DY2 YEAR IN REVIEW

April 1, 2016 - March 31, 2017

Report to the ACP Board of Directors
September 14, 2017

ADVOCATE COMMUNITY PROVIDERS

August 2017

Mario J. Paredes
Chief Executive Officer

To Our Valued ACP Partners,

When Advocate Community Providers (ACP) was recognized by New York State as DSRIP's 25th Performing Provider System (PPS), to the surprise of many in the healthcare establishment, our upstart physician-led network received the second-highest award. We begin our third year of operation with a deep sense of satisfaction and a long list of accomplishments toward achieving our mission of transforming health care – indeed, improving lives! – for New York's most vulnerable residents.

Today, ACP is a thriving, humming enterprise of 130 staff members, including esteemed additions to our leadership team – David Steinman, Corey Maher, Tonguc Yaman, Ricardo Rivera-Cardona, among others – and a strong network of world-class subject matter experts, including top consultants, vendors, partners, and collaborators.

Throughout, we are guided by the vision of our founders, Dr. Ramon Tallaj and Dr. Henry Chen, and the wisdom of the Medicaid Redesign Team and the Enhanced Oversight team at PCG. We also are grateful to Northwell Health for its invaluable partnership as our fiduciary partner. Montefiore Medical Center, our new fiduciary partner, is nationally recognized for clinical excellence and ranked among the top hospitals nationally and regionally by U.S. News & World Report. Importantly, Montefiore and ACP have a similar geographic footprint that will serve us well in achieving our DSRIP pay-for-performance goals.

We have much to be proud of, and grateful for, as we begin to see our efforts bear fruit in the offices of our network physicians, in the wellbeing of their patients, and in the health of our communities. Highlights:

- ACP is now nearly 3,500 providers strong, including 1,400 primary care physicians and 1,700 specialists!
- Since inception, ACP has distributed ~$13 million to physicians and specialists. A total of $22.4 million has been distributed overall. ACP has distributed the highest percentage of funds to physicians – 40.8% to PCPs and 6.1% to non-PCPs – versus a statewide average across all 25 PPSs of 3.89% and .73%.
- ACP is receiving and analyzing patient data from New York State, EHR partners, MCOs and others that will enable us to provide care coordination, clinical notifications, and dashboards to enhance patient care and enable physicians to improve their practices and thrive in a value-based environment.
- ~600 practices are on the way to achieving PCMH level 3 certification by December 31, 2017, a DSRIP requirement that also enhances quality and efficiency.
- Our cohort of ~50 Community Health Workers (CHWs) are on the ground in our communities, working with patients, medical providers, primary care teams, and community-based organizations to improve patient care and outcomes.

Of course, we have much to learn and hard work ahead of us to achieve our ambitious, challenging DSRIP milestones. As I've observed many times over, though, this ACP team is resourceful and relentless in tackling whatever challenges we face.

Thank you to our network of independent physicians and providers who are dedicated to improving the lives of underserved men, women, and children of New York. Together, we are united in our belief in the power of the bond between patient, and physician and emboldened by the opportunity to bring high-quality, culturally-competent health care to our city's most vulnerable residents.

Sincerely,

Mario J. Paredes
Chief Executive Officer

Two years ago, New York State designated Advocate Community Providers (ACP) as DSRIP's 25th Performing Provider System (PPS). We joined other PPSs across the state as agents in Governor Andrew Cuomo's ambitious initiative to transform and restructure New York State's health care delivery system.

With ~3,000 physicians and partners providing quality, coordinated care to more than 650,000 Medicaid beneficiaries, 130 staff members, and a strong network of world-class experts, consultants, partners, and collaborators, ACP has grown quickly from a start-up to a highly-efficient organization making real change in the most vulnerable communities in New York City.

We have distributed more money to primary care physicians than any other PPS. During the open enrollment period that ended on March 31, hundreds of physicians and providers chose to join the ACP network.

