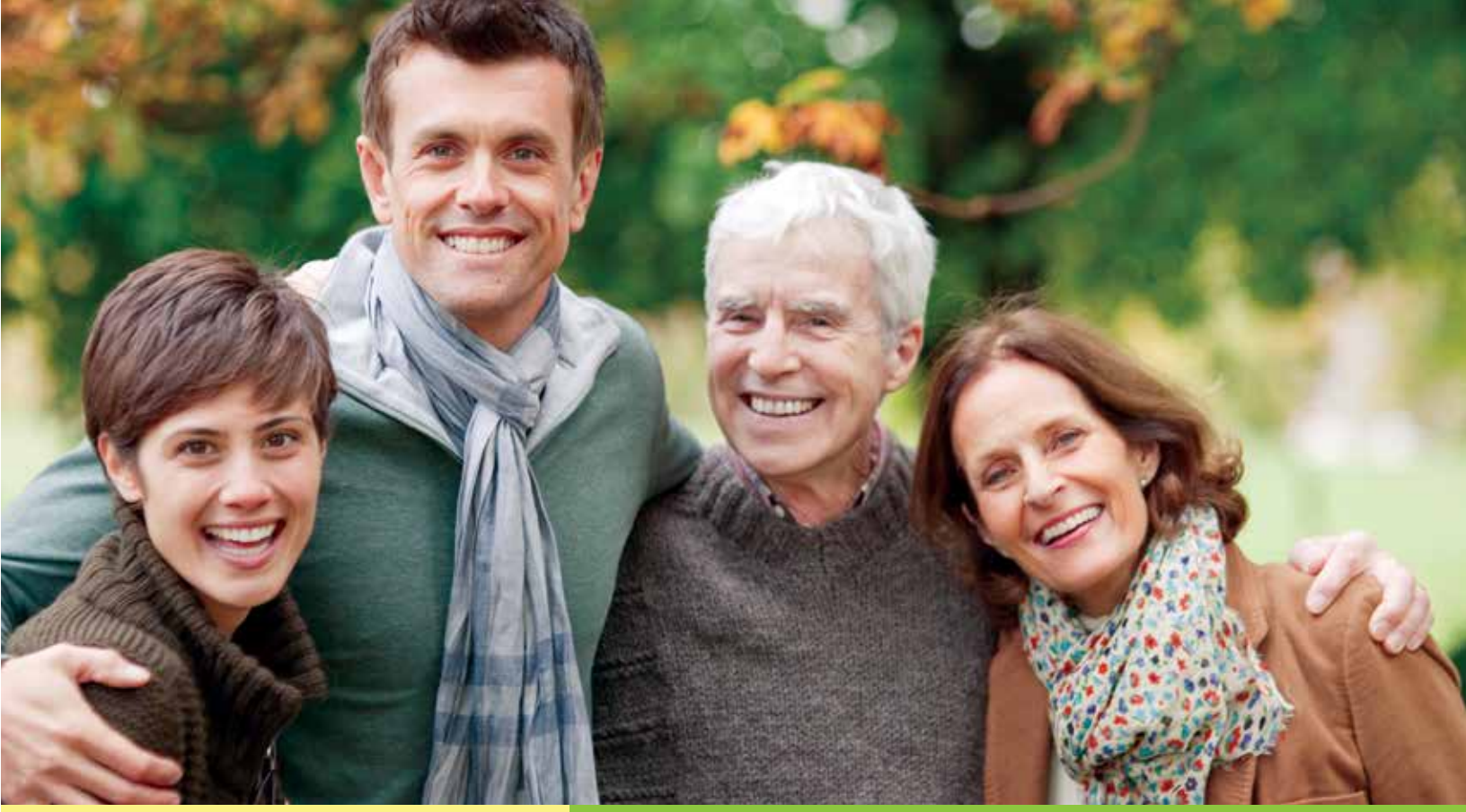


THE 2016 VALUE REPORT

ON 2015 RESULTS

PARKVIEW CARE PARTNERS

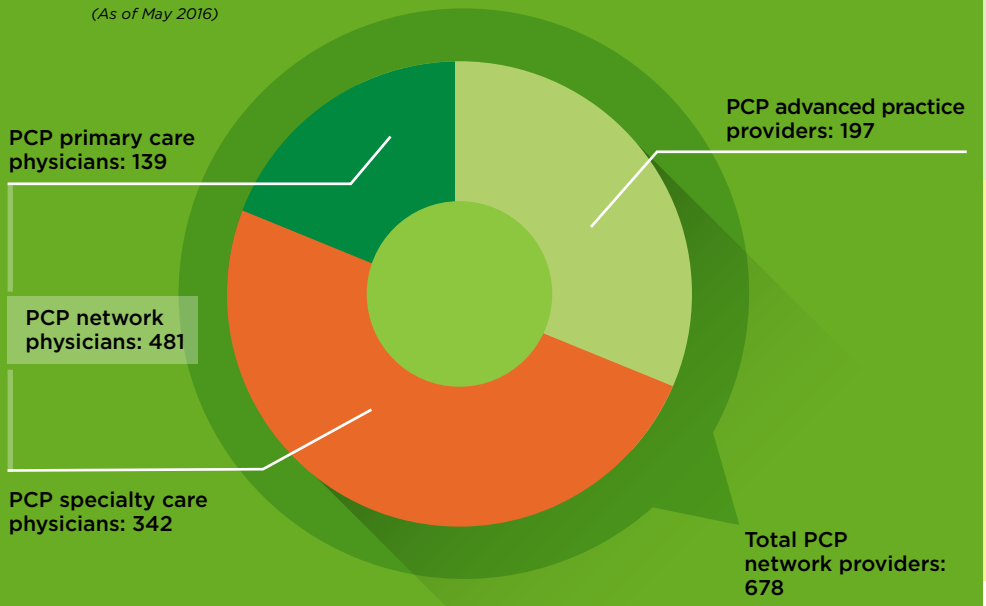
Executive summary

2015 clinical integration metrics

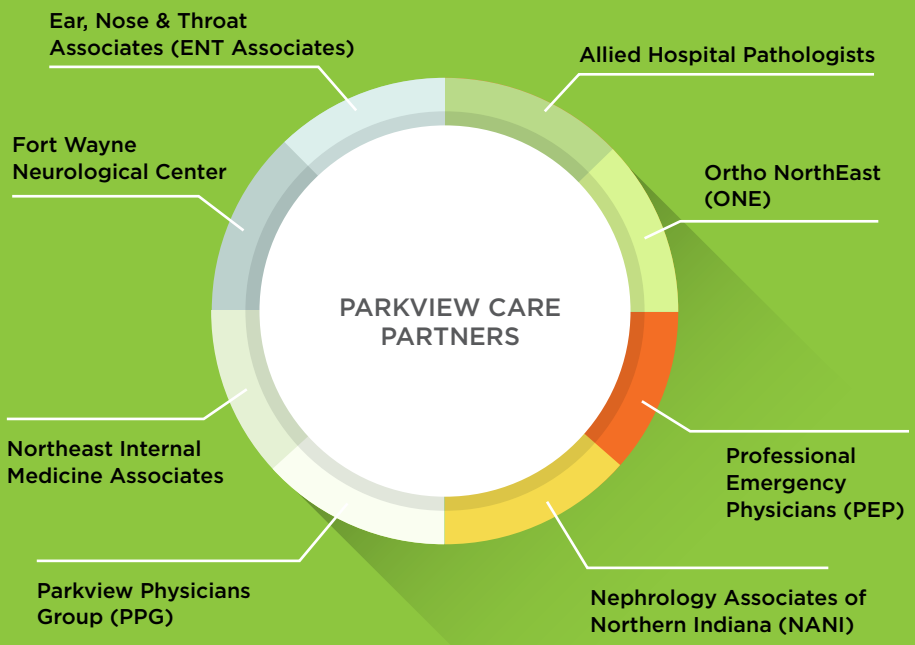
Out of 37 clinical integration metrics designed to prevent chronic disease, improve health and well-being, and improve efficiency and utilization measures, Parkview Care Partners achieved success in 31 areas. See page 15 for details.

