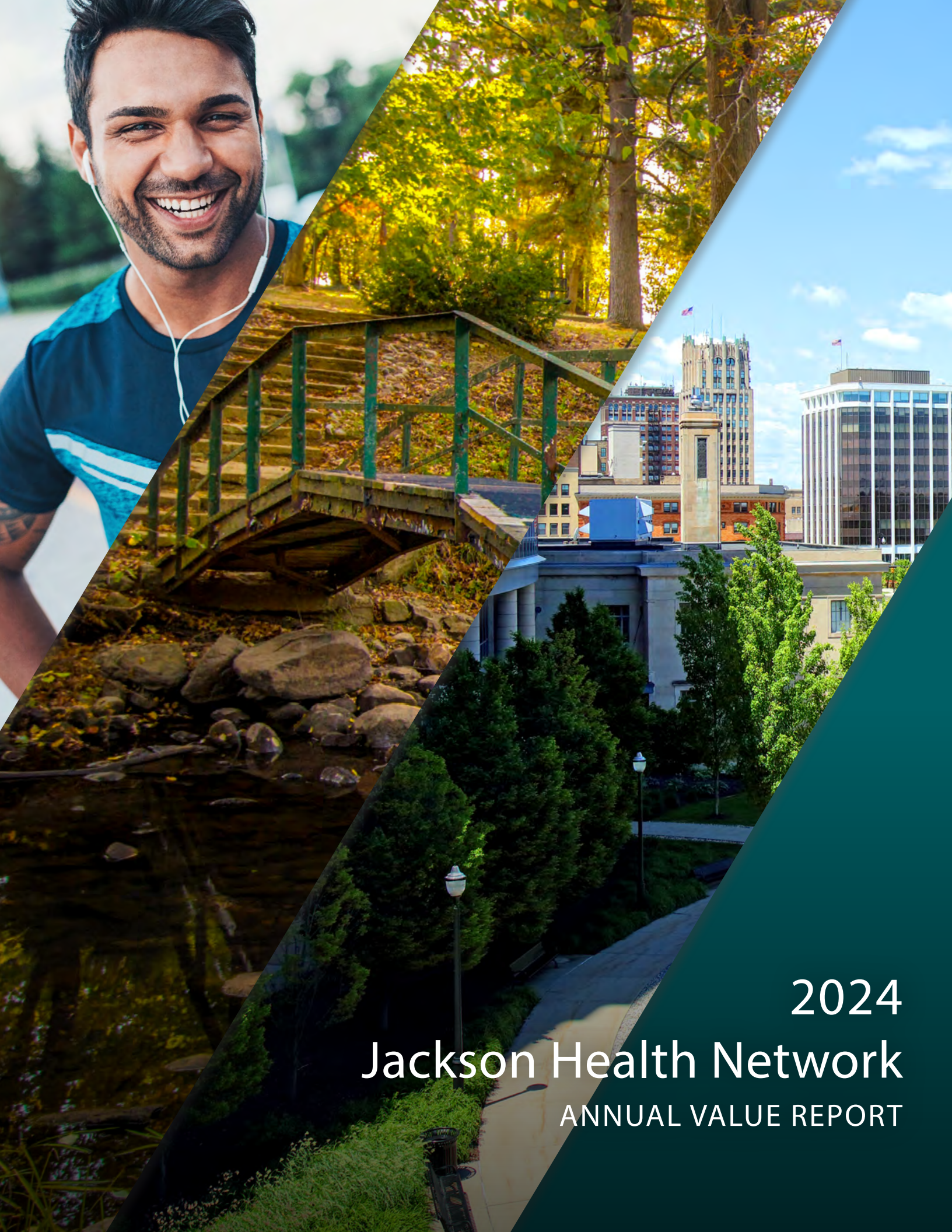


2024
Jackson Health Network
ANNUAL VALUE REPORT

The Jackson Health Network Vision

We, the Participants of the Network, will operate as a close partnership between Henry Ford Jackson Hospital andaffiliated 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

Jackson Health Network is a model clinically integrated network with nearly 1,000 providers caring for 140,000 lives in our community. The first physicians and hospital leaders came together in 2010 with an ambitious vision for the future of healthcare. That vision remains constant to this day, we believe in continuous pursuit of the Quadruple Aim – reduced cost, improved population health, more satisfied patients, and more fulfilled providers. The result is a highly engaged provider community, meaningfully invested in our region, measurably changing health outcomes.

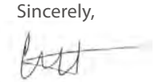
Each year we publish this report to maintain transparency of operations, highlight ongoing accomplishments, and orient toward the future. I am privileged to lead a team of exceptionally talented individuals across the network and division of population health. The population health framework in Jackson involves the strategic integration of Community Health, Population Health Management, Business Health, and the Jackson Health Network. These domains are designed to address the primary drivers of health outcomes – social, behavioral, environmental, and clinical. Ultimately, we as the provider community are financially accountable for these outcomes through our value-based contracts where we take on risk.

Many accomplishments from 2023 are worth reflecting on. We entered our second year of participation in the Mosaic ACO, receiving a tailwind of shared shavings based on our first year of performance. We successfully negotiated multiple new payor contracts, increasing the total to 24 payor/product agreements. We achieved the all-time highest score on our clinical integration program since evolving to a model that aligns with objectives of the Quadruple Aim. This performance translated into another strong year of program earnings and incentive distribution.

In addition to our performance, this report highlights essential partnerships with our community. We recognize that most needs driving health outcomes are social and behavioral, 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. The Jackson Care Hub is a clinical extension of this collaborative, a best-in-class 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. With our providers as partners, this community has completed over 500,000 screens for social needs in Jackson since the inception of the hub.

In closing, Jackson is a special community, with hard-working people and dedicated physicians. I could not be more proud of the work we do in service of the people of Jackson. If we remain committed to our vision and to each other, we will continue to change our world for the better.

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

Dear Colleagues,

Jackson Health Network (JHN) is proud to present its 2024 Value Report, highlighting achievements from the past year.

It goes without saying that our patients and our providers locally, and our network on a regional scale, are being forced to adapt to a healthcare landscape that at times seems to lack solid footing. It is difficult to keep up with all the changes!

Many of you likely have questions about what our network, and value-based care generally, will look like in the coming years. This report, and hopefully my sentiments as well, will reaffirm to you and your teams that how we have survived, and more importantly will continue to thrive, is a product of the efforts of past and present leaders and members. These successes will continue if we remain true to our values and experience.

The forces that affect how we deliver care- the payors who squeeze more from us and our patients, the turnover in our teams as employees seek better wages and satisfaction, the necessary expectations of patients and their families wanting a better experience with each encounter- can be managed, particularly if we demand of ourselves and our partners consistent and realistic targets for improvement each and every quarter. Our network is successful because we do not rest on past performance, and as we move more towards downside risk contracting the high standards we hold for ourselves will make our network both attractive for new members and reassuring to payors who we negotiate with.

Our network, led by Drs. Courtland Keteyian (CEO) and Amy Schultz (Executive Director), maintains a strong partnership with the Henry Ford Jackson Hospital administration, and more broadly the Henry Ford Health System and regional clinically integrated network (the Mosaic Accountable Care Organization). Our team's expertise and value, represented by Courtland and Amy and their outstanding executive/administrative cohorts, continues to shape the future of value-based care in the Southeastern Michigan space.

We appreciate your hard work, look forward to advocating on behalf of you and your patients, and welcome questions or feedback at any time.

