Achieving The Triple Aim For Our Community

Ray King, MD, Senior Vice President, Medical Affairs, Henry Ford Allegiance Health
January 27, 2017
“Health” is a bold, expansive aspiration. Let’s make sure that what we call “health care” is broad enough to get the job done”

-Realigning Health with Care, Stanford Social Innovation Review
Agenda

- State of the Community
- History Lesson
  - Crisis leads to vision
  - Coalesce community
- Key Infrastructure Pieces
  - Health Improvement Organization
  - Jackson Community Medical Record
  - Jackson Health Network
- The Future
  - True Population Health
A Snapshot of Our Community (Jackson, MI)

- County Population: 159,494 (US Census Bureau, 2015)
- Median Household Income: $45,452 (US Census Bureau, 2014)
- Unemployment Rate: 4.5% (U.S. Bureau of Labor Statistics, 2016)
- Smoking Rate: 30% (2014 CHA)
- Heart Disease Rate: 5% (2014 CHA)
- Obesity Rate: 40% (2014 CHA)
- Payer Mix: Medicare: 20.74%, Medicaid: 17.81% (JCMR, 2015)
A Snapshot of Henry Ford Allegiance Health

- Licensed Beds: 391
- Long-term acute care beds: 64
- Hospice residence: 20 beds
- Health System Staff: 3,800
- Medical Staff: 400
- Volunteers: 592
- Approximate Annual Activity:
  - Inpatient Admission: 14,500
  - ER Visits: 87,000
  - Outpatient Visits: 492,000
  - Births: 1,600
The Messy Middle

Future State
HEALTHY COMMUNITY
Patient-Centered Evidence-Based Systems

2nd Curve
2009-13
• Customer-driven excellence
• Learning and Innovation

2004-08
• Clinical development
• Reduce clinical variation

1988-03
• Quality management
• Build/integrate delivery system

1st Curve
Fragmented System
Variable quality, errors
Access, wait time issues
Unaffordable, losing payer (employer) support

• Personal and Community Health
• Financial Vitality
• Patient-centered care
• Communication/relationships
• Financial resilience

Adapted from Ian Morrison, The Second Curve: Managing the Velocity of Change, Diane Publishing, 1996 Revised Messy Middle; Aug 2009
AH Commitment to HEALTH IMPROVEMENT

2000
- "HIO created as ‘compact among patients, physicians, employers, the health system & health plan’"

2005
- JCMR Formed

2006
- HIO Coordinating Council

2009
- IHI ‘Triple Aim’ initiative

2010
- AHA Foster McGaw Award Recipient

2011
- Integration CIN/JCMR

2012
- Integration CIN/HIO
2010 Foster McGaw Award
## County Health Rankings

### JACKSON COUNTY 57 of 83

**Health Outcomes**
- Mortality: 46
- Morbidity: 63

### JACKSON COUNTY 56 of 83

**Health Factors**
- Health Behaviors: 72
- Clinical Care: 26
- Social & Economic: 44
- Physical Environment: 74
Where Did It Start?

Jackson
Michigan
HMO 40% actuarial rate increase.

Poor Health

Uninsured

Lower coverage

High Cost

Rising Premiums

Health Improvement Organization (HIO)

Health Maintenance Organization (HMO)
“...population health is even more challenging because it requires a Balanced Investment Portfolio across the other determinants of health like education, income, behaviors, and the physical environment”
(Source: Triple Aim – Plenary-Kindig Triple Aim Integrators)

**VARIABLES**
- Tobacco use
- Diet & Exercise
- Alcohol use
- Sexual Behavior
- Access to / Quality of Care
- Education / Employment
- Physical Environment
Community Health Innovation Region 2010: HIO Common Agenda

Over 30 cross-sector partners

Aligned Community Health Goals

Aligned Philanthropy/Community Benefit Investments

United Way

Jackson County

HIO

Active Living
Nutrition
Emotional Health
Smoke-free Lifestyle

Allegiance Health
Health Improvement Organization
Current

- IHI Triple Aim Participant since 2009

- 2015 recipient of SCALE grant

- HIO / Allegiance share positions with Jackson County Health Department (JCHD)
  - County Medical Director / Executive Director Population Health
  - County Health Officer / Allegiance Health Officer

- HIO backbone assists with formation of other strands
  - Cradle to Career
  - Financial Stability

- Working with JCHD to
  - Establish triple aim based community performance metrics
  - Community needs analyses

- One of five Michigan communities to participate in State’s $70M innovation Model Grant
What are we trying to accomplish?

