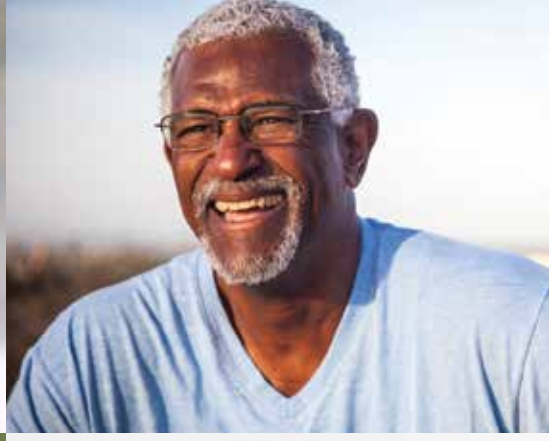
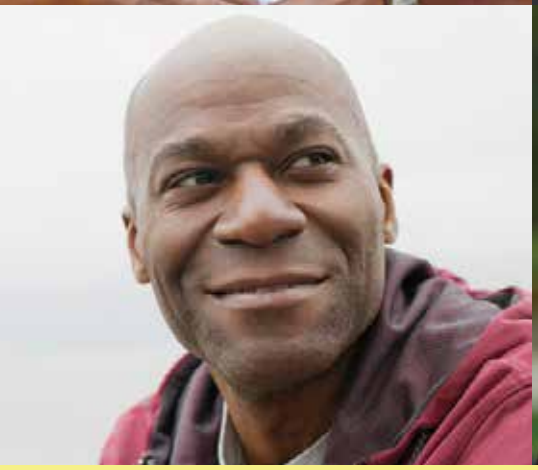


PCP VALUE REPORT 2017

A REPORT ON 2016 RESULTS

PARKVIEW CARE PARTNERS

Executive summary

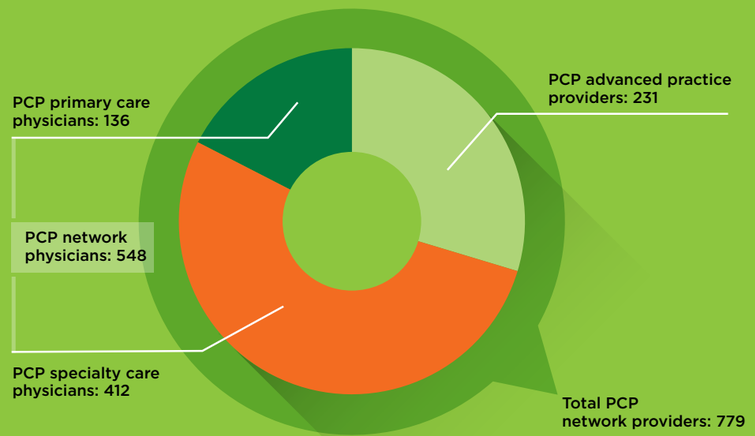
Parkview Care Partners (PCP) is a physician-led care management organization collaborating on a clinically integrated (CI) approach to healthcare delivery across the continuum of care. Clinical integration facilitates the coordination of patient care across medical conditions, providers, locations and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

2016 clinical integration metrics

Out of 38 clinical integration metrics designed to prevent chronic disease, improve health and well-being, and improve efficiency and utilization measures, PCP achieved success in 36 areas. See pages 13 and 14 for details.

Parkview Care Partners – by the numbers

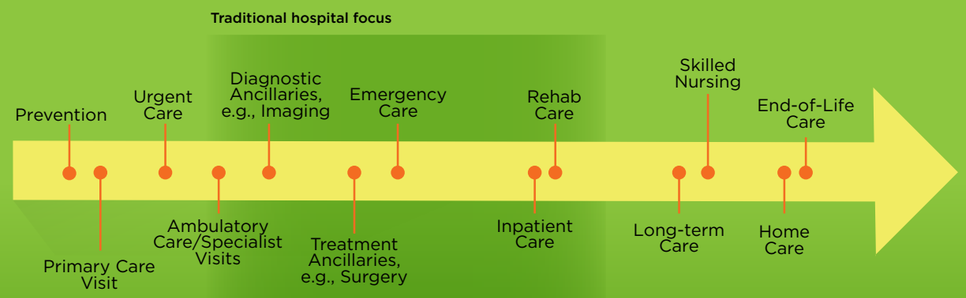
(As of May 2017)