In DY2 we saw tremendous growth and maturity as an organization, spurred by continued **Engagement and Outreach** to our physicians, patients, and the communities we serve; Improvements to our organization's **Infrastructure**, with key additions to our leadership team – David Steinman, Corey Maher, Ricardo Rivera, Tonguc Yaman, among others – and enhancements to our data management and IT department; and, through execution of **Projects and Partnerships** by ACP staff members with the support of strong and valuable partner organizations.

Even with our many accomplishments, there is still much to learn and more hard work ahead as we continue to achieve our challenging DSRIP milestones.

With the shift to pay for performance, we are aggressively focusing our efforts to prepare our network physicians and providers to thrive in the post-DSRIP environment. We are confident that ACP is ready for what lies ahead, and we will continue to bring high-quality, culturally-competent health care to the communities that have come to rely on us.

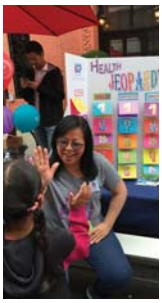
EXPANDING ENGAGEMENT AND OUTREACH

In DY2, ACP continued to focus on its raison d'etre – our network of physicians, providers, and partners who are the linchpin for Medicaid transformation in the communities we serve.
Our Provider Engagement team expanded to eight Provider Engagement Specialists, up from only two in November 2016, whose primary role is to support and engage our network members. From November through March, this team collected 229 Provider Participation Agreements (PPAs), which are a prerequisite for receiving Funds Flow. During the 2017 Network Open Enrollment period, this team helped identify and bring onboard ~300 new physicians and providers to the ACP network. We have been heartened by the enthusiasm of community health care providers to join our ACP network.

Throughout the year, ACP presented at various physician engagement meetings hosted by our partner IPAs in Queens, Brooklyn, the Bronx, and Manhattan. During these presentations, ACP leaders highlighted topics such as funds flow to engaged physicians, ACP-provided support for PCMH certification, and the availability of our Community Health Workers (CHWs) to facilitate patient care and education in the community and within the physicians' offices.

Building on progress made during DY1, ACP's Community Engagement Plan sought to increase awareness of ACP and DSRIP, create opportunities for community engagement in health and health care, and increase awareness and knowledge of health resources in the community. Through implementation of the Community Based Organization Partnership Program (CBOPP), seven CBOs were identified and engaged through formalized contractual agreements totaling $200,000.

ACP's "Health Week," held in August in the most health-distressed zip code in the Bronx, promoted community resources for healthy living. Events included nutritional seminars, concerts, walking tours, running and jogging events, and cultural activities. Partners included community fitness and health clubs, grocery stores, restaurants, churches, community centers, elected and appointed officials, and ACP's own medical practices and facilities.







ACP also devoted significant resources to creatively approaching patient engagement. Leveraging our cadre of Community Health Workers, ACP partnered with network physicians, IPAs, and health plans to engage "low utilizer" patients who had not seen their PCP in more than a year. While the task has proven to be challenging, we are excited by the results so far and the valuable role CHWs will play in our outreach.

In DY2, 12 additional CHWs were recruited, trained, and deployed in the community – bringing ACP to a total of 50 altogether – providing invaluable hands-on support for our physicians and their patients. For example, CHWs screened Medicaid beneficiaries for social determinants of health and connected those in need with the appropriate resources through the Medical Living Room Project. CHWs also conducted DASH nutrition plan workshops, made courtesy calls on ACP network providers to reinforce the importance of documenting Asthma Action Plans, and partnered with community-based organizations to host health seminars on prevalent chronic diseases. Also noteworthy is ACP's development of culturally competent health education materials. Low health literacy is a significant barrier to seeking care and adhering to a treatment plan. A Health Education Materials Workgroup was convened to develop materials using principles of the National Standards for Culturally and Linguistically Appropriate Services in Health Care. Materials ultimately will be added to the electronic health records our providers access, to ease the distribution process to patients.

BUILDING CAPACITY AND INFRASTRUCTURE

DY2 was a truly transformational year for ACP as a start-up organization that has grown by leaps and bounds. With our large provider network and massive roster of attributed patients, as well as the increasing complexity of our DSRIP milestones and requirements, ACP made several key additions to strengthen our leadership team, including David Steinman as Chief Operating Officer; Tonguç Taman as Chief Information Officer; Corey Maher as Chief Technology Officer; and Ricardo Rivera-Cardona as Chief Business Development Officer. Each of these individuals brings deep industry, technical, and professional experience to ACP.

