THE 2020 VALUE REPORT

A REPORT ON 2017, 2018 AND 2019 RESULTS

PARKVIEW CARE PARTNERS

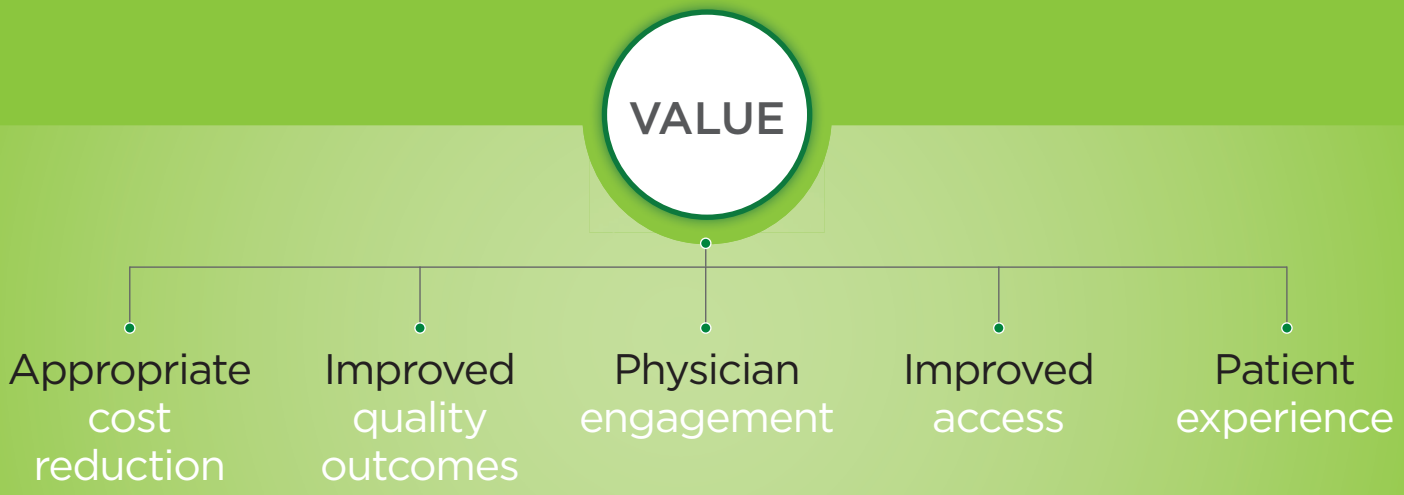
What is a Clinically Integrated Network?

Parkview Care Partners, LLC. – Established in 2013

A physician-led care management organization focused on improving the quality of care offered by our providers while leading the market in the transformation to value.

Executive summary

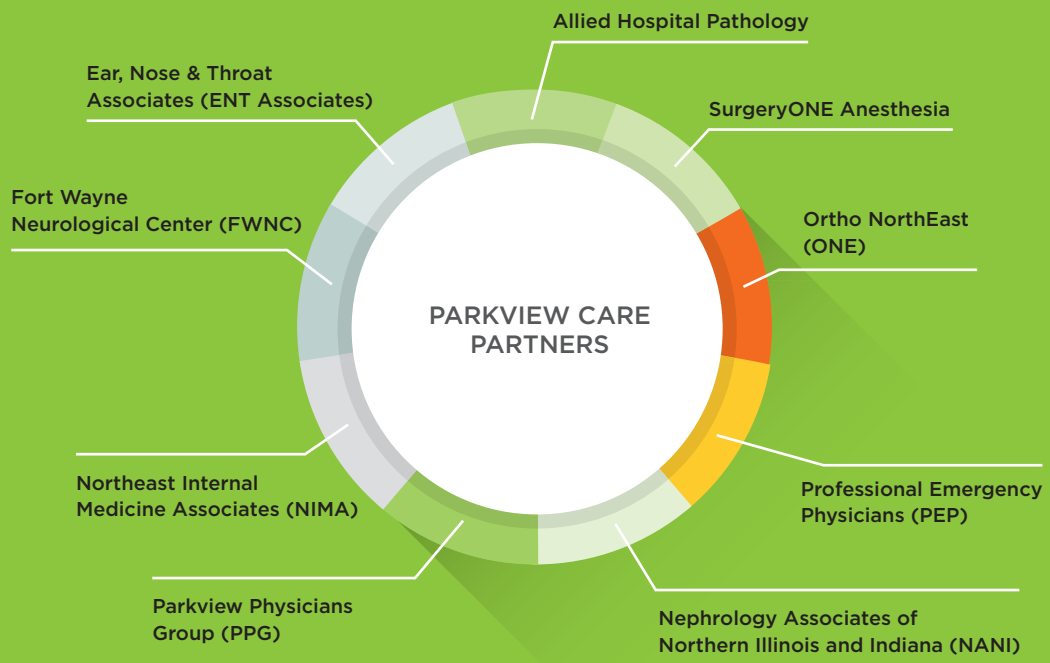
Parkview Care Partners (PCP) is a physician-led care management organization collaborating on a clinically integrated (CI) approach to healthcare delivery across the continuum of care. Clinical integration facilitates the coordination of patient care across medical conditions, providers, locations and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



Parkview Care Partners – Network Composition

SPECIALTY	2015	2016	2017	2018	2019	2020
Quantity of Primary Care Providers	**134**	**141**	**135**	**156**	**158**	**165**
Quantity of Specialty Providers	**315**	**350**	**416**	**436**	**478**	**503**
AFFILIATION	2015	2016	2017	2018	2019	2020
Quantity of Employed Providers	**366**	**386**	**404**	**436**	**483**	**522**
Quantity of Independent Providers	**83**	**105**	**147**	**156**	**153**	**146**
Total Physician Count	**449**	**491**	**551**	**592**	**636**	**668**
Percentage of Employed Providers	**82%**	**79%**	**73%**	**74%**	**76%**	**78%**

Physician groups within Parkview Care Partners



Number Served by Population Health Care Coordination Team

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

Total people served in 2019: 2,988 unique, engaged patients

Note: Data below reflects a change in how patient encounters were tracked, beginning in 2017 and continuing today.