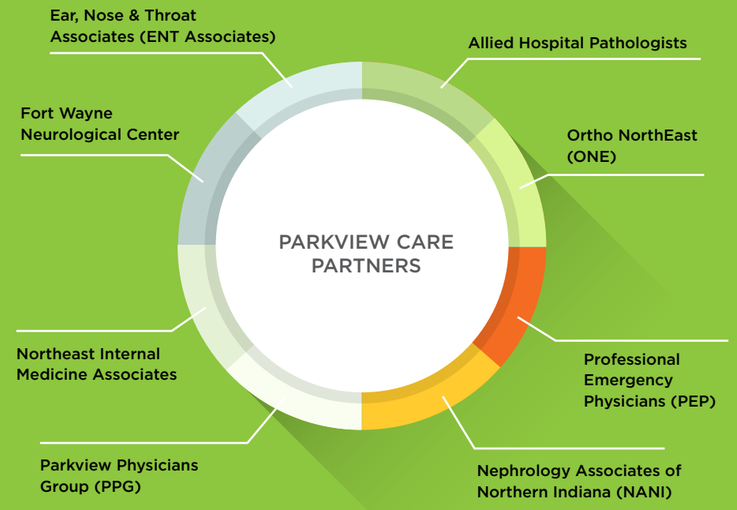
Managing for clinical effectiveness

Patient care continuum

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



Physician groups within Parkview Care Partners



Population Health Staffing

Care Coordination:	Clinical Integration Network and Payer Quality:	Senior Care and Parkview Welcome Clinic:	Alternative Payment Models:
19	9	15	5

Number of people served by the PCP care coordinating team

(The care coordinating team includes RN care coordinators, Medical Assistance Program and social support specialists.)

Total people served: 1,976 unique, engaged patients

Percentage of high-risk patients in value-based contracts seen: 2.89 percent of 68,349 covered lives

2016

Payer	Covered Lives	Unique, Engaged Patients	% of Covered Lives
Payer 1	48,834	154	0.3
Payer 2	9,079	313	3.4
Payer 3	10,436	488	4.6
Total	68,349	1,976	2.89

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

Table of contents

Physician led: Enhancing patient care through collaboration and innovation

It's a statement more commonly used these days, but what does it really mean to be physician led?

At the heart of every strong, physician-led organization, you'll find one thing in common: a patient-centric culture. Together, the more than 700 physicians and advanced practice providers, along with other care team members who make up Parkview Care Partners (PCP), are working together to deliver healthcare in ways that only a clinically integrated network can.

A patient-centric culture allows members of PCP to deliver innovative, high-quality services and care at the right time, in the right place and at the right cost.

In its third year, the PCP network demonstrated another strong year of growth and outcomes, while successfully managing costs and improving the health of those we serve. Within this report, we're pleased 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 strongest clinically integrated network in the northeast Indiana and northwest Ohio region.

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
Parkview Physicians Group (PPG) Board of Managers

At the heart of every strong, physician-led organization, you'll find one thing in common: a **patient-centric culture.**

Customized care for the consumer

Our clinicians are able to focus more intently on patient partnerships and outcomes because of support from Parkview Value Plus, our 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

There's a relatively new term that is being thrown around in healthcare: consumerism. As much as healthcare reform has forever changed how we deliver care, the rise of the healthcare consumer is also going to greatly impact what we do in the years to come.

Several years ago when organizing Parkview Care Partners (PCP), one exciting and important element of the clinically integrated network was our ability to further tailor personalized healthcare plans and options available to our patients.

As providers, we are here to serve our patients, who are each on unique journeys. As we work with our patients on their individualized health goals, PCP network members collaborate to develop the best care plans available, based on each individual's desired outcomes. Healthcare can be complicated, yet we're there to serve as guides, walking with our patients throughout their journeys to well-being.

Patients who receive care through the PCP network have a better understanding of their conditions and risks, and what screenings, care and resources are needed to prevent disease and avoid hospitalization.

