THE 2022 VALUE REPORT

A REPORT ON 2020 AND 2021 RESULTS

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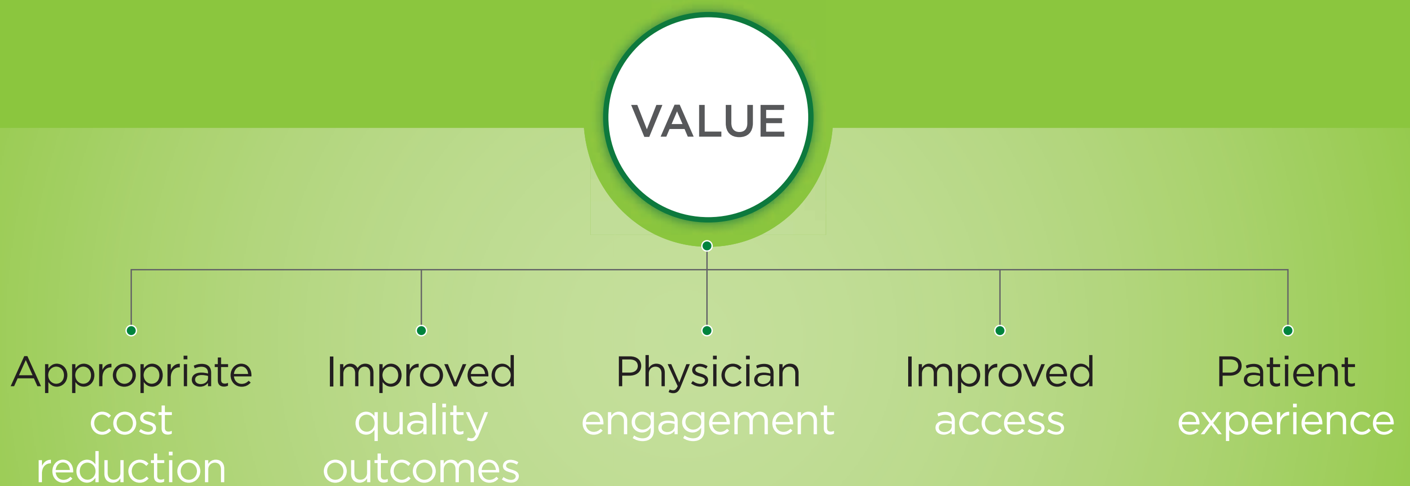
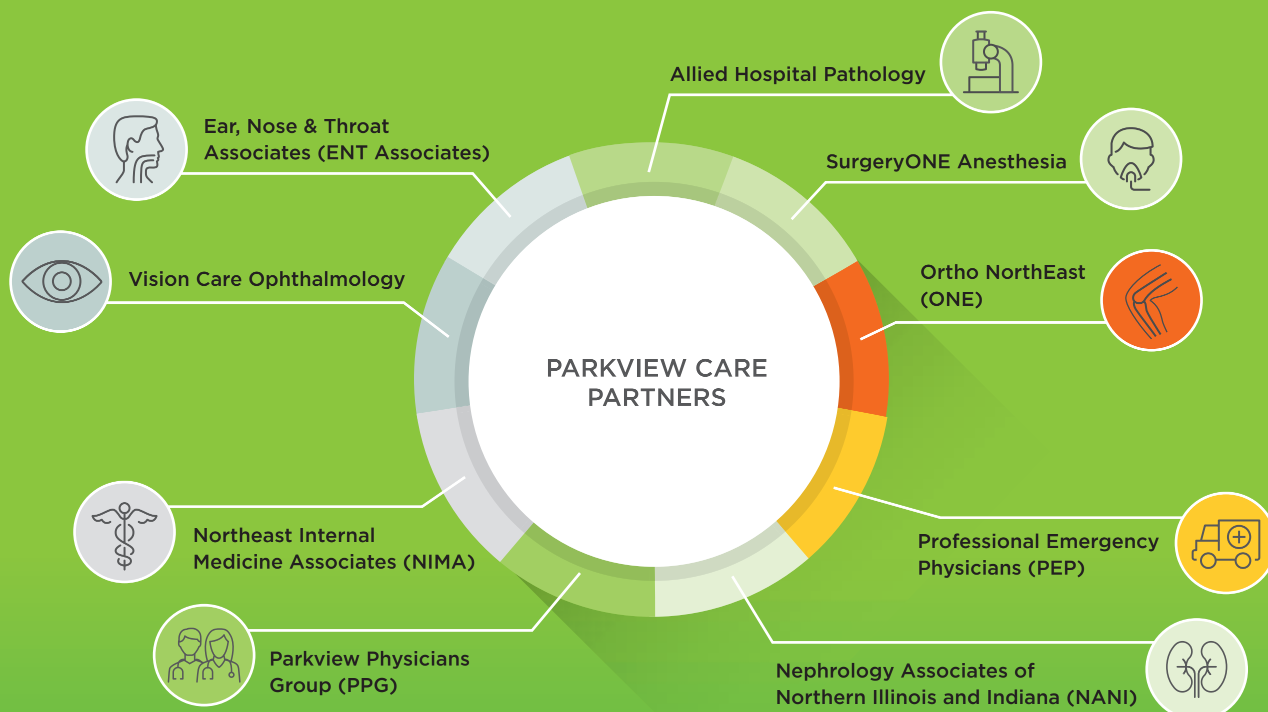
Executive summary

What is a Clinically Integrated Network (CIN)?

