THE 2015 VALUE REPORT

ON 2014 RESULTS

PARKVIEW CARE PARTNERS

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The Parkview Health Mission and Vision

MISSION
Parkview Health will improve the health and well-being of our communities.

VISION
Parkview Health will be your partner in health.

A letter to the community

The mission of Parkview Health is to improve the health and well-being of the communities we serve in northeast Indiana and northwest Ohio. We can only accomplish that mission through aligned partnerships and collaboration with patients, physicians, employers and payers.

But how can we work together to advance quality and safety and improve the patient experience at the best possible value? We are navigating a quickly changing healthcare landscape influenced by:

- Educated consumers who purchase healthcare based on quality scores and lowest price
- Legislation enabling more affordable and greater access to healthcare
- Government reimbursement to providers based on quality and outcomes (the U.S. Department of Health & Human Services [HHS] is taking steps to tie 90 percent of traditional Medicare payments to quality or value by 2018)
- Greater accountability and transparency among health systems and providers
- Technological advancements lengthening the average life span

Established in 2013, Parkview Care Partners (PCP) is a new entity of Parkview Health that brings clinical integration to our region. It's a physician-led care management organization collaborating on a clinically integrated approach to healthcare delivery. This model of care has emerged as a best practice in the delivery of healthcare services. Clinical integration facilitates the coordination of patient care across medical conditions, providers, locations and time.

Parkview Care Partners physician leaders and their roles include (left to right): **David Stein, MD,** *Chairman, PCP Contracting & Finance Committee;* **Raymond Dusman, MD, MBA,** *Chairman, PCP Board of Managers;* **and Thomas Bond, MD,** *Chairman, PCP Quality & Performance Improvement Committee.*
See page 30-31 for full credentials.

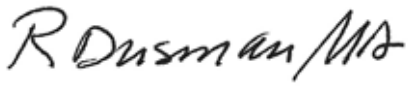
The goals of clinical integration:

- Improved clinical quality
- Greater patient safety and access
- Enhanced patient experience
- All at greater value to consumers and payers

The result is care that meets or exceeds established quality standards and is safe, timely, effective, efficient and focused on the patient.

We believe that a clinically integrated healthcare system drawing on the strengths of hospitals, providers, payers and employers is the key. Clinical integration will move healthcare delivery from today's fee-for-service environment (volume) to one of pay-for-performance (value). The ultimate goal is to create value through improved clinical quality, greater patient safety and access, and an enhanced patient experience. Clinical integration will lead to highly consistent quality performance, differentiating Parkview in the healthcare market with demonstrable value to patients, providers and payers.

This report outlines the steps taken during the first year of this journey and the value created by PCP for our patients, our community and our business partners.



Raymond Dusman, MD, MBA

Chairman, PCP Board of Managers
Chief Physician Executive, Parkview Health
Vice Chairman, Parkview Health Board of Directors
Chairman, Parkview Health Board of Directors Quality Committee and Governance Committee
Member, PPG Board of Managers










Executive summary

The increasing prevalence of chronic disease contributes greatly to increasing healthcare costs in the United States. Innovative new ways of delivering healthcare help prevent and minimize the effects of chronic disease. Parkview's solution is patient-centered care through clinical integration and population health management.

Objectives of clinical integration:

- Works to reduce the number of expensive interventions such as emergency department visits, hospitalizations, and imaging and diagnostic procedures
- Elimination of duplicate tests and services
- Better outcomes, which, over time, result in lower costs and greater well-being for the patient
- Reduction of lost work time, and greater co-worker productivity
- Lower claims costs for employer groups
- Increased value to payers

How do chronic diseases affect healthcare?[1]

Chronic diseases are widespread in our nation:

- As of 2012, about half of all U.S. adults (117 million people) had one or more chronic health conditions, and one in four adults had two or more conditions.
- In 2010, seven of the top 10 causes of death were from chronic diseases.
- In 2006, 84 percent of all healthcare spending was for the 50 percent of the population that had one or more chronic health conditions.

The best programs to deal with these chronic conditions:

- Focus on building trust between patients and primary care providers[2]
- Encourage patient accountability to take control of their own healthcare choices
- Focus on the patient's needs based on their own culture and values
- Identify high-risk patients and proactively manage their disease
- Set metrics to gauge steps providers take toward preventive care
- Train clinical teams and equip them with cutting-edge technology to improve patient care and outcomes[2]

[1] *Centers for Disease Control and Prevention*

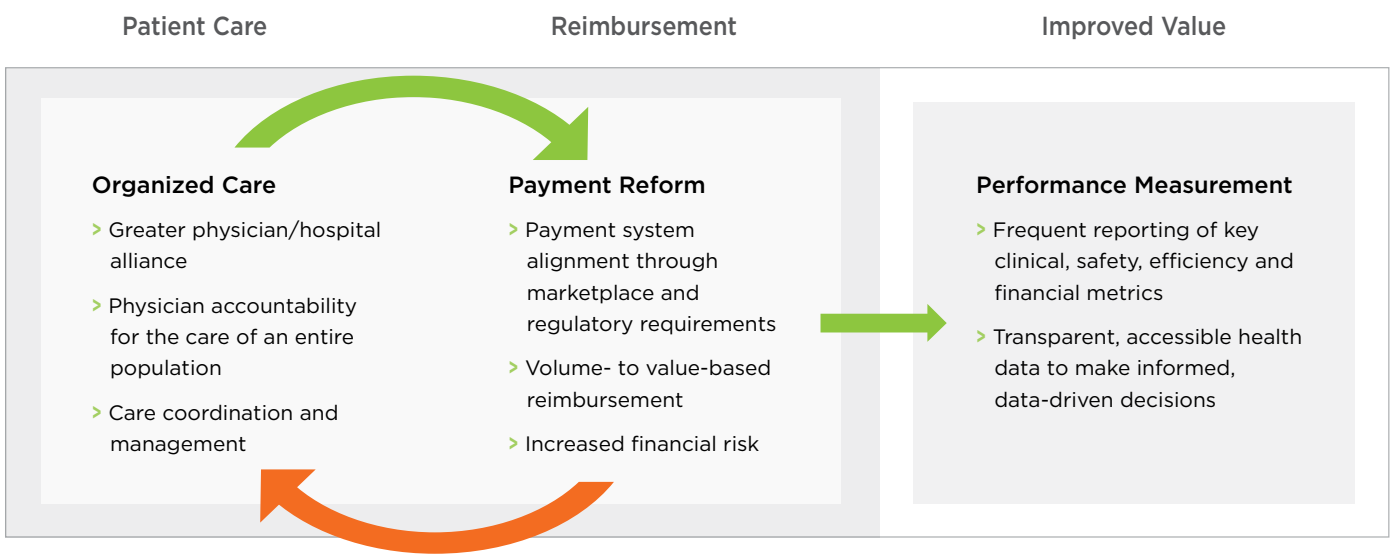
[2] *"Programs for High-Need Patients – What Makes the Good Ones Good?," Managed Care, December 2014*

Our solution: Patient-centered care through clinical integration and population health management.

With clinical integration, we are able to take a new approach to healthcare known as population health management. Population health allows us to set quality objectives for an entire group of patients for a specific disease, not just those actively seeking healthcare. The emphasis is focused on patient-centered, preventive, quality care across an entire population.

This new approach to healthcare delivery also enables long-term sustainable relationships with payers to uniquely address their populations' needs.

