

2011 Annual Report



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Uniting and leading physicians in our community in quality initiatives that ensure unsurpassed care $_{\text{for all patients}}$

AMBULATORY CARE MODEL PARTICIPANTS

A & S Khandelwal M.D., Inc.

Akron Internal Medicine Associates, Inc.

Austin Primary Care, LLC

B.S. Bonyo, D.O. & Associates

City Cardiology Associates

Community Health Care, Inc.

Dennis Yee, D.O.

Endocrine Associates

Falls Family Practice, Inc.

Family Medicine Center of Akron

Family Practice Center of Wadsworth

Hartville Internal Medicine Center, Inc.

Internal Medicine Center

Internal Medicine Specialists

Joseph F. Alexander Jr., M.D., Inc.

Michael A. Bianco, M.D.

NE Ohio Nephrology Associates, Inc.

Ohio Family Practice Centers, Inc.

Paragon Health Associates, LLC

Pax Medical Associates, Inc.

Pioneer Physicians Network, Inc.

Summa Physicians, Inc.

Waleed F. Nemer, M.D.

Leadership Message



In the 2010 annual report, we discussed building models of care for the future and our progress in the journey toward the transformation of healthcare. A year later, our physicians are continuing this journey, and have undoubtedly experienced a year of growth under the Summa Health Network Ambulatory Care Model.

In the 2011 annual report, you will read about our accomplishments in the models we built, our advancements through increased physician groups' participation and engagement, expansion of our clinical data repository, successes in quality improvement initiatives, and our collaborations with key payer partners.

"When you are trying to move the needle, it's a long journey, and there is value in communicating that journey."

– Michael Maggio, M.D.Chair, SHN Board of Managers

Today, our Ambulatory Care Model has more than 400 physicians. Our physician network development team educated physicians and their staff on the benefits of moving into this model. We have reached a critical mass of physician participation which is allowing us to engage willing payers. The annual report will demonstrate this growth in membership of the Ambulatory Care Model.

Our clinical data repository continues to add participants' clinical data monthly, and we have significantly increased the disparate systems providing records to our database. Participants in the Ambulatory Care Model actively use SHN's clinical data repository to validate and improve clinical metrics for their patients through group quality initiatives and individual practice dedication. This report will detail the major strides taken in utilization of the clinical data repository and staff member engagement accomplished by the Ambulatory Care Model.



"Moving forward into 2012, our group is ready to begin transformation with an actual payer agreement in hand," noted Dr. Terpylak.

The participants in today's model are more dedicated, more engaged, and more involved in the processes and workflow to transform healthcare than they were a year ago. They formulated and implemented successful quality initiatives in the areas of heart disease and diabetes. In this report, you'll understand why SHN's Ambulatory Care Model is ready to accept the challenges and rewards that accompany incentive-based payer agreements.

The first SHN Ambulatory Care Model payer agreements have been signed, and the implementation phase has begun. These agreements will require hard work, a new mindset, and additional resources than most medical groups possess. That's why this Model is so critical; it brings essential components together that would normally be unavailable to a practice. Uniting under the Ambulatory Care Model, we will achieve higher quality care than we have provided in the past.

We invite you to read our annual report to gain a greater understanding of our Model as well as our accomplishments from 2011.

Sincerely,

Charles R. Vignos, CPA

President

Mark Terpylak, D.O.

Physician Director

Michael Maggio, M.D.

Chair, Board of Managers

ichael Maggio MO

Who We Are

SHN's goals are to assist providers with managing their patient populations through clinical initiatives and improving the satisfaction of the patients they serve while increasing their reimbursement and reducing expenses.

Participation models supporting SHN's goals:

- Messenger Model
- Performance Incentive Model
- Ambulatory Care Model



As a Messenger Model PHO, Summa Health Network allows member choice for over 1,350 providers in regard to participation with managed care agreements. SHN negotiates the non-economic terms of managed care agreements and acts as a liaison between its members and managed care payers to assist with compliance and claims issues.

The Performance Incentive Model allowed SHN to partner with national and local payers to develop performance incentive programs which can enhance a practice's revenue. As a result of meeting quality measures that generate medical cost savings, the savings is shared between providers and payers.

The Ambulatory Care Model was formed in 2009 and currently consists of more than 400 SHN members. This Model includes collaborating and sharing clinical information among physician groups in order to improve the quality of care and reduce costs. Within this Model, all physicians utilize SHN's clinical data repository which aggregates clinical, claims, and hospital data into one source to assist with improving care. Participants in this Model actively are involved in quality improvement initiatives and tracking their clinical performance.

NewHealth Collaborative also exists as an entity under Summa Health System. NewHealth Collaborative was established in 2011 as an Accountable Care Organization (ACO) in response to healthcare reform's mandates for improvements in care coordination, information sharing, and value-based structures. Although

similar to SHN's Ambulatory Care Model in many ways, the NewHealth Collaborative contains hospital participants and involves all of Summa Health System, while SHN's Ambulatory Care Model is driven by ambulatory provider practices only.