Healthy person
Preventable condition
Worsened condition
Medical care & treatment required
Hospital care
Successful outcome
High cost outcome
Complications
No hospitalization
Acute care episode
Resumed health
Worsened condition
Continued health
Primary prevention
Preventable condition

Acuity and costs increase

Acute Care Episode

Source: Adapted from Harold Miller. *How to Create Accountable Care Organizations*, 2009
Figure 1
Innovation Driven U.S. Health Care System Evolution

**Uncoordinated Health Care System 1.0**
- Episodic Health Care
  - Sick care focus
  - Uncoordinated care
  - High use of Emergency Care
  - Multiple clinical records
  - Fragmentation of care
- Lack integrated care networks
- Lack of integration between acute and long-term care settings
- Lack quality and cost performance transparency
- Poorly coordinated Chronic Care Management

**Health System Transformation and Evolution Critical Path**

**Coordinated Seamless Health Care System 2.0**
- Patient/Person Centered
- Transparent Cost and Quality Performance
  - Results-oriented
  - Assures Access to Care
  - Improves Patient Experience
- Accountable provider networks designed around the patient, including LTC needs
- Shared Financial Risk
- HIT integrated
- Focus on care management and preventive care
  - Primary Care Medical Homes
  - Care management/prevention focused
  - Shared Decision-Making and Patient Self-Management

**Community Integrated Health Care System 3.0**
- Patient, Population, and Community-Centered
  - Community Health Resource Linked
  - Cost, Quality, and Population Health Outcome Transparency
  - Community Healthy Living Choices
- Community Health integrated networks capable of addressing psychosocial, economic and LTC needs
- Right care, at right time, in right setting
- Population-based reimbursement
- Learning Organization: Capable of rapid deployment of best practices
- Community Health Integrated
  - Community Healthy Living Oriented
  - Community Health Capacity Builder
  - Community based support developer
  - Shared community health responsibility
- E-health and tele-health capable
  - Wide use of remote monitoring and tele-health and e-health management
  - Health E-Learning resources, social networking, health literacy tools

Source: Adapted from “Primary Care and Community Integration: Innovative Approaches Accelerating Health System Transformation through State Level Innovation.” Presentation by Anthony Rodgers, Deputy Administrator, Center for Strategic Planning, Centers for Medicare & Medicaid Services. March 2012.
Transformation Necessary to Cross the “Crevasse”

1.0 Acute Health Care System
2.0 Accountable Care
3.0 Community Integrated Health Care System

Traditional: Service Line Growth
Consumerism: Retail

Fee for Service
Shared Savings (ACO)
Partial Capitation
Full Capitation

Value-Based Payment

Fee for Service with Performance Incentives

Destination of Choice
Demand Destruction

Increasing Risk

July 2015
Accountable Care: A Radical Shift in Thinking

Is an Emergency Hospital Admission a…

OR

...an Ambulatory Sentinel Event?

Good Thing!?......
• Fill a bed, take x-rays, do a procedure

$$$$$$

• Missed appointment?
• Unable to get into clinic?
• Failed to fill prescription?
• Unable to get Rx refill?
• PC / specialty miscommunication?
• Patient misunderstanding
• Failure to listen to patient?
• Missed lab or xray report?
Infrastructure

Jackson Michigan
Public Health Integration

• Unique partnership to share County Health Officer and Medical Director positions to integrate clinical and public health services
• Alignment of resources
• Integrated use of the shared electronic record
• Working on closed-loop referral processes between provider offices and public health
Patient Centered Medical Home

- 34 of 39 JHN primary care practices are BCBSM PCMH certified
- JHN participates in Michigan Primary Care Transformation (MiPCT) project
- JHN running additional care management pilot (embedded and remote) for two clients with additional patients through SIM and CPC+
- JHN piloting placing pharmacist into PCMH setting
- JHN piloting integration of Behavioral Health support into PCMH
- JHN Provider Servicing staff supports local practice transformation
Physician Engagement

- Physician Leadership Training Academy
- Physician dominated board (JHN) and committees
- Medical Director leadership
Jackson Community Medical Record (JCMR)

Our Community Electronic Health Record (EHR)
The JCMR Advantage

One Integrated Patient Chart

- Shared demographics, med list, allergies, problem list, notes, etc.
- Closed-loop ordering – referrals, tests, procedures
- Uniform decision
- Advanced clinical information sharing
- Support in achieving meaningful use
- Real-time interfaces
- Local payer PFP reporting
- Local support

By being on the same enterprise database, all social, family and past medical history is available.