Sincerely,

Anish Wadhwa, MD
Chairman of the Board, Jackson Health Network
Pulmonologist, Pulmonary Clinics of Southern Michigan, PC

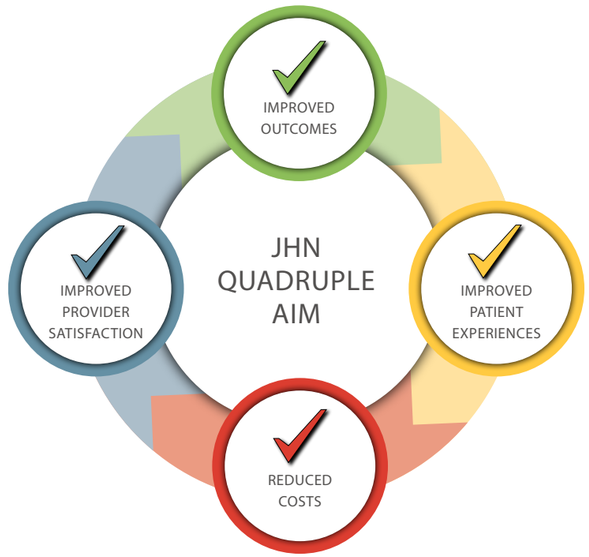
Why a Clinically Integrated Network

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.

"Jackson Health Network has been a good resource for our practice as we navigate the ins and outs of the Epic EMR system. Our Practice Transformation Specialist has been instrumental in helping us keep our PCMH capabilities up-to-date and is a wonderful resource for information regarding Compass and all that is necessary in that respect."

- Evelyn Eccles, MD - Primary Care Physician

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.

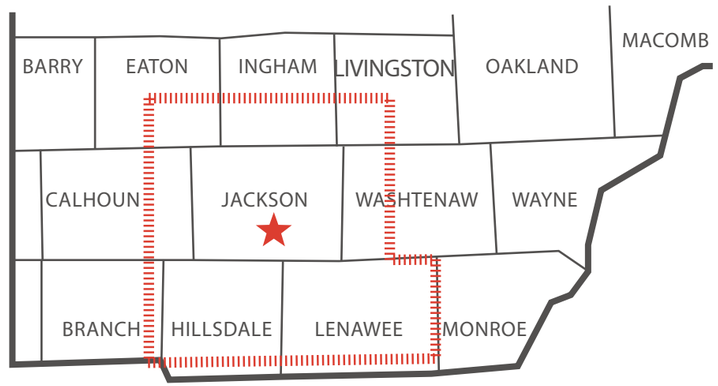
SPECIALTY TYPES

Primary Care

Family Medicine
General 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
Hospitalist - Adult Specialist
Hospitalist - Gastroenterology
Hospitalist - General
Hospitalist - Neurology
Hospitalist - Obstetrics
Hospitalist - Pediatrics
Hospitalist – Physical Medicine and Rehabilitation Infectious Disease
Hyperbaric Medicine/Wound Care
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



JHN BY THE NUMBERS*

991 Credentialed members

- **67%** Henry Ford Allegiance Medical Group
- **33%** Private Practice
- **131** Primary Care Providers
- **860** 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
- **93%** 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

130,000+ 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
- **10** Chronic Disease
- **9** Continuum of Care
- **10** Quality, Efficiency and Utilization
- **4** Patient Experience
- **2** Training and Citizenship
- **56** Specialty Metrics

73 Employees

- **32** Care coordinators, health coaches, transition coordinators, diabetes and nutrition educators
- **23** Clinical performance, credentialing, programmatic, and support staff
- **12** Leaders
- **3** Jackson Collaborative Network
- **3** Medical Directors

*As of November 1, 2023

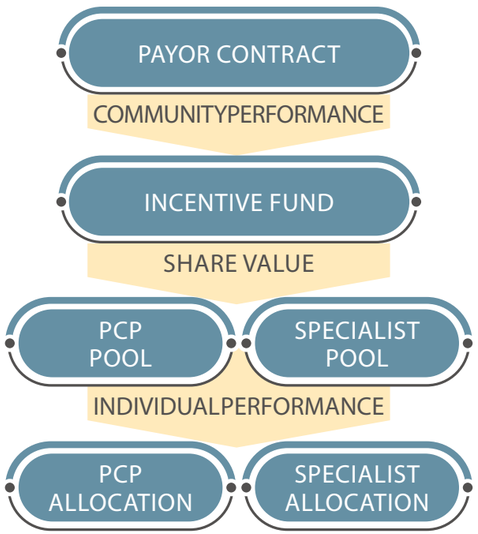
2023 Clinical Performance

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

2023 QUARTER 4 COMMUNITY SCORECARD

2023 Quarter 4 Overall Community Performance				2023 Q4 JHN Community Score		74.14%		
Bundle 1: Preventive Care								
Metric ID	Metric Name	Num	Den	Community Score	2023 Target	Points Earned	Max Points	YTD Trend
PC.100	Adult Covid-19 Vaccine	65,547	101,307	64.70%	65.85%	0	1	
PC.102	Pneumonia Vaccination	18,196	28,569	63.69%	60.10%	1	1	
PC.103	Immunizations: Birth - 2 years	1,099	1,639	67.05%	70.30%	0	1	
PC.106	BMI Activity Nutrition Counseling	64,864	93,372	69.47%	65.57%	1	1	
PC.111	Tobacco: Cessation Intervention	16,785	20,968	80.05%	78.41%	1	1	
PC.121	Adolescent Immunizations Combo 2 'IMA'	665	1,768	37.61%	37.08%	1	1	
PC.149	Well Child Visits: 3 - 11 years	10,740	14,600	73.56%	75.16%	0	1	
PC.150	Well-child visit: Birth - 15 months	1,304	1,640	79.51%	79.30%	1	1	
PC.152	Breast Cancer Screening	16,952	22,816	74.30%	72.64%	1	1	
PC.153	Cervical Cancer Screening	19,871	29,042	68.42%	73.18%	0	1	
PC.154	Colorectal Cancer Screening	28,309	42,138	67.18%	68.21%	0	1	
PC.161	Depression Screening: ≥12 years	72,298	87,590	82.54%	81.28%	1	1	
PC.166	Blood Lead Screening: Children	1,281	1,640	78.11%	67.29%	1	1	
						8	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.

