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Letter from The Chairman

Jackson Health Network (JHN) is proud to present the 2016 Value Report. In 2015, the JHN Clinical Integration (CI) Program marked the completion of its third full year. JHN, in partnership with local physicians and Henry Ford Allegiance Health, continues to work to achieve the Triple Aim—improved health outcomes, improved patient experience of care and lower per capita cost of health care for our community. During 2015, JHN expanded its CI Program and physician involvement to continue to advance work on key health concerns in our community as expressed by employers, individuals, physicians and the health system. We’re very pleased to report that we also enhanced our collaboration in 2015 by continuing our work with other community resources and expanding physician-led care teams on our quest for improved health.

Just over 250 physicians in the Jackson area participate in the JHN Clinical Integration Program and work with our administrative team to implement changes that will consistently drive improvement. Almost 60 of the physicians sit on various committees that help to identify and oversee our progress. We thank these individuals for their willingness to help lead this important work.

We are convinced the health care industry is undergoing a significant transformation that will impact both the delivery and financing of health care services. We further believe the result will be better care and improved outcomes. We are excited by the programs that are paying dividends and eager to undertake the future work. As I noted last year, we are committed to annually publishing the results of our efforts to allow you to help hold us accountable. In the interim, I encourage you to reach out to Dr. Ray King or our administrative team led by Dr. Amy Schultz, should you have any questions concerning our efforts to allow you to help hold us accountable.

During 2015, we completed the third full year of our Clinical Integration (CI) Program and are now presenting the key metric results and how these activities will bring better health to our community. Briefly noted in this report are other key events that are helping to shape or support this change: the affiliation with the Henry Ford Health System, the significant investment we are undertaking in 2016-2017 with the Epic electronic health record system, and participation in a new state-wide network designed to share best practices and support changes in the care delivery model.

This report also provides a glimpse into our work to integrate health care delivery with our local Health Improvement Organization (HIO), the Jackson County Health Department and behavioral health services, to help address various issues that impact our health and well-being.

We are proud of what we have accomplished and are looking forward to working with our community as we become the healthiest county in Michigan.

~ David Halsey, MD

Jackson Health Network, Chairmen

Letter from The President

Beginning in 2010, a group of local physicians and Henry Ford Allegiance Health began planning how our community would respond to the call for reforming the health care delivery system. We are now in the fifth year of our work that is clearly a journey and not a destination. I’m proud of the work our medical community and staff have accomplished. Changes are improving the health of our community, creating more efficient use of our resources, and favorably impacting utilization and cost of care. The challenge is to continue to push our work forward to obtain that consistent year-over-year advancement.

Our goal is to ensure we provide the right care in the right place at the right time for the right cost. This means helping the community stay healthy, implementing new ways to access and receive care, efficiently providing care when needed, and working to assure consistent support to patients as they transition between care modalities.

Jackson Health Network was formed as a vehicle to develop ideas and programs that work toward this new model. By 2012, we were running a six month pilot of our initial program for Henry Ford Allegiance Health Staff and their covered dependents. In 2015, we took the program live and added individuals covered by Priority Health. Since then, we’ve added multiple other payers to our client list and now have responsibility to over 75,000 people in the greater Jackson area.

Our approach is to identify key factors influencing the health and wellness of our community. We then develop programs that support physicians and Henry Ford Allegiance Health to deliver the needed care in a patient-centered, efficient manner. We further identify metrics for our program that help us to monitor its effectiveness.

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We are now in the fifth year of our work that is clearly a journey and not a destination. I’m proud of the work our medical community and staff have accomplished.~ Ray King, MD

Jackson Health Network, President

‘JHN expanded its Clinical Integration Program and physician involvement to continue to advance work on key health concerns in our community as expressed by employers, individuals, physicians and the health system’ — David Halsey, MD

‘We are now in the fifth year of our work that is clearly a journey and not a destination. I’m proud of the work our medical community and staff have accomplished.’ — Ray King, MD
**Who We Are**

We, the participants of the Jackson Health Network, will operate as a close partnership between Henry Ford Allegiance Health and affiliated physicians as a foundation for building an integrated system of health care delivery for the Jackson community and beyond.

