Landscape of Care Compass Network

Care Compass Network (CCN) 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. The counties served are Broome, Chemung, Chenango, Cortland, Delaware, Schuyler, Steuben, Tioga and Tompkins. There is a unique governance structure, in which six partners are the corporate members for CCN: Cayuga Health System, Inc.; Cortland Regional Medical Center, Inc.; Family Health Network of Central New York, Inc.; The Guthrie Clinic, Inc.; Our Lady of Lourdes Memorial Hospital, Inc.; and United Health Services, Inc. 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. 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. 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.

In order to effectively collaborate, communicate and track progress across the nine-county region, CCN developed four Regional Performing Units (RPUs): the North RPU (NRPU) comprised of Cortland, Tompkins, and Schuyler counties accounting for approximately 30% of the attributed Medicaid population; the West RPU (WRPU) comprised of Steuben and Chemung counties accounting for approximately 11% of the attributed Medicaid population; the South RPU (SRPU) comprised of Broome and Tioga counties accounting for approximately 46% of the attributed Medicaid population; and the East RPU (ERPU) comprised of Chenango and Delaware counties accounting for approximately 13% of the attributed Medicaid population (see Figure 1). These four RPU hubs 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. 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. 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.

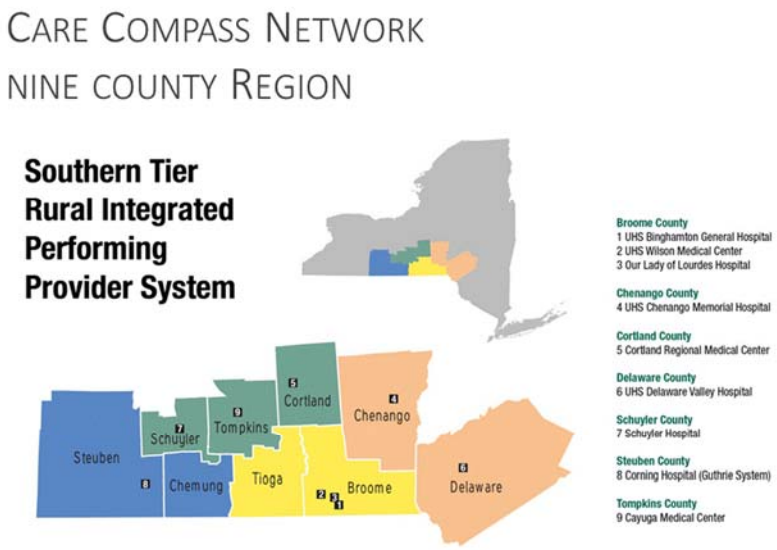


Figure 1 - Counties Served by CCN and RPUs

There is a population density in the SRPU around the Binghamton NY area where 3 of the 9 hospital systems in the PPS are located. This is a metro setting with public transportation, housing in walking distance to food, transportation and health care and non-health care services. However, the balance of Broome county, also in the SRPU, looks very different with a mix of bedroom communities and rural areas lacking good public transportation, with food deserts and little to no access to basic services such as pharmacies, walk-in clinics and social service programs. The NRPU mimics the make-up of the SRPU, as Ithaca and Cortland are metro city centers each with a regional hospital located within the city, even though the balance of the county is rural in nature. The WRPU and ERPU are more similar in nature based on geography and population. Each of these RPUs comprise a little over 11% of the population of CCN's attributed members. However, there is a large gap in primary care in these regions. Members are faced with transportation challenges for primary care appointments and other community based services that may be up to 45 minutes away from their homes. There are very limited public transit options in these areas, and even then, patients are required to find transportation to public transportation access points far away from their homes. Total travel time and length of appointments may require a patient to miss work for an entire day, which is not an ideal situation for these patients. Social determinants of health are always a pressing issue, but they are greatly magnified in the WRPU and ERPU due to the rural make-up and lack of services.

1 - Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs.

CCN services roughly 92,859 Medicaid patients across the nine counties (see Figure 2). Of the nine counties, six counties are Primary Care Health Professional Shortage Areas (HPSAs) making access to primary and preventative care a challenge for these areas. The HPSA counties are Broome, Chenango, Cortland, Delaware, Tioga and Tompkins.

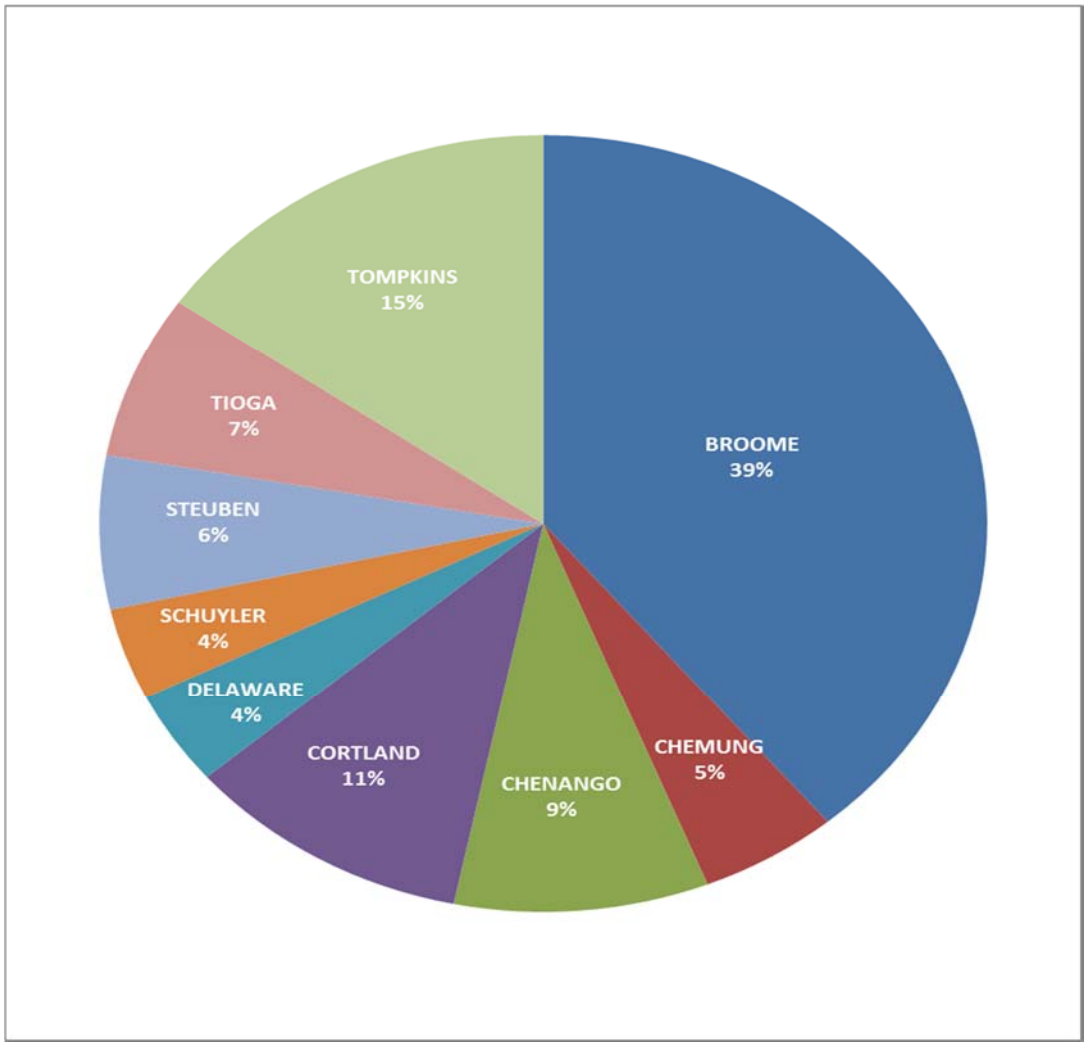


Figure 2: CCN Attributed Medicaid Lives by County

Of the 92,859 Medicaid patients about 33,122 or 36% are pediatrics from birth to age 18, the balance of the adult population is roughly 59,737 members or 64% (see Figure 3). CCN worked to identify the populations on a more regional level and found the break down county by county was similar in that 36% are pediatrics (0-18 yrs.), 40% are young adults (18-44 yrs.), 18% middle aged adults (45-64 yrs.) and the balance of 6% represent the elderly population (65 yrs. and older) (see Figure 3). Utilizing the age group break downs, CCN was able to see similarities in the percentage of age groups regardless of the RPU. This better helps to risk stratify pediatrics, adult care and elder care on a more

geographical basis as the challenges due to social determinates of health as well as access to care will change going from metro city centers into rural communities.

