TAKING GOOD CARE OF EACH OTHER

2021 YEAR IN REVIEW

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EASING THE WAY

We are Population Health.
We are a catalyst for better health outcomes.
We are trusted leaders, influencers, and change agents.

Our promise to Know Me, Care for Me, and Ease My Way starts with data. That means analyzing everything we do through the lens of social determinants of health as well as race, gender identity, sexual orientation, age, ability, religion, and socioeconomic status.

Care for patients is enabled through strategic payer and provider contracting. We contract for access, affordability, quality, improved patient outcomes, and experience.

Our patients, our members, and our communities are at the center of everything we do. We pay careful attention to current and future health policy regulations, prioritizing Medicaid and Medicare, and use our voice to speak up for policies that will ensure quality care for all our patients and members.

We deliver value through personalized care so that our patients, our members, and our communities can live well and thrive.

We welcome over 600,000 health plan members through timely, convenient, simple, and reliable care. We manage complexity and "Ease the Way" for our members through coordination of healthcare services and reduction of waste.

Mental Health is at a crossroads with COVID-19 amplifying, yet again, the crisis of access and the needs of so many. We lead the way in improving our nation's health by reducing stigma, expanding timely access, and improving quality mental health/substance use care for our people, our patients, and our communities.

Providence Home and Community Care department supports 192,000 people of all ages and healthcare conditions, especially those facing chronic life-limiting illnesses. We provide restorative care, longitudinal care, and care through the end of life.

Health is a human right, which is why our $50M investment in Health Equity has already made a difference in half a million lives. Still, there is more to do. Our call to action is to eliminate bias and structural racism so that we can truly realize Health Equity for all.

WE CONTINUE TO WORK TO BE MORE CURIOUS THAN AFRAID – TO WORK AS A COMMUNITY OF LEADERS IN POPULATION HEALTH TO FOLLOW OUR PROMISE WITH ACTION.

A LETTER FROM OUR PRESIDENT

Rhonda Medows, M.D.
President, Population Health
CEO, Ayin Health Solutions

Welcome to 2022!
We are living in a time of great discovery.

It is a challenging time for sure, but it's also a time of immense opportunity. Economic instability, workforce shortages, rising operational costs, health inequities, and a crisis around mental health are front and center in our work and personal lives. Now is the time to take action, to make change, and to rise up to make a difference as we shift into a new era...and address new realities in health care.

I invite every one of you to listen, to open your minds to new ways of thinking, and to speak up when you see injustice or issue. It can be scary, I know. But it's so important now more than ever to support the movement toward health equity, value-based care, financial sustainability for our mission, and paving the way for improvements in mental health care.

I feel tested every day to find better ways to serve and to endure the challenges before us. It is can be exhausting at times and exhilarating at others, but making this journey with all of you is greatly fulfilling. We have learned that our efforts must meet at the intersections of integrity, compassion, dignity, justice, and excellence in our professional and personal lives.

For health equity specifically, we need to listen and respond in new ways as well as acknowledge that some historical and recent healthcare practices created trauma and a lack of trust. Catholic social teaching insists we align with the true dignity of the human person. We know this is not only the right work, but the sacred work.

We have learned that bias and systemic racism penetrates our health care systems and therefore we must look at each aspect of our daily practices to ensure we support all populations. In the end, every effort MUST make healthcare a better experience, more affordable, and of greater quality to our patients and communities.

I have an invitation for you. As we progress through 2022, look out beyond your daily tasks. Notice. Notice where you see respect, compassion, hope, and gratitude. Notice where healing, forgiveness, and learning is necessary and then act. Guide that action to our mission's fruition. Action must follow our promising words.

BOARD AND COUNCIL MEMBERSHIPS

Dr. Medows proudly serves our community.

- Board Member, World Economic Forum
- Executive Board Member, Advisory Committee to the Director of the CDC
- Board Chair, Providence Health Plan
- Board Chair, Catholic Health Association
- Board Member, U.S. of Care
- Board Member, Seniorlink
- Board Member, Northwest Harvest Statewide Hunger Relief Agency
- Founding Fellow, The Health Evolution Forum
- Committee Member, American Hospital Association (AHA) COVID-19 Task Force
- Committee Member, American Hospital Association (AHA) Clinical Leaders Task Force for COVID-19
- Committee Member, American Hospital Association (AHA) Provider-Sponsored Health Plan Council
- Member, Association of State and Territorial Health Officials (ASTHO) Alumni Society
- Member, National Association of Medicaid Directors (NAMD) Alumni
- Member, Fellow of the American Academy of Family Physicians (AAFP)

Modern Healthcare's 100 Most Influential People in Healthcare

MODERN HEALTHCARE RECOGNITION

Modern Healthcare's Top 25 Women Leaders

ACHP
ALLIANCE OF COMMUNITY HEALTH PLANS

ACHP Inaugural Bernard J. Tyson Health Equity Award

Rod Hochman, M.D.
President, CEO
Providence

Rhonda Medows, M.D.
President, Population Health
CEO, Ayin Health Solutions

Tammy Wintrode
Project Manager/
Senior Executive Assistant

Don Antonucci
CEO, Providence Health Plan

Michael White
President, Providence Health Plan

Ruth Krystopolski
President, Ayin Health Solutions

Angela Marith
Chief of Staff

Daneen Calvin
Chief Mission Officer

Robert Hellrigel
Executive Vice President
Home and Community Care

Susan Klarner
Senior Vice President
Contracting

Karen Boudreau, M.D.
Senior Vice President
Enterprise Care Management

Deepak Sadagopan
Senior Vice President
Value-Based Care Programs
Population Health Informatics

Roger Dowdy, LICSW
Vice President
Mental Health Strategy

"A Population Health approach is vital for transforming healthcare. Thanks to our leaders in Population Health, Providence is on the cutting edge of value-based care – addressing disparities of care, bolstering patient quality and controlling costs, improving the patient and community experience, and ensuring we are financially sustainable well into our future. I'm grateful to everyone in Population Health for their commitment to our mission."

– Rod Hochman, M.D.

MULTIPLE PARTNERS TEAMING TOGETHER

All work done in the Population Health Management division is done through a Health Equity lens to support the elimination of health disparities and achieve Health Equity for all.