**The JHN Vision**

Jackson Health Network (JHN) is a collaboration between health care leaders, community leaders, physicians and Henry Ford Allegiance Health, working together to improve patient outcomes and safety, and reduce the overall costs through an integrated system of care. Functioning as a Clinically Integrated Network (CIN), JHN is designed to continuously improve outcomes and reduce costs. The program combines evidence-based medicine with an innovative pay-for-performance program that results in outstanding health outcomes and reduced costs.

JHN is excited to be tackling the challenge of reforming health care delivery in Jackson, Michigan. Working with our participating physicians and Henry Ford Allegiance Health, our goal is to deliver improved results — outcomes, experience of care and costs of care — year-over-year. We are pleased to present our early work and are seeing continuing signs of improved results.

Henry Ford Allegiance Health, physicians, and JHN staff understand the value of making Jackson the healthiest community in the state. A healthy population will help lead the resurgence of our region as others want to come to Jackson to enjoy the benefits of the healthiest community. We pledge our best efforts and encourage each person to reflect on their own wellness and commit to become more engaged in their own health.

Jackson Health Network
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(517) 705-7477
JacksonHealthNetwork.org

**Introduction and Goals**

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Henry Ford Allegiance Health, physicians, and JHN staff understand the value of making Jackson the healthiest community in the state. A healthy population will help lead the resurgence of our region as others want to come to Jackson to enjoy the benefits of the healthiest community. We pledge our best efforts and encourage each person to reflect on their own wellness and commit to become more engaged in their own health.
JHN leverages knowledge, dedication to care transformation and unity to drive better patient care in a single hospital community. We are committed to achieving the Triple Aim by continuously striving to improve quality, decrease cost and create value for our patients, community and payors.

Patient-Centered Focus
JHN firmly believes the experience of patients and their families is a crucial component of delivering quality care. All of our primary care providers are encouraged to actively pursue accreditation as Patient-Centered Medical Home and specialists to participate in the medical home neighborhood. JHN staff work hand-in-hand with member practices to advance patient-centered capabilities.

Dedication to Innovative Care Delivery
JHN recognizes the importance of advancing care delivery that is not only affordable, but also accessible to patients. In partnership with our hospital system, private practices and community leaders, we continuously strive to empower engage and connect with patients through new tools and informative resources, allowing patients to partner with their care team and take charge of their health.

JHN By The Numbers

**Clinical Integration (CI) Program**
- **40** Metrics of quality clinical care
- **13** Metrics for important structure and education
- **81.94%** of measure targets met in the 2015 CI Program

**Physicians, Licensed Psychologists, Podiatrists, and Advanced Practice Practitioners**
- **258**
- **45%** Private Practice Providers
- **55%** Henry Ford Allegiance Providers
- **9** Committees led by 55+ JHN Providers and Community Members

**Health Improvement Organization (HIO)**
- **1** Henry Ford Allegiance Health

**Hospital System**
- **1**

**Population Health Registry**
- **JHN Compass**
- **93%** of providers manage care in the JHN Compass
- **110,000+** Active patients in our primary care network and managed in the JHN Compass

**JHN Employees**
- **28**
- **13** Clinical Integration Team Members
- **15** Prevention and Community Health Team Members

**JHN By The Numbers**
- **1**

**Integrated System of Care**
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Monitoring for Common Complications of Diabetes

- Nephropathy Screening
- Retinal Eye Exam
- Foot Exam

JHN’s Clinical Integration (CI) Program identifies key performance measures categorized into six areas of focus including preventive care, chronic disease care, continuum of care, efficiency and utilization, patient experience and satisfaction, and education.

