

Improving Today.  
*Inventing Tomorrow.*

# Impact Report

**Vanderbilt Health**  
Affiliated Network

# stronger together

This is rewarding care. This is VHAN.

Together, we are improving the communities we call home.

We are 6,400+ strong providers joining forces to transform health care.

This is the story of  
*our impact.*

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# To Our Community,

From day one, Vanderbilt Health Affiliated Network has been focused on improving the lives of individuals, families, neighborhoods, communities and zip codes while elevating the health and wellbeing of our entire region. Since 2012, our network has continuously advanced the practice of medicine and our collective success with patients.

Even a global pandemic couldn't impede our progress. In fact, our network climbed every mountain with increased momentum by sharing best practices, collaboratively solving problems and leveraging a common set of tools and resources to ensure consistent, high-quality care in every corner of our coverage area.

Health care is changing before our eyes, and our network has responded in big ways. Now it's our turn to drive change by positively transforming the way care is delivered.

Our key values as a network include transparency and accountability. That's why we have produced this impact report to celebrate the network's historical accomplishments as well as our tremendous quality achievements for 2020 leading into 2021. Within these pages,

you will learn more about the key aims we have set for ourselves as a family of providers and performance metrics that help evaluate our performance to date. You'll also encounter individual patient stories that will make it abundantly clear where the real impact of our work lies.

We would like to thank every one of the providers, team members, practices, clinics and hospitals who make up this amazing network for your commitment to excellence. We would also like to thank the health plans, employers and brokers who place the health of their populations in our hands. We want to express our eternal gratitude to the individuals who trust us to care for their well-being on a daily basis.

As VHAN prepares to celebrate our 10th anniversary in 2022, we are reminded just how much our mission starts and ends with our community. We are improving today. We are inventing tomorrow. And together, we are positively impacting lives.

Now it's our turn to drive change by positively transforming the way care is delivered.



We are improving today.  
We are inventing tomorrow.  
And together, we are positively impacting lives.

The best, as they say, is yet to come!

**David R. Posch, MS**

Executive Director, VHAN  
Executive Vice President, Population Health

**Cynthia Powell, MD**

Chief Medical Officer, VHAN  
Senior Vice President, Population Health



# The Network Effect

The combined efforts of VHAN members and staff over our nine-year history have consistently produced market-leading results. Every year, we have outperformed the expected cost trend for our market by an average of 2.5% per year.

While financial results absolutely matter, we are focused on the high-quality clinical outcomes that drive cost savings.

**What VHAN Is Doing**  
Collectively as a network,  
VHAN's data shows:

Fewer  
Patients  
Visiting  
the ER

20%

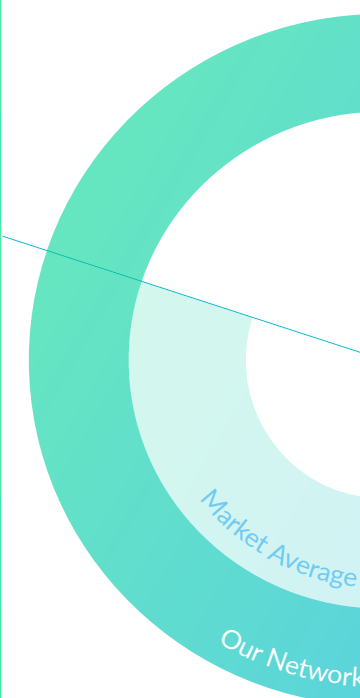
ER visits are nearly  
20% below market  
average



More  
Patient  
Well  
Care

20%

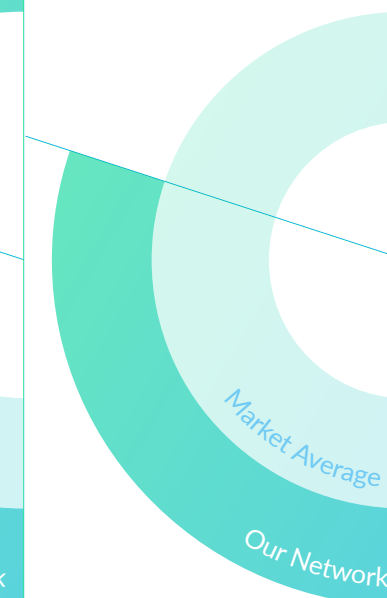
Well care is 20%  
above market  
average



Fewer  
Inpatient  
Admits

20%

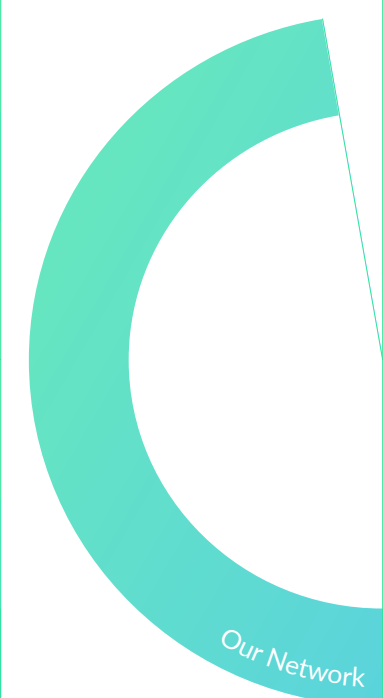
Inpatient admissions  
are 20% below  
market average



Lower  
Blood  
Sugar  
Levels

86%

of uncontrolled patients  
in VHAN's diabetes  
programs showed an  
average HbA1C decrease  
of 2.1%.





# Key Aims

The topline results we have achieved as a network are not possible without very specific efforts across multiple key areas. Based on the needs of the patients and communities we serve, VHAN currently has focused improvement and innovation efforts in 11 key categories.