2017	2018	2019
6,650 Referrals	4,351 Referrals	5,448 Referrals
4,730 Unique Patient Referrals	3,311 Unique Patient Referrals	4,459 Unique Patient Referrals
28,775 Encounter	14,281 Encounter	13,408 Encounter
16,057 Interventions	10,384 Interventions	17,046 Interventions
1,560 Unique Patients	1,585 Unique Patients	2,988 Unique Patients

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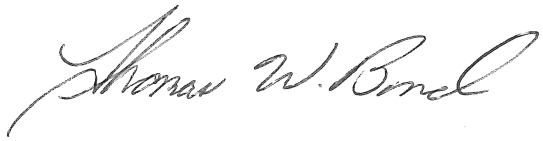
Message from the chairman

A clinically integrated network (CIN) brings multiple physician groups together to have a greater influence on patient outcomes. The idea is that together we are stronger and more impactful than we would be individually. More specifically, the collaboration of physicians and care teams collectively improves patient outcomes; whereas, it can otherwise become fragmented when each individual specialty or group is focused on individual goals versus common goals of a network that are aligned and centered around the patient.

The CIN's emphasis on driving value puts a constant spotlight on quality. The focus on quality measures results in reduction in complications of chronic diseases which reduces costs through potentially avoidable therapies, surgeries, hospitalizations, and emergency visits due to not being optimally managed or controlled. More importantly though, the focus on quality provides patients greater longevity and healthier years for the patient.

As a CIN, we are physician-led which means that our patients are at the center of everything we do. We remain committed to improving patient outcomes, improving access to the right care and at the right time, while appropriately reducing the cost of care through the integration of the network. Every physician and group that is part of the CIN is working towards prioritizing an individual health journey for each patient. By having goals centered around the patient and his or her outcomes, providers are able to come around that patient and deliver a teamwork approach to care.



Thomas Bond, MD

Chairman, Parkview Care Partners Board of Managers;
Chairman, Quality & Performance Committee, Parkview Health;
Chief Medical Officer, Parkview Physicians Group

Clinically Integrated Network governance

Board

Thomas Bond, MD, *Chair*
Thomas Gutwein, MD, *Secretary*
Thomas Curfman, MD
Raymond Dusman, MD
Michael Grabowski, MD
Alan McGee, MD
Berry Miller, MD
David Stein, MD
Mitch Stucky, MD
Mike Yurkanin, MD
David Jeans
Ben Miles

Finance Committee

David Stein, MD, *Chair*
Raymond Dusman, MD
Scott Karr, MD
Jason Row, MD
Mitchell Stucky, MD
Greg Johnson, DO
David Jeans

Quality & Performance Improvement Committee (QPIC)

Thomas Bond, MD, *Chair*
Lemuel Barrido, MD
Fen-Lei Chang, MD
Harin Chhatiawala, MD
Paul Conarty, MD
Michele Helfgott, MD
James Ingram, MD
Greg Johnson, DO
Vijay Kamineni, MD
Joshua Kline, MD
Jeffery Nickel, MD
Richard Nielsen, MD
Andrew O'Shaughnessy, MD
Jason Row, MD
Ronald Sarrazine, MD
David Stein, MD
Anusha Valluru, MD

Administrative Team

Greg Johnson, DO, ***Chief Clinical Integration Officer***
Joni Hissong, ***Vice President,***
Enterprise Care Management
Nicole Krouse, ***Director,*** *Clinically Integrated Network*
Stacey Bussel, ***Director,*** *Enterprise Care Management*
Chad Shirar, ***Director,*** *Diabetes Care Strategy*
Lynette Neher, ***Director,*** *Care Management Operations*

It's not about population health

Parkview Care Partner physicians have been consistently strong about establishing care plans for patients. As healthcare continues to move towards the transformation to value, not only do we need to create care plans for patients, but we need to partner with them to improve on the execution of that care plan. Execution of the care plan is led by the physician and driven by the numerous care team members including nurses, social workers, care coordinators, pharmacists, dietitians and others.

A key component to successful execution of care plans is the collaboration between the physician, care team, and patient to identify and address the barriers. It is about each patient's individual health journey and walking alongside them on their path.

It is for that reason that I say it's not about "population health" but instead, the care we provide is very personalized and customized to the circumstances and situations that surround each and every unique patient. When the term "population health" is used, it sounds like care is being addressed as an entire population.

In the strictest sense we are, but how we go about that is vastly more complex and involved, approaching care one-on-one and on an individual basis. There may be similarities in care plans, but each care plan is tailored for the patient.

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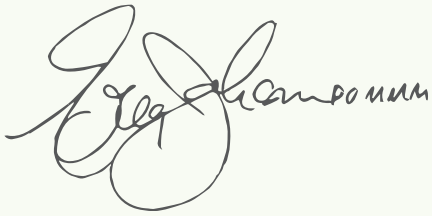


Greg Johnson, DO, MMM
Chief Clinical Integration Officer, Parkview Health

Partnering with patients on their personal health journey requires world-class teamwork and ultimately will help us lead the market in the transformation to value.