Medication lists, reconciliations and drug interactions across practices on the same database.

Lab Results automatically are assigned to the appropriate physician and patient independent of an electronic order.

By being on the same enterprise database, all allergies are shared across practices.
Jackson Community Medical Record

JCMR – June 2015 Statistics

- **Users**
  - 489 EPM (Practice Management) providers
  - 352 EHR (Electronic Health Record) providers
  - 2,236 Total users

- **Patient Encounters**
  - 62,088 visits (shared med lists, office notes, etc.)
    - 37,123 unique patients
    - 6,491 seen by more than one practice
  - 44,919 e-prescriptions

- **483,752 Interface Transactions including:**

<table>
<thead>
<tr>
<th>Interface Request</th>
<th>Volume</th>
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<tr>
<td>Lab Reports</td>
<td>121,348</td>
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<tr>
<td>Other Reports</td>
<td>37,953</td>
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Jackson Health Network (JHN)

Our Clinically Integrated Network
JHN Vision Statement

We, the Participants of The Network, will operate as a close partnership between Allegiance Health and affiliated physicians as a foundation for building an integrated system of health care delivery for the Jackson community and beyond.
The Basics - JHN Organizational Structure

- Network Board
  - Nominating Committee
  - Clinical Performance Committee
  - Payor Contracting
  - Credentialing Committee
  - Finance Committee
    - Incentive Methodology
  - EBMC
  - Measures
JHN – Current State

- **Participants**
  - 303 physicians contracted – 90% of local area PCPs
  - Includes 163 NPs, PAs and behavioral health providers
  - Allegiance Health
  - Local FQHC
  - Represent 28 specialties

- **Triple Aim focus – Improve health outcomes**

- **Base IT operational**
  - Registry
  - Scorecard
  - Care Management

- **Focus on physician engagement**

- **Evidence-based work groups supporting development of clinical programs**
Continuum of Care

- Strong ambulatory involvement – physician
- Working to involve chronic care services in program development
- Includes local FQHC
- Various clinical teams working across continuum
  - Disease site teams
  - Integrated health management
  - HIO
- Navigators tied to facility services
- Working to develop ties to:
  - Skilled Nursing Facilities, Long Term Acute Care
  - Inpatient services
Jackson Health Network
2015 Value Report

2014 Results

health

habits

fitness

diet

balance

prevention
The Clinical Integration (CI) Program

JHN Clinical Performance Program
Metrics, Bundles, Program
Clinical Program and Driving Principles

**Principles**
- Whole Patient
- Right Care
- Right Time
- Right Place
- Right Cost

**Triple Aim**
- Outcomes
- Experience
- Cost

**Five Domains of Care**
- Acute Care
- Chronic Care
- Behavioral Health
- Social (Community Partners?, Navigators?, Care F/U)
- Preventive
Guiding Principles

Determination of Value to Community Health

Determination of Financial Impact to Allegiance and It’s CIN Members

Balance of Initiatives Across Physician Member Specialties

Determination of Payor Interests and Willingness to Fund Process

Balanced Approach to Selecting Initiatives

Evidenced Based / Infrastructure & Design to Succeed
## 2016 JHN Metrics

### Bundle 1: Preventive
- **Disease Prevention**
  - Flu Vaccination
  - Pneumonia Vaccination
  - Immunizations 0-5 yrs
  - Immunizations Adolescent
  - Tobacco Use/Counsel
  - BMI Counsel

### Bundle 2: Chronic Disease
- **Cardiovascular Disease**
  - Comprehensive Care
  - Blood pressure Control
  - Use of ASA/Antiplatelet
  - Use of ACE/ARB
  - Use of Statin

### Bundle 3: Continuum of Care
- **Diabetes Mellitus**
  - Comprehensive Care
  - Blood pressure Control
  - HbA1c >5.0%
  - Nephropathy Monitoring
  - Hba1c Testing <7.0%
  - Retinal Eye Exam
  - Foot Exam
  - Use of ACE/ARB
  - Use of Statin

### Bundle 4: Efficiency/Utilization
- **Hypertension**
  - Blood Pressure Control

### Bundle 5: Patient Experience
- **Asthma**
  - Assessment & Action Plan
  - Medication Management

### Bundle 6: JHN Training
- **Heart Failure**
  - Use of Beta-blocker

### 2016 Monitor/Develop
- **2016 Monitor/Develop**
  - Blood Pressure Screening
  - PostNatal Care
  - Fall Risk Screening
  - Lead Screen - High Risk
  - Chlamydia Screening