Parkview Care Partners – by the numbers

(As of May 2016)



Physician groups within Parkview Care Partners



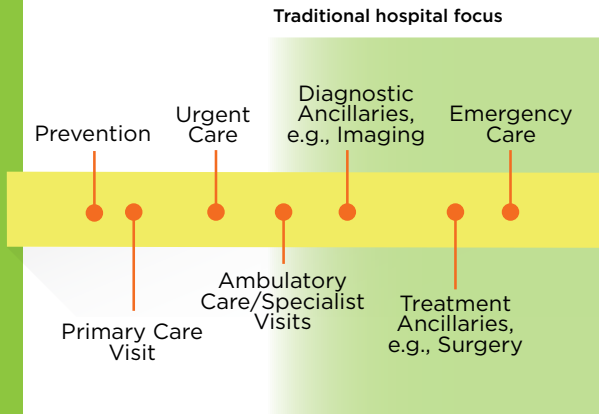
Quality of care

Value, in terms of reduced waste in healthcare

Managing for clinical effectiveness

Patient care continuum

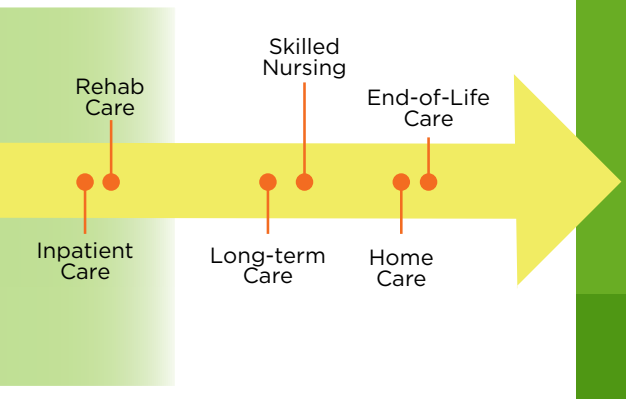
Clinical integration encompasses the entire patient care continuum, in partnership with primary care, specialty care, long-term care and much more.



Clinical integration works to improve:

The patient experience

The care provider experience



Number of people served by the PCP care advisor team

(The care advisor team includes RN care advisors, Medication Assistance Program specialists and social support specialists.)

Total people served: 1,529 high-risk patients

Percentage of high-risk patients in value-based contracts seen: 3.0 percent of 49,540 covered lives

July 2015 — March 2016

Payer	Covered Lives	High-risk Patients	% of Covered Lives
Payer 1	33,400	354	1.0
Payer 2	12,150	660	5.4
Payer 3	3,990	515	12.9
Total	49,540	1,529	3.0

Clinical integration can reduce waste in healthcare by:

- Identifying high-risk patients and proactively managing their care
- Managing chronic disease by providing better preventive care
- Building trust between patients and providers
- Building a more complete story of care by using an electronic health record across the continuum of care
- Meeting patients where they are to create a personal health journey
- Applying cutting-edge clinical technology

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

Table of contents

The Parkview mission and vision

As a community owned, not-for-profit organization, Parkview Health is dedicated to improving your health and inspiring your well-being by:

- Tailoring a personalized health journey to achieve your unique goals
- Demonstrating world-class teamwork as we partner with you along that journey
- Providing the excellence, innovation and value you seek in terms of convenience, compassion, service, cost and quality

Parkview Care Partners

Parkview Care Partners is a physician-led care management organization collaborating on a clinically integrated (CI) approach to healthcare delivery across the continuum of care. Clinical integration facilitates the coordination of patient care across medical conditions, providers, locations and time. The goal: improvements in quality of care, a better patient experience, increased value and greater professional satisfaction for physicians and other providers.

Physician-led innovation in healthcare

The work of Parkview Care Partners (PCP) mirrors the Parkview mission and vision, and is focused on providing healthcare excellence, innovation and value in terms of convenience, compassion, service, cost and quality.

This report reveals how PCP network members have changed the way we deliver healthcare to provide value for the people we serve and for our business partners.

We're proud to share the progress our network providers have made since we began this journey together in 2014. We're grateful for our members who embrace clinical integration, knowing we are doing what is right for the people we serve.

And, we're honored to lead the way as the only clinically integrated network in the northeast Indiana and northwest Ohio region.

R Dusman MD

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

Partners in a personal health journey

Our new model of healthcare delivery empowers the people we serve to tailor their personal journeys toward greater health and well-being. Our physicians and clinicians team up with patients to help them understand their conditions and risks, then provide screenings, care and resources to prevent disease and avoid hospitalization. This proactive, compassionate, partnership approach provides a better experience based on excellence, innovation and value for the patient and the clinical team.

Our clinicians are able to focus more intently on patient partnerships and outcomes because of support from Parkview Value Plus, a new business infrastructure to help PCP network members achieve CI quality goals. This infrastructure is essential to Parkview's progression in population health management as we move toward more value-based payer contracts.

Greg Johnson, DO, MMM
Chief Clinical Integration Officer, Parkview Health

PCP physician leaders and their roles include (left to right): **David Stein, MD,** Chairman, PCP Contracting & Finance Committee; **Thomas Bond, MD,** Chairman, PCP Quality & Performance Improvement Committee; **Greg Johnson, DO, MMM,** Chief Clinical Integration Officer, Parkview Health; and **Raymond Dusman, MD, MBA,** Chairman, PCP Board of Managers.

See pages 26 and 27 for full credentials.

The quadruple aim

Clinical integration works to achieve goals in four overarching areas — often referred to as the quadruple aim.

Quality of care

The PCP CI program facilitates the coordination of patient care across medical conditions, providers, settings and time. Consistent, measured quality parameters mean providers are focused on the best care and optimal health for patients. The goal is to provide patient-centered care that is safe, timely, effective and efficient, meeting or exceeding national quality standards.

The patient experience

People who seek care from PCP network providers experience a new style of healthcare delivery.

PCP is led by physicians who work to restructure their practice to provide excellent care for every person, every day.

We combine evidence-based medicine with an electronic health record that provides a single story of care for every patient, which is potentially shared by all of their providers in the network. Beyond just the physician, patients in value-based payer plans have an entire care team helping them understand their health status — meeting patients where they are to create a personal health journey. Nurses, social workers, medication specialists, behavioral health specialists and other experts help these patients get the resources they need to improve their own health and well-being.

And, this type of care is unique: PCP is the only clinically integrated provider network in the counties served by Parkview Health.

Value, in terms of reduced waste in healthcare

Unnecessary tests and diagnostic procedures are some of the most common sources of healthcare costs, and PCP providers work in partnership with patients to eliminate this kind of medical expense waste. Examples include:

- Duplicate or unneeded testing
- Hospital readmissions
- Delayed decisions or actions due to lack of information
- Avoidable emergency department visits
- Avoidable inpatient hospital stays

Improving the care provider experience

Parkview is focused on improving the health and well-being of people in our communities, including our own providers and clinical teams. We know that providers can achieve greater results when they have a better caregiver experience and know they are making a difference in the lives of the people they serve.

The physicians who lead PCP are rethinking the way member physicians interact with patients and co-workers. They are working to improve the care provider experience by:

- Providing care advisor teams that engage with high-risk patients who need extra services so that patients are more likely to follow the plan of care.
- Moving some non-clinical work from provider offices to a new centralized patient contact center.
- Improving clinical decision support in EpicCare*, Parkview's electronic health record, to help physicians know when patients are due for preventive care, and making those tests easier to order.
- Improving communication through the use of small "pods" of physicians who share best practices for office workflows.
- Providing leadership development for family medicine and specialty physicians.
- Analyzing electronic health record use and searching for greater efficiencies.

Plans to further improve the physician experience include:

- Implementation of a standard process to welcome the patient and prepare them in the examination room to be seen by the physician. The rooming clinical co-worker will capture important clinical information and address preventive care testing with the patient so the physician can focus on medical decision-making.
- A new focus on referral protocols and communication between primary and specialty care physicians for improved patient care and provider collaboration.
- New care team processes that provide more in-depth chart preparation.
- The increased availability of behavioral health resources.
- Care advisors embedded within primary care practices.