- **Ayin Health Solutions** – Launched in 2019, Ayin, a Population Health Management Service Organization (MSO), provides administrative management services, consulting services, clinical management, and digital solutions for employers, payers, providers, and government entities.
- **Enterprise Care Management and Coordination (ECMC)** – We partner with Providence regional leaders and caregivers to optimize delivery of whole-person care to vulnerable populations. Exploring patient and community level data, we identify populations for focus and intervene through strategic initiatives such as Health Equity, Medicaid Improvement, and Care Management optimization.
- **Home and Community Care (HCC)** – We provide a full range of services and support for people of all ages, especially those facing chronic or life-limiting illnesses. Our core competencies include restorative care, longitudinal care and care through the end of life. We serve more than 192,000 people a year, in their homes, in clinics, and in a variety of congregate living ministries. Providence HCC is the largest, not-for-profit provider of post-acute services in the country.
- **Mental Health** – We lead the way in improving our nation's health by reducing stigma, expanding timely access, and improving quality mental health/substance use care for our people, our patients, and our communities.
- **Payer and Provider Contracting** – In addition to managing the relationships with health plans and non-employed providers, the contracting team is responsible for negotiating fee-for-service and value-based agreements across the enterprise. The contracting portfolio comprises $18B in revenue, $1.3M lives in value-based care contracts, and supports Providence's competitive position in the markets we serve.
- **Providence Health Plan** – Providence Health Plan provides an array of insurance products primarily within the Providence footprint. We serve the community through fully insured and self-funded commercial customers, Medicaid, Medicare, and Affordable Care Act (ACA) programs, as well as a managed care organization that coordinates care for injured workers. We extend our support through strategic partnerships with organizations serving those most vulnerable in the community.
- **Value-Based Care (VBC)** – We support the organization by managing the performance of over 160 Value-Based Care contracts and arrangements covering over 1.9 million lives across Medicaid, Medicare, and Commercial populations. The Value-Based Care team works with other Providence teams and our payers to drive successful clinical quality outcomes and communicate performance across quality, patient experience and affordability measures. The team provides technologies and data informatics that allow bidirectional exchange of information with payers to bring greater value to our organization and the patients we serve.

SELECTED 2021 ACCOMPLISHMENTS ACROSS POPULATION HEALTH MANAGEMENT

- Ranked 5 out of 561 Medicare Shared Savings Programs nationwide, in terms of contribution to cost savings to Medicare.
- Consolidated performance reporting from 140 Value-Based Care contracts covering all seven regions of the system into a single interactive self-service, cloud-based resource.
- Inaugurated the Regional Payer Strategy and Growth Summit series, bringing together key stakeholders and leaders to review the current state of each market and develop strategies to reposition Providence for contracting growth and risk advancement through 2025.
- Implemented and scaled efforts aimed at reducing health disparities, touching more than half a million lives in collaboration with close to 700 community partners.
- Launched new Community Health Worker (CHW) programs in over 12 service areas to respond to COVID-19 and reduce health disparities among Black Indigenous and People of color (BIPOC) communities, culminating in a new systemwide CHW Council and workgroups to support the growth of new and existing CHW programs across the enterprise.
- Created a new measurement framework to include an Equity index to illustrate the cumulative impact of facing discrimination on multiple levels.
- Created composite risk scores for COVID-19 outreach to encompass risk of infection, risk of serious illness and mortality, and risk due to lack of vaccination top prioritize outreach and engagement efforts. This was shared on a national stage at the Health Information and Management Systems Society (HIMMS).
- Implemented Ayin Health's platform and solutions to help boost quality and efficiency for Providence Health Assurance's Oregon Medicaid population of more than 60k individuals.
- Implemented Epic (electronic health record) successfully at all Home Health and Hospice ministries across the organization. Connecting the entire continuum of care for our patients on a single electronic health record is helping us achieve our goals of creating a seamless care experience for patients, providing consistent workflows for caregivers, and ultimately offering safer, more reliable care. Moving to Epic also enhances care coordination and communication with other Epic providers.
- Received four or more CMS Quality Stars out of five in 21 of 24 home health locations. We are one of the largest home health providers on the West Coast.

LEADING THE WAY TO A HEALTHIER FUTURE

OUR 2022 GOALS AND COMMITMENTS

AYIN HEALTH SOLUTIONS

We will build solutions to bring value to our customers, resulting in better outcomes for all.

- Expand Ayin Health Solutions' client base and product offerings resulting in new communities benefiting from increased control over their healthcare dollars.

ENTERPRISE CARE MANAGEMENT AND COORDINATION

We will serve our communities to achieve their best health.

- Conduct and report effectiveness results on health equity interventions.
- Measure and improve health-related quality of life for patients who need chronic care management.
- Increase enrollment of Medicaid, Hospital Presumptive Eligibility, QHP's, and Charity for communities of color and those with a primary language other than English.

HOME AND COMMUNITY CARE

We will advance the care of people in their homes and communities beyond what is currently thought possible.

- Grow Program for All-Inclusive Care for the Elderly (PACE) membership by 50% over baseline.
- Grow Hospice patient days by 50% over baseline.
- Grow community-based Palliative Care patients served by 50% of baseline.

PROVIDENCE HEALTH PLAN

We will honor our heritage of being accountable for whole person care.

- Grow Providence members to 1M by 2026.
- Grow annual Health Plan revenue to $5B by 2026.

PAYER AND PROVIDER CONTRACTING

We will continue to expand with contracts that increase access to high-quality care and move reimbursement from transaction to value.

- Diversify contracting to include clinically integrated high-performing networks and solutions to barriers that limit Administrative Services Only (ASO) plan participation in value-based contracts.
- Initiate a systemwide process to identify and transform select payers from transactional relationships to strategic partnerships in a risk environment.

MENTAL HEALTH STRATEGY

We will sustain our role as a primary trusted health and wellness partner by making care easy, accessible, friendly, and affordable.

- Expand access to mental health resources and services to patients and caregivers.
- Demonstrate measurable improvements for our patients in depression treatment, suicide prevention care, and medication-assisted treatment for opioid use disorder.

VALUE-BASED CARE

We are the primary trusted health and wellness partner by making care easy, accessible, friendly, and affordable.

- Contribute to growth in total accountable lives to 1.5M and achieve performance targets of 110% Medicare yield in Medicare Advantage.
- Publish P&L for Medicare Advantage programs across the system.
- Improve annual re-evaluation rates and accuracy in coding and documentation to at least 85% of accountable Medicare lives.

Our vision, Health for a Better World, is driven by a belief that health is a human right. Every person deserves the chance to live their healthiest life.

At Providence, we recognize that long-standing inequities and systemic injustices exist in the world. This has led to health disparities among communities that have been marginalized because of their race, ethnicity, gender, sexual orientation, age, ability, religion or socioeconomic status.