### 2016 Monitor/Develop
- **2016 Monitor/Develop**
  - BMI Measure
  - Blood Pressure Screening
  - PostNatal Care
  - Fall Risk Screening
  - Lead Screen - High Risk
  - Chlamydia Screening

### 2016 Monitor/Develop
- **2016 Monitor/Develop**
  - Communication: Use of Smartphone App
  - Communication: Peer Survey on Quality
  - Participation in Care Coordination
  - In Network Utilization

### 2016 Payor Measures
- **2016 Payor Measures**
  - Depression Screen/Counsel – age 13-17 yrs
  - Depression Counsel – Adult
  - COPD Spirometry
  - ADHD Med Mgmt
  - Adult Well Visits
  - BH Initiative: Registry
  - Monitoring of Persistent Medications

### Additional Categories
- **OutPt Satisfaction**
  - Access to Care
  - Provider Communication
  - Office Staff Quality
  - Communication of Test Results

- **InPt Length of Stay**
  - Cave Specialty Score
  - 30-day Readmission Rate
  - All Diagnoses
  - COPD
  - Pneumonia
  - Heart Failure
  - AMI
  - CABG
  - Total knee/hip replacement

- **Accuray of Provider Assignment of Patients**

- **Evidence-Based Guideline Use**

- **Mortality Index**

- **Access to Care - OPV**

- **ED Patient Experience**
  - Doctor Courtesy/Respect
  - Doctors Listened
  - Doctors Explained
  - Doctor Time

- **OutPt Surgery Experience**
  - Courtesy & Friendliness of Anesthesiologist
  - Explanation by Anesthesia Staff

- **JHN Annual Meeting**

- **Physician Quality Champion**

- **Participation in Network Improvement**

- **JHN Training**
What Have We Accomplished?

- Impacts
  - Who are we impacting
  - Value Report
  - Improved CI scores
The Clinical Integration (CI) Program

Supporting Technology
## Compass Office Access

### JHN Quality Measures
**JHN Enterprise (Primary Care)**  
**04/27/2013 - 04/27/2015**

### Practice Patient List (0)

#### Bundle 1: Preventive Care

<table>
<thead>
<tr>
<th>Disease Prevention</th>
<th>Preventive</th>
<th>Pre</th>
<th>PC.101 Flu Vaccine 26.48%</th>
<th>PC.102 Pneumonia Vaccine 59.81%</th>
<th>PC.103 Childhood Imms 55.21%</th>
<th>PC.104 Adolescent Imms 73.57%</th>
<th>PC.105 BMI Screen 95.73%</th>
<th>PC.106 BMI Counsel 0.00%</th>
<th>PC.107 BP Screen 98.72%</th>
<th>PC.103 Tobacco Use 91.73%</th>
<th>PC.111 Tobacco Counseling 33.92%</th>
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<tr>
<td>Early Disease Detection 1</td>
<td>Well Visits Birth - 15m 52.96%</td>
<td>Well Visits</td>
<td>PC.150 Well Visits 3: 17 yrs 59.42%</td>
<td>PC.151 Breast CA Screen 59.53%</td>
<td>PC.152 Cervical CA Screen 60.28%</td>
<td>PC.153 Colorectal CA Screen 66.33%</td>
<td>PC.154 Chlamydia Screen</td>
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<td>Early Disease Detection 2</td>
<td>Depression Peds Screen</td>
<td>PC.159 Depression</td>
<td>PC.160 Depression Peds Counsel</td>
<td>PC.161 Depression Adult Screen 68.05%</td>
<td>PC.162 Depression Adult Counsel</td>
<td>PC.163 Prediabetes Diagnosis 33.93%</td>
<td>PC.164 Fall Risk Screen</td>
<td>PC.165 Advance Directives 67.91%</td>
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#### Bundle 2: Chronic Care

