Valence Health Has Been Helping Provider Organizations Progress Toward Value-Based Care Since 1996

- Technology-enabled services since 1996
- National presence with 400 employees, 4 offices
- Serve IDNs, IPAs, PHOs, ACOs
- Serve 35,000 physicians, 100+ hospitals
- Support 20 million patients
- 50 million member months in analytics and services
- Privately held
- 40% CAGR past 5 years

Select Clients Across the Value-Based Spectrum

<table>
<thead>
<tr>
<th>P4P</th>
<th>PCMH</th>
<th>CLINICAL INTEGRATION</th>
<th>SHARED SAVINGS</th>
<th>BUNDLED PAYMENT</th>
<th>SHARED RISK</th>
<th>CAPITATION FULL RISK</th>
<th>HEALTH PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Strategy (“Pathfinder”)</td>
<td>Clinical Integration</td>
<td>Risk Arrangements</td>
<td>Health Plans</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

IDN = Integrated Delivery Network, IPA = Independent Practice Association, PHO = Physician-Hospital Organization, ACO = Accountable Care Organization, CAGR = Compounded Annual Growth Rate, P4P = Pay for Performance, PCMH = Patient-Centered Medical Home
Our Approach: End-to-End Consulting and Technology Capabilities Meet the Full Spectrum of Value-based Care Needs

Design and Implement Practical, Meaningful, and Sustainable Value-Based Payment and Delivery Models

**Strategic & Tactical Support**
- Capability Assessment
- Financial Modeling
- Actuarial Analysis
- Strategic Planning
- Care Model Development
- Value-Based Contracting
- Business Case Development
- Requirements Definition

**Technology & Analytics**
- Population Health
- Clinical Integration
- Clinical Quality Reporting
- Cost and Utilization Analyses
- Risk Stratification

**Managed Services**
- Medical Management
- Member Services
- Claims Processing
- Provider Relations
- Contracting Negotiations
- Regulatory Reporting
- Interim Management
Higher Quality and Lower Cost Tied to Coordination and Compliance, And “Risk” Can Drive Both

Longitudinal Experience Of Ambulatory Medicare Beneficiaries Assigned To Extended Hospital Medical Staffs (EHMSs)

Strata based on 2000-02 performance

<table>
<thead>
<tr>
<th></th>
<th>Highest</th>
<th>High</th>
<th>Middling</th>
<th>Low</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospitals/EHMSs</td>
<td>169</td>
<td>735</td>
<td>2,090</td>
<td>937</td>
<td>232</td>
</tr>
<tr>
<td>Number of beneficiaries</td>
<td>296,822</td>
<td>916,116</td>
<td>2,530,111</td>
<td>942,236</td>
<td>296,850</td>
</tr>
<tr>
<td>Measures of quality and costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of ambulatory carea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography, ages 65–69</td>
<td>52.8%</td>
<td>50.5%</td>
<td>48.3%</td>
<td>45.5%</td>
<td>42.6%</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>12.6</td>
<td>12.9</td>
<td>13.9</td>
<td>13.5</td>
<td>13.7</td>
</tr>
<tr>
<td>Diabetic eye exams</td>
<td>41.7</td>
<td>41.8</td>
<td>40.7</td>
<td>39.4</td>
<td>39.0</td>
</tr>
<tr>
<td>Diabetess, HbA1c</td>
<td>59.5</td>
<td>57.7</td>
<td>55.8</td>
<td>54.7</td>
<td>53.1</td>
</tr>
<tr>
<td>Institutional utilizationb</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-stay hospital dischargesc</td>
<td>337</td>
<td>347</td>
<td>366</td>
<td>389</td>
<td>404</td>
</tr>
<tr>
<td>Long-stay hospital dischargesc</td>
<td>13</td>
<td>17</td>
<td>17</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>SNF dischargesc</td>
<td>70</td>
<td>73</td>
<td>76</td>
<td>82</td>
<td>86</td>
</tr>
<tr>
<td>Medicare institutional daysc</td>
<td>4.05</td>
<td>4.18</td>
<td>4.44</td>
<td>4.81</td>
<td>5.21</td>
</tr>
<tr>
<td>Number of care transitionsc</td>
<td>0.84</td>
<td>0.87</td>
<td>0.92</td>
<td>0.98</td>
<td>1.01</td>
</tr>
<tr>
<td>Spending per beneficiaryc</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician services</td>
<td>$2,242</td>
<td>$2,381</td>
<td>$2,641</td>
<td>$2,731</td>
<td>$3,012</td>
</tr>
<tr>
<td>Acute care hospital</td>
<td>2,221</td>
<td>2,272</td>
<td>2,379</td>
<td>2,514</td>
<td>2,613</td>
</tr>
<tr>
<td>Hospital and physician (total)</td>
<td>4,463</td>
<td>4,683</td>
<td>5,002</td>
<td>5,245</td>
<td>5,626</td>
</tr>
<tr>
<td>Concentration of care (medical staff)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary hospital</td>
<td>79.7</td>
<td>75.6</td>
<td>72.7</td>
<td>70.2</td>
<td>68.7</td>
</tr>
<tr>
<td>Primary and secondary hospital</td>
<td>67.6</td>
<td>84.1</td>
<td>81.0</td>
<td>80.1</td>
<td>77.7</td>
</tr>
<tr>
<td>Different physicians seen (average)</td>
<td>4.3</td>
<td>4.4</td>
<td>4.7</td>
<td>4.7</td>
<td>5.1</td>
</tr>
</tbody>
</table>