The Triple Aim requires simultaneous:

- Improvement in the health of populations
- Reduction of the per capita costs of healthcare
- Enhancement of the experience of care

Focusing on The Triple Aim – 2011 Annual Member Update Meeting

SHN held its Annual Member Update Meeting in May 2011 which focused on SHN's advancements in achieving The Triple Aim through the SHN Ambulatory Care Model. SHN hosted a keynote speaker for this event, William Warning, M.D., faculty chair of the Pennsylvania Patient Centered Medical Home Collaborative. Additional components of this meeting included sharing a physician's experience in utilizing SHN's clinical data repository, updating members on the current status of quality improvement initiatives driven by the Ambulatory Care Model, and providing insight into the Ambulatory Care Model payer engagement strategy.

Dr. Warning offered an understanding of chronic disease care coordination from his experiences within a Patient Centered Medical Home, and his expertise in this model provided supporting evidence on the positive impact to patients and

practices. In addition, Dr. Warning shared knowledge on tracking and improving clinical measurements and the associated challenges.

R. James Dom Dera, M.D., FAAFP,

from Ohio Family Practice Centers, Inc. in Akron, Ohio, shared his experiences utilizing SHN's clinical data repository in his office to improve patient care. This technology allows physicians within SHN's Ambulatory Care Model to actively track and improve quality measures related to diabetes, hypertension, cardiovascular disease, cancer screenings and smoking assessments. Through the combination of data from EMRs, claims and hospital laboratory and radiology results, data sharing also is accomplished and eliminates duplicate patient testing while providing the most up-to-date clinical patient information.

Suzanne Hughes, RN, former Summa
Health System director of population
health, demonstrated the successes
Ambulatory Care Model physicians
realized from their hypertension and
women's heart health outreach initiatives.
She also outlined current and upcoming
quality improvement programs inclusive
of the diabetes pilot program and
additional developments in the area of
hypertension.

Jeff Price, SHN vice president, presented insight to the SHN Ambulatory Care Model payer engagement strategy to attendees. He provided an explanation of the necessary physician commitment involved with the Ambulatory Care Model. The Annual Member Update Meeting concluded with an overview of the levels of transparency and payer partnerships necessary for success and ultimate achievement of The Triple Aim.

The Power of the SHN Clinical Data Repository

SHN's clinical data repository combines data from physician electronic medical record (EMR) systems, Summa Health System laboratory and radiology systems, and payer claims into a single database accessible to physicians in a user-friendly, webbased interface. In 2011, the SHN clinical data repository grew substantially with the increase of physician membership in the Ambulatory Care Model. Today, more than 200 physicians utilize the SHN clinical data repository and that number continues to grow.

Data repository implementations are continually launched and processed to reach all Ambulatory Care Model participants. At the time of this publication, the most recent groups to complete implementation were Falls Family Practice and Internal Medicine Specialists, both based in Cuyahoga Falls, Ohio, and A&S Khandelwal and Associates in Medina, Ohio.

Data was also utilized in quality improvement initiatives and measuring success in these endeavors. SHN's clinical data repository currently contains data for more than 200,000 patients seen by SHN Ambulatory Care Model participants.





SHN's Ambulatory Care Model physicians monitor the following measures:

- Hypertension
- Cardiovascular disease
- Diabetes
- Cancer screenings
- Tobacco use

As determined by the clinical data repository data, 100% of Dr. Dennis Yee's hypertensive patients have received a blood pressure screening within the last year.

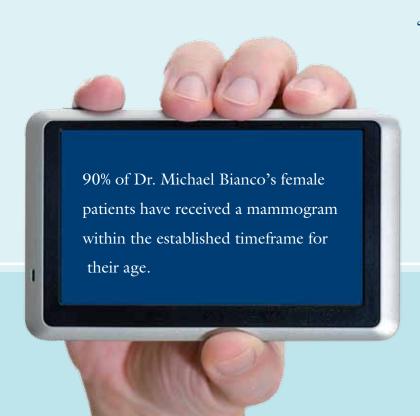
R. James Dom Dera, M.D., highlighted the use of SHN's clinical data repository during a fall lecture to family medicine residents and faculty at Summa Akron City Hospital. He shared how he uses this tool in his office and its effectiveness in managing his patients.

Adarsh Krishen, M.D., director of the Family Medicine Center of Akron, utilizes SHN's clinical data repository in the center's residency clinic and notes: "The clinical data repository has the potential to be a very powerful tool to help practices manage and track their patient populations for issues such as health maintenance and chronic diseases, as well as track progress when changes are made to improve care. It also is a great teaching tool to help residents learn about practice improvement and quality measures. It allows for the ability to plan for upcoming opportunities and work to reengage patients that have not been seen recently for essential care. The key is to be sure your chart data is as clean as possible."

In 2011, the SHN clinical data repository was upgraded to support the identification of multiple payer member populations. This change in software now allows payer membership files to be loaded directly into the data repository, enabling physicians to better manage specific payer populations. For example,

physicians can now filter searches on their patient population based on the patient's insurance. This feature will be a key resource to the Ambulatory Care Model participants in 2012 as they operationalize the components of their payer agreements.

New to the SHN Ambulatory Care Model in 2011, Summa Physicians, Inc. (SPI) began utilizing SHN's clinical data repository in the fall. Summa Physicians, Inc.'s (SPI) Chief Medical Officer Jay Williamson, M.D., has been leading this initiative. Although SPI was still implementing this tool at many sites, Dr. Williamson noted "SPI will likely be using the database for quality metrics in the future."