A Clinically Integrated Network, like Parkview Care Partners (PCP), is a physician-led care management organization that collaborates on a clinically integrated approach to healthcare delivery across the continuum of care — focusing on improving quality of care offered by providers while leading the market in the transformation to value. 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.**



Physician groups within Parkview Care Partners



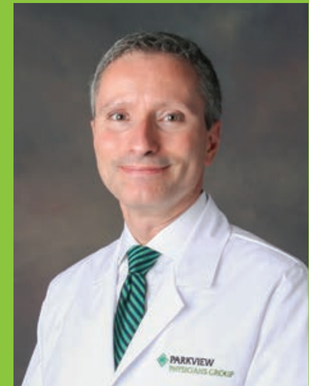
Parkview Care Partners Network Composition

YEAR	Quantity of Primary Care Providers	Quantity of Specialty Care Providers
2015	**134**	**315**
2016	**141**	**350**
2017	**135**	**416**
2018	**156**	**436**
2019	**158**	**478**
2020	**165**	**503**

YEAR	Quantity of Employed Providers	Quantity of Independent Providers
2015	**366**	**83**
2016	**386**	**105**
2017	**404**	**147**
2018	**436**	**156**
2019	**483**	**153**
2020	**522**	**146**

Total Physician Count
Percentage of Employed Providers

2015	2016	2017	2018	2019	2020
449	**491**	**551**	**592**	**636**	**668**
82%	**79%**	**73%**	**74%**	**76%**	**78%**



"As physicians, we are ultimately responsible for the quality of care we provide to patients. Our patients give us their trust, and in return, we owe them the best care that modern medicine has to offer. That's why it's so important for physician leaders in the CIN to set a high bar for quality as well as hold ourselves and our colleagues accountable to that standard."

Jason Row MD
Chief Medical Officer, PPG; Inpatient Service Line Physician Executive, Parkview Health; Care Design & Optimization Physician Executive, Parkview Health, QPIC member

"Participating in Parkview Care Partners allows physicians to help guide the quality measures in our healthcare delivery system, which then provides the tools necessary to empower better patient care."

Jeff Nickel, MD
Vice President, Professional Emergency Physicians; Co-Medical Director of Emergency Medicine, Parkview Regional Medical Center, QPIC member

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"Having the opportunity to be a part of the Quality & Performance Improvement Committee allows me and my fellow physicians to prioritize health measures that are meaningful and truly make a difference to the well-being of those who matter most to us: our patients."

Ronald Sarrazine, MD
PPG – Internal Medicine & Pediatrics
QPIC member

Message from the chairman

The onset of the COVID-19 pandemic in 2020 and 2021 caused us to face many challenges in almost every facet of our world. As you will read throughout this Value Report, it is commendable that an emphasis on quality and value remained not only a focus but also a priority during this time. Despite the challenges, physician leaders continued to come together to achieve higher standards of patient care. These efforts have allowed the CIN to maintain momentum with addressing ever-evolving care delivery methods, while being leveraged to assist with addressing both the anticipated and realized market changes.

It's no secret that there is an increasing focus on delivering better health outcomes more efficiently and at a lower cost. As chairman of the CIN Board and Quality & Performance Improvement Committee, I am able to see, month over month, the engagement of the physician leaders who are all dedicated to charting our destiny and helping influence the way care is delivered in our community. The impact the CIN makes leads to continued improvement in quality, outcomes, cost and, ultimately, value. I'd like to take this opportunity to thank our CIN physician leaders and all our high-performing CIN physician members for their dedication, commitment and remarkable efforts to improving the care delivery system and the patients we serve.

Thomas Bond, MD
Chairman, Parkview Care Partners Board of Managers; Chairman, Quality & Performance Improvement Committee, Parkview Health; Chief Medical Officer, PPG

"As a physician who does both outpatient and inpatient, I see the benefits PCP has to my teams. It lets me know which metrics I need to have my physicians keep up with, helps us maintain our standards and allows us to more easily follow-up on what is coming down the pipeline in the industry. And that means we can provide great healthcare with great outcomes."

Vijay Kamineni, MD
Northeast Internal Medicine Associates, QPIC member

Clinically Integrated Network governance

Board

Thomas Bond, MD, Chair, *PPG*

Thomas Gutwein, MD, Secretary,
Professional Emergency Physicians

Thomas Curfman, MD, *PPG*

Raymond Dusman, MD, *Parkview Health*

Carol Garrean, MD, *PPG*

Michael Grabowski, MD, *PPG*

Alan McGee, MD, *Orthopaedics Northeast (ONE)*

David Stein, MD, *Ear, Nose & Throat Associates*

Mitch Stucky, MD, *PPG*

Mike Yurkanin, MD, *PPG*

David Jeans, Senior Vice President,
Payor, Employer and Health Plan Strategy, Parkview Health

John Bowen, President,
Parkview Regional Medical Center & Affiliates

Finance Committee

David Stein, MD, *Chair, Ear, Nose & Throat Associates*
Raymond Dusman, MD, *Parkview Health*
Scott Karr, MD, *Orthopaedics Northeast (ONE)*
Jason Row, MD, *PPG*
Mitchell Stucky, MD, *PPG*
Greg Johnson, DO, MMM, *Parkview Health*
David Jeans, Senior Vice President,
Payor, Employer and Health Plan Strategy, Parkview Health

Administrative Team

Greg Johnson, DO, MMM,
Chief Clinical Integration & Employer Solutions Officer
Chris Hepler, Vice President,
Home & Transitional Services
Nicole Krouse, Director, *Clinically Integrated Network*
Stacey Bussel, Director, *Enterprise Care Management*
Chad Shirar, Director, *Diabetes Care Strategy*
Lynette Neher, Director, *Care Management Operations*

"Being a physician member of the Quality & Performance Improvement Committee allows me to participate and drive quality improvement opportunities for our patients. Physician leaders are ideal for leading discussions for the best interest of our patients while also driving implementation of initiatives."