Note: Quality Index on graph is average of Quality measures from Exhibit. All four quality compliance measures, essentially delivery of recommended test or care) were averaged to one number.
What is Clinical Integration?

Clinical Integration is “an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.”

- Federal Trade Commission (FTC) Definition
Crawl, Walk, Run: For Many Clinical Integration is a Starting Point in the Journey toward Value-Based Care

- Builds a foundation for value-based care and serves as a precursor for risk
- Drives physician leadership and engagement needed for further risk assumption
- Incents physician involvement without downside financial consequences
- Demonstrates to payors the willingness and ability to manage a population’s health

Clinical Integration Builds Quality and Efficiency

- Refute payor “report cards” and protect against de-selection
- Provide tools to measure and report to external bodies
- Build infrastructure for internal performance measurement, data sharing, and best practices
- Reduce overuse, underuse, and misuse of services
Provider Organizations Pursue Clinical Integration to Improve Physician Alignment and Achieve the Triple Aim

- Ties physicians closer to hospital and fosters collaboration to increase quality and efficiency
- Presents a powerful business model to thrive in the advent of consumerism, pay-for-performance, accountable care, and quality report cards
- Leverages existing efforts (e.g. PCMH)
- Allows hospitals to legally provide additional office practice support to CIN member physicians beyond just managed care contracting:
  - IT system infrastructure
  - Insurance
  - Group purchasing discounts
- Allows provider networks that include independent-based physicians to collectively negotiate with health plans without FTC prosecution

1. Improved quality and patient experience
2. Better health outcomes
3. Reduced per capita healthcare costs
At the Core of Clinical Integration is the Ability to Capture, Aggregate, and Act on Clinical Information

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**Network Development**
- Stakeholder Engagement
- Value Proposition
- Participation Criteria
- Physician Leadership
- Incentive Design

**Organization Structure & Planning**
- Payor Contracting Strategy
- Physician Governance
- Committees and Decision-Making
- Financial Structure
- Organizational Incentive Alignment

**IT Infrastructure and Capability**
- EMR & EHR
- Clinical and Financial
- Patient Engagement Tools
- Integration with existing systems

**Analytics**
- Clinical Metrics & Results
- Cost Analytics
- Standard vs. Ad-hoc Reporting
- Risk Identification
- Regulatory vs. Operational

**Cross-continuum Coordination**
- Strong Primary Care
- Communication
- Referral Management
- Population-Based Programs
- Shift to Ambulatory Management
- Transitions of Care

**Collaboration Platform**
- Common Protocols
- Physician-Guided Quality Best Practice Dissemination
- Clinical Metric Selection
- Peer Review; Transparency
- Build Network Culture
Not All Technology Platforms are Equal: Cost, Functionality, and Ease of Integration Vary Significantly

Options for acquiring necessary CI data and technology capabilities

1. Acquire all affiliate physician practices
2. Build technology platform from scratch
3. Purchase Health Information Exchange
4. Require affiliates to adopt unified EMR
5. Implement Vision®

- Timely implementation of cost-effective solution
- System-agnostic data aggregation for relevant and timely information and analytics
- Powerful, flexible matching and attribution logic
- Provider-friendly platform that can be managed without hiring additional resources
- Comprehensive patient profile for cross-continuum services

