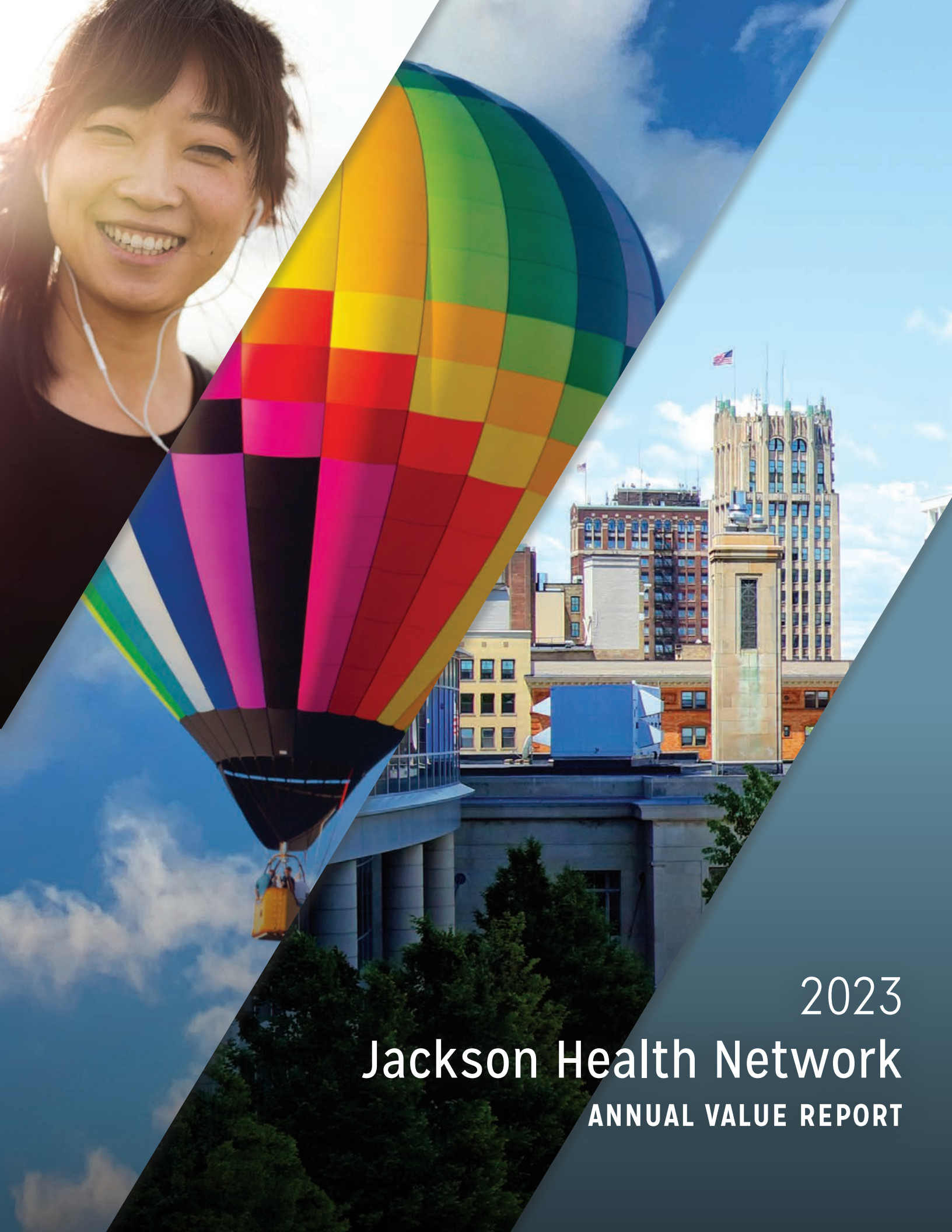


2023
Jackson Health Network
ANNUAL VALUE REPORT

The Jackson Health Network Vision

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

Jackson Health Network
One Jackson Square
100 E. Michigan Avenue, 5th Floor
Jackson, Michigan 49201
(517) 205-7477
JacksonHealthNetwork.org

Letter from the President

JHN is a model for clinical integration. In 2010, the first community physicians and hospital leaders came together with a vision for the future of care in Jackson. That vision was the Triple Aim – reduced cost, improved population health, and more satisfied patients. Fast forward more than a decade, and the network represents nearly 1,000 providers caring for more than 130,000 aligned lives. We evolved our vision to include a fourth aim, provider satisfaction, and enjoy a strong foundation supporting clinical integration and transformation. We benefit from a robust governance model including dozens of highly engaged providers. We share a common medical record that streamlines delivery of care in the community. We engage in value-based contracts that support redesign of the care environment. By nearly every measure, we are improving the health of the community, using resources more efficiently and delivering better value to our patients.

Our strength as a network helped us endure the challenges of the COVID-19 pandemic and speed our collective recovery. We delivered some of our strongest years of network clinical and financial performance in 2020, 2021 and 2022. We now face our "new normal," recognizing the world has changed, and that we must change as well. COVID-19 activity was steady through 2022, with ongoing hospitalizations and loss of life. Additional communicable disease challenges surfaced – Monkeypox, RSV, and Influenza – but were met with an active, coordinated response. We can be confident in our ability to sustain our practices when facing pressure and to innovate when our community is in need.

Many accomplishments from 2022 are worth reflecting on. We kicked off the new MOSAIC Accountable Care Organization with partners Henry Ford Physician Network and Covenant Health Partners. MOSAIC replaced the Federation ACO, which ceased operations at the end of 2021, with the unwinding of Affirmant Health Partners. The ACO covers nearly 50,000 Medicare lives and offers both the upside opportunity of shared savings and the downside exposure of shared losses. Another significant accomplishment in 2022 was the inclusion of an ambulatory surgery center in our contracts, which helps improve patient experience by providing access to high-demand services.

In addition to our performance, this report highlights essential partnerships with our community. We recognize that most needs driving health outcomes are social, and supporting upstream interventions is the most effective way to achieve our vision for a healthier community. The Health Improvement Organization and Jackson Collaborative Network represent the foundation of our community engagement, and backbone of our relationship with more than 200 community agencies that help address the social needs of Jackson residents. With the help of our providers, we completed over 200,000 screens for social needs. The Jackson Care Hub is the clinical extension of this collaborative, a closed-loop referral system integrated with our electronic health record, that navigates individuals to solutions they need for food, housing, transportation and various other gaps.

In closing, Jackson is a special community, with hard-working people and dedicated physicians. It is my privilege to engage with and support our providers in service of their important work. Events these past few years accelerated the pace of change in health care. Our ability to navigate this change relies upon our strength as a network and our commitment to working together.

Sincerely,

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

Letter from the Chairman

Greetings!

Jackson Health Network (JHN) is proud to present its 2022 Value Report, highlighting achievements from the past year.

Last year, coming off of the brunt of the COVID pandemic, the network still saw outstanding efficiency, productivity, and quality of care delivered to our patients. As suggested in my last communication this was then (and still now continues to be) a product of extraordinary efforts by primary care and specialty providers, JHN and hospital-based leadership, and importantly community-based partners in the region. Through continued commitment and concern about the welfare of those in Jackson and surrounding communities this network has met and often exceeded system and regional benchmarks.

Although they have had to navigate changes in their teams, the executive leadership- led by Drs. Courtland Keteyian (CEO) and Amy Schultz (Executive Director)- has continued to effectively advocate for its membership with the Henry Ford Jackson Hospital administration, and on a broader scale their expertise is helping to shape the future of care across the Southeast Michigan region (as part of Henry Ford Health) and also the state (as part of the Mosaic Accountable Care Organization (ACO)).

In the past few years financial and staffing pressures, across multiple workforce sectors, has been a significant issue. Turnover has certainly been a limiting factor at times. Philosophically a change in "how" we work is part of the new normal. Goals for 2023 certainly include continued focus on the "micro" measures (shared savings with payors to improve return to providers, quality of care, etc.) but in parallel JHN is looking to- in partnership with the hospital- continue the focus on the wellness and health of providers across the spectrum (the so-called fourth aim). This attention, along with continued emphasis on the value and necessity of Diversity, Equity, Inclusion and Justice in our workplaces and how we deliver care is paramount to continued success for our patients and the health of our teams.

As market dynamics continue to unfold there is much uncertainty in how we employ our office and hospital staff, how they perceive and value their work, and how we all assess satisfaction each day. JHN has demonstrated success in improving the quality of care that can be delivered. The leadership team is focused not only on ensuring that we strive to "raise the bar" for the care that is delivered, but also in partnership with all members we will strive in 2023 to continue to emphasize the health and wellbeing of the workforce so that our success can be sustained.

We appreciate your work, and as always will be available to take your feedback so we can effectively advocate for your interests in the future.

Sincerely,

Anish Wadhwa, MD

Chairman of the Board, Jackson Health Network

Pulmonologist, Pulmonary Clinics of Southern Michigan, PC

Why a Clinically Integrated Network

The challenges with healthcare delivery in the United States are well documented. Our system is designed to handle acute problems, and yet remains incredibly complex and difficult for most individuals to navigate. Additionally, we increasingly appreciate the impact of social factors on health outcomes. Without a robust approach to improve health behaviors and focus on prevention, the opportunity to intervene upstream passes, and we deal with the downstream consequences.

The costs associated with our current system are not sustainable. Healthcare is the fastest growing component of the federal budget and the rate of increase far exceeds GDP growth. The consequences are real for local communities, where rising health care costs undercut profitability for employers and drive jobs elsewhere. The new reality for providers involves a shift in accountability. Providers are increasingly accountable for both clinical and financial performance. To stay competitive, providers must deliver more value, not more care.

Quadruple Aim

The transition from an environment that rewards volume to one that requires value is a massive shift for the industry. In 2007, the Institute for Healthcare Improvement developed the Triple Aim as a set of goals to guide this transition. The Triple Aim framework prescribes improved quality, reduced costs and enhanced patient satisfaction. A "fourth aim" was added to ensure focus on provider satisfaction as well. This combination of objectives is now referred to as the Quadruple Aim.