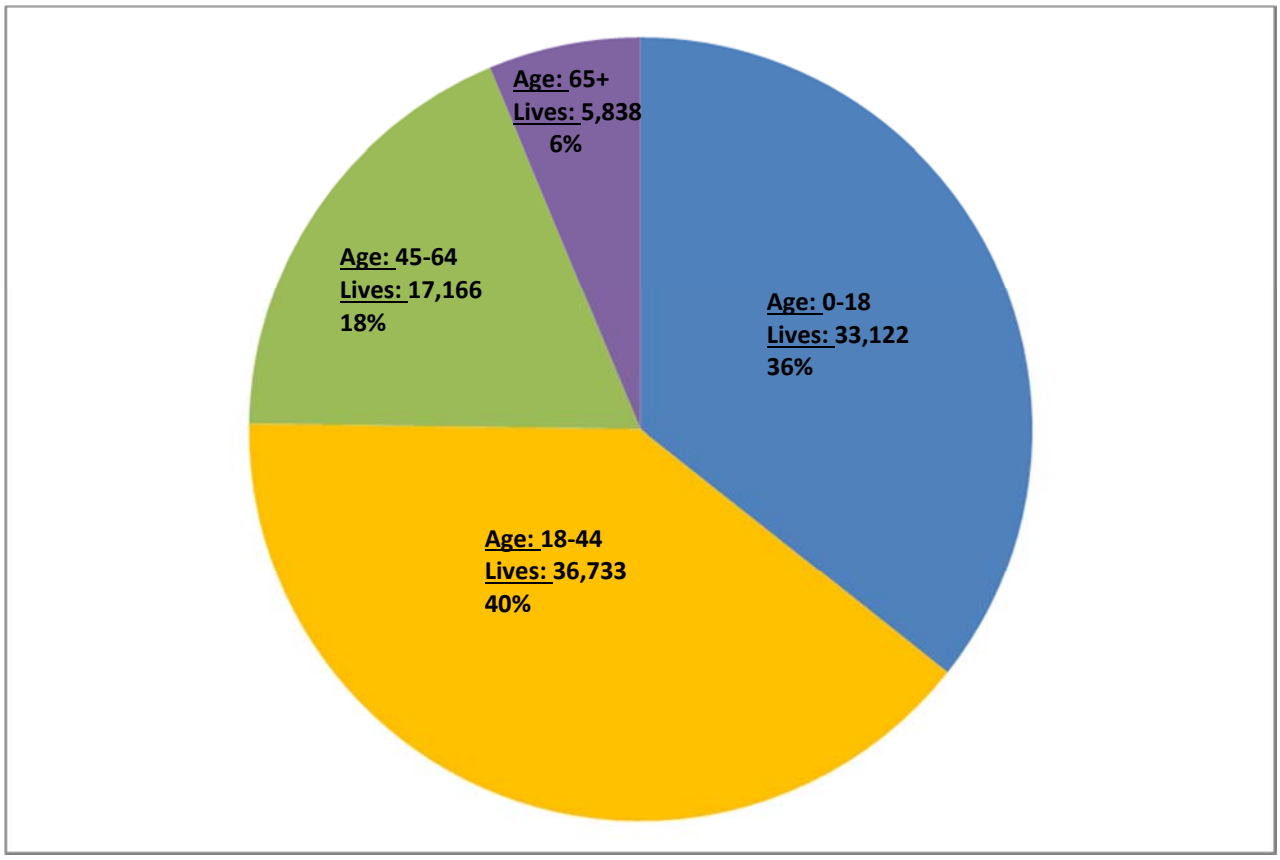


Figure 3: Care Compass Network Population by Age Group

In the PPS, there are several large medical groups that operate primary care practice sites and walk in clinics, as well as independently operating physicians mainly concentrated in the NRPU. Due to the PPS network having multiple health care systems, data detailing specific numbers for the varying types of providers is not readily available as it would be for a unionized health care system or for a PPS comprised of only one or two health care systems employing the majority of physicians and specialists. However, CCN is working with our corporate partners to gather the information relative to current capacity across provider types.

The CCN network is comprised of 85 practice sites currently seeking PCMH 2014 Level 3 certification or having shown intent to do so. Of these 85 practice sites, 18 currently have no level of certification, 2 are certified at PCMH 2011 Level 2 and 65 are certified as PCMH 2011 Level 3 (See Figure 4). The practices seeking this certification are made up of the large health systems encompassing the major health groups employing the vast majority of the PCPs, NPs and PAs across the nine-county region. The balance is the one FQHC operating within the PPS and a handful of independent physicians

RPU	Entity	PCMH	RHIO	Primary Care Locations / Providers	MA Member Attribution by RPU**
N	Cortland Regional Group Practices	Not Started	Health eConnections	2 / 31	30%
N	Cayuga Area Plan Providers***	Multiple practices at varied stages of progress	Health eConnections	24 / 46	
N	Family Health Network	2014 Level 3	Health eConnections	5 / 13	
S	Lourdes	2014 Level 3*	HealthLinkNY	7 / 93	59%
S/E	UHS Medical Group	2014 Level 3*	HealthLinkNY	30 / 144	
W	The Guthrie Clinic	2011 Level 3	HealthLinkNY	22 / 138	11%

Figure 4: Current PCMH Status for CCN PPS

* Application pending review by the National Committee for Quality Assurance (NCQA)
**Based on Salient and Partner Data
***Cayuga Area Plan/Preferred ("CAP") is a clinically integrated network for providers in the North RPU.

In the original survey assessment conducted in 2015, there were no primary care sites that had achieved NCQA PCMH 2014 at any level. The main focus to build on the current primary care model within the PPS is to aid organizations in the achievement of PCMH 2014 level 3 certification. PCMH is an evidence based approach to team based care which then leads to increased coordination, accessibility and reduction in avoidable emergency department use. Through rapid-cycle evaluation, CCN will be better able to understand how the transformation of practices and the majority of the primary care servicing the Medicaid population, is affecting the measures. A current evaluation of the NCQA database and the provider relations and outreach personnel within CCN shows that two partners have achieved PCMH 2014 level 3 certification with 2 independent physician sites in the final stages of application for this level. A 5th partner, a large medical group encompassing a bulk of the providers for the PPS, is also in the final stages of application for PCMH 2014 Level 3.

CCN contracted with third party vendor Iroquois Healthcare Association (IHA) to complete a compensation and benefits analysis for the PPS in June 2016. The resulting analysis reflects vacancy rates for the PPS as a whole and is not exclusive to Medicaid providers (see Figure 5) since primary care staffing is based on the practice needs regardless of payer. Along with the efforts of the project

management office to map the PCMH status of primary care sites within the PPS, IHA's analysis provided a view of the vacancy rate for jobs that directly affect redeployment of workforce in the primary care field. The vacancy rates shown solidify the HPSA status of most of the counties within the PPS and show the need to ensure that certified professionals work to the top of their licensure and that other efforts may need to be deployed to support needs with mid-level professionals and lower.

Primary Care Position	Vacancy Rate
Primary Care Physician	8.5
Primary Care Nurse Practitioners	9
Physician Assistants in Primary Care	6.3

Figure 5: IHA Vacancy Rates for CCN

This assessment demonstrates that partners within the PPS will need to continue their active recruitment and retention programs they have in place. The IHA analysis did include aggregated data from our region based on compensation. These compensation values can help the partnering organizations understand their overall ability to be competitive in staffing for this region and help to identify some fundamental salary challenges they may face. However, between the HPSA status of six of the nine counties and the vacancy rate data from IHA there is no room to redeploy the main workforce already engaged in primary care. As a result CCN's role is educating partnering organizations on staffing models related to a fee for service model, currently in existence across the PPS and the model all medical groups currently staff to at this time, to a value based payment staffing model, where focus is on staffing lower credentialed, and in some instances, non-credentialed staff to back fill gaps in services while allowing Physicians and the like to work at the top of their licensure.

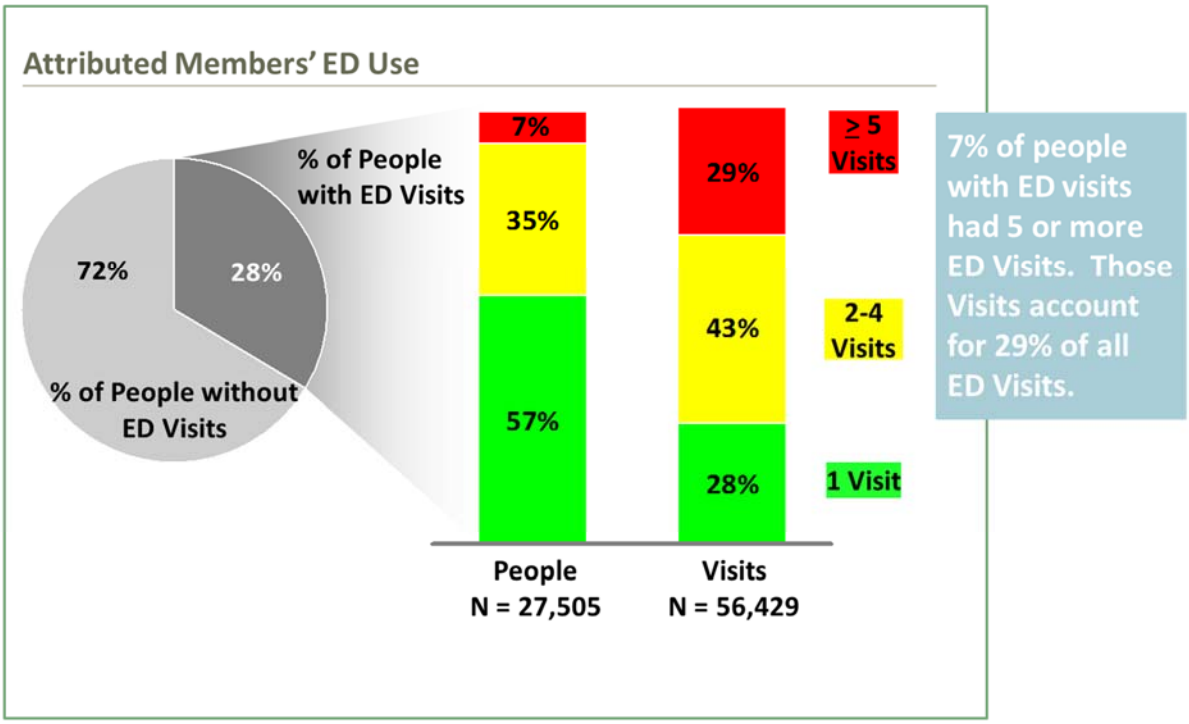
The PPS has set aside $4 million dedicated as incentive dollars to recognize infrastructure investments already made by the network. These incentives are intended to recognize and promote the continuation of efforts partners have already made which correlate directly to the requirements of DSRIP project 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. Sign on bonuses have started to be dispersed which have aided several health care systems in staffing the support staff needed to work in a capitation model. For example, UHS was able to adjust their budget based on their sign on bonus to create wellness coordinator positions across their health system. These coordinators will play a role in care coordination for patients within the UHS system and act as links to the CBOs in the community to ensure communication between a major health care system and smaller clinical and non-clinical community based services.

