CHI Saint Joseph Health Partners

2019 Annual Value Report

A PHYSICIAN-DRIVEN CLINICALLY INTEGRATED NETWORK

CREATING HEALTHIER COMMUNITIES

Welcome Message

Viren Bavishi, DO
Chief Medical Officer

Dorothy Lockhart, MBA, MSN, RN
Market Vice President

It is with great pleasure that we share the 2019 Value Report for CHI Saint Joseph Health Partners (Health Partners), formerly KentuckyOne Health Partners. It was an exciting year for Health Partners and not just in our name change! It was a year of innovative programing, collaboration with our business affiliates and additions to our leadership team. Inside you will learn more about these innovative programing changes and the successful outcomes of their implementation. You will also read patient impact stories, reminding us all why we do the work charged to us.

In 2019, Health Partners was named one of the 130 ACOs to Know by Becker's Hospital Review. In our effort to expand our ability to provide exemplary services, we recruited a chief medical officer from within the CHI Saint Joseph Health Medical Group and a full-time clinical pharmacist specialist. Also in 2019, we were confident enough in our abilities to serve our network of providers and patients that we entered into a double-sided risk agreement with the Medicare Shared Savings Program.

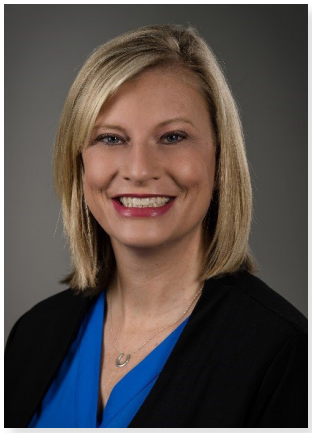
The upcoming year will bring a new focus to Health Partners; further expansion in prescription programs and ensuring that our network is at the forefront of value-based care opportunities. One of our most prominent focuses will be our direct to employer contracting. Health Partners will continue to lead the way in value-based care as we continue to be the longest standing Medicare ACO in Kentucky.

We are proud of Health Partners' foundation and are excited by the growth and innovation we have experienced. We express our sincerest gratitude to the Board of Managers, Board Committee members and all of the network providers and employees that continue to provide quality care to the patients we serve.

We look forward with anticipation to a promising future.

Meet the Leadership Team

Viren Bavishi, DO
Chief Medical Officer



Kristen G. Brown, MHA, CSPPM
Market Director - Operations

Emily Cox, PharmD, RPh
Clinical Pharmacist Specialist

Russelyn Cruse, BSN, RN
Market Director, Clinical Operations

Dorothy Lockhart, MBA, MSN, RN
Market Vice President

Shannon Nally, MSW
Network Development Specialist

Pamela Thompson, BSN, RN
Market Director, Clinical Operations

Kelly Tudor
Director of Business Development

Ron Waldridge, MD
Board Chair

Health Partners by the Numbers (2019)