JHN Quality Measures

JHN Enterprise (Primary Care)

Enterprise Patient List (130709)

Create Timestamp: Jan 19 2024 12:11PM
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Pop Health Key Indicators

HTN	DM	Obesity	Tob - Adult	SDoH-Food
39.9%	15.8%	46.3%	20.5%	2780

Meets Payer Target
Meets JHN Target
Within 5% of JHN Target
More than 5% below JHN Target
Organization or Payer monitor
no data / in development

Bundle 1:	Preventive	Care								
Disease Prevention	*PC.102 Pneumonia Vaccine 63.93%	*PC.150 WC Well Visits Birth - 15m 79.30%	*PC.103 Immunizations Birth - 2 yrs 67.24%	*PC.149 Well Child Visits 3-11y 72.91%	SM.767 Well Child Visits 12-17y 66.45%	*PC.121 Adol Imm Combo 2 (Tdap, MCV, HPV) 37.54%	PC.104 Adol Imm (Tdap, MCV) 87.66%	PC.120 Adol Imm (HPV) 37.76%	*PC.111 Tobacco Counseling 79.73%	*PC.166 Lead Screen 78.62%
Early Disease Detection	PC.156 Breast CA Scr 40-49yrs 64.06%	*PC.152 Breast CA Scr 50-74yrs 74.36%	*PC.153 Cervical CA Screen 67.90%	PC.155 Colorectal CA Scr 45-49yrs 41.82%	*PC.154 Colorectal CA Scr 50-74yrs 67.07%	PC.157 Lung CA Screen	*PC.161 Depression Screening 12+ yrs 82.33%	PC.164 Fall Risk Screen 90.68%	*PC.106 BMI Counsel 69.54%	*CC.318 Social Det of Health 74.48%
Preventive Care	*PC.100 Adult Covid Vaccine 64.74%	SM.766 Ped Covid Imm 6m-4y 3.65%	SM.764 Ped Covid Vaccine 5-17y 21.79%	PC.101 Flu Vaccine 26.29%	SM.728 Infant Imm 4th DTaP 74.14%	SM.729 Infant Imm 4th PCV 74.63%	*CC.323 Adv Care Plan 40.23%	CC.322 Care Mgmt 1.02%	CC.325 Post D/C Med-Rec 26.99%	PC.165 Senior Well Visit (65+) 48.19%
Bundle 2 :	**Chronic**	**Disease**	**Care**							
Cardiac & Respiratory Measures	CD.210 CVD Anti-Platelet Rx 86.46%	*CD.212 CVD Statin 88.35%	*CD.251 HTN BP Control 75.19%	CD.270 HF Beta-Blocker 87.52%	*CD.272 HFsys ACE / ARB / ARNi 82.95%	CD.273 ACE/ARB Annual Monitoring 79.69%	CD.280 COPD LAMA 50.79%	*CD.281 COPD CAT Assess 57.00%	CC.324 HCC Refresh 8.54%	CC.326 HCC Individual Refresh 13.62%
Diabetes Measures	*CD.244 DM BP Control 79.97%	*CD.245 DM HbA1c < 9.1% 81.56%	*CD.231 DM A1c < 8.0% 71.32%	*CD.246 DM Nephropathy Monitor 65.98%	*CD.239 DM Eye Exam 61.42%	*CD.242 DM Statin 81.81%	CD.235 DM A1c Testing 91.80%	CD.240 DM Foot Exam 59.90%	PC.163 Prediabetes Diagnosis 90.72%	SM.770 ED Efficiency 78.19%

Health RIsk **Care Mgmt**

88

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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

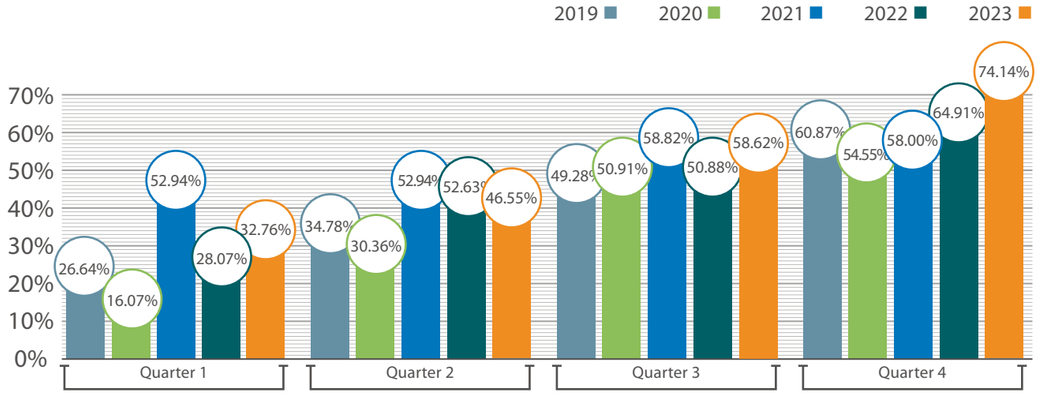
Next Appt at Non-PCP Practice: MM/DD/YYYY

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)	✗	

2023 Q4 CLINICAL INTEGRATION PROGRAM RESULTS

This is a summary of the 2023 JHN Clinical Integration (CI) Program Community Scorecard 4th quarter results. The Community Scorecard consists of Bundles 1 through 6 and is the payor-facing scorecard. At the close of the 2023 program year, JHN achieved a score of 74.14%. This is a 9.23% improvement over the 2022 program year. The 2023 program marks the highest overall performance by Jackson Health Network since 2015! The graph below displays the JHN Community score over the last 5 years.

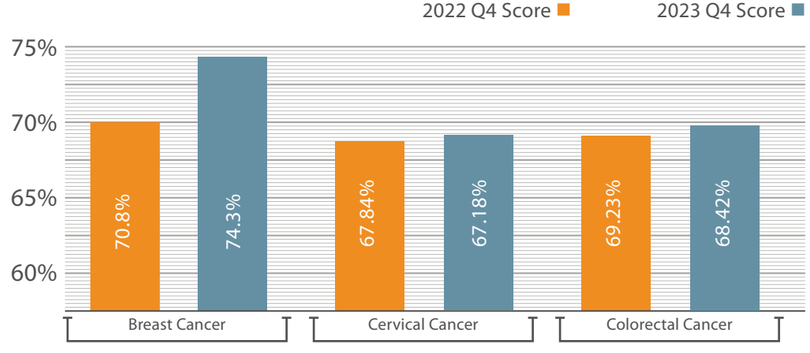
JHN COMMUNITY SCORECARD PERFORMANCE



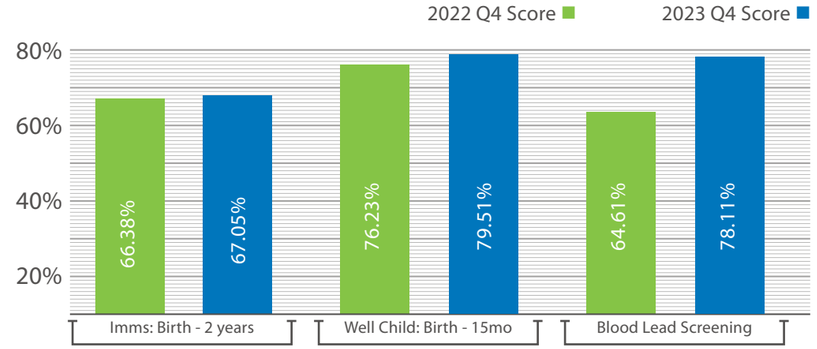
At the individual physician level, 100% of the 309 scorecard eligible physicians exceeded the 45% incentive threshold. This is the fourth year in a row that 100% physicians met this minimum threshold. Physician scores ranged from 48% to 107% by the end of 2023, with 71% ranging between 70% and 87%.

The process of setting targets for metrics on the JHN CI Program Community Scorecard occurs in January, after results from the previous calendar year have been computed. The Clinical Performance Committee (CPC) reviews and determines targets, then makes recommendations to the JHN Board of Directors (BOD). For most metrics, JHN compares to HEDIS targets, but for a select group of metrics, JHN used a target setting algorithm, called Glidepath starting in 2022. Three cancer screening metrics and three pediatric metric targets were calculating using the Glidepath methodology. This will push JHN to achieve the 75th percentile of National Benchmarks within three years. The below chart shows JHN's progress to achieve the 75th Benchmark at the end of 2023.