CCN also recently completed their first round of innovation fund awards where $2 million was set aside to fund innovation projects that would impact the PPS outside of or in parallel with the DSRIP funded projects chosen by the PPS. One of the awards was to Our Lady of Lourdes Memorial Hospital, Inc. (Lourdes) which was awarded $235,000 to develop what they are calling TelePST, Virtual Problem-Solving Therapy through MSWs and Medicaid Members. Technology will be placed in the patients' homes who have issues with depression so that they may access the services of an MSW trained in

depression care, self-care management techniques and having links to community organizations to aid the patient in counseling services focused on empowering and educating the patient on community resources to aid in an current episodic instance of depression as well as continuing services that the patient can then utilize to minimize crisis in the community. Lourdes was awarded an additional $412,000 to fund mobile outreach programs which will work to address care in the community preventing avoidable ER and in-patient admissions as well as Emergency Department coaches which will be trained to assist patients seen within the ER on follow up services, basic care coordination services to educate patients as well as providing alternative levels of care, outside the ER, to address their needs and aid in getting them into preventable health care treatment programs. Cayuga Area Preferred (CAP) was awarded $537,000 to pilot a VBP program amongst the physician practices participating with CAP, a key step to migrating practices to VBP. Guthrie was awarded $241,000 to initiate a program centered around ensuring patients with a diagnosis of CHF receive better preventative care before progression in their disease requires higher level of care and to reduce the requirement of that higher-level care by offering more robust services and early detection. The two remaining awards included a Mobility Management award of $225,000 to Rural Health Network of South Central NY and funding to CareFirst Hospice and Palliative Care organization which will partner with Guthrie and Lourdes on developing the HOMR (Hospital One-year Mortality Risk) research tool into practical applications to help identify patients who may benefit from palliative care services sooner as well as to help in normalizing the end of life discussion and increasing the Hospice stay rate across the PPS to meet and hopefully exceed the national average of 15 days in Hospice. These ancillary services will benefit patients directly in aiding in a large social determinate of health, transportation, and bringing needed additional assistance and data to physician groups so that they may better work to the top of their licensure. CCN will have an Innovation Fund RFP for DY3 and DY4 with an additional $2 million available for innovation awards for both of those years as well as for DY5 where $1 million for innovation awards is available.

In addition to DSRIP project specific funding each RPU has a budget to offer incentives within their region. All four RPUs are currently looking at models to fund CBOs in obtaining credentialed level staff such as MSWs, LCSWs, RNs and NPs. The focus is on rural areas often not awarded tuition reimbursement for staff as the funds are exhausted in the metro city areas which drives most of the workforce out of the PPS or at least into the metro city areas only. MSWs and LCSWs, while not PCPs, help to backfill a needed gap in care. Working at the top of their licensure they can provide episodic as well as continual behavioral health counselling services at CBOs and integrated within PCPs. This effort benefits the existing PCPs in working to the top of their licensure with better informed advice from clinicians to improve the quality of physical care for their patients. Staffing palliative care, certified home health agencies and the like with RNs and NPs works in the same manner to aid the PCP with the insight in the community to fully inform the PCP of the care needed for a patient, as applicable.

To assist in identifying needs, the analytics team has identified low, medium and high utilization of ERs (see Figures 6 and 7) and broken the data down by county of attribution for Medicaid patients including age range. As detailed earlier, since the age range across the PPS was stable for stratification within specific RPUs these numbers are replicated at the RPU specific level.



Source: Salient Interactive Miner; team analysis of claims data.
Time Period: June 2014 to July 2015

Figure 6: CCN PPS Super Utilizers of the ER

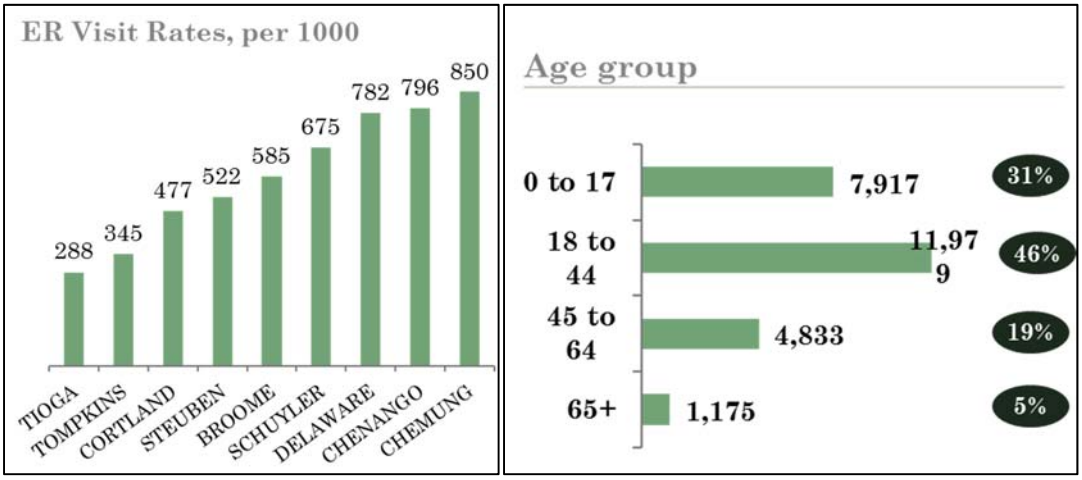
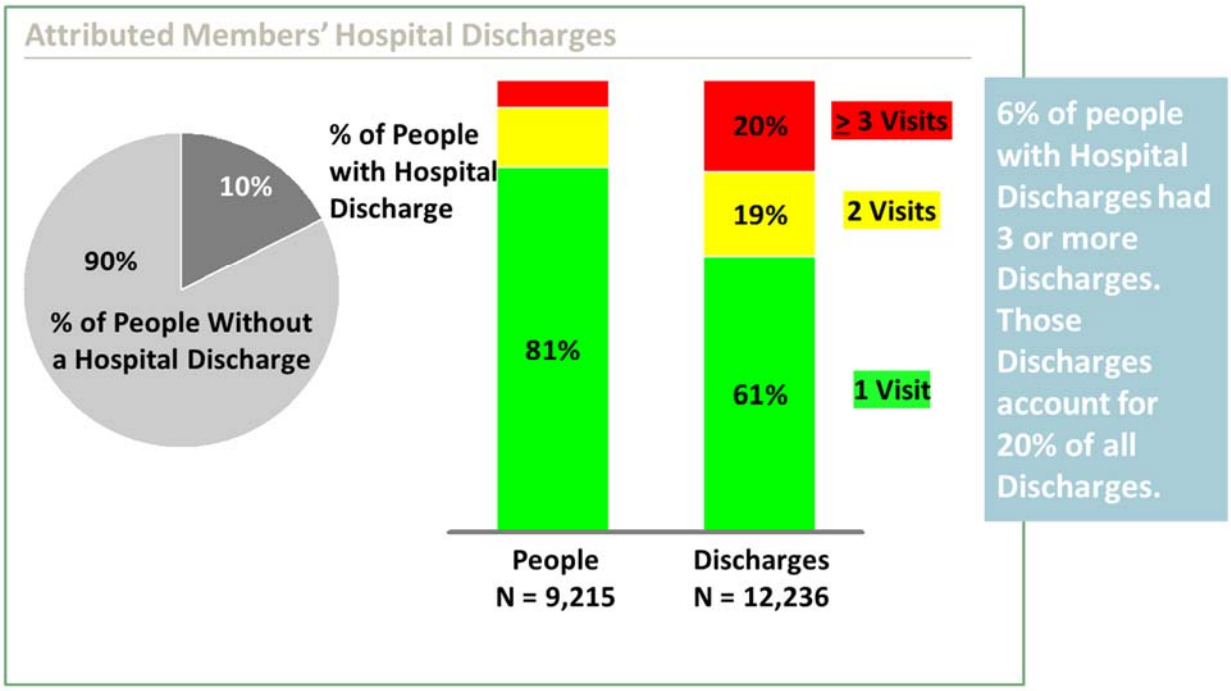


Figure 7: CCN PPS ER Rates by County and age break down

The team then identified low, medium and high utilization for inpatient hospitalizations (see Figures 8 and 9). This data is obtained via discharge data through Salient Interactive Miner as CCN does not have full access to this data from each hospital individually within the PPS.



Source: Salient Interactive Miner; team analysis of claims data.
Time Period: July 2014 to July 2015

Figure 8: CCN PPS Super Utilizers of IP Care based on Discharge

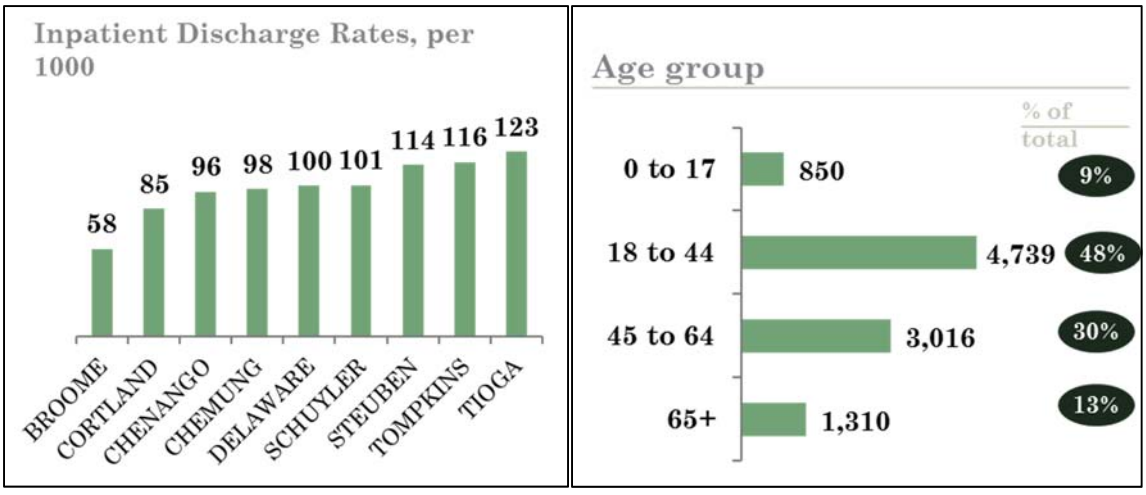


Figure 9: CCN PPS IP Rates by County and age break down

The work has begun to break this analysis down by county level as well to identify cohorts of super utilizers to focus rapid cycle improvement processes with the health care systems which will work to benefit Primary Care Providers, as in some of the identified innovation processes described above. As PCP practice sites work to achieve PCMH certification this data will prove beneficial to them in

identifying the access to care required as well as appropriate staffing for afterhours access to care. Since we overlap with PPSs in both the WRPU and ERPU as well as overlapping with health care systems in the PPS, members often seek services with multiple partnering organizations making this data analysis for one individual health care system next to impossible to fully achieve. In addition, smaller physician practices lack the resources in both funds and administration to run detailed analysis. These services are being provided by CCN to all partnering organizations to better baseline the PPS as a whole, each RPU and when applicable broken down to the county, zip code and servicing provider level.