Behavioral Health

Pediatric Well Child Visits

Adult Annual Wellness Visits

Medication Management

Diabetes Management

Cancer Screening

Readmissions/Transitions of Care

Reducing Unwarranted Variation in Care

Addressing Patient Needs

Growth

Access

Our vision is to improve members' ability to address the stigma and lack of support associated with childhood mental illness. We help our members accomplish this aim by equipping our pediatricians with behavioral health support.

Key Aim



# Behavioral Health

# Behavioral Health Why It Matters

In our region, mental illness is higher than the national average.

50% of mental illness occurs before age 14

Less than 50% receive adequate treatment at a young age

75% of mental illness takes root by the age of 24

Half of all mental illness in the United States occurs before the age of 14, with 75% taking root by the age of 24. Fewer than half of young people with mental illness receive adequate treatment. In our region, mental health diagnoses such as autism, depression, anxiety, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and behavioral problems are more prevalent than the national average.

## What VHAN Is Doing

### VHAN Pediatric Behavioral Health Consult Line

From 2018 to date, we have handled more than 1,500 calls through our phone line. These calls included over 540 medication consultations, helping providers prescribe the best behavioral health medications for patients who simply can't wait to get the help they need. In 2021, we provided more than 30 psychiatric evaluations, shortening the long wait time for pediatric patients seeking mental health care. Many VHAN pediatricians report that the consult line service is the greatest benefit of their membership.

### Provider Support Sessions

With behavioral health demands increasing in the past 18 months, VHAN initiated virtual provider support sessions with clinical psychiatrist Meg Benningfield, MD, to give pediatricians a place to meet and ask clinical questions or seek personal assistance. This year, providers have asked for guidance on patient medications and shared concerns over missed opportunities with patients.

Providers offered each other advice to address common problems such as lack of time and opportunity in patient appointments to address behavioral health concerns. Some advised on best practices for extending appointment times to meet each patient's individual needs. Together, we navigated the rough waters of 2020 and 2021, trying to minimize burnout and maximize patient care.



**1,500+**  
Consultation  
Calls



**540+**  
Medication  
Consultations



**30+**  
Psychiatric  
Evaluations



**Shorter Wait**  
for Mental  
Health Care



**Consult Line**  
#1 Benefit of  
VHAN by Pediatrics

## What People Are Saying

### MEMBERS

*"I found the VHAN consult line has helped me greatly, especially with accessing behavioral health care. The consult line has also been very helpful when I need to speak with the psychiatrist about the less straightforward cases."*

**Dr. Michael Ladd**  
Green Hills Pediatrics

### PATIENTS AND CAREGIVERS

*"Dr. Don Pierce was wonderful, and his suggestions spot on. Thank you so much again for orchestrating the appointment and talking me through the steps and details. One can feel so lost when things get off track, especially when we were still trying to learn our newly adopted son!"*

**Mother of a patient**



The True Value

# Alex's Story

Alex\*, having endured significant prior trauma, was adopted from Russia at the age of 13.

He quickly made friends and joined a soccer team. One year later, he seemed happy, but his adopted parents were concerned. They were aware Alex had endured significant trauma prior to the adoption and that he had been prescribed multiple medications. At the time, he was actively taking only one, an anti-psychotic typically used to treat serious psychiatric disorders. They knew little else about his actual diagnosis or need for medication.

An attempt to taper off and discontinue Alex's anti-psychotic medication resulted in him experiencing insomnia, aggression toward objects and defiance. On behalf of Alex's parents, his pediatrician reached out to the VHAN Pediatric Behavioral Health Consult Line for a psychiatry consult to clarify

Alex's diagnosis. In the end, the medication was not needed, but it had disrupted Alex's natural sleep cycle. The VHAN psychiatrist spent time educating Alex's family on his diagnosis and worked closely with Alex's pediatrician to put recommendations into action, including putting him on a low dose of a sleep medication. The plan has created a sense of hope and relief for the family.

"We feel so much more at ease," said Alex's mom following her latest consult. "It's nice to know we are not alone. We have settled into a wonderful routine, and Alex is getting exactly what he needs. You can feel so lost when things get off track. We are grateful for all the support. It's good to know Alex is going to be okay."

"We feel so much more at ease. It's nice to know we are not alone and to know Alex is going to be okay."

Alex's mom,  
following her latest consult





Our vision is to educate patients about the value of adolescent well visits to improve the health and wellness of pediatric patients.

Key Aim



# Pediatric Well Child Visits



We have an opportunity to increase these visits, which will:

Improve Overall Health

Lower Health Care Costs

Pediatric Well Child Visits

# Why It Matters

Wellness visits are a vital part of health and well-being for pediatric patients. Current data shows we have an opportunity to increase well visits for this population, particularly for adolescents, which will improve their overall health as well as ultimately lower the cost of care.

## What VHAN Is Doing

This year we renewed our communication efforts, equipping members with tools and resources to help improve pediatric wellness, and highlighting best practices across the network. These resources included:

### Learning Opportunities

VHAN developed podcasts and webinars, led by network members, to help improve well care for pediatric patients. We interviewed the Children's Clinic of Nashville about their team-based approach to improving adolescent wellness visit (AWV) engagement, and we provided an AWV webinar to provide actionable steps you can take to enhance these visits.

### Gender Identity Resources

A miniVHAN Mondays podcast featured Vanderbilt's Dr. Cassie Brady, pediatrician and LGBT health specialist, and Danielle McDonough, behavioral health LCSW, as they talked about ways to better engage patients and parents in meaningful conversations about adolescent gender identity. VHAN's Well Moment program provided a webinar for providers, patients and caregivers to better understand and support youth as they navigate gender transitions.