"What we've built in the Ambulatory Care
Model is a launching pad for better care.
We've meticulously developed a set of tools
that allow me to quickly look at the overall
health of my own patient population. I can
identify those patients who need more outreach
and attention."

- R. James Dom Dera, M.D.

Facilitating Change Through Quality Improvement Initiatives

WOMEN'S CARDIOVASCULAR DISEASE OUTREACH INITIATIVE

February is nationally recognized as American Heart Month. In conjunction with the American Heart Association's Go Red for Women campaign, the Quality Improvement Committee of the SHN Ambulatory Care Model initiated a program for women with cardiovascular disease and encouraged them to obtain current blood pressure and LDL (bad cholesterol) readings. The program consisted of a letter outreach with an accompanying survey for patients to provide additional information regarding health education and initiatives they would like their physician to offer. The Ambulatory Care Model participants acquired valuable information from the survey responses that will assist in developing future programs.

To implement this initiative, letters were generated to all female patients with cardiovascular disease diagnoses. Data from SHN's clinical data repository was used to identify which patients were noncompliant with the cardiovascular disease-specific clinical measures. Data validation processes completed by the

individual office staff ensured that letters generated were for the appropriate patients.

The success of this program was measured by the increase in women receiving additional clinical care for blood pressure and LDL testing after receiving the letter from their physician. Among the groups involved, between 15% and 45% of women acted upon the letter and received the needed care from their primary care physician. The overall average success for this initiative was 19%.

The SHN Ambulatory Care Model participants received essential information from their patients who responded to the survey regarding specific health topics they were interested in learning more about. Additionally, data was collected on how patients prefer to receive health information: via the internet, mail, or electronic formats. The survey provided a patient-centered factor to the initiative which was welcomed by the participating physician offices.

Women's cardiovascular disease outreach program goals:

- Patient education
- Patient initiative and call to action
- Gather information via survey
- Public relations for practices



"The Women's Heart Disease Initiative focused on the silent epidemic of heart disease in women."

Chimezie Amanambu, M.D.
 Pax Medical Associates, Inc.

DIABETES QUALITY IMPROVEMENT INITIATIVE

Diabetes quality improvement program goals:

- Improve clinical care and health status
- Enhance patient education and awareness on how to manage their diabetes

SHN's Ambulatory Care Model structured and piloted a diabetic quality improvement initiative throughout summer 2011 and began with the Family Practice Center of Wadsworth. The goals of this initiative were to improve blood pressure, LDL-C, and HbA1C for persons with diabetes, as well as enhance patient education.

Data from SHN's clinical data repository was used to generate educational letters and report cards to accompany patients

on their next visit. The staff of Family
Practice Center of Wadsworth mailed
these materials to patients two weeks
before their next diabetic visit. Through
this initiative, patients were encouraged
to record their clinical measures on the
report card and strive for improvement.
Additionally, patients were prescribed
web-based interactive videos from
Emmi relating to their condition,
which they were encouraged to view
in the physician's office or at home
after their visit.

To enhance the effectiveness of this program, the Family Practice Center of Wadsworth supplemented their office staff with an external diabetic educator. Through this resource, monthly group sessions were well attended by patients desiring to take an active role in controlling their condition.

Family Practice Center of Wadsworth patients showed a significant response in bringing their report cards to their follow-up appointments: 67% of patients brought their report card to their first appointment and 80% of patients returned to their second follow-up appointment with their report card. To date, 100% of patients with a third appointment brought their report card.





At the time of publication, more than 41% of patients were compliant with viewing their prescribed Emmi educational videos. This pilot ran from July 2011 to December 2011 and produced up to 20% point improvement in process measures (patients who had specific testing completed) for the Family Practice Center of Wadsworth.

The Family Practice Center of Wadsworth is currently continuing its initiatives through this pilot, and SHN's Ambulatory Care Model is implementing this program at other physician offices within the Ambulatory Care Model.

Ohio Family Practice Centers, Inc. will be one of the practices implementing this quality initiative in early 2012. Reflecting on the success of the pilot program with the Family Practice Center of Wadsworth, Dr. Dom Dera from Ohio Family Practice Centers, Inc. commented, "We took a high-performing group and made them better. This really is process improvement."

- "The program is a tool to engage patients in their healthcare. It provides a platform for a better office visit and we believe, better outcomes for the patients. The entire office is involved in helping patients meet their goals set by their physician."
- Pat Walker, Practice Administrator,
 Family Practice Center of Wadsworth
- "This program made me aware of little things I can do to keep my diabetes under control, such as buying a blood pressure machine for home use and taking an aspirin a day."
- Patient from the Family Practice Center of Wadsworth



Diabetes quality improvement program results:

- Blood pressure control experienced a 9% point increase
- LDL control to <130 mg/dl experienced a 9% point increase
- LDL control to <100 mg/dl experienced a 8% point increase
- HbA1c control to <9.0 experienced a 7% point increase

EMMI™ EDUCATIONAL INITIATIVE

Emmi offers concise, internet-based health education videos that help patients prepare for a health-related procedure or manage their health condition.

The Ambulatory Care Model launched a patient education quality improvement pilot with Community Health Care, Inc. Spearheaded by Dr. Jon Seager late in

2011, this initiative continues today.

Through this initiative, the group focuses on increasing blood pressure control rates, patient satisfaction, and patient engagement in their health for patients with hypertension.