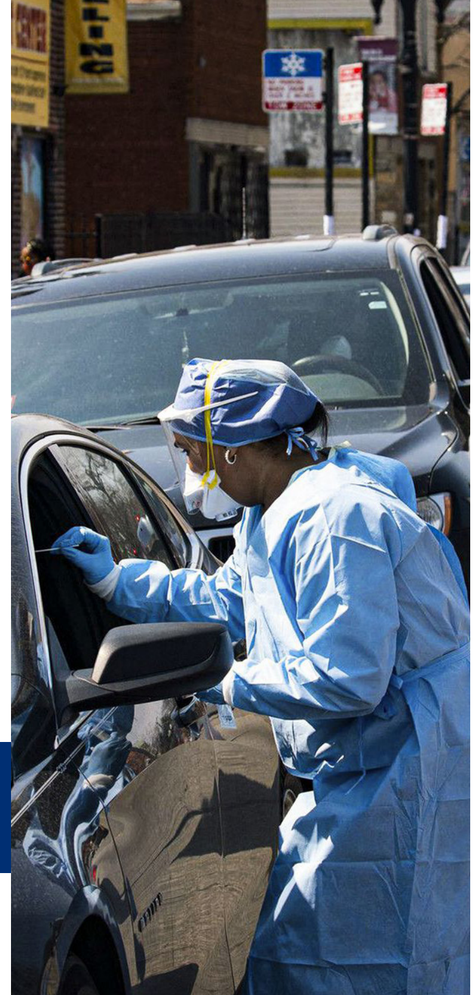
Each year, we serve more than 6 million people of every walk of life. We value each member of our diverse communities for their identities, journeys and experiences. And we commit to doing the personal and institutional work needed to live the values of Providence, which call us to welcome all and serve one another with respect and dignity.

In July, we celebrated the one-year anniversary of Providence's $50 million commitment to reduce health disparities and achieve health equity for our patients, health plan members and communities. To commemorate that milestone, we released our health equity statement, which commits us to:

1. Build, strengthen and maintain relationships with our diverse communities, including people of color, indigenous people, those who identify as LGBTQIA+ and others experiencing inequities, oppression, and discrimination.
2. Listen to and partner with our patients, communities, and health plan members to understand and actively reduce structural, racial, and cultural barriers to health for all.
3. Partner with community organizations to develop data-informed health equity strategies and implement proven practices to resolve the root causes of health disparities.
4. Amplify the voices of all people impacted by oppression. Advocate to reform the drivers of health, social and economic disparities. And in keeping with our faith tradition, use our voice to speak out against the structural racism and injustice that has led to a public health crisis.
5. Prevent further harm, humbly welcome discussion, and feedback, and foster a culture of continuous learning and transparency.

We have also re-written our Patient Rights and Responsibilities document to publicly affirm our commitment to equity—for both patients and caregivers.

CHANGE BEGINS WITH US



HEALTH EQUITY IS SOCIAL JUSTICE FOR HEALTH: THE ATTAINMENT OF THE HIGHEST LEVEL OF HEALTH FOR ALL PEOPLE

- In the U.S., Black people are twice as likely to die from diabetes as are white people.
- Rural counties have the highest premature death rate and rank lowest nationally in overall health outcomes.
- LGBTQIA+ youth are three times more likely to attempt suicide than are heterosexual youth.
- 19% of Americans 65 or older skip needed healthcare because of high out-of-pocket costs.
- Hispanic women are 60% more likely to be diagnosed with advanced stage cervical cancer than are white women.

ELIMINATING HEALTH DISPARITIES

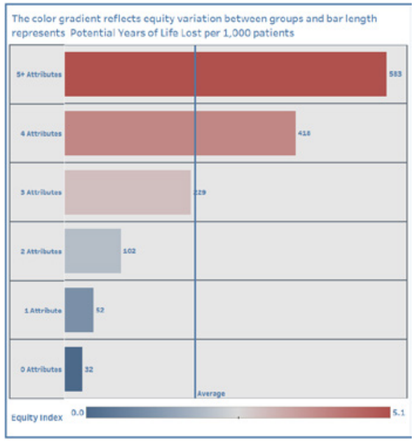
While there is still much work to be done, over the past 18 months, Providence caregivers have committed to doing the personal and institutional work to be anti-racist, partnering with our communities to address the root causes of health inequities, and amplifying the voices of people experiencing oppression. These efforts have impacted the lives of more than half a million individuals in our communities. Key highlights include:

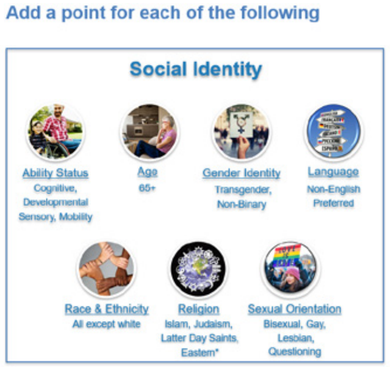
- Collaborations with approximately 700 community partner organizations to touch the lives of more than 572k individuals.
- Development of 12 new Community Health Worker programs and three mobile clinics.
- Launch of multiple community and clinic-based efforts aimed at eliminating health disparities in chronic conditions including hypertension and diabetes, as well as mental and behavioral health and access to care, including:
  - o A partnership with Live Chair Health to provide hypertension screenings in salons and barber shops in Los Angeles to reduce inequities in the Black population.
  - o Efforts to increase the Program for All-Inclusive Care for the Elderly (PACE) and hospice enrollment to rates that reflect the communities in which we operate.
  - o The launch of a pregnancy and birth outcome network in greater Seattle area aimed at improving outcomes for Black and Native/Indigenous populations.

BUILDING CAPACITY WITHIN OUR CAREGIVERS

To help our caregivers become more culturally responsive, the Health Equity team has continued its educational webcast service. This year, our webcasts focused on vaccine disparities and hesitancy, Black and African American communities, Hawaiian and Pacific Islander communities, and Muslim American communities. This series will continue through 2022. In partnership with Physician Enterprise, we will launch a series of quarterly medical education courses on the principles of health equity for all employed and affiliated providers.

As part of our ongoing efforts to support teams in identifying and addressing health disparities, Population Health has partnered with SmartRise Health to launch a collaborative learning model to advance health equity and accelerate change across Providence. The Health Equity Learning Collaboratives, which began in February 2022, include more than 30 teams from across the enterprise and focus on achieving measurable reductions of health disparities and improving social determinants of health that impact health outcomes. Specifically, the collaborative will include tracks focused on hypertension, diabetes, mental/behavioral health, and cancer screenings.





A DATA-INFORMED APPROACH

Leveraging industry best practices and standard metrics sets including those from the Centers for Medicare & Medicaid Services Office of Minority Health, National Quality Forum's (NQF) Disparities-Sensitive Measure Assessment and the National Committee for Quality Assurance's (NCQA), the Population Health Analytics team has developed a robust measurement framework that enables teams to measure:

- **Process Effectiveness:** Leading indicators including the number of lives impacted, referrals made, screenings completed, outreach attempts, and goals initiated.
- **Care Patterns:** Primary Care Provider connection and avoidable emergency department utilization as a rate per 1,000 patients.
- **Outcome Metrics:** Including health-related quality of life, mortality rate, reductions in clinical disparities including A1C, blood pressure, and body mass index.

These key indicators will be used to create scorecards for each funded initiative and will be used to support continuous process improvement efforts as well as identifying best practices that should be scaled across the enterprise.

We leveraged logic models as a conceptual construct for each program to chart the course, generate clarity around what success should look like and how to measure it, and how to tie activities and interventions to outcomes.

EQUITY INDEX

Discrimination based on age, race, gender, sexual orientation, disability, or religious preferences has been linked to disparities in health outcomes. Therefore, we developed an evidence-based discrimination (i.e., health equity) index that shows compounding effect of having multiple attributes of discrimination.