David Stein, MD
Ear, Nose & Throat Associates, QPIC member

Quality Performance & Improvement Committee

Thomas Bond, MD, Chair, *PPG*

Fen-Lei Chang, MD, *PPG*

Harin Chhatiawala, MD, *PPG*

Paul Conarty, MD, *PPG*

Sampath Ethiraj, MD, *PPG*

Michele Helfgott, MD, *PPG*

James Ingram, MD, *PPG*

Greg Johnson, DO, MMM, *Parkview Health*

Vijay Kamineni, MD,
Northeast Internal Medicine Associates

Joshua Kline, MD, *PPG*

Craig McBride, MD, *Allied Hospital Pathologists*

Jeffery Nickel, MD, *Professional Emergency Physicians*

Andrew O'Shaughnessy, MD,
Nephrology Associates of Northern Illinois and Indiana

Jason Row, MD, *PPG*

Ronald Sarrazine, MD, *PPG*

David Stein, MD, *Ear, Nose & Throat Associates*

Renna Thapa, MD, *PPG*

Anusha Valluru, MD, *PPG*

"PCP's Quality & Performance Improvement Committee has been one of the most rewarding committees on which I have had the privilege of serving. I believe the team has had great effect in driving positive change by virtue of the leadership of the physicians involved in formulating processes and metrics. We know this will have meaningful impact on our patients through the many quality initiatives the group facilitates."

Paul Conarty, MD
PPG – Colon & Rectal Surgery, QPIC member

Creating value through utilization review

Who is responsible for the high cost of healthcare? Pharmaceutical companies? Medical device companies? Providers? Patients? Hospitals? Payers? Nursing homes? There seems to be a lot of "finger pointing" aimed at identifying the entity that is responsible...but what's the correct answer?

I'd suggest looking at the current reimbursement model. A significant culprit for the increase in healthcare costs is transactional healthcare, meaning something gets done and is subsequently billed for. The only time revenue is generated is when something that is billable gets done. It's transactional, hence the name.

When I went into practice, we may have needed to see about 25 patients a day to pay bills, cover cost of practice, pay staff, etc. Then a payer came in and cut reimbursement by 11%, and another cut it by 7%. But the responsibility of generating revenue remained. We couldn't call the utility company and let them know we weren't going to pay what we owed because our reimbursements were cut. We couldn't go to staff and tell them we were cutting their salaries by 7%. The only thing we could do was see 29 patients a day instead of 25. But that soon turned into 31, 33, 35 patients a day.

We have never heard a patient or physician complain about being able to spend too much time together. There is a constant time crunch. It's a hamster wheel of needing to do more and see more patients in the same amount of time. And that is exactly what transactional healthcare is. It's all about volume. So, what is incentivized in transactional healthcare? Getting stuff done. That is what creates the price/volume dilemma. But it's more insidious and complicated than that. In a transactional model, utilization increases as there is an incentive to do more.

Greg Johnson, DO, MMM
Chief Clinical Integration & Employer Solutions Officer

As a result of this dilemma, an entire industry had to be created: utilization review/utilization management. I can humbly say that the people who do this work do a tremendous job of managing utilization in the current reimbursement model. But it doesn't really get to the crux of what is needed. Instead of focusing on what comes across as an effort to not pay providers, the focus should be on the types of utilization we can have a greater impact on.

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"Defining value in healthcare has always been an enigma, but that certainly will not stop the stakeholders from seeking this elusive concept. It is very advantageous for us, as providers, to be a part of the seeking process. Value will be defined with or without us — and I'd rather be in on the conversation."

Andrew O'Shaughnessy, MD
Nephrology Associates of Northern Illinois and Indiana, QPIC member

Creating value through utilization review

(continued)

Consider, for example, the three types of utilization.

1.) Appropriate: Someone comes into the emergency department with a chainsaw injury

2.) Inappropriate: Someone presents to the emergency room with chronic back pain

3.) Avoidable: Someone with diabetes presents with a blood sugar of 700, hypotension, symptoms of dizziness when they stand up, etc.

Let's say a patient presents to the emergency department six times in the last three months. They were given great care and received great service every time. But what does the payer see? A utilization problem. So, they start things called pre-certifications or pre-authorizations, UR, UM, denials, etc., that must be put into place because utilization is running amuck.

With utilization management being appropriately imposed on us, we are trying to prove the relevancy of the care provided. But does this offer value to the patient? Not likely. Instead, the patient's experience is lessened, along with the provider's experience. It does not drive value. In fact, it does just the opposite and instead drives up the cost of care.

As inappropriate or avoidable utilization goes down, value goes up. There are many programs that address avoidable or inappropriate utilization, but we need more. The challenge is that it's an added cost. We have to increase our internal costs in order to decrease our ED visits or admissions, and thus our revenue in the traditional volume/transactional model.

This is why value-based reimbursement is so critical. It will incentivize the delivery of care and support value-added services like care coordination, chronic disease management programs, and efforts to keep people out of the hospital and emergency department. Simply stated, future reimbursement models will not only enable and promote appropriate utilization but also support programs that address utilization that is avoidable or inappropriate. All while continuing to nurture Parkview's quality and service excellence.

Let's go to the value equation:

$$\text{VALUE} = \frac{\text{Quality} + \text{Safety}}{\text{Price} \times \text{Utilization}}$$

Physician leadership and engagement

While the Clinically Integrated Network has formal governance committees, we are grateful to the many physicians who have led and engaged for improved quality of care within their respective sections.

Christopher Frazier, MD, and Janet Prendergast, DO, Section Chiefs, Primary Care

These two physicians have made a positive impact on other providers with their approach of coming alongside the CIN to offer peer-to-peer support and perspective. Their engagement has absolutely led to improvement with identified opportunities, whether that be with workflow, patient conversations or even general mindset on quality measures.

"The future of quality-based reimbursement can seem quite daunting, with many factors affecting patient care. Patient engagement, social determinants of health, insurance coverage and managing time with patients during busy schedules are just a few examples of barriers we face as clinicians to reach our metrics. While it can be frustrating, as I work with my team and my peers to improve the metrics, I focus my attention first on how this can improve the patient's overall health to guide further office processes and changes to my practice."