Attributes of Clinical Integration



What is Parkview Care Partners?

The Parkview Care Partners Clinical Integration Program facilitates the coordination of patient care across medical conditions, providers, settings and time. The result is patient-centered care that is safe, timely, effective and efficient, meeting or exceeding national quality standards.

This collaboration supports the use of best practices in evidence-based medicine, technology and electronic health-record-based knowledge management. Benefit plans that include Parkview Care Partners physicians give employers better ability to control healthcare costs while providing employees with high-quality, high-value health and wellness resources. Consistent, measured quality parameters mean providers are focused on the best care and optimal health for patients.

Physician leaders restructure their practices to provide excellent service for every patient during every visit.

Physician leadership is important to a clinically integrated organization because, for most patients, providers — especially in primary care — are the front door to the entire health system. Physician leaders serve on committees and work to restructure their practices to provide excellent service for every patient during every visit.

Parkview Care Partners by the numbers

(As of July 15, 2015)

- PCP network physician members: 441
- PCP advanced practice providers: 304
- Primary care physicians: 137
- Specialty care physicians: 304
- Number of physician locations: 221

Learn more:
Watch the PCP infographic video on clinical integration at www.parkview.com/ParkviewCarePartners.

Parkview Care Partners Leaders

(Front row, left to right) Krystal Miller; Ellen O'Brien; Rhonda Sharp, MD; Michelle Collins-Austin, MD; Greg Johnson, DO; Duane Hougendobler, MD; Nidia Villalba, MD; (Second row) Jason Row, MD; Joshua Kline, MD; Terrence Watson, MD; Susan McAlister; Richard Nielsen, MD; Carol Garrean, MD; Jeffrey Nickel, MD; Lemuel Barrido, MD; (Third row) Paul Conarty, MD; Harin Chhatiawala, MD; Thomas Bond, MD; Fen-Lei Chang, MD; Keith Lehman, MD; Diane Conrad, MD; Anusha Valluru, MD; Cheryl McKinnon; Jillienne Kenner; (Fourth row) Joel Valcarcel, MD; Eric Reichenbach, MD; Anette Lane, MD; Tom Nelson; Patrick Daley, MD; James Parker; Ryan Singerman, DO; Ron Sarrazine, MD; Thomas Curfman, MD; Chris Frazier, MD. *Not pictured*: Jeffrey Brookes, MD; Mike Browning; Raymond Dusman, MD, MBA; Sue Ehinger, PhD; Gary Gize, MD; Michael Grabowski, MD; Thomas Gutwein, MD; Scott Karr, MD; Alan McGee, MD; Berry Miller, MD; David Stein, MD; and Mitchell Stucky, MD.

Patient benefits

- Greater value for their healthcare dollar
- More effective care management and outreach from a trusted source — their physician
- More reliable information to support their choice of health plans, physicians and hospitals
- Care coordination and continuity in their relationship with both physician and hospital

Employer benefits

- The ability to more effectively manage the healthcare costs of employees and their dependents through the purchase of more efficient healthcare services focused on keeping employees well
- Increased employee productivity and reduced absenteeism through better management of chronic disease
- Lower healthcare costs over the long term through the reduction of variation in physician practice patterns

"Parkview Care Partners' physician-led collaboration among employers, patients and providers will give the community the best opportunity, over time, to reduce cost, improve quality of care and, most importantly, improve quality of life."

David Stein, MD
Ear, Nose & Throat Associates

What is population health management?

Population health management is an approach to healthcare that sets quality objectives for all patients assigned to a provider, not just those actively seeking healthcare. The emphasis is focused on patient-centered, preventive, quality care across an entire population.

Parkview is moving toward a new approach in healthcare delivery:

- Preventive care to keep people well — rather than only treating them in hospitals after they're sick
- New patient interactions focused on well-being are being developed across the continuum of care and during transitions in care

The goal is to keep a patient population as healthy as possible, minimizing the need for expensive interventions such as emergency department visits, hospitalizations, imaging tests and diagnostic procedures.[1]

If this goal can be achieved, the result is lowered costs and a renewed focus on well-being. While population health management addresses high-risk and rising-risk patients who generate the majority of healthcare costs, it also systematically addresses the preventive and chronic care needs of people in specific populations.

Information technology is critical to the process of identifying and managing patient populations. Parkview Care Partners, providing the network of physicians and backed by Parkview's EpicCare electronic health record, is well-positioned to further develop population health management efforts.

[1] *"Population Health Management – A Roadmap for Provider- Based Automation in a New Era of Healthcare," Institute for Health Technology Transformation, 2012*

CI and ACOs: Their differences and similarities

A clinical integration program is an active, ongoing, physician-led program in which network physician participants modify practice patterns to create a high degree of interdependence and cooperation. The result is cost control and high quality standards. Clinically integrated networks can have agreements with preferred provider networks, commercial payers or employer groups.

Accountable Care Organizations (ACOs) are defined as a combination of hospitals, primary care physicians and specialists associated with a defined patient population accountable for total spending and quality of care for that patient population. ACOs can have agreements with commercial payers or Medicare under the Medicare Shared Savings Program.

Primary care physician teams

A new mentoring and information sharing structure within Parkview Physicians Group (PPG) is aimed at helping providers achieve new levels of office efficiency, productivity, quality and service excellence.

Twelve "pods" of 10 to 15 physicians each have been organized to improve communication, share quality data and metrics, and share best practices for overall improvement in quality and outcomes. Pod leaders are physicians who dedicate four hours each week to round in PPG primary care offices. During that time, they meet with providers, observe work flow and gather input for improvements.

As we move to a value-based model of care with population health management, the pod system will help Parkview determine the best ways to care for disease states and share best practices for running the most cost-effective practices, improving quality and creating the best possible patient experience.

Physician pod leaders serve as coaches and mentors in three areas:

- Quality, as measured by Parkview Care Partners quality data
- Access, measured by the percentage of same-day access and wait time for the next available appointment for services like routine physicals or blood pressure medication checks
- Service excellence, as measured by Professional Research Consultants (PRC) scores

Primary care is the cornerstone for access to the health system and its overall success. Each pod covers approximately 22,000 patients.

PPG Physician Pod Leaders
(First row, left to right) Rhonda Sharp, MD; Michelle Collins-Austin, MD; Duane Hougendobler, MD; Carol Garrean, MD; Nidia Villalba, MD; (Second row) Eric Reichenbach, MD; Terrence Watson, MD; Joshua Kline, MD; Keith Lehman, MD; Chris Frazier, MD; (Third row) Joel Valcarcel, MD; Anette Lane, MD; Ryan Singerman, DO

"Physicians and their clinical teams are communicating in ways that will help us develop a more standardized process for patient care throughout Parkview Health. The goal is to provide every patient with an excellent experience and the best quality of care during every step in the process."

Joshua Kline, MD
PPG — Family Medicine, Primary Care Service Line Physician Leader, Parkview Health

The role of the care advisor

Parkview Care Partners' care advisors are registered nurses serving as an extension of the primary care physician to provide additional support and guidance to patients who have complex, high-risk diseases. Their work is an extension of the patient education and self-awareness coaching that starts with the physician. The goal is to build relationships for better communication and higher patient compliance, resulting in a better patient experience and improved outcomes.