During the patients' visits, they are asked to view an Emmi interactive video on

hypertension before seeing the physician so that any questions they may have on the video can be answered that day by the physician. The use of this educational tool is believed to have increased clinical quality, enhanced efficiency, and improved patient satisfaction.

Multimedia technologies like Emmi are able to enhance, rather tan replace patient education. After viewing material on their own time, patients can present questions specific to their needs during the time shared with providers.

Tools like Emmi enhance the patient education process by:

- Providing a step-wise, modular approach to delivering pertinent information
- Allowing patients to process information at their own pace, in the setting most appropriate for them
- Delivering both verbal and visual information
- Giving providers feedback as to what material was viewed and when
- Delivering the same message and information, regardless of provider type and experience

The lessons of the Emmi initiative can help to determine:

- If office workflow can accommodate more robust education efforts
- If consistent messaging and presentation affects outcomes
- The likelihood of patient adherence to prescriptive education outside the office
- Patient preferences for receiving pertinent education materials
- How delivery environment (office vs. home) influences health outcomes
- Which tools are needed to support the process of patient education delivery
- How applying technology to the patient education process is received and accepted by patients, staff, and providers
- Courtesy of Jon Seager, M.D.
 Community Health Care, Inc.



- Increase blood pressure control rates
- Increase patient satisfaction
- Increase patient engagement in their health





"I enjoyed the Emmi educational video very much. It is a good reminder of what I need to do to be in control! It is easy to use and understand. Thank you."

- Patient from Community Health Care, Inc.





"Summa Health Network has done an outstanding job of working with its physicians to ensure they will reach each stage of Meaningful Use. It's great to see federal dollars used for the real purpose of this program, which is to make it easier for doctors and hospitals to use electronic medical records in a meaningful way. Accurate data and reports that show trends in patient care will lead to improved health for patients served in the community."

- James Carroll, Director, NECO REC

SHN Supports National Initiatives Through Meaningful Use

While the SHN Ambulatory Care Model focuses on local quality improvement initiatives, SHN also assists physicians in attaining national incentive programs based on EMR utilization. The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law as part of the American Recovery and Reinvestment Act (ARRA) of 2009. Under this law, Medicare and Medicaid incentive programs were created for eligible healthcare professionals who choose to implement and utilize electronic medical record (EMR) technology in a meaningful way, known as Meaningful Use. Providers are eligible to receive up to \$63,750 under Medicaid, and the maximum incentive available under the Medicare program is \$44,000 per provider. In order to demonstrate Meaningful Use, objectives and measures have been established to include all areas of the EMR functionality and utilization, including electronic prescribing and summaries, data protection, and tracking specific clinical metrics.

SHN continues to prepare physicians to achieve Meaningful Use incentives from Medicare and Medicaid and has partnered with the Northeast Central Ohio Regional Extension Center (NECO REC) to help provide these services. RECs were established under federal grants to provide assistance to primary care physician offices in the following areas:

- Office workflow assessment in preparation for EMR
- Selection and purchase of an EMR system
- In conjunction with EMR vendors, going live on the selected system
- Meeting Meaningful Use requirements with the selected system

SHN also provides physician offices with tools to help them achieve Meaningful Use. Some of these tools include risk analysis and management plan templates, sample template policies, and training presentations.

Physician Commitment and Contributions

The Ambulatory Care Model's Quality Improvement Committee met regularly throughout 2011 to lay the foundation for quality improvement initiatives. This physician-led committee functions to assist Ambulatory Care Model participants with improving their performance in targeted clinical quality measures and identifying patient outliers. In 2011, this committee took an active role in developing outreach programs with the assistance of SHN.



QUALITY IMPROVEMENT COMMITTEE

R. James Dom Dera Jr., M.D.

R. James Dom Dera Jr., M.D., joined
Summa Health Network PHO in 2001 and
was named Family Medicine Physician
of the year in 2011 by Summa Health
System. Dr. Dom Dera earned his medical
degree from The Ohio State University
College of Medicine and completed a
family medicine internship at Summa
Akron City Hospital. Dr. Dom Dera has
been a part of the SHN Board of Managers
for two years.

Matt Finneran, M.D.

Matt Finneran, M.D., has led the Family Practice Center of Wadsworth for 17 years. Dr. Finneran earned his medical degree from University of Cincinnati College of Medicine and is board certified in family medicine and geriatrics. Dr. Finneran served as the medical director of Meadow View Care Center nursing home in Seville, Ohio, from 1986 through 2010. He also is an associate professor of family medicine at Northeast Ohio Medical University (NEOMED).

Richard Hines, M.D.

Richard Hines, M.D. has been a member of Summa Health Network for the past 15 years. Dr. Hines earned his medical degree from Temple University School of Medicine and completed a family medicine internship at Summa Akron City Hospital. Dr. Hines serves as a preceptor at the Family Medicine Center of Akron.

Adarsh Krishen, M.D.

Director of the Family Medicine Center of Akron and associate director of Summa Family Medicine Residency Program, Adarsh Krishen, M.D., has been a part of Summa Health Network PHO for the past 15 years. Dr. Krishen earned his medical degree from Northeast Ohio Medical University (NEOMED) and completed a family medicine residency at Summa Akron City Hospital.

Michael J. Maggio, M.D.