Christopher Frazier, MD
Section Chief, PPG – Primary Care of Noble, Steuben and LaGrange Counties

"I feel as if the CIN gives providers the ability to leverage our clinical knowledge of what is best to promote health in our communities with the convenience of computer intelligence. You cannot know exact numbers but must believe that utilization of the CIN leads to GREATLY improved outcomes and health for our patients."

Janet Prendergast, DO
Section Chief, PPG – Family Medicine

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Physician leadership and engagement

Michael Lyons, DPM,
Section Chief, Podiatry and Orthopedics

An advocate for quality, Dr. Lyons constantly challenges his section to continuously reach new heights with measured goals. His focus and collaboration with the CIN team to ensure that measures are value-added and that there is a workflow to support his section in their success has created an undeniably positive and impactful change.

Hariom Joshi, MD,
Director, Medical ICU, Parkview Regional Medical Center

Dr. Joshi has shown incredible persistence while working with IS/BI and the CIN team to pave the way for being able to capture (or automate) multiple vent days measures, which is one of the most complex builds we've encountered. His ability to focus on measures that support his section has had a direct impact on patient outcomes and minimizing chances of infection and complications.

"The CIN has supported us to improve our ability to provide the safest care possible in a manner that emphasizes quality of care."

Hariom Joshi, MD
Director, Medical ICU, Parkview Regional Medical Center, PPG – Critical Care Medicine

Care coordination

Transitional care management for all VBC discharges

In the third quarter of 2021, Parkview Population Health began completing transitional care management phone calls to value-based patients discharging from the hospital to ensure they had appropriate follow-up with their physician after a hospital stay. Patients were called within 48 hours of discharge to determine their need for a 7- or 14-day post-hospital visit with a PCP. The team completed 1,909 calls to patients during the last two quarters of 2021.

"Participating in QPIC allows me to give a voice to what primary care values for the future of healthcare: excellent, patient-focused outcomes."

Jim Ingram, MD
Associate Chief Medical Officer, Parkview DeKalb Hospital; Section Chief, PPG, DeKalb; Epic Physician Builder, QPIC member

Advance 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 Population Health has 17 certified ACP Facilitators, including three who are certified as ACP Facilitator instructors supporting PPG. Population Health's group of ACP Facilitators facilitated a total of 162 conversations in 2020 and 2021.

Feedback from Population Health ACP Facilitator survey:

Q: What do you find most rewarding about being a certified ACP Facilitator?

A: "Although these are tough conversations to have, most of the time people walk away with a sense of relief and gratitude for having done it. And that is my favorite part. It feels like I was able to be a part of something bigger than just my story."

Parkview's high performing network

Continuum of care is a concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care. As patient care continues to increase in complexity, collaboration between an interdisciplinary team across care settings becomes critical to patient outcomes.

This is the reason the Parkview High Performing Network (HPN) team was created — to serve patients needing a skilled level of care during the next step in their journey. The team, which consists of physicians, nurse practitioners, integrated care coordinators, mobile integrated health community paramedics, and social support specialists, round on patients in six local skilled-nursing facilities.

The High Performing Network facilities accept high-risk/high-acuity patients who 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
- The Village at Pine Valley
- Heritage Park
- Saint Anne Communities
- Miller's Merry Manor

2021 HPN highlights

- Each High Performing Network facility worked especially hard in 2021 to accept COVID-19-positive patients, as well as transition clinically stable patients to a skilled level of care. This supported Parkview Health by ensuring acute care beds were available to assist the needs of people in northeast Indiana.
- In 2021, a Parkview physician or nurse practitioner rounded on a Parkview patient in a partner skilled-nursing facility over 12,500 times to help ensure continuity of care and treatment plan intervention.
- Over 5,000 encounters occurred in 2021 from a Parkview RN Care Coordinator or Social Support Specialist to engage with a patient around a care transition or discharge planning need.
- The average length of stay in a skilled nursing facility varies between 20-30 days. In 2021, the High Performing Network facilities had an average length of stay of 20 days.

30 Day All Cause Readmission Rates Three Year Trending

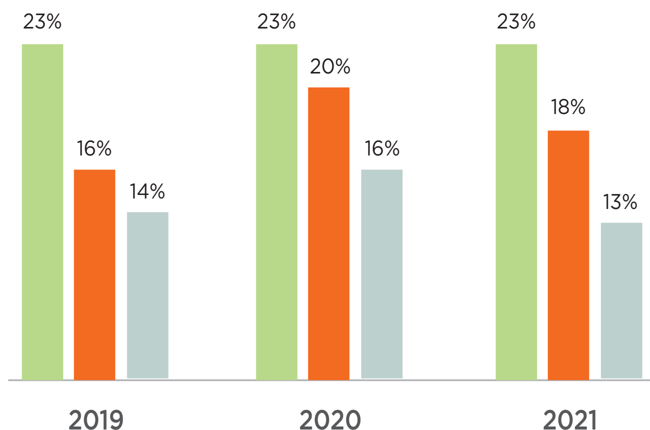
NON HPN COMPARED TO PARKVIEW VALUE BASED OUTCOMES

National Average

All Other Skilled Nursing Facilities

High Performing Network

NOTE: COVID-19 cases impacted 2020/2021 outcome



Clinical Integration Measures Snapshot

PROVIDER RELATIONS SPECIALISTS

Each physician member of the CIN has a Provider Relations Specialist who serves as an extension of the care team and supports members by tracking and monitoring performance with CIN measures. This helps ensure performance doesn't trend downward without awareness and intervention. Additionally, because Provider Relations Specialists round with many physicians and offices, they can share successes from other providers to help make a positive change in their own office/practice. The partnership between the physicians and Provider Relations Specialists has helped maintain 95% of all physician CIN members meeting optimal measure performance.