The following provides information on key clinical programs, along with tables representing the results of the 2015 program year.

### Diabetes Mellitus Care Performance

Ten of the quality clinical care measures are focused directly on management of patients with diabetes. An additional measure addresses early identification of patients at risk for developing the disease. Approximately 10% of the Michigan adults are diagnosed with diabetes, a rate slightly higher than US average. The Centers for Disease Control and Prevention estimates up to 27% of adults have prediabetes, but in Michigan, only about 8.2% report being told they are at high risk for developing the disease.

All measures of diabetic care improved in 2015. More than 90% of all diabetic patients were tested for control of blood glucose in 2015 and over 80% were controlled below a key marker of HbA1c <9.0%. This resulted in decreased progression of vision and peripheral sensory loss, as well as kidney and vascular disease in the more than 10,100 patients with diabetes cared for by JHN member physicians. Increased monitoring for complications allowed early recognition and treatment of associated debilitating diseases.

Identification of patients as pre-diabetic almost doubled in 2015. Nearly 400 more patients were alerted to their increased risk for diabetes and provided information regarding life changes to decrease that risk.


### 2015 Clinical Integration Program Results

#### Pre-diabetes Identification

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>56.05%</td>
<td>66.05%</td>
</tr>
<tr>
<td>National</td>
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</tr>
</tbody>
</table>

#### Monitoring for Common Complications of Diabetes

**Nephropathy Screening**

- 2013: 54.99%
- 2014: 54.66%
- 2015: 63.45%

**Retinal Eye Exam**

- 2013: 25.18%
- 2014: 38.05%
- 2015: 42.87%

**Foot Exam**

- 2013: 41.37%
- 2014: 63.11%
- 2015: 72.35%

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Identification of patients as pre-diabetic almost doubled in 2015. Nearly 400 more patients were alerted to their increased risk for diabetes and provided information regarding life changes to decrease that risk.
Cardiovascular Disease Care Performance

Multiple clinical care measures focus on prevention and optimal care to reduce progression of cardiovascular disease. Attention to obesity and tobacco cessation across the population is critical in decreasing known risk for development of the disease. Intervention for patients diagnosed with cardiovascular disease reduces progression and complications. The American Heart Association and American Stroke Association identified seven key health factors and behaviors increasing risk for heart attack and stroke. These key health factors include: smoking, physical activity, healthy diet, overweight/obesity, cholesterol, high blood pressure, and blood sugar/Diabetes. JHN measures are designed to impact these key risk factors in cardiovascular disease.

Excessive weight significantly increases the risk for cardiovascular disease. Obesity is prevalent in Jackson County with over 40% of the adult residents identified as obese – higher than the state (30.2%) and nation (34.9%). Over 95% of all patients seen by JHN providers were screened in 2015 for being overweight or obese allowing providers to actively engage patients in discussions of the impact of weight on risk for heart attack and stroke. Efforts in 2016 are focused on continued counseling on the importance of regular physical activity and good nutrition in decreasing this risk.

Management of patients diagnosed with cardiovascular disease improved for all components of care in 2015. Approximately 155 patients were at decreased risk for heart attack and stroke due to optimal management of this disease. Since the JHN program began, assurance of the use of aspirin or antiplatelet in prevention of heart attacks and strokes has increased significantly. This one factor is identified in research as being the most significant factor in prevention of these life altering events.

Patients with cardiovascular disease often have associated diabetes, hypertension, kidney disease, and potentially heart failure. Angiotensin converting enzyme (ACE) inhibitors or angiotension receptor blockers (ARB) medications reduce risk and improve survival from heart attacks, slow the progress of kidney disease and prevent continued weakening of the heart. Statin medications lower cholesterol and reduce the risk of blockage of arteries. By increasing the number of patients receiving these medications, JHN providers are saving lives.

Preventive Care Performance

The JHN CI Program demonstrated improvement in multiple preventive measures related to the health of our elderly population. Conversations regarding advanced planning for patients over the age of 55 years provide people with information to take control of their care in the event of a medical crisis. These measures, in addition to the improvement in disease management, provide an opportunity for enhanced quality of life for this population.

Depression decreases physical functioning, ability to work and interact with others, and compliance with medical treatment. In the elderly, literature associates depression with significantly poorer quality of life. A 21% increase since 2012 in annual screening for depression allowed for early identification and intervention in nearly 17,000 additional patients in 2015. Increased attention to a continuum of services for patients diagnosed with depression is being undertaken in 2016 with the goal of continued improvement in identification and development of treatment protocols from primary to behavioral health care and back.

Nationally, pneumonia leads to hospitalization of an estimated 440,000 seniors leading to 22,000 deaths annually. Vaccinations decrease risk of developing pneumonia by approximately 70%. Vaccination rates in JHN have increased 12% since 2012 allowing over 2,000 people to avoid pneumonia, which results in lives saved.

High smoking rates in the Jackson community contribute to a high incidence of lung disease, heart attacks and strokes. Ongoing education regarding the negative effects of smoking on the lungs and cardiovascular system is important for finding the “right moment” for the message to impact. Nearly half of the 20,000 smokers in the Jackson Health Network received information from their physician during 2015.

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Use of Aspirin or Antiplatelet Medications in CVD Patients

<table>
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<tr>
<th>Year</th>
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<tr>
<td>2014</td>
<td>65%</td>
<td>64%</td>
</tr>
<tr>
<td>2015</td>
<td>65%</td>
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Percentage of Patients on Important CVD Medications

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<tr>
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<td>63%</td>
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Rate of Depression Screening

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<th>Year</th>
<th>State</th>
<th>JHN (4H5)</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
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<tr>
<td>2013</td>
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<td>24%</td>
</tr>
<tr>
<td>2014</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td>2015</td>
<td>25%</td>
<td>24%</td>
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</table>

Rate of Pneumococcal Vaccine

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<tr>
<th>Year</th>
<th>State</th>
<th>JHN (4H5)</th>
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<tbody>
<tr>
<td>2012</td>
<td>65%</td>
<td>64%</td>
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<tr>
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<tr>
<td>2014</td>
<td>65%</td>
<td>64%</td>
</tr>
<tr>
<td>2015</td>
<td>65%</td>
<td>64%</td>
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Rate of Tobacco Cessation Counseling

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<thead>
<tr>
<th>Year</th>
<th>State</th>
<th>JHN (4H5)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>48%</td>
</tr>
<tr>
<td>2013</td>
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<td>48%</td>
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5. [Source](http://www.cdc.gov/immunization/hcp/coverage/default.htm) Vaccination rates in JHN have increased 12% since 2012 allowing over 2,000 people to avoid pneumonia, which results in lives saved.
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Community Collaboration

Health Improvement Organization (HIO)
HIO is a collaboration of community stakeholders committed to improving the health status of the community through an integrated health improvement infrastructure that addresses Jackson’s priority health issues. HIO membership spans more than 50 local health providers, non-profits, governmental entities, social service agencies, businesses, and community members. Partnership between the HIO and Jackson Health Network is critical to advancing the HIO’s goals relating to obesity reduction, reduction in tobacco use, improved behavioral health, maternal and child health, teen-pregnancy prevention, and substance abuse prevention. Prior to JHN’s participation in HIO Health Action Teams, dialogue around community-clinical linkages was limited to individual providers able to sit at the table. JHN’s presence allows the HIO to discuss and drive change at the systems level.

Public Health Integration
A Health Officer, shared between the Jackson County Health Department, Henry Ford Allegiance Health and Jackson Health Network, adds great value to our community health improvement efforts by facilitating further integration of health care and public health services.

Health integration activities include:
- Patient and practice resource data base
- Monthly health awareness topics
- Immunization action coalition
- Mutual staff training and orientation
- Health services access coalition to discuss service gaps and stakeholder engagement
- State health innovation model planning for development of a new model of care coordination
- Public health service integration

“The role of JHN at the health action team level is crucial in our ability to make continued progress in our action plans. In addition to enhanced coordination with providers, JHN also has access to population health data. Access to data is critical to the action teams assisting to identify areas of need as well as measuring our progress.”

— Sara Benedetto
Vice President and Chief Operating Officer, Center for Family Health
Team Leader, Maternal and Child Health Action Team

Our Community
Care Coordination

The goal of Care Coordination is to keep the healthy well, and to prevent any further complications for more complex populations. The belief is to treat the whole person, not only the disease. Patients are connected to a variety of community resources that assist in meeting individual medical, mental health, physical and social needs. This model of care provides help to patients at any stage of health.

The Care Coordination team is made up of many disciplines including registered nurses, licensed master’s social workers, licensed professional counselors, registered dieticians, pharmacists, and individuals with a concentration in exercise science. Care Coordination specializes in providing services beyond the typical medical services. Management of a disease happens outside the doctor’s office by the patient at home. Care Coordination links the patient at home with the doctor’s office by providing ongoing health coaching in between office visits, coordination of care with specialty providers or community resources, smooth transition out of the hospital, and personalized medication management. These services benefit the patient as a whole and address any factor preventing wellness.

For most of 2015, the major population served by the Care Coordination team came from those members in the Henry Ford Allegiance It’s Your Life program, plus employees of 14 different local businesses who purchased the It’s Your Life product. It’s Your Life is a leader in building comprehensive and personalized health management programs that make a difference. The initial focus of the program was on high risk (patients with multiple co-morbidities and health needs) and low risk (patients with very few health needs) populations totaling approximately 3,875 patients. On average, 171 members (or 4.4%) in the care coordination component of It’s Your Life were considered high risk. Typical risk stratification shows that 3-5% of the population is considered high risk, 15-20% has a rising risk, and the remainder is low risk and managed through health strategies, such as health coaching and preventative services. A long-term goal is to lower a patient’s risk status through the various interventions in Care Coordination.

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The Care Management team works diligently with the patient and their family to address all of their care needs, in order to achieve the most positive outcome. The collaboration and coordination across the care continuum is exemplary!" – Melissa McKinnon, Clinical Program Specialist II, Priority Health

Collaborative Efforts
“I think it’s been a positive experience having Gail in the office. We have many patients who can use the help of a Care Coordinator regarding anything from medication usage to following up on behavioral therapy. I think as a Patient Centered Medical Home, comprehensive care is definitely beneficial for the patient.” — Matt Rosenberg, M.D. Mid-Michigan Health Centers

“Having Gail, our Care Coordinator, physically in our office, has been a wonderful addition for our patients and our team. We are able to get direct communication from Gail about concerns she sees in our patients and we can talk with her about issues that she might be able to help our patients resolve. Our patients feel comfortable talking with Gail not only because of her skills and personality but also because they are able to do so in a familiar and comfortable place for them — our office! I wish we could use this program for all of our patients.” — Lisa K. Million, MD Springcrest Family Physicians

“Having a Care Coordinator available makes me feel more confident that my patients have the opportunity to gain access to the mental health resources they need. The Care Coordinator is able to clarify what resources are available and what they may mean to patients. It helps our patients feel comfortable to speak with someone who is part of the practice with whom they are already familiar. I believe this directs patients to the most appropriate resources and allows for more efficient use of mental health resources.” — Natalie Frisch Welch, MD Henry Ford Allegiance Family Medicine - North Street

Journey of Care Coordination

2001: It’s Your Life health management program started with hospital employees and spouses.
2002: JHN formed as a legal entity.
2003: Agreement in place with Priority Health to pilot JHN Care Coordination for hospital employees and spouses. JHN was expanded to all practices.
2004: JHN Care Coordination program aligned with the It’s Your Life health management program.
2005: JHN Care Coordination program purchased by MACI (local manufacturing company with >1200 employees).
2006: Agreement in place with Priority Health to pilot JHN Care Coordination for hospital employees and spouses. JHN was expanded to all practices.
2007: Agreement was in place to fully delegate JHN Care Coordination program to all persons insured through Priority Health.
2008: Pharmacist was hired and integrated into the medical home model to oversee medication and disease management.
2009: Transition Coordination program (discharge to 30 days post) was initiated to focus on reducing readmissions for patients from all payers.
2010: Targets achieved for Priority Health — Care Coordination work continues.
2011: Partnership established with HFA Behavioral Health and JHN to pilot having a Care Coordinator in a specialty practice to increase access to behavioral health services.
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2016: JHN Care Coordination program aligned with the It’s Your Life health management program.
2017: JHN and It’s Your Life leadership aligned to better deliver shared goals.

It’s Your Life health management program started with hospital employees and spouses.

JHN formed as a legal entity.

JHN Care Coordination program commenced with a focus on behavioral health and primary care integration. JHN was established in four practices.

JHN Care Coordination program purchased by MACI (local manufacturing company with >1200 employees).

Transition Coordination program (discharge to 30 days post) was initiated to focus on reducing readmissions for patients from all payers.

JHN and It’s Your Life leadership aligned to better deliver shared goals.

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Value Initiatives

Payer Benefits
JHN partners with payors on several value-based initiatives to benefit providers and patients, including:
• Improve quality of care, patient satisfaction, and decrease overall cost of care per member per month
• Decrease patient readmits by improving primary care physician follow-ups within 7 days of discharge
• All payor, all patient registry utilized for population health management for primary care physicians and specialists
• Monthly rounding with a JHN service representative to review payor quality programs and initiatives and assist in development of practice specific tailored action plans
• Improve patient access through marketing new service lines
• Improve patient outcomes through the initiatives we are pursuing. In 2015, Jackson Health Network actively participated in a pharmacy and behavioral health initiative.

Pharmacy Initiative
Given the complexity of medication regimens and potential adverse events, having clinical pharmacists with expertise in medication management as part of the integrated care team is critical. With clinical pharmacists reviewing all medications including prescriptions, over the counter, vitamins and supplements, they ensure efficacy, safety, and cost effective therapy, as part of standard care. Patients needing better disease control, ongoing medication management and adherence counseling, are identified by the pharmacists and treated more efficiently. The pharmacist acts as a transformation champion who understands operational and structural challenges, and who will provide the expertise needed to build an alternative care delivery model.

Behavioral Health Initiative
The severity, frequency and cost implications of mental health conditions cannot be ignored as a component of overall population management. There are a number of influences that prevent patients from receiving the care they need. To ensure patients receive fully coordinated care and to reduce preventable spending, JHN is working to improve communication and care coordination between providers in both co-located multidisciplinary and independent settings.
In an effort to improve access to behavioral health services in the Jackson community, JHN has been working with behavioral health providers and primary care physicians to overcome the burden of mental illness in the community by implementing and evaluating screening tools, providing proper education to primary care physicians, and opening the door to better collaboration between the primary care physicians and behavioral health providers.
JHN incorporated this initiative into its 2015 Clinical Integration Program. JHN is active in ongoing learning collaboratives, working with JHN and the community to successfully carry out changes in behavioral health and primary care integration.
Three behavioral health diagnoses are identified and monitored in the Clinical Performance Reporting System as a part of the Behavioral Health Initiative. Of the nearly 110,000 active patients in the JHN network, nearly 20% have been diagnosed with behavioral health concerns and even more are unknown.

Pharmacist Transforming Care and Quality (MPTCQ) pharmacy initiative, has allowed pharmacists to lend expertise through additional patient interactions, helping patients to decrease medication costs, minimize medication side effects, and overcome other medication-related compliance barriers so that patients can better manage their own health.”

— Nicole Gargano
PharmD, JHN Clinically Embedded Pharmacist

“Having JHN at the Behavioral Health Action Team has been extremely valuable as they offer guidance on how engaging doctors in the treatment of individuals experiencing a mental illness may produce a greater chance of recovery for the patient. Because of their involvement, we collected invaluable data on doctors’ perceptions of behavioral health services, allowing us to target strategies for greater impact.”

— Elizabeth Knoblauch
Director of Strategic Relations
LifeWays Community Mental Health Team Leader, Behavioral Health Action Team
KATE has a history of morbid obesity, severe arthritis, ankle fusion, bilateral rotator cuff repair and joint pain. Socially, she is on disability, has minimal family support and limited income. Her home is rented, which means that there is no allowance for safety modifications. The patient noticed that she was having multiple falls, and that these had increased over the past few weeks. Kate is at home by herself during the day as her spouse works. She was recently placed on a Phentanyl patch for pain. In addition, the Care Coordinator reviewed the case with our pharmacist who happens to be working with the Kate’s primary care provider. The pharmacist reviewed the medications and made recommendations that could result in fewer falls. This multidisciplinary team worked together to further act on the plan of care. The Care Coordinator assisted the patient with a Medicaid application and she was approved. She is now able to receive additional Region II services.

GEORGE was referred to Care Coordination due to frequent hospital readmissions. Several factors contributed to this, including poor cognition of complex facets of care, poor attendance at physician appointments due to transportation issues and poor family support. The collaborating care team included his primary care provider, a Care Coordinator, a pharmacist for medication management, a social worker, and home care and community resources. Getting to the root of the problem, George, who had a history of being admitted up to two times each month, has achieved successful follow-up with his primary care provider and has been out of the hospital for several months.

ERICA is inspired by many different things. As a two-year It’s Your Life (IYL) participant, she was especially inspired by her younger brother who was diagnosed with testicular cancer. Erica lost 40 pounds the first year in IYL and has since maintained it with continued weight training and running. She has also changed her diet and uses a fitness application on her phone to help keep her on track. Erica never used to run, but she reached her goal of ten 5K and 5-mile races and a Tough Mudder event, accompanied by her husband and siblings. Erica is now training to obtain a Spartan Trifecta.
Launching the pilot regions this summer will help us affect payment reform and lower costs for our residents. Through the pilots, the Michigan Department of Health and Human Services will work with the healthcare community to find the best ways to implement changes going forward.

— Tim Becker
Chief Deputy Director of the Michigan Department of Health and Human Services

The Future of Care in Jackson

Similar to what the banking or airline industries have already experienced, health care is undergoing a transformation. This transformation will improve how and where we access care, increase the focus on prevention and chronic disease management, integrate community services into health management, and elevate the way patients experience the health care delivery system. This change requires a fundamental change in how we pay for health care services to ensure appropriate alignment of efforts. This is no small task. However, JHN is committed to this course and is working with our care providers and payer partners to transition to this healthier new world.

JHN was one of the founding health organizations to assist in the development of the Affirmant Health Partners, a new state-wide clinically integrated network currently comprised of seven large high-quality Michigan-based health systems, along with their providers. Together, we are striving to identify and implement best practices, reduce variation, improve outcomes and lower per capita cost of care. We are excited to be a part of this endeavor and look forward to the opportunity to accelerate our work through this organization.

Our local health system has also joined forces with the Henry Ford Health System. We are actively working to identify opportunities to implement advance care models currently used by the system into the Jackson market. We are also coordinating with their clinically integrated network, Henry Ford Physician Network, to share other programs and learnings.

In 2016, the State of Michigan announced that Jackson was selected as a pilot site for the State Innovation Model (SIM). JHN and the HIO are joining together through this grant to introduce innovations over the coming years that support our transformational efforts, with the design to be spread across Michigan.

By focusing on our commitment to consistently improve health outcomes, improve how patients experience care and lower per capita cost of care, JHN will continue to push the evolution of the health care delivery system in Jackson. We are excited to be leading the change and look forward to working with the community in the coming years.
### Health System
Henry Ford Allegiance Health

### Primary Care
Family Practice
Rolando Beredo, MD, PLLC
Cedar Street Family Medicine
Center for Family Health
Cheryl Colletti, DO, PLLC
Columbia Medical Center
Grass Lake Medical Center
Henry Ford Allegiance Family Medicine
Robert Israel, MD
Donald Jones, MD, PC
Brad Kremer, MD, PLLC
Mid-Michigan Health Centers
David Munro, MD, PC
Lorna Pinson, MD, PLLC
Rose City Family Practice, PC
Springset Family Physicians, PC

### Specialty Care
Allergy & Immunology
Asthma Allergy Centers of Southwest Michigan

### Anesthesiology
Anesthesiology Associates

### Cardiology
Harish Jani, MD, PC
Henry Ford Allegiance Cardiology
Jackson Cardiology Associates, PA
Moses Munuza Jr., MD, PC

### Cardiovascular Surgery
University of Michigan Services

### Dermatology
Henry Ford Allegiance Dermatology
Walter Korytkowski, MD, PC

### Emergency Medicine
Henry Ford Allegiance Emergency Care

### Endocrinology
Ali Orandi, MD
Henry Ford Allegiance Endocrinology
David Halaby, MD

### Gastroenterology
Henry Ford Allegiance Gastroenterology
Mid-Michigan Gastroenterology Consultants
Nadeem Ulah, MD, LLC

### Geriatrics
Henry Ford Allegiance Senior Health Center

### Hematology / Oncology
Henry Ford Allegiance Hematology/Oncology

### Hospitals - General, OB, Pediatric
Henry Ford Allegiance Hospitalist Services
Independent Hospitalist Physicians
OB Hospitalist Group

### Infectious Disease
Donna O'Neill, MD, PC

### Neurology
Umesh Verma, MD

### Neurosurgery
Henry Ford Allegiance Neurosurgery

### Obstetrics / Gynecology
Center for Family Health Obstetrics
Gary Farhat, MD
Garland Scott, MD
Arthur Yende, MD, PC
Women First Health Services

### Occupational Medicine
Henry Ford Allegiance Occupational Health

### Orthopedic Surgery
Henry Ford Allegiance Orthopedics
Paul Kenyon, MD, PC
Allan Tompkins, MD, PC

### Otolaryngology
Henry Ford Allegiance Ear, Nose & Throat

### Pathology
Henry Ford Allegiance Pathology

### Physical Medicine & Rehabilitation
Henry Ford Allegiance Physical Medicine & Rehabilitation

### Plastic Surgery
Henry Ford Allegiance Plastic Surgery

### Psychiatry & Psychology
Henry Ford Allegiance Behavioral Health Services

### Pulmonary
Pulmonary Clinics of Southern Michigan, PC

### Radiology
Jackson Radiology Consultants

### Rheumatology
Henry Ford Allegiance Rheumatology

### Surgery
Henry Ford Allegiance General Surgery
Henry Ford Allegiance Trauma Surgery, SICU
Acute Care Clinic
Henry Ford Allegiance Thoracic Surgery
Henry Ford Allegiance Vascular Health

### Urology
Cascades Urology
Prison Urology

### Wound Care
Henry Ford Allegiance Wound Care & Hyperbaric Center
Jackson Health Network was envisioned and created by a hard-working group of people within the health care system and the community. We wish to express our deepest gratitude for all their efforts to develop the network, and for their ongoing work as we continue to expand and advance.

Thank You to Our Leaders

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