It's not about population health *(continued)*

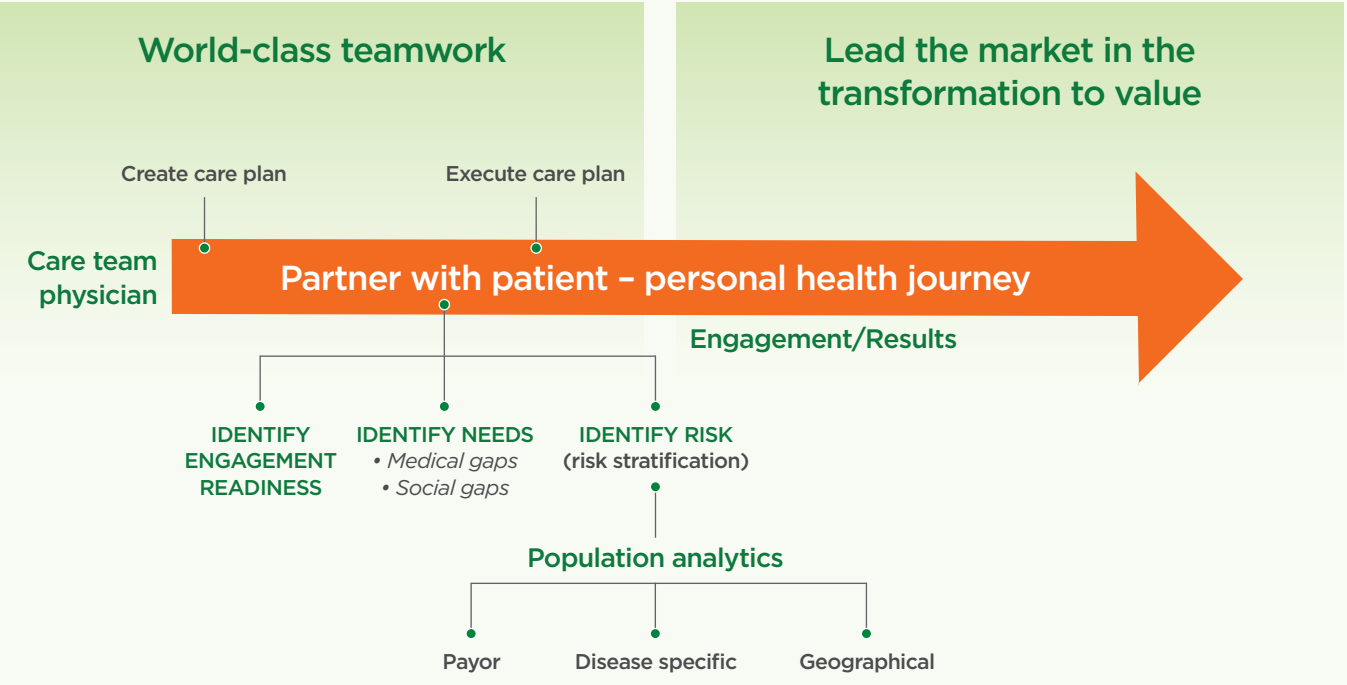
Starting from the bottom and working our way up the graphic, we use population health analytics to look at various data points and information to determine three main things:

IDENTIFY RISKS – for example, if we had a group of patients with diabetes we would want to determine who within that group is at the highest risk. This would allow us to know who would benefit most from additional care team support.

IDENTIFY NEEDS – when considering medical gaps, an example of this could be missing A1c lab work for a patient with diabetes. The second crucial part to identifying needs is considering the patient's social gaps. Essentially, these are the non-medical hurdles to overcome for successful execution of a care plan. An example of this could be ensuring that the patient has a means of transportation to complete their A1c or see their doctor.

IDENTIFY ENGAGEMENT READINESS – if a patient is not ready for change at this time, it is important to respect where that patient is and their decision. Instead, we accept them where they are, come alongside them and continue with them until they are ready. At that time, we are right next to them to assist in a way that is meaningful and realistic. We are all at different stages of engagement readiness, some may be more willing to make dietary changes or smoking cessation for example, but it's about helping the patient when they are ready to address those gaps.

Partnering with patients on their personal health journey requires world class teamwork and ultimately will help us lead the market in the transformation to value.



Improved value for patients, employers and payers

The value driven clinically integrated network of Parkview Care Partners sought out an opportunity to reduce potentially avoidable ED (emergency department) utilization for two specific diagnoses, UTI and headache. The project initially focused on one of the seven Parkview Walk-in Clinics and specifically, patients who were seen in that clinic and then presented to the ED within 24 hours. All patients who were admitted were excluded from the analysis as those ER visits are not viewed as "potentially avoidable".

The baseline data indicated that there was an average of 9 patients a month from January – July, 2019. The average ED cost for those two diagnoses was $5,099.39. Collaborating with the walk-in clinic staff, medical director, and operations team, a number of opportunities were brought forth for trial during the project. A few of those included calling the ED provider while the patient was still in the clinic and communicating to the patient that the ED was consulted and are in agreement with the plan of care, providing the patient with a realistic timeline/expectations for results, and standardizing medications prescribed (for example, addressing common rebound migraines that occur within 72 hours). The results, when compared to the same timeframe a year prior, were profound. When looking at 5 months' worth of data during the project, fifteen patients were seen in the ED compared to 46 during that same timeframe a year prior and resulted in over $150,000 of avoidable cost. Annualized, with one walk-in clinic, there is close to a $400,000 avoidable cost opportunity.

Furthermore, projects such as this one, exude the goal of a clinically integrated network — to improve and demonstrate value in healthcare. This project has many benefits including;

IMPROVED ACCESS: By reducing the number of potentially avoidable UTI and headache ED visits, the ED will be able to more quickly provide care for others who are present.

IMPROVE PATIENT SATISFACTION: Patients come to healthcare providers seeking relief and help. If after a visit, they don't receive the relief that they sought and within the timeframe they were expecting, they seek care and relief elsewhere; ultimately leaving them unsatisfied with the original outcome. By improving our communication and education, while appropriately addressing the realistic timeline for relief, we can positively impact the patient experience.

IMPROVED PROVIDER EXPERIENCE: By reducing the number of potentially avoidable visits that could be appropriately addressed in a different care setting, ED providers can care for those who are emergent.

APPROPRIATELY REDUCING COST: Generally speaking, patients who have a UTI or headache can appropriately seek relief and care from their primary care provider or walk-in clinic which is a lower cost option compared to the Emergency Department.

"The CIN meets frequently with payers in which there are established value-based arrangements to review data and discuss opportunities surrounding quality and utilization. It was through such meetings that "potentially avoidable" emergency department visits were brought forth as a possible metric to improve upon.

"This project spanned two groups, Parkview Physicians Group (PPG) and Professional Emergency Physicians (PEP) that worked collaboratively in order to improve the outcomes, experience and costs for patients, all of which are objectives of a CIN. Additionally, the teamwork that spanned the two groups — both independent and employed — exudes how a CIN brings together providers and aligns incentives and goals.