PRIMARY CARE MEASURES 2020/2021

	NCQA GOAL	GOAL MET 2020	GOAL MET 2021
CHRONIC AND ACUTE ILLNESS			
Diabetes Care			
HbA1c result > 9	36%	✔	✔
Nephropathy screening or evidence of nephropathy	94%	–	–
Eye exam	57%	✔	✔
Statin therapy diabetics age 40 – 75	69%	✔	✔
Cardiovascular Disease			
Statin therapy ages 21 – 75 males; 40 – 75 females	82%	✔	✔
Controlling high BP < 140/90 ages 18 and older	56%	✔	✔
ACE or ARB Therapy for patients with CAD and diabetes or LVEF < 40%	77%	✔	✔
PREVENTIVE CARE			
Breast Cancer Screening			
Women ages 50 – 74 who had a mammogram during measurement year or year prior	67%	✔	✔
Cervical Cancer Screening			
Women ages 21 – 65 pap smear 3 years or ages 30 – 65 pap with HPV every 5 years	53%	✔	✔
ColoRectal Screening			
ColoRectal screening ages 50-75; Colonoscopy – 10 years; CT Colonography – 5 years; Cologuard – 3 years or FOBT annually	53%	✔	✔
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	61%	✔	✔
Pneumonia Immunization			
Patients 65 years and older who received a pneumoccal vaccination	75%	✔	✔
Childhood Immunizations			
MMR by age of 24 months, 1*	90%	–	N/A
Varicella by age of 24 months, 1*	89%	–	N/A
Flu vaccine by age of 24 months, 2*	64%	–	–

"Physician leadership and their teams are able to provide evidence-based and data-driven input, discussions and implementation of quality measures. This helps improve the quality of healthcare and provide undeniable value to the institution."

Reena Thapa, MD, MBA
PPG – Internal Medicine, QPIC member

Clinical Integration Measures Snapshot

SPECIALTY MEASURES - 2021	CIN GOAL	GOAL MET
PPG – Cardiology ACE or ARB Therapy for Patients with CAD and Diabetes or LVSD *Patients with a diagnosis of coronary artery disease (CAD) who also have diabetes OR a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.*	> 77%	✔
PPG – General Surgery Readmission or ED visit within 30 days of hernia surgery or colonoscopy procedure *Patients who underwent either a hernia surgery or colonoscopy who had an ED visit within 30 days from their initial procedure/surgery date or experienced an unplanned readmission for any cause within 30 days from their initial procedure/surgery date.*	≤ 6%	✔
PPG – Hospital Medicine 30 Day Readmission Rate - All Cause *Patients who experienced an unplanned readmission for any cause within 30 days from their intial inpatient discharge date.*	≤ 17%	✔
PPG – Infectious Disease One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk *Patients with one or more of the following: born between the years 1945-1965, have a history of injection drug use, are receiving maintenance hemodialysis who have received a screening for hepatitis C virus (HCV) infection.*	≥ 40%	✔
PPG – Pediatrics Gastroenterlogy IBD Assessment of Hepatitis B Virus (HBV) IBD Assessment of Tuberculosis (TB) IBD Assessment of Varicella (VZV) *Patients with an active diagnosis of inflammatory bowel disease (IBD) and are on a biologic response modifier who have had the appropriate testing completed prior to intiating anti-TNF therapy.*	≥ 64% ≥ 64% ≥ 50%	✔ ✔ ✔
PPG – Plastic Surgery SSI for Breast Reconstruction *Patients who underwent a breast reconstruction surgical procedure that presented with a surgical site infection within 90 days of breast reconstruction procedure.*	≤ 3%	✔
PPG – OB/GYN Chlamydia(CHL) Screening in Women 16 to 24 Years of Age *Female patients who had appropriate testing at least once within measurement year.*	≥ 50%	✔
Professional Emergency Physicians (PEP) Opioid Prescription Rate *Patients who were prescribed an opioid medication at time of ED visit.*	≤ 15%	✔
Nephrology Associates of Northern Indiana (NANI) 30 Day Readmission - ESRD *Patients with a new diagnosis of ESRD who experienced an unplanned readmission within 30 days from their intial inpatient discharge date.*	≤ 35%	✔

Enhancements to diabetic care

DIABETES EDUCATION REDESIGN

This ongoing initiative began in 2021 with the goal of reducing patient cost, improving access, standardizing workflow and referrals, standardizing documentation, improving the overall patient experience and retention of educational material, and working more collaboratively with service lines impacted by diabetes.

In order to reach these goals related to care for diabetic patients, a number of enhancements were made, including: flowsheet documentation, centralized scheduling, patient-centered education delivery, and the addition of new roles to support the patient and family as well as follow-up care.

"Being on the Quality & Performance Improvement Committee has broadened my understanding of the quality measures as well as what goes into setting them and enforcing them. It has helped me ensure that our practice is driving quality and keeping up with other similar practices and health systems in the country."

Michele Helfgott, MD
PPG – Integrative Medicine, QPIC member

Diabetes care team enhancement roles:

- **Diabetes Care Navigator:** Works closely with all members of the diabetes care team to assist those living with diabetes in navigating the complexities of healthcare and directly addressing social determinants of health barriers. The main focus of the Diabetes Care Navigator is to ensure a smooth transition of care from one healthcare setting to another, as well as provide supportive resources for optimal diabetes health.
- **Community Engagement Specialist:** Focuses on the Burmese speaking population to address cultural and language barriers, including education, navigation, coordination and reinforcement of diabetes care principles.
- **Lifestyle Change Specialist (LCS):** Partners with diabetic individuals and their care teams to apply and reinforce the knowledge provided for optimal diabetes health. The LCS can assist the patient with a variety of behaviors such as: weight management, physical activity, nutrition, stress, sleep, tobacco cessation and medication adherence.

