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Michigan Selected for CMS Medical Demonstration Project

As some of you may have heard, Michigan was selected as one of eight states for participation in the CMS Multi-payer Advanced Primary Care Practice (Patient Centered Medical Home) Demonstration Project. This will be a major boost for PCMH development in the state, as well as our network! I will share with you bullet point highlights of this complex project. In addition, I will be available to answer any questions you may have.

The key points:

- Up to 477 2010 BCBSM PGIP Designated offices with about 1800 PCPs covering an estimated 1.8 million patients. Michigan is by far the largest of the 8 state projects. It is our hope that CMS will allow us to expand the initial office participants however that is unknown.
- The earliest CMS would allow us to start would be 7/1/11. Due to the complexity of the work that needs to be done, I believe a more realistic start date to be 1/1/12.
- Commercial, Medicaid and Medicare patients included from 17 different payers, including “straight” Medicare and Medicaid.
- The application states we must have a common payment methodology, which is a huge challenge for the payers. CMS is becoming more flexible on this.
- Must be budget neutral over the 3 years term of the project. Because our project is so much larger than other states, they will stop Michigan if we do not show early progress.
- Our funding target is \$9.76ppm from “straight” Medicare. \$7.76ppm from commercials and Medicaid. I do not expect this will be all “new money” as commercial and HMO Medicaid will probably wrap in some existing funds. At this point, I do not want to venture a guess as to how much new money there is other than to say I expect it to be substantial. The expectation is that the significant majority of the funds are to be applied to building teams in Medical Homes.
- The details of clinical model also need to be worked out however we know it will focus building physician lead teams to work on:
 - o Care Coordination
 - o Care/Case Management
 - o Self Management
 - o Community Linkages
- The evaluation work will be done by the U of M’s Michigan PGIP Analytics Consortium (MPAC) and the collaborative learning through the U of M’s Center for Healthcare Research and Transformation (CHRT). The Michigan Department of Community Health (MDCH) is responsible for overall management of the Project with the Michigan Primary Care Consortium (MPCC) doing the overall project management. Governance is through the “Steering Committee” which was formed by election. 6 from PO/PHOs, 5 from Payers and 7 appointed by MDCH including knowledge experts. I hold a PO/PHO seat so LHN will be well informed. I also expect to serve on the Clinical Workgroup.

In summary, this is a massive project that is coming at a good time for Michigan and Lakeshore. A strong highly functioning primary care base will give us a tremendous leg up if and when we enter into the anticipated Accountable Care reimbursement model. If you have any questions, please contact Paul Ponstein, DO, Medical Director at 231-672-3882 or ponsteip@trinity-health.org.

LHN Clinical Integration Update
Creating a Patient Centered Medical Network™
through Coordination of Care

The focus of Lakeshore Health Network’s Clinical Integration activities is the development and implementation of the Patient Centered Medical Network™, a model that LHN has developed and successfully trademarked. The Patient Centered Medical Network™ can be defined as: *A patient-centric, integrated care delivery network of providers who share a common vision to deliver excellence in quality, efficiency and service within the community we serve.*

We believe strongly in the benefits of a well-coordinated, patient centric, network of providers working together to achieve Triple Aim principles:

- Improved the health of the population
- Enhanced patient care experience
- Reduce, or at least control, the per capita cost of care

Research demonstrates coordination of care is a requirement of effective health care delivery, quality outcomes and improved safety. Thomas Bodenheimer, MD has published multiple articles on coordination of care. Bodenheimer wrote the article “Coordination of Care: A Major (Unreimbursed) Task of Primary Care”. See excerpt below:

For several decades, first-contact care, continuity of care, comprehensive care, and coordinated care have been core attributes of primary care. Of these features, perhaps the most problem-ridden is the task of coordinating the care of patients among multiple entities beyond the primary care practice, that is, specialists, ancillary services, pharmacies, hospitals, and home care agencies. Studies demonstrate that referrals from primary care physicians to specialists often lack sufficient (or any) flow of information in either direction. In this era of hospitalists, primary care physicians are often uninformed about what took place during their patients' hospital stay.

Under the medical home concept, patients enroll in a practice and join the panel of a physician within that practice. Patients know who is responsible for their care and physicians know which patients they are responsible for. One responsibility is to coordinate care with the rest of the health system. The medical home is not equivalent to a gatekeeper system, but if patients see a specialist without a referral, they must inform their medical home so that the practice can coordinate their care with the specialist.

Most definitions of “coordination of care” focus on information exchange among care providers to ensure that they all act toward a common goal. This focus is too narrow. Coordination also takes place between providers and patients and families.

Patients expect that their primary care physician will coordinate their care throughout the health system. For primary care to assume this responsibility, 2 things must happen: Everyone needs to have a medical home (usually a primary care practice), and payers need to reimburse primary care physicians for care coordination work.

Lakeshore Health Network is focused on improving coordination of care across our network. We currently have activities focused on improving the transition of patients from our inpatient setting to our ambulatory setting. Our work will also focus on pre and post hospitalization opportunities as well as opportunities to better link the overall system of care through improved process and flow of information. We look forward to continuing our network journey to create a seamless Patient Centered Medical Network™. If you have any questions or would like to discuss opportunities to advance these concepts within your practice, please contact Jen Bailey, Director Clinical Integration and Operations at 231-672-3742 or baileyjl@trinity-health.org.