(From left) **Carla Schaller, RN; Tracy Hammel, RN; Mary Ann Steiner, RN;** *and* **Susan McAlister, RN, DPN,** *director, Enterprise Care Management, Parkview Care Partners.*

Care advisors:

- Motivate high-risk patients to become accountable for their own health
- Help coordinate the care that can lead to greater health and well-being and lower long-term healthcare costs for each patient
- Coordinate patient care with specialty physicians or connect them with community resources
- Collaborate with the health plan to access benefits available to the patient
- Use motivational interviewing techniques when meeting with a patient by phone, in the home or during office visits with providers
- May refer patients to the Medication Assistance Program funded by donations to the Parkview Foundation
- Are easily accessible by patients who are anxious or afraid, helping them overcome personal or social barriers to improving their health

Using technology to enhance clinical quality

Parkview's adoption of new technology that paved the way for clinical integration began in 2011 with the launch of the most significant technology transformation in the organization's history. Parkview consolidated more than 50 clinical applications from approximately 12 vendors onto a single platform for electronic health records (EHR) — EpicCare®.

Now, physicians, nurses and other providers can view current, relevant and accurate information without the barriers of time and effort traditionally associated with searching for records or logging into several systems. EpicCare is a data repository offering a single story of care for every Parkview patient, summarizing nearly all of a patient's clinical encounters, including scheduling and billing.

With EpicCare as the foundation, Parkview MyChart® was implemented in 2012 to facilitate patient engagement. Providing more than just access to many of the available healthcare records, EpicCare enables patients to request appointment scheduling, view and graph lab results, request medication refills, send messages to their physicians, view their children's medical records and pay bills. (Adult children can also view their parents' medical records.) And it all takes place from the convenience of the patient's home computer or portable electronic device. Offering MyChart to patients has helped strengthen the relationship they have with clinicians and encourages them to become more invested in their own health.

While the EpicCare EHR and MyChart have immediately influenced the process by which providers treat illness, Parkview has begun to take the next step toward clinical integration and population health management by putting that data and information to work. By identifying and intervening with patients who are at risk for serious illness and disease, Parkview seeks to prevent the occurrence of these conditions. Parkview has developed patient disease registry databases of clinical information used to evaluate care

"Parkview Physicians Group providers and staff are changing the way care is delivered so we can proactively contact a patient when certain preventive measures are due. New technology that collects the patient's single story of care makes this possible and gives the patient more ways to communicate with their provider."

Mitchell Stucky, MD
PPG — Family Medicine
President, Parkview Physicians Group

processes and outcomes. These registries are used to monitor and track the care provided for patients with chronic diseases. They identify gaps in care for the provider, who can follow up with necessary preventive care or screenings.

The registries are focused on prevention and effective management of chronic diseases like diabetes, coronary artery disease and congestive heart failure. Provider access to better clinical data drives better and more consistent care. In 2014, using these patient registries, Parkview implemented a physician dashboard allowing providers and their care teams to assess gaps in care across a population and take action to reach out to those patients identified as having the greatest risk for chronic disease.

In 2015, Parkview will implement another EpicCare application to facilitate and manage the process of patient engagement. The engagement process is supported by nurse care advisors and PPG clinicians.

The care advisors and PPG clinicians will use the new application in conjunction with MyChart to define, understand, engage and track patient populations, as well as measure and improve care processes and outcomes over time.

Improving communication and accountability

MyChart strengthens the relationship between patients and physicians. Patients become more engaged and accountable for their own health.

Overview of 2014 quality results

The 2014 Parkview Care Partners Clinical Integration Program quality initiatives were selected by the Quality & Performance Improvement Committee due to their prevalence and rate of incidence in our region, as indicated in Parkview's electronic health record (EHR), EpicCare.

Also influential in their selection was:

- The 2012 Community Health Needs Assessment.[1] The study identifies health needs within northeast Indiana, particularly the counties in which Parkview-affiliated hospitals are located.
- The **Indiana State Health Improvement Plan** published by the Indiana State Department of Health and the National Committee for Quality Assurance **(NCQA) State of Health Care Quality 2014 Report**. Quality results in 2014 set a baseline for Parkview Care Partners providers.

How the measures were developed

The Quality & Performance Improvement Committee vigorously evaluates each potential measure on five key questions:

1. How important is the measure's impact on clinical quality, patient safety, efficiency and the overall patient experience?
2. Are there existing evidence-based studies and recommendations?
3. Is the measure endorsed by a national entity?
4. Is data collection feasible?
5. Does the quality measure fit in with local and national priorities?

All metrics align with the **Institute for Healthcare Improvement** Triple Aim: improving care for individuals, improving the health of populations and reducing per capita costs of healthcare. The metrics focus on patient-centered outcomes and require providers to make evidence-based decisions about how to effectively and efficiently daignose and treat patients.

The New Measures Subcommittee reviews current literature and recommends new quality metrics to the Parkview Care Partners Quality & Performance Improvement Committee. The committee provides final approval of the measures, assigns physician accountability, points and weights. The committee then recommends the measures to the Parkview Care Partners Board of Managers for final approval.

After the final measures are approved, the dashboards are built within the Parkview Care Partners care registry and are tested and validated prior to the new measurement year, Dec. 1 to Nov. 30.

Each quarter, Parkview Care Partners network providers receive an individual report indicating their quality performance compared to the standards set for each metric. Providers who do not meet goals receive assistance in evaluating current processes and procedures to make changes for improvement.

*[1]The report is available on **www.parkview.com** under Community - Community Health Improvement - Local Health Needs*

2014 clinical integration results

The following table provides insight into the Parkview Care Partners 2014 Clinical Integration Program performance. Results indicate that network providers met or exceeded goals in the majority of our target areas.

● Performance met or exceeded 2014 target ● Performance below 2014 target

Prevention of Chronic Disease	
Diabetes	
A1c test performed annually	●
A1c control: result < 7.5	●
A1c poorly controlled > 9	●
LDL test performed annually*	●
LDL control: < 100 or on Statin medication	●
BP control: < 140/80	●
Body mass index (BMI) measured annually	●
Comprehensive care: A1c test performed annually, A1c control: result < 7.5, LDL test performed annually, LDL control: < 100 or on Statin medication, BP control: < 140/80, and body mass index (BMI) measured annually	●
Coronary Artery Disease (CAD)	
LDL test performed annually*	●
LDL control: < 100 or on Statin medication	●
BP measured annually	●
Comprehensive care: LDL test performed annually, LDL control: < 100 or on Statin medication, BP measured annually*	●
Congestive Heart Failure	
Left ventricular ejection fraction assessment, inpatient setting	●
Health and Well-being	
Women's Health – Preventive Care Measures	
Cervical cancer screening	●
Breast cancer screening	●
Osteoporosis screening	●
Pediatric – Preventive Care Measures	
Well child care ages 3 – 6 years	●
Well care ages 12 – 21 years	●
Childhood immunizations:	
MMR	●
Varicella	●
Influenza	●
Hepatitis A	●
Rotavirus	●
Efficiency/Utilization Measures	
Acute Care	
Emergency Department visits per 1,000 patients	●
Average length of stay ages <65 and >65	●
30-day readmission rate	
All causes	●
CHF	●
Computer Physician Order Entry (CPOE) – inpatient	●
Ambulatory Care	
Generic medication prescription rate	●
Computer Physician Order Entry (CPOE) – outpatient	●
MRI per 1,000 patients	●
Professional Development	
Attendance at clinical integration education sessions	●

*Dependant upon patient compliance.