The Quadruple Aim is attainable through collaboration, and clinically integrated networks provide an important vehicle for pursuit of this shared goal. A clinically integrated network is a specially designated entity that grants key antitrust exemptions to providers and facilities that work together to achieve outcomes related to cost and quality. Tests of integration include shared governance, participation standards, performance objectives and IT systems for clinical data. Integrated entities can contract collectively on behalf of all their members. By working together, clinically integrated networks reduce waste and variation in care that do not yield better outcomes.

"The experience and support from our Practice Transformation representative has led to many accomplishments during our first two quarters of membership with Jackson Health Network. From preparing for PCMH designation to streamlining workflow within our practice, she assists our team in maximizing our opportunities and helps us to avoid pitfalls that others may have experienced."

-Terri Draper, Practice Manager
Jonesville Health Care, PLLC

What is Jackson Health Network?

The Jackson Health Network (JHN) is the Clinically Integrated Network for the communities in and surrounding Jackson, Michigan. We are a collaboration between community providers, employed physicians and Henry Ford Jackson Hospital. JHN officially formed in 2011 after a year of careful planning by local leaders. Since then, it has evolved into one of the most advanced clinically integrated networks in the Midwest.

JHN is physician led and its shared governance structure includes dozens of providers from the community. Network membership cares for nearly the entire population of Jackson County and is growing into adjacent geographies. JHN is highly integrated with data sharing and point of care clinical tools that support performance on clinical programs. The Network earns performance-based incentives through its various payor contracts and distributes these incentives to providers through a methodology that recognizes the provider's performance and impact on attributed lives. JHN is leading the transition to value-based care for the greater Jackson community.

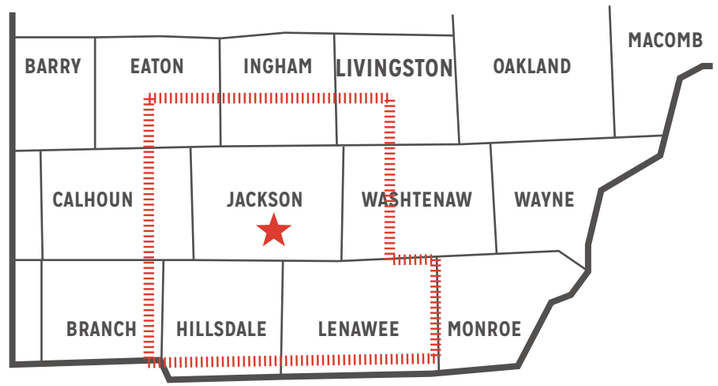
"Our PFAC group has been very helpful in improving some aspects of daily activities. Several suggestions, leading to changes, have been very well received by the majority of our patients. Very helpful to have outside opinions!"

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

JHN SERVICE NETWORK

The range of services provided by JHN providers encompasses 54 different specialty types spread across nine counties surrounding Jackson, Michigan. Jackson Health Network and Henry Ford Jackson Hospital are located at the center.

JHN Service Network covers the following Michigan counties: Calhoun, Eaton, Hillsdale, Ingham, Jackson, Lenawee, Livingston and Washtenaw.



SPECIALTY TYPES

Primary Care

Family Medicine
Internal Medicine
Pediatrics

Specialty Care

Allergy and Immunology
Anesthesiology
Audiology
Bariatric Surgery
Behavioral Health
Cardiology
Cardiovascular Surgery
Dermatology
Emergency Medicine
Endocrinology
Gastroenterology
General Surgery
Geriatrics
Hematology and Oncology
Hospitalists - Adult Specialist
Hospitalists - Gastroenterology
Hospitalists - General
Hospitalists - Neurology
Hospitalists - Pediatrics
Hospitalists - Obstetrics
Hyperbaric Medicine
Infectious Disease
Midwifery Services
Nephrology
Neurology
Neurosurgery
Obstetrics/Gynecology
Occupational Medicine
Ophthalmology
Optometry
Oral/Maxillofacial Surgery
Orthopedic Surgery
Otolaryngology
Pain Management
Pathology
Pediatric Cardiology
Physical Medicine and Rehabilitation
Plastic Surgery
Podiatry
Psychiatry
Pulmonary Medicine
Radiation Oncology
Radiology
Rheumatology
Sleep Medicine
Sports Medicine
Thoracic Surgery
Trauma Surgery
Urology
Vascular Surgery

JHN BY THE NUMBERS*

938 Credentialed members

70% Henry Ford Allegiance Medical Group

30% Private Practice

125 Primary Care Providers

813 Specialty Care Providers

7 Committees comprised of providers and community members

1 Hospital System
Henry Ford Jackson Hospital

1 Health Improvement Organization
HIO

1 Electronic Health Record
Epic

88% of JHN specialists utilize Epic as primary EHR

99% of primary care providers utilize Epic as primary EHR

100% of medical providers contribute clinical data to Epic

1 Population Health Registry
Compass

100% outpatient based medical providers utilize at point of care

131,000+ active patients in our primary care network and managed in the Compass

1 Clinical Integration (CI) Program
7 bundles comprised of evidenced-based metrics

13 Preventive Care

12 Chronic Disease

8 Continuum of Care

10 Quality, Efficiency and Utilization

4 Patient Experience

2 Training and Citizenship

33 Specialty Metrics

69 Employees

34 Care coordinators, health coaches, transition coordinators, diabetes and nutrition educators

21 Clinical performance, credentialing, programmatic, and support staff

9 Leaders

3 Jackson Collaborative Network

2 Medical Directors

*As of December 1, 2022

Jackson Health Network – 10 Years of Clinical Integration

MILESTONES

2011

- JHN birthed as Clinically Integrated Network (CIN)
- Executed its first Value Based Contract which included administrative funding, the JHN Clinical Integration (CI) program, and Care Management

2012

- Executed its second Value Based Contract, covering three product lines

2013

- The JHN Compass tool is developed (replaces 3rd party-vendor Phytel)

2014

- Paid out its first incentive payment to JHN physician members

2015

- Jackson Health Network absorbed Jackson Physicians Alliance
- Executes four additional Value Based Contracts, now totaling ten product lines
- JHN Compass is used for physician scorecards for the first time
- Paid its first million dollars in incentives to JHN physician members

2016

- JHN joins Affirmant (formally known as the Federation Care Network), a super CIN, that was comprised of 7 organizations across the state of Michigan
- Executes its first Jackson, MI employer risk arrangement contract
- Executes two additional Value Based Contracts, now totaling 14 product lines

2017

- JHN supports the transition from NextGen to Epic; JHN Compass transitions successfully
- Jackson, MI is selected as a State Innovation Model (SIM) region with 13 JHN primary care practices participating
- 21 JHN primary care practices accepted into the CMS Innovation Model Comprehensive Primary Care Plus (CPC+)
- Embedded Care Management is adopted in all primary care practices

2018

- JHN begins work to implement Social Determinants of Health (SDOH) screenings and integrates a standard screening tool within EPIC
- JHN supports the work to develop a SDOH screening platform, later to be called the Jackson Car Hub
- Executes its second Jackson, MI employer risk arrangement contract

2019

- The JHN Compass expands to HFMG in Detroit, MI
- JHN physicians join the Federation Accountable Care Organization (ACO), under a 3-year contract with CMS

2020

- Due to COVID-19 JHN provided support to all practices including regular updates from payors and the health department, developed a standardized procedure to safely reopen clinics during the pandemic, and provided incentive funding earlier in the year to help with revenue shortages
- Executes 1 additional Value Based Contract, now totaling 16 product lines

2021

- Executes 1 additional Value Based Contract, now totaling 17 product lines
- JHN executed is first Community Health Worker contract with two Medicaid health plans
- The Jackson Care Hub is widely used across the Network and community agencies
- Paid out its highest incentive totaling over $9 million dollars to JHN physician members

2022

Executes 1 Value Based Contract, now totaling 20 product lines

"In 10 years, Jackson Health Network has changed health care in this community, and we are poised to do so much more. The work we do isn't always visible, but our impact is significant, the people in the Jackson community are healthier, happier, and will live longer because of the work of those in JHN."

-Courtland Keteyian, MD, MBA, MPH, President and CEO
Jackson Health Network

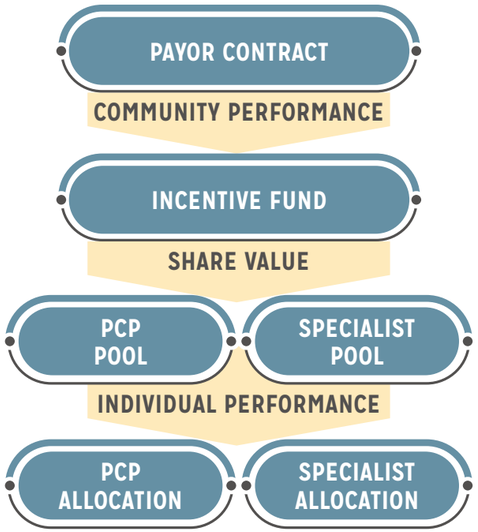
2023 Clinical Performance

CLINICAL INTEGRATION PROGRAM

Functioning as a Clinically Integrated Network (CIN), JHN combines evidence-based medicine with an innovative pay-for-performance program. This effort to advance the Quadruple Aim is called the Clinical Integration Program (CI Program).

The CI Program is the vehicle for steering population health in the Jackson area toward value-based care. It includes critical components for success, such as patient-payor alignment goals, quality and cost metrics with measurable benchmarks, and monitoring of progress via quarterly scorecards. It is the means by which the Network negotiates dollars to incentivize and increase monetary support for the value-based care delivered to patients who are seen by JHN members.

As of December 2022, JHN has twelve value-based contracts that make up nearly 80% of all insured patients attributed to a JHN primary care physician. These contracts support efforts to meet the Quadruple Aim through a variety of different incentivized initiatives. The performance of the Network (Community Performance) drives dollars into the incentive fund and then the performance of each individual physician (Individual Score) drives the amount paid to each member (as illustrated here).