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<tr>
<th>Cardiac Measures</th>
<th>Chronic</th>
<th>Disease</th>
<th>Chronic</th>
<th>Disease</th>
<th>Care</th>
<th>CD.201 CVD BP Control 72.95%</th>
<th>CD.205 CVD BMI 95.20%</th>
<th>CD.206 CVD Anti-Platelet Rx 84.88%</th>
<th>CD.207 CVD ACE-I / ARB 61.11%</th>
<th>CD.208 CVD Statin 78.37%</th>
<th>CD.209 CVD Comp Care 62.20%</th>
<th>CD.270 HF Beta-Blocker 80.99%</th>
<th>CD.251 HTN BP Control 75.95%</th>
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<td>Diabetes Measures</td>
<td>CD.231 DM BP Control 73.26%</td>
<td>CD.235 DM HbA1c Testing 80.11%</td>
<td>CD.236 DM HbA1c &lt; 7.0% 40.02%</td>
<td>CD.237 DM HbA1c &lt; 8.1% 77.08%</td>
<td>CD.238 DM Neph Monitor 53.46%</td>
<td>CD.239 DM Eye Exam 37.96%</td>
<td>CD.240 DM Foot Exam 65.25%</td>
<td>CD.241 DM ACE-I / ARB 66.72%</td>
<td>CD.242 DM Statin 67.70%</td>
<td>CD.243 DM Comp Care 15.80%</td>
<td>CD.244 DM Diuretic 24.82%</td>
<td>CD.245 DM Digoxin 31.47%</td>
<td>CD.246 DM Anticoagulants 7.50%</td>
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### Henry Ford Allegiance Health
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<th>Measure</th>
<th>2014</th>
<th>2015</th>
<th>Trend</th>
<th>Target</th>
<th>2014</th>
<th>2015</th>
<th>Trend</th>
<th>Target</th>
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<tr>
<td><strong>Bundle 1: Preventive Care</strong></td>
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<tr>
<td>Influenza Vaccination</td>
<td>27.36%</td>
<td>29.20%</td>
<td>↑ 30.10%</td>
<td>25.38%</td>
<td>26.92%</td>
<td>↑ 28.42%</td>
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<tr>
<td>Pneumonia Vaccination</td>
<td>55.44%</td>
<td>62.79%</td>
<td>↑ 50.98%</td>
<td>49.95%</td>
<td>58.00%</td>
<td>↑ 42.44%</td>
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<td>Body Mass Index (BMI) Measure</td>
<td>95.13%</td>
<td>95.46%</td>
<td>↑ 90.00%</td>
<td>95.37%</td>
<td>95.76%</td>
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<td>Blood Pressure Screening</td>
<td>98.78%</td>
<td>98.98%</td>
<td>↑ 95.00%</td>
<td>98.19%</td>
<td>96.89%</td>
<td>↑ 95.00%</td>
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<td><strong>Tobacco</strong></td>
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<td>Tobacco: Assessment of Use</td>
<td>90.41%</td>
<td>85.95%</td>
<td>↓ 90.03%</td>
<td>89.70%</td>
<td>86.17%</td>
<td>↓ 88.12%</td>
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<td>Tobacco: Cessation Intervention</td>
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<td>47.67%</td>
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<td>42.04%</td>
<td>49.06%</td>
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<td>Breast Cancer Screening</td>
<td>58.78%</td>
<td>60.64%</td>
<td>↑ 58.37%</td>
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<td>Cervical Cancer Screening</td>
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<td>61.44%</td>
<td>↑ 62.23%</td>
<td>58.11%</td>
<td>60.57%</td>
<td>↑ 60.68%</td>
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<td>Colorectal Cancer Screening - Adult</td>
<td>64.41%</td>
<td>67.94%</td>
<td>↑ 62.53%</td>
<td>63.50%</td>
<td>67.25%</td>
<td>↑ 64.11%</td>
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<td>Depression Screening - Adult</td>
<td>66.21%</td>
<td>71.80%</td>
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<td>64.75%</td>
<td>73.01%</td>
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<td>Prediabetes Diagnosis</td>
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<td>66.05%</td>
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<td>32.01%</td>
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<td>↑ 25.04%</td>
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<td>Advance Directive</td>