**EpicCare is the Parkview Health electronic health record system. As additional independent physician groups join Parkview Care Partners, we will continue to expand connectivity with other electronic health record systems. It is not a requirement of independent groups to be on EpicCare.*

Bringing value to the market for consumers

Parkview Care Partners works to increase the value[1] of healthcare for consumers. Value encompasses far more than lowest cost. It is quality, based on human aspects and clinical aspects of care, divided by cost.

Human aspects of care include quality of life, service experience, ability to navigate the system, maintenance of wellness and prevention of disease. Clinical aspects include process-oriented measures, indicators of health outcomes and actual outcomes. We define costs as direct healthcare costs and indirect costs, such as lost productivity.[2]

The creation of value can be summarized in three actionable categories:

- Alignment on metrics (set goals and measure activity around prevention of chronic disease, health and well-being, and efficiency/utilization measures).
- Data sharing (use of technology to create disease registries to manage populations of patients with similar disease states).
- Behavioral changes (educate consumers toward greater engagement and incentivize providers to implement quality measures and eliminate healthcare waste).

In other words, value equals healthcare outcomes and experience achieved per dollar spent.

Enterprise care management

Parkview has also invested in extensive inpatient care management teams. Case management began at Parkview in 1995 in the cardiovascular patient population. Now, case management is engaged system-wide to ensure safe and efficient transitions to the next level of care for high-risk patients on value-based plans and the uninsured.

The enterprise care management team meets patients where they are in their personalized health journey, incorporating patient-centric plans of care and identifying and resolving barriers to care. The team includes unit-based RN care managers, a trauma case manager, ED case managers and social support specialists to help support psycho-social challenges and difficult discharges.

Care managers work with various community resources to help support safe and smooth transitions to patients' homes, skilled nursing facilities, rehabilitation programs or long-term care facilities.

[1] *As defined by the Healthcare Leadership Council, an organization of chief executive officers within the healthcare field in the United States. Membership includes heads of health insurance companies, pharmaceutical companies, medical device manufacturers, pharmacy chains, hospitals and others.*

[2] *http://blog.sanofi.us/2015/03/13/healthcare-shifting-the-conversation-from-cost-to-value*

[3] *http://www.ndhi.org/files/5714/2507/8145/NORC_Slides.pdf*

$$\text{VALUE} = \frac{\text{Quality } \textit{(outcomes over the full cycle of care)} \text{ and Patient Experience}}{\text{Costs } \textit{(dollars spent over the full cycle of care)}\ [3]}$$

Parkview Care Partners clinical integration team

The PCP care advisor team includes nurses, social support specialists and Medication Assistance Program specialists. Front row, left to right: **Stacey Bussel, DNP, RN,** manager, Integrated Care Solutions; **Ellen O'Brien, BSN, RN,** manager, CI Quality Improvement and Clinical Outcomes; **Nick Hobbie, MPA,** clinical effectiveness project leader; **Susan McAlister, DNP, RN, CPHQ,** vice president, Clinical Integration, Parkview Health; and **Allison Keating,** manager, Value Based Contracts Data Analytics Outcomes. ***Second row:*** **Lisa Ludwig,** clinical outcomes population health coordinator; **Sheri Phillips, BSN, RN,** care advisor; **Heather Evans,** clinical outcomes population health coordinator; **Nicole Preston, BSN, RN,** care advisor; **Becky Myers,** CI provider relations coordinator; **Juliann LeMay, BSN, RN,** case management specialist; **Lori Cummick, BSN, RN,** care advisor; **Kristina Fraser, BSN, RN,** care advisor; **Katrina Koehler, RN,** CI provider relations specialist; **Jan Landrum,** CI provider relations coordinator; **Jill Schlotterback, BSN, RN,** care advisor; **Lisa Knox,** social support specialist; **Tracy Hammel, MSN, RN,** care advisor; **Amy Johnson,** coordinator, Medication Assistance Program; **Carla Schaller, BSN, RN,** care advisor team lead; **Mica Fensler, BSN, RN,** care advisor; **Martha Bushman, BSN, RN,** care advisor; **Sandy Koch, BSN, RN,** care advisor; **Teresa Hess, BSN, RN,** case management specialist; **Penny Campbell,** CI IS specialist; **Mary Ann Steiner, BSN, RN,** care advisor; **Peggy Sisco,** intake coordinator; and **Victoria Mansfield,** intake coordinator.

Care advisor team

Behavioral change among patients is a key factor in improving outcomes and increasing quality. To influence patient accountability for their own care, PCP has invested heavily in a care advisor team of nurse care advisors, social support specialists and Medication Assistance Program specialists. The care advisor team works with high-risk patients with complex diseases and co-morbidities in value-based contracts. Care for high-risk patients constitutes the bulk of healthcare costs.

For case studies on the work of care advisors and how they are changing patient behaviors and leading to reduced costs, see the section titled "Select CI initiatives, 2015" on page 16. ◆

Bringing value to the market for business: Parkview Value Plus

With two years of clinical integration experience in place, Parkview is now taking strides to lead our market's transformation to focus on value in a continuously changing healthcare environment.

Investments in and alignment of our infrastructure now allow Parkview to further expand value-based contracting and leverage synergies between several business function areas. These steps will enable continued growth of our clinically integrated network and offer clinical integration services to non-Parkview entities as Parkview Value Plus.

Parkview Value Plus is tasked with managing risk from third-party payers and self-funded/administrative service organization employers. Services offered by Parkview Value Plus are available to PCP network providers and regional employers who partner with Signature Care. Signature Care is a Preferred Provider Organization (PPO) and one of four products available to employers through Parkview Total Health.

Parkview Value Plus can provide:

- CI patient care advising
- CI quality metrics tracking
- Value-based contracts outcomes analysis
- Clinical data analysis
- Enterprise credentialing
- Enterprise care management

Contractual support services include:

- Contract management
- Self-funded employer relationship management

PARKVIEW VALUE PLUS

Overview of 2015 quality results

Quality metrics are established by the Quality & Performance Improvement Committee with the goal of achieving the quadruple aim (see page 7). Results in 2015 represent the first year of growth on top of baseline, foundational quality metrics achieved in 2014.

Each measure is evaluated 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?

PCP network providers receive quarterly reports on 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.

Results comparison: 2014 to 2015

Learning from our first year of clinical integration experience in 2014, PCP network providers took steps to improve CI quality results in 2015.

2015 initiatives that led to improved results include:

- A greater focus on use of the patient care registry to track patient care and identify gaps in care. Patient care registries are disease-specific and are based on information in EpicCare, Parkview's electronic health record. Based on age, gender and disease state, the registries identify patients who need to meet with their primary care physician for preventive measures or screenings, such as mammography or colonoscopy, and close gaps in care based on disease-specific measures.
- Improving the patient experience in terms of notifying patients about the need for care and scheduling appointments to close gaps in care.
- Improved documentation in and use of EpicCare, including an alert system that lets the physician know when a patient has gone without needed care.

The following data compare 2014 and 2015 PCP clinical integration quality results on key diabetic control measures, hypertension and low back pain. National averages are taken from the National Committee for Quality Assurance (NCQA) State of Health Care Quality 2015 Report.