CHANGE TO OUR SYSTEM ELECTRONIC MEDICAL RECORD (EMR)

We collaborated with our Information Technology teams to make changes to the EMR at a global level that reflect sensitive and inclusive language for people with varying gender identities as well as preferred language for varying ethnic populations.

HEALTH FOR A BETTER WORLD BY FOCUSING ON VALUE

IN 2021 WE:

- Managed performance across the spectrum of value-based care (VBC) programs and contracts that cover 1.9 million lives
- Earned 42.5M in net positive part A Medicare fee-for-service adjustments for superior performance in Hospital Promoting Interoperability
- Earned an average fee for service adjustment of 1.67% (estimated $5.5M in net positive part B adjustments for Medicare Shared Savings Programs, Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act)
- Managed 337 million lines of payor claims data and 45 million enrollment records
- Succeeded in being one of the first health systems in the country to ingest enrollment data using the Fast Healthcare Interoperability Resources (FHIR) interoperability standards
- Partnered with regional markets in 2020 to realize $449M in earnings from value-based payment contracts based on 2020 performance, representing an increase of 29% from 2019

REGIONAL PARTNERSHIPS

We partner with regions to establish Partnership Service Level Agreements (SLAs) in the form of yearly objectives and quarterly results.

VBC OPERATIONS AND ADMINISTRATION

- Portfolio performance reporting
- Strategic financial analysis
- Home and Community Care coding initiatives
- Account management support

MEDICARE VBC

- Centers for Medicaid and Medicaid Services (CMS) Performance attestation & audit
- Medicare VBC rules review & analysis
- Post-acute care data technology and partnerships

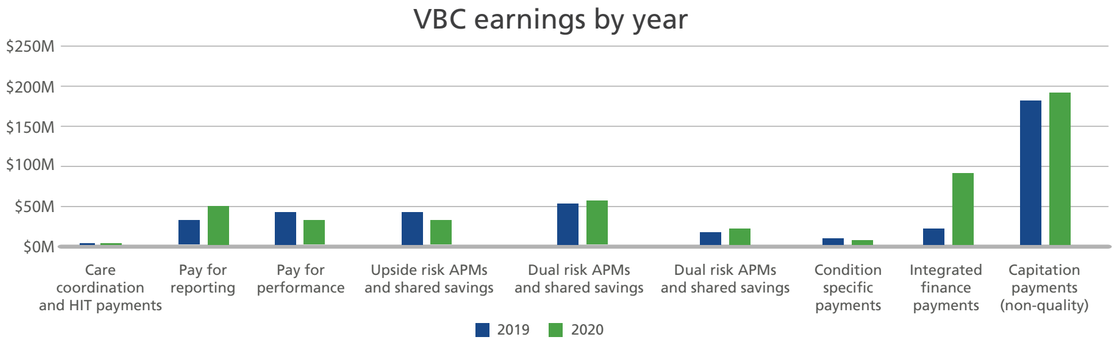
INFORMATICS

- Provide analytics capabilities to assess VBC performance
- Aggregate raw data from payers in the cloud

MODEL OF CARE

- Support clinically integrated network formations
- Guide MSSP action planning and review

PORTFOLIO PERFORMANCE REPORTING



DATA EXPANSION

Data Acquisition

- **Payers** core system
- **Providence providers** Epic
- **Network providers** EHR and billing system

Data Processing

Integrated data model

Analytic Applications

End Users

Data Acquisition and Interoperability

- Membership of ONC FAST Interoperability Steering Committee
- Leadership in FHIR adoption
- Participation in Da Vinci Collaborative

Processing

- Improved processing speed of claims over the past 3 years
- Manage 382M records from payers
- Development of advanced technologies with robotic process automation to reduce data acquisition time

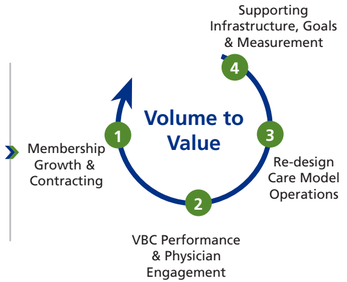
End User Analytics

- VBA: Single source of truth in VBC analytics

POPULATION HEALTH COUNCIL

Through 2025 the Population Health Council's focus on VBC care will be measured on systemwide growth and performance. An ambitious but achievable 2025 goal has been set to double current patients in Advanced Alternative Payment Model arrangements and perform at 120% of Medicare in Medicare Advantage (MA) programs. This will take our system from 1.1 million patients in these arrangements to 2.2 million in 2025, or roughly 40% of unique lives served, as well as substantially increase revenue in MA arrangements.

- "String of pearls"
- Interconnected set of strategies
- Shared responsibilities across governing councils



	Membership Growth	Portfolio Performance
2019	1.1M	106%
2025	2.2M	120%
	Accountable Lives	*% Medicare Yield*

VBC GOALS FOR SUCCESS WERE REGIONALLY LED AND SYSTEM SUPPORTED

The process of setting these goals was a system supported and regionally led collaboration with each region's domain experts and leadership, consulting with over 150 people. Working through existing measurement methodologies across the organization, we set targets that are relevant at the regional and system level.

NO ONE CARES ALONE

THE HEAVY TOLL AND OUR COMMITMENT TO WELL-BEING

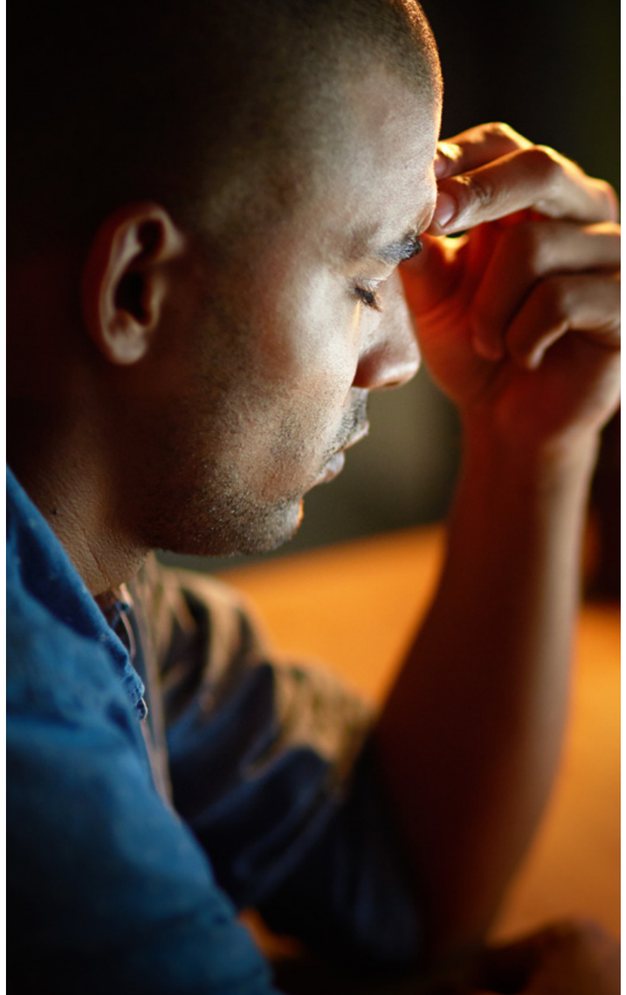
Prior to the COVID-19 pandemic, healthcare professionals were already at a heightened risk of burnout, mental health concerns, and suicide. As a result of the pandemic, we have only seen this trend accelerate and as healthcare leaders, we felt compelled to act.