Numbers Current as of December 31, 2019

115,000 Managed Lives

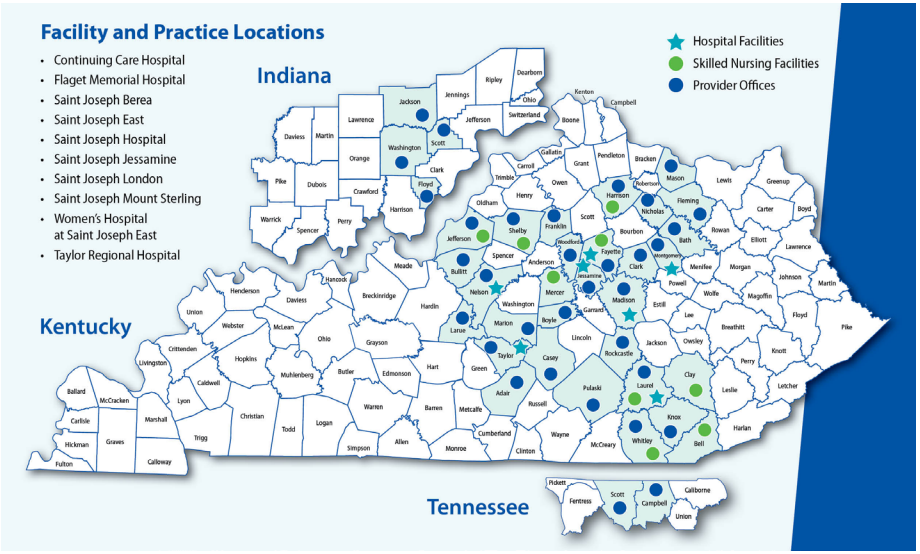
2,000 Providers

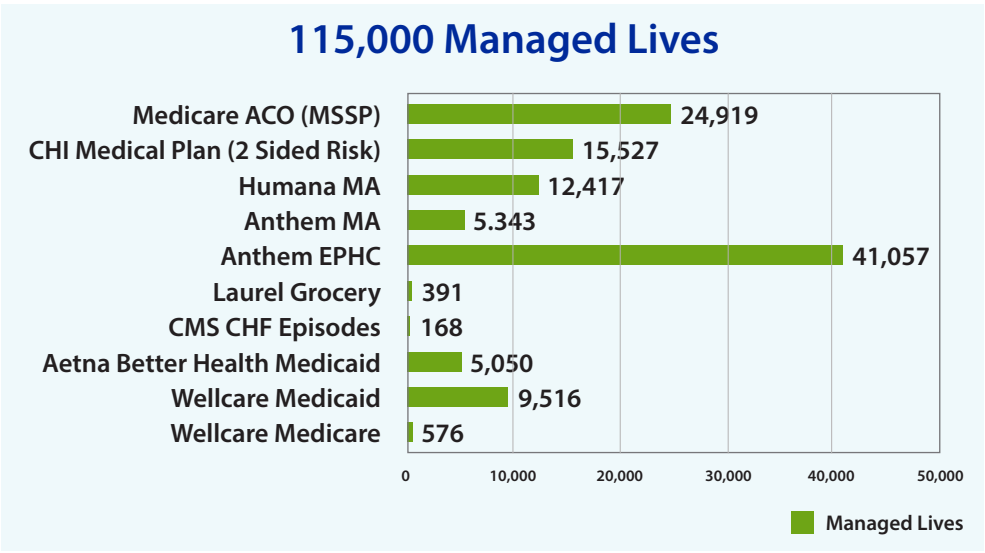
100 Provider Organizations

50 Post Acute Organizations

Earned Shared Savings/ Value Based Contracts

Sample of Programs and Savings	Managed Lives	5 Year Savings
Medicare (A-APM Next Gen ACO 2017)	27,000	$33M savings
Commercial (CHI Medical Plan)	20,000	$7M savings
Medicare Advantage	15,000	$3M savings
Major Joint Episodes	1,000	$4M savings





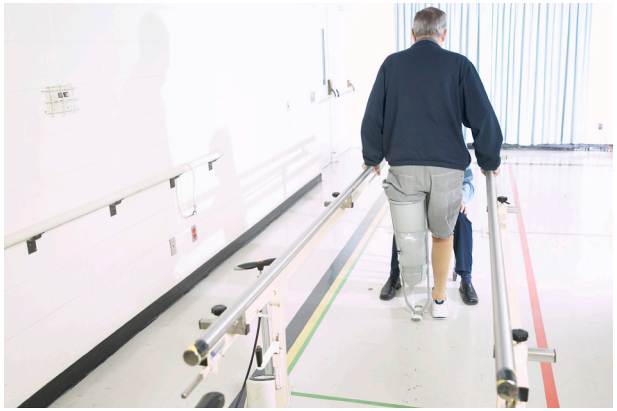
Medicare Shared Savings Program (MSSP) - Accountable Care Organization (ACO)

Accountable care organizations are groups of doctors, hospitals and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves from the Medicare program. CHI Saint Joseph Health Partners entered into the Medicare Shared Savings Program in July 2019. In addition to evidence-based quality measures upon which providers are scored, this contract also allows Medicare to waive a normally required three-night hospital inpatient stay prior to skilled rehab with a signed attestation from the CHI Saint Joseph Health Partners ACO provider/supplier and another ACO that is a Medicare-approved skilled nursing facility.

MAKING A DIFFERENCE: STORIES OF PATIENT SUCCESS

When a nurse with CHI Saint Joseph Health Partners (Health Partners) reached out to a patient for follow-up after joint replacement surgery, she learned that the patient was not doing well at home. The patient had received 10 days of skilled rehab after surgery, but a month later she had lost muscle mass in her leg and was in need of more intense rehab than home health could provide. The Health Partners nurse turned to a social worker on the team for help.

The social worker immediately thought of the MSSP SNF Waiver and verified that this patient was a managed life under this contract. Once verified, Health Partners was able to receive approval to place the patient in skilled rehab from the patient's CHI Saint Joseph Medical Group primary care physician. The team then reached out to the patient's chosen facility, The Willows at Harrodsburg, for placement. The Willows at Harrodsburg, a Medicare 5 star MSSP approved facility, was able to accept the patient within 48 hours of being contacted. Through the MSSP SNF Waiver, this patient was able to get the additional skilled rehab she needed, without a three-night inpatient stay.



Medicare Shared Savings Program (MSSP) - Accountable Care Organization (ACO)

Using benchmarks from the final year of Next Generation ACO in 2017, Health Partners was able to make significant improvements on key quality measures over a 2-year period. Breast cancer screening, colorectal cancer screening, A1c poor control, blood pressure controlled, and falls screening were among the most substantial improvements.