Self Management Support in the Patient Centered Medical Home

Effective self-management is key to not only maintaining wellness but also in improving outcomes of chronic disease. In the Patient Centered Medical Home, patients have a central role in determining their care, one that should foster a sense of responsibility for their own health. The most successful practices use a team approach: one in which providers and patients work together to define problems, set priorities, establish goals, create treatment plans, and solve problems along the way.

In order to maintain healthy lives, people with chronic conditions and their families undertake day-to-day activities to manage their condition. This management often involves understanding and following complex medical regimens, and challenging changes in lifestyle, such as weight loss or increasing exercise. These activities, called self-management, involve three different kinds of tasks: care of the body and management of the condition, adapting everyday activities and roles to the condition, and dealing with the emotions arising from having the condition. **Self-management support is the care and encouragement provided to people with chronic conditions to help them understand their central role in managing their illness, make informed decisions about care, and engage in healthy behaviors.**

Good self-management support involves collaboration between patient and their care provider, one in which the provider is a coach as well as clinician and the patient and family are managers of daily care. Through collaboration patients, family, and providers share information, understand a patient's goals, and create a plan that all can use to guide care at home and in the clinical setting. Health care systems can support effective self-management by providing care that builds patient and family skills and confidence, increases patient and family knowledge about the condition, increases provider's knowledge of the needs and preferences of the patient, and supports the patient and family in the psychosocial, as well as medical, responses to the condition

---from the Institute for HealthCare Improvement

As mentioned, in addition to the patient, providers must also be aware and responsive to the role that families, caregivers, and the community play in maintaining health. Better patient outcomes are achieved through the use of evidence-based techniques that emphasize patient empowerment (self management), collaborative goal setting, and problem-solving skills. The Patient Centered Medical Home utilizes a team approach to assess and assist patients in their self-management needs. Together they identify educational needs and barriers that limit success for improved outcomes and set action plans to remove these obstacles.

If you would like more information about Self Management support please contact Linda Mueller, RN, Network Clinical Manager at 231-672-3882.

ANNUAL GROUP CLASSES BEING OFFERED

~ Diabetes Education Program ~

Mercy H.E.A.R.T Center
1212 E. Sherman Blvd, Muskegon, MI 49444



Supermarket Shopping – Patients get tips on making the healthiest choices in each aisle of the grocery store.

Exercise Class — We will get your patients moving! They will work out with an Exercise Physiologist and become comfortable with using exercise equipment as well as designing their own home workouts.

Cooking Class — Your patients will learn how to make nutritious, diabetes-appropriate meals.

Carbohydrate Counting Class – Your patients will be provided with a review of carbohydrate counting and receive meal planning ideas.

Annual visits for diabetes education are typically covered by most insurance plans. Please call for more details at (231) 672-3648.

Lakeshore Health Network Ambulatory Case Management Services Update

In 2010 Lakeshore Health Network started a new service line to include ambulatory Case Management. This work was made possible through grant funding by Payers including Health Plan of Michigan, Access Health/Muskegon Care, and Blue Cross Blue Shield of Michigan. LHN currently has four Case Managers on staff to provide interventions both telephonically and face to face to support patient centered care across our network and within our community.

The goals of these positions remain:

- Engagement of the patient in their Patient Centered Medical Home
- Coordination of care between providers and facilities
- Establishment of collaborative plans of care including input from the patient, Case Manager, PCP and care team
- Improved compliance with PCP treatment plans including self-management and disease management recommendations
- Improved quality and utilization outcome measures

Lakeshore Health Network believes Case Management plays an important role in the implementation of our supported Clinical Integration models including the Chronic Care Model, Patient Centered Medical Home and the Patient Centered Medical Network™. LHN believes Case Management is best delivered in coordination with the medical home. Our vision is to structure ambulatory case management to be delivered in the provider office as part of the PCMH team. In order to achieve this vision, LHN must continue to demonstrate improved quality, utilization and satisfaction to all payers to fund these resources.

If you have any questions or would like to learn more about Lakeshore Health Network Case Management Services and how you can access and support the success of this role, please contact Jen Bailey, BSN RN Director Clinical Integration and Operations baileyjl@trinity-health.org or (231) 672-3742.

Electronic prescribing

We've been getting plenty of great feedback from individual LHN offices regarding specific issues they've run into with electronic prescribing.

Please keep that feedback coming - this is very helpful!

Thanks to experiences the network has shared with us, we've been able to compare notes with pharmacies and software vendors to collaboratively trouble shoot problems and address deficiencies.

In the long run this feedback can help make electronic prescribing more seamless while also translating into a better – and safer – experience for patients.

Helping to resolve e-prescribing issues is a priority, so please contact Jason Barnum with any specific problems you encounter, as well as for any concerns, comments, or questions regarding e-prescribing. Every effort will be made to return messages as soon as possible.

Jason can be reached via phone at (231) 672-6713 or via e-mail at barnumj@trinity-health.org.