It will be years before we'll fully grasp the emotional toll the COVID-19 pandemic has left in its wake. However, we are committed to identifying ways to care for the mental well-being of our caregivers. We also understand addressing this growing need will be key in both our continued fight against the pandemic and in our future together.

To address these needs, a workgroup was assembled early in the pandemic. Members included representatives from system and regional mental health, population health, human resources, mission, communications, and others. Borrowing from well-established public health approaches, a primary (education and information), secondary (self-guided resources) and tertiary (clinical support) intervention model was developed, ranging from pro-active to reactive services. This collection of programs became known as "No One Cares Alone."

CREATING A CULTURE OF WELLNESS

We aim to advance a culture of wellness and resilience at Providence that is responsive and adaptive to the needs of our caregivers. Help-seeking behavior must be encouraged and supported at all levels. The Providence promise to, "know me, care for me, ease my way," is one that not only applies to our patients, but to our caregivers as well. As a national leader, we can't simply prioritize the well-being of our caregivers, it must be a prerequisite. Only then will we be able to provide better care for our patients.



STARTING WITH EACH OF US: IT'S TIME FOR A CHECK-UP

Monitoring our physical health with routine checkups for blood pressure and other issues is common. An annual mental health screening should be treated with the same priority. As with physical conditions, it allows for early identification, monitoring, and, if needed, connects us with the necessary resources to prevent problems from worsening.

In partnership with the American Foundation for Suicide Prevention (AFSP), we began to roll-out the My Mental Health Matters campaign in July 2021. The intent of this campaign was to normalize talking about mental health—that it's okay to not be okay. Working in healthcare in any capacity can be challenging. This stress has never been greater than the past two years. The campaign consisted of three elements:

- Normalizing help-seeking behaviors through ongoing education around signs and symptoms of mental health to address stigma, utilizing traditional (e.g., newsletters) and non-traditional (e.g., social media) communication channels
- An annual, ongoing invitation to complete a confidential and anonymous, online mental health check-up
- Access to appropriate mental health resources, including clinical professionals (in-person or via telehealth)

3,000+ CAREGIVERS HAVE COMPLETED A MENTAL HEALTH CHECK-UP IN THE FIRST SIX MONTHS SINCE GOING LIVE.

LEADING THROUGH THESE CHALLENGING TIMES

To ensure our core leaders are equipped with the resources they need to address their own stress and that of their teams, we also launched a Core Leader Outreach program, a proactive invitation for leaders to join a virtual consultation with our team of Wellness Consultants, made up of Chaplains and Behavioral Health Professional from across Providence. During this time, the consultant engages in supportive listening to provide guidance to resources as well as coaching to empower them and their teams during times of stress. Core Leader Outreach is available to all core leaders in all departments across the health system and not solely limited to clinical units. In addition to proactive outreach, the Wellness Consultants have provided support to numerous departments after a critical event. Over 300 core leaders have engaged with a Wellness Consultant resulting in a downstream impact to over 7,600 front-line caregivers in 2021.

BECOMING A MENTAL HEALTH LITERATE ORGANIZATION

The warning signs for someone at risk of suicide don't typically occur just behind a doctor or therapist's door. They can happen in our places of work, in our communities and even at home. To successfully care for each other and our family/friends during this time and beyond, we recognize that we will need to become the most mental health literate organization in the country. To accomplish this, a brief, 50-minute Caregiver Suicide Prevention training was launched. A live, virtual version kicked off in November 2021 and an online module became available through Human Resource's Learning Management System in January 2022. Of note, over 23,000 caregivers completed this training in the first month of its introduction. Both the live version and the module are open to any caregiver who wishes to enroll. Participants are empowered to act as suicide prevention gatekeepers by learning how to support and respond to peers, colleagues or family members who may be experiencing a mental health concern.

ELEVATING OUR MENTAL WELL-BEING ECOSYSTEM

The system Behavioral Health and Human Resource Caregiver Well-being teams have collaboratively been working to ensure caregivers understand and can efficiently navigate the mental wellness resources available to them. As a result of these efforts, web-based, mental wellness resources have been accessed over 240,000 times. As we continue to learn, these services will evolve to meet the needs of our caregivers. We recognize that asking for help may be challenging; however, we also know that asking for help isn't giving up, but rather is a sign of strength and resilience.

Often times core leaders feel alone and feel like there is nowhere for them to turn for guidance and help. Thank you for doing this for us.

– Core leader outreach participant

Payer Contracting

Providence payer contracting is a critical business pillar with the responsibility of ensuring appropriate system revenue for healthcare services covered by health plans. In recent years, the traditional model of healthcare reimbursement has fundamentally transformed to a value-based model and payer contracting's responsibility has expanded with this evolution. In addition to securing fee-for-service rates for services, we now also ensure reimbursement models that align to the value of the care provided to patients in all settings across all lines of business. In 2021, payer contracting:

- Implemented and facilitated six Regional Payer Strategy and Growth Summits to ensure alignment and collaboration of all contributors to Providence's Destination Health 2025 targets of doubled accountable lives, increased Medicare Advantage yield, and development of a glidepath to capitation across regions
- Implemented national payer steering committees in support of an intentional strategic partner discernment process
- Managed over 13k contracts representing $18B in revenue
- Achieved the goal of initiating all top 10 commercial contract renewals 180 days in advance of termination in all markets
- Exceeded 2021 aggregate target reimbursement rate by +.10%
- Increased net revenue (all else equal) by $244.3M attributable to rate trend increases
- Recovered claims shortfalls representing over $60m in additional revenue
- Added nearly 90k lives to value-based contracting, including 75k lives in advanced alternative payment model contracts (HCPLAN 3/4)
- Embedded contracting representation in multiple clinical institute leadership channels to align understanding and drive solutions
- Expanded the contracting team model to dedicate subject matter experts to the Ambulatory Care Network and Home and Community Care service lines
- Utilized contracting compliance resources to offset outside legal expenditures representing a potential savings of $720k

ASSURING THE RIGHT PAYMENT FOR THE RIGHT CARE

Provider Network Contracting

- Developed the Clinically Integrated Network in Orange County and Los Angeles
- Contracted with sufficient provider network to meet market requirements for the Providence Health Network, Oscar Health Plan, Orange County, Los Angeles, High Desert, and Northern California Medical Group Networks, and direct-to-employer networks in support of growth targets
- Earned $1M in contracting fees from joint venture partners for contracting services
- Renegotiated affiliate and downstream contracts resulting in claims expense savings of approximately $600k

BOLD PLANS FOR GROWTH, MORE WAYS TO SERVE

PROVIDENCE Health Plan

In 2021, Providence Health Plan (PHP) made it easier for members to find a provider they identify with through a comprehensive provider directory that incorporates voluntarily disclosed race, ethnicity, sexual orientation, training in cultural responsivity, and more.