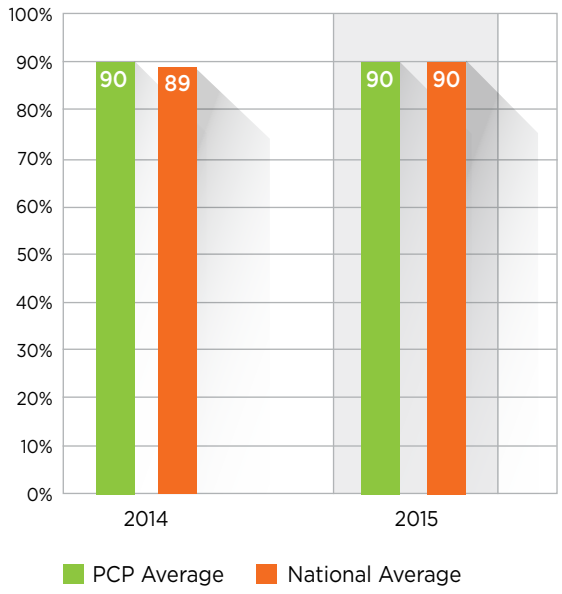
Diabetic Control

Management of disease indicators such as A1c can have dramatic effects on a patient's overall level of well-being and disease avoidance. For example, a 1 percent drop in A1c can produce a 35 percent reduction in a patient's risk of micro-vascular complications, according to the American Diabetes Association. PCP performance of A1c management is 10 percent better than the national performance. This means 1,900 more diabetics under PCP value-based contracts have a 35 percent reduction in risk of micro-vascular complications such as retinopathy, neuropathy and nephropathy.

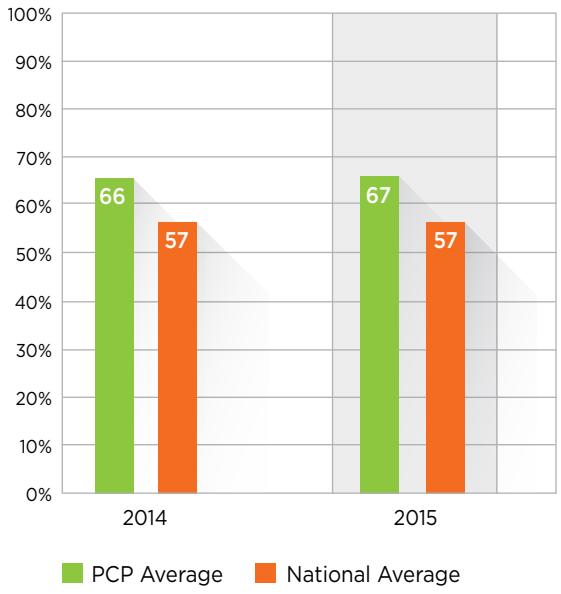
"Physicians and providers within the Parkview Care Partners network are leading the transformation of healthcare, working with people to tailor personalized health journeys."

David Stein, MD
Ear, Nose & Throat Associates

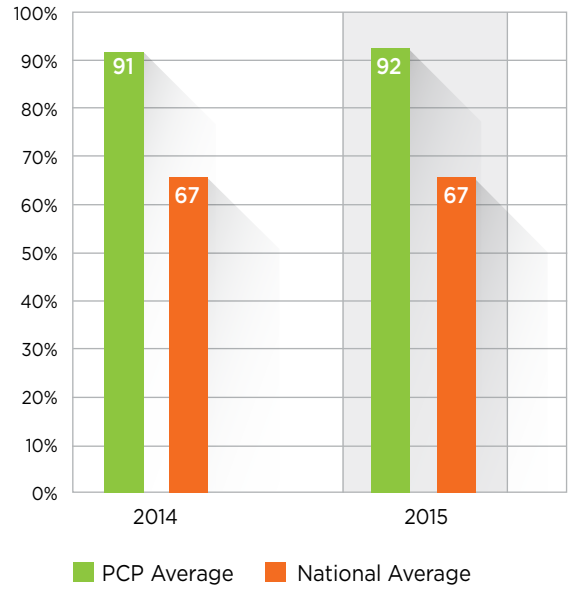
Diabetic A1c screening



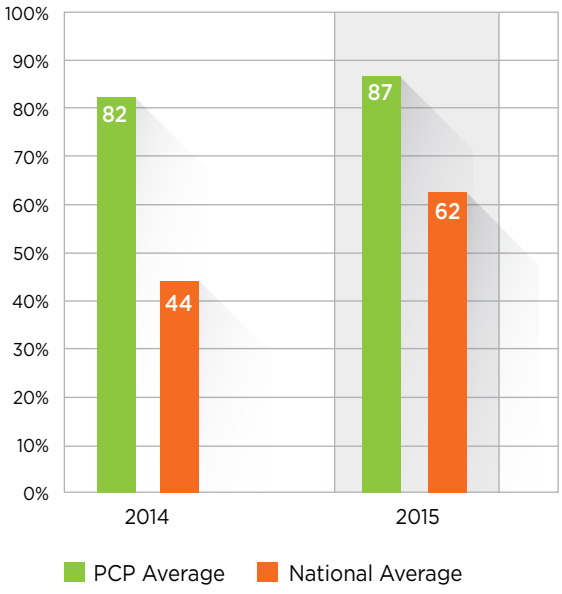
Diabetic A1c < 8[1,2]



Diabetic A1c < 9[1]



Diabetic BP control < 140/80[1]

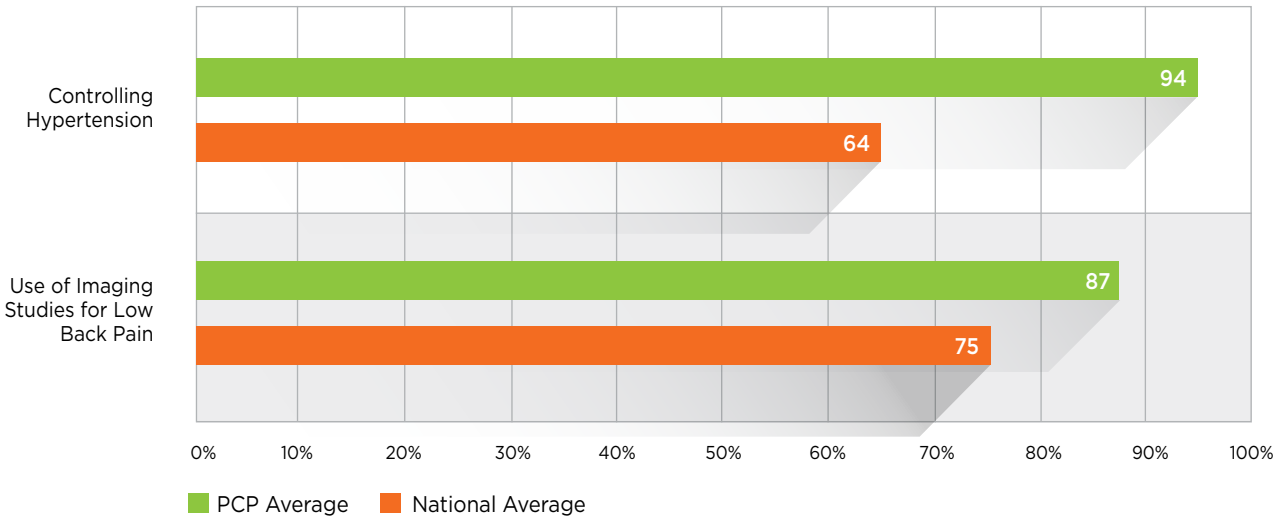


Source: The National Committee for Quality Assurance (NCQA) State of Health Care Quality 2015 Report.

[1]Based on lowest level during the measurement year.

[2]PCP measures A1c < 7.5.

Controlling hypertension and low back pain



Source: The National Committee for Quality Assurance (NCQA) State of Health Care Quality 2015 Report.

Well-child care

Measure	2014	2015	Increase in patients screened	Increase in patients seen
Well-child care, age 3-6 years	64% screened (6,487 out of 10,155)	63% screened (9,248 out of 14,680)	2,761	4,525
Well-child care, age 12-21 years	37% screened (8,148 out of 21,872)	40% screened (13,128 out of 32,930)	4,980	11,058

Increases in patients seen are reflective of market growth within PPG through the addition of new providers and the addition of Wabash County, Indiana, to our service area.

Women's health screening

Measure	2014	2015	Increase in patients screened	Increase in patients seen
Osteoporosis screening	41% screened (9,258 out of 22,751)	56% screened (15,091 out of 26,877)	5,833	4,126
Breast cancer screening	56% screened (27,463 out of 48,787)	57% screened (39,425 out of 68,681)	11,962	19,894
Cervical cancer screening	40% screened (19,397 out of 47,963)	53% screened (41,723 out of 78,133)	22,326	30,170

Increases in patients seen are reflective of increased use of the care registry database within PPG — Primary Care and PPG — OB/GYN.