<td>65.48%</td>
<td>71.62%</td>
<td>↑ 61.59%</td>
<td>61.63%</td>
<td>69.94%</td>
<td>↑ 63.01%</td>
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<td><strong>Bundle 2: Chronic Disease Care</strong></td>
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<td><strong>Cardiovascular Disease</strong></td>
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<tr>
<td>CVD: blood Pressure Control ≤140/90</td>
<td>72.49%</td>
<td>74.97%</td>
<td>↑ 75.82%</td>
<td>70.60%</td>
<td>74.87%</td>
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<tr>
<td>CVD: Body Mass Index</td>
<td>95.20%</td>
<td>96.46%</td>
<td>↑ 94.92%</td>
<td>94.74%</td>
<td>96.03%</td>
<td>↑ 94.81%</td>
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<td>CVD: Use of Aspirin/Antiplatelet</td>
<td>82.56%</td>
<td>85.71%</td>
<td>↑ 83.70%</td>
<td>81.38%</td>
<td>84.89%</td>
<td>↑ 82.63%</td>
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<td>CVD: Use of ACE-I / ARB</td>
<td>59.18%</td>
<td>62.53%</td>
<td>↑ 61.55%</td>
<td>59.62%</td>
<td>63.71%</td>
<td>↑ 61.77%</td>
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<td>CVD: Use of Statin</td>
<td>75.18%</td>
<td>79.98%</td>
<td>↑ 75.14%</td>
<td>74.33%</td>
<td>79.80%</td>
<td>↑ 75.10%</td>
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<td><strong>Diabetes Mellitus</strong></td>
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<tr>
<td>DM: Blood Pressure Control</td>
<td>43.65%</td>
<td>73.03%</td>
<td>↑ 56.86%</td>
<td>44.07%</td>
<td>74.83%</td>
<td>↑ 55.03%</td>
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<tr>
<td>DM: HbA1c Testing</td>
<td>88.32%</td>
<td>90.86%</td>
<td>↑ 86.22%</td>
<td>85.21%</td>
<td>89.38%</td>
<td>↑ 82.21%</td>
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<tr>
<td>DM: HbA1c &lt; 7.0%</td>
<td>42.18%</td>
<td>42.19%</td>
<td>↑ 43.07%</td>
<td>39.21%</td>
<td>41.01%</td>
<td>↑ 41.71%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM: HbA1c ≤ 9.0%</td>
<td>78.30%</td>
<td>80.10%</td>
<td>↑ 76.32%</td>
<td>74.57%</td>
<td>78.83%</td>
<td>↑ 71.35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM: Nephropathy Screening</td>
<td>54.66%</td>
<td>63.45%</td>
<td>↑ 56.40%</td>
<td>51.54%</td>
<td>62.79%</td>
<td>↑ 56.74%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM: Retinal Eye Exam</td>
<td>38.05%</td>
<td>42.87%</td>
<td>↑ 36.09%</td>
<td>36.26%</td>
<td>42.45%</td>
<td>↑ 35.17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM: Foot Exam</td>
<td>63.11%</td>
<td>72.35%</td>
<td>↑ 68.70%</td>
<td>59.83%</td>
<td>70.02%</td>
<td>↑ 70.84%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM: Use of ACE-I / ARB</td>
<td>66.53%</td>
<td>79.71%</td>
<td>↑ 69.18%</td>
<td>61.88%</td>
<td>79.23%</td>
<td>↑ 68.80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM: Use of Statin</td>
<td>66.44%</td>
<td>70.22%</td>
<td>↑ 67.17%</td>
<td>61.43%</td>
<td>70.04%</td>
<td>↑ 68.57%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension: Blood Pressure Control</td>
<td>68.64%</td>
<td>76.44%</td>
<td>↑ 68.70%</td>
<td>65.71%</td>
<td>75.90%</td>
<td>↑ 68.61%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Asthma</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma: Assessment</td>
<td>35.74%</td>
<td>43.22%</td>
<td>↑ 28.39%</td>
<td>30.64%</td>
<td>40.66%</td>
<td>↑ 24.78%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma: Action Plan</td>
<td>34.26%</td>
<td>41.11%</td>
<td>↑ 25.08%</td>
<td>31.60%</td>
<td>40.76%</td>
<td>↑ 20.06%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma: Medication Management</td>
<td>86.63%</td>
<td>88.00%</td>
<td>↑ 55.26%</td>
<td>78.72%</td>
<td>89.06%</td>
<td>↑ 49.29%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Clinical Program Comparison