Coupling the above data with the data warehouse CCN is developing that will collect data from both CBOs and Physician practices, the PCP and care coordinators will have a better picture as to the real needs of a patient. PCPs will be freed up to focus on entering an exam room to deliver care to a patient, with the added benefit of having additional important information about the patient from other sources to allow the PCP to better analyze, diagnose and discuss the care plan with the patient. It is the belief in this truly integrated system it will drive not only patient satisfaction but physician satisfaction which increases retention, increase quality and access to care while reducing duplication of services, and thus driving down costs.

Lastly, since the concentration of independent primary care practices are in the NRPU, CCN has supported the consulting fees of Research & Marketing Systems (RMS) to help them go through the application process to achieve PCMH 2014 Level 3. These smaller practice sites are eager to obtain PCMH recognition but the overall build in infrastructure, coupled with the work load associated with application process was proving to be too heavy of a lift. With expertise in coordinating PCMH recognition, RMS will help these independent practices that may not have had the time or resources to make the transition to PCMH by September 2017. Working in conjunction with the NRPU PCMH quality subcommittee, RMS has begun the efforts to assess eight practices encompassing seventeen sites and sixty-eight providers. Eight practices within the NRPU are not interested in PCMH certification and either do not currently bill Medicaid or do not wish to participate in the DSRIP efforts. Unless requested, outreach, invitation to participate as well as educational materials and opportunities are still provided to any partners not currently in a position to participate with the DSRIP efforts. The PPS Primary Care Provider (PCP) Network Analysis, provided to CCN to aid in the formation of the primary care plan helped to identify that these eight practices are not currently listed as safety net providers or the number of overall Medicaid lives is small and services for these members may be accessible within a PCMH setting.

2 - How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?

As noted in publications from sources such as the American Medical Association Journal and the US National Library of Medicine, there has been a decrease in Primary Care Physicians (PCP) due to medical students pursuing specialties rather than going into primary care. This coupled with the retirement rates within our community leaves the nine-county region lacking adequate numbers of PCPs in areas defined as HPSA counties. PCMH 2014 level 3 certification plays a major role in primary care expansion, and Care Compass Network will be providing support to practice sites in a multitude of ways to achieve this certification. The need for electronic communication to keep PCPs at the center of care

when their members are offered services elsewhere is key. RHIO connectivity with inclusion of the SHIN-NY will help build the technology needed for PCPs to access all available records pertaining to their patients and provide better care and effective care management. CCN has recently awarded innovation funding in the South RPU for a telehealth initiative. Establishing a TelePST program will provide basic problem solving skills, coping skills, education on access for health care and emphasize the importance of establishing and maintaining a primary care provider relationship over a series of six video TelePST sessions. This program will impact Medicaid members in Broome, Tioga, Chenango and Delaware Counties.

CCN is devoted to providing incentives to practices to achieve NCQA PCMH 2014 level 3 through consulting funds, incentive funds up to $40,000 for the process of completing and achieving PCMH 2014 Level 3 certification, as well as a sign on bonus that includes a tier of funds for having already achieved PCMH 2014 level 3. CCN will continue to engage PCPs and help find a way to build a team with them, across the PPS, so they may fully participate in the PCMH process. Through educational efforts tying together DSRIP project work and PCMH standards for certification, CCN aids practice sites, especially those smaller practices lacking more administrative roles, with a quick glimpse to see how the efforts they put into one initiative tie to another. In a landscape where our providers are looking at not only PCMH Certification, CCNs eleven DSRIP projects, Medicare initiatives through MACRA, MIPS and/or APM, EHR standards and incentives, RHIO connectivity and more, the PPS plays a critical role of helping the practices navigate through the maze of overlapping PPSs, RHIOs, incentive programs and standards through programs tied with DSRIP initiatives and those that are not but can be influenced by the DSRIP efforts such as MACRA and understanding APM.

From the 58 partners that indicated some type of electronic health record (EHR) or electronic medical record (EMR) existed at their site in the original survey assessment, only 15 identified as offering primary care services. The general lack of EMRs across PCPs, clinical and non-clinical sites has been identified as a need for the PPS. In order to ensure electronic tracking of a member receiving services across the region, it is important to build an electronic infrastructure that allows PCPs to obtain and share clinical information and information related to social determinants of health that is essential to the continuum of care for patients. Through the Capital Restructuring Finance Program (CRFP), CCN has secured the necessary funding to deploy an IT infrastructure that will support these activities for PCPs. With the award of the CRFP funds CCN put forth several Request for Proposals (RFPs) in May of 2016. The proposals CCN receive covered EMRs as well as other technical platforms to aid in getting sites access to the electronic systems needed given their unique business model and patient population and to be able to better share information, securely, for continuum of care. The proposals CCN received were in the following categories: Behavioral Health Screening Tool (BHST), Population Health and Care Management (PHM), Long-term Care Post-Acute EMR (LTPAC), Primary Care EMR system (PC) and Telemedicine and Telehealth Technology (TM). The PC platform will be of most use to a PCP practice site who is currently lacking an EMR in addition to the TM technology so that a PCP can expand care through telehealth and telemedicine platforms to offer care where the patient needs the care. Onsite presentations and meetings have begun from the vendors and selection committee comprised of various partners amongst the PPS, including those who have a good understanding of electronic infrastructures related to EMRs, screening tools and the like. However, it was critical to ensure the inclusion of committee members who did not have a technical background so that they could help the committee in deciding on a platform that not only incorporated the technological needs for the

intended group using the IT platform, but, the platform chosen was one not technically challenging for any user. The committee selection was broad asking for volunteers to join for the selection process and included practice managers, care coordinators and staff from PCP practice sites as well as credentialed staff in nursing from clinical community organizations. The selection committee for each RFP will present the recommended options to CCN's Clinical Governance Committee, the IT Informatics and Data Governance committee and the Board of Directors.

The vendors selected to participate in the process are offering electronic processes to streamline the behavioral health screening tools. Some may also offer the ability to add additional survey like tools in the platform for use in multiple locations but beneficial to primary care. These could include the electronic adaptation of surveys and forms such as the PAM Survey and eMOLST which would benefit the primary care physician and staff as well as the patient receiving services. Having access to the PAM survey score in the electronic database could aid a physician and the staff at a PCP practice site a better understanding of the health literacy level and engagement of the patient which then helps them form their discussion of diagnosis, treatment and preventative measures at a level the patient can understand. As PCPs move into offering more appropriate levels of palliative care in the clinic setting, eMOLST access becomes critical so not only can a physician access the eMOLST system in a more stream line manner, through their EMR and not external, but, they can electronically collaborate with other physicians often responsible for altering a care plan with patients: In patient palliative care, specialists in disease classes and pain management, pharmaceutical, social workers etc. And foremost the BH screens and diagnosis from community based behavioral health clinics then also become accessible to the PCP. With the inclusion of a behavioral health diagnosis, medications prescribed by BH specialists all alter the course of physical care the PCP needs to be aware of and can cause complications without the inclusion of this information. This also aids practice sites interested in the 3.a.i Integration of Behavioral Health and PCMH Practices beginning implementation of the project. Even though CCN will have a full integration model embedding the BH specialist directly into the PCMH site, the efficient flow of real time BH screenings, scoring and recommendations will help keep efficiencies in the office setting. The tentative finalization of the selection process for BHST is due to conclude in late October of 2016 and the PPS can begin the electronic implementation across the PPS by December 2016. The PHM platforms will offer a unique tie between community based organizations (CBO) offering care/case management services and clinical sites who may also offer case management services. The PHM platform vendor selection process has begun with the selection committee reviewing and rating each submitted proposal. The process is currently slated to complete by mid-December 2016 so CCN can begin implementation in January 2017. This platform will be the main structure in place for full electronic implementation of care coordination services across multiple providers, multiple systems and a vast geographic area. The LTPAC, PC and TM proposals are all in the process of being evaluated by the selection committees for each. The tentative schedule for completion of those is January of 2017 so CCN can begin the implementation process February 2017.