On the technology front, the addition of a Chief Information Officer and Chief Technology Officer has been key to accelerating ACP's technology infrastructure and capabilities as we focus on value-based payments, data analytics, and pay for performance. Initiatives included an inventory of ACP's vendor relationships, data sharing agreements, plans, and state regulatory systems. In the fall, this team developed a custom-built data warehouse to securely store and analyze health data. Technology staff members also underwent intensive training in data analytics at General Assembly. With the assistance of our partners at Optimus Health Analytics, we established an onsite IT support function. All of this was done to improve efficiency and employee satisfaction, as well as improve access to physicians across our network.

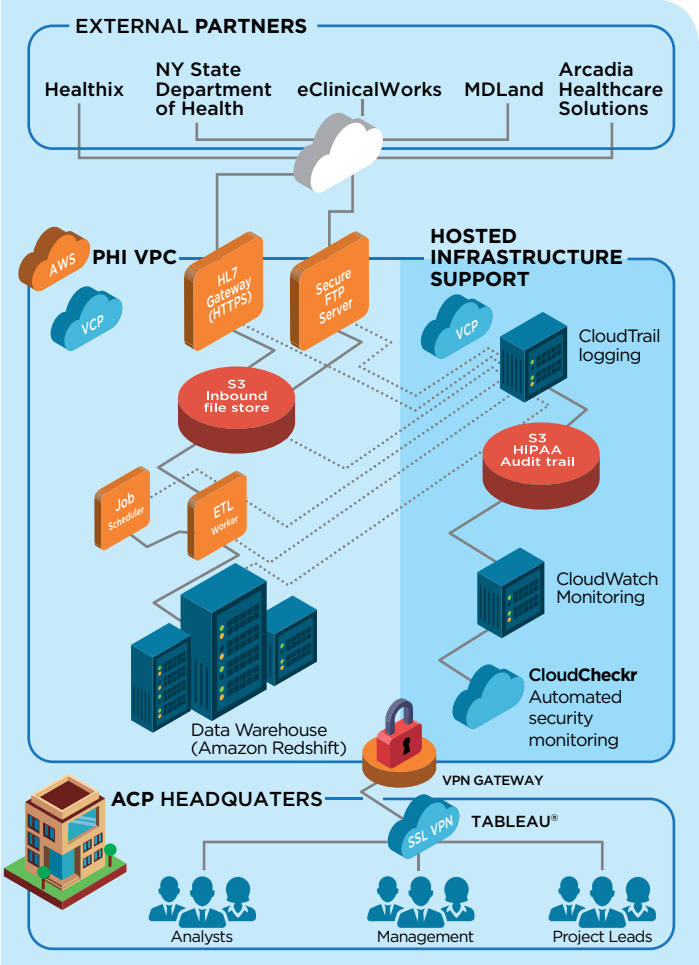
ACP's rebuild and redesign was rewarded when the New York State Department of Health cleared ACP to receive state patient claims data. In DY3, we look forward to incorporating industry-leading tool sets from Arcadia, Google GSuite, 3M, and others. These vendor partners will help ACP work toward an integrated delivery stem that will encompass the network's health care professionals – medical, behavioral, post-acute, long-term care, and community based service providers.

Execution of ACP's marketing and communications strategies built awareness among key audiences. A major initiative in DY2 was the relaunch of our website, www.acppps.org. Using a new content management system (WordPress) and new design, interest in our site increased from about 2,400 page views and about 1,700 unique web visits in April 2016, to more than 50,000 page views and 37,000 unique web visits in April 2017. ACP also expanded our social media presence, debuting on Twitter in July and on Facebook in August. The ACP blog, launched in February, provides a forum for staff members to write about timely, relevant topics.

In a PR highlight, ACP's COO and network physician Dr. Abe Adebayo were featured on NY1's "Health Beat" to discuss DSRIP and ACP.