### Pediatric Asthma Training

VHAN hosted a pediatric asthma webinar and developed a new quick reference guide to help providers diagnose and treat asthma more effectively.

### New Specialty Care for Pediatric Patients

Rager Adolescent Health, which provides important specialty care for pediatric patients, recently joined VHAN. VHAN members can refer patients to this specialty care practice for adolescent reproductive health services, adolescent disordered eating, and issues related to LGBTQ+ youth and young adults.

Nearly 60% of VHAN pediatric practices are National Committee for Quality Assurance (NCQA) certified patient center medical homes (PCMH).

NCQA research\* shows that PCMHs improve clinical quality while enhancing the patient experience and increasing staff satisfaction. In many cases, PCMHs also reduce health care costs. Practices that earn recognition have made a commitment to continuous quality improvement and a patient-centered approach to care.

\*Source:  
[www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/benefits-support/pcmh-evidence](http://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/benefits-support/pcmh-evidence)

Our vision is to promote health and wellness among our senior patients while decreasing total cost of care and fostering better relationships between patients and providers.

Key Aim



# Adult Annual Wellness Visits



# Why It Matters

Medicare Annual Wellness Visits (AWVs) play a vital role in caring for adults 65 years and older.

These visits are a once-a-year prevention-focused encounter that gives patients dedicated time with the provider to update their health stats and address gaps in care. From medication reviews to mental health checks, these visits are invaluable in maintaining necessary support for seniors.

## Characteristics of Medicare Annual Wellness Visits

- For adults 65 and older
- Once a Year
- Prevention Focused
- Dedicated Time with Provider
- Address Gaps in Care
- Medication Review
- Mental Health Check

## What VHAN Is Doing



### >42% AWV Completion Rate

In 2020, Connected Care ACOs participating in the Medicare Shared Savings Program (MSSP) collectively achieved greater than a 42% AWV completion rate. Not only is this above the industry average of 19%, but ACOs also saw a 2% increase in AWV completion compared to 2019, despite the pandemic. Patients receiving AWV's have an overall higher rate of preventive health screenings and lower total cost of care—an average reduction of \$418 per beneficiary. AWVs also build better patient/provider relationships and provide a significant increase in MSSP quality measure performance.



### Workgroup Tracking and Recommendations

The AWV Workgroup is engaging monthly with practices to track interventions and make recommendations. As part of this work, clinical champions have been identified at 83% of targeted practices, with 100% adopting action plans to customize interventions at the organization level. Interventions include EMR optimization, patient outreach activities, telehealth implementation, split-billing/visit conversions, and leveraging RNs to help perform AWVs.



### Best Practice Sharing

Two miniVHAN podcast episodes supported network AWV efforts, including best practices for performing, documenting and billing AWVs. One episode highlighted Catherine Stober, MD, who achieved a 97% AWV completion rate in 2020, of her nearly 500 eligible patients.



### Learning Exchange Opportunities

A Learning Exchange focused on opportunities to engage patients in AWVs and optimize HCC (Hierarchical Condition Category) coding accuracy took place June 2021, with more than 20 physicians, quality leaders and VHAN staff represented. Challenges and solutions were shared via VHAN's virtual community, VHANTage Point, with a live wrap-up call to discuss key findings and next steps. Takeaways were then shared with the broader network through various channels, including [this article](#).

[www.vhan.com/5-key-takeaways-from-the-awv-and-mra-coding-learning-exchange](http://www.vhan.com/5-key-takeaways-from-the-awv-and-mra-coding-learning-exchange)

The VHAN team provides a monthly stratified roster of patients with overdue screenings, including annual wellness visit completion, making identification and outreach easier for practices.

Our vision is to improve the health of the population and decrease the total cost of care by ensuring each medication is indicated, effective, safe and accessible.

Key Aim



# Medication Management

# Medication Management

## Why It Matters

Medication costs (retail and medicine/pharmacology) account for 30% of the overall total cost of care *and are rising each year*. Cost drivers include increasing cost and utilization of specialty medications and some traditional medications to treat conditions such as diabetes.



While the cost of medications is an important driver to the total cost of care, medications are also the most common tool for the treatment of chronic conditions, so it is critical to ensure appropriate use to achieve the best outcomes. Further, the downstream costs associated with inappropriate medication use are also staggering. Medication-related errors are a top preventable cause of serious adverse health events and avoidable readmissions, resulting in poor outcomes and an increasing total cost of care.

### What VHAN Is Doing

#### Comprehensive Medication Management

The VHAN Pharmacy Team works with patients to review their medications, assessing each drug to ensure that it is indicated, safe, effective and accessible at a reasonable cost. Pharmacists also assess the patient's conditions and compliance with evidence-based treatment guidelines, ensuring patients with diabetes are taking a statin and kidney protective drug, for instance. Pharmacists identify medication-related problems and work with the patient and care team to resolve them based on patient goals and priorities.

#### Therapeutic Alternatives Program (TAP)

By decreasing utilization of low-value medications over eight therapeutic categories, TAP has identified \$4 million in potential savings. VHAN has created analytics and reporting tools to support this program, including creating an opportunity estimator, practice reports and other resources, which can be found on the [VHAN Hub](#).



In 2020, the VHAN Pharmacy Team worked with approximately 1,400 patients to optimize medications for chronic disease management, transitions of care and polypharmacy.



# The True Value Sarah's Story


Sarah is a 70-year-old former nurse living in rural Tennessee.