**COMPARE:** What Information a Physician Obtains from Different Data Sources

<table>
<thead>
<tr>
<th>Category</th>
<th>Sample Question</th>
<th>Claims Data Shallow and late</th>
<th>EMR Point Solution Incomplete</th>
<th>CI Powered by Vision® Balanced and useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk clinical scenarios</td>
<td>Who are my poorly controlled diabetics?</td>
<td>Here are all patients with at least two diabetes claims with the same payor.</td>
<td>Here are the diabetics you have seen. Who knows about the ones you haven't seen.</td>
<td>Here are all the diabetics with a glucose &gt;400 attributed to you.</td>
</tr>
<tr>
<td>Pay for Quality (P4Q)</td>
<td>How am I performing on my HEDIS measures?</td>
<td>Here is how you did last year.</td>
<td>We don’t capture all your patients, and we can’t see clinical events outside of your clinic.</td>
<td>Here is a list of the diabetics assigned to you with open and upcoming care gaps.</td>
</tr>
</tbody>
</table>
The Role of World Class Data Acquisition and Complexity Management

Aggregates disparate data across hundreds of practice sites while maintaining security and HIPAA compliance

**Inputs**

- Provider Sites
- Data Sources

**Outputs**

- **Clinical Measures and Quality Improvement**
  - National measures (e.g. HEDIS)
  - Clinical Integration measures
  - Client-created measures

- **Population Analytics for Risk Stratification**
  - Population health reporting
  - Identification of gaps in care and high-risk patients

- **Programmatic Risk Management**
  - Proficient and proactive performance management
  - Action list for each patient (e.g. overdue care)

**Provides timely, useable information customized to viewer:**

**Administrative Level**
- Network-wide quality monitoring
- Useful for Quality Committee or CMO

**Practice Level**
- All providers and patients associated with a tax ID number
- Useful for Practice Managers

**Physician Level**
- Individual physician performance
- Complete patient profiles for all attributed patients
Data Aggregation, Analytics, and Reporting Empower Providers to Manage Health Across the Continuum

<table>
<thead>
<tr>
<th>Critical IT Capabilities for CINs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data aggregation from disparate sources</strong></td>
</tr>
<tr>
<td>• Including EMRs, hospital data, demographics, lab data, claims, etc.</td>
</tr>
<tr>
<td>• Across hundreds of provider locations</td>
</tr>
<tr>
<td><strong>Advanced analytics and ad-hoc querying</strong></td>
</tr>
<tr>
<td>• High-risk patient identification</td>
</tr>
<tr>
<td>• Quality dashboard</td>
</tr>
<tr>
<td>• Reporting with only one-month lag time</td>
</tr>
<tr>
<td><strong>Multiple views of care delivery and care management across the network</strong></td>
</tr>
<tr>
<td>• Patient-level, population-level</td>
</tr>
<tr>
<td>• Provider, administrative</td>
</tr>
<tr>
<td><strong>Evaluation of employed and affiliated provider quality performance</strong></td>
</tr>
<tr>
<td>• CIN measures performance</td>
</tr>
<tr>
<td>• Primary care and specialist measures</td>
</tr>
</tbody>
</table>

Establishes the basis for FTC-compliant Clinical Integration

Powers smooth integration across heterogeneous IT systems

Addresses system-wide strategic considerations

IT = Information Technology, EMR = Electronic Medical Record, FTC = Federal Trade Commission
Alignment with Key Physicians Requires Balance Between Value Drivers

Disparate physician groups with varied perspectives

<table>
<thead>
<tr>
<th>Qualities the CIN Needs (Recruitment Criteria)</th>
<th>Benefits the CIN Offers (Value Proposition)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High-quality physician groups with strong values</td>
<td>• Increased access to continuum of care data</td>
</tr>
<tr>
<td>• Good cultural fits and appetites for innovation</td>
<td>• Performance &amp; benchmarking data</td>
</tr>
<tr>
<td>• Experience in value-based models</td>
<td>• Promotion of a quality brand</td>
</tr>
<tr>
<td>• Groups willing and able to share data; have effectively adopted an EHR</td>
<td>• Preserve reimbursement opportunities</td>
</tr>
<tr>
<td>• Eagerness to help build and shape the CIN, including physician (especially PCP) participation in leadership</td>
<td>• More voice in market</td>
</tr>
<tr>
<td>• Broad enough geography and PCP/Specialist coverage to provide care across the continuum</td>
<td>• Improved PCP-Specialist communication</td>
</tr>
<tr>
<td></td>
<td>• Improved coordination of care and services for patients</td>
</tr>
<tr>
<td></td>
<td>• Optimize current IT capabilities</td>
</tr>
<tr>
<td></td>
<td>• Maintain or enhance patient volume</td>
</tr>
</tbody>
</table>

Engaged, collaborative, aligned physician network
Building a Multi-System Clinically Integrated Network

AHA Leadership Summit – July 21, 2014

Select slides from the IHN portion of this presentation may be available upon request. Please email Patti.Ruff@ihnwi.com to request them.