2015 clinical integration results

The following table provides insight into the PCP 2015 CI program performance. Results indicate that network providers in primary care met or exceeded goals in the majority of our target areas.

● Performance met or exceeded 2015 target ● Performance below 2015 target

Chronic Disease Care	
Diabetes	
A1c test performed annually	●
A1c control: result <7.5%	●
A1c poorly controlled: >9%	●
LDL test performed annually	●
LDL control: <100 mg/dL or on statin medication	●
BP control: <140/80 mm/Hg	●
Body mass index (BMI) measured annually	●
Comprehensive care: A1c test performed annually; A1c control: result <7.5%; LDL test performed annually; LDL control: <100 mg/dL or on statin medication; BP control: <140/80 mm/Hg; and body mass index (BMI) measured annually	●
Coronary Artery Disease (CAD)	
LDL test performed annually	●
LDL control: <100 mg/dL or on statin medication	●
BP measured annually	●
Comprehensive care: LDL test performed annually; LDL control: <100 mg/dL or on statin medication; BP measured annually	●
Congestive Heart Failure	
Left ventricular ejection fraction assessment inpatient setting	●
Health and Well-being	
Preventive Care Measures	
Cervical Cancer Screening	●
Breast Cancer Screening	●
Osteoporosis Screening	●
Colorectal Cancer Screening	●
Influenza Vaccination	●
Tobacco Use: Screening and Cessation Counseling	●
BP Pressure Control	●
Pediatric – Preventive Care Measures	
Well-child care ages 3 – 6 years	●
Well-child care ages 12 – 21 years	●
Childhood immunizations:	
MMR	●
Varicella	●
Influenza	●
Hepatitis A	●
Rotavirus	●
Efficiency/Utilization Measures	
Acute Care	
Use of imaging studies for low back pain	●
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	●

Select CI initiatives, 2015

30-day readmission rates

The Hospital Readmissions Reduction Program (HRRP) section of the Affordable Care Act (ACA) penalizes hospitals with higher-than-expected readmission rates within 30 days of discharge by withholding up to 3 percent of their total Medicare payments.

The effect of the HRRP has been largely positive. Readmission rates declined nationally, and the Centers for Medicare & Medicaid Services (CMS) touted these results as evidence that the ACA had begun to bend the cost curve. From 2008 through 2013, the likelihood of a Medicare beneficiary being readmitted within 30 days decreased from 19 percent to 17.8 percent, translating to hundreds of millions of dollars in savings to Medicare.[1]

When a patient covered by a value-based contract is admitted to any Parkview hospital, the clinical integration care advisor team is notified of the admission. A potential readmission risk stratification is noted in EpicCare, and high-risk patients are automatically referred to an RN care advisor via primary care physician medical protocol.[2] In the fourth quarter of 2015, PCP encountered 643 post-discharge patients at high risk for readmission.

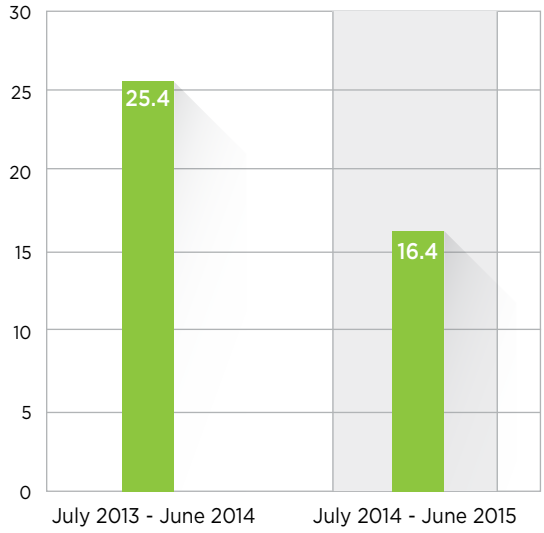
High-risk, potential 30-day readmission patients are contacted by an RN care advisor within two business days after the acute care discharge. The acute care discharge instructions are reviewed, and a full assessment may be warranted, depending on the post-discharge responses. The care advisor assesses whether the patient's needs are being met as they attempt to return to their pre-hospital state of well-being.

CMS currently measures successful hospital discharges based on the 30-day readmission rate. Parkview Health is preparing for future CMS measures now by looking at 30-, 60- and 90-day readmission rates — looking ahead for opportunities for further improvement.

Successful prevention of readmissions is the result of:

- Proactive discharge planning.
- Greater patient accountability, compliance and self-care with encouragement and education from care advisors.
- Partnerships with long-term care facilities that recognize, assess and treat residents. This allows the resident to remain in their place of residence.
- Better communication during transitions from inpatient to outpatient care.
- In-home assessment and assistance for patients without traditional Medicare.

Hospital readmissions per 1,000 patients
PCP value-based contract #1



[1](JAMA Forum: Ashish K. JHA;Seeking Rational Approaches to Fixing Hospital Readmissions, Sept. 24, 2015).

[2]Based on LACE score of 9 or greater – anticipated length of stay, acuity, comorbidities and ED visits in the prior six months.

Potentially avoidable ED visits

The rate of potentially avoidable emergency department visits is measured as a reflection of the quality of patient care, the overall patient experience and the opportunity to potentially avoid unnecessary costs incurred in the hospital setting.

By monitoring and following up on patients, and providing education regarding access to care other than the ED, patients with Ambulatory Care Sensitive Conditions (ACSC) identified by the U.S. Department of Health and Human Services can receive the care they need at a fraction of the cost. ACSCs include angina, asthma, chronic obstructive pulmonary disease (COPD), diabetes, grand mal status and other epileptic convulsions, heart failure, pulmonary edema and hypertension.

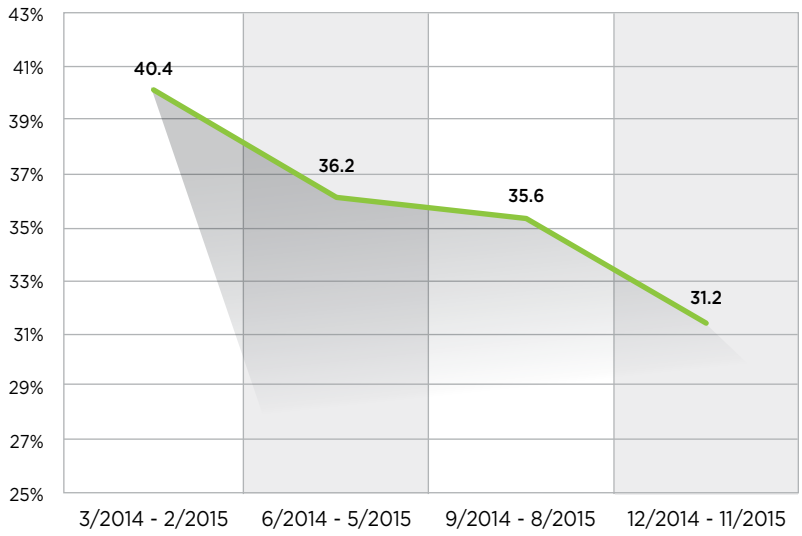
Elimination of every ED visit is not our goal. Rather, our goal is to prevent avoidable ED visits and hospital readmissions through the prevention and management of diseases and conditions. As we participate increasingly in shared risk, value-based contracts, it makes financial sense, and clinical sense from the patient's perspective, to provide care in the most appropriate setting to avoid ED visits and readmissions.

At Parkview Health, we have taken a multi-faceted approach to assisting patients with the access they need to medical care.

Our value-based contract partners have identified ED admission diagnoses that potentially could be treated in a less "emergent" location. Patients who have used the ED for conditions determined to be less emergent receive a letter the day after their ED visit. The letter expresses appreciation for their selection of Parkview and provides information on primary care, same-day appointments and Parkview walk-in clinics. PPG physicians have worked diligently in 2015 to recruit additional medical staff and reconfigure office work flows to add additional visit times for emergent patients.