Patients, physicians, payors and many others benefit from the JHN Clinical Integration program. This program enhances coordination across the continuum of care, reduction in healthcare costs by improving efficiency, improved provider satisfaction through a convenient patient registry tool and scorecard, and overall better health outcomes. This section of the report will go into detail about JHN's clinical performance outcomes and the tools used to continuously improve year after year.

SCORECARDS

When choosing effective JHN scorecard metrics, many components are considered:

- Health care landscape - Program metrics should move us from volume to value.
- Population health - Chosen metrics should be large enough to affect a considerable population.
- Payor alignment - To create alignment, effectively identify and harmonize metrics with payor incentives.
- Program engagement - Promote the engagement of both primary care and specialty care.
- Data validity - Metric data must be valid, timely and readily generated.

There are two distinct types of JHN scorecards – a Community scorecard which reflects Network performance, and Individual scorecards, which reflect each physician's performance.

The Community scorecard is a compilation of the work performed by all physicians in the Network and reflects the collaborative nature of our program. It provides a picture of our success as a Clinically Integrated Network. The Community scorecard consists of seven bundles of metrics:

Bundle 1 – Preventive Care
Bundle 2 – Chronic Disease Care
Bundle 3 – Continuum of Care
Bundle 4 – Quality, Efficiency and Utilization
Bundle 5 – Patient Experience
Bundle 6 – JHN Education and Citizenship
Bundle 7 - Meaningful Specialty Metrics

Individual scorecards for Specialists have continued to evolve over the last 2 years and we work with specialist providers to make their scorecards more meaningful to their specialty through 2-way communication to add and remove metrics that are relevant to our ever-changing healthcare climate.

JHN works collaboratively with each provider office to do personalized action plans for all providers in the network to be successful in managing their patients. The goal is to have the best care for the patient not only in health but also a collaborative involvement with the patient and the patients family to ensure the patient receives the best care and patient experience.

JACKSON HEALTH NETWORK

2022 QUARTER 4 COMMUNITY SCORECARD

2022 Quarter 4 Overall Community Performance				2022 Q4 JHN Community Score		64.91%	
Bundle 1: Preventive Care							
Metric ID	**Metric Name**	**Num**	**Den**	**Community Score**	**2022 Target**	**Points Earned**	**Max Points**
PC.100	Adult Covid-19 Vaccine	64,396	100,548	64.05%	**52.19%**	**1**	1
PC.102	Pneumonia Vaccination	18,453	25,930	71.16%	**70.65%**	1	1
PC.103	Immunizations: Birth - 2 years	1,096	1,651	66.38%	**63.60%**	1	1
PC.104	Immunizations: Adolescent Mening&Tdap	1,464	1,665	87.93%	**89.20%**	0	1
PC.106	BMI Activity Nutrition Counseling	59,331	93,058	63.76%	**48.35%**	**1**	1
PC.111	Tobacco: Cessation Intervention	16,343	21,151	77.27%	**73.02%**	**1**	1
PC.120	Immunizations: Adolescent HPV by Age 13	776	1,666	46.58%	**47.80%**	0	1
PC.150	Well-child visit: Birth - 15 months	1,260	1,653	76.23%	**74.71%**	**1**	1
PC.151	Well-child visit: 3-21 years	19,733	30,399	64.91%	**65.97%**	0	1
PC.152	Breast Cancer Screening	20,691	29,226	70.80%	**70.38%**	**1**	1
PC.153	Cervical Cancer Screening	20,222	29,208	69.23%	**71.15%**	0	1
PC.154	Colorectal Cancer Screening	27,628	40,723	67.84%	**68.72%**	0	1
PC.161	Depression Screening: ≥12 years	72,726	89,759	81.02%	**81.28%**	0	1
						7	**13**

COMPASS

JHN's population health management tool is known as Compass. Homegrown and continuously evolving, Compass has been used to calculate the performance in Bundle 1 and Bundle 2 since 2015. Compass captures preventive care and chronic disease management data from Epic and provides a snapshot of real-time clinical information to JHN members and staff daily.

Compass displays three categories of reports:

- Enterprise Compass - containing all the same functionality as the practice Compass, this view provides the community level view into how the Network is performing in each Bundle 1 and Bundle 2 metric.
- Practice Compass - known as Compass Color Map, performance metric data with report flexibility that can be sliced to the practice or provider level to assist with navigation toward benchmarks and targets. The practice Compass enables practice staff to access their complete patient list (active patients have a documented vital sign in EPIC within the last two years) and drill down by preventive metric or chronic disease to identify which patients are overdue for services. These lists are used by care teams to proactively outreach to patients to close gaps in care.
- Patient Compass - patient specific preventive and chronic disease evidence-based care for concurrent use at the point-of-care, accessed with one simple click in Epic.

Rankings | Targets Within Reach Report | ***JHN Quality Measures*** | View Report Details | Value Sets | Meets Payer Target
JHN Enterprise (Primary Care) | Specialty Colormap | Meets JHN Target
Within 5% of JHN Target
More than 5% below JHN Target
Organization or Payer monitor
no data / in development

Create Timestamp: Dec 2 2022 11:22AM
Data Timestamp: Dec 1 2022 12:00AM

Enterprise Patient List (129647) | Appointment List | Trend Data

Help | Pop Health Key Indicators | Quality Primary Health Scorecard

Rankings | Televox gap call report...

HTN	DM	Obesity	Tob - Adult	Tob - Ped	SDoH-Food
37.9%	15.0%	46.2%	20.9%	1.0%	1566

Bundle 1:	Preventive	Care								
Disease Prevention	PC.102 Pneumonia Vaccine 71.11%	PC.150 WC Well Visits Birth - 15m 75.76%	PC.103 Immunizations Birth - 2 yrs 65.61%	SM.728 Infant Imm 4th DTaP 73.99%	SM.729 Infant Imm 4th PCV 74.30%	PC.151 Well Visits 3-21 yrs 64.57%	PC.104 Immunizations Adolescent 87.00%	PC.120 Adolescent HPV Imms 46.50%	PC.111 Tobacco Counseling 76.53%	
Early Disease Detection	PC.152 Breast CA Screen 70.89%	PC.153 Cervical CA Screen 69.26%	PC.154 Colorectal CA Screen 67.90%	PC.161 Depression Screening 12+ yrs 80.74%	PC.164 Fall Risk Screen 90.86%	PC.106 BMI Counsel 62.83%	CC.318 Social Det of Health 64.37%	PC.100 Adult Covid Vaccine 63.81%	SM.764 Ped Covid Vaccine 23.83%	SM.999 Covid-19 Imm (6m-4)
Preventive Care	PC.105 BMI Screen 95.39%	PC.166 Lead Screen 65.75%	PC.107 BP Screen 98.51%	PC.109 Tobacco Use 89.30%	PC.101 Flu Vaccine 20.41%	PC.163 Prediabetes Diagnosis 84.69%	CC.323 Adv Care Plan 19.38%	CC.322 Care Mgmt 1.00%		
Bundle 2 :	**Chronic**	**Disease**	**Care**							
Cardiac & Respiratory Measures	CD.210 CVD Anti-Platelet Rx 85.54%	CD.212 CVD Statin 87.56%	CD.251 HTN BP Control 73.05%	CD.270 HF Beta-Blocker 86.21%	CD.272 HFsys ACE / ARB / ARNi 77.17%	CD.273 ACE/ARB Annual Monitoring 79.75%	CD.280 COPD LAMA 46.38%	PC.190 COPD CAT Assess 27.46%		
Diabetes Measures	CD.244 DM BP Control 78.00%	CD.245 DM HbA1c < 9.1% 81.11%	CD.231 DM A1c < 8.0% 70.54%	CD.246 DM Nephropathy Monitor 69.58%	CD.239 DM Eye Exam 55.53%	CD.242 DM Statin 79.03%	CD.235 DM A1c Testing 92.65%	CD.240 DM Foot Exam 59.27%		

Health RIsk: 88

Care Mgmt

Run Timestamp: Dec 2 2022 12:40PM
Data Timestamp: Dec 1 2022 12:00AM

JHN Patient Compass Report

TEST PATIENT (MRN), 61 yr M (MM/DD/YYYY)

PCP Practice: PCP PRACTICE NAME

PCP: PCP NAME

Next Appt at PCP Practice: MM/DD/YYYY

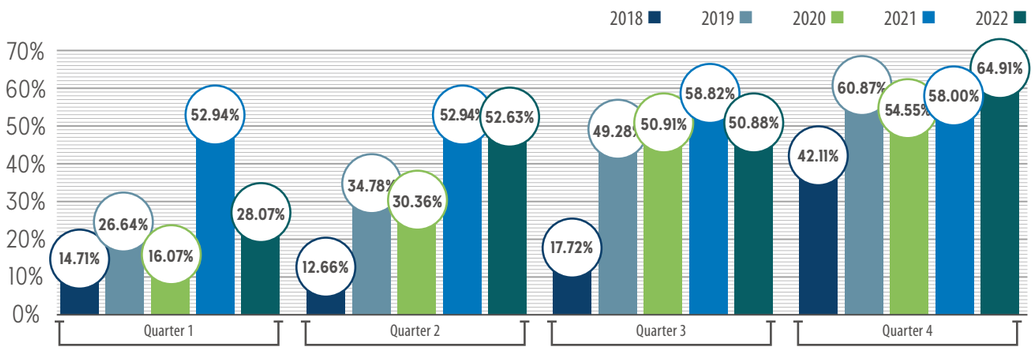
Next Appt at Non-PCP Practice: MM/DD/YYYY

