project teams to assist in the development of relationships between mobile teams and law enforcement units where they do not currently exist. Beyond collaboration efforts, CCN has also helped to support training for local law enforcement by supporting the Emotionally Disturbed Persons Response Team (EDPRT) training program.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
No changes to the population served by the project.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass NetworkCare Compass Network

Project: 3.b.i3.b.i

Challenges the PPS has encountered in project implementation:
In part of developing and executing the funds flow model, Care Compass Network has encountered some challenges in terms of identifying activities that could be reimbursable for contracted partner organizations that are not currently reimbursable through Medicaid – e.g., the fear of "double dipping". Additionally, the combination of multiple EMR requirements and PCMH certification make the clinical integration projects more daunting than others. For this reason, contracting has been slow to start – at least, relative to the Domain 2 projects. It is also difficult to generate buy-in with providers as many view DSRIP as "another" set of mandates, amongst many. In terms of standardizing clinical guidelines, providers feel that they already implement "best practices" and so as soon as what is proposed diverges from what is already done, the PPS gets some pushback. While there is incentive tied to DSRIP, its often not enough to pay what providers feel is fair to compensate them for their time and efforts.
Efforts to mitigate challenges identified above:
Care Compass Network has been sorting out reimbursable v. non-reimbursable interventions through Medicaid. Additionally, the reports requested in association with this project require either a rather burdensome data pull or require EMRs be built out to produce panels of patients that require attention with or at-risk of cardiovascular disease. The understanding is that eventually these reports will be commonplace enough that providers will customize the EMR accordingly rather than go through the effort of manually recreating these reports whenever they are requested by the PPS or even payers perhaps at a future date. With Care Compass Network's clinical governance structure up and running at this point in time, the intent is to vet clinical guidelines and the like through quality subcommittees in order to address some of the concerns providers and their associated health systems have. If challenges can be mitigated, they then happen at this level rather than stalling the Clinical Governance Committee's efforts to push guidelines forward to the Board of Directors. This also helps to create some sense of ownership and bolster buy-in to a degree. The use of the quality committees at the RPU level also helps to obtain provider buy-in from the ground level up, helping to mitigate challenges of change associated with the delivery system reform program.

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Implementation approaches that the PPS considers a best practice:

The PPS considers its regional clinical governance quality sub-committees a best practice. This helps to ensure that challenges or opportunities unique to a region or health system are acknowledged moving forward especially for geographically spread PPSs. It also considers the flexibility in its implementation an advantage in that many providers are disenfranchised when particular initiatives such as the Million Hearts Campaign is referenced. Often times, these initiatives phase out faster than they achieve their goals. We use our Clinical Governance to provide us with the best practices they have found and are willing to incorporate where applicable, borrowing from multiple established evidence-based practices. Additionally, acknowledging existing efforts is also very important. This project requires very many training reports and while the PPS can provide opportunities, we should not be duplicating existing efforts that are happening at the provider-level simply to "box check".

The PPS has also begun to build its Chronic Disease Self-Management Program (CDSMP) (Stanford Model) infrastructure. While often times "speed & scale" becomes all-consuming for PPSs, Care Compass Network acknowledges that the outcomes desired in association with DSRIP require additional interventions that we will have to begin now even as speed & scale begins to take off. We have had seven individuals complete master trainer training in order to begin to build the infrastructure necessary to implement across the 9-county region. This is a major step for the region where prior to these seven being trained, there was only one master trainer identified within the PPS network.

The project team is led by two co-leads who have varied backgrounds, one working for a major healthcare system in the region and another working for a community-based organization. This combination of experience helps to promote diversity of thought within the project team. The team has also been characterized by strong physician leadership from partner organizations which the PPS attributes as a strength in terms of approach.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

None to report – our PPS Quarterly Reports are rather comprehensive.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

N/A at this time – the Community Needs Assessment was used to identify projects that correlated with a need or gap in services.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass Network