Upon implementation of these processes, electronic documentation services will be available for agencies and will broaden the communication between partners across the PPS. In this process, primary care is a lead focus as any system chosen to aid those physician sites currently lacking a robust electronic system. We see in practice multiple EMRs and multiple electronic systems that do not communicate which each system smoothly. Physicians, regardless of practice location and specialty, often complain of EMR fatigue, needing one platform, less clicks, less external sources to have to access,

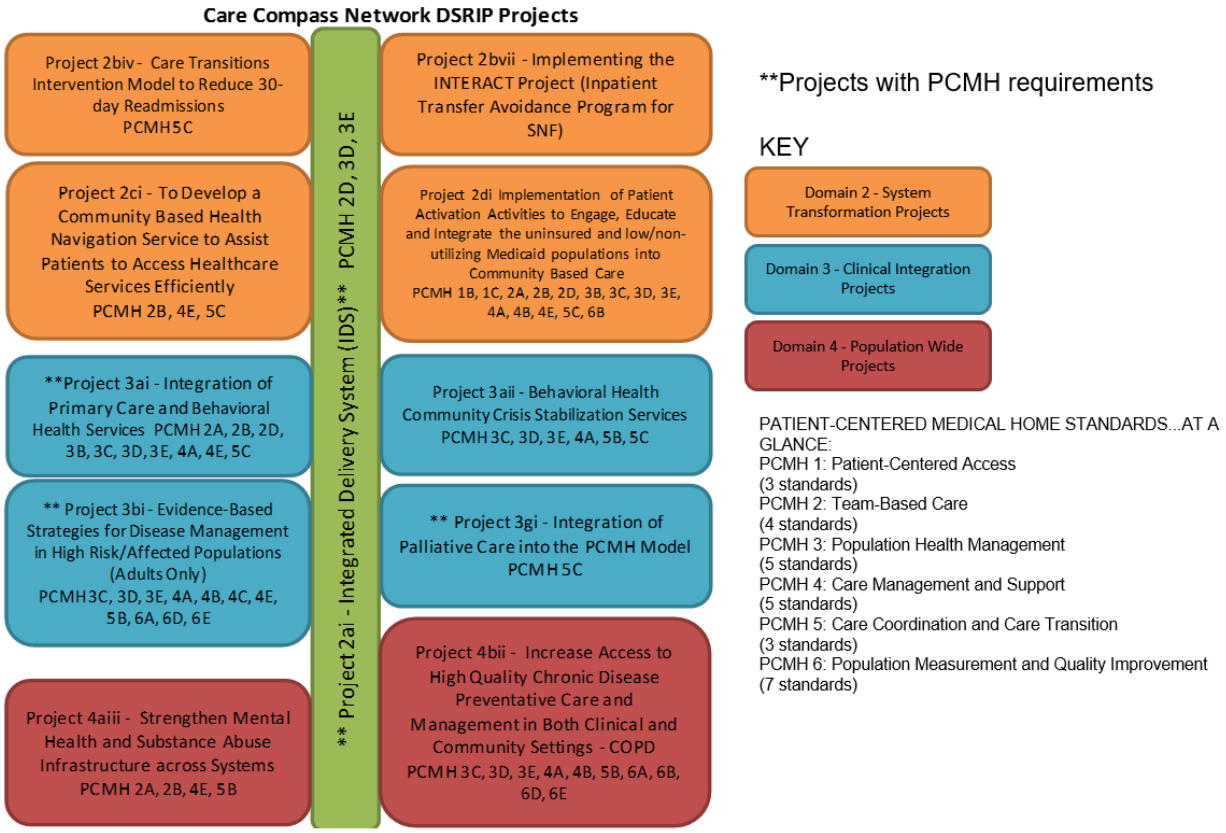
sign into and the like so that they may focus care on the patient and not on the computer. This improves the quality of care a patient receives as well since most satisfaction scores show that when patients believe their physician focused more on a computer than on them their scores reflect this. As patient satisfaction scores rise physician and staff satisfaction also increases. This overall effect increases the quality of care a patient receives and often improves productivity, efficiency and drives down cost. This requires the ability to electronically integrate with the RHIO's, SHIN-NY and other technical platforms for true integration of care through medical record and case management tracking. Once each platform has been selected CCN will aid in the training and support of this implementation with adequate resources for each PCP to reduce the disruption as much as possible while aiding in fulfillment of the benefit of the EMR. The analytics team has begun the process of identifying practice sites in greatest need of electronic integration. This initial step helps bridge the gap in an electronic system for those sites currently not connected electronically. The next step will be identifying the required training. Each vendor chosen has different trainings that are available for their system, they will work in conjunction with CCN's IT and project management office to roll out the electronic system specific training to partners. CCN's IT department will work between vendors for separate systems and the practice site to ensure integration between multiple systems selected and then train both the clinical and non-clinical staff on full use of the system at their practice location.

CCN is working on the development of care coordination efforts as a function and not necessarily an individual in all cases. The electronic infrastructure is needed in order to fully implement care coordination in this manner, but, once developed training will be available for all levels from non-clinical CBOs and clinical CBOs to PCP practice sites and hospital systems so the full care team members know how they will access important and pertinent information related to the Care Plan for an individual patient. The PPS has staff dedicated to working on primary care initiatives and implementation of primary care related projects. This staff is continuously working on opportunities to electronically integrate primary care providers and provide continuing training to them using our online learning tool which we license from Health Workforce New York (HWapps). Any initial trainings will be available for reference on the HWapps platform. In addition, as trainings are developed through the implementation of the eleven DSRIP projects, continuing analysis identifying gaps in coverage and care across the PPS, as well as best practices identified in implementation any trainings created to incorporate these needs will also be available for partners on the HWapps platform.

Throughout CCN, regional stakeholder meetings are held which include participation from PCPs, practice managers, nurses, clinical staff, behavioral health specialists, government agencies health system administrators and CBOs. There is open discussion amongst the groups of not only the needs of the PPS and the patients, on a regional level, but the sharing of best practices across a consortium of partners so they all keep the same goals in mind and understand their effort is directly affecting another organizations output and the care of the patient that crosses through these systems. There is a very collaborative effort in these meetings where you have the agencies that are supporting the efforts of the PCPs directly listening to the need of the PCP practice sites and working together to regionally implement their combined efforts for the most efficient and highest quality care for the holistic care of the patient.

3 - What is the PPS's strategy for how primary care will play a central role in an integrated delivery system?

Given the diverse nature of CCNs 9 counties it is important to keep consistency within the delivery of services for continuum of care across the PPS and in overlap regions, but also, provide care in a unique manner to better service the community and PCPs serving these members. The service delivery will vary greatly if a member is within a metro city setting, suburban setting or rural area. How the care is delivered is centered around the PCP and the services they access for their unique member population.



As seen in the above graphic, Project 2ai, the Integrated Delivery System project, acts as the spine of the implementation plan to transform the delivery of health care back to a focus on primary care with the PCP at the center of the team. The incentives aid in the migration from the current delivery of services focused on an inpatient setting to community based care. Re-education of members and partners along with building relationships between clinical and non-clinical groups is a foundation of the framework for true system transformation. Through team building efforts the PCP is the beginning and end of delivery for the associated member. With the focus of PCPs at the center of care CCN can identify the true care coordination and case management needs of the PPS once the infrastructure is built to support the proposed level of care coordination. This integration will aid PCPs in a sustainable manner so they can communicate and receive in information required from CBOs, Behavior Health, Palliative Care Agencies and the like to understand the social determinates of health and the role they play in the overall physical healthcare and education for the member at hand.

In addition to these implementation efforts, our six corporate partners are heavily represented in our governance committees. The full board includes the CEOs of the PPS six member organizations as well as five board members voted from the PPS Stakeholders, as facilitated through the PAC Executive Council. In addition to representation from the six health systems, Cayuga Area Plan/Preferred (CAP) is an Accountable Care Organization (ACO) providing services to beneficiaries located throughout the Tompkins county area. CAP had previously been operating in the CCN North RPU as a federally certified Clinically Integrated Network (CIN) representing a population of independent physicians throughout Schuyler, Tompkins, and Cortland counties. The newly established CAP ACO is a clinically integrated network made up of these same 215 primary care physicians, specialty physicians, along with Cayuga Health System and its facilities who are dedicated to bringing a system of high quality, coordinated healthcare to our region. There are several representatives from the CAP team that participate in the CCN governance committees. The governance committees of CCN contain a good mix of healthcare system members and members from community based organizations who provide a multitude of services. On the Clinical Governance Committee and Compliance & Audit Committee about 66% of the members represent healthcare system providers with the remaining 34% representing community based providers. On the Finance Committee about 55% of the members represent healthcare system providers with the remaining 45% of members being community based providers. On the IT Committee representation is 50-50 between healthcare system providers and community based providers. In the RPU Quality committees the majority in most of the committees is membership from community based providers with the South RPU having 67% members from CBOs, the North RPU having 70% of members from CBOs, the West RPU having 65% members from CBOs and the East RPU having 86% members from CBOs. Representation of healthcare system providers, the FQHC and the ACO in the CCN governance committees are displayed in the table below.

Committee	**Name and Title**	**Organization**
Board of Directors	John Rudd, President/CEO	Cayuga Medical Center
Board of Directors	Joseph Scopelliti, M.D., President/CEO	Guthrie Clinic
Board of Directors	Kathryn Connerton, President/CEO	Our Lady of Lourdes Memorial Hospital, Inc.
Board of Directors	Mark Webster, President/CEO	Cortland Regional Medical Center
Board of Directors	Matthew Salanger, President/CEO	United Health Services Hospitals, Inc.
Board of Directors	Rob Lawlis, Executive Director	Cayuga Area Plan/Preferred (CAP)
Board of Directors	Walter Priest, Executive Director	Family Health Network (FQHC)
Clinical Governance Committee	Anita Newman, Patient Care Coordinator	United Health Services Hospitals, Inc.
Clinical Governance Committee	Annie DePugh, Director Population Health	United Health Services Hospitals, Inc.