As providers, we are here to serve our patients, who are each on unique journeys.

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 practices 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 can potentially be 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 ED 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 we serve.

The quadruple aim
continued

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

- Providing care coordinator 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 indirect work out of clinical offices to a new centralized patient contact center.
- Improving clinical decision support in EpicCare*, our electronic health record, to help physicians know when patients are due for preventive care and by 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 availability of behavioral health resources.
- Care coordinators embedded within primary care practices.

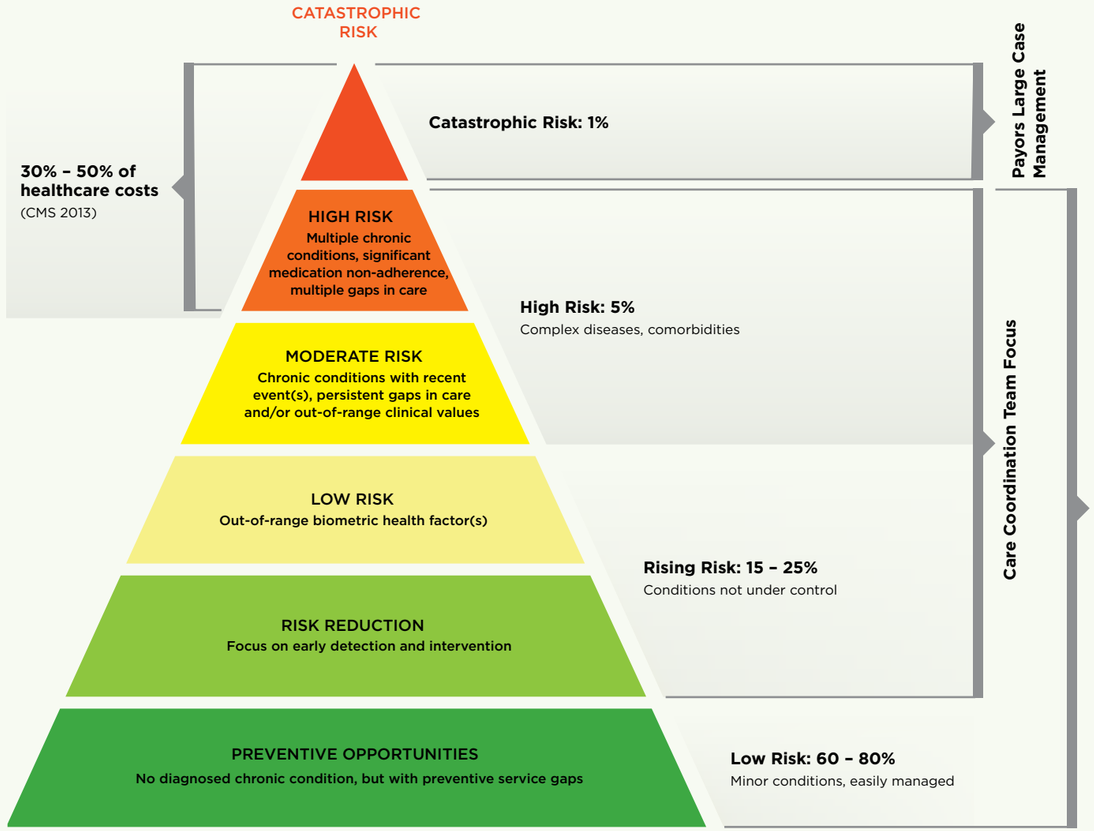
* *EpicCare is the Parkview Health electronic health record system. As additional independent physician groups join Parkview Care Partners, we will continue to expand connectivity with other electronic health record systems. It is not a requirement of independent groups to be on EpicCare.*

"It is truly rewarding to be involved with a provider-led organization committed to meeting quality and metric goals organically. We are continuously striving to meet our dual mandate of community health care improvement and strong financial performance."

David Stein, MD
Ear, Nose & Throat Associates

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.



Bringing value to the market

Parkview Care Partners works to increase the value[1] of healthcare for the people we serve — first and foremost, our patients — as well as our payer and employer partners. 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 assure 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 journeys, 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*

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

Bringing value to the market for business: Parkview Value Plus

With three 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.