Avoidable ED visits
PCP value-based contract #2

Potentially avoidable ED visits as a percentage of total ED visits



A small number of patients use the ED on a consistent basis, as they would a primary care physician. These patients are identified due to their frequency of ED visits and hospitalizations. PCP network providers want to help these patients obtain better health and connect them with care plans, and in high-risk cases covered by a value-based contract, an RN care advisor.

Care plans are "flagged" in EpicCare for all ED physicians to review and provide follow-up care. The RN care advisor meets with the patient to assess their needs, ranging from coordination of care to medical access to social determinants of care. When the patient presents to the hospital or the ED, the RN care advisor meets them upon admission to continue to assist in the condition of care efforts. PCP care advisors are tracking changes in ED usage habits among patients before and after care advisor activity to measure effectiveness.

Chronic case management

Parkview has established care advisor teams of nurses, social support specialists, Medication Assistance Program specialists, pharmacists, dietitians and other Parkview and community healthcare professionals to help high-risk patients covered by value-based contracts reach their goals toward health and well-being.

Care advisors are focused on both human and clinical aspects of patient care. Their tasks include:

Personal patient contact

- Contact patient to assess the patient's understanding of his or her health status and develop a plan of care to achieve positive outcomes.
- Coach the patient on disease management needs.

Promotion of patient engagement

- Monitor and encourage adherence to prescribed medications.
- Accompany patient to office appointments to encourage compliance with plan of care.
- Encourage patient to have accountability for healthcare.
- Encourage completion of routine health maintenance and disease-specific care guidelines.
- Maintain ongoing contact to monitor progress.

Provision of resources

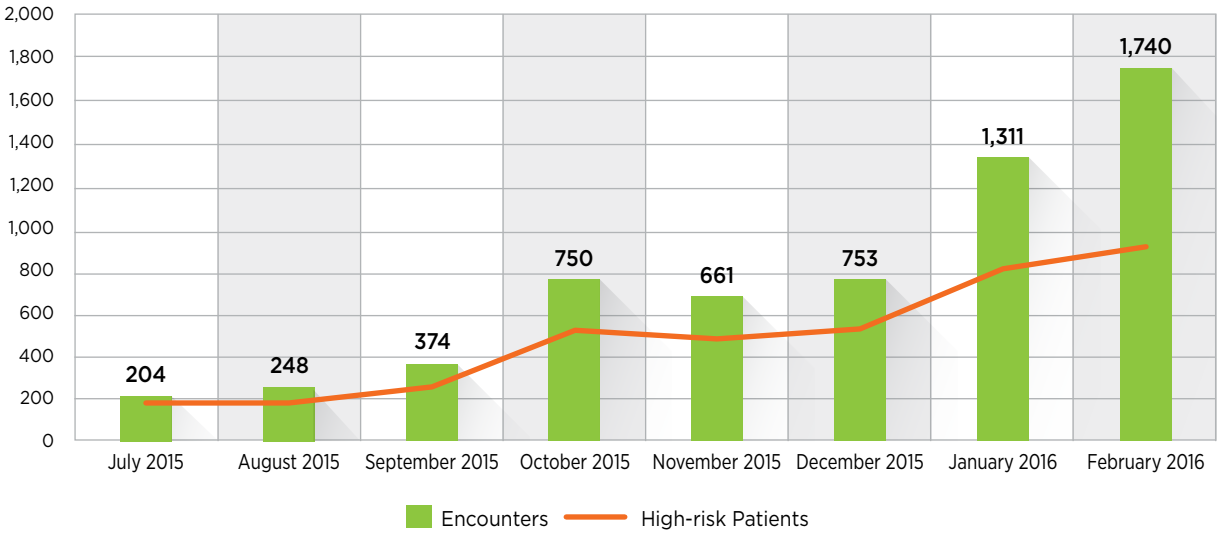
- Medication Assistance Program or social work specialist as needed.
- Conduct home visits to assess environment and social support/needs.
- Provide resources to assist the patient to reach his/her optimal state of health.
- Assess social issues and connect resources.



Assisting in navigation through the healthcare system

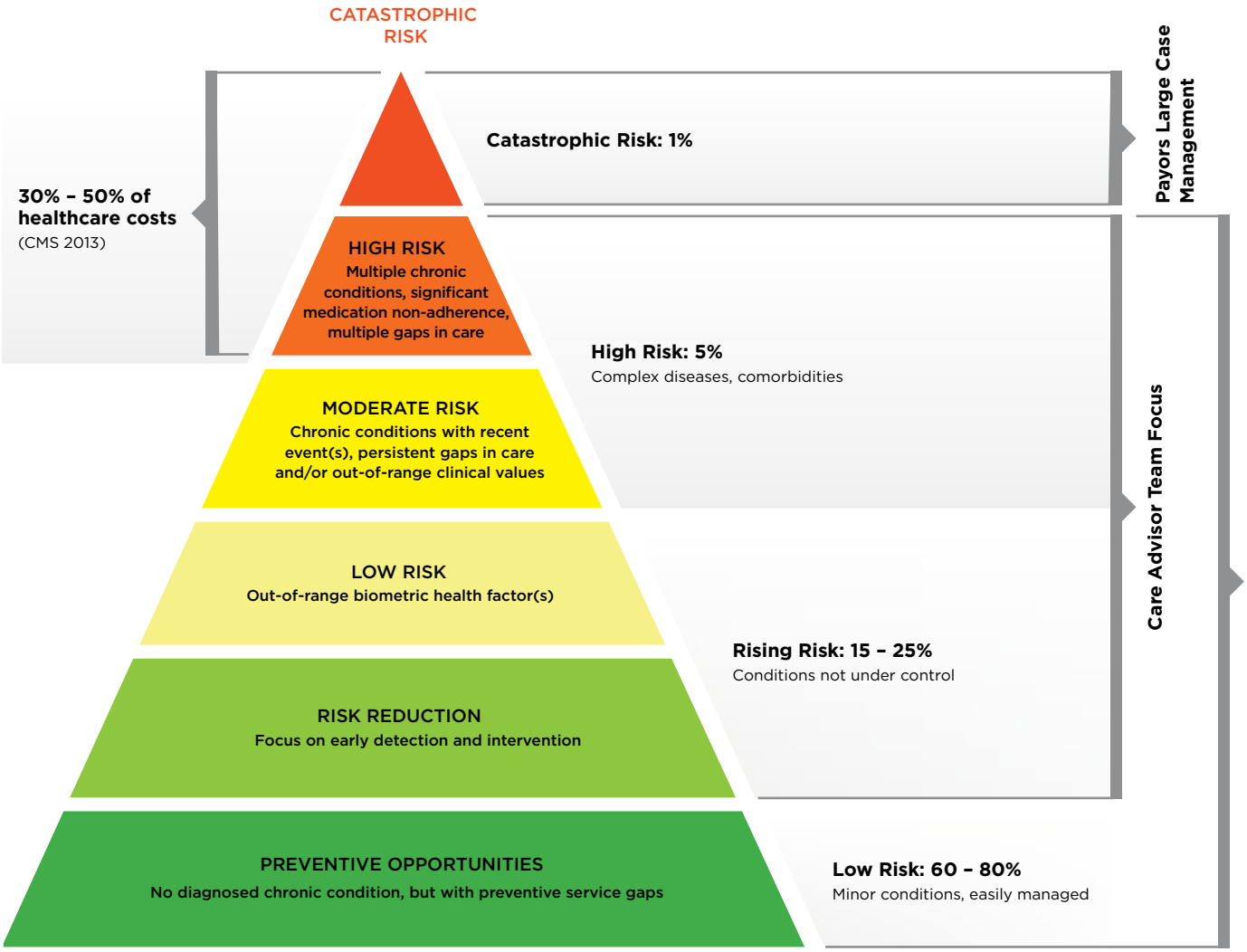
- Provide guidance on referrals, medication assistance, dietitians, pharmacists, social work and other community resources.
- Manage transitions from hospital acute care to home or a skilled nursing facility, or from a skilled nursing facility to home.
- Coordinate home healthcare.
- Follow-up care after an ED visit.
- Suggest specialty physicians within the network for better continuity of care.
- Facilitate follow-up appointments with provider.
- Provide feedback to referring provider on progress.
- Connect patients not covered by a value-based contract with alternative sources for case management.