Clinical Governance Committee	David Evelyn, MD, Vice President Cayuga Medical Affairs	Cayuga Medical Center
Clinical Governance Committee	Douglas Rahner, MD, Family Medicine	Family Health Network (FQHC)
Clinical Governance Committee	John Giannone, MD, Family Medicine and Primary Care	United Health Services Hospitals, Inc.
Clinical Governance Committee	Laura Manning, Director Operations and Human Resources	Guthrie Clinic
Clinical Governance Committee	Russell Woglom, MD, Corning Medical Director	Guthrie Clinic
Clinical Governance Committee	Michael Lavin, MD, Psychiatry Director	Lourdes Center for Mental Health
Clinical Governance Committee	Frank Floyd, MD, Associate Medical Director, Primary Care	United Health Services Hospitals, Inc.
Compliance & Audit Committee	Ann Homer, Corporate Compliance and Privacy Officer	Family Health Network (FQHC)
Compliance & Audit Committee	Pete Chermak, Director of Corporate Responsibility/HIPAA Responsibility	Our Lady of Lourdes Memorial Hospital, Inc.
Compliance & Audit Committee	Susan Eoannou, Corporate Compliance Officer	Cortland Regional Medical Center
Compliance & Audit Committee	Roger Lathrop, Compliance Officer	Guthrie Clinic
Compliance & Audit Committee	Caroline Louey, Compliance Director/Officer	Cayuga Medical Center
Compliance & Audit Committee	Francis Macafee, Vice President, Finance/CFO	Guthrie Clinic
Compliance & Audit Committee	Pat Nervina, Corporate Compliance Administrator	United Health Services Hospitals, Inc.
Compliance & Audit Committee	Anne Wolanski, VP, Quality & Risk Management/CRO	Our Lady of Lourdes Memorial Hospital, Inc.
Finance Committee	Dave MacDougall, Senior VP of Finance and Information Services, System CFO	United Health Services Hospitals, Inc.
Finance Committee	Denise Wrinn, VP Finance/CFO	Cortland Regional Medical Center
Finance Committee	John Collett, VP/CFO	Cayuga Medical Center

Finance Committee	Paula Bilodeau, CFO	Family Health Network (FQHC)
Finance Committee	Rick Bennett, CPA, EVP/CFO	Guthrie Clinic
Finance Committee	Sean Mills, CFO	Our Lady of Lourdes Memorial Hospital, Inc.
IT and Data Governance	Bert Robles, Chief Information Officer	Guthrie Clinic
IT and Data Governance	Bob Duthe, Chief Information Officer	Cortland Regional Medical Center
IT and Data Governance	John-Paul Mead, MD, PCP and EMR Director	Cayuga Medical Associates
IT and Data Governance	Rob Lawlis, Executive Director	Cayuga Area Plan/Preferred (CAP)
IT and Data Governance	Sri Poranki, PI Facilitator/Lean Engineer	United Health Services Hospitals, Inc.
IT and Data Governance	Susan Carman, Chief Information Officer	United Health Services Hospitals, Inc.
Governance Sub-Committees	**Name and Title**	**Organization**
VBP Committee	John Collett, VP/CFO	Cayuga Medical Center
VBP Committee	Dave Clements, AVP Business Analytics & Managed Care	Our Lady of Lourdes Memorial Hospital, Inc.
VBP Committee	Dave MacDougall, Senior VP of Finance and Information Services, System CFO	United Health Services Hospitals, Inc.
IT Technology Advisory	Rob Lawlis, Executive Director	Cayuga Area Plan/Preferred (CAP)
IT Technology Advisory	Annie DePugh, Director Population Health	United Health Services Hospitals, Inc.
IT Technology Advisory	Bob Duthe, Chief Information Officer	Cortland Regional Medical Center
IT Technology Advisory	John-Paul Mead, MD, PCP and EMR Director	Cayuga Medical Associates
IT Technology Advisory	Sri Poranki, PI Facilitator/Lean Engineer	United Health Services Hospitals, Inc.
IT Technology Advisory	Joseph Tokash, Director, Infrastructure and Communications	Guthrie Clinic
IT Technology Advisory	Thomas Yeager, Chief Medical Information Officer	Guthrie Medical Group
IT Technology Advisory	Wayne Teris, Chief Medical Information Officer	Our Lady of Lourdes Memorial Hospital, Inc.
IT Technology Advisory	Sandra Cherinko, Director Specialty Services	Our Lady of Lourdes Memorial Hospital, Inc.

IT Technology Advisory	Stacie Hanson, Quality Manager	Our Lady of Lourdes Memorial Hospital, Inc.
IT & Data Security	Susan Carman, Chief Information Officer	United Health Services Hospitals, Inc.
IT & Data Security	James Cicak, IT Security Manager	Guthrie Clinic
RPU Quality Committees (sub-committees to Clinical Governance)	**Name and Title**	**Organization**
West RPU Quality Committee	Laura Manning, Director Operations and Human Resources	Guthrie Clinic
West RPU Quality Committee	Russell Woglom, MD, Corning Medical Director	Guthrie Clinic
West RPU Quality Committee	Adrienne Abbott, VP Nursing	Guthrie Clinic
West RPU Quality Committee	Donna Chapman, Director of Human Resources and Labor Relations	Guthrie Clinic
West RPU Quality Committee	Gale Stermer, Director of Clinical Data Reporting	Guthrie Clinic
West RPU Quality Committee	Garrett Hoover, President Corning Hospital	Guthrie Clinic
West RPU Quality Committee	Michael Post, Behavioral Sciences	Guthrie Clinic
West RPU Quality Committee	Rebecca Polly, Manager of Patient Services	Guthrie Clinic
West RPU Quality Committee	Rita Urbanek, Senior Director, Quality	Guthrie Clinic
West RPU Quality Committee	Sheree Vail, System Director, Care Coordination/Social Work	Guthrie Clinic
West RPU Quality Committee	Brian Cassetta,	Guthrie Clinic
South RPU Behavioral Health	Michael Lavin, MD, Psychiatry Director	Lourdes Center for Mental Health
South RPU Behavioral Health	Sue Law, Nurse Manager	United Health Services Hospitals, Inc.
South RPU Behavioral Health	Ellen Jones, LCSW	United Health Services Hospitals, Inc.
South RPU Behavioral Health	Cindy Fletcher, Social Worker	United Health Services Hospitals, Inc.
South RPU Disease Management	Frank Floyd, MD, Associate Medical Director, Primary Care	United Health Services Hospitals, Inc.
South RPU Disease Management	Karen Bayer, Director Community Health Services	United Health Services Hospitals, Inc.

South RPU Disease Management	Susan Paradez, Certified Dietitician Nurtitionist	United Health Services Hospitals, Inc.
South RPU Disease Management	Kris Marks,Pallative Care Administrative Director	United Health Services Hospitals, Inc.
South RPU Disease Management	Kathleen Wold, Director Quality Management	United Health Services Hospitals, Inc.
South RPU Disease Management	Julie Howard,	Our Lady of Lourdes Memorial Hospital, Inc.
South RPU Disease Management	Debbie Blakeney, AVP Continuum of Care	Our Lady of Lourdes Memorial Hospital, Inc.
South RPU Onboarding	Annie DePugh, Director Population Health	United Health Services Hospitals, Inc.
East RPU Quality Committee	Anita Newman, Patient Care Coordinator	United Health Services Hospitals, Inc.
East RPU Quality Committee	Chris Kisacky, VP Operations	United Health Services Hospitals, Inc.
East RPU Quality Committee	Dotti Kruppo, Director Delaware Valley Hospital	United Health Services Hospitals, Inc.
East RPU Quality Committee	John Giannone, MD, Family Medicine and Primary Care	United Health Services Hospitals, Inc.
North RPU Disease Management	David Evelyn, MD, Vice President Cayuga Medical Affairs	Cayuga Medical Center
North RPU Disease Management	Emily Mallar RN, MS, Director, Care Management	Cayuga Area Plan/Preferred (CAP)
North RPU Disease Management	Darshan Patel, MD, Vice President Medical Affairs	Cortland Regional Medical Center
North RPU Disease Management	Danielle Jones, RN, Care Coordinator	Cayuga Area Plan/Preferred (CAP)
North RPU Disease Management	Millissa Ross, Field Supervisor	Cortland Regional Medical Center
North RPU Disease Management	Joan Skawski, Director of QI and CM	Cortland Regional Medical Center
North RPU Behavioral Health	Kim Osborne, Vice President for Operations	Family Health Network (FQHC)
North RPU Behavioral Health	Mary Wright, Vice President Nursing Services	Cortland Regional Medical Center
North RPU Behavioral Health	Jeanne Chapple, RN, BSN, Director of Behavioral Science Unit	Cayuga Medical Center
North RPU Behavioral Health	Bernice Hayward,RN, MSN, Care Coordinator	Cayuga Area Plan/Preferred (CAP)

North RPU Behavioral Health	Hank Gerson, MD, Medical Director Behavioral Science	Cayuga Medical Center
North RPU Onboarding	Lisa Tinelli-Marshall, Certified Applications Counselor	Family Health Network (FQHC)
North RPU Onboarding	Nancy Fuller, Director HIM and Privacy Officer	Cortland Regional Medical Center
North RPU Onboarding	Wendy Kolodziejczyk, Patient Financial Service Manager	Cortland Regional Medical Center
North RPU Onboarding	Carrie Stock, MHA, Manager Analytics & Practice Support	Cayuga Area Plan/Preferred (CAP)
North RPU PCMH	Douglas Rahner, MD, Family Medicine	Family Health Network (FQHC)
North RPU PCMH	Kelly Hirsch, Director of Quality Improvement	Cortland Regional Medical Center
North RPU PCMH	Susan Ryan, Director of Case Management	Cortland Regional Medical Center
North RPU PCMH	Susan Penny, Practice Manager	Ithaca Primary Care
North RPU PCMH	Amy Carver, MBA, Business Analyst	Cayuga Area Plan/Preferred (CAP)
North RPU PCMH	Meredith Titterington,MA, Practice Support Specialist	Cayuga Area Plan/Preferred (CAP)
North RPU PCMH	Gail Rhodes, Practice Manager CMA	Cayuga Medical Associates
North RPU PCMH	Laura Manning, Director Operations and Human Resources	Guthrie Clinic

4 - What is the PPS's strategy to enable primary care to participate effectively in value-based payments?