Bundle	ID	Measure	Details	Status	Expires
Preventive Care	PC.154	Colorectal Cancer Screening	PR COLONOSCOPY FLEXIBLE DIAGNOSTIC (45378) on 11/22/2017 <= 10 years old	✓	Nov 2027
	PC.161	Depression Screening	11/28/2022 <= 1 Yr old, (PHQ2 Flowsheet)	✓	Nov 2023
	PC.106	BMI Counseling	BMI of 32.71 on 11/28/2022, BMI Counseling: 05/16/2022 <= 24 months old	✓	May 2024
	CC.318	Social Determinants of Health	10/25/2022 <= 1 Yr old	✓	Oct 2023
	PC.100	Covid-19 Vaccine	Covid-19 Vaccine: COVID-19 Pfizer, 12 yr.+ (Purple Cap) on: 03/12/2021; COVID-19 Pfizer, 12 yr.+ (Purple Cap) on: 04/08/2021; COVID-19 Pfizer, 12 yr. + (Purple Cap) on: 11/12/2021; COVID-19 Pfizer Tris-Sucrose, 12 yr. + (PRIMARY SERIES) on: 05/16/2022; Pfizer Bivalent BOOSTER, Tris-Sucrose, 12 Yr. + on: 10/25/2022	✓	
	PC.105	Body Mass Index (BMI)	11/28/2022 <= 24 months old	✓	Nov 2024
	PC.107	Blood Pressure Documented	11/28/2022 <= 24 months old	✓	Nov 2024
	PC.109	Tobacco Assessment of Use	(Smoking: Former, Smokeless: Never) 11/28/2022 <= 1 Yr old	✓	Nov 2023
	PC.101	Flu Vaccine	10/25/2022 >= 07/01/2022, (Influenza Quad PF)	✓	
Chronic Disease Care	CD.251	HTN BP Controlled	140/66 on 11/28/2022 at JACKSON PHYS MED & REHAB (>= 140/90, <= 1 Yr)	✗	
	CD.273	Persistent Med Monitoring for ACEi/ARB	LISINOPRIL 2.5 MG TABLET (lisinopril) started on 02/02/2021 (18+ months) :: serum creatine lab (after 08/01/2021) on 08/27/2022 <= 1 Yr old :: blood potassium lab (after 08/01/2021) on 08/27/2022 <= 1 Yr old02/02/2021	✓	
	CD.244	DM BP Control	140/66 on 11/28/2022 (>= 140/90, <= 1 Yr)	✗	
	CD.245	DM HbA1C < 9.1%	8.8 on 07/05/2022 (< 9.1, <= 12 months)	✓	Jul 2023
	CD.231	DM A1c Control < 8	8.8 on 07/05/2022 (>= 8.0, <= 12 months)	✗	
	CD.246	DM Nephropathy Screening	MicroAlbumin: 07/05/2022 <= 1 Yr old :: Serum Creatinine: 08/27/2022 <= 1 Yr old :: EGFR: 08/02/2021 > 1 Yr old	✓	Jul 2023
	CD.239	DM Eye Exam	11/07/2022 <= 1 Yr old, (HM Override:)	✓	Nov 2023
	CD.242	DM Use of Statins	No active statin medication found.	✗	
	CD.235	DM HbA1C Performed	07/05/2022 <= 12 months old	✓	Jul 2023
	CD.240	DM Foot Exam	03/02/2021 > 1 Yr old, SDE EPIC#14043 (diabetic foot exam performed)	✗	

2022 Q4 CLINICAL INTEGRATION PROGRAM RESULTS

In 2022, JHN exceeded its 45% incentive threshold with a score of 64.91%. This is a 6.72% improvement over the previous year. By year-end, JHN achieved a Community Score better than the 2019 Quarter 4 score, directly before the COVID-19 pandemic. Additionally, at the individual physician level, 100% of physicians exceeded the 45% incentive threshold and 99% will partake in financial rewards paid in 2023. ***This is the third year in a row that 100% physicians met the 45% threshold!***

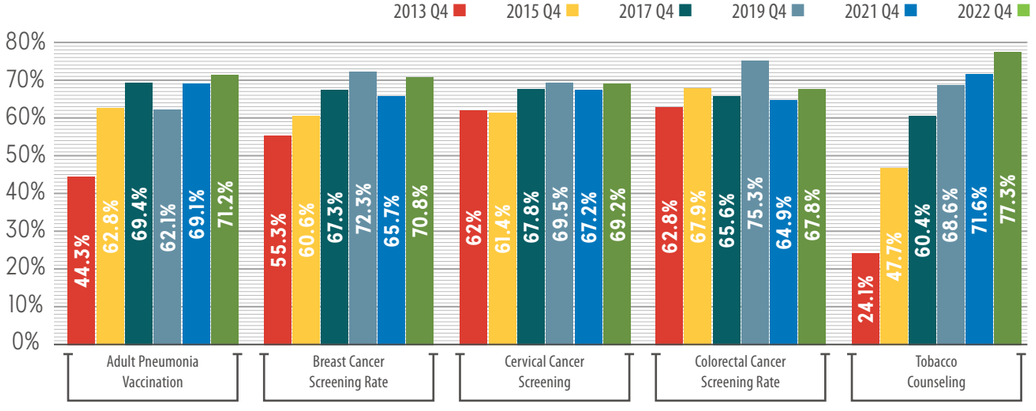
Keep in mind, JHN strategically chose NOT to raise targets in 2021 due to the upheaval in healthcare from the COVID-19 pandemic which began in March of 2020. In 2022, in an effort to boost performance in its cancer screening metrics, found in bundle 1, JHN adopted the "Glide Path" target setting model. This model will push JHN to achieve the 75th percentile of National Benchmarks within five years. The graph below displays the JHN Community score from quarter to quarter. Quarter 4 2022, has been the best performance in the last 5 years!



Bundle 1: Preventive Care

The Preventive Care Bundle includes metrics such as well visits, screenings, and immunizations. JHN earned 7 of the 13 (54%) available points, which is the best JHN has performed since prior to the pandemic. Bundle 1 overall is is on the up swing.

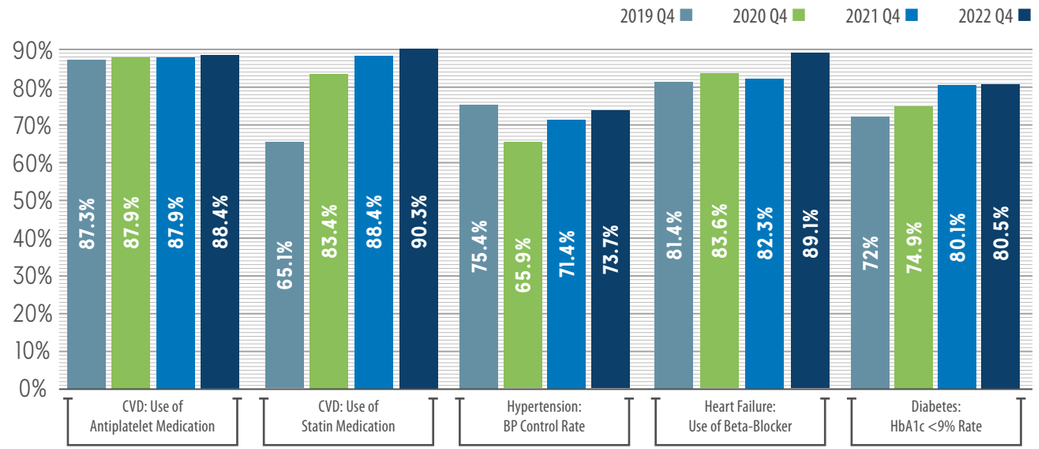
A few highlights from Bundle 1 include an opportunity in both Adolescent Immunizations, but these two metrics will be rolled together as one metric in the 2023 Program. Well-child visits 3-21 target was not reached in 2022. In 2023, this metric will be split into two age groups. Breast Cancer Screening met its first year Glide Path target, however, Cervical or Colorectal cancer screening did not.



Bundle 2: Chronic Disease Care

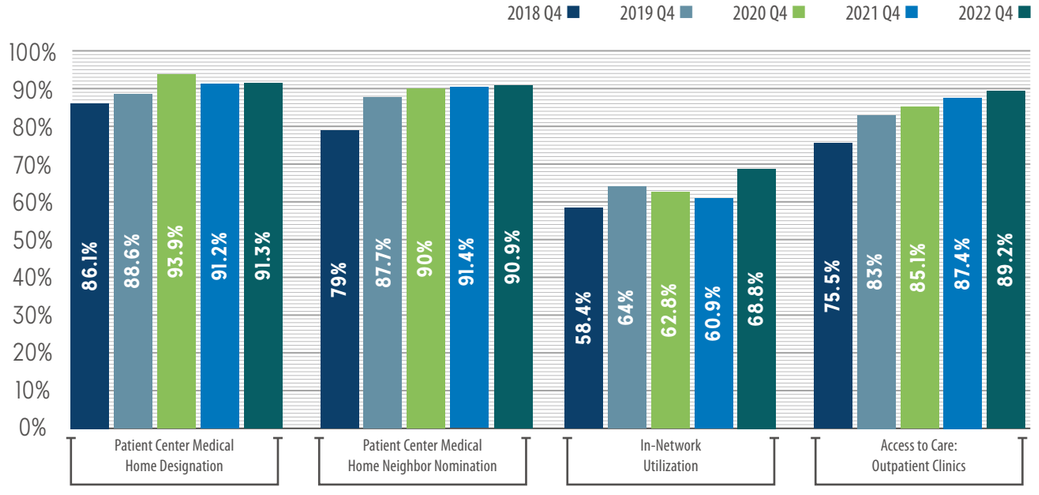
The Chronic Disease Care bundle includes metrics related to Diabetes, Congestive Heart Failure, Hypertension, and Cardiovascular Disease. JHN earned 9 of the available 11 points (82%) in this bundle. We have not only returned to pre-pandemic performance-level in this bundle, but we are exceeding them.

Only two metrics missed the 2022 target in Bundle 2, which include the following. The CVD Use of Antiplatelet Medication metric target was missed by 12 patients. This metric will retire after 2022. The second metric missed is Diabetic Retinal Eye Exam. Strides are being made in this metric as documentation processes are improved across the Network.