CANCER SCREENING GLIDEPATH



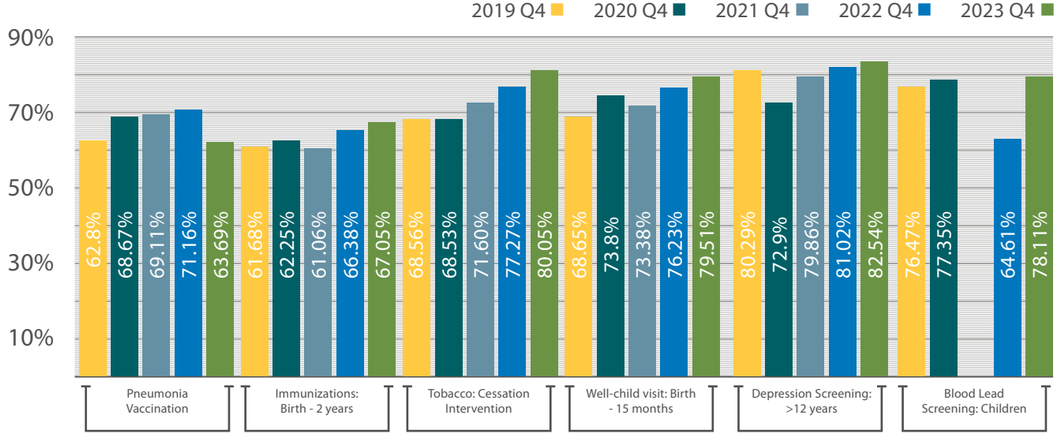
PEDIATRIC MEASURE GLIDEPATH



Bundle 1: Preventive Care

The Preventive Care Bundle includes metrics such as well visits, screenings, and immunizations. JHN earned 8 of the 13 (61.54%) available points. Although JHN scored better than the pandemic years (2020 – 2022), the pre-pandemic score of 68.75% has not yet been reached.

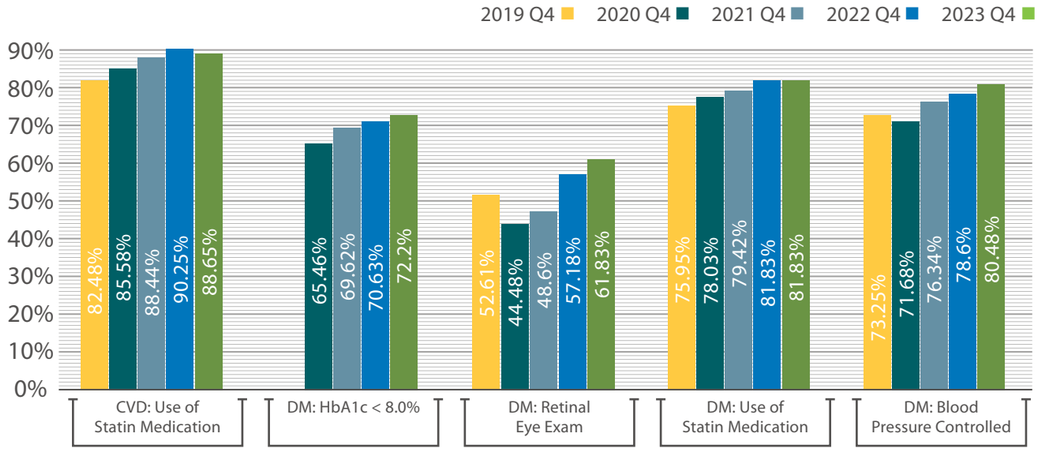
Displayed in the graph are seven metrics that have shown improvement in the last five year and of those, six improved over 2022 performance. Tobacco Cessation Intervention and Well Child: Birth – 15 months had the highest increase, both improving more than 10% since 2019. Blood Lead Screening performance improved 13% in 2023, after a recall halted screenings the last two years, and is now above national 75th percentile.

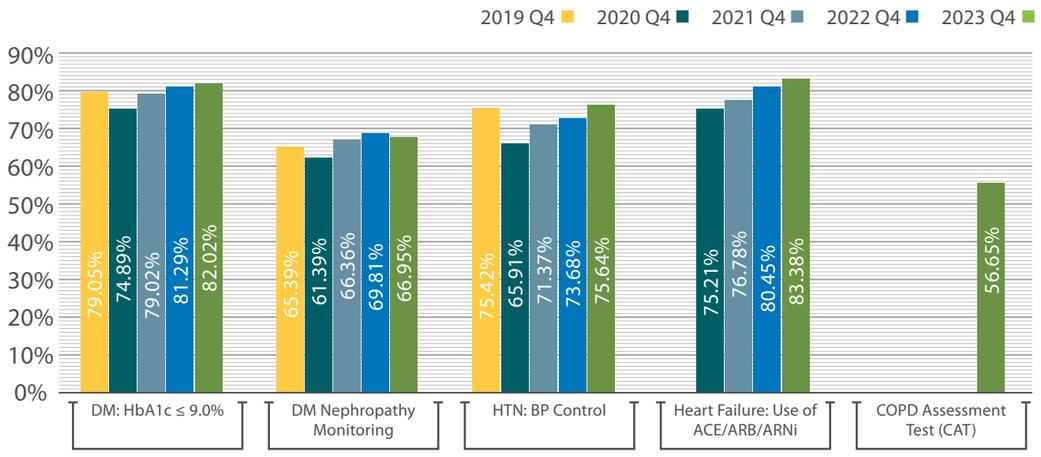


Bundle 2: Chronic Disease Care

The Chronic Disease Care bundle includes metrics related to Diabetes, Congestive Heart Failure, Hypertension, and Cardiovascular Disease. JHN earned all of the available 10 points (100%) in this bundle. We have not only returned to pre-pandemic performance-level in this bundle, but we are exceeding them!

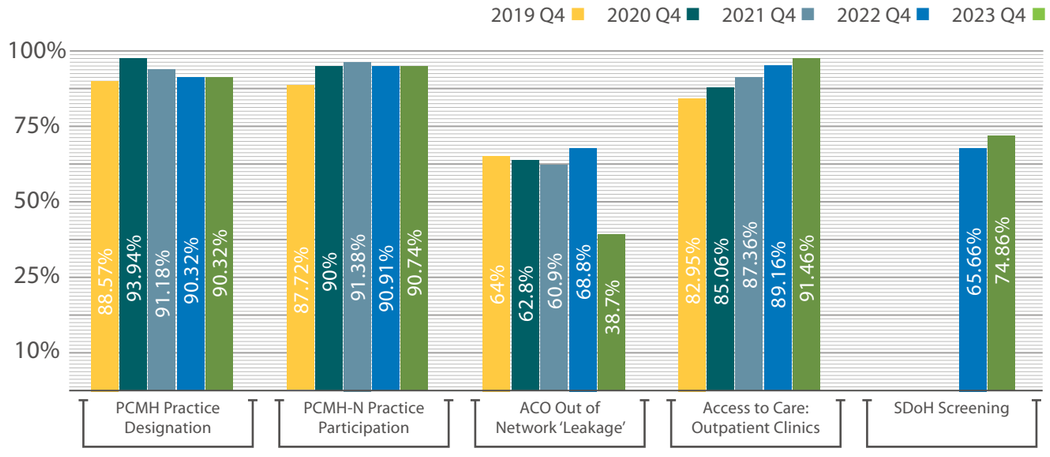
Diabetic Eye Exam is a wonderful win! A huge amount of effort went into achieving this metric target in 2023, including improvement in practice and EPIC workflow processes. Highlighted in the graphic are all ten Bundle 2 metrics showing steady performance improvement over the last five years.