Struggling to manage complex medical conditions while fighting through impaired cognition and memory loss, Sarah had become a familiar face at the hospital and had two tackleboxes full of medications.

A lack of communication between specialists and a lack of overall coordination of care had resulted in 27 medication discrepancies for Sarah. The network came to the rescue, with Sarah's care providers, a VHAN pharmacist and a local pharmacy collaborating to review, update

and reduce her medications while also lowering her monthly medication costs. The team also encouraged Sarah to keep a log of her blood sugar levels and consistently followed up to monitor and adjust her medications as needed.

The results have been dramatic. Sarah's A1c levels improved from 13.6% to 7.7%. She greatly reduced her chronic pain and fatigue. And since the added support from the network, she has not been to the emergency room for an avoidable visit.



Since the  
added support  
from the network,  
Sarah has not been to  
the emergency room  
for an avoidable visit.

Our vision is to improve outcomes and decrease the total cost of care while providing unparalleled service for patients with diabetes. We help our members accomplish this aim by providing high-touch support for patients with uncontrolled diabetes and working with practices to implement quality improvement efforts.

Key Aim

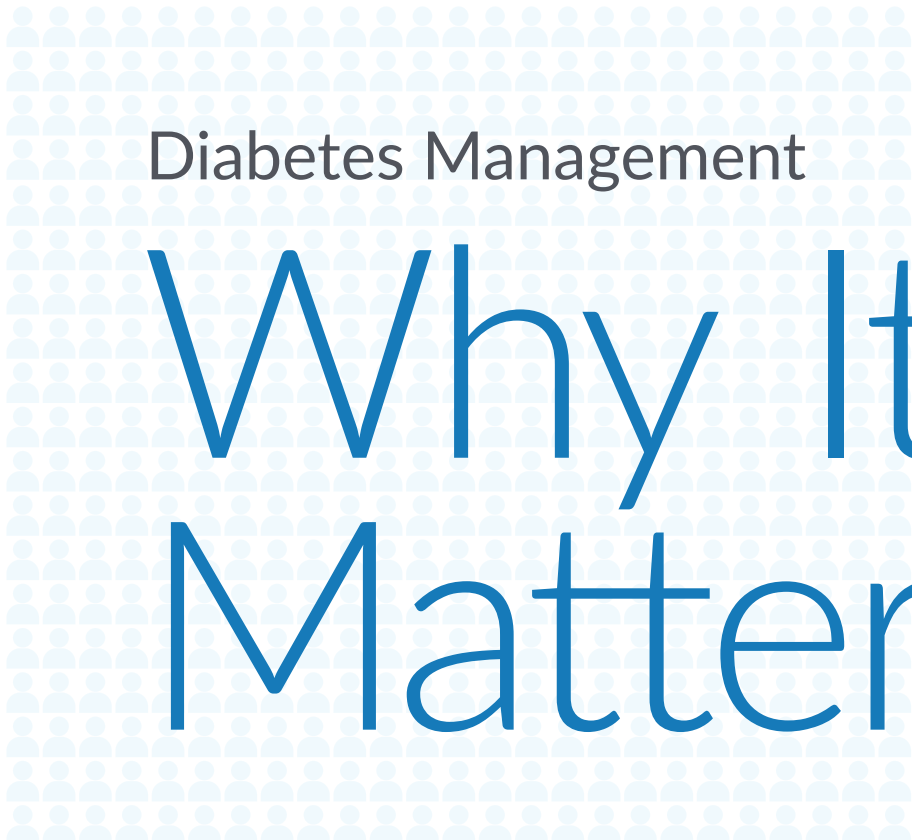


# Diabetes Management





250K estimated additional patients going undiagnosed



Diabetes Management

# Why It Matters

Tennessee ranks 5<sup>th</sup> highest across the United States in diabetes prevalence, with 13% (or 650,000) of adult patients having a diagnosis of diabetes and an estimated 250,000 patients going undiagnosed. Diabetes and its associated complications such as dialysis and heart disease not only negatively impact patients' lives, but it is also costly. These complications can be avoided by ensuring better A1c control and guideline-based screening and health maintenance.

## What People Are Saying

*"The VHAN Diabetes Management Program is making life-changing and health-enhancing differences in the lives of my patients. The work represents the very best of what VHAN should stand for in our community."*

VUMC Provider



## What VHAN Is Doing

Since 2019, VHAN has had a 50% increase in the number of patients with poorly controlled diabetes newly enrolled in our diabetes program representing patients across all VHAN plans.



### We took the following steps

to improve health outcomes and lower the cost of care for all patients with diabetes.



Implemented a high-touch care management program for patients with uncontrolled diabetes



Improved data connections to better track A1c data for patients across network



Developed and implemented a Diabetes Care Path, which includes a medication algorithm and health maintenance recommendations



Distributed Gaps report to alert practices of patients with open diabetes gaps



Developed several VHAN Hub member resources, including QuizTime, webinars, diabetes patient classes, shared decision-making resources, patient report cards and other patient education materials



The True Value

# Danielle's Story

Danielle had an A1c measurement of 13.7% and a BMI of 31.

Afraid of needles, she was uncomfortable with the idea of daily insulin injections. She was also having trouble planning and preparing healthy meals. A VHAN practice called upon the network's care navigator team to help Danielle improve her health. In partnership with her primary care physician, the team worked with her on medication management to potentially avoid the need for insulin treatments. They also encouraged her to start using GLP1 to address satiety and weight-related concerns.

Danielle was encouraged to monitor her blood sugar regularly and given a customized meal plan and walking program. Routine check-ins from a Care Navigator rounded out Danielle's care plan.