We also added numerous additional data points on race, ethnicity, and language for membership—gaining greater insights into health inequities and disparities for our members so we can tailor meaningful interventions.

As the COVID-19 pandemic illuminated disparities among our community members, Providence Health Plan reached out to over 12,000 Black, Brown, Indigenous, People of Color (BBIPOC) members to support education and navigation around vaccination and testing, assisted with no-cost transportation to COVID-19 vaccinations for vulnerable members, and gave over $100k in grants to community clinics to support efforts in fighting COVID-19.

GROWING HEALTH PLAN FOOTPRINT

Providence Health Plan has embarked on a multi-year growth initiative to expand into all Providence regions within the next five years. This expansion will bring the unique health plan enterprise value proposition to each region; materially increasing the annual enterprise contribution and positively impacting quality and volumes. This expansion includes all lines of business: Medicare Advantage, individual and group, as well as self-funded.

From California to Alaska, Oregon to Montana, Providence Health Plans is committed to supporting the population health shift from fee-for-service to value-based care. Each regional expansion is founded on a Providence-focused provider network and our unique real-time data analytics capabilities; combining to drive population health improvements.

Providence Health Plan success is best defined as delivering True Health to the communities we serve. While it's critical to maintain healthy financial performance to operate efficiently, it's equally important to live up to our values by providing the highest quality and most compassionate care possible. This is achieved through working extensively with our provider partners, analyzing how our services are used through data, and engaging directly with members to ensure the best and most appropriate care is received.

COMMITTED TO COMMUNITY PARTNERSHIPS

In 2021, PHP donated approximately $1.6M toward fighting food insecurity, supporting Afghan refugee services, to the patient assistance fund, and to organizations focused on access to care, behavioral health, and housing insecurity.

RECOGNIZED FOR EXCELLENCE

Providence Health Assurance (PHA) was awarded Medicare's highest rating of 5 stars for its 2022 Medicare Advantage programs. PHA has achieved 4.5- or 5-star ratings for 10 consecutive years and annually ranks as one of the highest rated plans in Oregon. Providence Medicare Advantage is among the best in the nation when it comes to clinical quality, effective operations, and positive member experience. In our Medicaid work, 100% of funds received were distributed to provide groups to support investments in patient care throughout the pandemic. These investments resulted in improved performance in 15% of our quality measures during an exceptionally challenging year.

HOME AND COMMUNITY CARE

In 2021, all our Home and Community Care service lines leaned in heavily to care for patients, residents, participants and families impacted by COVID-19 across all settings of care and we maximized all care delivery during surge periods. In addition to caring for those sick with COVID-19, we continued to grow programs to meet the increasing demand for our services in all markets we serve. We also continued working to complete our network of services in our major markets.

GROWTH ACROSS SERVICE LINES

- Home Health and Hospice ministries began serving patients in Clark County, Washington.
- Providence Hospice of Seattle received Certificate of Need approval from the Washington State Department of Health to expand services into Pierce County. Hospice operations team quickly ramped up and began serving patients in that community.
- Community Based Palliative Care expanded into Washington's King and Snohomish counties.
- Hospice expansion of provider visits in the home across Los Angeles County, Orange County and the Inland Empire/High Desert to deepen clinical support to Southern California patients and families with more medically complex interventions.
- Home Infusion expanded services in Los Angeles County.
- Pharmacy added two new products in 503B manufacturing business line.
- Relocation and growth of Ambulatory Infusion Suite based in Renton, Washington to better meet infusion needs of the community.
- Home Medical Equipment expanded acute consignment services in Oregon and Washington.
- Active construction to prepare for new Program of All-Inclusive Care for the Elderly (PACE) site opening April 2022 in Everett, Washington.
- Strong PACE member growth at new Spokane, Washington site exceeding expectations by 200%.

LAUNCH INNOVATIVE HOME-BASED CARE DELIVERY

- Hospital at Home is now available to patients in southwest Washington region in partnership with our Telehealth team. Patients in our Providence Hospital at Home program receive inpatient-level home care from Home Health caregivers as an alternative option to acute brick-and-mortar facilities.
- Launched Tele Palliative Care Program to support critical access in hospitals that do not have palliative care clinicians in-house to support patient and family care needs.

COMMITMENT TO HOUSING

Providence Supportive Housing added two new properties to its portfolio in 2021. With these acquisitions we now provide 747 units of permanent affordable housing with service coordination for the elderly and people with disabilities, and 98 units of non-congregate emergency shelter for individuals and families experiencing homelessness.

- We acquired Cal Anderson House Apartments located in Seattle's Capitol Hill neighborhood. Cal Anderson House Apartments offers 23 one-bedroom Supportive Housing apartments for people with disabilities. We are working on a plan to rehabilitate the property to ensure it remains in service to the community for decades to come.
- Providence Supportive Housing took ownership of a motel in McMinnville, Oregon where we are partnering with the Yamhill Community Action Partnership to run a non-congregate shelter for families experiencing homelessness and in need of emergency housing. In the coming years we plan to transition the 55-unit motel to a Supportive Housing ministry to provide secure and permanent low-income housing.

IN SUPPORT OF OUR HEALTH EQUITY AND VALUE-BASED INITIATIVES, WE ACQUIRED IRVINGTON VILLAGE ASSISTED LIVING (AL) IN NE PORTLAND

- Providence has been leasing space in Irvington Village for 12 years and operating a PACE ministry, serving vulnerable older adults with low incomes.
- Irvington Village currently has 77 tenants with 68% enrolled in the PACE program. Purchasing this facility ensures we'll continue to fulfill our Mission and uphold our commitment to provide much-needed healthcare services and affordable housing to seniors with low incomes in NE Portland.
- It also enables us to continue our commitment to serve diverse populations as 22% of PACE participants at Irvington Village are Black, 6% are Hispanic or Latino, and 5% are Asian.

MORE INNOVATIVE PROGRAMS THAT PUT PATIENTS FIRST

In addition to the direct work in supporting health equity initiatives, our Enterprise Care Management and Coordination analytics team responded to system and regional needs for better patient care.

Mental Health Treatment Improvement

- Developed an enterprise level dashboard showing patient improvement for depression related treatment in primary care.
- Evaluated baseline data to establish targets for future performance improvement efforts as it pertains to medication-assisted treatment for Alcohol and Opioid Use Disorders.
- Developed reports to identify patients with high depression scores indicating the potential for self-harm and needing rapid outreach to ensure patient safety.