Enhancements to diabetic care

IDX-DR FOR DIABETIC RETINOPATHY

As the first FDA-cleared autonomous artificial intelligence technology, IDx-DR is intended to diagnose diabetic retinopathy at the point of care. This means images do not need to be sent to an eye care specialist for reading and interpretation.

Although diabetic retinopathy is the leading cause of blindness in working adults, only ~15% of people living with diabetes complete their yearly diabetic eye exam. With estimates showing that there is only one ophthalmologist for every 14,000 patients with diabetes, the use of IDx-DR improves access to diabetic retinopathy testing and provides early and easy referral to eye care specialists for those who test positive — significantly reducing the risk of further eye health complications as well as overall cost.

Since we began our six-month pilot in early 2021 (and continued our relationship with IDx), we have seen the following retinal exam results:

- **500+ exams performed**
- **91% of patients left the office with a diagnostic result**
- **38% of patients tested positive for diabetic retinopathy**
- **100% of patients who tested positive were provided with an ophthalmology referral for follow-up**
- **50+ patients who tested positive were referred to Vision Care Ophthalmology (Parkview Care Partners ophthalmology group) and scheduled for a visit in fewer than seven days on average**

Value-based care outcomes results

CIN physician members are supported in several ways to help achieve optimal success with our value-based contacts, whether that be with quality measures or patient gaps in care, appropriate utilization of healthcare services, or reduction of cost of care. The support roles within the CIN team help maximize success and improve value for our patients and community.

Outreach and pre-charting

The CIN outreach and pre-charting initiative is a way to take some of the burden from office staff by aiding in scheduling and managing patient visits for those who have not been seen for the current year. When patients are scheduled, the conditions that have not been addressed for the measurement year are highlighted for the physician.

With the onset of COVID-19, challenges with patient management were heightened due to medical office closures and increased fear of exposure. To combat these pandemic-related challenges, efforts surrounding patient outreach and education were amplified, and as a result, over ***86% of all value-based care patients were seen annually.*** Of those scheduled by the CIN, 85% of patients followed through with their appointment with their physician.

Dr. Elizabeth Brauchla, PPG – Family Medicine, in Warsaw was able to save a patient's life by addressing an old diagnosis documented by another provider. She noticed a diagnosis pre-charted by the CIN team of aortic aneurism and followed up by ordering additional testing. Upon reviewing the results, she facilitated the next step in the continuum of care, resulting in a surgery that may have saved the patient from being faced with a sudden medical emergency and, potentially, a fatal outcome.

Chase workflow

Chase workflow is a process where value-based claims data is utilized to chase down the results from external sources and enter them into Epic. This process not only informs the provider of the completed test results, but also provides a fuller picture of the patient when care or testing is performed outside of Parkview. It also lessens the burden for care team members to complete the task of retrieving the results, leaving more time for direct patient care in the office.

In 2020, ***the outcomes team chased and resulted just over 1,200 test results.*** Because this was a new process that was fully implemented in 2020, there was a backlog of results. Subsequent years should have far less results to chase down than the first year, which was evident in 2021, with 369 results chased down and entered into Epic.

Value-based care outcomes results

Eye exams

Retrieving or tracking down eye exam results for patients can be a challenge for members of the care team. A few years ago, a workflow was established within Epic for providers who receive the referral. Results are routed to the CIN where they are then entered and scanned into the chart. This has allowed for a larger number of eye exam results to be tracked and entered into Epic.

2018	2019	2020	2021
13,892	16,964	16,197	15,530
Eye exams	Eye exams	Eye exams	Eye exams

"I am so happy to be a part of the physician-led Parkview Care Partners group because it allows physicians like me to monitor the quality measures in our healthcare system, which in turn helps us obtain excellent patient care."

Anusha Valluru, MD
PPG – OB/GYN, Epic Physician Builder, QPIC member

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Value-based care outcomes results

Value-based care highlight:
UnitedHealthcare

Despite the challenges that came with COVID-19, the Clinically Integrated Network was informed that our providers were the highest performing quality group for UnitedHealthcare in the state of Indiana in 2020. This is a testament to the many physicians, care teams and support staff who all work together for the betterment of our patients.

"During the most challenging time in history to provide medical care, the Parkview ACO achieved outstanding results in the quality of care for UnitedHealthcare patients. Parkview saw improved or steady performance in our designated quality measures, driven by increased access to care by primary care physicians. Not only did the quality measures improve, but Parkview demonstrated a laser-focus on high-risk members with chronic conditions, while maintaining a critical focus on patient experience. UnitedHealthcare is grateful to have Parkview as a key partner to improve the care of our members."

Charlotte MacBeth
Health Plan CEO, Indiana, Medicare and Medicaid, United Healthcare

"The CIN helps demonstrate how well we stack up with others using national standards of health maintenance. This keeps us constantly motivated to do our very best."

Harin Chhatiawala, MD
PPG - Internal Medicine, QPIC member

Parkview ACO was the highest quality ACO in the state of Indiana for UHC in 2020.

In ACO 2020 Final STARs Comparison

ACO	ACO STAR Rating (2020 Final)
Parkview	**4.55**
ACO 2	4.45
ACO 3	4.4
ACO 4	4.25
ACO 5	4.1
ACO 6	3.85

Source: Final 2020 PCOR (April runout) or final QBC STAR Rating, if applicable

The impact of a pharmacy-led statin medication initiative

Clinical pharmacists serve as a valuable resource to care providers and their patients. The clinical pharmacists at Parkview Health provide remote patient care as part of the Care Coordination and Clinical Integration teams, including comprehensive medication reviews, patient education and drug utilization reviews.