Measure Name	2019 Rate	ACO Mean
Getting Timely Care, Appointments, and Information	87.24	85.86
How Well Your Providers Communicate	94.01	94.11
Patients' Rating of Provider	92.90	92.69
Access to Specialist	80.92	81.54
Health Promotion and Education	50.77	60.44
Shared Decision Making	61.02	62.78
Health Status/Functional Status	71.68	73.79
Stewardship of Patient Resources	27.99	26.17
Courteous and Helpful Office Staff	91.38	92.84
Care Coordination	87.86	86.89
Preventative Care and Screening: Influenza Immunization	69.81	74.77
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	78.57	78.04
Colorectal Cancer Screen	73.23	70.76
Breast Cancer Screening	71.22	73.84
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	84.58	82.17
Diabetes: Hemoglobin A1c Poor Control (>9%) (lower is better)	12.31	13.88
Controlling High Blood Pressure	74.7	75.04

Please note, the ACO-40 Depression Remission at 12 months quality measure is not included in public reporting due to low sample size.

Medicare Shared Savings Program (MSSP) - Accountable Care Organization (ACO)

ACO Participants

All Women OB/GYN, PSC

Associates For Women's Care, PSC

Bardstown Womens Health, Care LLC

Digestive & Liver Clinic, PLLC

Douglas Nesbitt, MD

East Louisville Dermatology, PSC

Emmanuel Yumang, MD, PLLC

Flaget Healthcare, INC

Internal Medicine Associates, PSC

Jewish Hospital & St. Marys Healthcare, INC

Kentuckiana Ear, Nose & Throat, PSC

Kentucky Cardiology, PLLC

Kentucky Diabetes Endocrinology Center, PSC

Kentucky Eye Center, PSC

Kentucky Eye Surgery Associates, PSC

KentuckyOne Health Medical Group, INC

KentuckyOne Health Medical Group - Louisville Region, INC

Kleinert Kutz and Associates Hand Care Center

Lexington Foot And Ankle Center, PSC

Michael J. Doyle MD, PLLC

National Behavioral Health

Pediatric Heartcare Partners, PSC

Pomeroy & Rhoads Orthopedics, PLLC

Rajesh Sheth, MD

Rheumatology Associates

Saint Joseph Health System, INC

Sandeep Kapoor, MD, PLLC

Sleep Center of Kentuckiana, LLC

Taylor County Hospital District Health Facilities Corporation

Taylor Regional Medical Group, LLC

Thomas P. Von Unrug MD, INC

University Medical Center, INC

MSSP ACO Approved Skilled Nursing Facilities

Columbus Regional Hospital

Crestview Nursing, LLC

Daviess County Hospital

Hanging Rock LTC, LLC

HillCrest Nursing Home of Corbin, INC

Lake Forest Post Acute, LLC

Landmark of Laurel Creek Rehabilitation And Nursing Center

Laurel Housing INC

LP Lexington Tanbark Road, LLC

LP Louisville Hospital South, LLC

LP Louisville South, LLC

Masonic Homes of Kentucky, INC

Middlesboro Operations, LLC

Nazareth Home, INC

The Third And Oak Corporation

Trilogy Healthcare of Cynthiana, LLC

Trilogy Healthcare of Fayette I, LLC

Trilogy Healthcare of Fayette II, LLC

Trilogy Healthcare of Louisville East, LLC

Trilogy Healthcare of Louisville Northeast, LLC

Trilogy Healthcare of Louisville Southwest, LLC

Trilogy Healthcare of Mercer, LLC

Vibra Rehabilitation Hospital of Southern Indiana, LLC

Whitley Operations, LLC

Williamsburg Nursing Home, INC

Transitions of Care Program (TOC)

Patient Qualification:

1. Documented diagnosis (DRG based) of:
   Congestive Heart Failure
   Acute Mycardial Infarction
   Coronary Artery Bypass Graft Surgery
   Pneumonia
   Chronic Obstructive Pulmonary Disease
   Total Knee Arthroplasty/Total Hi Arthroplasty
2. A readmission risk score at or above the set threshold at each facility

Follow-up Services:

- Home Health has initiated services (if applicable)
- Skilled Nursing Facility care is productive (if applicable)
- Patient has filled new prescriptions and understand their current medication list
- Patient knows when their follow-up appointments are scheduled; if patient does not have a PCP, referral is made to a provider within our clinically integrated network (CIN)
- Patient has transportation to medical appointments
- Patient understands their medical condition
- Other health care barriers and social determinants of health are addressed

In an effort to support the CHI Saint Joseph Health system, a Transitions of Care (TOC) program was initiated in May 2019. TOC is a 30-day follow-up service for select high-risk patients with the goal of:

- Improving access to needed resources
- Reducing barriers to care
- Prevent readmission utilizing post-acute care options

By partnering with CHI Saint Joseph Health hospitals: Saint Joseph Hospital, Saint Joseph East, Saint Joseph Berea, Saint Joseph Mount Sterling, and Saint Joseph London, Health Partners was able to provide this service, regardless of payor, at no cost to the patient.