Clinical services available through Parkview Value Plus include:

- Integrated care coordination
- CI quality metrics
- Value-based outcomes
- Data analytics
- Enterprise credentialing
- Enterprise care management

Contractual support services include:

- Contracting
- Self-funded employer relationships

PARKVIEW VALUE PLUS

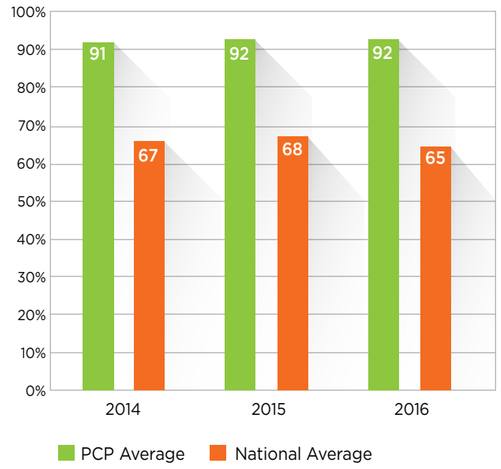
"As a finance professional, it is exciting to see physician collaboration result in improved patient outcomes that, in turn, translate to further growth for Parkview Care Partners and increased value for the people we serve."

Scott Berry, CPA, CGMA
Director, Corporate Accounting
Parkview Health

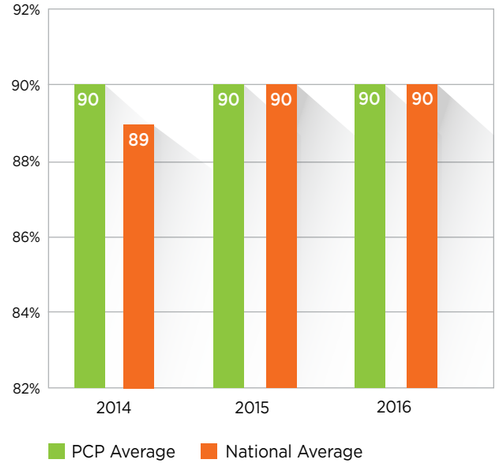
Results comparison: 2014, 2015 & 2016

Quality metrics are established by the Quality & Performance Improvement Committee with the goal of achieving the quadruple aim.

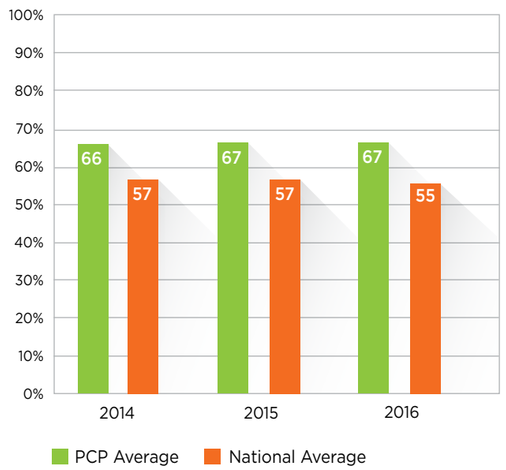
Diabetic A1c < 9[1]



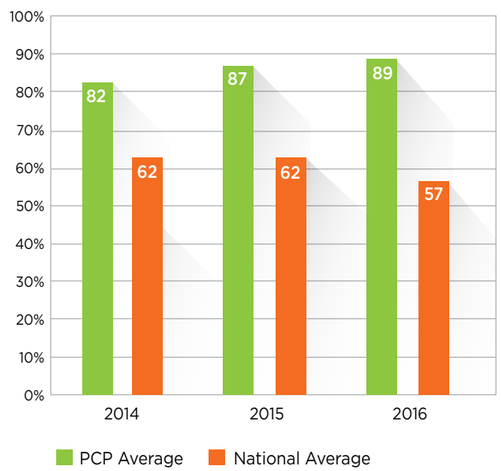
Diabetic A1c screening



Diabetic A1c < 8[1,2]



Diabetic BP control < 140/80[1]



Source: The National Committee for Quality Assurance (NCQA) State of Health Care Quality 2016 Report.

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

[2]PCP measures A1c < 7.5.