Project: 3.g.i

Challenges the PPS has encountered in project implementation:
On January 26th, 2016, the Department of Health (DOH) provided an update to the PPSs that a change to the project was forthcoming within 45 days, which would impact how screenings were performed, and therefore changing how speed and scale was calculated for the PPSs. This came amidst a heavy contracting push which had been ongoing by the Care Compass Network (CCN) provider relations team. As a result of the announcement and pending change, several partners indicated concern with contracting for a program with yet to be finalized revisions. As a result, our project team shifted focus to keep partners and project teams informed, placing a temporary pause on contracting efforts. On March 18th, 2016 the Palliative Care Outcome Scale (POS) was announced to the PPSs, which is still under review by CMS, but the PPS was given enough information to allow the project team to move forward, beginning with updates to the implementation plan to incorporate the new guidance. With new guidance available, CCN partners now had to understand a new program associated with the POS, specifically how to understand the basis for form completion. As part of the updated program, Hospice & Palliative Care agencies have been asked to aid in completion of this form. However, for the Hospice & Palliative Care organization since there has been little to no funding stream for just Palliative Care their estimates on numbers are tough to predict. Associated with this change is the PPSs governance program which was designed to provide oversight to the work of the PPS. Following program update announcements, the new approach, forms, and toolkits required review by the Regional Performing Unit (RPU) quality subcommittees. The project manager presented the changes to each of the RPU quality subcommittees in late March thru early April. At the Clinical Governance Committee meeting on April 28th, 2016 the clinical guidelines were approved with the next step of approaching the Finance Committee for funding approval. Since the POS was now the requirement the PPS needed to prove out speed and scale, funding needed to be identified and allocated to allow the PPS to reimburse for completion of the POS at partnering sites, which was completed on June 2nd, 2016. Lastly, following approvals at the respective governance committees the updated guidelines and fund flow models were approved by the Board of Directors (BOD) on June 14th, 2016, allowing for implementation as well as funds flow. In summary, the governance model the PPSs were encouraged to develop in year one of DSRIP are active and in use. In summary when programmatic changes are presented, the cycle for adaption is approximately three months. Although this is a very quick response time, when PPSs are evaluated in three-month review cycles this presents major potential to impact performance measures. From a long range perspective sustainable funding remains a challenge for sustainable implementation. Managed Care Organizations (MCOs) do not have published criteria requiring the coverage of services for

palliative care. Since palliative care can often encompass a team ranging from a PCP, RN, clergy/social worker/counselor, or palliative care agency, it is difficult in the current payment model to have robust services provided as there is no existing reimbursement for these services. Although the introduction of Value Based Payments (VBP) will help in changing this landscape, the real key is to allow for agencies who must retain staff to be able to bill for medically necessary services, such as but not limited to, in home care and advocacy that a palliative care agency could provide. While there is a milestone by which the PPSs are required to have agreements with the MCOs and the MCOs in turn have been directed to communicate to the PPSs this is still not enough to aid in this aspect of delivery system reform. Several MCOs have been very difficult in getting a touch point to discuss the matter and often leave one with the sense they will cover the costs when they are mandated to and not sooner.

Since Palliative Care agencies have not been able to bill for straight palliative care services until they become end of life (Hospice) services, they have a harder time or lack incentive to track members that would qualify for palliative care. PCPs face the same obstacle, as they often treat palliative patients without the classification of palliative care. CCN looked to the salient pre-defined collection to aid in educating partners what members to look at and to even attempt “hot spotting” efforts to look for members that may qualify. However, there are limitations as to the use of the Salient collections. Firstly, there is no clear definition as to why cancer codes were exclusively chosen to create the Salient collection for palliative services. Secondly, some items have been included in the palliative care Salient collection such as debility which is not believed to be a standalone item that would cause someone to be referred for palliative care treatment. Our project team has also noted several codes that the Palliative Care work group does see within Palliative Care Specialist offices and Palliative Care agencies, but, were not listed out by Salient.

Another great tie into the 3.g.i project would be 3.a.i Model 1: Integration of BH in a PCMH. PCPs classically are not given much, if any, formalized training on palliative care. They also, once mentored by senior physicians, tend to encounter what their typical practice historically has treated. Dedicated palliative care training is left out of most common education as well as the mentoring process for most, leaving PCPs without the tools to accurately identify a broad base of members in need of services. There is also the stigma attached that Palliative Care is all about pain management and attracts drug seeking behavior. Yet, again the education system does little to re-educate on non-opioid use and how to identify drug seeking behavior. The integration of a BH specialist could aid in not only the initial conversation with a member, their family and support group, but may have better training on some of the issues while PCPs have the ability to catch up to the new landscape of primary care. Yet, regulations preventing true integration and the mass confusion on how to integrate and have a sustainable model prevent many PCPs from actively engaging in the 3.a.i project.

Palliative care has historically not benefited from unstimulated growth, it is a component of healthcare that requires intentional training, focus, and discipline. Inherent to the healthcare system are varying degrees of education, expectations, and assumptions amongst providers, clinical staff, and even community based organizations that may lead to confusion of Palliative care with Hospice and end of life care. Education for proper use of Medical Orders for Life Sustaining Treatment (MOLST) and Advanced Care Directives (ACD) as well as understanding and enforcement of the Palliative Care Information Act (PCIA) and The Palliative Care Access Act (PCAA) is lacking. There is precedence for palliative care being established to complete a MOLST on every patient as the belief is this will normalize the conversation, while others complete the MOLST incorrectly, lacking correct information, correct sign off and tracking. ACDs are often not discussed or a brochure may be handed to a patient to research on their own leaving many to not follow PCIA and PCAA.