Select CI initiatives in 2014

The following 2014 data on these key clinical initiatives supports the clinical integration concept that quality enhancements lead to cost savings.

- Diabetes
- Coronary artery disease
- Generic medications
- Hospital readmissions

Diabetes

The challenge

According to the Centers for Disease Control and Prevention (CDC), in 2014, 29.1 million people in the United States had diabetes. Of those, 21 million have been diagnosed and 8.1 million, or 27.8 percent, are thought to be undiagnosed. From the same report, it is estimated that in 2012, total cost — both direct and indirect — was $245 billion. Average medical expenditures among people with diagnosed diabetes were 2.3 times higher than among people without diabetes. Estimated indirect cost — including disability, work loss and premature death — was estimated to be $69 million. (From the **CDC National Diabetes Statistics Report**.)

Case for improvement

Diabetes is a complex disease associated with serious complications such as heart disease, stroke, blindness, amputations and kidney disease. Multifactorial risk-reduction strategies, patient self-management education, and care coordination between the healthcare team and the patient and their support network can reduce organ damage and complications commonly occurring in diabetic patients.

Our objective

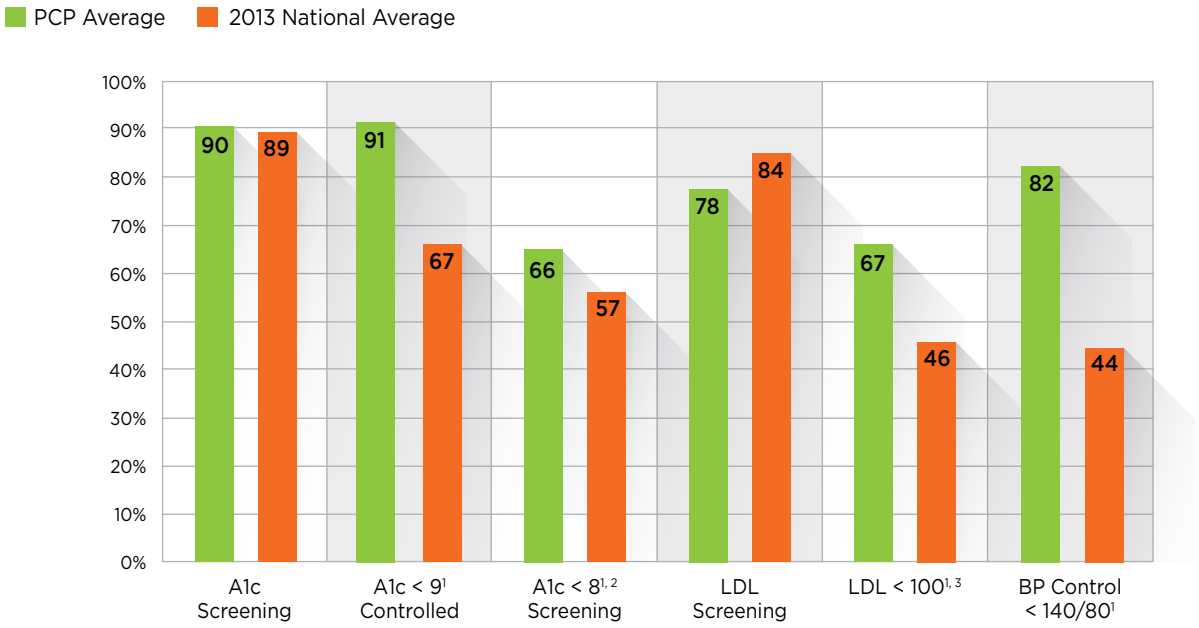
Parkview Care Partners' objective is to improve care and lessen the complications of diabetes by aggressively tracking and managing several critical performance measures.

Reduction of A1c by one percent can reduce the risk for developing microvascular and nerve complications by up to 40 percent, and with a well-controlled cholesterol level, there is a 25 to 55 percent reduction in coronary artery heart disease. (From the **American Diabetes Association Standards of Medical Care in Diabetes – 2015**.)

The Parkview Care Partners' registry alerts physicians to patients who need chronic care management to help reduce and prevent complications of the disease.

Diabetes management results

PCP 2014 performance for care among 16,601 diabetic patients



Source: The National Committee for Quality Assurance (NCQA) ***State of Health Care Quality 2014 Report***.

[1]Based on lowest level during the measurement year.
[2]PCP measures A1c < 7.5.
[3]Based on LDL < 100 or on statin therapy.

2015 initiatives and priorities

Parkview offers extensive outpatient services to help diabetics manage their disease and minimize complications.

Programs include:

- Parkview's Diabetes Treatment Center will help patients develop an individual care plan for managing their diabetes
- Intensive insulin therapy/Insulin Pump Initiation Program
- Continuous glucose monitoring, providing feedback reports to the patient's physician
- Pregnancy and Diabetes Program
- Seminars and workshops
- Support groups in most counties
- YMCA of Greater Fort Wayne diabetes prevention program

Coronary artery disease

The challenge

Coronary artery disease (CAD) is the most preventable form of coronary vascular disease. CAD results in 502,000 deaths annually, 185,000 of which are due to myocardial infarction. The annual economic cost of 1.2 million myocardial infarctions (700,000 of which are first infarctions) is $133 billion.[1]

An American Heart Association policy statement concluded that costs will rise to more than $1 trillion annually in the United States by the year 2030, suggesting the great need for preventive measures.[2]

It is estimated that by the year 2020, coronary artery disease will be the leading cause of death and disability worldwide.[1]

Case for improvement

Coronary artery disease is preventable. A greater focus on prevention may alter future projections for coronary artery disease.

Every 38.7 mg/dL decline in LDL cholesterol results in a 21 percent decrease in cardiovascular events.[1] Use of statin therapy has shown to reduce LDL levels on average by 30 to 50 percent.[3]

Coronary vascular disease results in 502,000 deaths annually...

Our objective

Following the American College of Cardiology/ American Heart Association 2013 guidelines on the treatment of cholesterol, Parkview Care Partners' quality measures for all patients diagnosed with coronary artery disease include an annual LDL screening, LDL control of less than 100 or on statin therapy, and blood pressure monitoring. We follow evidence-based medicine to prevent undesirable outcomes, organ damage and other complications from the disease process.

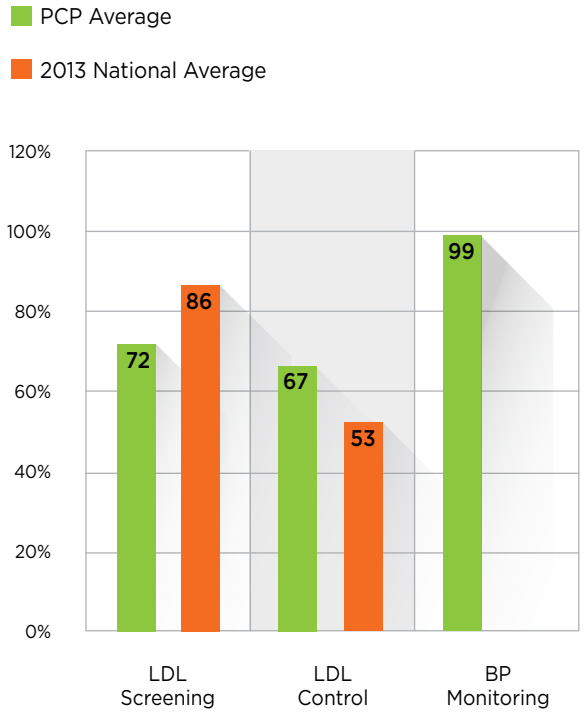
[1] ***"Primary and Secondary Prevention of CAD," December 2014***
[2] ***"Value of Primordial and Primary Prevention for Cardiovascular Disease: A Policy Statement from American Heart Association", August 2011***
[3] ***"2013 ACC/AHA Blood Cholesterol Guideline," Stone NJ, et al.***

Heart disease prevention measures

Parkview Care Partners physicians focus on three measures to prevent heart disease: LDL testing, LDL control and blood pressure assessment.