2016 clinical integration results

The following table provides insight into the PCP 2016 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 2016 target ● Performance below 2016 target

Chronic and Acute Illness			
Diabetes Care threshold > 20 patients		2015	2016
HbA1c screening	≥ 90%	●	●
HbA1c result > 9	≤ 15%	●	●
HbA1c result ≤ 7.5	≥ 60%	●	●
Statin Therapy ages 40-75	≥ 50%		●
BP control ≤ 140/90 mm/Hg	≥ 75%	●	●
Body Mass Index (BMI)	≥ 90%	●	●
Nephropathy Screening or Evidence of Nephropathy	≥ 10%		●
Eye Exam	≥ 10%		●
Comprehensive Care	≥ 40%	●	●
Coronary Artery Disease			
Statin Therapy ages 21-75 males; 40-75 females	≥ 50%		●
BP control < 140/90 ages 18-59; < 150/90 age 60 and older	≥ 75%		●
Comprehensive Care	≥ 64%		●
Congestive Heart Failure			
Heart Failure - LVEF Assessment Inpatient Setting	≥ 90%	●	●
Asthma threshold > 10 patients			
Patients ages 5-64 prescribed asthma control medication	≥ 75%		●
Hypertension Control			
BP control < 140/90 ages 18-59; < 150/90 age 60 and older	≥ 75%	●	●
Pharyngitis			
Patients ages 2-18 w/ solitary diagnosis of pharyngitis, prescribed an antibiotic and received Group A strep test	≥ 50%		●
Preventive Care			
Osteoporosis Screening			
Females ages 65-85 who have DXA measurement	≥ 50%	●	●
Breast Cancer Screening			
Women ages 40-74 who have had a mammogram during measurement year or year prior	≥ 55%	●	●
Cervical Cancer Screening			
Women ages 21-65 Pap smear every 3 years or ages 30-65 Pap w/ HPV performed every 5 years	≥ 47%	●	●
Colorectal Screening			
Colorectal Screening ages 50-75: Colonoscopy - every 10 yrs, CT Colonography - every 5 yrs, Cologuard - every 3 yrs or FOBT annually	≥ 60%	●	●
Tobacco Use			
Patients age ≥ 18 screened and cessation counseling provided if screened positive for tobacco use	≥ 60%	●	●

2016 clinical integration results
continued

			2015	2016
Influenza Immunization				
Patients age 6 mo and older seen for a visit Oct 1 - March 31, received an influenza immunization, who reported previous receipt OR declined		≥ 52%	●	●
Childhood Immunizations threshold > 6 patients				
MMR by age of 30 months		≥ 75%	●	●
Varicella by age of 30 months		≥ 75%	●	●
Flu vaccine by age of 30 months		≥ 57%	●	●
Hepatitis A vaccine by age of 30 months		≥ 65%	●	●
Rotavirus vaccine by age of 12 months		≥ 80%	●	●
Well Care threshold > 6 patients				
Patients ages 3-6 years		≥ 56%	●	●
Patients ages 12-21 years		≥ 37%	●	●
Efficiency Measures				
Generic Medication Prescription Rate 12/1/2015 - 11/30/2016 Data				
Note: Data limited to covered Parkview Employees Health Plan		≥ 60%	●	●
Use of Imaging Studies for Low Back Pain				
Patients ages 18-50 with a primary diagnosis of low back pain who did not have an imaging study within 28 days of diagnosis		≥ 80%	●	●
30 day Readmission Rate ≥ 6 discharges YTD 9/30/2016 Data				
CHF		≤ 20%	●	●
All cause hospital performance		≤ 12%	●	●
Average Length of Stay All providers > 6 discharges excludes newborns and SNF, case adjusted YTD 12/31/2016 Data	Goal	Discharges		
Population < 65 years of age	≤ 25%	0	●	●
Population ≥ 65 years of age	≤ 25%	0	●	●
Non-Clinical/Infrastructure Measures				
Clinical Integration - Care Registry Activity Access Galileo 10 out of 12 months - 3.00 Points distributed 4Q		≥ 83%		●
CPOE Usage - Inpatient		≥ 60%	●	●
CPOE Usage - Outpatient YTD 11/30/2016 Data		≥ 60%	●	●

"Parkview Care Partners, through its population health initiative and quality measures, is allowing physicians and advanced practice providers to work collaboratively on improving the health of our community in ways that we could never have done on our own as individual practice groups."