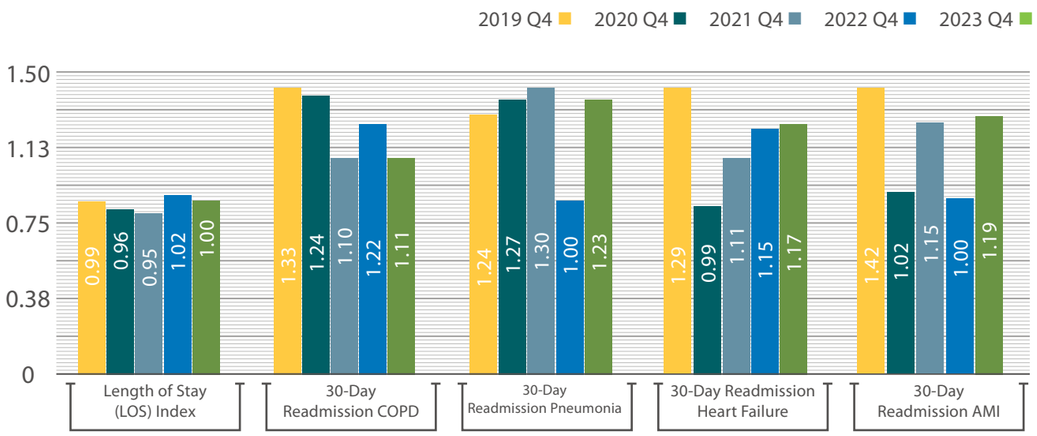
Bundle 3: Continuum of Care

The Continuum of Care performed very well this year earning 12 of 13 points (92%). JHN gained two points for HCC RAF score, just meeting the 1.3 target. Patient Centered Medical Home (PCMH) metrics make up a significant portion of this bundle (5 of 11 points). Newer to the JHN Community Scorecard is the Social Determinants of Health (SDoH) screening metric. This metric captures the percent of active JHN patients who have had at least one SDoH screen in the calendar year. By the end of 2023, almost 75% of all JHN patients were screened exhibiting the significant work the Network has accomplished at supporting patients with socioeconomical needs.



Bundle 4: Quality, Efficiency & Utilization

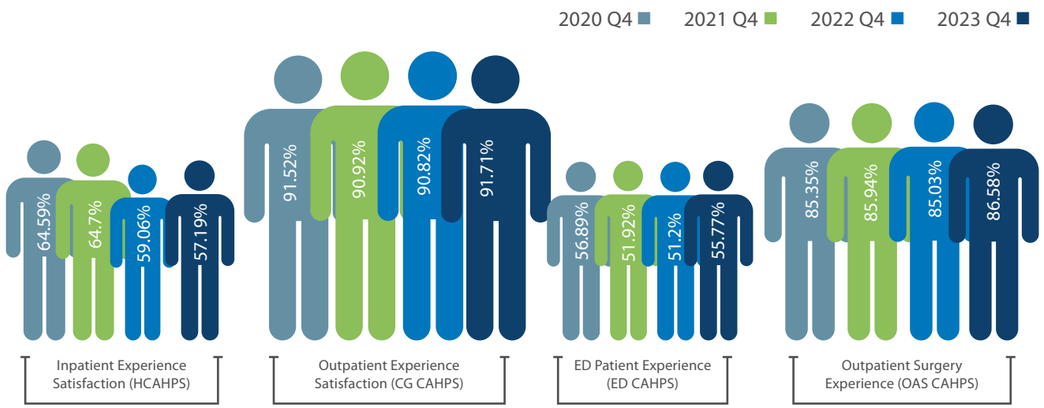
The Quality, Efficiency, and Utilization bundle earned 3 of 10 points (30%). Bundle 4 continues to be a challenge for the Network. From 2020 – 2022, the pandemic effect helped this bundle due to the decrease in hospital and ED utilization. Unfortunately, none of the 30-day readmission metric targets were achieved. Length of stay just met the target as well as two newer metrics, ACO Hospital Inpatient admissions and the CMS HAC Reduction Program.



Bundle 5: Patient Experience

'Willingness to Recommend' is highly correlated with all physician communication questions on the survey.

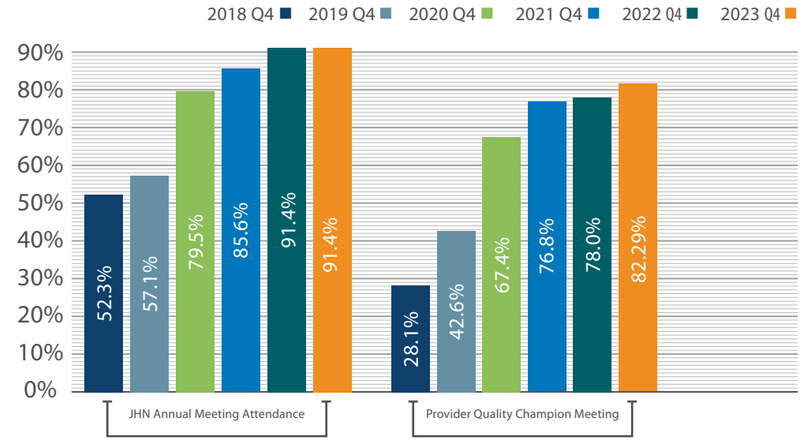
JHN earned only 6 of the 8 points (75%) possible points in this bundle, an improvement of 50% over 2022. Although JHN's percentile rankings continue to be low compared nationally, three of the four service lines have improved year over year.



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 92.04% attendance! Provider Quality Champion attendance was up 4% from last year with 82% attendance. Physician engagement is a key indicator of JHN's success.

Overall, Jackson Health Network exceeded many goals in 2023. As a Network, 45% is the minimum threshold allowed for physicians to partake in financial rewards, and the Network as a whole achieved the highest Community Score in 8 years! There are still opportunities for improvement within Bundle 1, Preventive Service, and Bundle 4, Utilization. These two areas are part of the Network's performance improvement strategy in 2024.



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

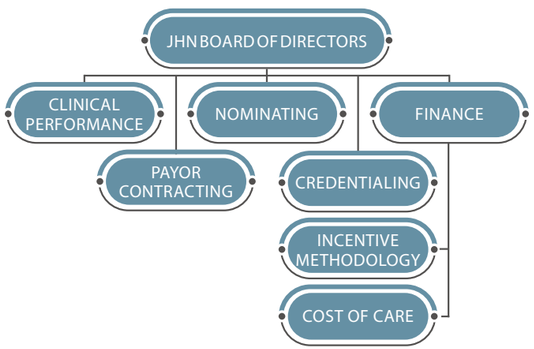
Network Management and Support

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. 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 2023, 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 2023 93% 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 2023 included:

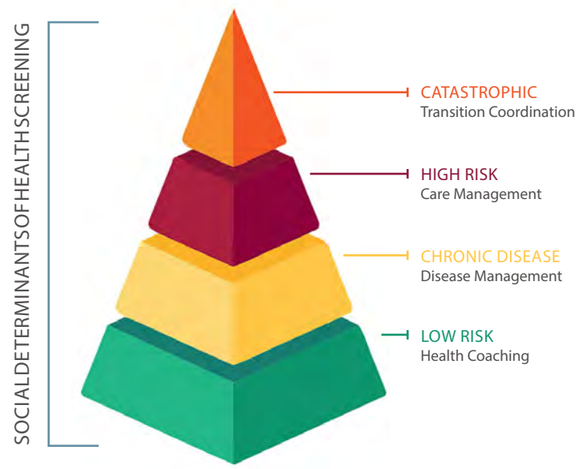
- Strategies to increase patient compliance in primary prevention and chronic disease care
- Emergency Department Utilization
- Improve alignment of attributed patients to a JHN Primary Care Provider
- Maintenance in the Patient Centered Medical Home Program
- Improve documentation and reporting of Hierarchical Condition Category (HCC)
- Engage targeted specialty groups in population based value based reimbursement through effective and efficient care delivery

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.