"We are fortunate to have highly engaged physician members who are continuously evaluating performance and improving for our patients. It is examples like the potentially avoidable ED project, having a high-performing network of providers, and strong partnerships with payers that allow us to lead the market in the transformation to value-based care."

David Stein, MD
Chairman, PCP Finance Committee; Member, PCP Board of Managers;
Member, PCP Quality & Performance Improvement Committee; Ear, Nose & Throat Associates

Humana and Parkview collaboration: Partnership upholds population health ideals

I have had the great pleasure of working with the Parkview Health physician and business leaders as they moved their practice down the value-based care continuum over the last four years. Shifting the focus of their nearly 668 physicians from operating under a traditional fee-for-service care model to one aimed at improving value and population health has not been an easy road, but the benefit to their patients and the practice has been evident and well worth the effort.

The practice group took the first step on the value-based care path when they adopted a shared-savings model and better leveraged their strong community connections to expand their population health efforts. They have taken the time to understand and reach out to the communities they serve and developed welcome centers with the priority of engaging patients in their annual wellness visits. Improving population health means ensuring patients get the right care, at the right time and in the right place. For instance, a Parkview emergency department pilot helped to identify patients whose health would benefit from consistent care management and outreach versus repeated, costly emergency room visits; just one of many examples of the innovative spirit of this health system.

Success on the value-based care path leading to improved population health isn't achieved by working in a silo but rather the opposite; it takes a team. It takes partnerships, integration and open communication with all segments of the healthcare industry. Humana has worked very closely with Parkview, providing the data they've needed to accurately adjust risk, code and stratify patient panels to identify those most vulnerable. We are committed to the success of the practices we work with and can only serve our members when aligned to these physician partners.

Our regular communications and meetings with Parkview's leadership team, including Dr. Greg Johnson, chief clinical integration officer, and David Jeans, senior vice president, Payor, Employer and Health Plan Strategies, Parkview Health, has been essential to moving the practice successfully to the full-risk end of the value-based care spectrum. As you see in this annual report, they show improvements in patient health, physician satisfaction, hospital star ratings and financial success.

"I applaud the efforts of Parkview Health for its dedication to working together with us, and others in the healthcare industry, to provide real value to those they care for every day."

Nisha Patel, MD
Regional Vice President, Health Services
Humana

UnitedHealthcare and Parkview collaboration: Payer relationships benefit patients/members

Value-based care is about shifting the healthcare system to a model that emphasizes the importance of keeping people healthy and rewards physicians for coordinating care, for providing the appropriate care for each patient's situation, and for actual health outcomes. When it comes to making value-based care a reality, our partnership with providers is the key to success. In the UnitedHealthcare and Parkview Care Partners alliance, we take action on achieving the Quadruple Aim of healthcare through improving the six elements of clinical transformation; improving high risk patient care, improving access to care, reducing avoidable admissions, reducing non-emergent ER visits, improving quality and coding accuracy, and improving growth and satisfaction.

The UnitedHealthcare ACO Core Team is comprised of a dedicated team including a transformation consultant who is the day-to-day clinical partner, an ACO cccount manager who oversees contract performance and roster management, the chief medical officer, who is the clinical expert and leader, and a member of the Health Care Economics team who provides analytics and reporting support. UnitedHealthcare offers technology tools which provide insight into inpatient and ER visits, HEDIS performance, CMS hospital star rating care opportunities, accurate diagnostic coding: suspects, patient registries, episodes of care and risk stratification. The ACO Core Team meets monthly with the Parkview team to review opportunities for improvement, discuss new processes and workflows, share hospital practice benchmarking and best practices. Goals are established in a shared approach and success is measured through the level of engagement and a variety of monthly reporting tools.

The successful collaboration and clinical integration between Parkview Care Partners and UnitedHealthcare is vital to produce meaningful changes for the patients we collectively serve. Together, we are making this a reality.

Julie Daftari, MD
Chief Medical Officer, Indiana Medicare & Retirement UnitedHealthcare Clinical Services

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

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

Bringing value to patients:
High-risk medications in the elderly

Following a routine data audit in 2018 with Ortho NorthEast (ONE), it was discovered that some providers had high usage rates of diphenydramine, a high-risk medication. The CIN provider relations specialist (whose role is to support physicians with their success in the CIN) and pharmacist worked with ONE team members to determine a root cause and investigate possible solutions. ONE's leadership identified that diphenhydramine is used and necessary for patients with contrast sensitivity. Many times, a non-contrast study would not give the providers the appropriate results; therefore, this was not a viable solution to reduce diphenhydramine usage.

The CIN pharmacist searched available literature, guidelines and policies from other organizations to seek a possible alternative. It was discovered that University of California, San Francisco, used ceterizine as an alternative medication for contrast sensitivity for the elderly population.

ONE leadership took the recommendation of cetirizine instead of diphenhydramine usage to the ONE protocol committee for review, and the ONE physicians agreed to use cetirizine instead of diphenhydramine for patients over 65 years old.

While the overall prescribing rate for high-risk medications for the practice is low, there was opportunity to improve; in fact, one of the providers with a 21% prescribing rate in 2018 dropped to a 12% rate in 2019.

This was a great collaborative effort and example of strong network partnerships.

"I was impressed with ONE leadership's openness to a recommended change and their willingness to facilitate that with their physicians."

Sarah Pfaehler, PharmD, MBA, BCPS
Clinical Integration Pharmacist, Parkview Health

"After data analysis, identifying quality concerns can sometimes be the easy part, while finding subject experts willing to assist in a solution can prove to be more difficult. We are very grateful to have such a willing CIN partner in Parkview."

Tom Pawlik, ATC/L, MS
Clinical Informatics Engineer, Ortho NorthEast

Achieving outcome goals: The high performing network

Nationwide, patients' care continues to increase in complexity necessitating continuous improvement on a number of different fronts, including managing chronic conditions, collaboration between physicians, education to patients, alignment of social services, and many more factors. It also requires better continuity of care across varying levels of care, such as from outpatient to inpatient providers, and from inpatient providers to home health or skilled nursing facilities. For that reason, Parkview established a High Performing Network (HPN) made up of several skilled nursing facilities. There are a number of benefits to patients that exist due to the partnership.

