<p align="center">ATTACHMENT APR</p>

<p align="center">DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM
ACCOUNTABLE CARE ORGANIZATION (ACO) PY2 ANNUAL PROGRESS REPORT
RESPONSE FORM</p>

<p align="center">PART 1: PY2 PROGRESS REPORT EXECUTIVE SUMMARY</p>

General Information

Full ACO Name:	Signature ACO
ACO Address:	680 Centre Street

Part 1. PY2 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

During PY2, our goals still remained focused on our original plans as outlined in the PY2 Full Participation Plan, mainly to establish a strong ACO foundation on which to build programs that will bend our cost curve, while maintaining high quality of care for our patients, which included goals of Cost & Utilization Management, Quality, Member Experience and Engagement, and Integration of Physical Health, BH, LTSS and Health-Related Social Services (see section 2 in the PY2 Full Participation Plan).

In PY2, the ACO leveraged DSRIP funding to achieve the goals as outlined in this section by newly implementing, expanding and operationalizing Complex Care Management, Pharmacy Management, Quality Management, SUD and BH Management, Advanced Technology, Patient Engagement and Enrollment, and Risk Coding. These programs each aimed from a different perspective, to achieve our strategic goals. We have continued in partnership with our MCO and have learned many lessons. Though these lessons seemed painful at the time, they directed us to adjust accordingly as we laid out plans. Many areas experienced these types of "growing pains," from sharing information between the ACO and the MCO, to how best to use data at the ACO level all proved challenging. Knowing who our beginning population was became obviously very important very early on. During the first year we made great strides in setting up teams, hiring individuals, and moving the programs to the practice-level of care for our population. In the second year, we developed a cadence of data sharing, and saw good strides with providers and patients becoming engaged in understanding the ACO and its goals. All of the above were fundamental to a strong start for these programs.

These programs were critical to the success of the ACO as we began to manage this very challenging population. In order to simultaneously maintain high-quality care and bend the cost curve, these programs have to be successful, and will be the foundation for a strong ACO in the future. As we continue to build out these programs, we know that there will still be challenges. As we work to address not only the

clinical conditions for this population but also the social determinants of health, we may find that resource ratios may need adjustments. We have only begun to learn the population's baseline which will be important for us to tailor these programs in order to meet the specific needs that the population demands moving forward.

1.2 PY2 Investments Overview and Progress toward Goals

Our investment approach supports our ACO's overall performance and strategy in several important ways. A central component of this strategy is executing on our population health management program. This program is overseen and managed by the Sr. Vice President of Population Medicine, ACO Medical Director, Director of Population Medicine, as well as the Chiefs of Internal Medicine and Family Practice. This team is responsible for implementing the ACO strategy, population health management programs which includes primary-care based Complex Care Management team focusing on the top 2-3% of members. These programs are complimented by local programs overseen by the ACO, in which each practice site has been identified as important to addressing local member needs. To prevent duplication with local programs, local program leaders are provided lists of patients enrolled in primary care complex care management.

Our DSRIP investment strategy is to make targeted investments in high-impact programs (supported by either research or our collective experience) aimed at fulfilling our overall goals, most importantly Total Cost of Care (TCOC) reduction and increased quality for our members. Our focus has been on clinical and financial integration of the programs, while at the same time increasing quality for our members and moving toward total cost of care reduction. During PY2, the ACO made great progress in continuing to stand up many initiatives and implementing strategic investments, as outlined below:

1. **Complex Care Management:** The Complex Care Management (CCM) team continued to reach out and engage our "high risk" identified patients (we utilized the analytical program Arcadia). We have seen a positive return on investment with a decrease in emergency department visits and inpatient hospital admissions. This year we also incorporated the ED Transition Community Health Worker (CHW) into the team. The CHW continued to see patients in the ED providing assistance with choosing a provider if they did not have one, scheduling follow up appointments and arranging transportation to those appointments. For the period of Mar 2018-May 2019, we saw a 41% reduction in Inpatient Med/Surg Admissions and 33% reduction in ED visits relative to historical benchmarks for Signature active and discharged CCM enrollees, resulting in a $1.2M return on investment.

2. **Pharmacy Management**: We saw all of our ACO patients being discharged from the hospital having a pharmacist-driven medication reconciliation done. This then triggered a notification to the PCP who would see the patient after the hospitalization, thereby maintaining a truly up to date medication list for our ACO patients. The team was also involved in the asthma medication ration quality metric. They worked with providers and educated patients regarding inhaler usage. The team also worked closely with our MCO on formulary changes, notifying providers of the changes and what the replacement recommendations were.