Michael J. Maggio, M.D., has chaired the SHN Board of Managers since 2003. He also continues to serve on the Summa Health System Board, Summa Health System Finance and Investment Committees since 2003. Dr. Maggio practices at Summa Physicians, Inc. — Internal Medicine in Stow, Ohio. After earning his medical degree from University of Cincinnati College of Medicine, he completed an internal medicine internship at Summa Akron City Hospital.

Richard May Jr., M.D.

Richard May Jr., M.D., earned his medical degree from The Ohio State University College of Medicine and completed a nephrology internship at Summa Akron City Hospital. He has been a member of Summa Health Network for the past 14 years. Dr. May has been an integral member of the Quality Improvement Committee since its inception by providing specialty insight and perspective. Dr. May practices at Northeast Ohio Nephrology Associates, Inc. in Akron, Ohio.



In 2011, this committee took an active role in developing outreach programs with the assistance of SHN.

Mark Meyer, M.D.

Mark Meyer, M.D., currently is president of Pioneer Physicians Network, Inc. Dr. Meyer has been practicing at Pioneer Physicians Network, Inc. for 16 years. He earned his medical degree from University of Cincinnati College of Medicine and has been a member of Summa Health Network for the past 15 years.

Jon Seager, M.D.

Jon Seager, M.D., has been a part of Summa Health Network for the past nine years and currently is piloting Summa Health Network's hypertension educational initiative at his practice.

Dr. Seager earned his medical degree from The Ohio State University College of Medicine and completed a family medicine residency at Summa Barberton Hospital. While currently serving as the Vice President of The Ohio Academy of Family Physicians, Dr. Seager practices with Community Health Care, Inc. at the Hartville Family Physicians location.

Mark Terpylak, D.O.

Mark Terpylak, D.O., has been physician director of Summa Health Network since 2006. He earned his medical degree from Ohio University College of Osteopathic Medicine. Dr. Terpylak has served as chairman of the SHN Quality Improvement Committee since its development in 2009 and has been instrumental in the development of SHN's Ambulatory Care Model. Dr. Terpylak specializes in obstetrics and gynecology and has led Paragon Health Associates, LLC for 20 years.

Jay Williamson, M.D.

Jay Williamson, M.D. currently serves as the chief medical officer for Summa Physicians, Inc. Dr. Williamson earned his medical degree from The Ohio State University College of Medicine, and completed his family medicine internship and residency at Summa Akron City Hospital. Dr. Williamson currently serves on the board of SummaCare Insurance Company and Akron Community Health Resources.



QUALITY IMPROVEMENT TASK FORCE

Office Staff Dedication

In addition to the Quality Improvement Committee, the participants in the Ambulatory Care Model select a staff member from each of their practices to serve on the Quality Improvement Task Force. This committee was developed in 2010 to support the Quality Improvement Committee's initiatives. Meeting routinely to vet office workflow enhancements and data capture in SHN's clinical data repository, this group now has become a major component of the Ambulatory Care Model in operationalizing quality improvement programs.

In 2011, this committee discussed topics such as patient health literacy and the development of patient outreach programs for women's heart disease and diabetes. Specifically for the diabetes pilot program, this task force developed a documented process that could be duplicated and applied at other Ambulatory Care Model participant offices.

The Quality Improvement Task Force also took a leading role in authenticating data capture within SHN's clinical data repository. Throughout the year, SHN staff worked with the committee

to continually refresh the use of the clinical data repository functionality. A standardization process was put in place to assist in capturing data for diabetic retinal exams. Additionally, to ensure data accuracy for all measures, a data validation process was implemented.

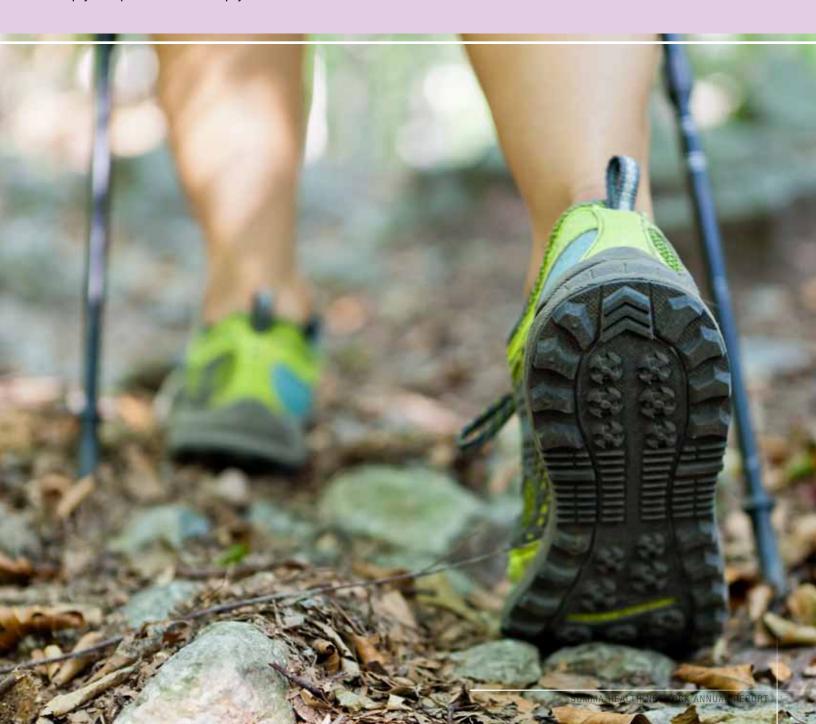
Having worked through this activity for her practice, MaryHelen Hanson from Community Health Care, Inc. noted, "After receiving representative data for each measure and confirming that information in SHN's clinical data repository matched my information in eClinicalWorks, I would say that the information collected in the clinical data repository from our EMR is accurate and we will continue to use it to take care of our patients."