Efforts to mitigate challenges identified above:

CCN actively looked for the roll out of the implementation plan and once the POS was released immediately had a project work group meeting to discuss working this into the implementation plan. Education on the form was gathered from the POS website and the group worked through an implementation plan to roll this into to project contracts. While training timelines within PCP organizations still vary, during contracting discussions we encourage PCP partners to use the local Palliative Care agency to help complete the form during the palliative care encounter with the member. At least two large partnering organizations are submitting a contract to participate in 3.g.i with the plan to partner with the area Palliative Care agency. This will build the relationship between PCPs and Hospice & Palliative Care providers which over all is a sustainable plan post DSRIP.

While depending on when notification of a large change to a project implementation plan arises there is not much to offer from a time management perspective internally. From the time of notification receipt, we were pleased that our governance model was able to adapt quickly, and partners maintained engagement through clear and consistent communications.

CCN has compiled a listing of all MCOs within the PPS as well as a worklist for all steps and milestones dealing with engagement with MCOs. We have created an internal workgroup to track this work list and have a key contact for the MCOs so that the touch points made are as useful as possible. The CCN Finance Manager has already facilitated some discussions as the contact point for MCOs and we will move forward with this strategy to ensure ease of communication with these organizations. The matter of having them cover services not yet mandated to cover though remains something the PPS must ardently work on, giving data to show out comes once the implementation process has been underway for at least three years to show correlation between improved care, cost reduction and inclusion of palliative care services.

CCN also has incentivized Palliative Care organizations through the budget to help build needed personnel and infrastructure to support the need that will arise once hot spotting efforts are completed and if and when MCOs cover repayment for these entities.

CCN continues to work with partners and PCG on clarity and applications for License Threshold and Integrated Licensure. Partners still remain confused as OMH representatives have provided conflicting information. At a Regional Planning Consortium for integration of behavioral health and MCOs the same conflicting information was present by the presenters and attendees. CCN will continue participation in this consortium to best understand the changing landscape and aid in supporting and educating the partners. At this time partners are asked to hire behavioral health personnel, build or remodel existing clinical space, including waiting rooms and file storage area and keep separate the services for which they are being asked to integrate. For this the PPS is aiding them through the budget to offset some of this capital investment, however, billing for services is still an area of confusion and concern that PCMH providers will have to assume the risk of doing for little no reimbursement while we all navigate and understand the regulations regarding true integration.

The PPS has incentivized partners through the INTERACT project as well as 3.g.i to sign up for and utilize eMOLST. This is the best electronic tracking for MOLST forms and allows a partner to complete the form correctly, following the correct check list and requesting the appropriate level of sign of from a physician. The eMOLST team has already had on-site training and information seminars with a few major partners

within the PPS and CCN has requested her presence at RPU meetings to help lead the discussion of the importance and difference between ACP and MOLST.

Through our reporting mechanism we have requested PCMH sites to alert us when a patient is considered for Palliative Care but does not receive this care, as well this is in part captured on the POS.

Implementation approaches that the PPS considers a best practice:

Obtaining full buy-in from each of the five Hospice and Palliative Care Agencies within the PPS has been critical. Each agency has maintained at least one representative that actively participants in the 3.g.i project work group meetings including program development.

Participation in a coalition with a national organization, The Center to Advance Palliative Care (CAPC). This coalition has aided all of the PPSs statewide and CAPC identifying the fiscal struggle smaller agencies would have in purchasing a full CAPC membership. However, this membership with this coalition is comprehensive and a bench mark for the industry, so CAPC has been able to offer a membership to the PPS in order to help those smaller independent physicians' offices, organizations and such the same level of training for a continuum of care.