Financial stability milestones 6, 7, and 8 are all centered around the process by which Care Compass Network (CCN) will aid in facilitating Value-Based Payment (VBP) agreements. In August of 2015 the VBP Sub-Committee was formed and is chaired by John Collett, CFO, Cayuga Medical Center, one of the lead hospital and medical group organizations located in the PPS. United Health Services Hospitals (UHSH) and Our Lady of Lourdes Memorial Hospital, Inc. (OLOL) also have members who sit and are active on the VBP committee that meets on a monthly basis. This directly links three major medical groups to the formation of the PPS wide plan for VBP agreements and implementation**.** On September 30th, of 2015 a contract was executed with John Gahan, formally with DOH, who came with a high level of expertise and experience in VBP arrangements. In December of 2015, Mr. Gahan attended each of the four Regional Performing Unit's (RPU) stakeholder meeting to deliver a VBP presentation

and was open for discussion at each. He also presented at the PAC Stakeholders meeting on December 11th, 2015 where the presentation was recorded and made available on CCN's website for those that may not have been able to attend one of the five meetings where this was presented as well as to be used for later reference.

CCN's strategy to enable primary care to participate effectively in VBP arrangements includes building relationships between Community Based Organizations (CBOs) and Physician Networks & Practices to cover non-medical needs for patients. The social determinants of health are often situations CBOs are aiding a patient in navigating through, but is often not communicated to the physicians caring for the patient. Likewise, the physicians are often disconnected from the social determinants their patients are facing leaving a disconnect between the care a physician is attempting to offer and the care the patient is eligible to receive. There is no state or national data tracking the outcome of fulfilling social determinants of health. This is the key needed to form more useful relationships between healthcare systems and CBOs so the data can be used to inform the VBP model. The PPS is continuing its education on Value-Based Payment arrangements through the completion of the milestone which includes a step for regional payer forums where CBOs and network providers can come and get an understanding of how they can participate in the value-based payment world that will grow throughout DSRIP. One such forum occurred on August 25th with United Healthcare and was attended by more than 40 individuals from more than 30 organizations (mostly CBOs). We are encouraging partners contracting with the MCOs to model their arrangements in ways that align with DSRIP such as using the same metrics from the projects in which they are participating.

CCN has noticed there is wide spread confusion among providers in the network on other VBP programs such as Merit-Based Incentive Payment System (MIPS) as part of Medicare delivery system reform. CCN believes the same level of confusion will exist for providers on DSRIP efforts and VBP arrangements through Medicaid delivery system reform. To mitigate this confusion, CCN will continue to provide forums and education to partners and guidance on the project work. The focus will be on transforming the delivery of care through an incentivized structure. Education is a critical step for PCPs to transform from a fee-for-service to a value based payment system. In addition to forums, CCN also maintains a VBP section on the website for continuing educational resources and references available to the general public.

The CCN analytics and population health management team will work in systems similar to those used by the Managed Care Organizations (MCOs) to outline and track physician excellence. This analytical model will assess the standards put forth by the PPS and at a high level CCN will be able to see those achievements and identify gaps to those standards. Through this process CCN can then drill down into the data to the level of one associated member and the PCP at the head of their care team. Through this analysis, CCN can fine tune the project implementations and help transform PCPs into a VBP system such as the MCOs have begun implementing with the physician groups. These analytics will then help drive over all care coordination services, identifying members to aid in educating them on needs, offering effective interventions and aiding in the relationship building between PCPs and CBOs. The link between these groups will make a VBP payment processes deployable across physician networks, keeping PCPs as the center of gravity of the care team while offering a financial mechanism to incentivize and coordinate community based care for all the needs of the attributed member.

Key issues for shifting to VBP such as technical assistance on contracting and data analysis, ensuring primary care providers receive necessary data from hospitals/emergency departments, clinical and non-clinical CBOs, creating transition plans, addressing workforce needs and behavioral health

integration will be managed in a multitude of ways and means. As the geographical and organizational structure of our PPS does not lend itself to contracting by the PPS on behalf of the providers, Care Compass Network intends to act as a facilitator or convener between partners in the network and the MCOs. CCN anticipates being able to utilize its population health data and information to support the network partners from an analytics standpoint, and ensuring providers receive data that is necessary for them to create the best arrangements possible. CCN is nearing completion of our Phase 1 implementation of the CCN Data Warehouse, which will bring in data from partners' DSRIP project work, the NY Medicaid claims data, and, moving forward, social determinant data from a variety of sources. Using the Data Warehouse, CCN will build project dashboards and reports, performance metric dashboards, and a variety of reports. We have identified dashboard metrics for project monitoring and have begun building standard performance reports using data currently available to us, including Salient. The CCN Data Warehouse is an integral piece of the IT systems which will support CCN's Population Health approach and the reports will be used to provide technical assistance to CCN's Partners. In addition, the project work of the PPS will serve as case studies to showcase efforts and results to the MCOs so that work done by organizations not typically involved with MCOs could be made reimbursable through new contracts for services.

5 - How does your PPS's funds flow support your primary care strategies?

The concept of 'flexible' was 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. 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. Through the flexible funds flow methodology, the PPS is 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, 3ai, currently in DY2 CCN pays $10 for a behavioral health screening. An example of a performance metric could look like CCN reimbursing $8-9 for the screening and an additional $5-6 for confirmation of a warm hand-off. 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. The CCN Funds Flow Methodology which was introduced to each of the four Regional Performing Units and the PAC Stakeholders at the monthly meeting when the value-based payment discussions outlined in fundamental 4 took place as well. Care Compass Network (CCN) operates as a fully transparent organization and any updates and modifications to the funds flow model are regularly presented to the partners for review and input.

The PPS has allocated approximately $46 million across the waiver period to implement the projects, exclusive of IT and other capital expenses. For DY2, commitments have been made for $5.3 million (as of 10/27/2016) to partner organizations (of which $2.4 million is for CBOs), but this will only happen through actual performance. Few, if any of these sums will be paid directly to primary

care providers as the vast majority of primary care providers in the PPS are under the umbrella of a larger medical group (UHS, Guthrie, Lourdes) with only the providers in the North RPU (Tompkins, Cortland, and Schuyler counties) existing in a more independent fashion, although the majority of those providers are still being tied together through an IPA in Tompkins County (Cayuga Area Physicians, or CAP). In addition, the PPS has allocated $4 million to partner organizations as an incentive for their existing infrastructure (could also be interpreted as an engagement payment) through a sign-on bonus which recognizes previous investments in EHRs, RHIO connectivity, PCMH certification, DSRIP project involvement, and the population of Medicaid members served by those organizations. An additional allocation of $16 million has been set aside as a "high-performance" incentive, the methodology for distribution of which has not yet been determined. Through the reallocation of revenue loss dollars, $7 million has been appropriated for an "Innovation" fund in which partners submit proposals to improve outcomes of the Medicaid members they serve. $2 million is being made available in years 2, 3, and 4 of the waiver period, with the remaining $1 million being made available for DY5. Payments are not being made to fund staff, as CCN took that concept akin to grant funding, which is not something we want to encourage since the goal of DSRIP is to move our partners in the direction of readiness for Value-Based Payment arrangements. Consider the following four steps to "readiness:"

1. Grant-based funding
2. Fee for service funding
3. Fee-for-value funding (Upside only)
4. Fee-for-value funding (Upside & Downside)

All of our partner organizations exist already in at least the first step, grant-based funding. In order to establish a level playing field with regards to Medicaid (as a survey from 2015 indicated none of our partner organizations have any existing VBP arrangements for that population), CCN has adopted a fee-for-service payment structure for DY2 contracting in order to begin the learning and adjustments necessary at organizations currently existing in a grant-based funding world as they begin to prepare for engaging in VBP.

Specific to each project chosen for implementation across CCN's 9 county region, almost $18 million in capital funds have been set aside to help support the technological needs of implementing each of the projects to further aid in the communication. Capital funds have also been allocated for a Telemedicine and Telehealth Technology system useful in care transitions, disease management and behavioral health projects. CCN will be purchasing a care management platform available to all CCN partners for use in population health management work. For partners with an existing population health management system, data integration will be put into place in order to complement these existing population health activities already being undertaken by our partners. A Behavioral Health Screening Tool in addition to the purchase of tablets for contracted partners can be used to load numerous surveys for use in the Behavioral health field such as PHQ-2 and PHQ-9. Also, the potential exists to add additional surveys including, but not limited to, the PAM Survey, the Integrated Palliative Care Outcome Scale (IPOS), and eMOLST. Through the adoption and implementation of these tools, communication to a PCP from providers caring for associated members can be more efficient and effective in care management.

Funds are available as part of the contract with CCN to participate in the Integration of PCP and Behavioral Health project (3ai) to aid in the building of physical space for PCP needs and the building of trained staff to support the team that the PCP leads. CCN has allocated funding through the project 3ai contract for the renovation of space in primary care offices to accommodate Behavioral Health Providers, and likewise in Behavioral Health clinics to accommodate for Primary Care Providers. We provide up to $50,000 for each site for this integration. For project 3.g.i each Palliative Care Agency can obtain up to $20,000 to support the hiring and training of staff to provide home based visits. This will give the PCP a trained team to aid in the continuum of care. As part of the CCN contract for participating in the Integrated Delivery System, CCN has a PCMH certification payment model to provide primary care provider partners up to $40,000 for PCMH 2014 Level 3 certification in either a tiered payment or lump sum model. The funding is available to all provider types, including both the larger medical groups as well as the smaller independent practices. Funding was provided to incent partners to continue in PCMH development prior to the finalization of the PPS funds flow/governance models. Partners who achieved 2011 PCMH Level 3 were eligible for a sign-on bonus in the contracting stage, and would be eligible for a lesser achievement incentive when 2014 PCMH Level 3 is achieved. There are 85 practice sites in the network with 2% of the sites having achieved PCMH 2014 Level 3 certification, 78% of the sites with PCMH 2011 certification and 20% of the sites without any certification.

6 - How is the PPS progressing toward integrating primary care and behavioral health (building beyond what is reported for project 3.a.i)?

Medicaid Accelerated eXchange (MAX) Series

In late 2015, Care Compass Network (CCN) was provided the opportunity to participate in the MAX program. Facilitated by the Department of Health (DOH) and KPMG, MAX is an 8-month intensive learning collaborative bringing clinicians, behavioral health specialists and management staff to transform and redesign the way care is delivered to support the 3ai DSRIP initiatives and outcome metrics.