The High Performing Network facilities accept high risk/high acuity patients that oftentimes require additional healthcare services and medical attention. Those facilities include:

- Ashton Creek Health & Rehabilitation Center
- Kingston Care Center of Fort Wayne
- Lutheran Life Villages
- Heritage Park
- Saint Anne Communities
- Miller's Merry Manor

Patients predominately choose to go to one of the HPN facilities. When they do, they are seen by a physician or nurse practitioner every day, for the first five days which is a critical time in the transition of care. Thereafter, the provider sees patients weekly for the duration of the admission unless their acuity warrants more frequent visits. Additionally, a care coordinator and social support specialist see the patient on day three of admission, attend every patient care conference and see the patient weekly for the duration of the admission. HPN's have a provider on-call on weekends in case a patient's condition regresses. This goes beyond state requirements of a provider seeing a patient once every 30 days.

"The great collaboration and teamwork between our High Performing Network partners and Parkview care team members including physicians, nurse practitioners, care coordinators and social support specialists assures excellent care and a smooth transition for our patients."

Joni Hissong, MSN, RN, CPHQ
Vice President, Enterprise Care Management
Parkview Health

Skilled Nursing Facility Collaboration and Readmission/ER Visits

2018	Average CMI (Case Mix Index)	30-Day Readmission Rate	30-Day ER Visits
High Performance Network Allen County	*	12.7%	9.6%
"Other" Allen County Skilled Nursing Facilities	*	18.9%	10.3%
2019			
High Performance Network Allen County	2.32%	15.8%	10.4%
"Other" Allen County Skilled Nursing Facilities	1.94%	16.5%	8.7%

• Data in this category is not available for 2018.

Defining measures and goals

To ensure measures remain relevant and meaningful they are reviewed yearly by a physician lead from each respective specialty. Measure selection is approached by considering a number of different sources. One of those sources is the value-based care contract measures. It is often found that breaking measures into smaller pieces allows the network to be more successful. For example, 30-day all-cause readmission rate is one outcome measure. Working with physician leads who are helping to determine measures entails discussing metrics that could have a positive impact on the outcome measure, in this case, readmissions. To illustrate further, we are able to narrow in on particular diagnoses that have a higher risk of readmission and measure how often we are scheduling and seeing those patients within seven days of a hospital discharge. Approaching measures in that way has resulted in incremental positive change and has had an impact on the network's success with value-based care.

MIPS (merit-based incentive payment system) measures are also considered for inclusion as they are nationally recognized metrics and often align with data that groups report to CMS. Some specialties also have other national registries to which they submit data, and including those measures into the CIN allows them to aggregate all quality into one central location to monitor performance and patient outcomes.

Lastly, we discuss processes and populations that may be able to be managed differently and/or more effectively by having data and reports available to help facilitate the change.

Once measures are chosen, the data is reviewed to determine an appropriate measure goal for physicians to achieve. The goal is to see performance improve year over year and eventually get to a point where measures are retired due to sustained success and new measures can be chosen.

Andy O'Shaughnessy, MD

Member, Parkview Care Partners Quality & Performance Improvement Committee; Nephrology Associates of Northern Illinois and Indiana (NANI)

Having physicians heavily involved in the measure selection helps with buy-in, engagement and continued improved outcomes for patients.

"As the physician lead for nephrology, this whole measure selection process has been a surprisingly positive experience. Every medical specialty has different quality indicators that are relevant to their own disease process and patient base. These indicators can be broad and nationwide (often prescribed by our individual national governing body) or more narrow and relevant to just the idiosyncrasies of our own group. But whatever the source, the indicators are by nature bit of a stretch to achieve. It is within this stretch that four objectives line up: my desire to practice good medicine lines up with the healthcare system's need to deliver an always-improving service which lines up with the payer's desire for a fiducially responsible process which, most importantly, lines up with the patient's desire for better health. Appropriate indicator selection is a win-win-win-win game. All players get to improve."

Measures and year-over-year comparison

	2017	2018	2019
CHRONIC AND ACUTE ILLNESS			
Diabetes Care			
HbA1c result > 9	8%	21%	19%
Nephropathy screening or evidence of nephropathy	89%	92%	92%
Eye exam	43%	47%	54%
Statin therapy diabetics age 40 – 75	68%	72%	77%
Foot exam	-	62%	65%
Cardiovascular Disease			
Statin therapy ages 21 – 75 males; 40 – 75 females	81%	82%	83%
Controlling high BP < 140/90 ages 18 and older	92%	71%	70%
ACE or ARB Therapy for patients with CAD and diabetes or LVEF < 40%	-	79%	79%
Use of aspirin or another antithrombotic for IVD	-	88%	87%
Beta-Blocker therapy for LVSD	-	80%	81%
PREVENTIVE CARE			
Osteoporosis Screening			
Females ages 65 – 85 who have DXA measurement	75%	66%	-
Breast Cancer Screening			
Women ages 50 – 74 who had a mammogram during measurement year or year prior	55%	70%	72%
Cervical Cancer Screening			
Women ages 21 – 65 pap smear 3 years or ages 30 – 65 pap with HPV every 5 years	54%	58%	-
ColoRectal Screening			
ColoRectal screening ages 50-75; Colonoscopy – 10 years; CT Colonography – 5 years; Cologuard – 3 years or FOBT annually	61%	64%	65%
Tobacco Use			
Patients age > 18 screened and cessation counseling provided if screened positive for tobacco use	93%	95%	96%
Influenza Immunization			
Patients age 6 months and older seen for a visit Oct. 1 – March 31, received an influenza immunization, who reported previous receipt OR declined	56%	60%	62%
Pneumonia Immunization			
Patients 65 years and older who received a pneumoccal vaccination	–	81%	82%
Depression Screening			
Patients 12 years and older screened for clinical depression and if positive, had a follow-up plan documented	–	100%	100%

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Measures and year-over-year comparison *(continued)*