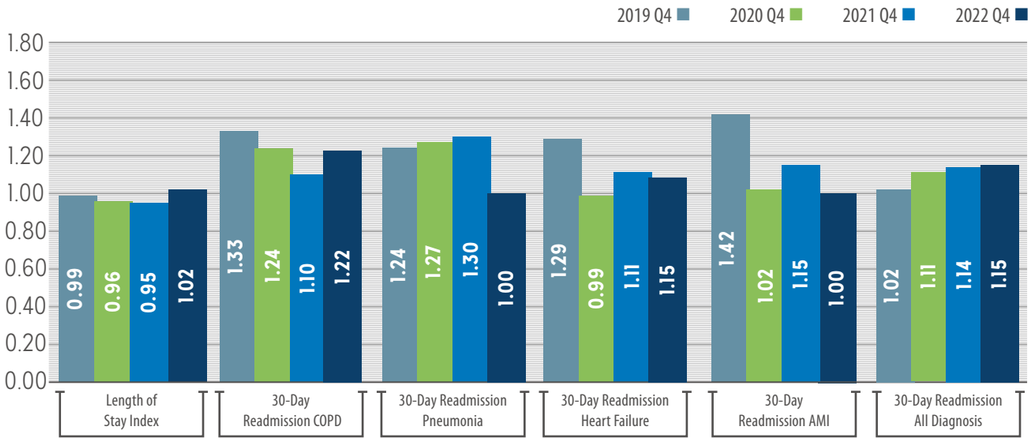
Bundle 3: Continuum of Care

The Continuum of Care performed very well this year earning 11 of 13 points (85%). JHN gained the Longitudinal Care Management metric points by end of year, however, lost points in the Skilled Nursing Facility (SNF) Admits metric. Patient Centered Medical Home (PCMH) metrics make up a significant portion of this bundle (5 of 11 points).



Bundle 4: Quality, Efficiency & Utilization

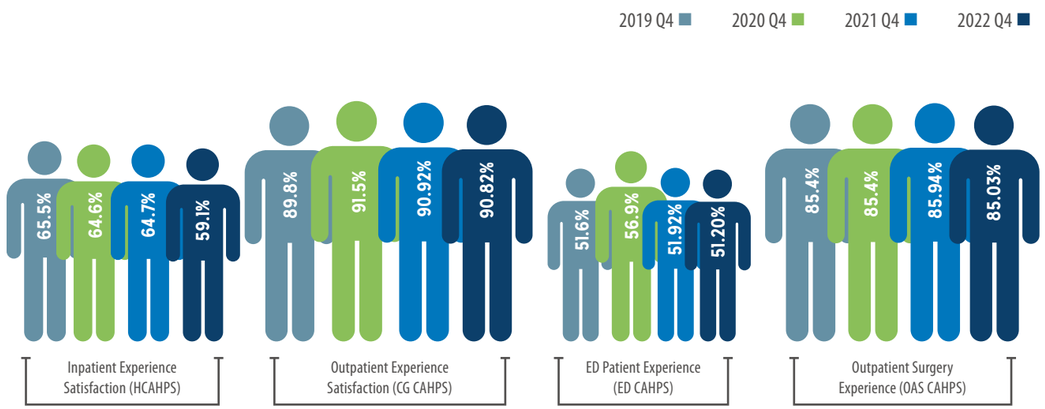
The Quality, Efficiency, and Utilization bundle earned 6 of 10 points (60%). Historically, Bundle 4 has been JHN's toughest bundle. In general, the pandemic helped this bundle due to an overall decrease in utilization. Two of the readmission index metrics were successful - Pneumonia and AMI. The Patient Safety Indicator index metric was also successful. And all three ACO utilization metrics were favorable to targets in 2022.



Bundle 5: Patient Experience

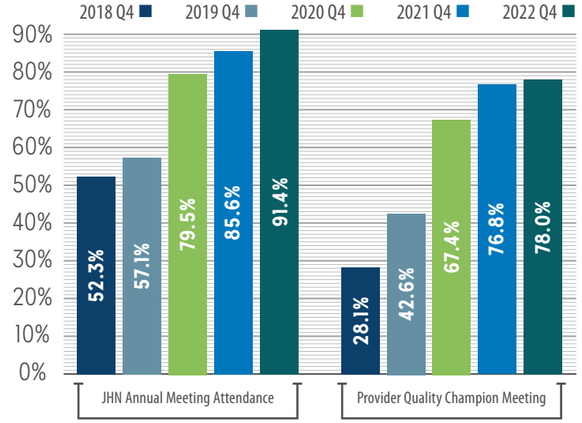
'Willingness to Recommend' is the Press Ganey component measured across each of the four service lines. 'Willingness to Recommend' is highly correlated with all physician communication questions on the survey.

JHN earned only 2 of the 8 points (25%) possible points in this bundle. JHN's percentile rankings are low when compared nationally and will place a strong emphasis on patient experience improvement in 2023.



Bundle 6: JHN Training & Citizenship

All available points were earned in this bundle (100%). JHN surpassed its Annual Meeting metric cap with a score of 91.38% attendance! Provider Quality Champion attendance was up 2% from last year. Physician engagement is a key indicator for JHN's success in 2022.



Overall, Jackson Health Network exceeded many goals in 2022. As a Network, 45% is the minimum threshold allowed for physicians to partake in financial rewards, and the Network was well above that threshold. There are still large opportunities within Bundle 4, utilization, and Bundle 5, patient experience. These two areas are part of the Network's performance strategy in 2023.

I would like to thank the JHN practice transformation team and their dedication to providing targeted education to our physicians allowing us to apply best practices for the Jackson community. We deeply appreciate the individualized provider education that assists our doctors in understanding what JHN has to offer. We utilize the tools and education to work with other PCMH providers to improve the health and well being of the Jackson community. As a result of their hard work and dedication to our practice we have improved our overall community scorecards to the highest levels in years. Orthopedics, sports medicine, and podiatry appreciate your dedication and look forward to improving access to care and patient outcomes in 2023.

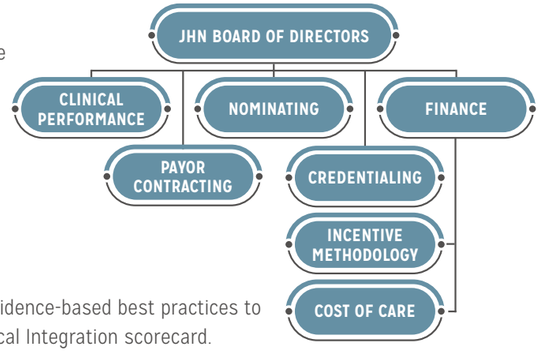
Joanna Plate - Nurse Manager of Ortho, Podiatry, Sports Med, Henry Ford Health

Network Management and Support

Jackson Health Network's success can be attributed to its ability to operate a multifaceted institution through systematic Network management and support. There are several key areas in which JHN has demonstrated innovative leadership and dedication. Effective management of the Network is achieved through its governance structure, shared information technology, centralized payor credentialing and enrollment, practice transformation, patient-centered care and continued education and support. Who are the "customers" of Jackson Health Network? The patient, patient caregivers and patient advocates, physicians – both employed and Independent, all JHN Practices and their staff, Medicare and Medicaid, Michigan Health Plans, The Jackson Collaborative Network and Health Improvement Organization, Henry Ford Jackson Hospital, Henry Ford Health, Jackson County Health Department, CHTN, and Mosaic ACO. And finally, the communities of Calhoun, Eaton, Hillsdale, Ingham, Jackson, Lenawee, Livingston and Washtenaw.

GOVERNANCE

In 2022, Jackson Health Network had five committees, one sub-committee and one workgroup that reported to the Board of Directors. These committees are comprised of diverse representation including primary care physicians, specialists, advanced practice providers, administrative leaders, and community leaders. As the Network has grown and developed, each committee's corresponding responsibilities have evolved as well.



Clinical Performance Committee applies research and evidence-based best practices to establish and monitor performance of the Network's Clinical Integration scorecard.

Nominating Committee garners participation interest and recommends committee membership that represents a diversity of skills and experiences to support successful functioning of the Network's governance.

Finance Committee oversees all financial aspects of the Network finance, including the operating budget, incentive distributions and other Board-allocated funding decisions.

Payor Contracting Committee oversees the Network's contracts with health insurance carriers to promote payment and economic models that align with value-driven care.

Credentialing Committee reviews applications for both new members and those seeking renewal with the Network to ensure compliance with the professional standards established by the Network for our providers. Most health plans delegate this responsibility to the Network for more integrated credentialing.

Incentive Methodology Sub-Committee defines the approach for distributing incentives to the Network by establishing alignment amongst payor contracts and funding all the way through performance-based pay-outs to Network providers.

Cost of Care Work Group identifies and discusses opportunities for improving value-driven clinical performance, particularly related to opportunities for removing non-value-added care and improving cost containment.

INNOVATIVE SHARED RESOURCES

Program Performance and Clinical Quality

Program performance is the management of incentive programs and clinical quality initiatives using analytics to ensure the Network and its practices achieve goals and maximize its return through value-based incentives. Using the practice transformation team and JHN's robust intranet, analytics are provided to all members on a regular basis. Additionally, program performance ensures all health plans receive supplemental data from JHN's community EHR, EPIC. This data completes a full picture of the care provided to JHN patients.

Clinical Quality plays a dynamic role in development, implementation and maintenance of clinical performance measurement, cross-continuum, in the JHN Clinical Integration Program. The Clinical Quality Coordinator has expertise in metric development and operationalization, including knowledge of AHRQ, NQF, HEDIS and CMS metrics. Clinical Quality also monitors metric performance to drive improvement on the quadruple aim goals for population health in the current value-based landscape, along with applying clinically relevant up-to-date evidence-based medicine and best practice guidelines which support population health of the Jackson and surrounding communities.