Coronary artery disease results

PCP 2014 performance for care among 15,595 coronary artery disease patients



*Source: **"State of Health Care Quality 2014 Report,"** National Committee for Quality Assurance (NCQA), Oct. 22, 2014.*

- *PCP averages are based on lowest level during the measurement year*
- *Based on LDL < 100 or if on statin therapy*

2015 initiatives and priorities

Parkview Care Partners has added two new metrics to our 2015 quality initiatives:

- Hypertension control
- Tobacco smoking screening and cessation counseling

The Million Hearts Initiative

Parkview Care Partners cardiologists are participating in the ***Million Hearts™ Initiative***. Million Hearts is a national initiative that has set an ambitious goal of preventing one million heart attacks and strokes by 2017. The program brings together communities, health systems, nonprofit organizations, federal agencies and private-sector partners from across the country to fight heart disease and stroke.

Million Hearts™

Million Hearts aims to prevent heart disease and stroke by:

- Improving access to effective care
- Improving the quality of care using the Million Hearts ABCS metrics (details below)
- Focusing clinical attention on the prevention of heart attack and stroke
- Activating the public to lead a heart-healthy lifestyle
- Improving the prescription of and adherence to appropriate medications using ABCS measures

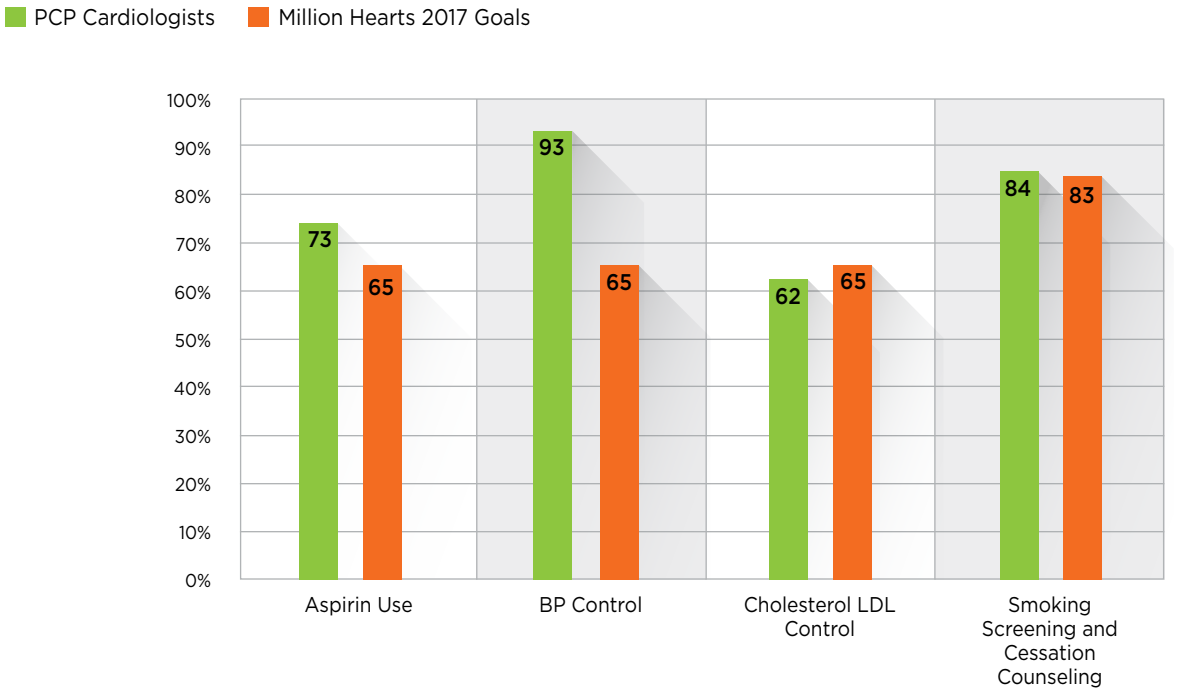
The ABCS metrics are:

- Appropriate aspirin therapy for those who need it
- Blood pressure control
- Cholesterol management
- Smoking cessation

ABCS metrics continued:

Parkview is experiencing favorable results in using the ABCS measures. In 2014, Parkview Care Partners has already exceeded three of four Million Hearts goals set for 2017.

PCP 2014 performance of care provided vs. Million Hearts 2017 goals



Source: ***http://millionhearts.hhs.gov/Docs/MH_Fact_Sheet.pdf***

"Physicians within the Parkview Care Partners network now have an up-to-date snapshot of our quality results. We have more real-time feedback that helps us correlate enhancements to the process of delivering care with improved patient outcomes. We can see more readily that the changes we are making in healthcare delivery result in better quality of life for our patients."

Thomas Bond, MD
PPG — Family Medicine
Chairman, PCP Quality and Performance Improvement Committee
Chief Medical Officer, PPG

Generic medications

The challenge

Population health management requires the ability of physicians to change patient behaviors. One of the key ways to keep patient conditions from declining is to focus on medication adherence. Patients who can't afford their medications are likely to ignore their doctor's orders and simply go without.

Parkview Care Partner physicians are moving patients beyond this hurdle by prescribing less expensive generic medications and offering programs to assist low-income, uninsured and underinsured patients with their medication expenses.

In 2013, use of generic medications in the United States saved $239 billion.[2]

As consumers and healthcare providers are working to control healthcare costs, generic medications offer an effective cost savings strategy. On average, a generic drug can cost 80 to 85 percent less than the brand-name equivalent. Use of generic medications can lower the patient's copays or out-of-pocket costs and lower the prescription drug costs for payers. Express Scripts statistics show that for every one percent increase in generic drug use, prescription benefit plan sponsors reduce their cost of providing prescription drug benefits by one percent.[1]

Use of generic medications can lower the patient's copays or out-of-pocket costs and lower the prescription drug costs for payers.

Case for improvement

According to a 2014 analysis by the IMS Institute for Healthcare Informatics, generic drug use generated nearly $1.5 trillion in savings to the U.S. healthcare industry from 2004 to 2013. In 2013 alone, generics saved $239 billion.[2]

[1] *"The Express Scripts 2013 Drug Trend Report," The Express Scripts® Lab, April 2014*

[2] ***Annual generic utilization and savings data compiled from IMS Health, the Generic Pharmaceutical Association, and the Congressional Budget Office. Hatch-Waxman: Driving Access, Savings & Innovation***

The American Heart Association reported in July 2013 that, "Poor medication adherence takes the lives of 125,000 Americans annually and costs the healthcare system nearly $300 billion a year in additional doctor visits, emergency department visits and hospitalizations."[3]

Our objective

Beyond cost savings, our objective is to increase patient adherence to medication, which improves health outcomes. This strategy reinforces our current vision within Parkview Care Partners of improved clinical outcomes, greater patient safety and access, and enhanced patient experience, all at a lower cost.