After six months of support, Danielle's A1c had dropped to 6.1%, and her BMI was cut to 26. She reported how much more confident she feels in her ability to manage her diabetes and how much she appreciates being included in the decision-making progress with her care team.



After six months of support, Danielle's A1c had dropped to 6.1%, and her BMI was cut to 26.

Our vision is to improve the health and wellness of VHAN patients through the completion of preventive cancer screenings.

Key Aim



# Cancer Screening

# Cancer Screening

# Why It Matters

Screenings are primary tools in cancer prevention and early detection. Our region currently ranks in the middle of the pack nationally for preventive cancer screenings. Meanwhile, we are above the national average for many common cancer diagnoses. Improving compliance with preventive cancer screenings can save countless lives.

Our Region Ranks Above National Average for Common Cancer Diagnoses

At Mid-Range of National Average for Preventive Cancer Screenings

## What VHAN Is Doing

Here are some of the ways that VHAN practices improved their cancer screening rates:

### Identified Clinical Champions

Each participating practice has a clinical champion who leads efforts to prioritize cancer screening rates. Clinical champions meet quarterly with VHAN staff to identify areas for improvement.

### Leveraged Gaps in Care Reports

VHAN provides monthly reports that clearly indicate gaps in patient care.

### Partnered With VHAN

Nearly 3/4 of primary care impact practices have had targeted meetings, created action plans, and tracked interventions and improvements over time. VHAN has provided several tools related to cancer screening, including a shared decision-making guide for colorectal cancer screening, Lung Cancer Screening Care Path and wellness checklists that indicate when patients are due for screenings. Best practices from network members were collected to inform a Cancer Screening Best Practice Guide that includes foundational, intermediate and advanced interventions for practices to customize and implement. MiniVHAN podcast episodes highlighted patient engagement tactics related to cancer screenings, including conversations with Dr. Zach Logan (Weatherstone Family Wellness and Sumner County Regional Medical Director), Dr. Kanthi Narra (Maury Regional Health and Maury County Regional Medical Director), and Dr. Martha Shepherd and Kim Gill (Vanderbilt Health at Metro Nashville Public Schools).

### Participated in Shared Learning

Late fall of 2020, VHAN conducted a Learning Exchange focused on engaging and motivating patients to seek preventive screenings. The Learning Exchange took place via VHAN's digital community platform, VHANTage Point, and was the first use case of the new platform. With a 45% participation rate of invitees across the network, best practices and challenges were discussed, with five key themes and opportunities identified and shared back with VHAN staff as well as with the broader network.

For our Medicare aged patients, VHAN has achieved an average of 75.5% screening rate for breast cancer and 78% for colorectal cancer. This is across VHAN's Medicare Advantage contracts and Connected Care ACOs participating in the Medicare Shared Savings Program (MSSP).

(Data is from CY 2020.)



Our vision is to reduce preventable readmissions by creating collaborative transitions of care processes to increase team-based support for at-risk and high-risk patients post-discharge.

Key Aim



# Readmissions/ Transitions of Care

## Readmissions/ Transitions of Care

# Why It Matters

Patient transitions are rarely well-coordinated, and follow-up care is highly variable and inconsistent, leading to poor patient outcomes. Working directly with our VHAN hospital systems and practices, we aim to improve the transition process and improve continuity of care, thus reducing adverse events and readmissions.

Working directly with our VHAN  
hospital systems and practices to:

- Improve the Transition Process
- Improve Continuity of Care
- Reduce Adverse Events and Readmissions

## What VHAN Is Doing

### Three-phase Interaction Action Plan

VHAN created an action plan to reduce the readmissions rate by 2% and improve transitions of care. The plan focuses on 1) practice operations, 2) hospital discharge planning and follow-up, and 3) post-acute care utilization.

Using patient-level data analysis, the plan identifies readmissions trends and opportunities to refocus or implement new interventions. It also places an enhanced focus on medication management, improved patient follow-up, and coordination of care across settings and providers. Data-driven approaches are targeted at improving workflows, exploring home-based care models, and increasing advanced care planning and palliative care initiatives.

### Identification of Readmission Trends and High ED Utilization

Using 2019 as baseline, we found that readmission rates at seven large VHAN practices were higher than VHAN's median readmission rate. Clinical Quality Transformation Advisors (formerly called Population Health Associates) completed a transitions of care assessment with each practice, and then shared engagement strategies for preventing readmissions.

Those strategies included:

**Developing action plans for five focus practices** that involved choosing a clinical champion, gaining and using real-time data of patient discharges, calling patients with a discharge from ED/Inpatient within 24-48 hours, and using a Care Management/team-based approach with patients at high risk for readmissions. Chart reviews have been performed to identify reasons for readmission related to diagnosis, timing and other categories.

**Leveraging best practices** from a high-performing practice to help improve rates at lower-performing practices.

**Sharing readmission rates**, clinical categories for readmissions, initial facility and readmitting facility with five practices.

**Publishing and sharing** a monthly emergency department report. Practices were asked to review familiar faces and pinpoint outreach for education and care management opportunities.

1  
Practice  
Operations

2  
Hospital  
Discharge and  
Follow-up

3  
Post-acute  
Care Utilization

All focus practices had a decrease in readmission rates for their Medicare population, and three focus practices had a decrease in their readmission rates for the commercial population.



# The True Value

# Robert's Story

Robert is 77 years old and was recently hospitalized due to shortness of breath and lower extremity edema.