Centralized Payor Credentialing and Enrollment

Delegated credentialing agreements streamline and expedite the credentialing process. JHN monitors provider credentialing and payor enrollment to ensure providers are properly credentialed and enrolled. Credentialing is an essential step to ensure rendered services are accurately reimbursed by contracted payors. JHN Provider Affairs is working towards NCQA accreditation. JHN has built strong relationships with its payor partners which ensures questions or claims issues are resolved quickly. Additionally, JHN meets with payor partners monthly to centralize all payor updates and then produces a monthly payor newsletter to the Network, reducing the burden on practice administration and billers from sifting through the many payor communications sent out daily. Maintenance and reconciliation of the payor membership attribution lists is also supported .

Patient Centered Medical Home Support

Each Primary Care and Specialist practice, along with inpatient departments participate through JHN in the Blue Cross Blue Shield of Michigan (BCBSM) Physician Group Incentive Program (PGIP) Patient Centered Medical Home (PCMH) program. JHN's PTPS team is responsible for supporting the PCMH/PCMH-N model including managing patient care, providing preventive and treatment services, actively engaging with all stakeholders to optimize cost/use of services, and to build trust and coordination between PCPs and specialists. Through this program Primary Care and Specialists are eligible for fee schedule uplifts ranging from 3% - 15%. Additionally, PCMH designation for Primary Care provides several other incentives/uplifts under other State of Michigan health plans who recognize this program as a standard of care.

Shared Information Technology

As patients navigate through a very complex health care system, a shared information technology (IT) platform is necessary for Network providers to deliver more value to their patients. With the transition to Epic in 2017, in partnership with Henry Ford Health, JHN providers gained a necessary foundational platform to reduce waste and variation in care.

Using Epic, the JHN Compass can collect clinical data on the population of patients attributed to JHN providers. Data is shared among all providers either through full adoption of EPIC or through a limited access version called JHN Gateway. As of year-end 2022 99% of primary care and 88% of specialists in JHN use EPIC as their electronic health record, including Henry Ford Jackson Hospital entities, the Jackson County Health Department, and many independent physician practices. The ability of the Network to view and share relevant clinical data on shared populations has been a huge shift towards meeting the Quadruple Aim objectives.

Practice Transformation Project Specialists

One of the unique features of JHN is its view of practice-level customer support. Every clinic is assigned a Practice Transformation Project Specialist who meets with the practice manager or point of contact each month. The goal of the practice transformation team is to reduce the burden placed on practices by the many required quality performance programs. This is achieved by the team organizing and delivering specific messaging to guide the practice to success. Comprised of various expertise levels and backgrounds that harmoniously work together, the team delivers efficient customer service to JHN members.

Each month, the practice transformation team, with guidance from JHN leadership, develops a standardized agenda for primary care and specialty care offices. The team understands the complex nature of running a medical practice and takes this into consideration when delivering monthly messages and strategies to improve performance. The team collaborates with the practice manager each month to develop action plans based on the practice's goals and the quality performance program expectations.

Priority areas of focus in 2022 included:

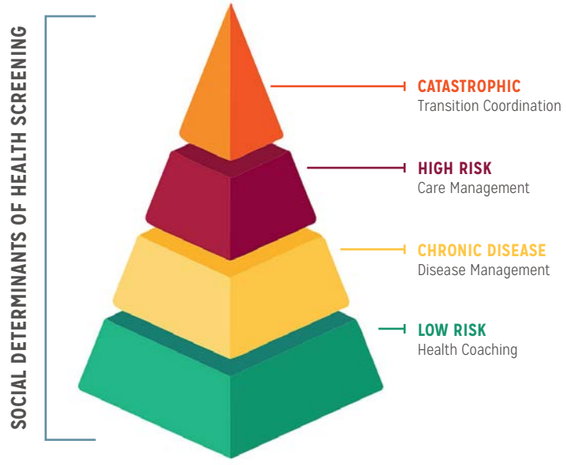
- Strategies to close care gaps missed in 2021 due to COVID-19.
- Performance improvement in the JHN CI Program.
- Patient Centered Medical Home.
- Updates and communication from contracted health plans.

Physician Education, Training and Support

To ensure clinicians receive the education needed to be successful in JHN quality performance programs, providers are offered a variety of opportunities to receive continuing education and to collaborate with other providers who are participating in similar programs. Continuing education and collaboration from providers are offered through JHN's Provider-Quality Champion meetings, regular presentations given by JHN leadership or outside speakers, and through convenient online training modules.

POPULATION HEALTH MANAGEMENT

According to the American Hospital Association, "Population Health Management refers to the process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models." As an integral part of Jackson Health Network, Population Health Management is comprised of several programs aimed at providing risk-level appropriate interventions to a group of targeted individuals. Whether keeping healthy populations well, or mitigating the progression of disease, our focus is patient-centered and has a strong emphasis on providing care that addresses the medical, social and behavioral needs of the people served.



Transition Coordination

In April 2016, after recognizing the negative impacts that readmissions can have on the Quadruple Aim, Jackson Health Network, Henry Ford Jackson Hospital and community partners worked together to address this critical issue. The result was the launch of Transition Coordination. This program is designed to ease a person's transition from hospital to community.

Regardless of a patient's primary care provider, anyone discharged from Henry Ford Jackson Hospital with an identified high risk diagnosis receives a call within 24 to 48 hours post discharge.

This call, among the others that are extended throughout the course of 30 days, aims to mitigate barriers (e.g., accessing equipment and medications by reviewing discharge instructions, ensuring follow-up with primary and specialty care, and providing ongoing education to people on how to better cope with their conditions).

EXAMPLES OF THE TYPES OF CONDITIONS TARGETED BY THIS TALENTED GROUP OF REGISTERED NURSES.

Over time, connections were made 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.

Transition Coordination continues to evolve. This year, the team partnered with the Post-Acute Surveillance (PACS) team to monitor any Accountable Care Organization patient (e.g., patients with Medicare) that discharges to short-term rehabilitation (STR). The coordination between the PACS team and the STR helps to reduce length of stay and assist in planning for a successful discharge back into the community. Patients also receive a call after their return to home, with similar goals and interventions as those that discharge from the hospital. In addition, Transition Coordinators have begun calling ACO patients that present back at the HFJH Emergency Department within 30 days of an inpatient discharge. These advancements in who receives the skilled care of the Transition Coordinators is exciting and will undoubtedly continue to evolve for the Network.

Care Management

The Commission for Case Management Certification (CCMC) defines Case Management as a "professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the 'Quadruple Aim,' of improving the experience of care, improving the health of populations, and reducing per capita costs of health care".

Case Manager, often used interchangeably with the term Care Manager, is an interdependent member of the patient-centered care team. Care Managers employed by Jackson Health Network are either Licensed Master Social Workers (LMSWs) or Registered Nurses (RNs) who are experts in managing complex medical conditions, motivational interviewing, care coordination and all stages of change a patient may experience. Jackson Health Network-employed Care Mangers are required to obtain certification through the Commission for Case Manager Certification, the first and largest nationally accredited organization that certifies Case Managers and disability management specialists. These individuals have proven to be a vital component of the care team and have successfully been embedded into primary care.

Collaborative Care (CoCM)

In 2022, HFJH Medical Group, JHN, and HFJH Behavioral Health have partnered to pilot and pursue a strategy for addressing access to behavioral health services using the Collaborative Care Model (CoCM). This evidence-based program is designed to treat common mental health conditions in a patient's trusted and frequented primary care medical home.

Patients experiencing symptoms of mild to moderate depression and/or anxiety are referred by their Primary Care Provider (PCP) to a specially trained JHN Behavioral Health Care Manager (BHCM). The JHN BHCM offers convenient access via virtual appointments providing short-term, goal-oriented intervention typically consisting of 4-6 sessions.

The CoCM team is made up of the patient, PCP, Behavioral Health Care Manager (BHCM) and Psychiatric Consultant (PC). Primary care providers and behavioral health case managers work alongside a psychiatrist who provides support and treatment planning recommendations for prescribing and managing behavioral health medications.

Diabetes Education Center

The goal of the Diabetes Education Center is to help improve diabetes related outcomes by providing comprehensive Diabetes Self-Management Education (DSME), which includes either 1:1 or group education. Patients who completed their education plan saw an average reduction of 1.5% in their A1c within 3 months. Every 1% decrease in A1c is associated with a 40% decrease in long-term diabetes-related complications. Improved glycemic control is associated with lower frequency of all-cause hospital readmission within 30 days. In addition to improve glycemic control, DSME participants generally experience reductions in BMI, blood pressure, and have better clinical care outcomes which results in improved quality of life for our patients and a lower financial burden on the health system.

Patients who participate in DSME are consistently providing positive feedback about their experience at the Diabetes Education Center! They report that they appreciate how diabetes is explained and that it helps them understand the disease process much better, they have their concerns addressed, they feel heard, they receive help with meal planning, and that the classes are fun and that information is delivered in a collaborative manner.

"Jackson Health Network has been instrumental in our success as a practice. Our monthly rounding visits help keep us on track and identify areas that need our focus. Compass also is a very useful tool that encourages us to improve weekly. It is valuable to see how we're doing at any given time."

- The Office Staff at Donald C. Jones, MD, PC

Collaboration Efforts

Effective management of the Network is demonstrated through the many systematic processes built for success and through the collaborative efforts and partnerships with organizations and teams sharing the same values and objectives. The shared values and objectives can be summarized as strengthening the Jackson community and to create a healthier and happier population.

JACKSON COLLABORATIVE NETWORK/HIO

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.

In early 2020, local collective impact efforts were formally integrated, and shared governance and operational structures were established. This integrated network is referred to as the Jackson Collaborative Network.

Jackson
COLLABORATIVE NETWORK
www.JacksonCollaborativeNetwork.org

The Jackson Collaborative Network is comprised of more than 500 individual partners representing more than 150 local agencies. Network partners are united by a commitment to shared values of Equity, Authentic Engagement and Continuous Learning. This work is guided by community assessment efforts that make data available to assist members to identify, prioritize and address common root causes of disparities with an emphasis on creating sustainable change, ultimately resulting in improved outcomes for residents. Partners are actively engaged in the development and implementation of action plans in alignment with shared goals. The most recent Collaborative Community Assessment report and Infographics can be found on the Jackson Collaborative Network website, http://www.JacksonCollaborativeNetwork.org.