PCP care advisor activity



Our approach to risk classification

Integrated care management that delivers the right care, for the right person, at the right time, and in the right location.



Care advisor case study #1

Age: 23

Gender: Male

Condition: Various complaints of back pain

Hospital use five months prior to care advisor engagement: Ten ED visits at a cost of $16,279

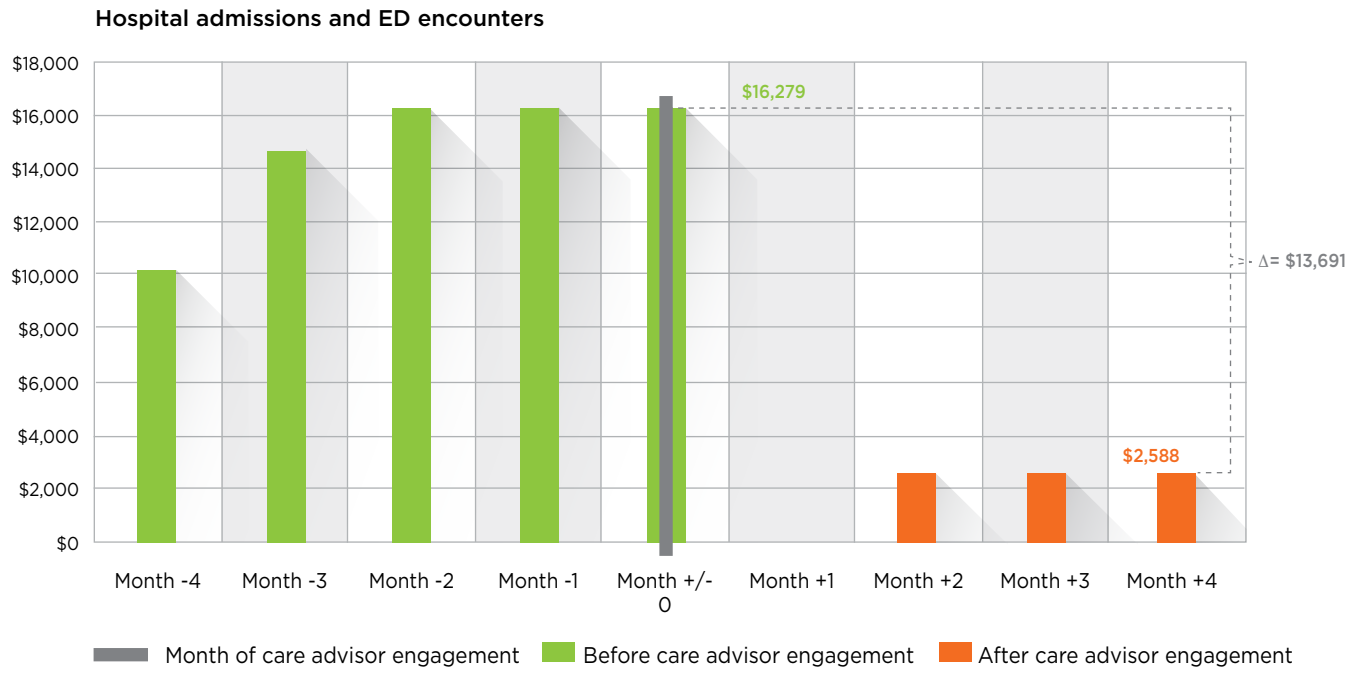
Hospital use five months after care advisor engagement: One ED visit at a cost of $2,588

Savings: $13,691

The care advisor assisted this patient with obtaining pain medications through his primary care physician. Management of the back pain decreased the need for ED visits and associated radiology encounters.

Although the patient originally declined care advising services, persistence on the part of the care advisor paid off.

Case Study #1: Male, back pain



Care advisor case study #2

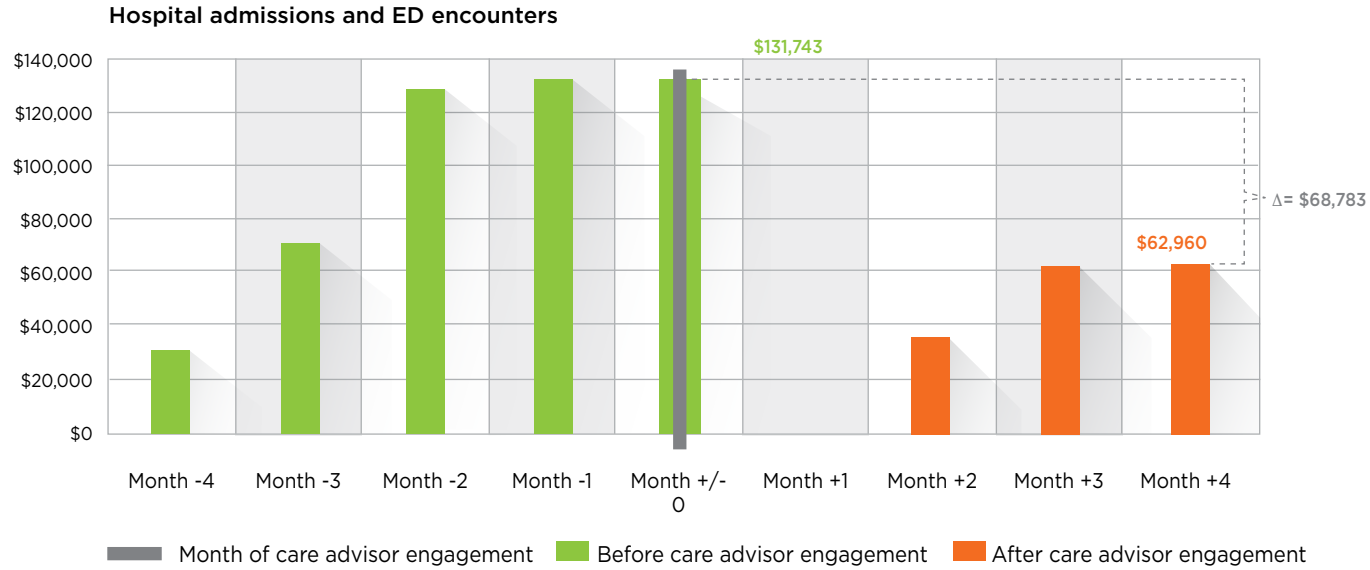
Age: 59
Gender: Female
Condition: Congestive heart failure
Hospital use five months prior to care advisor:
Six hospital admissions and two ED visits at a cost of $131,743
Hospital use five months after care advisor: Three hospital admissions and three ED visits at a cost of $62,960

Savings: $68,783

This patient faced multi-vessel coronary artery disease (managed medically), ischemic cardiomyopathy, COPD and Ménière's disease. In a five-month period, she was admitted for chest pain, vertigo and congestive heart failure (CHF). Upon discharge, she received CHF education, encouragement for medication compliance, medication reconciliation and a better-organized daily medication process from an RN care advisor. The care advisor also made sure the patient followed up with a cardiologist and her primary care provider. One month later, the patient experienced a fall unrelated to her medical condition, fracturing her femur. Over the following four months, the patient was admitted to the hospital for gastroenteritis, vertigo, a pulmonary embolism and ICD placement. She also paid a visit to the ED for dizziness in the same time period.