3. **Quality Management:** We have made significant strides during PY2 in hiring appropriate individuals to help in managing our quality metrics, in combination with our partner MCO. We were able to see where our quality metrics were hitting targets and where we needed to focus our efforts for particular metrics that were under goal. We were able to achieve threshold or goal on most of the pay for performance metrics in PY2.

4. **Patient Engagement and Enrollment:** During PY2, it became necessary for the ACO to build new processes around patient engagement. For patients without future appointments or those with gaps in care, we developed processes to create outreach opportunities to schedule appointments. Strong PCP engagement impacts a number of ACO performance drivers: maintaining enrollment, ensuring appropriate risk adjustment, providing opportunities to meet quality metrics, and the management of overall utilization and medical expense. Therefore, we shifted DSRIP priorities to adjust for this new program.

5. **Risk Coding:** During PY2, our teams of Risk Coding Specialist were able to perform prospective and retrospective reviews of our coding effort to ensure that we were assigning the appropriate diagnoses for the ACO population. The benefits of appropriate coding include improved opportunity for patients to be identified for care management programs and/or disease intervention programs. The ACO Risk Coding Specialist ensured that we are assigning the appropriate diagnosis for the ACO population, as well as using systematic approaches to leverage a robust data model to easily integrate with our existing EMR.

1.3 Success and Challenges of PY2

The ACO had several successes in PY2, as we continued to launch and manage the ACO toward our investment strategy to make targeted investments in high-impact programs (supported by either research or our collective experience) which were aimed at fulfilling our overall goals, most importantly TCOC reduction and increased quality for our members.

1. **Complex Care Management:** At the very foundation of our ACO are medical management and Complex Care Management, which are vital to our success. During PY2, we continued with a solid Complex Care Management team who worked on quality measures by outreaching patients and assisting them with scheduling appointments, coordinating appropriate referrals to specialists, completed assessments within 72 hours after an ED visit, engaged patients identified as high risk, and offered assistance to help patients achieve their overall healthcare goals. Our teams are fully staffed and preliminary data is already showing a positive ROI, where we are reducing ED visits and hospital admissions for patients enrolled in our complex care management program for the ACO.

2. **Risk Coding:** In PY2 Risk Coding and IT solutions were developed to ensure that we were assigning the appropriate diagnoses for the ACO population. The benefits of appropriate coding included improved opportunity for patients to be identified for care management programs and/or disease intervention programs. As such, we launched two coding initiatives and we have seen some positive benefits as a result:

a. **Obesity:** The ACO developed a focused process around Obesity coding and rolled this initiative out to the all the practices in which all patients were weighed at each visit and heights entered to automatically calculate a BMI (Body Mass Index). When a patient fell outside of the normal ranges, including overweight, obesity, or morbid obesity, the clinician was triggered to both address and document a plan. Within the EMR, the clinician has the ability to select items such as "referral to nutritionist, dietician, endocrinology, discuss exercise and healthier eating choices". Our population is not immune to the epidemic of overweight/obesity currently affecting our country, and by addressing obesity during visits with their PCPs; we are able to offer them the tools necessary to best help them succeed. Also important is the added benefit of accurately coding our population for overall population risk management and tracking.
Homelessness: The ACO developed a process to aid in identifying if a patient is homelessness in an effort to aid patients with their housing needs. Early results indicate that we have seen a steady improvement in identifying our homeless population. Patients who have been identified as having insecure housing or are homeless are given information regarding our monthly "Housing 101 Workshop," where a Social Worker and Community Health Worker from the ACO are there to assist patients with their housing needs and will refer to them CCM or other community resources as needed.

The ACO did face some challenges in PY2, of which two were particularly formidable:

1. **Behavioral Health (BH) Management Team:** During PY2, we were able to fill the position of Chief of Psychiatry, but even with the fulfillment of this position our organization's lack of experience in directly managing behavioral health, led to a slow start to mapping out the details of our approach in this area. The ACO will work with this leader to develop and implement a BH program for our ACO in PY3.

2. **Advance Technology and Analytics:** During PY2, we developed in partnership with our MCO, a different tool to directly manage our CCM's program within our electronic medical record. The reason for including the CCM's documentation, comprehensive assessments, and care plans made it easier for medical staff and providers to stay up-to-date with patients enrolled in CCM without having to utilize another program. Another challenge within this initiative remains that we are planning a transition to another EMR system in 2020 (initially was slated for rollout in late 2019), and the workaround developed in our current EMR in 2018 will have to be redesigned with the new EMR in mind. As Signature has decided to continue with one patient, one record, one signature our IT team is building all of the CCM current documentation into our new EMR. When the upgrade and transition does take place Signature Healthcare (hospital and ambulatory) will be utilizing the same EMR. Until the upgrade and conversion this will continue to be a built out into PY3.