Welcome
~Kathy Brink, RN~
To the LHN Team

We are pleased to announce that Kathy Brink, RN is transitioning her position as Quality Improvement Facilitator from MHP Quality Care Transformation Department to Lakeshore Health Network's Clinical Team. Kathy will continue to work on her current projects including transitions of care and support the hospitalists.

Feeding the Community

Have you ever wondered how or where your next meal would come from? Many families in our community struggle to find enough food to feed their family each day. Lakeshore Health Network has been challenging the physicians and their staff to help feed the people in our community. This year's Gleaner Truck Challenge was a huge success. The Lakeshore Health Network staff, along with LHN Physicians and their office staff worked together to raise an all time Challenge record of \$10,507.00.

Lakeshore Health Network and Muskegon County Cooperating Churches are working together to schedule the Gleaner food trucks to help the community.

Gleaner truck Sponsors and calendar of events:

January 29, 2011	West Michigan Emergency Services	MATS Bus Station
February 26, 2011	Dr. Patricia Roy and Family	MATS Bus Station
March 26, 2011	Dr. Brian Gluck and Dr. Eric Kivisto	MATS Bus Station
April 20, 2011	Westshore Family Medicine	MHP Hackley Campus
May 2011 - TBA	West Michigan Emergency Services	MHP Hackley Campus
May or September 2011	Dr. Frederick DeTorres	Muskegon Catholic Central
August 20, 2011	Lakeshore Health Network	Fruitland Covenant Church
August—TBA	West Michigan Emergency Services	MHP Hackley Campus
October 15, 2011	Lakeshore Health Network	Fruitland Covenant Church
October or November	West Michigan Emergency Services	MHP Hackley Campus



If you would like to volunteer to help at an event or if you have any questions, please contact Cindy Curran at currensc@trinity-health.org or (231) 672-3882.

It's never too late to help the people in our Community!

MSO News

Announcing a new after hours service - AMBS Call Center. They are a local company and compliment the other two existing companies offered through the Lakeshore Health Network's MSO. This is a good time to review and compare your current after hours company to see if the MSO companies can provide you the opportunity to decrease your after hours costs but not quality. If you would like more information, view the after hour prices or any other MSO agreements, please contact Carrie Uthe at 231-672-3882.

Other MSO Discounts:

Universal Studios
Rental Car Agreements
Hotel Discounts
Walt Disney World
Medical Supply Companies



Muskegon Medication Disposal 2011 Events Calendar

*You can dispose of your
Unused, Expired Medications and Sharps*

February 19, 2011

Fruitport Fire Station (Airline Road)

April 30, 2011

Muskegon Fire Station (Central Station)

June 18, 2011

Dalton Twp. Fire Station (Riley Thompson Road)

October 8, 2011

Norton Shores Fire Station (Pontaluna Road)

All events are from 10:00 a.m. - 2:00 p.m.

Directors Corner

Linda Bailey, Executive Director

The Mission, *Lakeshore Health Network exists to serve the residents of the Lakeshore through a partnership of the community and health care providers, dedicated to delivering value and excellence within a “Patient Centered Medical Network”™.* sets a lofty vision for our organization. The work to achieve this vision is focused yet broad but clearly defines a key element of “Partnership”.

The Network has reached out to many in our community to better understand our community needs and resource availability. We have chosen to leverage the resources in our community to assist our patients in meeting their individual health care goals.

Muskegon and Oceana counties have rich environments with many social service resources that have led to enhance community and health care outcomes. Examples of how we partner are demonstrated with our relationship with 211. This resource is used daily by our physician offices and hospitals in both Muskegon and Oceana County. It provides one stop shopping for linkage to critical resources such as housing, food, heat, jobs etc. The list goes on and on and includes more than 8000 community resources. They assist us in facilitating the needs of our patients with the resources available in our community. Additionally, 211 tracks the number of calls against the services requested. That information is important as we plan for unmet needs in our community.

The Muskegon Community Health Project is another extremely valuable resource to our Network and community. They provide our physician offices with support for our patients with limited or no coverage for health care. They assist patients in filing the proper financial documents for evaluation for charity care and/or submission of paperwork for consideration of Medicaid and/or food stamps. The services don’t stop there. In some instances patients can be referred to the Pharmacy Gleaner for evaluation for low or no cost pharmaceutical support. The Health Project also runs multiple community collaborations to address health care needs and has extensive outreach programs.

In Oceana County, LHN participates with a Community Collaborative that brings the various social service organizations to the table to integrate and coordinate our efforts in supporting the community. These are only a few of the ways that Lakeshore Health Network partners with the community to meet the needs of our residents. Yes, we are fortunate to live and work in a community that offers the breath and depth of community resources as well as the desire to work together for the benefit of all.

MISSION STATEMENT:

Lakeshore Health Network exists to serve the residents of the Lakeshore through a partnership of the community and health care providers, dedicated to delivering value and excellence within a “Patient Centered Medical Network”™.

Lakeshore Health Network

1560 E. Sherman Blvd, Suite 145
Muskegon MI 49444
(231) 672-3882
lhnpho.org

Route This Issue To:
