Jackson Health Network

2019 VALUE REPORT

Jackson Health Network
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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.

This work is well underway, and since 2010, the Jackson Health Network has evolved into a model for clinical integration. As a network, we strive to achieve the Quadruple Aim – better quality, lower cost, improved patient experience and improved provider satisfaction. We understand that this objective is not a destination, but a journey, and that our shared success relies upon how well we can work together.

Today, JHN represents over 600 providers caring for more than 120,000 aligned lives in the greater Jackson community. I am immensely proud of the work put forth by our medical community, and appreciate the countless hours contributed by physicians on our board and various committees. This engagement, over years, is the foundation of our success. In pursuit of better value for our patients, we are measurably improving the health of our community, more efficiently using constrained resources, and favorably impacting both quality and cost of care. The continued challenge is to aim high, push forward and achieve year over year improvement.

Teamwork is a theme reflected in many of the new initiatives and successes from 2018. For the first time, we convened collaborative meetings of practice managers from both primary care and specialty practices. These gatherings generated productive dialogue and insights to help better direct our programs and efforts. We piloted new contracts with several local employers who will share financial risk, helping to lay the groundwork for a future focused on value-based reimbursement. Finally, as members of the Affirmant Federation ACO, we reduced costs for our Medicare patients. This success, in turn, led to substantial shared savings for physicians in our network.

In addition to our performance as a network, this report highlights essential partnerships with our local Health Improvement Organization (HIO) and the Jackson County Health Department. These organizations help target critical social determinants that influence both individual and community health. We recognize these areas as increasingly important to the overall well-being of our patients.

Stepping into this new role this year, I am honored and deeply thankful for the opportunity to serve and will strive to maintain the high standard set by Dr. King, who is now retired. As President and CEO, I will do my best to listen, engage and support our providers in this important work. The pace of change in health care will only accelerate with time. Our ability to navigate this change relies upon our strength as a network, and I challenge each of us to renew our commitment to working together.

Sincerely,

Courtland Keteyian, MD, MBA, MPH
President/CEO, Jackson Health Network
Vice President, Population Health, Henry Ford Allegiance Health
Medical Director, Occupational Health, Henry Ford Allegiance Health

Letter from the Chairman

Welcome! Jackson Health Network is proud to present its 2019 Value Report highlighting achievements in 2018.

In 2018 we marked the completion of another year working with local physicians and Henry Ford Allegiance Health to achieve the Quadruple Aim. JHN continued to advance work on key health objectives in our community as expressed by employers, individuals, physicians and the health system. We are excited that our programs are paying dividends and eager to undertake the future work.

All evidence points toward a significant transformation in the health care industry that will impact both delivery and financing of services. We believe the result of this overhaul will be better care and improved outcomes for our patients.

As we move forward, we are excited to welcome Courtland Keteyian, MD, as our new JHN President and CEO, transitioning from Ray King, MD. We are grateful to Dr. King for his transformative vision and leadership which were instrumental in the creation of this network.

We are committed to annually publishing the results of our efforts so that you can hold us accountable. In the interim, I encourage you to reach out to Dr. Keteyian, or our administrative team led by Dr. Amy Schultz, Executive Director for JHN, should you have any questions concerning our program or its results.

Sincerely,

David Halsey, MD

Chairman of the Board, Jackson Health Network

Practice Owner, Internal Medicine/Endocrinology

Celebrating the Retirement of Ray King, MD

First & Former President, 2010 - June 2019, Jackson Health Network

With a passion for community health, Dr. King was a driving force in the development of the Population Health strategy and structure, including both the Health Improvement Organization and Jackson Health Network. A lifelong Jackson resident, Dr. King was a member of the Henry Ford Allegiance Health medical staff and a family medicine practitioner in the community since 1984. That same year, he founded what would become Henry Ford Allegiance Family Medicine – Townsend.

Dr. King can still be seen at Jackson Health Network a few times a month as he continues to do what he loves and works with the team on several projects. But more importantly, Dr. King is fully enjoying his retirement. He and his wife recently moved to western Michigan to be closer to their children and grandchildren.

Dr. King has our deepest gratitude. His special connection to this community, and his investment of time, energy and effort to improve the health of the people of Jackson leaves a remarkable legacy.

We wish Dr. King good health and happiness for his well-deserved retirement.

Introduction

Jackson Health Network (JHN) is a physician-led Clinically Integrated Network (CIN) designed to continuously improve health outcomes of the population served, reduce overall health expenditures, and create efficiencies through enhanced collaboration between health care professionals, the hospital system, physicians and community leaders. The Board of Directors and all committees are physician led. Representation on the Board is equally shared by employed and independent physicians. JHN is excited to be tackling the challenge of reforming health care delivery in Jackson, Michigan. We are pleased to present the work we accomplished in 2018 and show you improving results.

Population health is the foundational approach used by JHN to measure health outcomes in the Jackson Community. A healthy population will help lead the resurgence of our region, with others wanting to come and enjoy the benefits of a healthy community. We pledge our best efforts and encourage all people to reflect on their own wellness and commit to becoming more engaged in their own health.

The Jackson Health Network Vision

We, the Participants of the 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.

Health Care Transformation

This is a challenging time to practice medicine. Health care transformation is proving to have a significant impact on virtually every aspect of medicine from accessing health care to reimbursement. Demands for quality and safety outcomes continue to rise. Even the way patients choose their physician has changed.

Our challenge is driven by ongoing concerns regarding the cost and quality of health care. According to the Kaiser Family Foundation, we are approaching a point at which health care will account for 20 percent of the gross domestic product. This is unsustainable. In addition to mounting costs, our nation's mediocre quality outcomes, which have been substantiated by multiple sources, cannot be ignored. Major players outside of health care are seeing opportunities and feeling the need to disrupt how care is currently provided. We can no longer sidestep issues, such as the over utilization of services and inefficient health care delivery processes, that lead to high levels of waste. Nor can we continue to miss opportunities to provide the right care, in the right place, at the right time, for the right cost.

We need to determine how to improve overall health for our community and nation without breaking the bank or overburdening health care providers. We need to implement new tools and improved information technologies, introduce new legal structures, and align health care payment models to support a transformed health care delivery model.

The four areas the Network continues to improve and evolve year after year are:

- **Personalization**. The patient experience must be tailored more closely to the needs of individuals. JHN primary care and specialty care practice practices are dedicated patient centered medical homes (PCMH). Since 2009, the practices have worked to achieve and maintain PCMH designation status under the Blue Cross Blue Shield of Michigan program.
- **Access.** The continuum of care needs to be improved to allow consumers access when and where they need it. Avoiding unnecessary emergency and hospital utilization are primary components to reducing high costs. Across the Network, practices have added after-hours and weekend appointments to provide additional access points of care in the community, when primary care offices are closed.
- **Incentives.** Well-designed incentives hold promise of motivating providers to make better choices. JHN's clinical integration program and value-based contracts with health plans promote and reward high quality and cost-efficient care.
- **Innovation.** New product concepts must be carefully designed to meet the needs and wants of patients. In 2018, the community, including Henry Ford Allegiance Health, ambulatory primary and specialty care practices, and the county health department, moved to the Epic electronic medical record. With Epic being used across most access points, patients' medical histories are available at point of care. Epic also offers multiple innovative options for patients to connect with their providers when they need them, such as MyChart and e-Visits.

The Network is continuously identifying innovative ways to enhance health care in our community, from the development of an all payor, all patient registry that is used by physicians and across the network, to working with health plans to support and adopt JHN's Clinical Integration (CI) program as their own pay-for-performance program in our community. This will help support the long-term viability of both independent and Henry Ford Allegiance employed practices and physicians. We hope that you will take the time to read the 2019 Value Report and learn more about the amazing work happening in this community.

JHN By The Numbers

622 Credentialed members

60% Henry Ford Allegiance Medical Group

40% Private Practice providers

123 Primary Care Providers

499 Specialty Care Providers

45 Clinical Specialties / Attribution Bundles

9 Committees comprised of 60 providers and community members

1 Hospital System
Henry Ford Allegiance Health

1 Health Improvement Organization
HIO

1 Electronic Health Record
Epic

77% utilize Epic as primary EHR

10% utilize JHN Gateway to document clinical data into Epic

1 Population Health Registry
JHN Compass

93% utilize at point of care and to manage clinical quality outcomes

120,000+ Active patients in our primary care network and managed in the JHN Compass

1 Clinical Integration (CI) Program
58 total metrics

28 Preventive and Chronic Disease

7 Continuum of Care

13 Efficiency and Utilization

4 Patient Experience

6 Training and Citizenship

56 Employees

23 Care coordinators, health coaches, transition coordinators, behavioral health liaison, diabetes and nutrition educators

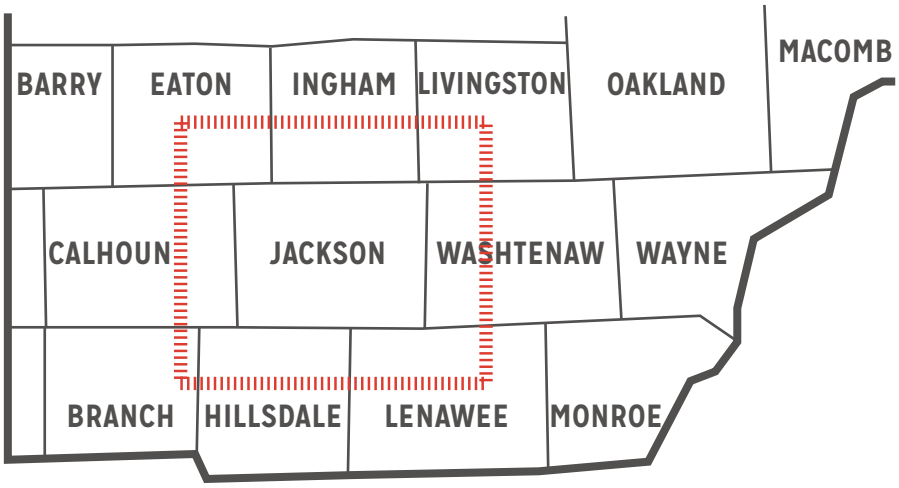
9 Clinical performance and provider support staff

24 Leadership and other support staff

JHN Service Network

The range of services provided by JHN providers encompasses 45 different specialty types spread across eight counties surrounding Jackson, Michigan.

Counties include: Jackson, Ingham, Calhoun, Hillsdale, Lenawee, Eaton, Livingston, Washtenaw



Specialties types:

Primary Care:

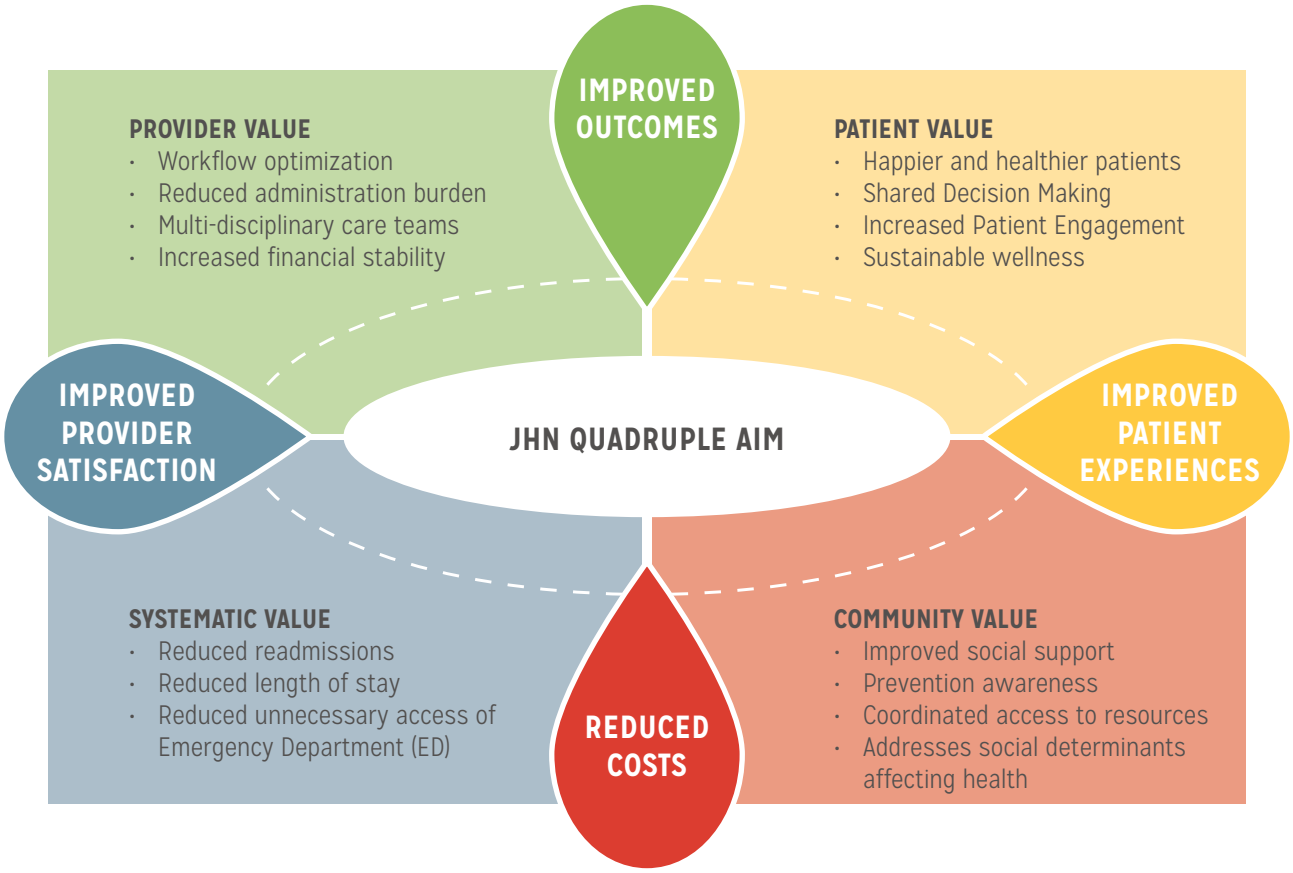
Family Medicine
Internal Medicine
Pediatrics

Specialty Care:

Allergy & Immunology
Anesthesiology
Audiology
Behavioral Health
Cardiology
Cosmetic & Reconstructive Plastic Surgery
Dermatology
Emergency Medicine
Endocrinology
Gastroenterology
General Surgery
Geriatrics
Hyperbaric Medicine
Hematology & Oncology
Hospitalists - Adult Specialist
Hospitalists - General
Hospitalists - Pediatrics
Hospitalists OB
Infectious Disease
Midwifery Services
Nephrology
Neurology
Neurosurgery
Obstetrics/Gynecology
Occupational Medicine
Ophthalmology
Optometry
Oral/Maxillofacial Surgery
Orthopedic Surgery
Otolaryngology
Pain Management
Pathology
Physical Medicine & Rehabilitation
Podiatry
Pulmonary Medicine
Radiology
Rheumatology
Thoracic Surgery
Trauma Surgery
Urology
Wound Care
Vascular Surgery

Quadruple Aim

In 2017, the JHN Board approved the evolution of our guiding principle from the Triple Aim - enhancing patient experience, improving population health, and reducing costs, to the Quadruple Aim, which adds a fourth goal to reduce provider burnout and improve their satisfaction. The Network addresses each aim through a variety of strategies. These strategies are influenced by JHN's community partners, initiatives JHN is involved in at the State and Government level, feedback from our Members, and guidance from the JHN Board of Directors. As you read the next sections of this report, you will learn about several of the strategies used by the Network to address the goals of the Quadruple Aim in 2018



Improved Outcomes

Affirmant

In April 2015, JHN formally began collaborating with Affirmant Health Partners, the state-wide Clinically Integrated Network. Affirmant Health Partners is a collaboration of 6-leading health systems:

- Bronson Healthcare
- Covenant Healthcare
- Henry Ford Health System
- Spectrum Health Lakeland
- MidMichigan Health
- Sparrow Health System

Together, thousands of physicians from around the state work in partnership to promote best practices and programs that will have an impact on reducing the cost of health care and improving the health of Michigan residents. The partnership aims to collaborate with patients, colleagues and community partners to consistently improve the quality and cost-effectiveness of health care.

In January 2019, JHN was presented with an opportunity to be involved in the Care Management Workgroup through Affirmant.

Goals of this workgroup include:

- Use best practices from Affirmant's local chapters to establish a standardized approach to care management.
- Establish an implementation plan to help each local chapter further accelerate its care management efforts and initiatives.
- Embed principles of safety culture and process improvement to support end user success.

- Use evidence-based, best practices to establish a standardized and optimized approach to care management performance.
- In collaboration with the Evidence-based Best Practice subcommittee, develop a monitoring and evaluation process for data sharing.
- Access applicable technologies for usability to accomplish initiatives.

To date, we have been able to create standard Care Management competencies and have agreed upon outcome and process measures. We continue to move toward the development of a standardized and optimal approach to our Care Management Programs.

Jackson Community Medical Record (JCMR) Affiliation

The need for a single medical record was one of the first tools identified as a high priority among physicians and leaders in Jackson, Michigan. Local physicians, with the support of Henry Ford Allegiance Health, created Jackson Community Medical Record (JCMR), an independent entity, to build, support and manage Jackson's Community Electronic Health Record (EHR). Now, all hospital-owned ambulatory care clinics, many privately owned clinics, the local federally qualified health clinic and the health departments are utilizing the same instance of Epic.

With the implementation of Epic in the Jackson community, and in partnership with JCMR and Henry Ford Allegiance Health, JHN providers have the tools necessary to support population health, health care operations and how patients experience care.

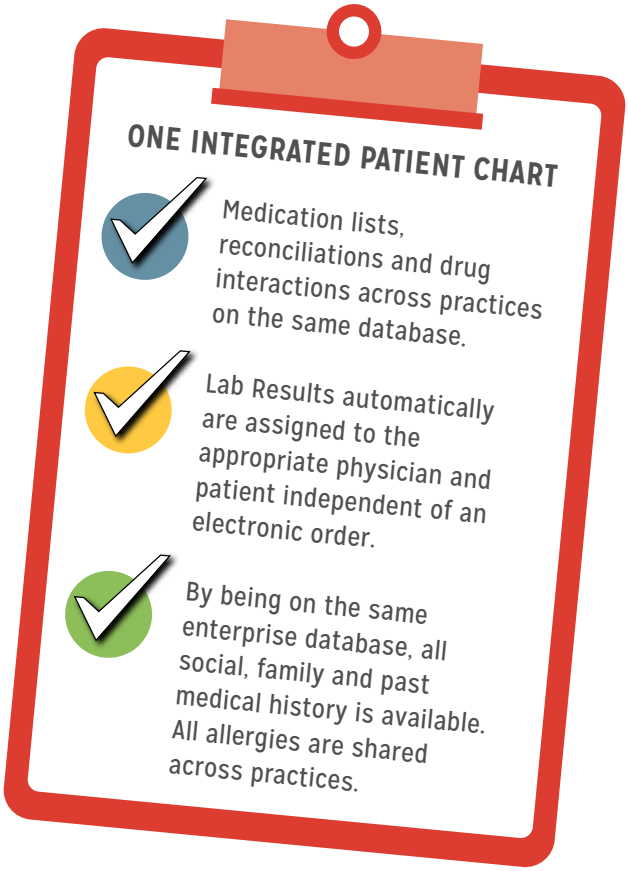
Epic is a foundation of clinical support for providers.

Current State

- Comprehensive clinical record available to provider at point of care
- Comprehensive record to prospectively identify patients with gaps in care
- Data from all Network providers included – Core, Community Connect and others through a gateway data entry portal
- Succinct information included from non-network providers integrated into record
- Focused effort to reduce provider "burden" to capture/maintain record (physician burnout)
- Social determinants of health data
- Health risk assessment data, immunization data and other data sets

Future State

- Integration of medical and pharmacy claim information
- AI-identification of best practice treatments and outcomes/risk



Health Improvement Organization

The Health Improvement Organization (HIO) community collaborative was founded in 2000 based on the shared understanding that in order to achieve long-term impact on health outcomes, improvements must extend beyond acute medical care to affect the social, economic and environmental determinants of health. The HIO Coordinating Council was established as a multi-disciplinary team of stakeholders responsible for assessment of community health status, identification of priorities, oversight of development and implementation of a Community Health Improvement Action Plan and evaluation of progress toward established goals.

Over the past several years, Jackson's collaborative improvement efforts have expanded in scope to include the Cradle to Career (C2C) education initiative and the Financial Stability Network (FSN). These new network entities were developed with cross-sector integration in mind. Activities targeted toward reducing disparities in health, educational attainment and poverty reduction are collectively leveraged toward population-level improvements across outcome areas.