COVID-19 Outreach

- A composite COVID-19 risk and dashboard to assist regions in identifying populations for outreach.

Value-Based Contracts

- Provided data to show value and services provided by care management teams for various value-based contracts in support of ongoing per member per month payments received from payers.

Avoidable Emergency Department Reduction

- Developed a risk model to predict patients likely to have an Avoidable Emergency Department visit in the next six months to inform proactive caregiver engagement. We also performed analysis to identify key drivers of avoidable emergency department utilization. These findings will be used to develop segments in 2022.

Climate and Environmental Risk Patient Identification

- Developed logic and published report for caregivers to proactively identify patients who may need support during extreme heat events. Other environmental lists to be generated in 2022.

Care Management Optimization

- Delivered COACH and RELATE trainings engaging 129 caregivers. This included the first CHW cohort and word-for-word language interpretation and translation of COACH materials for our Spanish-speaking caregivers.
- Co-led the build design optimization and enhancement of a care management module within Epic (our electronic medical record), including creating standardized Epic access and navigational tools to support Community Health Worker workflows.
- Creation of standardized administrations departments in Epic for Care Management teams across the system as well as setup of billing infrastructure for ambulatory Care Management teams.
- Facilitated an Acute Care Modernization collaborative to establish a systemwide program description and guidelines. The scope of the collaborative spanned case management, utilization management, social work, discharge planning, denials and appeals, and Physician Advisor to 1) facilitate safe and efficient patient care, flow and transition to home or the next site of care and 2) assess appropriateness of care, seeking to ensure appropriate payment, including recovery of payment through the management of denials and appeals.
- Deployed live and on-demand Emotionally Connect Partner and Respond (eCPR) trainings for caregivers, which provides guidance on how to support and respond to peers, colleagues, family members or community members experiencing mental health concerns.
- Provided data to support grant applications to various teams throughout the year. Purdue Foundation approved a $200k grant for service area opioid use disorder treatment programs, including Walla Walla Community Paramedic Program for ED Diversion and Fall Prevention, Alaska Medicaid Care Coordination Demonstration Project, and SAMSA grant data support for southwest Washington team.

STEADFAST IN CARING FOR THE MOST VULNERABLE IN OUR COMMUNITIES

Growing Providence's Community Health Worker Workforce to Promote Health Equity

Providence is committed to investing and growing the Community Health Worker (CHW) workforce, who serve as a bridge between their communities and the healthcare system, fostering greater trust and enhancing the healthcare system's ability to honor, respect and be responsive to the culture, identity, and language of each person, in every encounter. As members of the communities where they work and live, CHWs possess an intrinsic understanding of those they serve, which is central to who CHWs are and what they do. CHWs, now more than ever, play an increasingly important role in the healthcare workforce. This was evident during the pandemic as CHWs across Providence directed their efforts to increasing access to COVID-19 related services, such as testing, PPE and supplies, contact tracing, and vaccinations through direct outreach and community events, as well as providing resource linkages, emotional and social support, health outreach, and advocacy.

NEW HEALTH EQUITY-FUNDED CHW PROGRAMS IN 2021

Growing evidence supports CHWs' effectiveness in improving health outcomes such as medication adherence, quality of life, disease self-management, access to care, and preventative care. Community Health Worker models are recognized for their effectiveness in reducing health disparities and advancing equity, particularly among communities that have been historically marginalized. For this reason, more than 12 service areas sought health equity funding to support new CHW programs focused on either reducing health disparities or addressing the disproportionate impact of COVID-19 among Black, Brown, Indigenous and People of Color. All CHW programs are aiming to reduce disparities in access, patient experience and clinical outcomes, many with a focus on hypertension, diabetes, and mental health.

COMMUNITY HEALTH WORKER/PROMOTORES DE SALUD COUNCIL

With increased need to respond to the disproportionate impact of the pandemic on communities of color, Providence's Community Health Worker Programs have grown, with CHW programs in almost every state across our footprint. To support this rapidly growing workforce of both new and long-standing CHW programs, Population Health and Community Health Investment (CHI) co-sponsored a systemwide council and subsequent workgroups with the aim of co-developing shared practices, approaches, tools, and resources that welcome, support, integrate, elevate, and advance opportunities for CHWs across the organization.

In 2021, two workgroups were formed. The first workgroup focused on creating a framework and supporting materials for communicating the unique role and value of CHWs at Providence, which is foundational to future efforts focused on training and development, Human Resources, and program evaluation.

2021 ACCOMPLISHMENTS:

- Standardized Epic access and navigational tools to support Community Health Worker workflow
- Developed a tiered model framework for CHW roles
- Established core competencies and scope of practice by tier, based on the Community Health Worker Core Consensus Project
- Adopted a standard definition to describe CHWs as defined by the American Public Health Association
- Compiled a hiring toolkit, including resources and equity considerations for hiring, recruiting, and interviewing prospective CHWs
- Drafted materials to socialize the role of CHWs to care teams

DOCUMENTATION STANDARDIZATION

The CHW Council's documentation workgroup kicked off in June 2021 to develop the tools needed for CHWs to document effectively in Epic. The goals of this group were to understand the definitions that are commonly used within this work and develop the information needed to create a CHW specific Epic template that will improve workflows, information sharing, and data reporting. Documentation within Epic is essential for integration within the care team, but also facilitates future opportunities for measuring outcomes and reimbursement as a growing number of states like Oregon and California are beginning to cover services provided by CHWs.

WHAT IS A COMMUNITY HEALTH WORKER?

"A community health worker is a front-line public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural [responsiveness] of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy."

– American Public Health Association

Ayin | Health Solutions

DELIVERING TRUE HEALTH TO THE COMMUNITIES WE SERVE – AYIN HEALTH SOLUTIONS

Ayin Health Solutions began serving two new health plan customers for plan year 2021: a new Medicare Advantage MSO client and Providence Health Assurance's Oregon Medicaid line of business. In addition, Ayin Quality Insights and PH Tech's Community Integration Manager platform saw additional features released throughout the year. These enhancements focused on improving health plan and provider access to meaningful analytics and data including community-level insight into vaccination rates across populations. Ayin also supported statewide COVID-19 vaccination efforts within Oregon by staffing a portion of the state's vaccine information call center and developing a vaccine reimbursement program in coordination with the Oregon Health Authority.

2022 VALUES IN ACTION AWARDEES

As 2021 came to a close, nearly 50 Population Health caregivers were nominated by their colleagues to the systemwide Values In Action program, which honors people who embody the Providence Mission and Core Values. These are the faces of Providence—people who offer themselves as vessels of God's healing love, poured out for other caregivers, our patients, plan members, and the broader community.