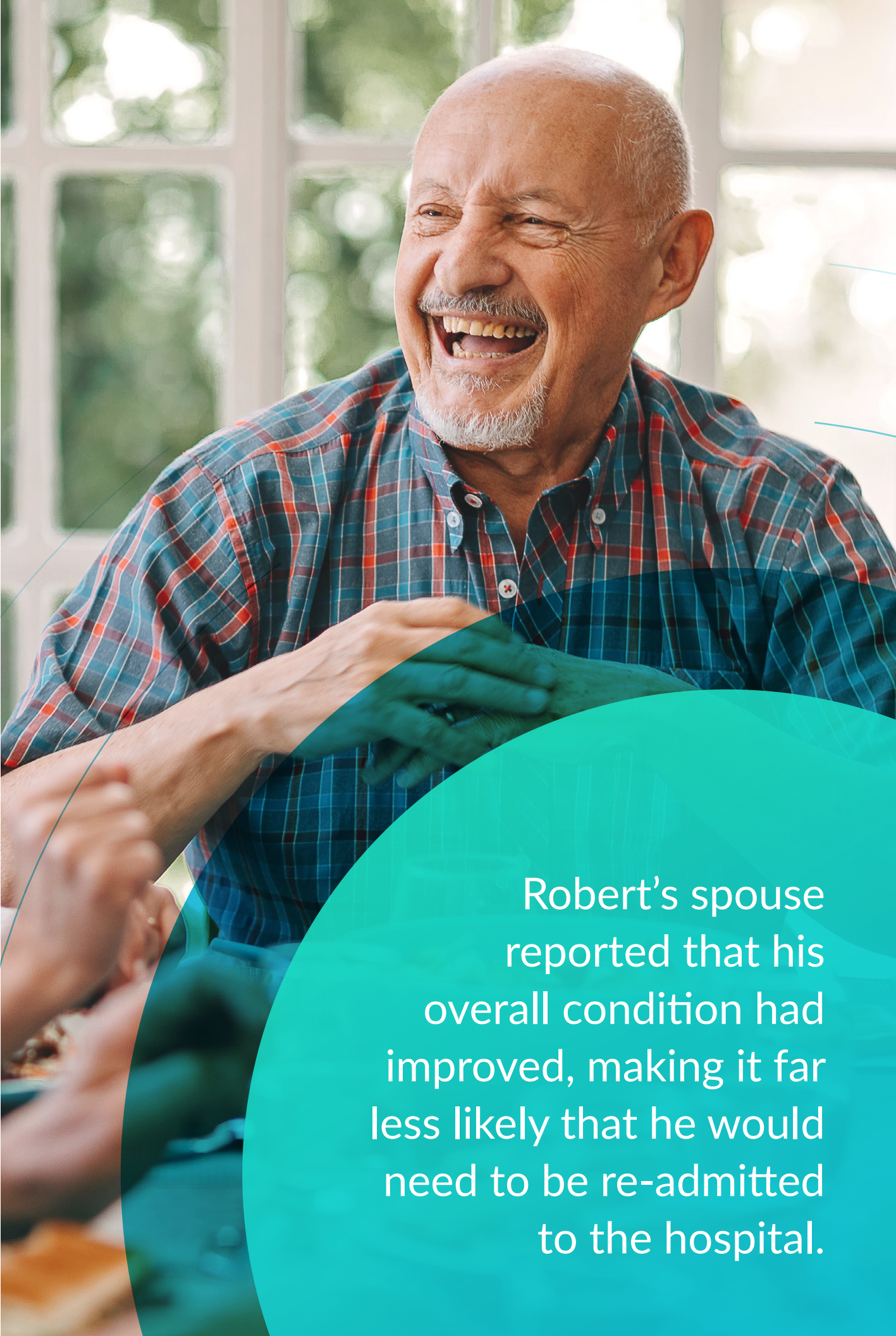
He has a history of high blood pressure and high cholesterol. After Robert was discharged from the hospital, a VHAN RN followed up and learned that Robert needed extra support.

During an initial check-in call, Robert was unable to find his discharge paperwork. The nurse knew it was not likely that he was properly taking medications or following his care plan. The nurse explained to Robert how to administer his dosages and the reasons for taking each medication. She also coordinated with a home health provider

and alerted them to the likely medication discrepancies. Robert's primary care physician and cardiologist were both notified of his discharge and the concerns shared by his nurse.

On a follow-up call, the VHAN RN spoke with Robert's spouse, who reported that he was feeling better. Robert had been compliant with sodium restrictions, had lost some weight and was now taking all of his medications appropriately. His overall condition had improved, making it far less likely that he would need to be re-admitted to the hospital.

Robert's spouse reported that his overall condition had improved, making it far less likely that he would need to be re-admitted to the hospital.





Our vision is to use evidence-based clinical guidelines to create a standardized approach that effectively addresses variations in care in the treatment of low back pain.

Key Aim



**Reducing  
Unwarranted  
Variation  
in Care**

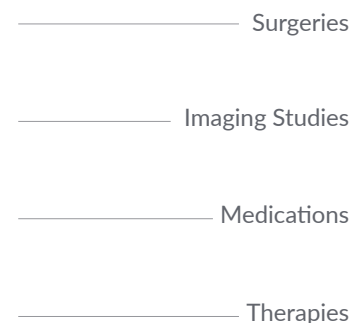
## Reducing Unwarranted Variation in Care

# Why It Matters

The variability in low back pain care across the United States is significant. Not all surgeries, imaging studies, medications or therapies are medically necessary for acute, uncomplicated cases of low back pain. The process for a patient to access the appropriate care can be costly and time-intensive with a wide range of potential outcomes.

### Variability in low back pain care across the U.S. is significant.

Some treatment is often medically unnecessary



## What VHAN Is Doing

### Low Back Pain Care Path Pilot

A pilot conducted at select VHAN practices shows significant improvements in physical therapy and opioids, and imaging has decreased. The pilot has also revealed that many of the patients bypass their PCP in support of an orthopedic consult.