The CCN project oversight group, the Coordinating Council, was unanimous in support of the behavioral health based integration program and location. Our Lady of Lourdes Memorial Hospital (Lourdes) assembled a team consisting of a Primary care provider, LMSW, Nurse Manager, Operations Manager and Director of Clinical Services for their Robinson Street clinic roll out of project 3ai. CCN dedicated an inclusive PPS PMO resource to support the initiative and pilot development. The location was selected based on its high volume of Medicaid beneficiaries that it served across the PPS. In this effort, CCN was one of eight PPSs participating in the MAX program for integration of behavioral health in primary care.

At the time of implementation, the Robinson Street practice had a minimal awareness of integration concepts however had not yet started the journey. Lourdes Robinson Street was jointly chosen due to its significant Medicaid population served spread among the seven primary care providers (PCP). Initial implementation plan was to embed a BHC at the location one day a week and migrate to full time status depending on the initial assessments and needs of the

clinic. However, due to the high demand and need of the patients, the BHC was working five days per week effective May 2016.

With the level 3 co-location of a BHC in the clinic came many challenges and barriers such as logistics, cultural challenges, education and data management. These included workflow related topics such as patient management, utilization of EMR systems, communication between the BHC and PCP, licensure/billing requirements, provider engagement, referral and care management. The sponsoring organization 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 from Care Compass Network.

Currently, the Lourdes Robinson Street Primary Care has completed its final month of the intensive learning collaborative. Even after this short period of time, the investment in the MAX program has begun to show significant results. A summary of achievements to date are highlighted below:

(1) Embedding a behavioral health consultant on site five days a week at the practice in May 2016.
(2) Successfully completed 1330 PHQ-9 screenings for all patients between the ages of 20-50 age range since March 2016.
(3) 96% screening completion rate for the period of March -September 2016. 1330 out of 1386 PHQ-9 screening
(4) Improvement in patient and provider engagement has been key to the team's success.
(5) Patients prefer the brief intervention model at the primary care site versus the scheduled counseling sessions. This could be due to time constraints or that their depression is situational in nature.
(6) Incorporate Clinic and ED social worker's workflow process to close the gap in care
(7) Screenings and warm hand offs allow the team to refer patients for appropriate treatment and intervention.

The PPS has begun to advertise and showcase these results in an effort to engage the partners of the PPS in Fact Based Optimism and has hosting a MAX workshop in December 2016. This program provided the PPS with local experience which has proven valuable to show the community 'DSRIP is happening' in our region of NYS. The work of DSRIP, although challenging, is possible and is making a difference.

Lourdes Primary Care
Care Compass Network

Our Cohort

(Data reflects Mar '16 – Jun '16)

Adults 20-50 years with mild/acute depression scoring **HQ**

32 (1 day/week)
148 (5 day/week)

Our Actions (Workshop 2 Action Plans)

1. **Coordinated Care**
   ***50** huddles across **7** PCPs completed since implementation*
2. **Expand PHQ9 Screening**
   ***61** referrals made to BH for all PHQ9 scores over 15 since implementation*
3. **Increase PHQ9 Completion**
   ***495** completed PHQ9s since implementation of script*

BRIGHT IDEA!
Bringing the huddle to the provider" – to address availability challenges of providers, the Action Team implemented mini huddles with PCP, nurse and Social Worker focused on behavioral health aspects of care.

Our Impact

(Data reflects Mar '16 – Jun '16)

	BEFORE *(Mar '16 - Apr '16)*	AFTER *(May '16 - Jun '16)*	%Δ *(from Baseline)*
Total Screening Rates	66.5 avg/month	310 avg/month	366 %
Warm Handoffs	4.5 avg/month	15 avg/month	233 %
Follow-up (for PHQ9 score 15-27)	8 avg/month	32.3 avg/month	303 %

Our Story

Patient was referred to SW by a NP due PHQ9 score of 24. SW met with the patient following medical appointment – reported a history of PTSD following a sexual assault and tried counseling once before; however, only went to one session and refused subsequent treatment until now. Patient reported a recent increase in her symptoms of anxiety and depression. Patient agreed to start an SSRI prescribed by PCP and appeared open to counseling. SW discussed options including community agencies, psychiatric services, and new program of coming to PCP office for brief counseling. Patient disclosed that she felt more comfortable coming to her doctor's office as it was a familiar place and liked the idea of the brief intervention approach. Patient agreed to continue seeing SW, stating **"it sounds like a good start, especially due to my past experience with counseling".**

Following the establishment of protocol adoption and implementation of the 3ai program at the Robinson Street clinic, the Lourdes action team is pursuing the incorporation of SBIRT framework to encourage the additional assessment of substance use disorder screening with evidence based tools such as the CAGE-AID, CAGE, DAST 10, or AUDIT depending on the patient's result on the prescreened questionnaires. This is in addition to screening for Depression with the PHQ-9 which the MAX rollout had initially focused on. The lessons learned are being shared with the CCN project team so best practices can be shared with organizations across the region. At this time these screenings are recorded on paper until which time the RFP's outlined in Fundamental #2 are fully implemented. These tools represent a strong representation of screenings adopted by the CCN Clinical Governance Committee and Board of Directors in October 2015, including:

- Depression: PHQ-9
- Anxiety: GAD-7
- Substance Abuse: CAGE-AID, AUDIT, DAST, CRAFFT and NIAAA
- Trauma: PC-PTSD, PCL-C
- Suicide / Violence: Nursing Assessment for Suicide/Violence (4 Questions), 4Q, UHS Long Version
- BH Works Screening Tool
- 'CCN Treatment Protocol and follow up guidelines' based on PHQ-9
- Generic Screening Tool and Follow-up Protocol
- SBIRT – Screening, Brief Intervention and Referral to Treatment
- Pediatric Symptom Checklist - PSC

With learnings from the MAX program the CCN office has recognized the tremendous organizational lift associated with implementing the program and is targeting continued Sharing of Best Practices as well as dedicating CCN Resources to expand BH/PCP colocation efforts.

Sharing of Best Practices

CCN has 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, 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/techniques helped to facilitate the process. For example, how was the topic of 'operating at the top of license' difficult and solved as part of this roll out. The PMO staff responsible for the MAX program and 3ai project efforts, Bouakham Rosetti, has also participated in PPS Clinical Governance conversations and also discussed best practices and lessons learned across the state, including the annual DSRIP symposium in Syracuse, NY. CCN is looking to incorporate

Primary care provider, mental health professional trainings or workshops on common behavioral health disorders, BH medication management and evidence-based interventions to support a culturally diverse workforce and integration. Trainings and workshops will target PCP's on understanding special needs of beneficiaries with behavioral health needs (e.g., the physical side of addiction, medication management, physical ailments that can exacerbate or cause behavioral health needs etc.) Additionally, provider focused engagement events will continue to be performed to help educate and raise awareness. As an existing best practice adopted by the PPS, CCN will continue to promote subject matter leaders and collaborations across the PPS on a going forward basis.

Partner Support

Moving forward CCN also seeks to build on the momentum and experience gained as part of the MAX program. CCN has recently hired a credentialed professional (LCSW-R, ACHP-SW) to join the behavioral health integration efforts with Project Manager Bouakham Rosetti. The provision of dedicated human capital resources made available to the partners has proven to be a leading practice.

Behavioral Health Specialist	Vacancy Rate
Psychiatrist [1]	24%
Psychiatric Nurse Practitioner [1]	10%
Psychologist [2]	0%
Licensed Clinical Social Worker [2]	2%
Substance Abuse and Behavioral Disorders Counselors [3]	24%

The program development as well as long-term sustainability of integrated care will also rely heavily on the PPSs ability to recruit and retain skilled and talented professionals in the CCN region and deploy staff at the top of licensure. In June of 2016, CCN partnered with Iroquois Healthcare Association (IHA) to complete a PPS-wide compensation and benefits analysis. The results provided a lens to the vacancy rate across the PPS for positions critical to integration of BH and PCP services. The 3ai project team, in conjunction with the Workforce team, will work to develop recruitment and retention models for the PPS for identified critical needs. Additionally, CCN is helping to promote synergies between a BHC, PCP, and other downstream providers through the use of care coordination platforms associated with PCMH and the overall IDS infrastructure of 2ai.

Incentives and Investments

CCN has also worked to develop appropriate incentives and investments to promote successful integration of primary care to behavioral health settings, as well as integration of behavioral health services to the primary care setting. Categories developed or being pursued include

[1] Work in hospital inpatient and Article 31 & 32 facilities
[2] Note low rates could be reflective of private practice employment setting
[3] Predominately work in Outpatient Article 31 and 32 facilities

(i) Co-location startup funding: For the renovation of space in primary care offices to accommodate Behavioral Health Providers, and likewise in Behavioral Health clinics to accommodate for Primary Care Providers.
(ii) Innovation Program: Annual open RFP where partners can submit proposals for innovative program development to expand, build on, or compliment the projects.
(iii) RFP Distribution: Prepared on an as needed basis for development of complex programs within CCN. Examples include 123, Abc, etc.
(iv) Pay for Effort / Speed & Scale: In place today! Reimbursement models defined and published through 2015 to reimburse CCN partners for their clinical work associated with DSRIP.
(v) Acquisition of Local Subject Matter Experts
(vi) Pilot Programs: Upcoming – to be informed by CCN analytics and results of population health analysis.
(vii) Recruitment and Retention Programs: Upcoming- to be informed by the recently completion of major workforce strategies.

The PPS is also seeking proposals for possible innovation funds to develop ambulatory detox services in the PPS (currently very limited), which provides medical services, including primary care services, in an inpatient and outpatient treatment setting. Additionally, CCN is seeking proposals for the development of a psychiatric residency program in Broome County based out of Upstate Medical School. This will support the psychiatry workforce needs in the PPS for both model 1 and model 2.