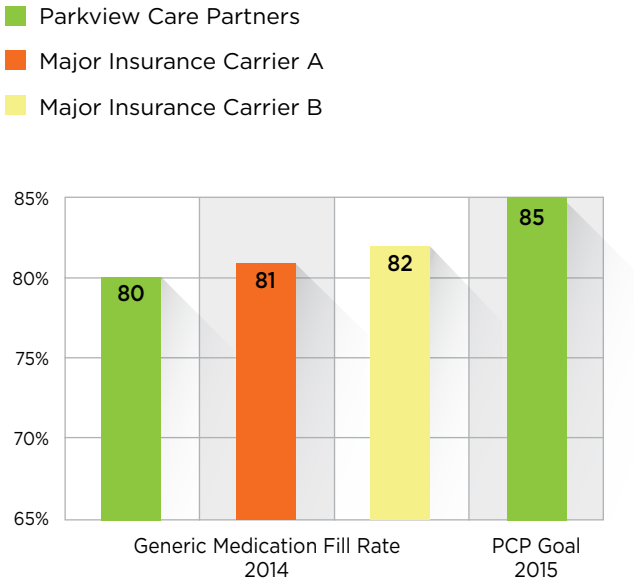
2015 initiatives and priorities

We will continue to focus on increasing generic prescription fill rates among our patients. While 2014 results reflect only claims data from Signature Care members, we will measure broader results in 2015 by collecting pharmacy claims data from additional payers. Parkview's ***Medication Assistance Program*** (MAP) will continue to help low-income, underinsured and uninsured patients with drug costs.

Generic medication fill rate results

Parkview Care Partners' overall generic medication fill rate was 80 percent in 2014, well beyond our target goal and closely aligned with other national organizations.

PCP 2014 generic fill rate on 19,670 prescriptions



Source: ***"New Express Scripts Analysis Reveals Trends Among Health Exchange Members," Express Scripts, Oct. 8, 2014***

Source: ***"CVS Health Reports Strong Profit Growth For Full Year 2014; Fourth Quarter Adjusted EPS At High End Of Company's Expectations," CVS Health, Feb. 10, 2015***

[3] ***"Medication Adherence – Taking Your Meds as Directed," The American Heart Association, 2013***

Avoiding readmissions

Appropriate care planning, both in hospital and upon discharge, can prevent avoidable hospital readmissions.

Avoidable hospital readmissions

The challenge

A hospital readmission occurs when a patient is admitted to a hospital within a specified time period after being discharged from an earlier (initial) hospitalization. For Medicare, this time period is defined as 30 days, and includes hospital readmissions to any hospital, not just the facility at which the patient was originally admitted.[1]

The Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reductions Program (HRRP) in October 2012 to rein in costs by curbing hospital readmission rates. The Center for Medicare and Medicaid Services (CMS) began imposing readmission penalties in 2013.[1]

For reimbursement withholdings levied in 2013 and 2014, CMS focused on readmissions occurring after initial hospitalizations for heart attack, heart failure and pneumonia.

Case for improvement

Readmission rates at Parkview Regional Medical Center have not resulted in penalties. Initiatives that contributed to a low 30–day readmission rate in 2014 include:

- Proactive discharge planning
- Greater patient accountability, compliance and self-care
- Long-term care facilities that recognize, assess and treat residents without returning them to the hospital

[1] ***"Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program," Jan. 29, 2015,*** *Cristina Boccuti and Giselle Casillas, The Henry J. Kaiser Family Foundation*

- Better communication during transitions from inpatient to outpatient care
- In-home assessment and assistance for patients with traditional Medicare
- Clinical teams that monitored and treated semi-acute patients for less than 24 hours without a hospital admission
- Observation units are less costly compared with inpatient admission[2]

Results

The CMS Hospital Compare quality database reports that overall, all-cause unplanned readmission outcomes for Parkview Regional Medical Center and Parkview Hospital Randallia are favorable compared to national outcomes.

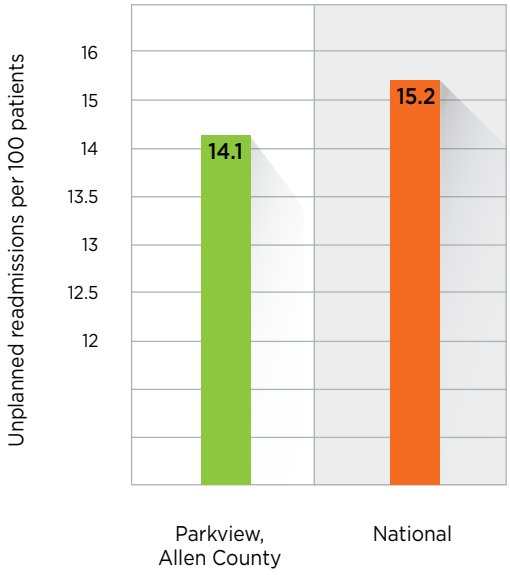
In the most recent period reported, covering hospital discharges in the third quarter of 2013 through the second quarter of 2014, Parkview's Allen County hospitals achieved "Better than National" designation, with readmissions for all causes at a rate of 14.1 patients per 100, compared to the national rate of 15.2.

[2] ***"Revisiting the economic efficiencies of observation units," Managed Care, March 2015***

Hospital Compare Report – 30-Day Hospital-Wide All-Cause Unplanned Readmission Rate

Parkview Regional Medical Center and Parkview Hospital Randallia

3Q, 2013, through 2Q, 2014



*Source: **www.Medicare.gov/HospitalCompare, July 2015***

Our Objective

Our objective is to prevent all avoidable readmissions by focusing on patients' self-care management.

2015 initiatives and priorities

In 2015, Parkview will focus on the following initiatives to further reduce hospital readmissions:

- Chronic disease management with an emphasis on patient self-care management and rapid exacerbation intervention to prevent hospitalizations
- Models of payment with value-based contracts that allow for alternatives to long-term care, including intensive home care, tele-monitoring, virtual care, private duty nursing or adult day care
- Follow-up visits with patients with a high likelihood of readmission
- Coordination of transitions of care
- Advance directives and Physicians Orders for Scope of Treatment (POST) discussions between patients and physicians in primary and specialty care

Why choose Parkview?

The patient experience at Parkview

Parkview gauges overall patient perception of care by conducting telephone interviews with patients after healthcare services are received. Parkview has employed Professional Research Consultants (PRC) — a nationally known healthcare marketing research company headquartered in Omaha, Neb. — for this service since 2004.

Seven five-star award winners scored in the top 10 percent.

Several Parkview Health facilities and physicians were recognized with the 2014 PRC Excellence in Healthcare Awards. Seven five-star award winners scored in the top 10 percent in the PRC national client database for 2013. These awards are based on the percentage of patients who rate the facility, healthcare provider, outpatient service line, or inpatient unit "Excellent" for the overall quality of care provided.

Five four-star award winners scored in the top 25 percent. The data was collected through phone interviews conducted by PRC.