Finance highlights included implementing Phase I Funds Flow Plans and distributing Phase I incentive payments that are essential to the transformation of our physicians' practices. A Financial Sustainability plan was implemented to identify providers who may be financially fragile and benefit from early intervention. Finance finalized a comprehensive five-year operating budget, leveraging key stakeholders to ensure a balanced budget for the remaining years of DSRIP. Highlights include reserving $5.5 million to help ~600 network practices achieve PCMH level 3 NCQA certification by the end of this year. Finance responsibilities include managing funds to ensure that we can adequately continue to achieve DSRIP goals, as well as review of payroll, contracts, and invoices before distributing requested DSRIP funds.

ACP Compliance is responsible for creating and maintaining written policies and procedures as part of DSRIP, as mandated by New York State Office of the Medicaid Inspector General (OMIG). Highlights included developing policies and procedures related to Finance, Workforce, Human Resources, Governance, and Operations, guiding ACP through an external audit of accounting and auditing standards, and conducting an organizational risk assessment of ACP's departments.



PROJECTS AND PARTNERSHIPS

Throughout DY2, ACP engaged in numerous programs, projects, and partnerships to provide resources and tools patients need to live a healthy life. We are proud to say that ACP successfully met or exceeded the vast majority of project goals in DY2.

Health Home at-Risk Intervention Program continued to make progress in identifying and supporting patients who suffer from a progressive chronic disease and are at risk of developing a secondary condition, but who do not qualify for the state's Medicaid Health Home program. The team has coordinated with Queens Coordinated Care Partners (QCCP) and Community Care of Brooklyn (CCB), and established a partnership with Centers Health Care (Centers Link) in an effort to understand how to best support providers, and improve clinical outcomes by quickly connecting at-risk patients with care management services. A health coach training program is under development for medical assistants to help support patients in following a care plan and becoming empowered and self-reliant. Looking forward, the Health Home at-Risk project team is partnering with QCCP to support Health Home eligible patients in the enrollment process.

Emergency Department (ED) Care Triage Program worked to reduce preventable emergency department use by identifying and addressing the root causes of unnecessary visits. A major initiative was ensuring ED patients attend their follow-up appointments and begin to solidify a relationship with a PCP.

The ED Care project team saw a steady increase in follow-up appointment volume. Preliminary reporting shows a 38% increase in follow-up appointments – 27,473 ACP patients completed their follow-up appointments, compared to the DY1 goal of 19,500. The ED Care project's team focus is on provider support, like working with PCPs to identify patients who are misusing EDs; patient education, like informational pamphlets about when a trip to the ED is warranted and when it is not; and technology solutions, like an online appointment scheduling solution.

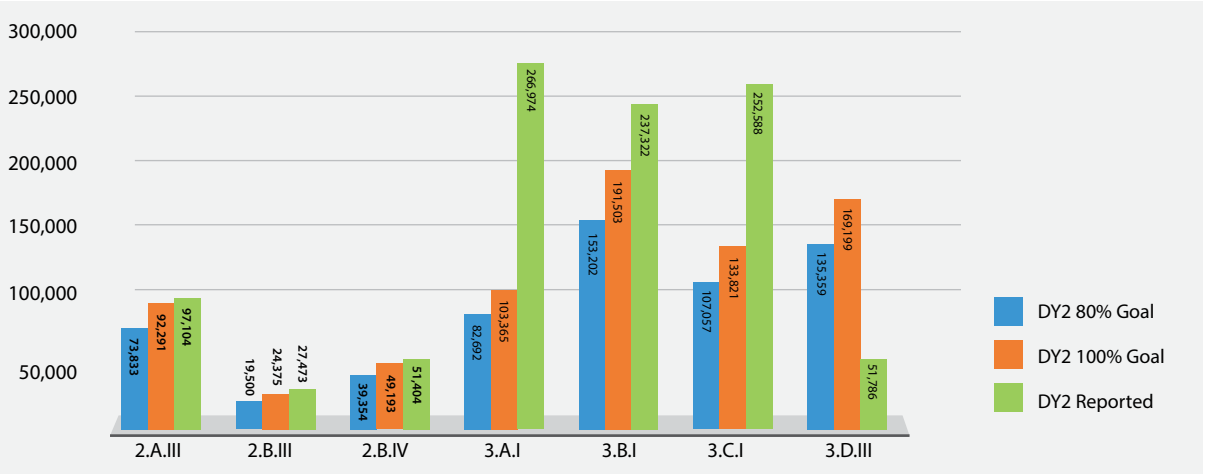
Care Transitions Intervention Model, which works to reduce 30-day readmissions for patients with chronic conditions. Improving transitions between care settings is critical to improving quality of life and clinical outcomes, making patients less likely to return to the hospital. A major avenue to reducing readmissions is ACP's participation in the Medicaid Accelerated eXchange (MAX) Series.