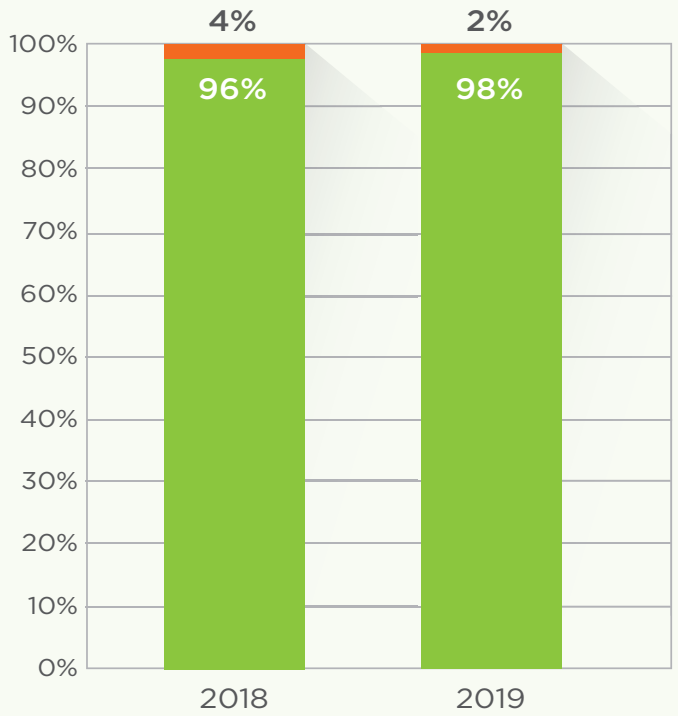
	2017	2018	2019
PREVENTIVE CARE *(CONTINUED)*			
Childhood Immunizations			
MMR by age of 24 months, 1*	80%	82%	83%
Varicella by age of 24 months, 1*	79%	82%	83%
Flu vaccine by age of 24 months, 2*	72%	46%	45%
Hepatitis A vaccine by age of 24 months, 1*	78%	81%	82%
Rotavirus vaccine by age of 24 months, full series*	71%	66%	68%
Dtap, 4	-	67%	69%
IPV, 3	-	84%	86%
HIB, 3	-	81%	84%
Hepatitis B, 3	-	85%	86%
Prevnar, 4	-	71%	73%
Combo 4 (Dtap, IPV, MMR, HIB, HepB, VZV, PCV, HepA)	-	63%	66%
Combo 7 (Dtap, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV)	-	54%	57%
Well Care			
Patients ages 0 – 15 months who received 6 well care visits	60%	66%	70%
Patients ages 3 – 6 years	62%	65%	68%
Patients ages 12 – 17 years	46%	49%	60%

The data consists of 2017, 2018, and 2019 overall CIN measure performance as well as national CMS and NCQA benchmarks for each measure, if available.

Year-end network performance comparison

Percentage of physicians who achieved optimal CIN performance

Percentage of physicians scoring below target performance goal



Care coordination: Patient impact stories

SITUATION: Extreme heat frequently brings grandmother to ED

- Worked with patient who had multiple ED visits for headaches and dehydration due to extreme heat and no air conditioner in the home
- Primary caregiver for her grandson and two of her own children
- Food insecurity

IMPACT:

- Obtained an air conditioner through a local church
- Connected with Population Health's community garden and local food banks for food
- Connected patient with resources that paid for grandson's daycare

SITUATION: Cancer patient provided broad-based care

- Referral for a 54-year-old patient with stage IV colon cancer
- Care coordinator met patient in the home and was prepared with many resources related to cancer
- Quickly realized the need was very different — the only furniture in the home was one chair
- Patient shared that recently she had no food, very few clothes that fit related to her new ostomy, did not have a winter coat last year, and often did not have gas or money to go to follow-up appointments
- Reported being very lonely and not much connection with friends

IMPACT:

- Care coordinator quickly went to work to connect patient with the appropriate resources
- Reached out to Cancer Services, Catholic Charities, Sonshine Ministries, cancer support groups, local food bank and Mustard Seed
- Within a short time, the patient received:
  - Food from the food bank
  - Clothes from Sonshine Ministries that worked with the ostomy
  - Gas cards and personal supplies from Cancer Services
  - Winter coat from Catholic Charities
  - Furniture from Mustard Seed
- Needs were quickly identified as broad in nature, including:
  - Physical and mental health – patient reported being lonely and not having a social network
  - Environmental, as she had only one piece of furniture in the house
  - Food insecurity, as patient reported having no food on several occasions
  - Inadequate clothing and lack of funds to buy gas to travel to follow-up appointments

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Care coordination: Patient impact stories

(continued)

SITUATION: Patient education reduces ED visits

- Patient with seven ED visits in last year
- Care coordinator reached out and scheduled a home visit to better understand patient's challenges
- Patient shared he is on Medicaid and has financial challenges
- Patient explained that he often did not have his medications related to no transportation
- Challenged with understanding how to take the medications

IMPACT:

- Care coordinator collaborated with a local pharmacy
- Medications are now pre-packaged and delivered directly to patient's home
- Barrier removed with transportation and the patient now understands how to take meds
- Patient is very appreciative, and has had no further ED visits since medications have been delivered to home

Community garden

During the summer seasons of 2018 and 2019, Population Health grew and harvested an array of produce items at a local community garden, located at Lifehouse Church in Huntertown. This produce was then donated to Population Health patients identified as having food insecurities. The team has been able to deliver approximately 175 pounds of fresh vegetables to approximately 20 patients. One such patient was a single mother with four small children. She is employed as a CNA and often works 12-hour shifts. She reported having struggles with being able to afford food for her family. On top of these stressors, she was dealing with a new medical diagnosis while also trying to care for her aging parents. The Population Health team was pleased to be able to serve this patient by providing her with produce to supplement her family's meals for the week.

Advanced care planning

As a health system, we cannot honor a patient's wishes for his/her future healthcare if we do not know what those wishes are.

Advance care planning (ACP) is the process in which individuals are thoughtful about and share their values, goals and wishes that impact future healthcare decisions. If at some time in the future, the same individuals are unable to express their preferences, their families and healthcare teams are prepared make decisions that respect these stated preferences of their loved one or patient.