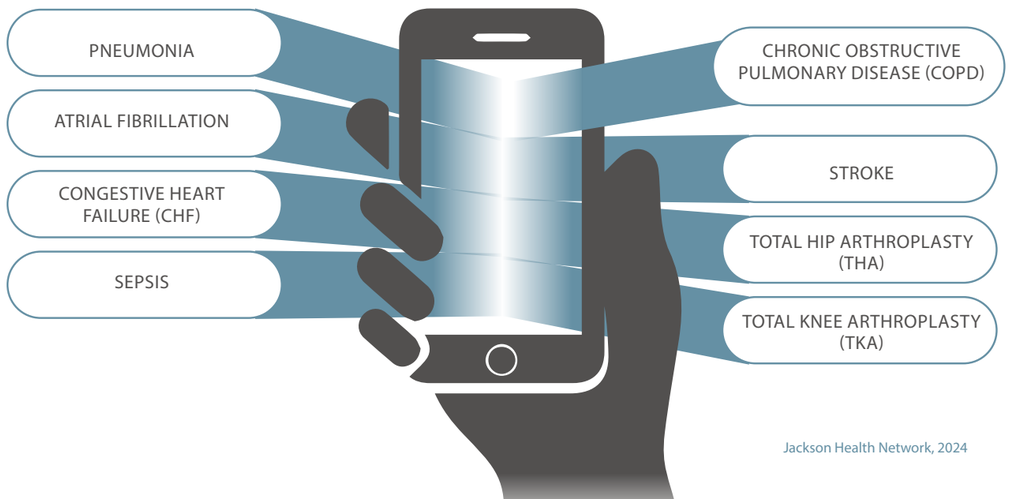
Transition Coordination

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, along with additional follow-up phone calls, that are extended throughout the course of 30 days, aims to assist patients in following through with the discharge plan developed in the hospital as well as helping to mitigate barriers to success once the patient has returned to home (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).

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 also linked to Care Management as hand-offs can be made for patients needing assistance beyond 30 days.

In addition to work done with patients that return to home from an inpatient stay, this team is 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. Finally, there is continued interest and development in connecting patients that are seen in the Emergency Department back to the Transition Coordinators. While these are not new, it is evident that this is an area that provides an opportunity to redirect patients to home with assistance from the Transition Coordination team and prevent a readmission to the hospital. Currently, this team is reaching out to ACO patients that present back to the HFJH Emergency Department within 30 days of an inpatient discharge. The work the Transition Coordination team does is undoubtedly beneficial to the patients they reach and will continue to evolve for the Network in this upcoming year.

Care Management

The Case Management Society of America (CMSA) defines case management as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes" (CMSA, 2022).

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. They help patients organize, coordinate, and navigate their care in today's increasingly complex healthcare setting.

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 partnered to 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.

The program was initially piloted in June 2022 by four JHN primary care offices. As s of December 2023, CoCM has expanded to include ten JHN primary care offices.

Diabetes Education Center

Improving diabetes-related outcomes through Diabetes Self-Management Education (DSME) is the priority at the Diabetes Education Center. DSME is delivered to patients via group education or 1:1 intervention. In 2023, patients who completed their education plan saw an average reduction of 1.5% in A1c within 3 months, from an average 8.5% pre-education to 7.0% post-education.The national average is 1% reduction.

A key component in increasing the number of patients receiving DSME is patient satisfaction. In 2023, patient satisfaction results show 99% of patients completing an education plan rated the program as excellent. In addition, 100% of patients reported the DSME program helped them find something they could do to better manage their diabetes. Individual feedback in 2023 most frequently saw the words "helpful" and "thank you" included in patient comments. Additional positive feedback included "I didn't feel judged. I felt heard and treated with respect" and "made it very comfortable and [educator is] very non-judgmental" as well as "[Educator] gave me the tools to make life changes for better health."

"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.

"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 COLLABORATIVE NETWORK/HIO

Jackson
COLLABORATIVE NETWORK
www.JacksonCollaborativeNetwork.org

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.

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 Collaborative Network partners 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

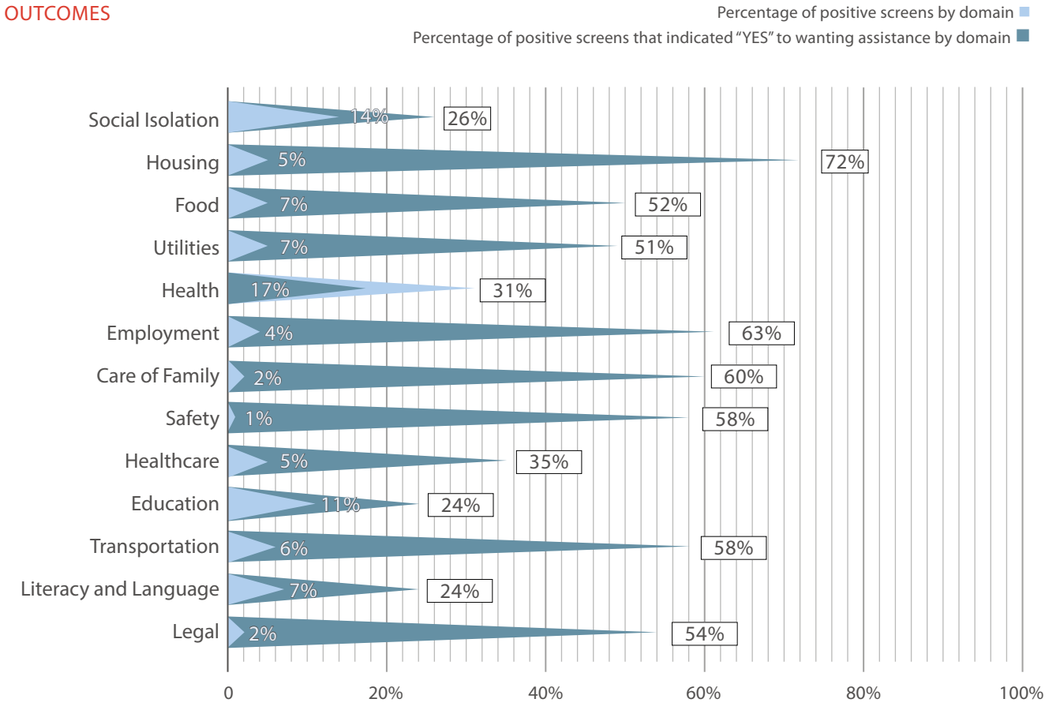
The Centers for Disease Control and Prevention (CDC) report that the conditions in places where people live, learn, work and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH). Poverty in the Jackson community limits access to healthy food and safe neighborhoods, resulting in more education to improve patients' quality of life. Primary and Specialty care teams are trained to screen patients for SDOH at the doctor's office. Both primary and specialty care practices are screening their patients for SDOH, resulting in over 192,000 SDOH screens administered to our patients in 2023. Additionally, the JHN Board of Directors approved SDOH screening as an incentive metric in the JHN CI Program, which began in January 2022.