This group will continue to meet monthly in 2012 to assist in achieving the visions of the Quality Improvement Committee and improve the quality of care for their patients.

Performance Incentive Model: The beginning of the journey

Established prior to the development of SHN's Ambulatory Care Model, SHN's Performance Incentive Model continues to offer incentive programs with national and local payers to participants. The programs under this Model were developed and offered by payers to provide incentives to physicians who utilize EMR in their

offices and meet clinical measures based on claims data. These programs are offered to primary care and specialty care providers according to payer. As of today, more than 400 physicians participate in at least one program through SHN.



The three elements of SHN's Performance Incentive Model programs are:

- 1. EMR implementation
- 2. Cost effectiveness
- 3. Clinical quality

EMR IMPLEMENTATION

With the assistance of SHN, EMR implementation in the Akron area continues to grow. From 2006 to 2009, SHN offered an EMR grant program to provide physicians with seed money to acquire EMR in their practices. SHN members selected eClinicalWorks in 2006 as the preferred EMR vendor, and today, assistance continues through the maintenance of the SHN eClinicalWorks Hosted Model and the SHN EMR Implementation Program. Once physicians are part of SHN's EMR Implementation Program, the Performance Incentive and Ambulatory Care Models are available to them.

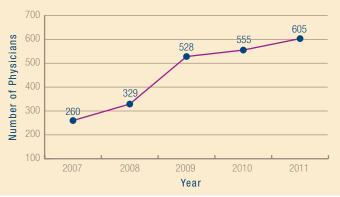
Today there are more than 600 physicians involved in SHN's EMR implementation program, and more than 200 of those physicians use SHN's eClinicalWorks Hosted Model.

"SHN's eClinicalWorks Hosted Model affords many benefits to its physicians such as preferred pricing for eClinicalWorks software, IT expertise and support, a committed relationship with eClinicalWorks, hands-on application assistance from healthcare professionals and much more. Utilizing eClinicalWorks' software and SHN's eClinicalWorks Hosted Model has many advantages, but probably the biggest is improved patient care. Everything contained in a patient's record can be accessed extremely fast from laboratory, radiology and transcription results, to current medications and medication history including contraindications. In addition, physicians gain the convenience of e-prescribing to the patient's preferred pharmacy. Also, by using SHN's secure data center, physicians don't need to worry about purchasing a server or data backups, and access can be obtained any time, from anywhere there is Internet availability."

- Fran Evans

Sr. Clinical Systems Analyst, Summa Health System







SHN EMR IMPLEMENTATION TEAM:

Pam Banchy, System Director, Clinical Systems Linda Wozniak, Sr. Clinical Systems Analyst **Brian Engel, Application Support Specialist** Fran Evans, Sr. Clinical Systems Analyst Ricky Aldridge, Sr. Application Support Specialist

COST EFFECTIVENESS

Since 2007, SHN physicians' generic prescribing rate has steadily increased, demonstrating value for the patients in our community. According to midyear results available at the time of this publication, SHN physicians are on target to reach an average 78% generic prescribing rate in the 2011 calendar year with a local payer. The use of generic prescribing provides affordable medications to patients and helps to reduce healthcare costs.

New to the Ambulatory Care Model in 2011, Dr. Dennis Yee was on target to achieve a generic prescribing rate of more than 94% with a local payer in 2011.





How changing a new patient's medications from new, brand-name drugs to established generics cemented the doctor patient bond — from the chair of SHN Board of Managers, Michael Maggio, M.D.:

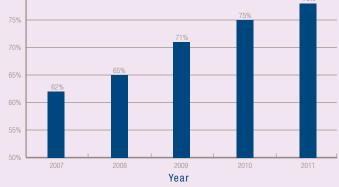
"Mary came to see me as a new patient with a constellation of three common diagnoses: hypercholesterolemia, diabetes, and hypertension. Her treatment plan, though relatively simple, consisted of three new and expensive medications. Initially, she was thankful to her previous physician for starting her off with samples and supplementing her pharmacy supply with more samples. But since she lost her job — and with it, her insurance — she was finding it very difficult to pay for her medications. Her treatment consisted of Lipitor at \$160/month, Januvia at \$200/month, and Bystolic at \$70/month. After some discussion, we changed these to generic medications: Simvastatin at \$30/ month, Metformin at \$20/month, and Atenolol at \$20/month. This cut her medication costs from \$430/month to \$70/month, or \$4,320 in savings per year.

She tolerated these changes well and her diseases remain under good control. She plans to use the savings for a vacation with her husband to celebrate their 25th wedding anniversary. It took a bit of extra time building a new patient's trust, but it certainly has gone a long way toward cementing our long-term relationship."

SHN PHYSICIAN GENERIC PRESCRIBING RATE

80%





All participants in SHN's Ambulatory Care Model and Performance Incentive Model, these groups each received the maximum incentive with a national payer for the combination of their clinical performance, use of EMR, and generic prescribing standards.