Thomas Bond, MD, CMO, PPG
PPG — Family Medicine, New Haven

Innovative CI initiatives

Utilization

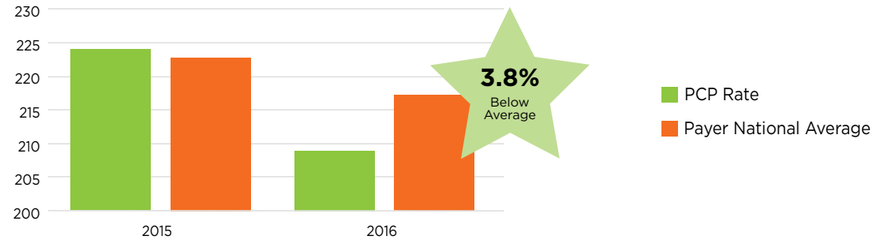
Parkview has developed a care model that has been successful in reducing patient admissions, effectively managing acute care and reducing readmissions by coordinating care across the continuum.

Acute admission rates

Successful prevention of acute admissions is the result of:

- Effective identification of at-risk patients
- Implementation of patient-centric interventions to meet patients' needs
- Coordination of care for patients in their homes in a way that keeps patients healthy, both physically and mentally
- Appropriate and proactive management of chronic conditions

Acute Admits per 1,000

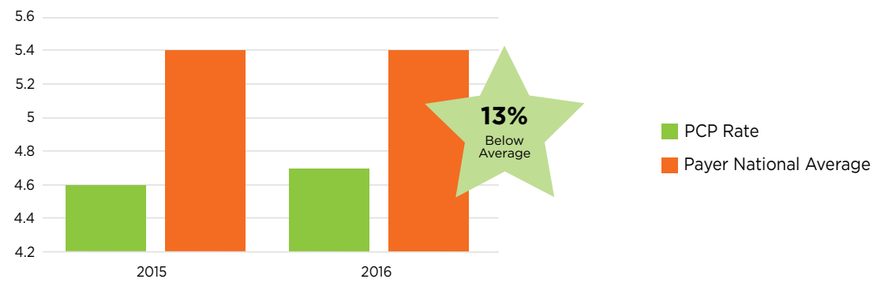


Acute average length of stay

Successful management of acute length of stay is the result of:

- Discharge planning upon admission
- Partnerships with post-acute providers to allow for expedited admissions
- Supporting post-acute providers to medically manage patients with a higher acuity of care
- Collaboration with payers to expedite and/or eliminate the need for prior authorization for post-acute services

Acute Average Length of Stay



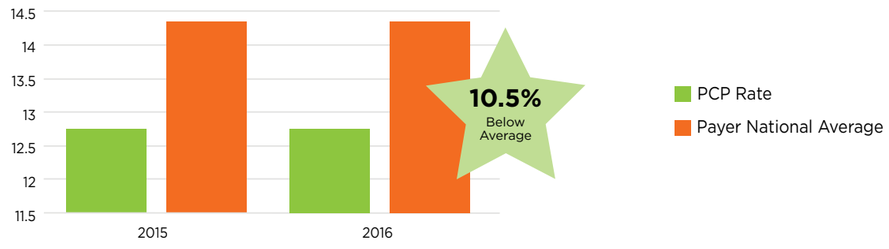
Innovative CI initiatives
continued

30-day readmission rates

Successful prevention of readmissions is the result of:

- Proactive discharge planning
- Greater patient accountability, compliance and self-care with encouragement and education from care coordinators
- Partnering with the high-performing network of skilled nursing facilities (SNF) to recognize, assess and treat people in their places of residence
- Better communication during transitions from inpatient to outpatient care
- In-home assessment and assistance for patients, such as our ambulatory medication assistance program