When looking at the total spend for acute, uncomplicated low back pain, the largest area of opportunity is in imaging. We know many of these patients do not need an MRI or CT as indicated by the diagnosis codes provided by our providers. We estimate \$1.3M in potential savings on imaging alone across our network. This initiative also fits in well with other campaigns such as "Choosing Wisely."

### Data-Driven Support for VHAN Members

This technical support has included:



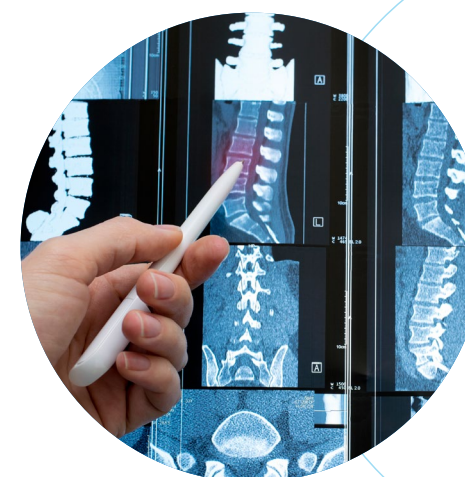
Electronic medical record (EMR) enablement for point-of-care assistance



Guidance for process improvement, proper coding, physician education, patient education handouts, chart reviews and Key Performance Indicator (KPI) reviews.



KPI reporting on imaging, physical therapy and opioids to help practices visualize opportunities for improvement on metrics. Also engaged practices to share data on regular cadence and develop front-end reporting from the EMR.



Heritage Medical Associates' participation as an "early adopter" in the Low Back Pain Care Path resulted in an overall decrease in the total cost of care PMPM by 39%,

with reduction in unnecessary advanced imaging, physical therapy and opioid prescribing. Physician champion leadership, team based care, and specialist and patient engagement were keys to their success.

We are committed to delivering high-quality care by actively listening to our patients, strengthening real-time feedback loops and addressing needs that extend beyond the exam room.

Key Aim



# Addressing Patient Needs



Addressing Patient Needs

# Why It Matters

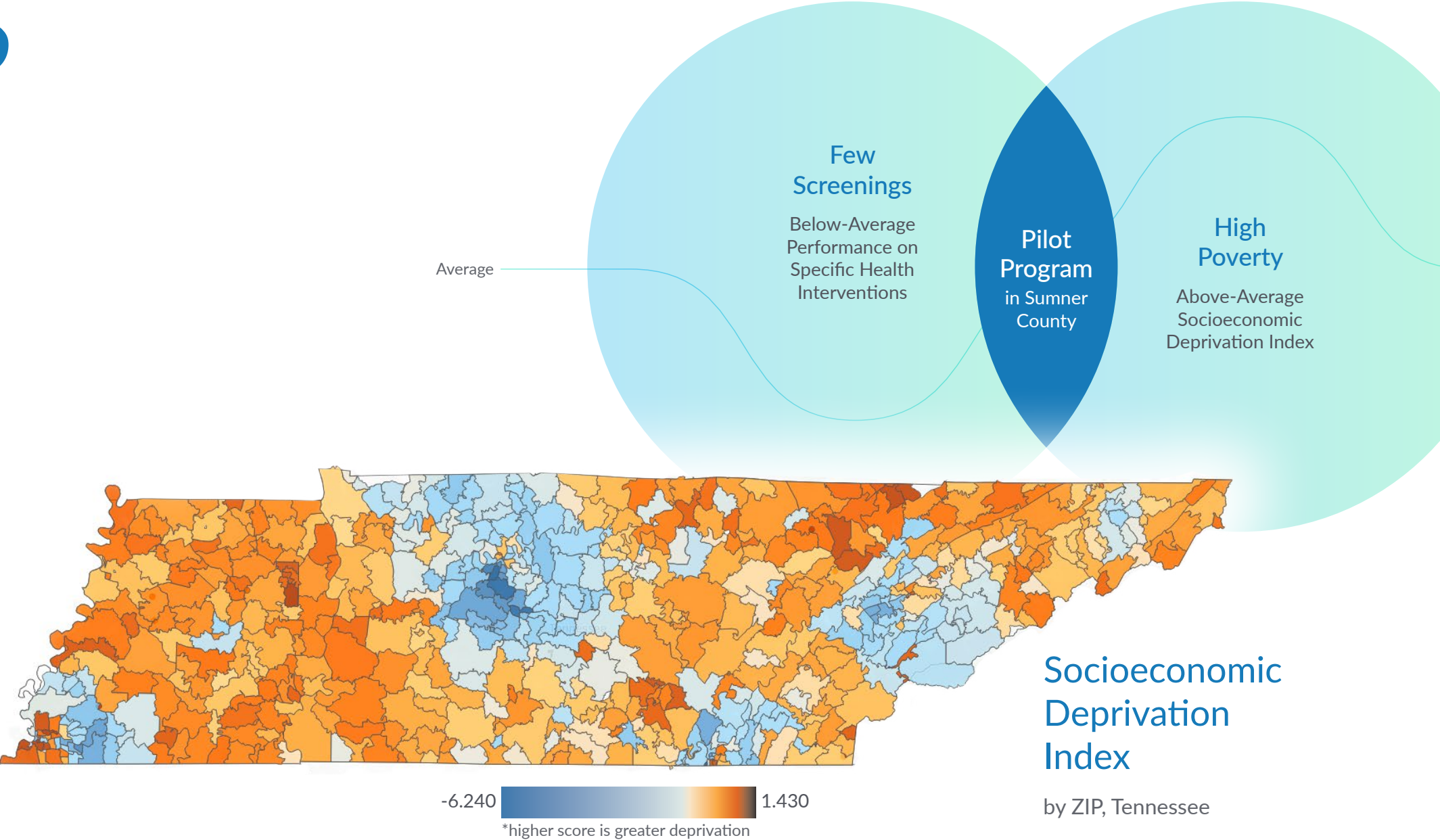
Everyone deserves access to quality care, no matter where they reside. VHAN has examined the needs of communities across Tennessee to determine ways to improve cancer screening rates, increase access to wellness visits and implement other health initiatives that result in better care for our patients.