AWARDEES SELECTED FOR DIVISION RECOGNITION

Hanna Amanuel – Sr. Educator Lead, Practice Optimization, Enterprise Care Management

Jessica Bugge – Sr. Administrative Assistant, Payer Contracting

Elizabeth Paukert, RN – Care Coord, Case / Disease Management, PHP Health Care Services

Jim Sobeck – Manager, Application Support, PHP IT Administration

DIVISION AWARDEE SELECTED FOR SYSTEM RECOGNITION

Cash Spencer – Senior Manager, ASO Account Services, Sales/Marketing Providence Health Plan

"I am nominating Cash Spencer for her outstanding and persistent dedication to the communities she serves, which includes the 36 counties of the state of Oregon. She is a steadfast advocate for health equity and inclusion as evidenced by her volunteerism during 2021 through COVID-19 vaccination clinics with special emphasis on clinics in underserved communities in the Portland Metro area. Further, Cash is a relentless proponent of unanimous juries, having served on a nonunanimous jury in 2016 which convicted a person via a vote of 11-2 in the state of Oregon.

"After her juror experience, Cash became tenacious in her search for justice via her work with StillinPrison.org. Until April 2020, Oregon was the only state that still allowed nonunanimous jury convictions. That's when a U.S. Supreme Court decision uprooted the status quo in Oregon, finding nonunanimous jury verdicts to be unconstitutional. News media nationally recognized Cash for this important work including the Philadelphia Tribune. Cash lives the Mission of Providence in so many ways, every day."

– Helen Noonan-Harnsberger, PharmD, Vice President – Pharmacy, Providence Health Plan

HOME AND COMMUNITY CARE AWARDEE SELECTED FOR SYSTEM RECOGNITION

Dora Frank – Laundry Aide, Providence Mount St. Vincent

"Dora Frank attended a vocational school earning a high school diploma and then participated in a work study program for individuals with learning challenges. This program prepared Dora to enter a work setting and begin her new job in the laundry department at Providence Mount St. Vincent, fondly known as The Mount, 45 years ago.

"Dora is a dedicated caregiver who draws from a deep personal well of discipline, tenacity, and positive spirit to show up every day without fail and with a devotion to working hard. Dora's weekday routine includes getting up at 2 a.m. to take care of household chores, provide personal caregiving to her partner and taking care of her cat, 'Boots.' At 4 a.m. she takes two buses to get to work and starts her job at 6 a.m. at The Mount.

"As a laundry aide, she is responsible for washing, folding, and delivering laundry to the residents in the skilled nursing center. In her daily tasks, Dora demonstrates the value of Compassion in her encounters with residents and patients. She always shows Respect and Dignity in each encounter, knowing each moment is special and can brighten someone's day. Dora works hard to accomplish her tasks each day, but never at the expense of others. She emulates the value of Justice by her kindness to everyone."

– Charlene Boyd, Administrator, Providence Mount St. Vincent

ASSESSING OUR FAITHFULNESS TO CATHOLIC HEALTH CARE'S CORE COMMITMENTS

Providence completed its first-ever systemwide Mission Fidelity Assessment (MFA) in 2021—a tool and process created by the Catholic Health Association (CHA). The objective is to ensure and strengthen our commitment and faithfulness to our Catholic identity by understanding, in a deeper way—through data and conversation, our current practices and areas of opportunity within seven core commitments of Catholic Health Care.

Contracting leader Lori Fleming commented: "The experience of working together to reflect on and respond to these questions was surprising, enlightening, and important. I know I came away with a new-found commitment to serving the Providence Mission—and a clearer picture of how to do that within my role."

During 2022, Population Health will work to achieve two goals selected from the list of recommendations: Health Equity and Integration of Behavioral Health into Primary Care.

2021 FINANCIAL HEALTH ACCOMPLISHMENTS

Value-Based Care

- Realized $449M in earnings from value-based payment contracts based on 2020 performance through partnerships with regional markets
- Earned approximately $26.1M in shared savings in the MSSP
- Earned $43M in net positive part A Medicare FFS adjustments for superior performance in Hospital Promoting Interoperability
- Earned an average FFS adjustment of 1.67% (estimating $5.5M in net positive part B adjustment for MSSP and MACRA)

Payer Contracting

- Managed over 13k contracts representing $18B in revenue
- Exceeded 2021 aggregate target reimbursement rate increases by +.10%
- Increased net revenue (all else equal) by $244.3M attributable to rate trend increases
- Recovered claims shortfalls representing over $60M in additional revenue
- Added nearly 90k lives to value-based contracting, including 75k lives in advanced alternative payment model contracts (HCPLAN 3/4)
- Utilized contracting compliance resources to offset legal expenditures representing a potential savings of $720k

Provider Contracting

- Earned over $1M in contracting fees from joint venture partners
- Renegotiated affiliate and downstream contracts resulting in expense savings of ~$600k

Care Management

- Achieved 19 fewer avoidable ED visits per 1,000 unique Medicaid lives compared to YE2020

Mental Health

- Closed gaps in mental health contracts leading to reduction of unnecessary claim denials

Providence Health Plan

- Recorded over $20M of financial relief to communities served through premium credits in recognition of pandemic pressures
- Achieved $40M of managed care savings
- Contributed positive NOI margin to the Providence organization

Ayin Health Solutions

- Served twice as many Medicaid members in 2021 while maintaining a 4.8% margin

THE POPULATION HEALTH DIVISION HAS MUCH TO BE PROUD OF AND WE WILL CONTINUE TO PERSEVERE TO ENSURE THE FUTURE IS BRIGHT FOR OUR PATIENTS, MEMBERS, AND COMMUNITIES. WE COMMIT TO DEEPENING OUR EXPLORATION OF WHAT IS POSSIBLE ON BEHALF OF THOSE WE SERVE.

What if we get even better at data exchange so that we achieve full alignment of value to patient, provider, and payer?

What if we redefine contracting to move away from decades of fee for service and utilize our ability as change agents to transition to a value-centric healthcare system?

What if we improve alignment of data and the most critical metrics to increase our influence in ways that we know are hyper-relevant?

What if we welcome more plan members by getting ahead of the evolvement towards value and enhancing our ability to adapt?

What if we make screening for behavioral health conditions as normal as a blood pressure check?

What if we provide the right care at the right time to every caregiver and patient in need of mental health services?

What if we invest in predictive and results-based analytics relevant to Palliative Care, Pace, and Medicare Advantage plans to ensure personalized care to all we serve?

We see our future as a community capable of rising above our biases by owning our mistakes, asking “what if …” and working to heal the trauma caused by structural racism.

Enough is enough when it comes to mental health stigma and payment inequities.

We will move away from fee for service and embrace value.

Our future is bright. Our future is for all.

52 hospitals

119,887 caregivers

950 clinics

36k nurses

4.5M unique patients served

25k physicians

1.9M lives covered

1.9B* community benefit

***Unaudited**

HEALTH IS A HUMAN RIGHT.

providence.org/about/initiatives/population-health

Our Mission

As expressions of God's healing love,
witnessed through the ministry of Jesus,
we are steadfast in serving all,
especially those who are poor and vulnerable.

Our Values

Compassion
Dignity
Justice
Excellence
Integrity

Providence