PCP Scores Year-end 2013-2015

- 2013: 3 (≥90%), 43 (70-<90%), 12 (45-<70%), 4 (<45%)
- 2014: 4 (≥90%), 38 (70-<90%), 3 (45-<70%), 3 (<45%)
- 2015: 30 (≥90%), 30 (70-<90%), 10 (45-<70%), 4 (<45%)
PCP Scorecards

PCP CI Program Score
2015 Q4
JHN Gateway Tool

<table>
<thead>
<tr>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem List</td>
</tr>
<tr>
<td>Allergies</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>Vitals</td>
</tr>
<tr>
<td>Clinical Guidelines</td>
</tr>
<tr>
<td>Lab results</td>
</tr>
<tr>
<td>Tobacco / Asthma</td>
</tr>
<tr>
<td>Advanced Directives</td>
</tr>
</tbody>
</table>

Save & Close
### JHN QM Bundle

#### Preventive Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu Vaccine</td>
<td>No data found &gt;= 07/01/2014</td>
<td>✗</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>01/13/2015 &lt;= 24 months old</td>
<td>✔</td>
</tr>
<tr>
<td>BMI Counseling</td>
<td>38</td>
<td>✗</td>
</tr>
<tr>
<td>Blood Pressure Documented</td>
<td>01/13/2015 &lt;= 24 months old</td>
<td>✔</td>
</tr>
<tr>
<td>Tobacco Assessment of Use</td>
<td>(current) 04/16/2015 &lt;= 1 yr old</td>
<td>✔</td>
</tr>
<tr>
<td>Tobacco Cessation Counseling</td>
<td>01/17/2014 &gt; 1 Yr old</td>
<td>✗</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>09/20/2013 &lt;= 24 months old</td>
<td>✔</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>09/05/2013 &lt;= 36 months old</td>
<td>✔</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>12/23/2014 &lt;= 1 Yr old</td>
<td>✔</td>
</tr>
</tbody>
</table>

#### Chronic Disease Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTN BP Controlled</td>
<td>160/80 on 01/13/2015 (&gt;= 140/90, &lt;= 1 Yr)</td>
<td>✗</td>
</tr>
<tr>
<td>DM BP Control</td>
<td>160/80 on 01/13/2015 (&gt;= 140/90, &lt;= 1 Yr)</td>
<td>✗</td>
</tr>
<tr>
<td>DM HbA1C Performed</td>
<td>09/18/2014 &lt;= 1 Yr old</td>
<td>✗</td>
</tr>
<tr>
<td>DM HbA1C &lt; 7.0%</td>
<td>11.3 on 09/18/2014 (&gt;= 7.0, &lt;= 1 Yr)</td>
<td>✗</td>
</tr>
<tr>
<td>DM HbA1C &lt; 9.1%</td>
<td>11.3 on 09/18/2014 (&gt;= 9.1, &lt;= 1 Yr)</td>
<td>✗</td>
</tr>
<tr>
<td>DM Nephropathy Screening</td>
<td>MAU: 08/20/2014 &lt;= 1 Yr old: SC: Sep 18 2014 11:32 AM &lt;= 1 Yr old</td>
<td>✔</td>
</tr>
</tbody>
</table>
TeleVox Outreach Calls

- Proactive outreach using automated call system
- Available to providers on JCMR
- Meets outreach capabilities for PGIP program
- Measures included
  - Asthma
  - ADHD
  - COPD
  - CVD
  - DM
  - CHF
  - HTN
  - Hyperlipidemia
  - Well Visits – peds, adult, senior
Care Management

Behavioral Health Integration

Expanding Care Team
Patient Identification Process

Prospective Identification

- It’s Your Life – HRA Data
- Referrals - Providers - Hospital - Self
- INPT, ED, OBS Utilization (Non-Allegiance facilities)
- Predictive Modeling Information
- Pharmacy Utilization
- High-Cost Claims (> $50K)

Retrospective Identification

DATA MANAGEMENT by JHN

Currently Care Managed by JHN or JHN Provider

Yes

Monitor current CM Plan

No

Apply Risk Stratification Score

Score ≤ 1

Score ≥ 2 - 4

Assessment triggers need for additional follow-up from Care Coordinator

Yes

Feedback to PCP Provider

No

Comprehensive Health Assessment

Feedback to PCP Provider

Develop Care Management Plan with Patient

Refer to alternatives based on need

Provide Ongoing Care Management Services

Initial Assessment

IYL Health Coach

Community Referral

Self Management

Feedback to PCP Provider
CHAT: Comprehensive Health Assessment Tool

- Documented in JCMR
- Covers 5 Domains:
  - medical, social, functional, psychological, and self management
- Used by Care Coordinators and IYL (It’s Your Life) Health Coaches
The Care Management Folder – Opens to the Physician Dashboard which provides an overview of the care plan.
Conditions Being Managed

<table>
<thead>
<tr>
<th>Care Management Problem</th>
<th>ICD9 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus, Type II Controlled</td>
<td>250.00</td>
</tr>
<tr>
<td>Hypertension</td>
<td>401.90</td>
</tr>
</tbody>
</table>