- Ohio Family Practice Centers, Inc.
- Austin Primary Care, LLC
- Community Health Care, Inc.
- **Family Practice Center** of Wadsworth
- Internal Medicine Specialists, Inc.
- **Pioneer Physicians Network**
- **City Cardiology Associates**
- **PAX Medical Associates**

CLINICAL QUALITY

A major factor in each performance incentive program is achieving set targets of clinical quality measures. Under each program, the respective payer has selected the clinical measures for their program such as cancer screening rates, diabetes care, hypertension control, and depression screening. The payer then tracks compliance through patient visits and claims data to report incentives earned.

In 2011, with a national payer, each participating SHN physician group received an average of 9% total incentive for exceptional performance in clinical measures.

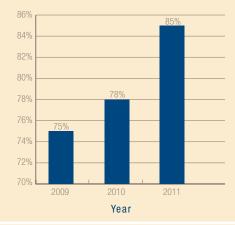
Additionally in 2011, continual improvement was found to be prevalent with the percentage of SHN physician



groups who met above-target measures with a national payer on HbA1c testing for diabetic patients.

With this same performance incentive program, City Cardiology Associates (an Ambulatory Care Model participant) scored 100% for LDL and HbA1c testing for their diabetic patients.

PERCENTAGE OF GROUPS WHO ACHIEVED ABOVE TARGET MEASURES FOR HBA1C TESTING



2011 Cancer screening results with a national payer:

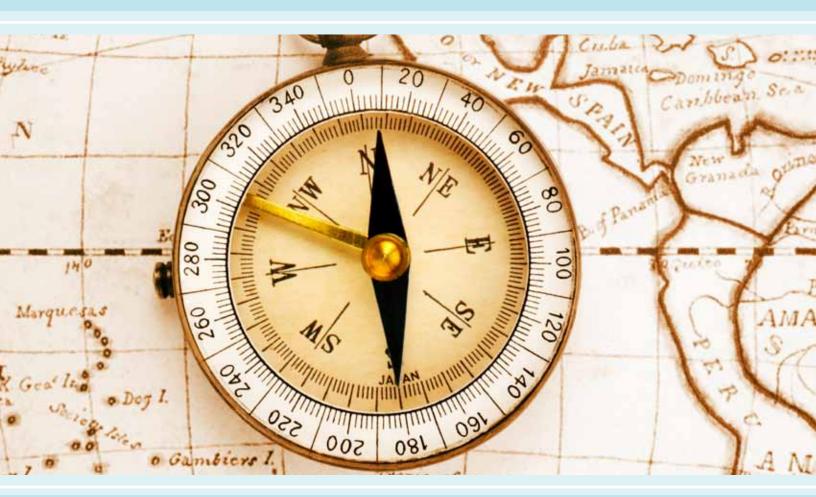
- 75% of SHN physician groups met the target measures for breast cancer screenings
- 100% of SHN physician groups met the target measures for cervical cancer screenings



Payer Contracting Committee Achievements

In the current fee-for-service reimbursement model, Medicare, Medicaid, and commercial insurance payers pay for healthcare services such as office visits, surgeries, and hospitalizations on a per-unit basis. This payment Model yields greater payments to physicians based on the volume of individual services provided.

This reimbursement system is no longer affordable. SHN's Ambulatory Care Model has been designed to support a transition to a new reimbursement model that rewards delivery of value through improved outcomes and overall reductions in medical cost trends. This model will provide appropriate value-based incentives to ultimately reduce the cost of care.



"The goal was not quantity of contracts, but the quality of the partnership."

- Rodney Ison, M.D., Community Health Care, Inc.

Historically, providers execute agreements with payers; however, SHN's Ambulatory Care Model executes partnerships. A partnership is a collaboration that acknowledges the needs of the payer, the provider, and the patient. Some of the key attributes required in an SHN Ambulatory Care Model partnership include:

- Innovative payment models rewarding quality improvement and cost reduction
- Equitable monetary incentives to develop the infrastructure
- Financial and clinical transparency of the care being delivered
- Clinical data exchange between payer, provider, and patients
- Joint operating committee where key operational leaders from both parties dedicate time and resources to monitor the partnership's progress toward advancing changes in the delivery of care

Over the past year, the Payer Contracting Committee evaluated potential payers to partner with the Ambulatory Care Model. The Payer Contracting Committee's focus centered on engaging the following payer types: commercial, Medicare Advantage, and Medicaid. Recognizing that these payer types offer different populations, challenges, and incentive models, it was essential to engage all three.

During this process, SHN learned that just like the providers in the marketplace, some payers are further along than others in adopting this new way of managing and financing the healthcare needs of a population.

SHN is excited to announce that the Payer Contracting Committee's efforts resulted in successfully securing SHN's first Ambulatory Care Model payer partnerships. These new partnerships offer a solid starting point to advance the Ambulatory Care Model's clinical initiatives and financial model development for managing and improving the overall health status of their respective populations.

These Medicare and Medicaid product lines will continue to dominate the providers' payer mix. Regardless of how healthcare reform is rolled out, it will significantly change how providers interact with both the Medicare Advantage and Medicaid populations. Although critics debate the specifics of the current healthcare reform law, they all agree — as does SHN —that creating new healthcare delivery and financial models for government programs will be imperative.