Parkview utilizes the Respecting Choices® model of ACP, which is an evidence-based program shown to improve overall patient care, as well as population health outcomes.

Population Health has been involved with ACP at Parkview since it was introduced in mid-2017. Currently, Parkview has 13 certified ACP facilitators, including three who are certified as ACP Facilitator Instructors. Population Health's group of ACP Facilitators facilitated a total of 108 ACP conversations in 2018, and 228 ACP conversations during 2019. These conversations have occurred in patient homes, inside our High Performing Network (HPN) member skilled nursing facilities, as well as at provider offices, spanning the continuum of the team.

Care management
within the emergency department

Frequent emergency department (ED) users make up 4 – 8% of ED patients, account for 21 – 28% of total ED visits, and as much as 32% of emergency medical services (EMS) transports. In 2012, Jeff Nickel, MD, FACEP, medical director, ED, Parkview Hospital Randallia, began collaborating with Parkview Emergency Department case managers to identify and manage frequent ED users through the use of ED care plans.

The main goals of this program are:

- **Identify and redirect frequent ED users to the appropriate level of care**
- **Connect patients with community services and support**
- **Decrease unnecessary testing, duplicate testing and repeated radiological exposure**

The program started with a small group of frequent ED users in Parkview's Allen County facilities and in 2018, expanded to more than 700 patients with ED care plans in place in all Parkview facilities, including Allen County and community hospitals. Through the implementation of this collaborative effort, the ED case managers have assisted frequent ED users with connection, collaboration and continuity across the continuum of care.

Through a 2018 Student Education and Research Fellowship (SERF) project, the ED Care Management program has been able to identify the impact of this collaboration with Professional Emergency Physicians (PEP). Frequent ED users for this program are defined as five visits in a six-month period. Additional referrals to the program come from ED physicians, staff, case managers and hospitalists for a variety of concerns, including the absence of a primary care physician, difficulty affording medications and social issues.

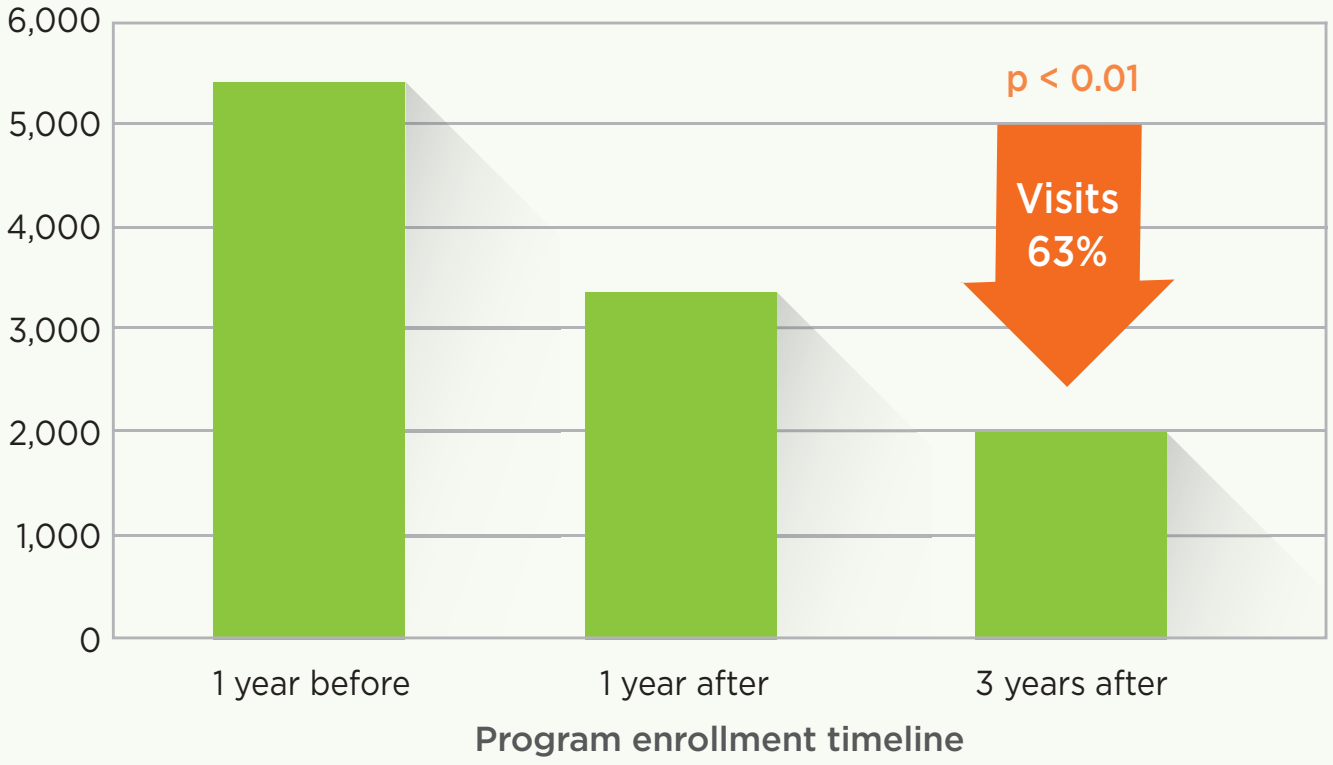
The 2018 SERF project identified that the ED Care Management program has had a statistically significant impact across all measured areas, including a decrease in ED visits, a decrease in testing and radiological exposure and a decrease in cost to the organization, while showing an increase in the number of those insured and connected with a primary care physician.

"Since inception, the ED Care Management program has been extremely successful in decreasing costs, utilization of ancillary testing and ED visits. Most importantly, it has helped many of our patients become connected with accessible and appropriate continuing care to manage their healthcare needs."