Active Medications

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Dose</th>
<th>Sig</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIORICET</td>
<td>50 mg-300 mg-40 mg</td>
<td>take 1-2 capsule by oral route every 4 hours as needed not to exceed 6 capsules per 24hrs</td>
<td>12/05/2013</td>
</tr>
<tr>
<td>LIPTOR</td>
<td>40 mg</td>
<td>take 1 tablet by oral route</td>
<td>12/03/2013</td>
</tr>
</tbody>
</table>

Graphs

- PHQ 9
- Peak Flow
- A1C

A1C Graph

Care Plans

<table>
<thead>
<tr>
<th>Date</th>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
<th>Next Review</th>
<th>Status</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/05/2013</td>
<td>Diabetes mellitus type 2 in obese</td>
<td>Wall twice a week</td>
<td></td>
<td>/ /</td>
<td>New</td>
<td>11/05/2013</td>
</tr>
<tr>
<td>10/22/2013</td>
<td>Angina at rest</td>
<td>Goal 1</td>
<td>Eat more</td>
<td>/ /</td>
<td>New</td>
<td>10/22/2013</td>
</tr>
<tr>
<td>10/16/2013</td>
<td>Diabetes mellitus type 2 in obese</td>
<td>This is the second goal</td>
<td></td>
<td>10/23/2013</td>
<td>New</td>
<td>10/16/2013</td>
</tr>
<tr>
<td>10/16/2013</td>
<td>Diabetes mellitus type 2 in obese</td>
<td>This is the first goal</td>
<td></td>
<td>10/17/2013</td>
<td>New</td>
<td>10/15/2013</td>
</tr>
<tr>
<td>10/08/2013</td>
<td>Untreated sleep apnea</td>
<td>Patient states he is afraid to use CPAP because he is afraid he will choke 1) Explore technology (computer, TV, radio, etc.) actions for relief</td>
<td>10/23/2013</td>
<td>New</td>
<td>10/09/2013</td>
<td></td>
</tr>
</tbody>
</table>

Provider/Care Manager Communication

- Right-click in grid and select Add New to start a new communication or double-click on a row to respond.

<table>
<thead>
<tr>
<th>Date</th>
<th>Comment</th>
<th>Response</th>
<th>Care Manager</th>
<th>PCP</th>
</tr>
</thead>
</table>
Care Management Expansion

• Statistics

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td># Lives Impacted</td>
<td>10,000</td>
<td>65,000</td>
</tr>
<tr>
<td># Payors Supported</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

• Expanding in 2017 to include:
  • SIM PCMH Model
  • Comprehensive Primary Care Plus (CPC+)
  • HAP
Engaging Physicians in Hospital Outcomes

Jackson
Michigan
Using Size and Complexity to Improve Outcomes

Reducing Readmissions

- Early 2014 created cross continuum team
  - Included all stakeholders from ED to our Clinically Integrated Network (CIN)
  - Created RN driven chronic disease education team
    - Education for patients and families at their convenience
    - Make first follow up appointments
  - Verbal handoff to CIN patient navigator
  - Leveraged IT to flag ED patients who had been discharged in the past 30 days
Reducing Readmissions

Henry Ford Allegiance Health
Overall Inpatient Readmission Rate by Fiscal Year

*Denominator excludes patients who expired, left against medical advice, or were transferred to another hospital during their initial visit; planned readmissions are also exclude
Quality and Safety

"A" Patient Safety Rating

- For the 5th year in a row, has earned a top rating of “A” on the Hospital Safety ScoreSM from The Leapfrog Group

“Four-Star” Overall Hospital Quality “Star” Rating

- Reflecting significant commitment to quality and safety, in addition to community health

Healthgrades “Five-Star” for Excellence in Patient Safety

- Eight consecutive years
The future

Jackson
Michigan
Competing in this World

Keys to Success
- Attributed patients - Obtain & Retain
- Responsive to Consumer demands
- Longer term thinking
- Community buy-in
- Infrastructure
  - “Right-design”
  - “Right-sizing”
- Savings generated re-invested to continue to improve
  - Improvements in upstream determinants no longer expenses but investments
Network’s Perspective

- Can’t move fast enough; can’t move slow enough
- Development time not acknowledged
- Balancing the need to address more “opportunities” while trying to improve results from current programs
- Moving target
- Dynamic process – how to get this to work without wheels falling off
Thank you!

Any Questions?