Care Management and Transition Coordination teams work in tandem with JHN Community Health Workers (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 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.

OUTCOMES



Source: Jackson Care Hub Data Brief January 1, 2023 - December 31, 2023. In 2023, 192,860 SDOH screens were conducted on patients in Jackson County.

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

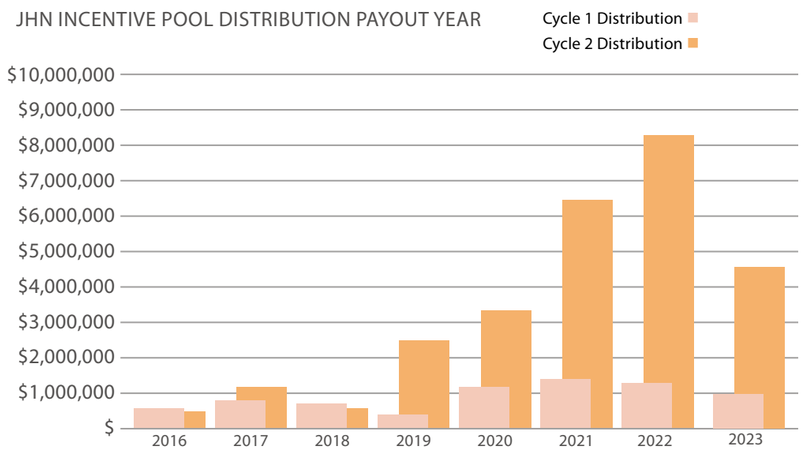
In January 2022, we kicked off the new MOSAIC Accountable Care Organization (ACO) with partners Henry Ford Physician Network and Covenant Health Partners. MOSAIC replaced the Federation ACO, which ceased operations at the end of 2021 with the unwinding of Affirmant Health Partners. The ACO covers nearly 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.

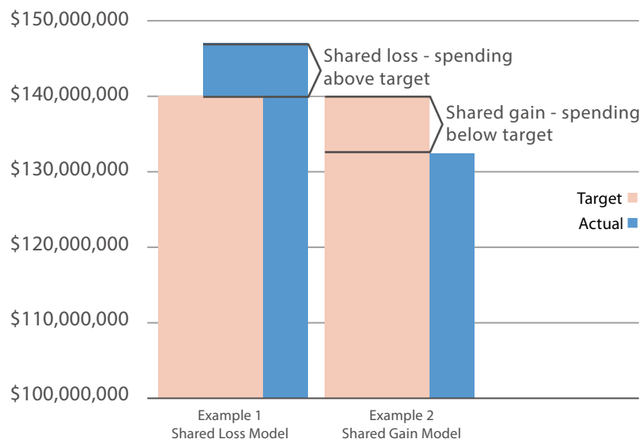
As the graph to the right shows, the Network's incentive value-based performance on these total cost-of-care arrangements has driven the considerable growth in the Network's incentive pool. These shared savings incentives are the majority of the Cycle 2 incentive distributions, and these include contributions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



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.

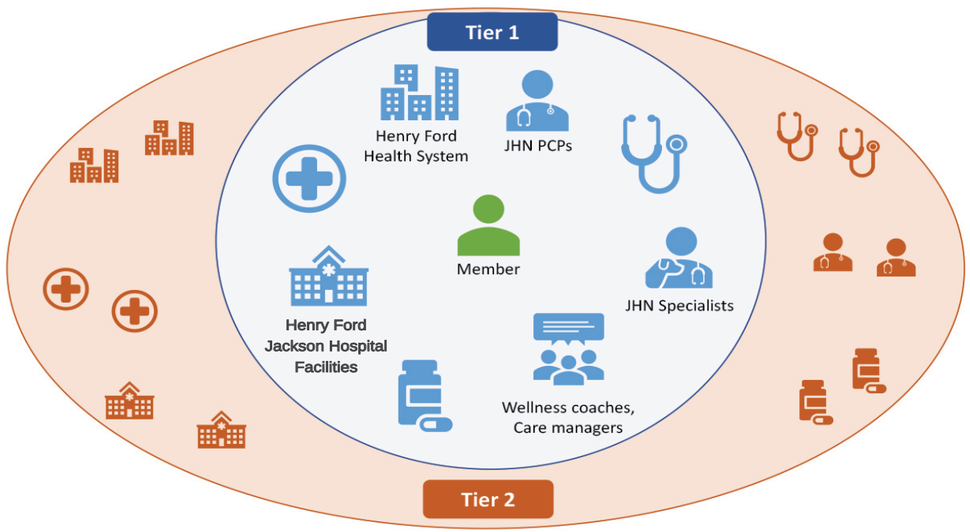
EXAMPLES: FINANCIAL UPSIDE / DOWNSIDE MODEL



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



Value Proposition

CLINICALLY INTEGRATED NETWORK (CIN)

Jackson Health Network (JHN) is

- A legal entity that allows physicians, other providers, hospitals and other facilities to work together to improve quality, reduce cost and enhance experience for patients and providers (Quadruple Aim).
- Able to engage in joint contracting that aligns payment methods with new care delivery models.
- Expected to demonstrate improved quality outcomes and cost efficiency year after year.

ACCESS TO PAYOR CONTRACTS AND VALUE-BASED REVENUE

The Network collectively drives better quality outcomes and lowers overall cost of care. The Network negotiates professional value-based contracts directly with commercial, Medicare Advantage and Medicaid health plans.

Physician Value

Collective contracting benefits all JHN members, allowing for JHN to negotiate competitive rates, align incentives and add value-based terms on behalf of network providers. The JHN Board of Directors is comprised of and led by physicians who believe that provider incentives should go directly back to providers. JHN negotiates separate administrative funding to maximize the incentive payouts.

PERSONALIZED CUSTOMER CARE

Each office is assigned its own practice liaison who meets monthly with the office manager to deliver quality and utilization program support, deliver important payor updates and review performance reports for various contracts. This person will work closely with the practice to optimize success through regular action planning and accountability, focusing on the highest value activities.

Physician Value

JHN's customer service model is provider centric. Each practice develops longitudinal relationships with their JHN liaison who becomes the practice's one-stop shop for everything related to JHN. This includes but is not limited to support in quality and utilization programs, Patient Center Medical Home, payor contracts, fee schedule/claim issues, money left on the table, payor opportunities, credentialling and care management.

CENTRALIZED PAYOR ENROLLMENT

JHN's centralized credentialing and enrollment processes synchronize provider credentialing and enrollment for our contracted health plans, requiring only one appointment process every two years for all the health plans combined.

Physician Value

JHN has assumed the delegated credentialing activities for 80% of its contracts. This results in a streamlined approach for its members by expediting the credentialing and enrollment process. Credentialing efficiency improves revenue cycle management and ultimately lowers operational costs.