As a partner in Jackson's collective impact efforts, JHN is focused on supporting alignment of clinical and community systems to positively impact shared goals and reduce disparities, resulting in improved health outcomes for all residents.

SOCIAL DETERMINANTS OF HEALTH

The Centers for Disease Control and Prevention (CDC) report that the conditions in 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). Poverty in the Jackson community limits access to healthy food and safe neighborhoods, resulting in more education being required to improve patients' health. Care managers are trained to screen patients for SDOH and link them to appropriate community resources. 100% of primary care practices are screening their patients for SDOH, resulting in over 73,000 SDOH screens administered to our patients in 2022. Additionally, the JHN Board of Directors approved SDOH screening as an incentive metric in the JHN CI Program, which began in January 2022.

In 2022, JHN signed contracts with two Managed Medicaid health plans to provide CHW services to beneficiaries attributed to JHN. To deliver high-quality care to our community, this new and exciting work allowed us an opportunity to contract with three agencies already providing CHW services to the Jackson community: Central Michigan 2-1-1, ARE (Activities Recovery Empowerment) Drop-In Center, and Center for Family Health.

"The positive impact of working with Jackson Health Network monthly has elevated the knowledge of free resources available in Jackson County for all patients. This information has been posted in The Community Resource binder and the feedback has been outstanding! Many patients have successfully used these resources, improving the quality of life for the patient and/or family."

- Natalie Harrington, Practice Manager
Arthur Vendola, MD, PC

"Jackson Health Network has been instrumental in our success as a practice. Our monthly rounding visits help keep us on track and identify areas that need our focus. Compass also is a very useful tool that encourages us to improve weekly. It is valuable to see how we're doing at any given time."

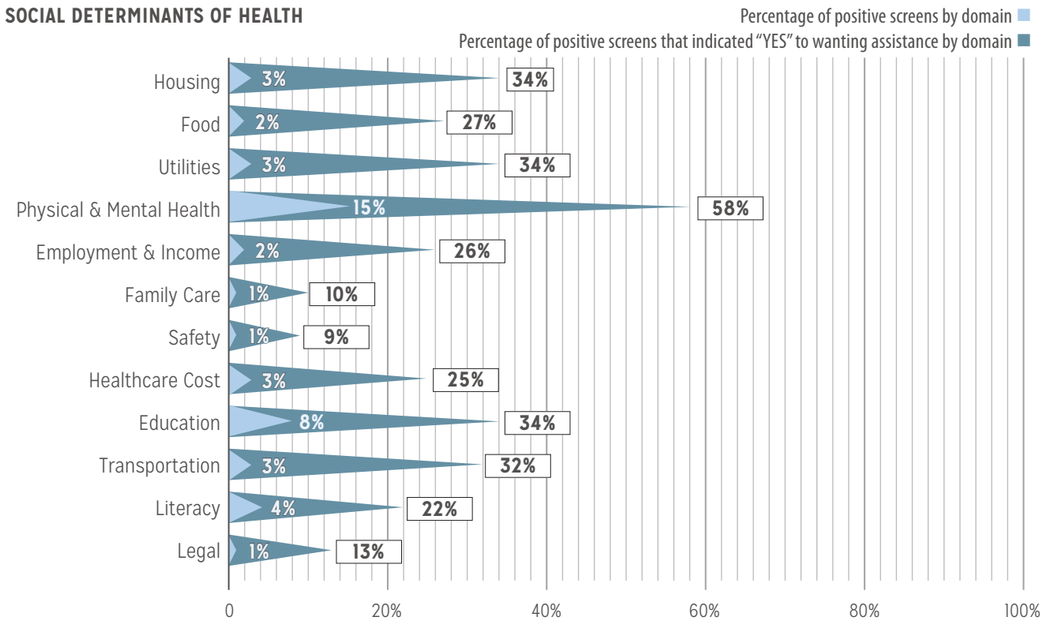
- The Office Staff at Donald C. Jones, MD, PC

Care Management and Transition Coordination teams also work in tandem with contracted CHWs to address the socio-economic needs of patients. CHW's assist with clerical, task-based work associated with addressing SDOH needs of our patients. 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. CHWs may have an associate degree in a human-service related field or specialized CHW training provided by the State of Michigan. In addition to their work with Medicaid health plans and the Population Health Management team, these individuals are experts at connecting patients to resources in the community using both their formal knowledge and lived experience, as well as the Jackson Care Hub.

The Jackson Care Hub is a secure web-based network that enables service agencies across Jackson to coordinate care for residents. Providers working in healthcare, housing, transportation, education, and many other sectors can all utilize a single system to identify local resources and refer clients directly to partner agencies for needed care. By aligning diverse resources, we can meet the needs of people in our community.

The highest areas of need in our community have been identified through data collection efforts. The table below shows a breakdown of positive SDOH needs identified by domain. The data is used to inform existing and new services and resources offered in the community and ensures the needs of the community are met.

SOCIAL DETERMINANTS OF HEALTH



Source: Jackson Care Hub Data Brief January 1, 2022 - December 31, 2022

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 recognizes the value of collaboration with JCHD to address population health in Jackson County. The health department and network collaborate closely on population health improvement efforts to ensure integration of health care and public health services in the community. Additionally, JCHD utilizes Epic, the shared community electronic health record, for all its clinical services, which helps provide more seamless transitions and data exchange for care provided in the community.

HENRY FORD HEALTH

Affiliation with Henry Ford Health (HFH) creates opportunities for Henry Ford Jackson Hospital (HFJH) and Jackson Health Network to collaborate with the broader system around shared opportunities in pursuit of the Quadruple Aim. These shared opportunities included infrastructure and technology development, learning and continuous improvement, scaling of best practices, and advancement of shared strategies for provider engagement. Collaboration includes care redesign, population health management, and transformation of health care financing.

Affiliation with HFH also connects HFJH and JHN with their subsidiary provider-sponsored health plan, Health Alliance Plan (HAP). HAP is a full-service health insurance company with various product portfolios for individuals, companies and organizations, serving over half a million members across 20+ counties in Michigan. While JHN maintains successful contractual relationships with a variety of commercial and governmental payors, collaborating with HAP in an integrated delivery system model creates additional opportunities to care for our populations more seamlessly and comprehensively through coordination of payor and provider services.

MOSAIC ACCOUNTABLE CARE ORGANIZATION

In January 2022, we kicked off the new MOSAIC Accountable Care Organization (ACO) with partners Henry Ford Physician Network and Covenant Health Partners. MOSAIC replaced the Federation ACO, which ceased operations at the end of 2021 with the unwinding of Affirmant Health Partners. The ACO covers nearly 50,000 Medicare lives. We participate in the Medicare Shared Savings Program (MSSP) Enhanced Track, which provides for "first dollar" opportunities for shared savings (up to 75%) and shared losses (minimum 40% to maximum 75%). Although this ACO is smaller than the Federation ACO, and there is potential for significant downside risk, we are highly aligned with our partners around delivering better care at lower cost.

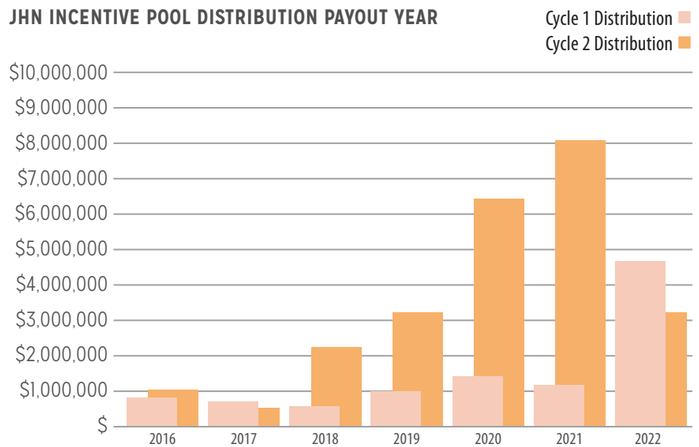
For more information: https://www.henryford.com/about/mosaic-aco

Financial Performance

As Jackson Health Network evolves, the Network's payor contracts increasingly emphasize value-based terms, including financial accountability for the total cost-of-care.

As the graph to the right shows, the Network's incentive value-based performance on these total cost-of-care arrangements has driven the considerable growth in the Network's incentive pool. These shared savings incentives are the majority of the Cycle 2 incentive distributions, and these include contributions from commercial, Medicaid and Medicare contracts.

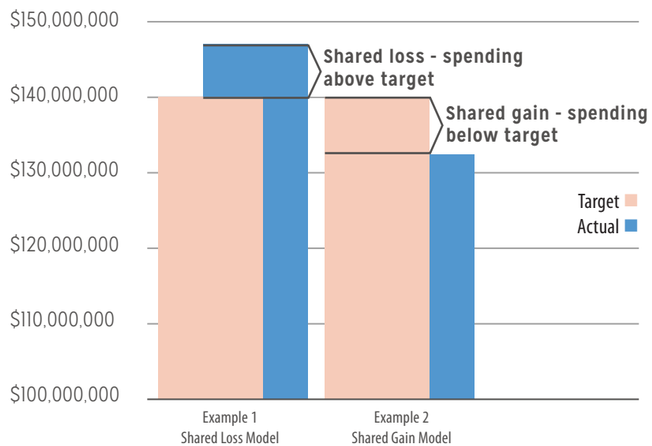
JHN INCENTIVE POOL DISTRIBUTION PAYOUT YEAR



Cycle I is mostly quality incentives and Cycle 2 is mostly TCOC. First ACO distribution was in 2018. JHN has paid over $20M in incentives since 2014.

The example on the right shows how these shared upside/downside contracts are structured. Cost targets are set, often based on risk-adjusted attributed lives, and select quality thresholds are often established as well. Based on quality and total cost-of-care performance, the Network may share in a percentage of the upside gains or downside losses, which varies by payor class and arrangement. For example, for all four performance years through 2020, the Network shared in approximately 40-50 percent of the savings for the Federation ACO lives which outperformed the actuarially established cost target by above two percent each of those years.

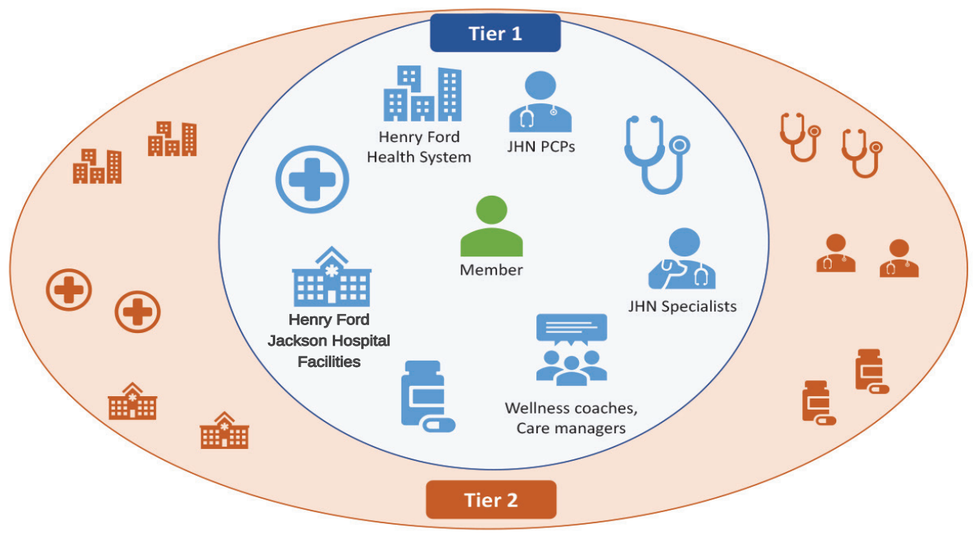
EXAMPLES: FINANCIAL UPSIDE / DOWNSIDE MODEL



The Network has also engaged directly with local employers in similar arrangements aimed at bending the cost curve. These contracts are structured around the clinically integrated Network's ability to drive value through a high-performing Tier 1 which focuses on coordinated high-value care delivery. This innovative approach allows employers to more actively engage with the provider Network to improve the health of their employees while proactively addressing costs.

HOW TIER 1 NETWORK SUPPORTS VALUE-DRIVEN HEALTH CARE DELIVERY:

- High-value physician network(s) with physician-defined quality goals
- Upstream provider partnership, including benefits roll-out and customized education
- Integrated electronic medical record supporting connected care and limited duplication
- Care coordination and care management for the hightest need population



JHN's Value Proposition for Clinicians

CLINICALLY INTEGRATED NETWORK (CIN)

Jackson Health Network (JHN) is

- A Clinically Integrated Network
- A legal entity that allows hospitals and physicians to work together to improve patient experience, produce quality outcomes, reduce overall cost of care, and enhance work-life balance for its providers
- Able to engage in joint contracting that aligns payment methods with new care delivery models
- Expected to demonstrate improved quality outcomes and efficiency year after year

Community Medical Record

JHN works with Community Health Technology Network (CHTN) to offer physician members the electronic health record (EHR) Epic.

Physician Value: Epic is an electronic medical record that is CMS Meaningful Use certified. It provides many features for providers, staff and patients. MyChart, for instance, is an online portal which allows patients to view their own medical record and message their provider.

Access to Epic improves the ability of physicians and office staff to manage patient health with a shared EHR. Medical information can be viewed by the PCP, specialist, hospitalist or other care team 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 on 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 physician and office staff's ability 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 customer service.

Value Based Reimbursement

The network is able to 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.

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 for the patients we serve.

Access to Payor Contracts

With JHN, physicians can participate in commercial and government plans, directly with employers and in state-wide efforts.

Physician Value: Providers will 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.

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 the right care in the right place at the right time.

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 stake-holders 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 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 the 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 week-end 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.

"The team of experts that Jackson Health Network has assembled to work directly with the payers on reimbursement, billing, and contracting issues and concerns has been very supportive of our practice. Time and talent are often hard to secure for the smaller practices so knowing this team has our best interest at heart when working with the payers is priceless."

-Terri Draper, Practice Manager
Jonesville Health Care, PLLC

Population Management Success Stories

CARE MANAGEMENT

A 63 year-old female patient with a diagnosis of portal vein thrombosis was referred to Care Management by her PCP for medication assistance. The patient's commercial insurance coverage changed, and she was unable to fill her Xarelto prescription as it was not covered on her new plan. The patient informed the care manager she was quoted $1000 for the Xarelto prescription, and that the pharmacist tried, but was unable to locate any savings for her. The Care Manager assisted the patient with applying for the manufacturer's patient savings program. The patient was approved for paying $10 per thirty-day supply of Xarelto.

A 74-year-old patient was referred by his Primary Care Provider (PCP) to care management due to caregiver stress. The patient provides care for both his wife and his sister with dementia residing in the home. The patient was initially hesitant to accept assistance but engaged with the care manager for emotional support. After a couple months of working with the care manager, the patient allowed the care manager to coordinate services through for the three of them including Meals on Wheels, housekeeping, and respite services.

DIABETES EDUCATION

A patient completed an initial assessment for Diabetes Self-Management Education in January 2022. The patient was newly diagnosed with an A1c of 7.3%, did not want to start medication, but wanted to work on lifestyle changes instead. In September, the patient reported losing 35 pounds simply by monitoring carbohydrate intake and walking 30 minutes most days. The patient's A1c was down to 5.3% and has remained under 5.5% for seven months. All this without diabetes medications! The patient shared successes with other class participants who were impressed and motivated to push themselves even more.

In December 2021 a patient's Lantus was increased from 22 units a day to 26 units/day (in addition to taking 3 oral medications for diabetes). After being referred for Diabetes Self-Management Education and working closely with the Diabetes Education Specialist, the patient reported losing 13 pounds within 2 months. The patient has increased their activity and was able to decrease the Lantus to 12 units/day. The patient continues to work towards their goal of eliminating the need for insulin completely, something the patient thought they would never be able to do.

TRANSITION COORDINATION

A Transition Coordinator (TC) noted that a patient discharged from the hospital with an address but no phone number on file. The patient did not see the Community Paramedic prior to discharge, so follow-up care was not initiated. The TC coordinated with the Community Paramedic to go to the patient's home and leave her contact information. The patient and the TC were able to make contact, and she was able to assist the patient with arranging needed follow-up medical visits and facilitating medication access as the patient had none of their medications. The patient had not seen a physician in 5 years so establishing primary care was of the utmost importance.

COLLABORATIVE CARE

A 29-year-old male who presented with generalized anxiety disorder with panic attacks and depression was referred to Collaborative Care. Both the GAD-7 and PHQ-9 scores were 16 when the patient started treatment. The patient was frequently challenged with excessive worry about family, was not sleeping well, experienced repeated panic attacks, and struggled at work. Together with the Behavioral Health Case Manager, Primary Care Provider and Psychiatric Consult, a care plan was developed to help the patient acknowledge cognitive distortions, challenge anxious thoughts, and implement implement relaxation techniques, time management skills, sleep hygiene and self-care. The patient reported utilizing the learned skills to help manage worries at work and home and be more present with family. Additionally, a medication combination was introduced to assist with symptom management. Upon discharge from Collaborative Care, both the GAD-7 and PHQ-9 scores were reduced to 1.

Future of Care in Jackson

Courtland Keteyian, MD, MBA, MPH
President/CEO, Jackson Health Network

We have something special in Jackson. For more than a decade we have pursued the Quadruple Aim – reducing cost, improving population health, and improving satisfaction for patients and providers. Today, after years of building, we have more than just a chassis, we have the vehicle needed to succeed in value-based care. Our network is strong, with nearly 1,000 providers and more than 130,000 aligned lives. We are uniquely integrated with community support entities to address upstream social determinants that drive health outcomes and costs. We have payor contracts that support our model and reward us for delivering value. Few, if any, organizations across the county have the comprehensive solution we have in Jackson.

We are fortunate for the position we are in because the future is uncertain. The pandemic is not over, but our ability to respond is stable. As the public health emergency ends, we again will have the exposure of significant downside risk in the ACO. This population represents more than 20% of annual spending in the network, and the exposure could exceed 40%. We must continue to focus on risk coding to influence our spending target and do the hard work necessary to remove cost from the delivery system.

Leading the way to provide value is also important because new forces are exerting influence on healthcare. Private equity, which started with consolidation of specialty practices, has moved into primary care. Numerous equity-backed entities are offering a suite of comprehensive services in the quest to align more lives. Industry is also expressing new interest. Amazon launched a virtual clinic available 24/7. Aetna and CVS merged several years ago to create an umbrella health company. Walgreens partnered with VillageMD to accelerate the opening of primary care clinics at Walgreens locations. The largest employer of physicians in the country with over 60,000 doctors is Optum Care, a subsidiary of United Health Group.

Change is clearly the constant in the future of healthcare. While we face threats to our traditional model of practice, the challenges force us to innovate and evolve. To quote Henry Ford, "Whether you think you can or you can't, you're right." We can, and we will. JHN has always been, and will always be, as strong as our commitment to working together. If we trust in our values and remain focused on the Quadruple Aim, Jackson will be a healthier, more vibrant, and sustainable community.

Thank You to Our Leaders

We wish to extend a sincere thank you to the Network's governance members, with a special thank you to our Board of Directors for their service. The below list includes our 2022 Jackson Health Network Board of Directors.

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Jackson Health Network was envisioned and created by a hard-working group of people within the healthcare 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.

OUR SKILLED TEAM OF EXPERTS

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