30 Day Readmission Rate

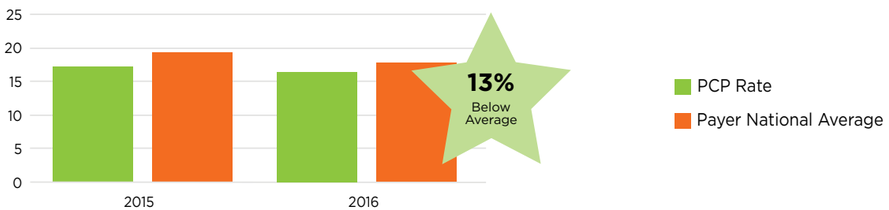


Select CI programs and outcomes

High-performing SNF Network

Parkview has developed a community partnership with six long-term care facilities — Ashton Creek, Lutheran Life Villages-Pine Valley, Kingston Care Center, Miller's Merry Manor, Saint Anne's Home and Heritage Park — to form a high-performing SNF network. These facilities are located in close proximity to Parkview Regional Medical Center and Parkview Hospital Randallia.

Skilled Nursing Facility Average Length of Stay



The partnership benefits Parkview, participating SNF and patients through collaboration on pilot programs such as medication reconciliation, sepsis early detection and rapid response (see below), and has reduced the average length of stay. Parkview's partnership with Ashton Creek can be seen in its Transitional Care Unit, where patients' vital signs are monitored remotely by Parkview. The high-performing SNF network also provides participants with a common voice to payers, including CMS.

The high-performing network:

- Offers continuation of care providers from the hospital to SNF, with a team of two medical directors, four nurse practitioners and a SNF care coordinator
- Provides a partnership that's resulting in innovative pilot programs
- Affords caregivers a common, better understanding of hospital and skilled nursing challenges
- Improves care for patients in their transitions from hospital to home

Community Paramedicine Program

Community Paramedicine is a unique patient care model in which five paramedics work outside of their traditional emergency medicine roles to provide follow-up and preventive in-residence care for specific types of patients.

For example, Community Paramedicine paramedics, working under physician direction, collaborate with the high-performing SNF to help treat residents with early signs of sepsis. When SNF residents have a deterioration of clinical symptoms, a Community Paramedicine rapid response team intervenes. Early treatment protocols significantly decrease the frequency of residents being transported to an acute care facility.

Parkview is piloting the Community Paramedicine program in Allen and Huntington counties in a two-year health initiative funded by a grant from the Indiana Department of Health.

This model of care has:

- Resulted in a significant decrease in ED utilization and hospitalization
- Decreased the number of transfers, resulting in improved safety (out of more than 1,800 runs, 156 resulted in ambulance transports)
- Allowed people to stay in their places of residence for treatment
- Decreased costs to Medicare and value-based payers

"The Care Coordination team has partnered with hundreds of patients and their care teams to a develop a plan of care that improves individual health, well-being and outcomes while decreasing unnecessary utilization."

Stacey Bussel, DNP, RN, CCCTM
Regional Manager, Integrated Care Coordination
Parkview Health

Recognitions, honors, awards

2017

ANCC Magnet™
American Nurses Credentialing Center (ANCC)
Parkview Health

2017 Most Wired
Hospitals & Health Networks
Parkview Health

2017 Workplace of the Year
The Advisory Board Company
Parkview Health

15 Top Health Systems®
Truven Health Analytics™
Parkview Health

2016

2016 Workplace of the Year
The Advisory Board Company
Parkview Health

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

2016 Hospital of the Year
Lions Eye Bank
Parkview Regional Medical Center

Silver-level Beacon Award for Excellence
The American Association of Critical-Care Nurses (AACN)
Inpatient Cardiac Unit at Parkview Heart Institute

50 Hospitals with Innovation Programs
Becker's Hospital Review
Parkview Mirro Center for Research and Innovation

2016 Leapfrog Top Hospital Award
Parkview Regional Medical Center

2016 Most Wired
Hospitals & Health Networks
Parkview Health

The Commission on Accreditation of Medical Transport Systems
Parkview Samaritan

2015

2015 Hospital of the Year
Lions Eye Bank
Parkview Regional Medical Center

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

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

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

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

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

100 Top Hospitals®
Truven Health Analytics™
Parkview Huntington Hospital

Professional Research Consultants (PRC) Excellence in Healthcare Awards

2015 Most Wired
Hospitals & Health Networks
Parkview Health

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CARE PARTNERS

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