> "Multidisciplinary physician involvement assures broad feedback when establishing and evaluating our quality measures. This is invaluable as we strive to improve the quality of care provided for all of our patients."
>
> **Craig McBride, MD**
> *Laboratory Medical Director, Parkview Health, Allied Hospital Pathology, QPIC member*

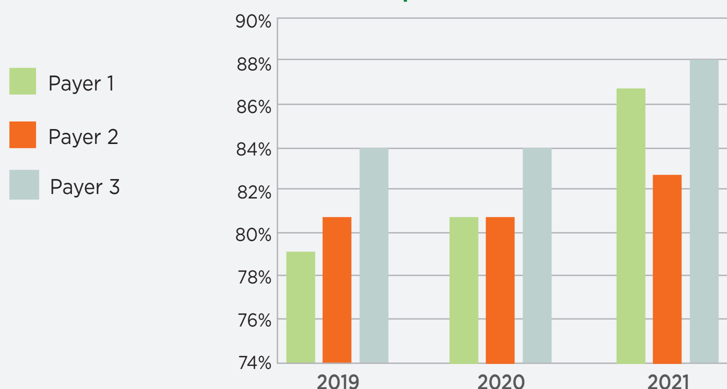
A critical part of the care team, pharmacists collaborate with providers and patients on medication management, provide education on medication therapy topics and provide guidance on clinical integration measure compliance. They also offer much-needed outreach for value-based contract measure compliance, including Medication Adherence Measure outreach, Osteoporosis and Fractures outreach, and Statin Measure outreach. These important steps in the care journey help improve medication dosing, patient adherence and appropriate follow-up treatment.

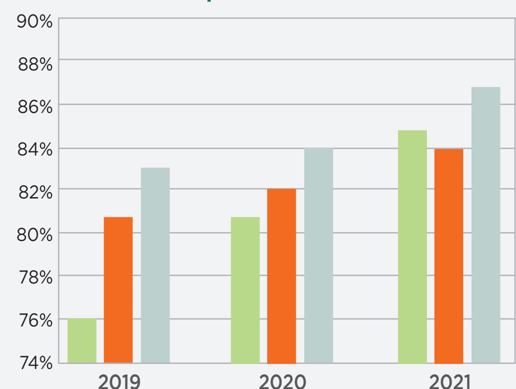
Improving care gaps with statin review & outreach

With the goal of improving adherence to guideline recommendations for use of statin medications, a pharmacy-led initiative directed by Sarah Pfaehler, PharmD, MBA, BCPS, PACS, was created in 2021. The initiative aimed to measure compliance of the Statin Use in Persons with Diabetes (SUPD) and the Statin Therapy for Patients with Cardiovascular Disease (SPC) measures through provider and/or patient outreach.

Patients on the value-based contract care gap lists for SUPD or SPC measures were compiled into a single work queue for review by pharmacy students on rotation with ambulatory care pharmacists. A standardized process outlined review of patient profiles and outreach to either providers or patients, with focused outreach occurring during the fourth quarter of 2021.

As a result of this review and outreach, care gap closure rates increased over the course of the measurement years (2019, 2020 and 2021), with a greater increase noted at the end of the 2021 measurement year. Thanks to this pharmacy-led initiative, SUPD and SPC compliance rates increased, which is a valuable indicator of guideline adherence for the use of statin medications.





Employer pilots

Employer pilot risk-sharing program

In late 2020, Parkview Health and Parkview Employer Solutions partnered with four current Parkview Signature Care groups to pilot a value-based health improvement program. The program pairs historical claims data with clinical data in Parkview's electronic medical record system to analyze which health plan members could benefit most from additional care coordination resources. This specifically includes members who are considered rising risk for an inpatient hospitalization or emergency department visit, as well as those who are determined to have the potential of higher cost to the health plan in the next year.

Parkview's specialized care coordination team is comprised of nurses, pharmacists and social support specialists who assist with locating resources and providing patient education. Resources can include medication assistance, diabetes education, chronic condition management assistance, as well as other collaborative care as part of the patient's extended care team. Each member's complete list of medications is reviewed by one of our clinical pharmacists to determine appropriate alternative options, including those that may be more cost-effective, based on several factors such as the member's medication adherence. In the end, Parkview's team tailors a personalized plan that helps members meet their healthcare needs.

The goal of the pilot program was to allow Parkview additional opportunities to partner with local regional employers to lower overall cost of care while improving quality and outcomes for their highest risk health plan members. Due to the success of this pilot, Parkview recently launched a new health plan product called Parkview Value Plus which incorporates all the elements described above with access to Parkview's High Performing Network of providers who are part of the Clinically Integrated Network.

Employer pilots

Insights from the pilot:

Pilot groups: 4

Start date: March 1, 2021

Total employees on health plan: 1,388

Estimated attributed members in pilot: 2,000

Program length: 3 years

Total participants in initial pilot group: 122

Engagement rate of participants: 67%

Preliminary first year program savings on 122 participants: $612,000

Reduction in ER visits: 31 (a reduction of 37%)

Visits per claimant: 1.4

ED utilization per 1,000:
Decreased in one cohort from 18.9 to 7.9 over 12 months; decreased in another from 16.5 to 6.5 in 12 months

A1C under 8.0

Controlled diabetics at beginning of pilot: 64%

Controlled diabetics as of June 1, 2022: 68%

Medication adherence score:
Increased from 82.6 to 97.83 in 12 months for one pilot group

PARTNERSHIP SUCCESS

Catalyst Ventures

"We believe the key to controlling rising healthcare costs starts with genuinely caring for each coworker's overall health as well as strategic alignment with all who participate in the continuum of a person's health: the provider, the payer, the employer, the broker and our coworkers. We have been able to combat rising healthcare costs by investing in various resources to help employees successfully navigate their health journeys. Parkview has played a large role in our success. The Parkview team continually brings forward ideas on how we can help our coworkers and their families overcome barriers they may have in living a healthier lifestyle. These strategies are proving to be effective while helping us positively bend the curve on the cost of healthcare. We greatly value the true strategic partnership we have with Parkview."