These networks are comprised of 550 members representing 148 local agencies. Members are united by a commitment to shared values of Equity, Authentic Engagement, and Continuous Learning. This work is guided by community assessment efforts that data members utilize to identify, prioritize and address common root causes of disparities with an emphasis on creating sustainable change, ultimately resulting in improved outcomes for residents. Members are actively involved in either the governance structure or action teams, and/or they champion strategies within community action plans addressing health improvement, educational attainment and financial stability in Jackson County.

JHN's participation in the HIO enables the networks to align improvement in the clinical and community systems to impact shared goals for improved health.

Jackson County Health Department

The mission of the Jackson County Health Department (JCHD) is to create and promote a healthy community through disease prevention and control. JHN leadership recognized the value of collaboration with JCHD to address community health needs of Jackson. To ensure strong and continued collaboration exists, JHN's medical director position also serves as medical director of the JCHD. In addition, a health officer is shared between the Jackson County Health Department, Henry Ford Allegiance Health and Jackson Health Network. This adds great value to our community health improvement efforts by facilitating further integration of health care and public health services. Lastly, to ensure true transitions of care and efficient collaboration, the JCHD is fully operational on the community EHR, Epic. Epic is used within their clinic to document treatments, coordinate and make referrals within JHN.

Public health impacts the quality of life in our community and works to protect a shared population. When public health fails, the population may suffer – making close collaboration a vital element in JHN's population management strategy.

"Our collaboration with the Jackson Health Network has assisted LifeWays with meeting our mission of inspiring hope and promoting life-enhancing recovery. The data collected through the JHN has been invaluable as we begin implementation of our 24/7 Crisis Center."

- Chad L. Surque, Director of Strategic Relations, Lifeways Community Mental Health

The JCHD utilizes JHN as an avenue to communicate important public safety and health related topics as they occur. This is completed through JHN's monthly rounding visits, email communication and presentations at practice manager collaborative meetings.

Health integration activities resulting from the JHN and JCHD partnership include:

- Education on JCHD services as well as the health concerns related to the dangers of lead exposure, vaping and sexually transmitted diseases.
- Promotion of better health for children.
- Collaboration with Community Care Linkage.
- Determination of the social determinants of health.

2018 Clinical Integration Program Results

Jackson Health Network is a collaboration between health care leaders, community leaders, physicians and Henry Ford Allegiance Health – all working together to improve patient outcomes and safety while reducing costs through an integrated system of care. By functioning as a Clinically Integrated Network (CIN), JHN works toward these goals by combining evidence-based medicine with an innovative pay-for-performance program that results in outstanding health outcomes and reduced costs.

JHN's Clinical Integration (CI) Program is the vehicle for steering health care in Jackson toward value-based care. Six areas of CI Program focus are expressed as the six bundles of the JHN Scorecard.

- **Bundle 1** – Preventive Care
- **Bundle 2** – Chronic Disease Care
- **Bundle 3** – Continuum of Care
- **Bundle 4** – Quality, Efficiency, & Utilization
- **Bundle 5** - Patient Experience
- **Bundle 6** – JHN Education & Citizenship

Bundle metrics are determined by keeping multiple factors in mind:

- **Health care landscape** - Metrics should move us from volume-to-value
- **Payor alignment** - Identify and harmonize metrics with payor incentives
- **Data validity** - Metric data should be valid and readily generated
- **Population health** - Metric denominators should be large enough to effect population health
- **Program engagement** - Scale the scorecard to a size that is digestible by the physician membership and promotes engagement of both primary care and specialty care providers

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"The collaborative partnership that Henry Ford Allegiance Health System and Jackson County Health Department have is valuable and critical to the community. Integrating public health and the health care sectors assures residents receive a continuity of care that includes prevention and promotion of healthy lifestyles."

- Rashmi Travis, MPH, CHES, Jackson County Health Officer

In 2018, CI Program efforts centered around the Compass Metrics (Bundles 1 & 2), Patient-Centered Medical Home process development (Bundle 3), and Quality, Efficiency, & Utilization (Bundle 4).

There are two functions with the Compass – Patient Compass and Practice Compass. The Patient Compass is the JHN population health management tool which seamlessly extracts data from Epic for use by practitioners at the point of care. The Practice Compass provides practice-level and individual-provider-level metric compliance reporting.

2018 was the first full year using Epic as the electronic medical record (EMR), and intensive education efforts were aimed at capturing documentation in Epic for display on the Compass.

Patient-Centered Medical Home (PCMH) and Patient-Centered Medical Home-Neighbor (PCMH-N) are health care business operations management systems used by JHN practices to improve care delivery processes which lead to better health outcomes through work flow optimization. Practice Transformation Specialists have been trained under the Blue Cross Blue Shield of Michigan (BCBSM) transformation program to assess, evaluate, educate and expand PCMH capabilities in every ambulatory clinic.

In 2018, 86 percent of primary care practices in Jackson Health Network were designated as a Patient Centered Medical Home by BCBSM. In addition, 80 percent of specialty practices adopted at least 20 new PCMH processes. Due to their engagement and progress in the program, JHN nominated these specialty practices to BCBSM for a value-based uplift in fee-for-service revenue.

With value-based reimbursement (and increasingly down-side risk on the horizon), network-wide efforts must be leveraged to control cost and utilization. In 2018, the Cost & Utilization bundle helped us steer program focus and accounted for 25 percent of the CI Program—an increase from previous years.

System level changes start with clinical leadership and can take years to fully realize. In 2018, JHN worked to strategically align resources to target care processes and re-engineer programs across the network, which will ultimately lead to value-care. Collaborative work with the hospital took place to reduce re-admissions, an area of intense focus for the hospital. Improvement is imperative for a value-based health care model. Progress will be measured by continuous improvement year-over-year.

STRATEGICALLY ALIGNED RESOURCES

Reduce re-admissions

- Transition Care Coordination with a focus on CHF, COPD, pneumonia, Total Hip/Knee and CABG
- Coordination with inpatient Nurse Educator Team
- Community Paramedic Program

Decrease in ED visits

- Adoption of Health Information Exchange (HIE) reporting including daily discharge reports
- Monthly High ED utilizer reports

Decrease total cost of care

- Integration of Care Management into Primary Care Setting
- Applying Choosing Wisely Best Practices
- High-tech Imaging Reduction Efforts

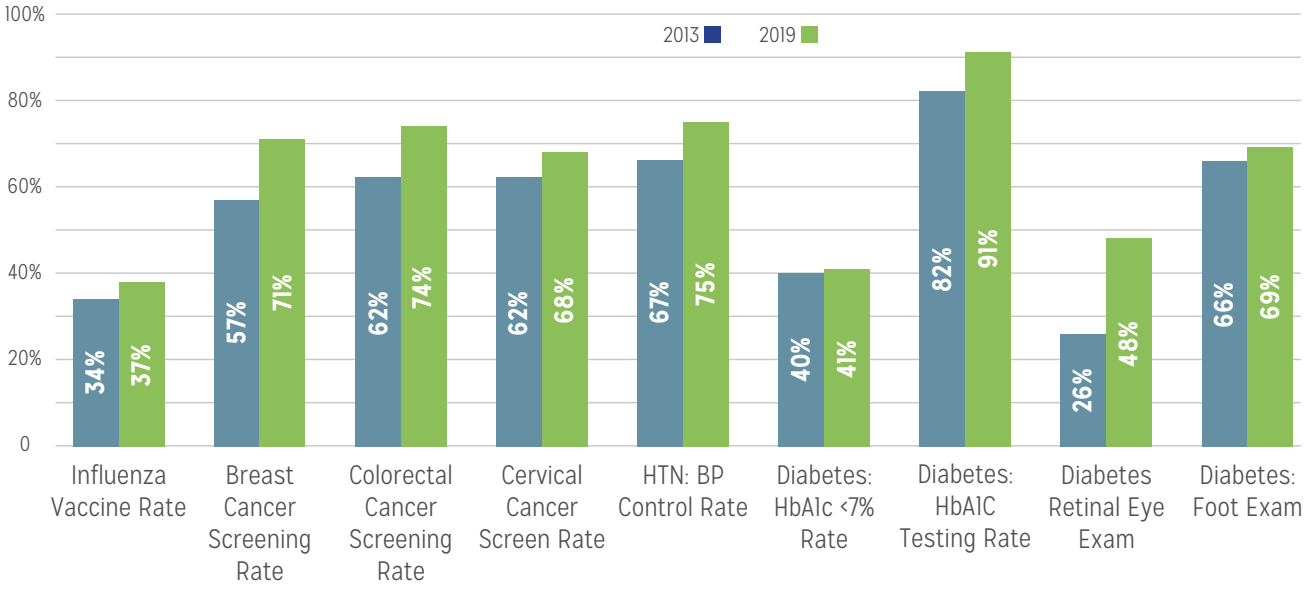
The JHN scorecard monitors CI Program performance. A threshold of 45 percent is required for individual physicians to partake in financial incentive rewards.

The network's absolute performance in terms of quality metrics continues to increase year-over-year, while JHN continues to raise the bar for quality thresholds.

When you look at individual metrics year after year, JHN is seeing improvement. Below shows the improvement in several JHN measures from 2013 to 2018.

A continuous opportunity exists to align the CI scorecard and incentive process with upside/downside accountability, especially as we move toward shared risk payor contracts. Now, more than ever, it is crucial to perform appropriate services—the right service, at the right time, at the right place, at the right cost.

PREVENTIVE AND CHRONIC DISEASE PERFORMANCE



"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 has access to population health data. Access to data is critical to the action teams, assisting them in identifying 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

Improved Patient Experiences

Patient and Family Advisory Councils

While engaging patients and family members as equal partners in health care is essential to achieving quality and safety goals, few organizations today include their input at all levels of organizational decision-making. Health systems and organizations across the nation are beginning to recognize the benefits of a patient-centered culture by leveraging the unique knowledge and opinions of their patients.

The Patient and Family Advisory Council (PFAC) goals of improving the patient experience and quality of care align with the JHN mission as a Clinically Integrated Network. Practices that formally create a structured PFAC and meet with their PFAC at least three times in a year earn a bonus point in the JHN CI Program.

Today, nearly 75 percent of JHN's primary care practices have adopted PFACs of their own. Each PFAC is unique to the practice location with the practice recruiting patients and their family members to join. Agendas are developed at the practice level based on their needs and questions, and then the information is provided to practice owners and executive leadership. Topics discussed at practice PFACs in 2018 included:

- Automated appointment reminder system and office phone systems
- Policies such as Use of Opioid Prescriptions
- Communication preferences
- Epic's MyChart patient portal
- Patient satisfaction questionnaire

Press Ganey Patient Satisfaction Survey

Patient satisfaction is both an indicator of quality of care and a component of quality care. Relationships are key in any customer service industry, particularly in health care where patient investment in the advice of a physician can improve compliance. In 2015, the JHN BOD acknowledged this by funding patient satisfaction surveying for its ambulatory care clinics through the vendor Press Ganey.

Today, any patient who receives care within the Network could potentially receive a CG-CAHPS survey asking them to provide feedback on their recent visit. The results of these surveys are tabulated and prepared by Press Ganey and then delivered to JHN members on a monthly and quarterly basis. JHN's practice transformation specialist team reviews the results with office staff and identifies areas of improvement based on patient's ratings and their comments. Evidence shows that improved patient satisfaction may decrease the incidence of malpractice cases, patient defection to other providers, and negative word-of-mouth advertising as well as increase patient referrals.

"Our PFAC group has been very helpful in improving some aspects of daily activities. Several suggestions, leading to changes have been very well received by the majority of our patients. Very helpful to have outside opinions!"

- Karen Warner, Practice Manager – David Halsey, MD, PC

Reduced Health Care Costs

Population Management

The focus of Population Management is to use data and risk stratification processes to understand characteristics of a population, identify appropriate risk-level interventions and measure the effectiveness of the work completed. An integral component of this work is facilitating coordinated care and empowering patients to be engaged in their physical, mental and social health and well-being.

The Population Management team is comprised of multiple disciplines, including RNs, LMSWs, LPCs and RDs, as well as individuals with a concentration in exercise science. Our model of care provides help to patients at any stage of health. Our goal is to keep healthy patients well while preventing any further complications for more complex populations. We believe in treating the person, not the disease. We connect people to a variety of community sources that will assist in meeting their medical, mental health, physical and social needs.

Population Management strives to:

- Motivate people to adapt and maintain healthy behaviors.
- Work with people to create achievable personal goals that align with the clinical plan of care.
- Facilitate communication between multiple providers.
- Identify and connect people with community resources.
- Provide expertise in navigating the health system.
- Address psychosocial stressors.
- Advocate to ensure that health needs are met.
- Maintain multidisciplinary collaboration to provide a comprehensive approach to care.

JHN COMPASS

JHN's population health management tool is known as The Compass. Created internally, The Compass has been used for JHN Scorecard calculation since 2015. The Compass withstood the 2017 electronic medical record (EMR) transition from NextGen to Epic. The data bridge was highly successful. Therefore, use of The Compass as JHN's population health tool was solidified for the future.

The Compass displays two categories of reports:

- **Patient Compass** – patient-specific preventive and chronic disease information for use at point-of-care, at the time of a patient visit.
- **Practice Compass** – known as The Compass "Color Map," metric data with report flexibility which can be sliced to the practice or provider level to assist with navigation toward benchmarks and targets.

The Compass captures preventive care and chronic disease management data from the EMR, and this feeds the JHN Scorecard for Bundles 1 and 2 at both the community level and the individual physician level.

The evolution of The Compass continues and includes the following feature categories:

- Care management
- Social determinants of health screening
- Risk-score display

The Compass is easily accessed with one click within Epic. The Compass puts information at the user's fingertips and assists in applying evidence-based medicine to our Jackson population.

JHN QUALITY MEASURES

Bundle 1:	Preventive	Care								
JHN Incentive Disease Prevention	PC.101 Flu Vaccine 22.36%	PC.102 Pneumonia Vaccine 59.04%	PC.150 WC Well Visits Birth - 15m 66.25%	PC.103 Immunizations Birth - 2 yrs 60.95%	PC.166 Lead Screen 75.62%	PC.151 Well Visits 3-21 yrs 65.79%	PC.104 Immunizations Adolescent 87.27%	PC.111 Tobacco Counseling 66.84%		
JHN Incentive Early Disease Detection	PC.152 Breast CA Screen 71.20%	PC.153 Cervical CA Screen 68.16%	PC.154 Colorectal CA Screen 74.53%	PC.161 Depression Screening 12+ yrs 78.58%	PC.163 Prediabetes Diagnosis 91.85%	PC.164 Fall Risk Screen 87.43%				
JHN Monitor Preventive Care	PC.105 BMI Screen 94.03%	PC.106 BMI Counsel 57.02%	PC.107 BP Screen 98.18%	PC.120 Adolescent HPV Imms 58.97%	PC.167 Registry - High Risk Geriatric Med 100.00%	PC.168 Registry - High Risk Geri Med (2+) 100.00%	PC.109 Tobacco Use 89.31%			
Bundle 2 :	**Chronic**	**Disease**	**Care**							
Cardiac & Respiratory Measures	CD.210 CVD Anti-Platelet Rx 87.43%	CD.211 CVD ACE-I / ARB 64.90%	CD.212 CVD Statin 82.56%	CD.251 HTN BP Control 75.53%	CD.270 HF Beta-Blocker 81.44%	CD.254 Asthma Action Plan 30.81%	CD.255 Asthma Med Mgmt 86.10%			
Diabetes Measures	CD.244 DM BP Control 74.05%	CD.235 DM A1c Testing 91.94%	CD.245 DM HbA1c < 9.1% 78.24%	CD.236 DM A1c < 7.0% 42.39%	CD.246 DM Nephropathy Monitor 64.83%	CD.239 DM Eye Exam 50.51%	CD.240 DM Foot Exam 73.08%	CD.241 DM ACE-I / ARB 85.51%	CD.242 DM Statin 75.62%	

Sample image from the Compass Color Map.

Transition Coordination

In April 2016, after recognizing the negative impacts that readmissions can have on the Quadruple Aim, JHN, HFAH and community partners worked together to address this critical issue. The result was the launch of Transition Coordination in April 2016. Transition Coordination is designed to ease the transition from hospital to community.

Regardless of a patient's primary care provider, anyone discharged from Henry Ford Allegiance Health with a diagnosis of COPD, CHF, TKA/THA, pneumonia, AMI, CABG, A-Fib, diabetes, renal failure, stroke or sepsis receives a call within 24 to 48 hours post discharge. This call, among the others that are extended throughout the course of 30 days, is aimed at mitigating barriers (e.g., accessing equipment and medications), reviewing discharge instructions, ensuring follow-up with primary and specialty care, and providing education to people on how to better cope with their conditions.

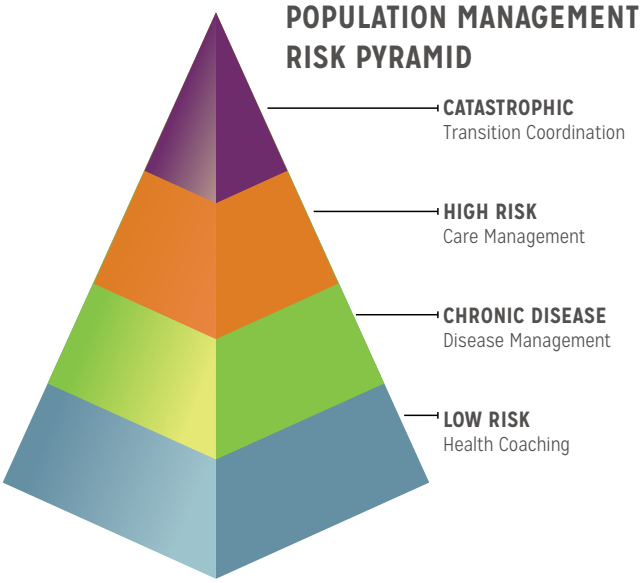
Over time, we have made connections with the community paramedic program to provide additional intervention and avoid utilization of the Emergency Department. Transition Coordination is linked to Care Management as hand-offs can be made for patients needing assistance beyond 30 days. Since its inception, this successful program has helped HFAH readmission rates continue to decline.

Care Management

"Care management programs apply systems, science, incentives and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively" (Center for Health Care Strategies, 2007).

Care Management strives to:

- Work alongside physicians, providers and office staff to assist in the patient's care.
- Focus on goal setting and monitoring, behavior modification, condition management and community resource referrals.
- Identify high-risk persons in need of care management.
- Screen referrals, conduct assessments, provide intensive follow-up, provide self-management support, track a person's progress over time and develop care plans.
- Collaborate with various members involved in the patient's care and/or services being provided.



JHN Care Managers have either LMSW or RN licensure and are experts in managing complex medical conditions, motivational interviewing, coordination of care and stages of change.

Community Navigation Specialists

2-1-1 Community Navigation Specialists provide clerical, task-based work associated with Care Management services. These individuals primarily focus on linking patients to services in the community, including access to housing and food, assistance with medication co-pays, and transportation to and from doctor appointments.

2-1-1 Community Navigation Specialists have an associate's degree in a human service-related field. In addition to their work with care management, these individuals are experts at connecting patients to resources in the community, using both their in-depth database and the Jackson Care Hub.

Social Determinants of Health

From the CDC: conditions in the places where people live, learn, work and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH).

We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. We also know that differences in health are striking in communities with poor SDOH such as unstable housing, low income, unsafe neighborhoods and substandard education. By applying what we know about SDOH, we can not only improve individual and population health, but also advance health equity.

Implementation of the Jackson Care Hub

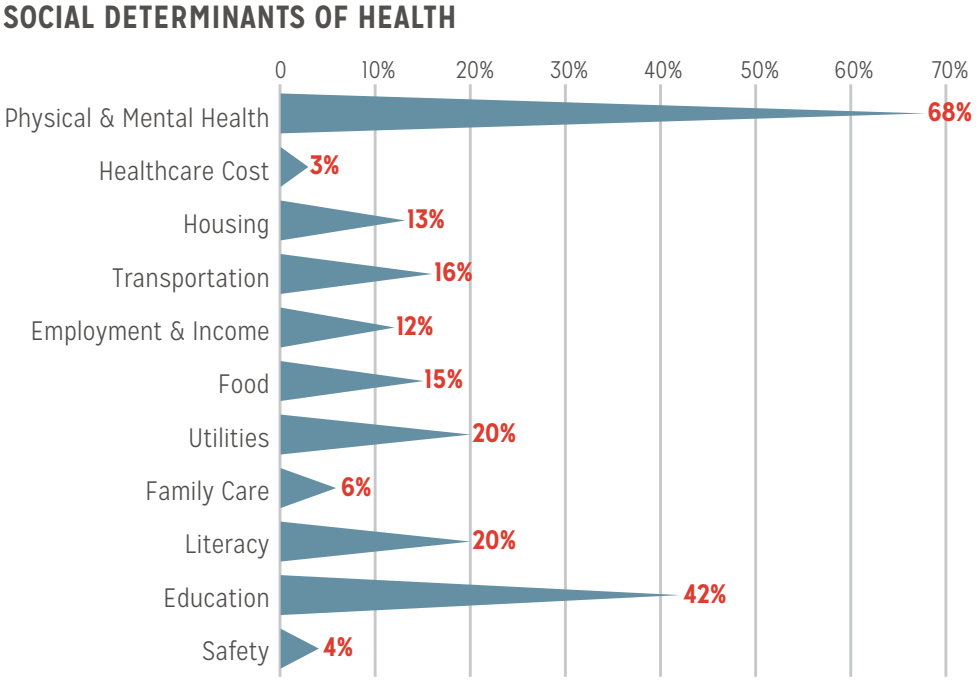
The Jackson Care Hub was designed as result of the Clinical Community Linkages strategy. This is an online platform that allows community organizations to screen for social determinants, assess an individual's needs to determine the most appropriate resources and then make an electronic referral to the selected organization real time. The system then allows the receiving organization to manage the referral that they were sent and work it through to completion. As the organization manages that referral, the original screening organization is provided with real time feedback of the progress being made with that referral.

What is JHN doing to address Social Determinants of Health in our community?

In May 2018, Jackson Health Network implemented the SDOH screen across 12 practices as required by the State Innovation Model (SIM). Since that time, 11 more practices voluntarily began screening their patients for SDOH needs, totaling 23 practices. As a result, over 50,000 SDOH screens have been administered to our patients. Of those individuals, around 15,000 screens yielded at least one identified need by the patient; around 33% of those patients with identified needs requested assistance and were referred to community resources by utilizing both the Jackson Care Hub and Community Navigation Specialists.

Needs of Our Community

Through collection of data, we were able to identify the highest areas of need in our community. The table below shows a breakdown of positive SDOH needs identified by domain. As we continue to collect data, we are hopeful that this will inform existing and new services/resources that our community offers.



Improved Provider Satisfaction

Practice Manager Collaborative Meetings

Each year, our practices and office staff are required to meet ever-increasing expectations. This leads to burnout and turnover, which can ultimately lead to lost revenue and poor patient satisfaction. To address this concern, JHN has used collaboration as a tactic for several years.

In 2017, JHN began holding small group meetings with practice managers from primary care offices to focus on initial integration of care management. By the end of 2017, JHN saw the benefit practices received from this type of learning environment and began working toward bringing specialist office managers to the table to address a broader scope of topics.

By July 2018, JHN held bi-monthly practice manager collaborative meetings where JHN staff would facilitate conversations between primary care and specialty care office managers on topics, such as:

- Establishing the specialty referral process and communication with primary care practices.
- Defining a patient's care team and how to identify them in Epic.
- Navigating hospital transitions of care and how to streamline the entire episode of care and ensure success outcomes.
- Understanding the role of community engagement and how to access resources for patients.

These meetings have become an important part of JHN's clinical integration strategy and will continue while there is a need for improvement. Currently, practices of all types send a mix of office staff, supervisors, regional managers, quality teams and executive leadership to the bi-monthly meetings. The broad scope of attendees allows for comprehensive discussion. Time is also devoted to specific concerns raised by team members who do the day to day work.

Monthly Rounding with Practice Transformation Specialists

Because not everything can be solved or delivered in a group setting, every clinic is assigned a Practice Transformation Specialist who rounds monthly. The JHN Board of Directors understands the value in monthly rounding. Since 2016, every office requesting monthly rounding is required to keep those visits at least 75 percent of the time, as a condition of their JHN participation.

Together, JHN leadership and the clinical performance support staff develop standardized monthly agendas for primary care offices and specialist offices. The topics reviewed each month are standardized to raise member awareness regarding specific areas in which JHN requires improvement or education and to move practices along the transformation spectrum at the same pace, to allow for collaboration to happen organically between offices.

JHN provides support to primary care and specialty offices on a variety of topics and tasks, including:

- Review of performance outcomes related to incentive programs at the Network level and the individual practice level.
- Patient Centered Medical Home Capability Assessment, Review and Adoption.
- Reminders for upcoming trainings and Network events.
- Updates and communication from contracted health plans.
- Public health updates.

Physician Education, Training and Support

JHN seeks to ensure both practice staff and practitioners receive the support and education they need to be successful. Through membership in JHN, providers are offered a variety of opportunities to learn, grow and become better at delivering care that is meaningful to their patients. Continuing education and engagement from providers are offered through JHN's Provider-Quality Champion meetings, large group presentations given by JHN leadership or outside speakers, and through convenient online training modules. JHN providers receive the modules for free, thanks to JHN's affiliation with Affirmant Health Partners.

Support for providers takes many forms, including:

- Provider Quality Champion Meetings, comprised of small focus groups of providers from all backgrounds who come together to discuss hot topics in health care, raise awareness and concerns and brainstorm solutions to address current issues.
- Large group meetings, such as the JHN annual meeting or the JHN annual strategic retreat, address broader topics and look ahead to what's to come. JHN has hosted speakers from across the country who share our strong desire to improve health care.
- Access to an online CME training platform called COMET™ is available to JHN through its affiliation with Affirmant Health Partners. Continuing education in areas such as preventive health improves provider comfort in educating their patients. COMET™ offers programs in several areas to facilitate patient education, including motivational interviewing, tobacco cessation and nutritional counseling.

Value Proposition - For Clinicians

Value Based Reimbursement: JHN can collaboratively drive higher quality and greater savings that are then translated to incentive payments directly back to participating physician members.

Physician Value: Physicians are eligible to benefit from performance incentives, shared savings, advanced payments (PMPMs) and fee schedule uplifts.

Access to Payor Contracts: With JHN, physicians can participate in commercial and government plans, directly with employers and state-wide efforts, via Affirmant Health Partners.

Physician Value: Providers benefit from centralized contracting with payors and the strengths of the full Network.

Centralized Payor Enrollment: Providers will experience coordinated credentialing and assistance with enrollment in contracted health plans. JHN monitors the provider credentialing and payor enrollment process to help practices ensure their providers are properly credentialed and enrolled to support provider/payor alignment.

Physician Value: JHN's practice transformation team and delegated credentialing agreements streamline and expedite the credentialing process.

Community Medical Record: JHN works with Jackson Community Medical Record (JCMR) to offer physician members the electronic health record (EHR) Epic.

Physician Value: Epic is an electronic medical record that is certified for MIPS reporting. It provides many features for providers, staff and patients. MyChart, for instance, is an online portal that allows patients to view their own medical records. Access to Epic improves the ability of physicians and office staff to manage patient health with a shared EHR. Information can be viewed by the PCP, specialist and other providers.

JHN Compass: The JHN Compass is our homegrown population health management system. The tool compiles data from Epic into one easy-to-use dashboard, which allows physicians and office staff to:

- Monitor performance in clinical measures.
- Drill down by measure to identify patients needing services.
- Receive assistance with pre-visit planning via the patient-level compass dashboard.

Physician Value: Improves the ability of physicians and office staff to manage their patient's health through a population health tool.

Practice Transformation Service Team: Each provider office is assigned its own liaison for communicating JHN information. Practices receive monthly office visits for direct support.

Physician Value: JHN improves physician access to best practice processes and elevates overall performance. JHN develops and maintains personalized service.

Longitudinal Care Management: JHN's care management team provides long-term, relationship-based (longitudinal) care management to patients who have been identified as having some combination of multiple comorbidities, complex treatment regimens, frailty and functional impairment, behavioral and social risks, and serious mental illness.

Physician Value: Care management services are aimed at reducing hospitalization and crisis-driven care while improving quality of life and health outcomes.

Value Proposition - For Employer Groups

Preferred Network Health Plan: The preferred network approach starts with employee engagement through a plan design aimed at engaging employees in their health care. The design emphasizes right care at the right time for the right person.

Employer Value: Offers employees a health plan option with a high-value health care delivery network invested in the long-term health of employees. Provides employers with a health plan option that is more financially sustainable by better managing costs.

Value-Based Reimbursement: Value-based reimbursement is a redesigned approach to the local health care payment ecosystem that engages employers, payors, patients, providers and other stakeholders in new ways. The outcome rewards high-value health care by rewarding better outcomes and more cost-efficient care delivery.

Employer Value: Offers a health plan option for employers that is truly committed to long-term financial sustainability. Plan designs are available for both fully-insured and self-funded employers.

Longitudinal Emphasis on Health Care: Because health should be viewed over a multi-year horizon, a strong relationship with the primary care provider (PCP) is essential. Additionally, wellness and care management services help engage patients beyond the PCP office to provide a more holistic view of health.

Employer Value: Healthy employees have fewer absences and higher engagement, which often translate to better productivity.

Robust Specialty Network: Through JHN and HFAH, most specialty care is available locally. The full Henry Ford Health System is also available within the preferred network, for those with more rare and complex health issues requiring subspecialty access. When patients receive specialty care in-network, it allows JHN providers and care teams to better communicate and manage patients through these episodes of care.

Employer Value: Health plan design with access to specialty care that connects back to patient's primary care team, allowing for a more coordinated care experience.

Expanded Patient-Centered Access: JHN continues to develop more convenient and lower-cost care sites. Sites of care include walk-in clinics with weekend and after-hours availability, telehealth video visits and electronic messaging (e-visits) with providers. These modalities offer options for patients, especially for lower-acuity needs.

Employer Value: Access to lower acuity care sites helps reduce unnecessary use of the emergency room and other more expensive options. It also reduces absenteeism, as employees can receive the care they need with greater flexibility.

Value Proposition - For Patients and Community

Making It Easier to Access Specialty Behavioral Health Services: Jackson Health Network (JHN) is working to make it easier for patients to access specialty behavioral health services. Primary care doctors will receive special education that will allow them to care for patients with lower levels of behavioral health concerns. Behavioral Health Case Managers are available to help patients feel comfortable through this change in how services are delivered. This change will mean easier access for patients in need of specialty behavioral health services.

Identifying and Meeting Needs for Better Health: Jackson Health Network primary care practices are working to ensure patients have all the basic things they need to be healthy and well. Starting in May 2018, more than 50,000 patients were screened by their doctors. Out of that group, 15,000 of the patients found at least one unmet, thanks to being screened. As more doctor practices began to screen their patients, the benefits of screening were even easier to see. To date, about 33% of the screened patients who found an unmet need took the next step of requesting assistance and were connected to community resources and/or a specialist who would help match resources to meet needs.

Tobacco Treatment Services: Primary care doctors began using the electronic medical record to refer their patients who were ready to quit smoking and want help. As a result, in November 2018, Tobacco Treatment Services saw an increase in referrals for counseling and tobacco prescriptions. Patients who would like the help Tobacco Treatment Services can provide can enroll in the program and then agree to participate in scheduled sessions.

Success Stories

Participant "Kate" has a history of morbid obesity, severe arthritis, s/p ankle fusion, s/p bilateral rotator cuff repair and joint pain. Socially, the patient 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. 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 meds and made recommendations that could result in fewer falls. This multidisciplinary team worked together to further act on the plan of care. Also, the Care Coordinator assisted the patient with a Medicaid application and she was approved. She is now able to receive additional Region II services.

Participant "George" was referred to Care Coordination due to frequent hospital readmissions. There were several reasons that contributed to this, including poor cognition of patient and other facets of care, poor attendance at physician appointments due to transportation issues and poor family support on part of his children. 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.

Participant "Douglas" called physician office, tearful, asking for assistance with high medical bills that were coming in. Patient had a previous hospital stay and had been receiving bills for her care but was unable to pay them. Referral was made to 211 Community Navigation Specialist (CNS) by Care Manager. CNS phoned patient and arranged for a home visit to complete assessment and apply for assistance online due to patient being blind. CNS has made subsequent home visits with patient to assist with completing follow up paperwork required for assistance. Patient now has the assistance needed to move forward and had a reduction in the cost of the prior medical bills making it manageable.

Looking Ahead – The Future of Care

Since Jackson Health Network's earliest days, we acknowledged that health care is in a state of transition. Eventually, the days of fee-for-service reimbursement will evolve into a future focused on value, defined as increased quality at lower cost. That conceptual value framework is no longer a long-term possibility, but now an impending reality. Our future relies on how well we navigate the change.

Starting in 2018, JHN took on several contracts with shared risk, meaning we were financially incentivized with upside gains and responsible for sharing downside losses, depending on our cost performance against actuarial benchmarks. These agreements were made with Jackson employers and provided a mechanism to pilot this new model. The preliminary results for performance on these contracts in 2018 were favorable. Participation continues in 2019. By 2021, in addition to these local contracts, JHN will assume downside risk in its agreement with Medicare through the Affirmant Federation ACO. This Medicare program, known as "Pathways to Success," represents a major paradigm shift in financing how we care for one of the largest segments of patients in our Network.

To be successful in contracts with downside risk, we must aggressively target opportunities for savings and strategically invest in resources that improve delivery of care. We will strive to deliver care at the right time, in the right place, at the right cost. One key driver of cohesion in the network is high adoption of a shared electronic medical record. Currently, most primary care physicians and specialists in JHN use Epic, which allows unprecedented ability to access shared patient information. Looking forward, we will continue to support the adoption of this common platform.

With all this change, and increasing stress placed on providers, the JHN Board of Directors identified provider burnout as a major risk to the future success of the Network. The underlying cause for burnout is understood to be multifactorial. Going forward, JHN will work to understand specific drivers of burnout in our provider community and invest in resources to better support provider satisfaction. We cannot succeed as a network without recognizing the essential contributions made to our overall performance by each of our providers.

By maintaining our focus on the Quadruple Aim, JHN will continue to push the evolution of the health care delivery system in Jackson. We are excited to lead this change and look forward to helping to create a healthier, more vibrant and sustainable community.

A Thank You to Our Leaders

Jackson Health Network was envisioned and created by a hard-working group of people within the health care system and our community. We wish to express our deepest gratitude for their efforts to develop the Network and for their ongoing work as we continue to grow and expand.

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