As a result of this dedicated service, Health Partners was able to serve over 500 high-risk patients and demonstrated a reduction of acute care readmissions by 17% in the first year alone.

"...reduction of acute care readmissions by 17% in the first year alone."

MAKING A DIFFERENCE: STORIES OF PATIENT SUCCESS

When an Ambulatory Care Coordination Assistant on the Health Partners team contacted a TOC patient for follow-up care after an admission, she learned that the patient did not plan to keep their follow-up appointments due to mobility issues. The patient had called the provider office to ask if a wheelchair could be provided and assistance into the building once the patient arrived but, due to staffing limitations, the office was unable to oblige. The Health Partners assistant made a quick decision to ensure that the patient could keep their follow-up appointment. Arrangements were made for the Health Partners assistant to meet the patient in the parking lot where they would have a wheelchair ready for the patient. The assistant escorted the patient to their appointment and back to their car afterwards. Health Partners staff commonly go the extra step to ensure that there are no barriers to needed follow-up care.

Post-Acute Collaborative

In 2019 Health Partners joined CHI VNA Health at Home to create a Post-Acute Collaborative. Held quarterly, area skilled nursing facility administrators, skilled nursing facility discharge planners and facility representatives were invited to the Saint Joseph campus for lunch and learning opportunities. In each meeting, both Health Partners and CHI VNA would review new initiatives and programs with those in attendance. Meetings included a guest speaker from community partners engaging the audience on follow-up services their organization provides. The CHI partners were pleased to have the following providers among those that presented in 2019:

Jane Owens, FNP	Mobile Heart Clinic
MaryAnn Heenan	AeroCare
Robin Dodd, BSN, RN	Sound Physicians

"The collaborative between VNA and CHI Saint Joseph Health Partners has brought clinical excellence, efficiency, improved communication, and most importantly, streamlined transitions through the healthcare continuum. The leaders and team from CHI Saint Joseph Health Partners have ensured our home health and hospice patients are given the resources and support to secure safe transitions from hospital to post-acute. All of our home health and hospice key indicators have improved as a result of this partnership. We are grateful to be a part of the future of health care and transitions of care."

Susan Carmical, MHA, FACHE
Area Director of Operations
VNA Health at Home

Pharmacy

Emily Cox, PharmD, RPh
Clinical Pharmacist Specialist

Emily Cox, PHarmD, RPh, was hired in 2019 as a Managed Care Pharmacy Specialist for Health Partners. Emily obtained her Doctor of Pharmacy degree from the University of Kentucky's College of Pharmacy. Emily has over 20 years of clinical and patient care experience, with five of those years spent managing drug optimization and outcomes for Toyota Motor Manufacturing Kentucky's worksite pharmacy.

What is a Managed Care Pharmacist's role in supporting the Clinically Integrated Network?

Emily is a licensed pharmacist who can assist provider partners in better assessment of medication management and access to achieve better outcomes through a needs-based collaborative approach.

- Identify provider partner goals and assist in providing solutions to achieve those goals
- Quality-oriented outcomes partner
- Medication therapy management expert
- Highly familiar with drug benefit design, prescription filling procedures and prior authorization mechanisms
- Liaison for CHI Employee Diabetes & Nutrition Care Center Program
- Clinical pharmacy education resource
- Working in synergy with nurse and social worker Ambulatory Care Coordinators to provide total patient care

Bundle Payment Care Improvement Advanced (BPCI-A) Program

In October 2018, Saint Joseph Hospital decided to pilot the BPCI-A program with Medicare for Congestive Heart Failure (CHF). The purpose of the BPCI-A program was to improve quality, reduce acute care length of stay and prevent avoidable readmissions. Health Partners was positioned to provide outpatient care management services for this population through nursing and social work follow-up services for 90 days after the acute care discharge.

While the pilot was not continued into a second year, one notable success was the enhanced communication channels between Health Partners staff and skilled nursing facilities (SNF) in the area. Communication between the SNF and Health Partners is vital to the coordination of a patient's follow-up services once they are home. Health Partners deployed disease-specific assessment forms to each SNF which continually provided Health Partners staff a clear picture of the patient's progress throughout skilled rehab and advance notice to start planning their care needs after discharge.

"The hope of Saint Joseph Health Partners is that together, we can reduce readmissions and bring better care to those we serve."

Shannon Nally, MSW
Network Development Specialist