Brian More
President, Catalyst Ventures LLC

East Noble School Corporation

"East Noble School Corporation and Parkview Health are working together to build a trusting relationship and understanding of the current healthcare situation. Parkview understands that healthcare costs can often be one of the top three expenses for employers. Because of this, they are working with us to ease the burden of increasing costs by developing innovative programs for our employees. East Noble loves our relationship with Parkview, and we continue to grow closer as time goes on."

Brian Leitch
Chief Finance & Operations Officer, East Noble School Corporation

Patient success

IMPACT STORY 1

The Transitional Care Clinic recently served a 52-year-old patient after a 12-day inpatient hospital stay. The team was able to work with the patient to coordinate an office visit shortly after an inpatient dialysis appointment to reduce the number of trips to the hospital campus.

The patient had a lot of factors impacting his well-being. He was not working, had no income at the time of his visit to the clinic and had not filled a single prescription due to cost. The Transitional Care Clinic coordinated support from the Medication Assistance Program and secured a 30-day supply of his medication, which the patient was able to fill at the outpatient pharmacy after his visit. The clinic also connected the patient to Change Healthcare to assist with a disability application. Resources were provided to support transportation needs for future medical appointments, and it was identified that he would also benefit from referrals to support food insecurity.

A full medication reconciliation was completed by a pharmacist, and education was provided on each medication. As the patient was new to dialysis, the clinic team educated him on how to monitor for fluid overload and the need for smoking cessation. Because the patient did not have a primary care physician, the clinic team worked on location and patient preference and had the patient setup with a primary care physician appointment the following week.

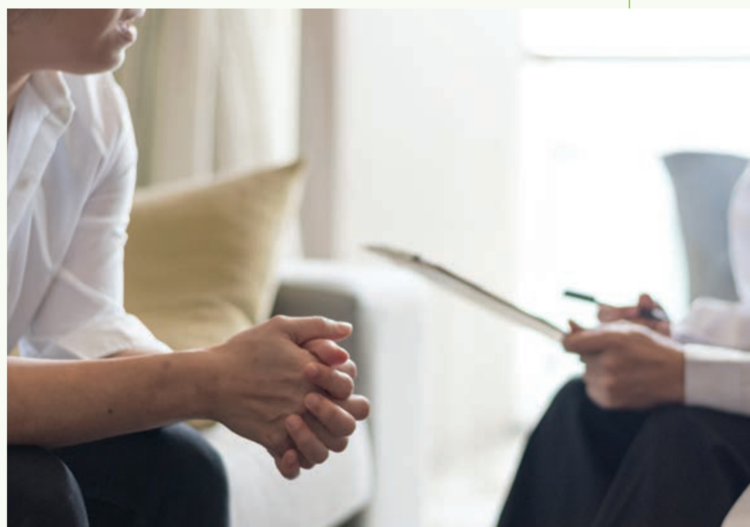
Through his visit to the clinic, this patient had comprehensive intervention for multiple identified needs and left with a primary care resource to support the on-going needs of his treatment plan.

Patient success

IMPACT STORY 2

A patient that appeared well-controlled with an A1C of 5.6% was referred to the Lifestyle Change Specialist (LCS) because she was having recurring hypoglycemic and hyperglycemic instances but was not concerned about the hypoglycemia. The LCS was able to talk with the patient about hypoglycemia as well as the side effects and potential dangers associated with this condition. With her permission, the LCS then messaged the patient's primary care physician (PCP), who changed the patient's medications. Due to her extensive medical history, including a CVA and breast cancer, the patient's PCP put her on medications and Continuous Glucose Monitor (CGM).

After these changes were made, per her CGM data, the patient is now in range 99% of the time, with zero hypoglycemia instances. The patient also increased her intentional physical activity and changed her eating habits to incorporate more protein and fresh produce. She has since improved her BMI from 33.6kg/m to 30.3kg/m and lost a total of 16 pounds in three months. Thanks to support from her LCS and PCP, the patient reports that she has more energy and feels better overall.



"Being a part of the Quality & Performance Improvement Committee has helped me practically apply my healthcare knowledge. Being involved in validating various quality metrics gives me immense joy as I am able to learn the clinical objective of various sections across the board and positively change the way I practice healthcare."

Sampath Ethiraj, MD, MBA
PPG – Hospital Medicine Medical Director, Parkview Randallia Inpatient Units, QPIC member

Patient success

IMPACT STORY 3

A 73-year-old female patient was referred by her primary care physician due to a need for a repeat, diagnostic mammogram. The patient was refusing the mammogram due to the cost of the co-pay, and after completing an assessment, the Care Coordinator revealed that she was also missing specialty appointments due to a lack of transportation and the associated cost. The Social Support Specialist connected the patient with Parkview Financial Assistance to determine if she would qualify for any financial help through Parkview.

After working with the Financial Assistance team, the patient scheduled her mammogram, recommended CT scan and colonoscopy, all of which she had been delaying due to cost. The patient also agreed to choose a new specialty provider who would be able to come to her town locally, which would address the transportation issue she was having. As a result of the work with the Population Health Care Coordination team, the patient was able to receive the care she needed.

"Participating in Parkview Care Partners (PCP) means physicians are better able to understand how we perform compared to others around the country. This makes it possible to identify opportunities and best practices while continuing to improve the care we provide to our patients and the community. The partnership between PCP and physicians allows Parkview to lead the way in value and quality in northeast Indiana and northwest Ohio."

Joshua Kline, MD
Physician Leader, Primary Care Service Line; Chief Medical Officer, Parkview Health, PPG - Family Medicine, QPIC member

Parkview Health
P.O. Box 5600
Fort Wayne, IN 46895-5600

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