A culture of well-being within Parkview and in the community

At Parkview, we believe the concept of well-being will help each of us make the right choices for a lifetime. We're helping our 9,087 employees learn to take accountability for finding their own path to greater health and well-being through the MyWell-Being program.

We define well-being as a balance of the physical, spiritual, psychological and social elements of who we are.

We offer co-workers a health assessment so they can know their current state of well-being, then incentivize co-workers to take action to achieve their goals, including a discount on annual healthcare insurance premiums. Fun, social activities and interactions provide opportunities to take advantage of many existing Parkview well-being resources.

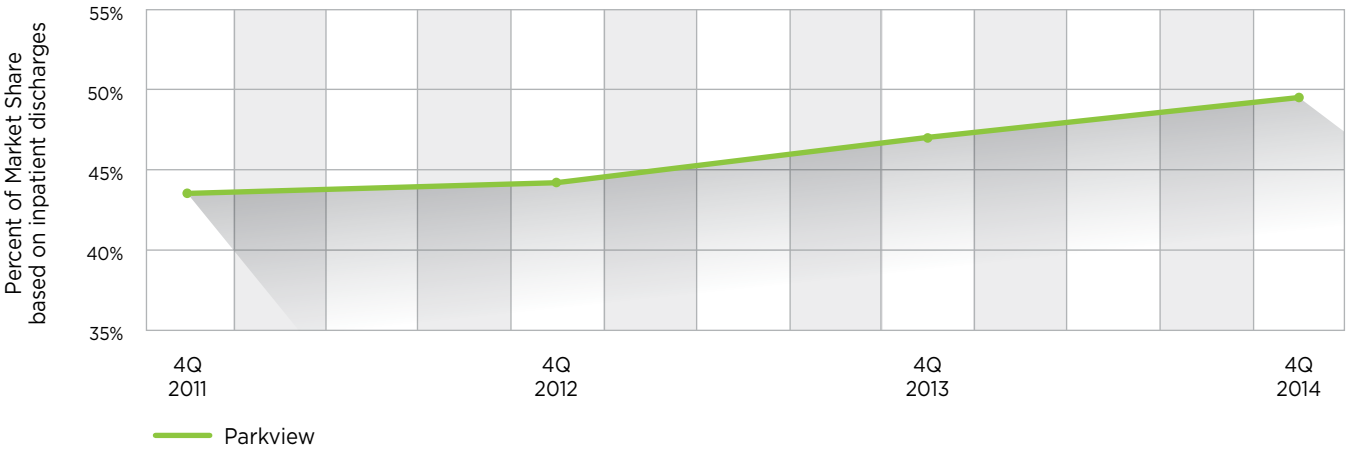
PARKVIEW My Well-Being

For the community, Parkview has launched the "GO" campaign (*www.ParkviewGO.com*) that sets the healthcare system apart as a healthcare leader in the community in ways that encourage fun participation. The message is focused on our friends, family and neighbors in the community. We want to keep them healthy and out of the hospital, not just provide care when they're sick.

It's a message that is unique in our region. For this campaign, we go beyond messages that promote our service lines and hospitals to focus on influencing the life choices made by people in the communities we serve. We're challenging the community to take steps to create a healthier version of themselves with a greater sense of well-being.

Parkview Health market share growth

More people choose Parkview year after year.



Source: IHA Dimensions Hospital Inpatient Discharges

Who we are

Parkview Care Partners is a physician-led care management organization combining the resources of Parkview Health with Parkview Physicians Group and select independent physicians in northeast Indiana and northwest Ohio.

Parkview Health

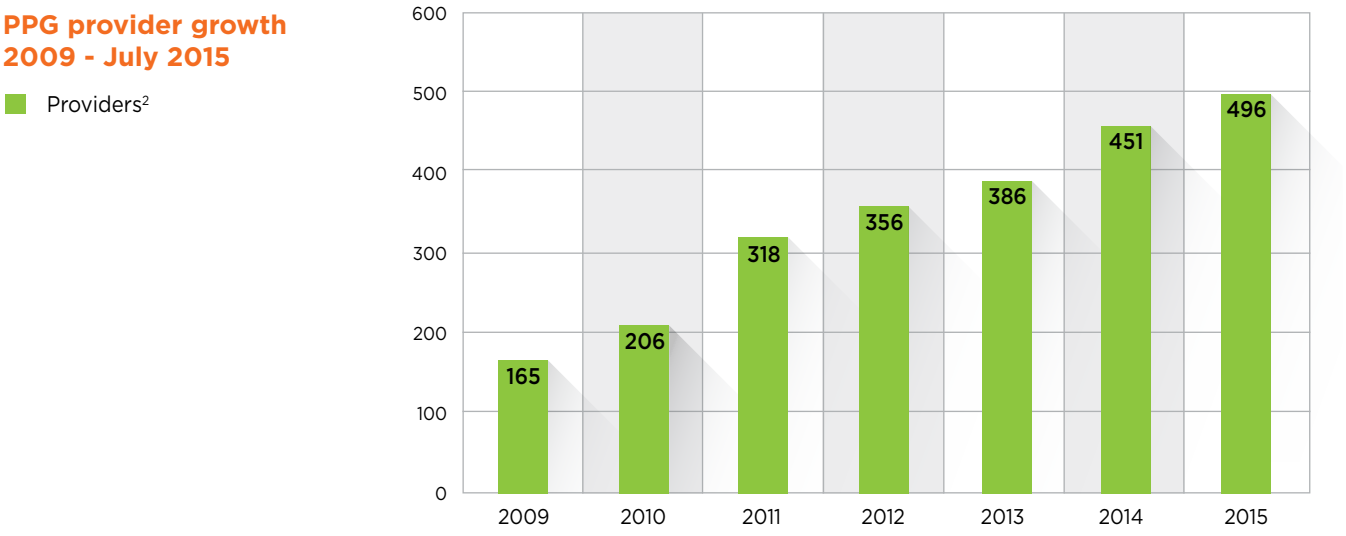
Parkview Health is a not-for-profit, community-based health system serving northeast Indiana and northwest Ohio, covering a population of more than 820,000. We have nine hospitals, 358 physicians, 138 advanced practice providers[1], 9,087 employees, 1.9 million patient encounters annually and a mission to improve the health and well-being of our communities.

Parkview Physicians Group

Parkview Physicians Group (PPG) is a physician-led and governed member of Parkview Health. PPG is the region's largest medical group, with more than 358 physicians and 138 advanced practice providers practicing at more than 100 locations throughout northeast Indiana and northwest Ohio. These providers work with specialty and independent physicians in the network to complete the continuum of care.

PPG comprises more than 25 specialties, including: Behavioral Health, Cardiology, Cardiovascular Surgery, Colon and Rectal Surgery, Critical Care Medicine, Endocrinology, Family Medicine, Gastroenterology, General Surgery, Hospital Medicine, Infectious Disease Services, Integrative Medicine, Intensive Care Medicine, Internal Medicine, Neonatology, Obstetrics & Gynecology, Orthopedic Surgery, Pediatrics, Physical Medicine & Rehabilitation, Podiatric Surgery, Psychiatry, Pulmonology, Rheumatology, Sleep Medicine and Urology.