The Care Transitions Intervention project team aims to reduce 30-day readmissions by 10% during the MAX Series program period. ACP has partnered with an affiliated transitional care team, Rapid Care Solutions (RCS), that provides 30-day transitional care services to ensure patients are stable upon discharge and at home.

The goal of the **Integration of Behavioral Health & Substance Abuse in Primary Care** project is to reduce the cost, reduce hospitalization, and decrease the stigma of mental health by integrating these services directly with primary care facilities. This project successfully met the patient engagement requirements for DY2 with over 170,000 patients having been screened for depression. In addition, the project team worked to establish several pilot programs to advance ACP's efforts to develop a series of steps that providers can take to move toward integration of these services into their own practices.

ACP's **Cardiovascular Disease Management in High-Risk/ Affected Populations** project aims to bring down rates of cardiovascular disease among ACP's population and is on track to meet the Million Hearts campaign goal – a five-year initiative co-led by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS). The team engaged nearly 900 providers in the initiative, using reporting tools to identify and serve patients at risk of disease, like patients with hypertension who haven't visited their physician lately. The team has implemented the Stanford Model of educational seminars, connecting patients to Community Based Organizations.

DSRIP YEAR 2 ACP PATIENT ENGAGEMENT RESULTS



ACP's **Diabetes Management in High Risk/Affected Populations** project aims to help diabetic patients manage their disease. The project team is especially focused on giving patients the tools they need to self-manage the disease; the team has engaged 913 providers to date.

The project team has orchestrated the training and certification of 20 Community Health Workers in the Stanford Model of Diabetes Program, an evidence-based workshop for diabetes self-management. The project team works closely with PCPs to ensure they are trained to monitor diabetic patients' electronic health records, including via the Salient system which allows providers to remotely track their patients' clinical metrics.

ACP's **Chronic Disease Prevention** project aims to provide targeted access to disease screening and prevention methods – like nutrition plans – to ACP's population.

The results of the analysis allowed the project team to target "hot spots" throughout New York City with particularly high rates and risk of chronic disease with educational opportunities such as seminars, health fairs, and nutrition workshops. A key strategy of the Chronic Disease Prevention project team is ACP's adaption of the DASH nutrition plan – a plan proven to reduce the risk of stroke, heart disease, heart failure, and diabetes – adapted to the culinary preferences of the communities ACP serves.

ACP's **Tobacco Cessation** project identifies and educates tobacco users about cessation therapies utilizing the Chronic Disease Prevention team's hotspot data to target community engagement campaigns, including a "Talk to Your Doctor About Tobacco" initiative. The team is in the process of further analyzing tobacco use and cost among ACP's population. Additionally, ACP staff participated in training to pilot the American Lung Association's Freedom from Smoking program.

And finally, another project that has been met with great success was the **DASH (Dietary Approaches to Stop Hypertension) Nutrition Plan.** Adopted throughout ACP this previous year, we've tailored this nutrition and exercise plan specifically tailored to the cultural and dietary preferences of our Chinese and Latino communities – to support Cardiovascular, Diabetes, Asthma and Chronic Disease projects.

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Through the launch of our **DASH blog** and numerous video demonstrations on our **YouTube channel** – in Spanish, English, Cantonese, and Mandarin – we've been able to directly communicate with our patients across social media.

PARTNERSHIPS

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