JHN COMPASS

- The JHN Compass is a homegrown population health management tool. The tool compiles data from EPIC and the Michigan Health Information Exchange which feeds data into one easy-to-use dashboard allowing physicians and staff to:
- Monitor performance in multiple clinical measures in real-time.
- Drill down to the patient level to see all recommended care and due dates.
- Perform a variety of population health functions, such as pre-visit planning, point of care service and gaps in care outreach.

Physician Value

Improves the physician and office staff's ability to manage their patient panel and quality outcomes. The JHN Compass is not available anywhere else.

This unique tool built by JHN staff, continuously evolves through feedback from physicians and staff who use it every day. JHN Compass can be accessed through a link in Epic or through any web browser.

CONNECTING CARE AND TECHNOLOGY

Community Health Technology Network supports JHN providers who are subscribed to the community health electronic health record (EHR) Epic. JHN's Epic is integrated with Henry Ford Health, connecting JHN's community of providers to all EHR data for shared populations. Primary Care Providers, Specialists, Hospitals, Urgent Cares and Surgery Centers are all linked together, ensuring streamlined coordination across systems of care.

Physician Value

JHN members are offered access to a robust system that is continuously evolving to meet the changing needs of healthcare delivery and reporting requirements established by CMS and Commercial Health Plans. Our instance of EPIC allows data sharing between care team members to ensure each patient's medical history is available anywhere in the Network where the patient is seen.

CARE COORDINATION

Care coordination is care that occurs outside the doctor's office. Care managers and community health workers (CHW) support patients who have been identified as having a combination of multiple comorbidities, complex treatment regimens, frailty and functional impairment, behavioral and social risks, and serious mental illness. Care management and CHW services are aimed at reducing hospitalization and crisis-driven care, while improving quality of life and health outcomes for the patients we serve.

Physician Value

JJHN offers affordable access to care coordination services for primary care. The additional support from an expanded care team allows the physicians to operate at the top of their license by offsetting certain functions to a nurse care manager or LMSW. This collaboration benefits the patient by giving them additional support in meeting their treatment plan goals.

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

An elderly patient was referred to care management because he was tearful during a visit with his primary care provider after his power was shut off for non-payment. Both the patient and his wife used CPAP machines and his wife was diagnosed with Multiple Sclerosis. The patient had recently quit his job to take care of his wife, and his wife's social security was their only source of income.

The care manager assisted the patient with completing a Medical Needs form for Consumers Energy. The patient's power was restored the same day, however, $265 was still owed to Consumers Energy within 14 days to prevent any further shut-offs. The care manager and community health worker assisted the patient with completing the Salvation Army Energy Needs Application process and with obtaining resources from other local agencies. Upon follow-up, the patient expressed his gratitude by stating, "You are an angel!"

DIABETES EDUCATION

A patient with type 2 Diabetes was referred to the Diabetes Education Center at the end of 2022 with a hemoglobin A1c of 8.6%. Patient's blood pressure was 132/84 and his body mass index was 31.7. His diet was mainly made up of highly processed carbohydrate, high sodium, and high saturated fat and he was drinking 56 oz of sugary drinks each day. In addition, he was smoking 1 pack of cigarettes per day.

The patient attended an initial appointment in 2022, then attended 2 group education sessions in April 2023. He was unable to complete the 3rd education class due to the death of his mother. By May 2023, his A1c increased to 9.5%. The diabetes educator reached out to the patient, and he completed his third diabetes education class in June 2023.

In August 2023, the patient's A1c was 6.7% and his BP was down to 116/68. He'd been cutting back on smoking on his own, then engaged in treatment with Henry Ford Jackson Tobacco Treatment Services. He also made many diet changes including eliminating all sugar-sweetened beverages and packing his lunch for work. He was able to stop his insulin and remains compliant with his other DM medications.

He is also using a continuous glucose monitor to learn how foods affected his blood sugars.

The patient reported the education classes helped save his life. "I was going down the same road as my mom. I want to be around for my kids, and I didn't want them to go through what I did. I never thought I'd be able to have diabetes and be in control.".

TRANSITION COORDINATION

Transition Coordination received a referral regarding a patient with multiple post-discharge needs. The primary issue was that the patient was in need of nutritional supplement (Ensure) that had been recommended by a dietitian and ordered by the provider due to undernourishment. After attempting multiple modes of getting the patient his Ensure, including Meals on Wheels and an initial denial from the insurance company it was discovered there was an option for an over-the-counter benefit that could be utilized for the nutritional supplement. The insurance company was able to order 2 cases of Ensure to be delivered to the patient, however delivery would take up to 10 business days.

The With the assistance of the Community Paramedics, the Transition Coordinator worked with a local food bank to locate and deliver another case of Ensure for the patient so he would not have to wait. There was also a referral made to WellWise (previously Region 2 Area Agency on Aging) which connected the patient to Advanced Illness Management for his Chronic Obstructive Pulmonary Disease. The Transition Coordinator ensured the patient had follow-up appointments with his specialist and the primary care provider and provided education related to the patient's chronic illness to improve function and reduce the likelihood of a readmission.

COLLABORATIVE CARE

A young woman with a long history of depression and anxiety was referred to CoCM due to persistent anxiety and depression since the birth of her son more than 10 years ago. The patient had an excellent response to medication recommendations and therapeutic interventions provided by the Behavioral Health Case Manager. At CoCM completion, the patient reported that their depression and anxiety were resolved.

A high functioning woman in her 60s was referred to CoCM with depression and anxiety. She could not identify triggering factors for worsening symptoms. After engaging with the program, she is feeling back to her, "normal" self and enjoying activities.

Future of Care in Jackson

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

Our pursuit of the Quadruple Aim now spans more than a decade. After years of building, we have the vehicle needed to succeed in value-based care. Our network is a model organization, and we are strong, with nearly 1,000 provider and more than 130,000 aligned lives.

During 2023 we participated in an assessment by a third-party consulting firm to assess our readiness for the future. The good news from that assessment is that, at present, we are one of the most sophisticated and highest performing networks in the nation. Our quality performance is excellent, we have payor relationships unlike anywhere else in the country, and we have uniquely integrated services to address social drivers of health outcomes. Our most significant opportunities remain in reducing cost and utilization of services. In this area we perform below average against most benchmarks. This creates tremendous opportunity to more care further upstream and improve efficiency by eliminating delivery of services that do not improve the health of our patients.

One essential ingredient we are lacking to fully realize the potential of improving our efficiency on cost and utilization is scale. We are limited in our ability to take on significant risk, and therefore greater upside, because random variation could cause performance to fluctuate too much for us to financially absorb. By adding additional lives, we moderate the impact of random variation, and setup for success in contracts with significant upside and downside potential. Achieving scale is the single most important priority for us to succeed in the future. The leadership team is working hard to identify like-minded partners that could both augment our performance and help us achieve the size we need to safely increase the risk-level in our contracts.

The pressure for us to accelerate performance is omnipresent. Numerous equity-backed entities position themselves as solutions that enable performance in primary care. The largest employer of physicians in the country now is Optum Care, a subsidiary of United Health Group. Flashy power point presentations and a slick sales team, however, do not compete with the substance we provide. Our key differentiator is clinical integration. By working together, we benefit from the antitrust protections that allow us to contract cohesively, and this drives unparalleled value for our providers.

While there are many threats, I have never been more optimistic about this network and our community. To quote the late business theorist and economist W. Edward Demings, “It is not necessary to change, survival is not

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 2023 Jackson Health Network Board of Directors.

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Samir Parikh, MD

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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