Ambulatory Care Model partnerships effective January 1, 2012:

- Medicare Advantage: Humana
- Medicaid: Buckeye Community Health Plan



Continuing the Journey

In 2012, the SHN Ambulatory Care Model participants will step into new territory with two dedicated, exclusive payer agreements. As Quality Improvement Committee member Dr. Richard Hines noted, "This is where the rubber meets the road; this is really make or break for us."

All participants in the Ambulatory Care Model will be working closely with SHN administration to maximize the potential of the Ambulatory Care Model agreements. They are now working with David Littlejohn, RN, as the new SHN quality improvement director. David brings experience to the Ambulatory Care Model from his nursing background as well as data capture, monitoring, and analysis for quality improvement from working with Summa Health System's Cardiovascular Institute. David will champion the development of quality initiatives in support of the Ambulatory Care Model agreements.

In addition to the initial implementation of Ambulatory Care Model agreements in 2012, the diabetes quality initiative will be rolled-out across the Model participants. Additional quality metrics also will be added to the data captured in SHN's clinical data repository, such as body mass index.



EMR IMPLEMENTATION PROGRAM PARTICIPANTS

Akron Community Health Resources Akron Dermatology Associates, Inc.

Barry J. Fish, M.D., LLC Bharat J. Shah, M.D., Inc.

Brewster Family Wellness Center

Children's Consultants for Digestive Care

Cirino Eye Center, Inc.

Crystal Arthritis Center, Inc.

Curtis W. Hawkins, M.D.

Doylestown Medical Center, Inc.

Eliot N. Mostow, M.D., Inc.

Fairlawn Family Practice, Inc.

Family Medical Care Plus Inc.

Family Physicians, Inc.

Foot and Ankle Institute, Inc.

Grenville Machado, M.D., Inc.

Hudson Family Practice, Inc.

Hudson Foot Clinic, Inc.

Mark S. Brigham, D.O.

Medina Cardiovascular Associates, Inc.

Melodie A. Phillips, M.D., LLC

NE Ohio Pediatric Pulmonary Center

Neera Agarwal-Antal, M.D.

Neurology & Neuroscience Associates, Inc.

Norman W. Lefkovitz, M.D., Inc.

NE Ohio Foot & Ankle Surgical Associates

OB/GYN Associates of Akron, Inc.

Obstetrics & Gynecology of Bath, Inc.

Ohio ENT Associates

Ohio Foot and Ankle Center, LLC

Ohio Valley Plastic Surgery

Portage Surgical Associates

Premier Renal Care, LLC

Primary Care Physicians of Stow

Reproductive Gynecology, Inc.

Robinson Health Affiliates

Stephen J. Francis, M.D., Inc.

Summit Gastroenterology Associates

Summit Pulmonary & Internal Medicine

System Optics — Novus Clinic

Total Lifetime Care Med Affiliates, Inc.

Unity Health Network, LLC

Urology One. Inc.

Valerie Fuller, D.O.

Western Reserve Professional Group

Women's Health Group, Inc.

Yatish Goyal, M.D.

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D'Anthony Harvey

Pax Medical Associates

Marti Hysell

City Cardiology Associates

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Pioneer Physicians Network, Inc.

Lucy Niggel

Falls Family Practice

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Family Practice Center of Akron

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Paragon Health Associates

Pat Walker

Family Practice Center of Wadsworth

Marsha Watson

Community Health Care, Inc.

Kathy Wiczen

Ohio Family Practice Centers, Inc.

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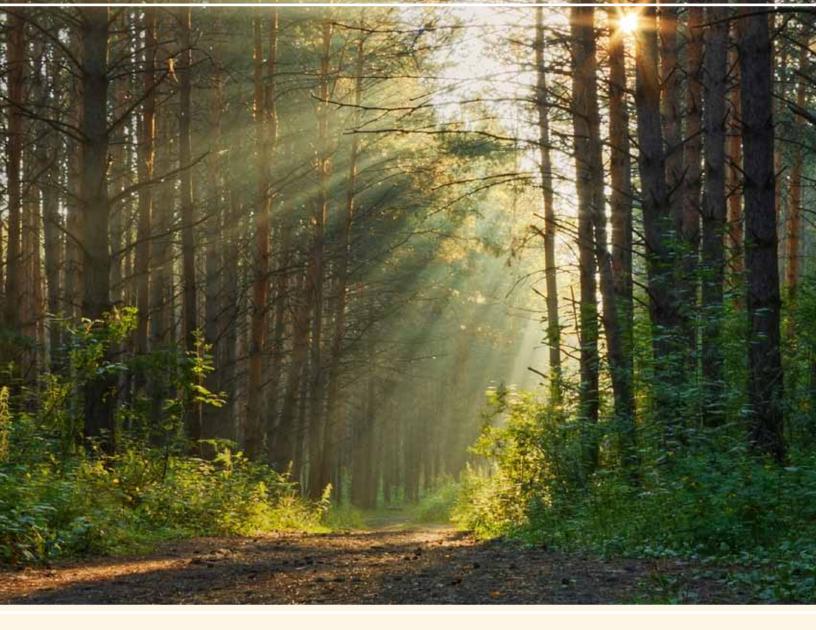
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Quality Improvement Director

Continuing the journey toward the transformation of healthcare