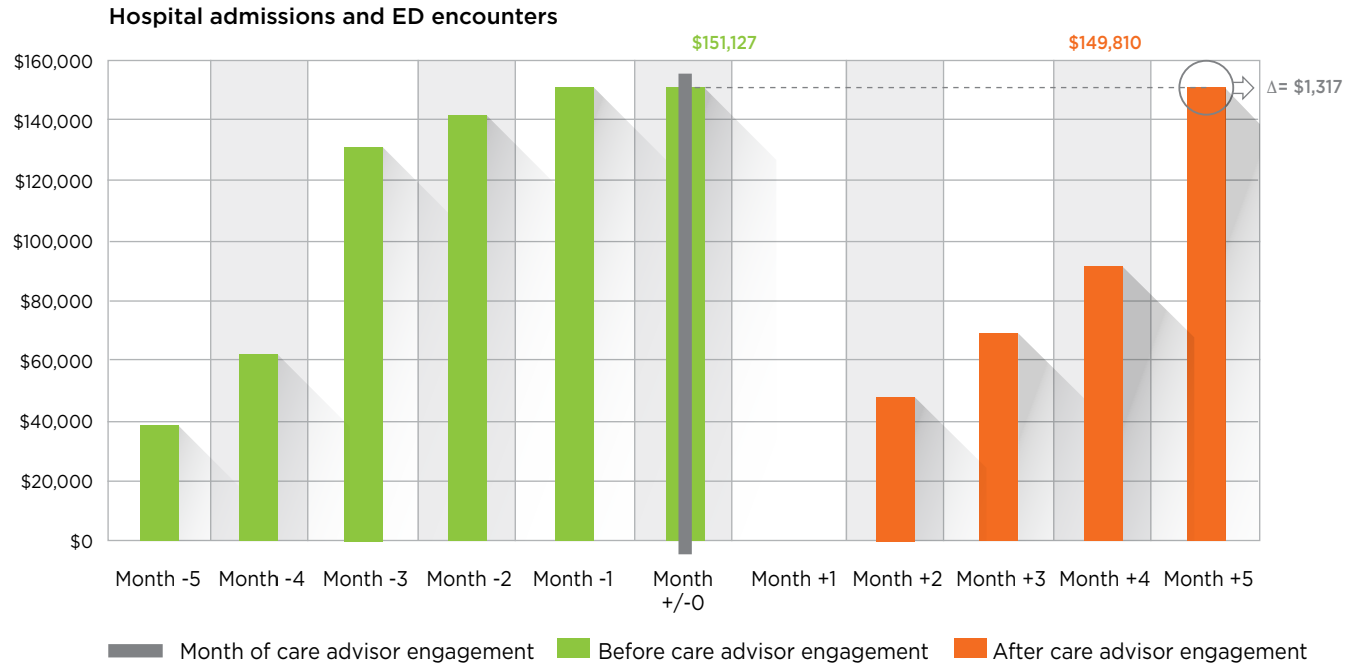
The patient has since experienced no inpatient stays or ED visits and has been feeling better and is gaining weight. Her cardiologist is working to decrease the side effects from medication to help ensure compliance.

Case Study #2: Female, CHF



Care advisor case study #3

Case Study #3: Male, COPD



Age: 68

Gender: Male

Condition: Chronic obstructive pulmonary disease, congestive heart failure, diabetes, hypertension, chronic pain, benign prostatic hyperplasia, GERD, anemia, bipolar disorder, depression and anxiety

Hospital use five months prior to care advisor engagement:
Three hospital admissions and 17 ED visits at a cost of $151,127

Hospital use five months after care advisor engagement:
Five hospital admissions and three ED visits at a cost of $149,810

Savings: $1,317

While the cost savings in this case are not as dramatic, the care advisor's persistence in checking up on this patient over a five month period helped him eventually realize that he could not manage his own care at home. At one discharge, he was insistent on going home with home healthcare even though a skilled nursing facility was ready to have him return.

The comorbidities he faced resulted in 17 ED visits for respiratory complaints, pain, anxiety and a fall prior to care advisor involvement, along with three hospital admissions for chest pain, gastrointestinal bleeding and shortness of breath.

(Continued on page 24.)

(Continued from page 23.)

He did receive care from Parkview Home Health & Hospice and another home care agency, and called his primary care physician office two or three times a week. He would also consult with home health or primary care before going to the ER.

Five months after care advisor intervention, the patient experienced five unrelated hospital admissions for COPD exacerbation, sepsis, gastrointestinal hemorrhage and agitation. Three ED visits under the care advisor's involvement were related to respiratory problems.

During repeated transfers between the hospital, skilled nursing facility and home, discharge case managers documented care to be sure discharge needs were met.

Who we are

Read the 2014 PCP Value Report online.

Parkview Care Partners

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. For more detail, visit Parkview.com/ParkviewCarePartners.

Parkview Value Plus

Parkview Value Plus is a service organization that manages risk from third-party payers and self-funded/administrative service organization employers. Clinical and contractual support services offered by Parkview Value Plus are available to PCP network providers and regional employers who partner with Signature Care. Signature Care is a Preferred Provider Organization (PPO) and one of four products available to employers through Parkview Total Health. For more detail, please see page 11.

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, more than 10,000 employees and 1.9 million patient encounters annually. Our mission is stated on page 4 of this report. For more detail, visit Parkview.com.

Recognitions, honors, awards (Parkview Health)

June 2016
Midas+ Platinum Quality Award
Midas+ Solutions
Parkview Regional Medical Center

May 2016
Get with the Guidelines®–Stroke Gold Plus Quality Achievement Award with Target: Stroke Honor Roll Elite Plus
American Heart Association/American Stroke Association
Parkview Stanley Wissman Stroke Center

March 2016
2016 Workplace of the Year
The Advisory Board Company
Parkview Health

March 2016
100 Top Hospitals® by Truven Health Analytics™
Parkview Regional Medical Center
Parkview Huntington Hospital

November 2015
Top Performer on Key Quality Measures®
by The Joint Commission
Parkview Health

November 2015
Performance Leader in Quality and Outcomes
iVantage Health Analytics and the National Organization of State Offices of Rural Health
Parkview LaGrange Hospital

October 2015
National Surgical Quality Improvement Program
The American College of Surgeons National Surgical Quality Improvement Program
Parkview Regional Medical Center

September 2015
Top 100 Critical Access Hospitals
iVantage Hospital Strength Index
Parkview LaGrange Hospital

August 2015 and 2014
Hospitals & Health Networks Most Wired Award
Parkview Health

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

Meet our leaders

Parkview Care Partners physician leadership governance teams

Board of Managers

The Board of Managers oversees the business operations 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

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

Greg Johnson, DO, MMM, CPE

Parkview Health: Chief Clinical Integration Officer

Alan McGee, MD

Ortho NorthEast

Parkview Health: Orthopedic Service Line Physician Leader; Board of Directors

Ben Miles

Parkview Health: President, Parkview Regional Medical Center & Affiliates

Berry Miller, MD

PPG — Family Medicine

David Stein, MD

Ear, Nose & Throat Associates

PCP: Chairman, Contracting & Finance Committee

Mitchell Stucky, MD

PPG: President; PPG — Family Medicine

Jeanné Wickens

Parkview Health: Chief Financial Officer

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 and Parkview Center on Aging and Health; Neuroscience Service Line Physician Leader

Quality & Performance Improvement Committee continued

Harin Chhatiawala, MD

PPG — Internal Medicine

Paul Conarty, MD

PPG — Colon & Rectal Surgery

Parkview Health: Associate Chief Medical Officer, Parkview Regional Medical Center

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, MMM, CPE

Parkview Health: Chief Clinical Information Officer

Joshua Kline, MD

PPG: Chief Medical Officer; 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

Mark Pierce, MD

Parkview Health: Chief Medical Informatics Officer; PPG — Family 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 and create consistencies
- Recommends to the Board of Managers the financial incentives for meeting quality and efficiency goals and appropriately decreasing costs

David Stein, MD

Ear, Nose & Throat Associates

PCP: Chairman, 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

Greg Johnson, DO, MMM, CPE

Parkview Health: Chief Clinical Integration Officer

Scott Karr, MD

Ortho NorthEast

Mitchell Stucky, MD

PPG: President; Board of Managers; PPG — Family Medicine

Jason Row, MD

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

Jeanné Wickens

Parkview Health: Chief Financial Officer




PARKVIEW
CARE PARTNERS

www.parkview.com/parkviewcarepartners