Also, NCQA PCMH 2014 level 3 certification is a large component of DSRIP activities and project. Our North regional provider's unit (NRPU) has formed a quality subcommittee specifically for PCMH and has secured the funds to offer consulting to help practices through their roadmaps to achieve 2014 level 3 certification. The remaining three RPUs are comprised of highly organized physician networks each on strong paths to PCMH attainment. The kick-off meeting on June 28th began the process to help those individual practice sites within the PPS obtain consulting from a vendor for PCMH readiness and application submission. The NRPU has our largest concentration of independent physician practices within the nine-county region so a consultant and quality sub-committee play a large role in helping them achieve this and then begin participation within the 3.g.i project.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The CCN project manager has taken on the effort to hot spot for members who may qualify for Palliative Care services with a primary care physician. The predefined collection from the Salient interactive miner does not have any description as to why these specific ICD9 and now 10 codes were chosen. In reaching out to the Salient support staff, they could only indicate that this methodology was only meant to serve as a starting point. As a result, CCN has built an in-house collection, taking the Salient defined collection for palliative medicine, removing items that as a standalone should not be an indication of palliative care (i.e., debility as a co-condition but not just debility on its own.) After this was complete, the project team accessed other Salient collections to see what was included for chronic illnesses and performed an analysis of PPS-wide palliative care agencies to determine what demographic of patients commonly receive palliative care and end of life services within the PPS. This analysis was also reviewed by a Director of Medicine of Palliative Care who helped direct which illnesses could be cared for effectively at a primary care

physician instead of referred to a specialty service such as her own. This collection is now being translated into an outline devoid of the ICD codes to help educate the PCPs on members they could start focusing on to access if palliative care is right for this member. Physicians often know when their member has crossed a threshold from managing a chronic condition to a declining state, this outline will help in educating PCPs who may not have had a robust training in medical school or through mentorship on Palliative Care. This will then help to give a data point to physicians which is key to their acceptance of a new way of delivering care and not just relying on gut instinct. The next step would be to collect data from physicians who implement the Clinical Triggers showing the potential need for palliative care, once offered, look to see if those members do fit the outline of the ICD codes and then the PPS can develop a base model of applicable data to aid in making Palliative Care more easily identifiable so that physicians feel confident in offering these services without crossing into a situation where they give up hope on a members future but look to proactively treat, through the use of palliative care, those conditions leading to better sustainable care entering into end of life situations.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The initial community needs assessment accurately identified a gap in services within the PPS. As we progress with implementation we believe we will be very likely to locate more members than was initially predicted as per the actively engaged estimates which were prepared in late 2014. As the implementation period gains more historical reference points and palliative care conversations held across the PPS normalizes, infrastructure grows, and reimbursement is made possible, more patients will come to see the benefit of Palliative Care and not fear this as Hospice and end of life care.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass Network

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:
Challenges identified are: 1. Limited data sharing ability and collaboration for treatment among providers with multiple EHRs or no EHRs 2. Minimal communication/collaboration between OMH, DOH, OASAS, CBOs and Primary care providers 3. Limited mental health clinics or services available to meet needs. Shortage of psychiatry providers to assist PCP in managing higher level need patient cases and those who are not responding to treatment or medications
Efforts to mitigate challenges identified above:
1. **Behavioral Health Information Technology Screening Tool Platform -** Care Compass Network is investing funding and resources to bridge the gap in data sharing and treatments among clinical providers and community based organizations (CBOs). The 3ai and 4aiii Project team is in the evaluation and selection process for a behavioral health (BH) vendor for our PPS. We anticipate this BH IT solution to be selected and contract to be signed by the end of DY2, Q3. The BH IT solution will assist BH and primary care providers to efficiently screen/identify, treat, refer, and track patients with behavioral and mental health issues through an evidenced based solution. We anticipate the collection of standardized data elements will help to facilitate and evaluate treatment protocols based on engaged members' outcomes and frequency of ED visits. The 4aiii and 3ai programs will pilot a selected tablet solution under the Integrating Behavioral Health and Primary Care project and be incorporated into project 3aii – Crisis Stabilization and project 4aiii Strengthening Mental Health and Substance Abuse Infrastructure. 2. **Improve Collaboration & Communication –** CCN's strategy is to continue to develop Mental, Emotional and Behavioral Health promotion and disorder prevention partnerships with the local OMH, DOH, OASAS, schools and primary care providers. We have a Behavioral Health Quality Subcommittee in place at each of the 4 Regional Performance Units (RPU) who will evaluate the program functions, efficacy and report results to the PPS level Clinical Governance Committee. The Behavioral Health Quality Subcommittee have representation from DOH, OMH, OASAS, Primary Care, CBOs and management. 3. **Workforce shortage and services –** We are facilitating the communication between providers to collaborate to make co-location a possibility in order for the PPS to address the short of MEB and

Substance abuse services for members. CCN is aggressively targeting primary care clinics who are not participating in 3ai Model projects and community based organizations to engage in the screening of members using evidence-based screening tools to help identify unmet behavioral health needs. The 4aiii project team believes early detection and early intervention will help to mitigate future chronic health illnesses and costly medical expenses. The project team is in collaboration with the two other DSRIP projects—Integrating Behavioral Health and Primary Care (3ai) and Community-Based Navigation (2ci) to further promote access to mental health services and address the social determinant factors for members who are screened. To address the limited psychiatry in our PPS, we are evaluating tele psych platforms which will give the PPS, providers and members leverage to cover more lives in our rural counties. Additionally, the presence of multiple DSRIP programs focused on mental health services have empowered efforts and awareness of services within the PPS. Funding models for direct startup including acquisition of professionals has been included in projects 3aii – Crisis Stabilization as well as 3ai – Integration of Primary Care and Behavioral Health.