PPG provider growth 2009 - July 2015



[1]*As of July 15, 2015. Advanced practice providers include nurse practitioners and physician assistants.*
[2]*Providers include physicians and advanced practice providers.*

Recognitions, honors, awards

March 2015

American Heart Association/American Stroke Association, Get With The Guidelines® – Stroke Gold Plus Achievement Award, Primary Stroke Centers Certification and Honor Roll Recognition
Parkview Stanley Wissman Stroke Center

March 2015 and 2014

Truven Health Analytics™ 100 Top Hospitals® Award
Parkview Huntington Hospital

November 2014

The Joint Commission, 2013 Top Performer on Key Quality Measures

- *Parkview Ortho Hospital – Surgical Care*
- *Parkview Whitley Hospital – Pneumonia*
- *Parkview Huntington Hospital – Pneumonia and Surgical Care*
- *Parkview LaGrange Hospital – Pneumonia*

July 2014

The Joint Commission and American Heart Association/American Stroke Association, Advanced Certification for Primary Stroke Centers
Parkview Stanley Wissman Stroke Center

August 2014

Hospitals & Health Networks 2014 Most Wired Award
Parkview Health

February 2014

American Nurses Association's National Database of Nursing Quality Indicators (NDNQI®) Award for Outstanding Nursing Quality for a Community Hospital
Parkview Whitley Hospital

November 2013

Get With The Guidelines – Stroke Gold Plus Quality Achievement Award
Parkview Stanley Wissman Stroke Center

June 2013

The American College of Surgeons 2012 Outstanding Achievement Award
Parkview Comprehensive Cancer Center

January 2013

Get With the Guidelines – Stroke Gold Quality Award
Parkview Regional Medical Center

Parkview's dedicated team

July 2015

Parkview Care Partners physician leadership governance teams

Board of Managers

The Board of Managers oversees the business and operation of Parkview Care Partners and establishes business goals and strategies for Parkview Care Partners. The Board of Managers is responsible for evaluating and implementing input and decisions from the Quality & Performance Improvement Committee and the Contracting & Finance Committee.

Raymond Dusman, MD, MBA
PCP: Chairman, Board of Managers
PPG: Board of Managers
Parkview Health: Chief Physician Executive; Vice Chairman, Board of Directors; Chairman, Board Quality Committee and Board Governance Committee

Thomas Bond, MD
PCP: Chairman, Quality & Performance Improvement Committee
PPG: Chief Medical Officer;
PPG — Family Medicine
Parkview Health: Board of Directors Quality Committee

Jeffrey Brookes, MD
Parkview Health: Chief Physician / Quality Officer — Community Hospitals

Thomas Curfman, MD
Fort Wayne Neurological Center

Sue Ehinger, PhD
Parkview Health: Chief Experience Officer

Gary Gize, MD
Fort Wayne Medical Oncology and Hematology

Michael Grabowski, MD
PPG: Board of Managers; PPG — General Surgical Specialists
Parkview Health: Surgical Service Line Physician Leader

Thomas Gutwein, MD, Professional Emergency Physicians
Parkview Health: Emergency Department/ Pre-hospital Service Line Physician Leader; Medical Director, Emergency Department, Parkview Regional Medical Center & Affiliates

Alan McGee, MD , Ortho NorthEast
Parkview Health: Orthopedic Service Line Physician Leader; Board of Directors

Berry Miller, MD
PPG — Family Medicine

David Stein, MD
Ear, Nose & Throat Associates

Mitchell Stucky, MD
PPG: President;
PPG — Family Medicine

Quality & Performance Improvement Committee

The Quality & Performance Improvement Committee is responsible for improving patient outcomes and reducing costs. The committee recommends which clinical outcomes will be measured and sets performance expectations based on national quality standards. The committee also:

- Establishes network provider member credentialing criteria
- Provides quality and efficiency performance metric reports related to healthcare outcomes for patients served
- Ensures the PCP Clinical Integration Program addresses market and regulatory needs and includes a balance of measures including, but not limited to, patient experience, quality improvement, patient safety and cost-effectiveness
- Recommends the appropriate distribution of incentive funds to physicians to reward improved clinical performance and the achievement of other organizational strategies and objectives

Thomas Bond, MD
PCP: Chairman, Quality & Performance Improvement Committee
PPG: Chief Medical Officer;
PPG — Family Medicine
Parkview Health: Board of Directors Quality Committee

Lemuel Barrido, MD
PPG — Hospital Medicine

Fen-Lei Chang, MD, PhD
Fort Wayne Neurological Center
Associate Dean and Director, Indiana University School of Medicine — Fort Wayne
Parkview Health: Medical Director, Parkview Stanley Wissman Stroke Center; Neuroscience Service Line Physician Leader

Harin Chhatiawala, MD
PPG — Internal Medicine

Paul Conarty, MD
PPG — Colon & Rectal Surgery

Patrick Daley, MD
PPG: Chairman, PPG Quality Committee;
PPG — Cardiology
Parkview Health: Board of Directors Quality Committee

Quality & Performance Improvement Committee continued

Raymond Dusman, MD, MBA
PCP: Chairman, Board of Managers
PPG: Board of Managers
Parkview Health: Chief Physician Executive; Vice Chairman, Board of Directors; Chairman, Board Quality Committee and Board Governance Committee

Greg Johnson, DO
Parkview Health: Chief Medical Officer, Parkview Regional Medical Center & Affiliates; Inpatient Medicine Service Line Physician Leader

Joshua Kline, MD
PPG: Board of Managers;
PPG — Family Medicine
Parkview Health: Primary Care Service Line Physician Leader; Board of Directors

Jeffrey Nickel, MD , Professional Emergency Physicians
Parkview Health: Medical Director, Emergency Department, Parkview Regional Medical Center & Affiliates

Richard Nielsen, MD
PPG: Medical Director,
PPG — Hospital Medicine

Jason Row, MD
PPG: Chairman, Ohio PPG Primary Care & Specialty Physicians Committee; Chairman, PPG Ohio Executive Committee; Board of Managers; PPG — Family Medicine

Ronald Sarrazine, MD
PPG — Internal Medicine & Pediatrics

Anusha Valluru, MD
PPG — OB/GYN

Contracting & Finance Committee

The Contracting & Finance Committee oversees the development of value-based provider contracts with payers. The committee also:

- Identifies opportunities for improved financial performance in the delivery of healthcare to maximize efficiencies, create consistencies and appropriately decrease costs
- Recommends to the Board of Managers the financial incentives for meeting quality and efficiency goals

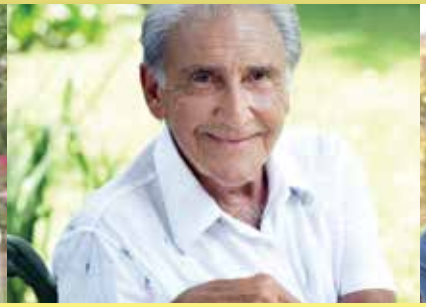
David Stein, MD, Ear, Nose & Throat Associates
PCP: Chairman, Contracting & Finance Committee

Scott Karr, MD
Ortho NorthEast

Mitchell Stucky, MD
PPG: President; Past Chairman, Board of Managers; PPG — Family Medicine

Raymond Dusman, MD, MBA
PCP: Chairman, Board of Managers
PPG: Board of Managers
Parkview Health: Chief Physician Executive; Vice Chairman, Board of Directors; Chairman, Board Quality Committee and Board Governance Committee






PARKVIEW
CARE PARTNERS

www.parkview.com/parkviewcarepartners