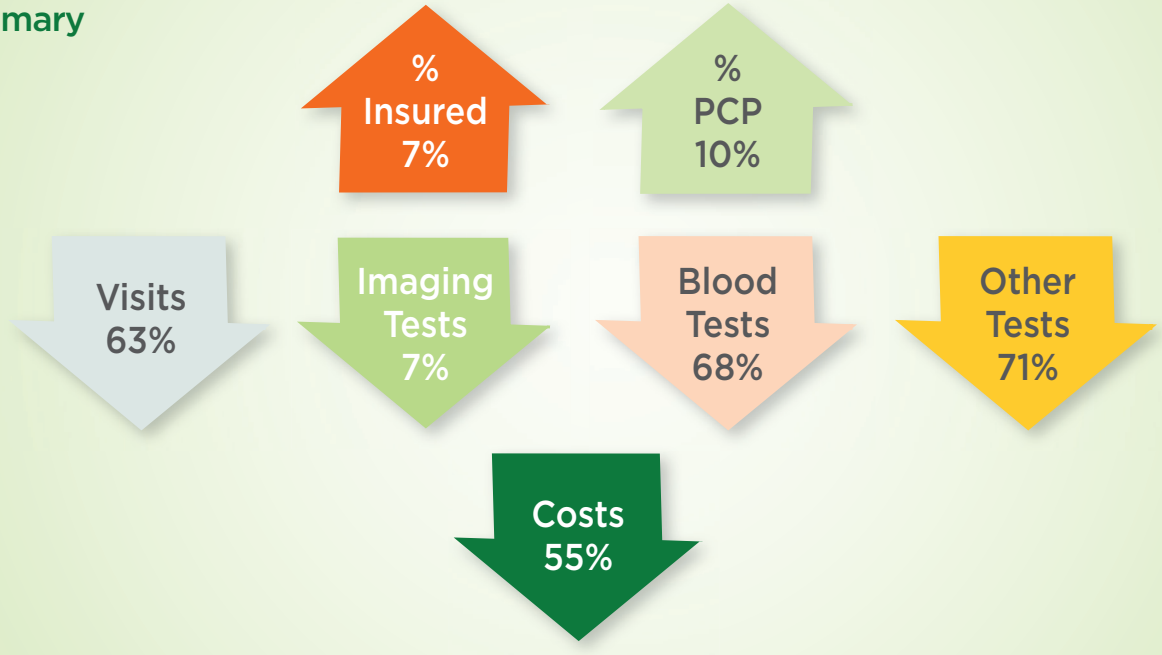
Jeffrey Nickel, MD, FACEP
Member, PCP Quality & Performance Improvement Committee; Medical Director, Emergency Department of Parkview Hospital Randallia; and Professional Emergency Physicians (PEP)

Care management
within the emergency department *(continued)*

Total ER visits of 378 case management patients



Summary



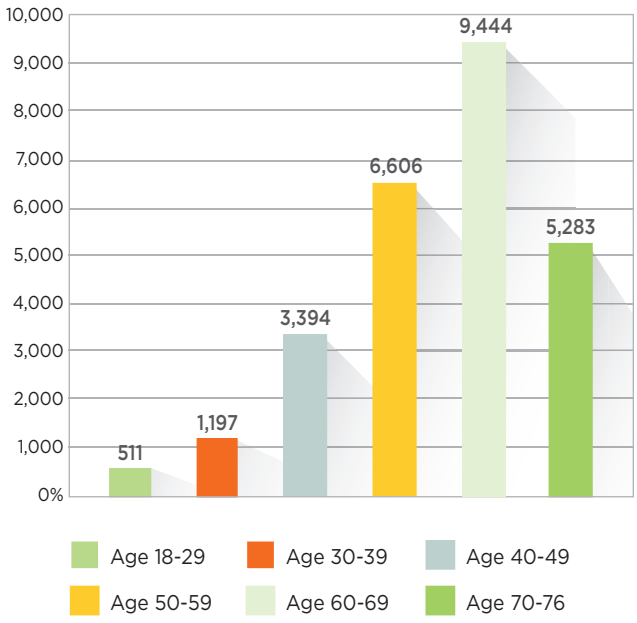
Redesigning diabetes care

Parkview is dedicated to providing quality diabetes care, education, and support to the population that it serves. Chad Shirar joined Parkview as director for Diabetes Services in 2018, and Emily Schroeder, MD, PhD, Parkview Physicians Group (PPG) – Endocrinology, became medical director for Parkview Diabetes Services in 2019. They have been partnering with clinical and administrative teams throughout Parkview Health to further elevate diabetes services to a unique level for the region.

Successes from 2018-2019 include:

- **Established a Diabetes Steering Committee with related task forces to address diabetes prevention, education, ambulatory care and acute care.**
- **Successfully built and implemented a diabetes registry, including more than 65,000 community members, allowing Parkview to review population data in order to identify and target areas of greatest need.**
- **Strengthened the partnership between Parkview, the YMCA of Greater Fort Wayne and other community YMCAs to encourage enrollment in the YMCA Diabetes Prevention Program.**
- **Expanded a clinical pharmacy program to place pharmacists within 13 PPG primary care practices to better integrate diabetes care with the primary care teams at these locations.**
- **Implemented system-wide Glucommander, an inpatient diabetes management tool that produces algorithms to adjust insulin doses throughout hospitalization, thus improving blood glucose control and hospital outcomes.**
- **Launched 12-month program with Renaissance Point YMCA and Parkview Community Nursing to provide evidence-based, patient-centered diabetes education and support to underserved men over age 50, who have been diagnosed with, or are at risk for, diabetes. Support groups meet monthly, with the goal of reducing risk factors for diabetes and heart disease by facilitating lifestyle changes and improving engagement in overall health decisions.**

CIN diabetes patients by age



Process improvement: Diabetic eye exams

For individuals with diabetes, getting regular eye exams are critical, but it can be a challenge for care teams to identify the source and acquire eye exam results.

A few years ago, the diabetes team added another step in the process so that the physician who receives the referral for a diabetic eye exam is also provided with a fax number for results to be sent. The CIN receives the fax and enters the information into Epic. This helps to ensure that the patient's results are available to their primary care physician or the provider who ordered the eye exam.

The CIN works with physicians and care teams to promote awareness and proper utilization of the SmartPhrase and as a result, we have continued to experience an increase in volume.

Results CIN has entered into Epic:

2017	2018	2019
11,774	13,892	16,964
Eye exams	Eye exams	Eye exams

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