Implementation approaches that the PPS considers a best practice:

Cornell University – Collaborative Model of Care Event –
CCN is working to help support a collaborative care model for all four of the Behavioral Health Projects including an educational workshop for partners on how to integrate behavioral health services in primary care setting. One major PPS efforts to date is the Cornell University – Gannett Health Services Clinical team who will present their rationale, collaborative approaches and challenges to integration on 7/26/2016. CCN extended the invite to OMH, DOH, OASAS partners as to educate on the process of collaboration that the primary care providers are facing and how they can work together in a team based setting; an effort which had a positive turnout and something we would look to duplicate in future quarters.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Reimbursing for 2 screenings for patients who initially screens positive - CCN is encouraging partners via incentive dollars supported by contracted services to perform up to 2 screenings for patients who initially screens positive. This will allow the PPS to monitor and track member outcomes and treatments and provide incentive to partners to do perform these screenings. Partners who are contracted for the 4aiii project are required to utilized the recommended follow up process and protocols as approved by the Clinical Governance Committee under 3ai project.

Partnering with 2ci Community Navigation – Partners participating in the 4aiii project are strongly encouraged to participate in 2ci as the two projects go hand in hand and the activities would be reimbursable by CCN. The 4aiii project team believes screenings for MEB and substance abuse is essential, but it is critical for the partners to be able to properly navigate the members who screens positive to the appropriate behavioral health services, primary care, community and social resources and other health care services.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

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No updates or changes to report.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Care Compass Network

Project: 4.b.ii

Challenges the PPS has encountered in project implementation:
Challenges and mitigation plans which face project 4bii for our PPS closely resemble the items noted in the narrative for 3bi due to close overlap in program missions. With regards to project 4bii, Care Compass Network has encountered some challenges in terms creating provider buy-in as many view DSRIP as "another" set of mandates. In terms of standardizing clinical guidelines, providers feel that they already implement "best practices" and so as soon as what is proposed diverges from what is already done, the PPS gets some pushback. While there is incentive tied to DSRIP, its often not enough to pay what providers feel is fair to compensate them for their time and efforts.
Efforts to mitigate challenges identified above:
With Care Compass Network's clinical governance structure up and running at this point in time, the intent is to vet clinical guidelines and the like through quality subcommittees in order to address some of the concerns providers and their associated health systems have. If challenges can be mitigated, they then happen at this level rather than stalling the Clinical Governance Committee's efforts to push guidelines forward to the Board of Directors. This also helps to create some sense of ownership and bolster buy-in to a degree.
Implementation approaches that the PPS considers a best practice:
The PPS would consider its regional clinical governance quality sub-committees a best practice. This helps to ensure that challenges or opportunities unique to a region or health system are acknowledged moving forward especially for geographically spread PPSs. It would also consider the flexibility in its implementation an advantage in that many providers are disenfranchised when particular initiatives such as the Million Hearts Campaign is referenced. Often times, these initiatives phase out faster than they achieve their goals. We use our Clinical Governance to provide us with the best practices they have found and are willing to incorporate where applicable, borrowing from multiple established evidence-based practices. Additionally, acknowledging existing efforts is also very important.

The PPS has also begun to build its Chronic Disease Self-Management Program (CDSMP) (Stanford Model) infrastructure. We have had several individuals complete master trainer training in order to begin to build the infrastructure necessary to implement across the 9-county region.
The project team is led by two co-leads who have varied backgrounds, one working for a major healthcare system in the region and another working for a community-based organization. This combination of experience helps to promote diversity of thought within the project team. The team has also been characterized by strong physician leadership from partner organizations which the PPS attributes as a strength in terms of approach.

The PPS has also adopted the GOLD standards as a framework for this project, setting the foundation for common understanding regarding the COPD disease state.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

None to report – our PPS Quarterly Reports are rather comprehensive.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

N/A at this time – the Community Needs Assessment was used to identify projects that correlated with a need or gap in services.