## What VHAN Is Doing

Using VHAN member data and data from ExploreTNhealth, we are identifying zip codes that have below-average performance on specific health interventions, such as cancer screenings.

Based on these findings, a pilot is being developed to focus on preventive cancer screenings in the Sumner County service area.

A community health worker will partner with local providers to close these gaps and promote colorectal cancer screening outreach.





## The True Value

# Helen's Story


The VHAN Social Work team often bridges the gap between patients and their providers, identifying issues that might put a patient at risk, such as difficulty getting medications, worsening symptoms or—in the following patient's case—the risk of falling at home.

Helen\* was an elderly patient managing several serious medical diagnoses, including a vascular disorder, diabetes, congestive heart failure and swelling in her lower extremities. But her most recent encounters with the health care system had just as much to do with her environment as it did her health status.

Helen took a hard fall while trying to enter her home, and she broke a foot in the process. In a follow-up call by a VHAN social worker, Helen admitted that her mobility had been compromised by her health conditions and that she really wished she had a ramp to get in and out of the house more easily. Her social worker took on the challenge and started making phone calls to local organizations, including area churches.

The social worker eventually connected with a men's group at the First Baptist Church in Selmer, Tennessee. The group regularly takes on community service projects and agreed to build a ramp for Helen. Shortly afterward, the men's group arrived at Helen's house with building materials and an eagerness to get to work.

The patient was delighted with her new ramp, and the social worker felt gratified because she knew how much this ramp would change Helen's life by helping her avoid falls. It was just as powerful a health intervention as a visit to the doctor, a needed procedure or a new medication.



The social worker engagement was just as powerful a health intervention as a visit to the doctor, a needed procedure or a new medication.



Our vision is to expand lives under management while establishing structural and operational capabilities required to support expanded participation in value-based care models.

Key Aim

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# Growth



# Growth

# Why It Matters

The more we grow our lives under contract as a network, the more we can innovate on behalf of our community

and create new ways of delivering and financing health care

VHAN practices can most effectively adopt population health strategies and participate in value-based care best practices when a sufficient proportion of their patient base is included in such contracts. The more we grow our lives under contract as a network, the more we can innovate on behalf of our community to create new ways of delivering and financing health care.

## What VHAN Is Doing



### Expanding Our Reach

Since 2020, we have added new payors and new lives to the network, expanding our reach to additional communities in the southeast.



### Increasing Our Covered Lives

From July 2020 to September 2021, VHAN experienced a 15% increase in total lives, from 267,918 to 309,513.



### Adding New Contracts

UnitedHealthcare NexusACO (UHC NexusACO) and Aetna Medicare Advantage (MA) added 5,648 current lives: 1,150 UHC Nexus ACO and 4,498 Aetna MA.



Our vision is to improve the frequency and consistency of in-network support across primary care, specialist visits and admissions while meeting the clinical, geographic and access needs of all patients.

Key Aim



# Access

Create more access points  
for patients to get precisely  
the care they need

Telehealth

Virtual Options

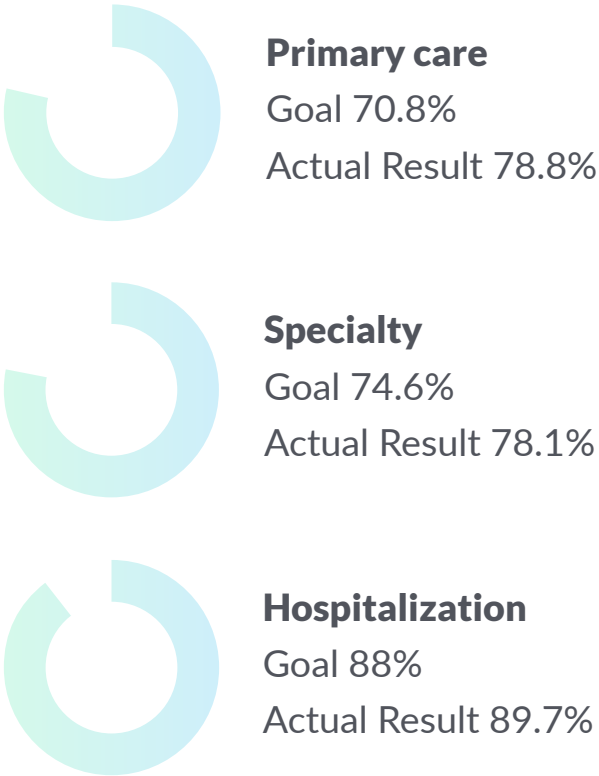
Access

# Why It Matters

When VHAN patients obtain care outside the network, the opportunity to impact the cost and quality of their care is diminished if not eliminated. In addition to maintaining consistent care, we should strive to create more access points for patients to get precisely the care they need, including telehealth and virtual options where appropriate.

## What VHAN Is Doing

This year, VHAN met or exceeded in-network access and utilization goals, including:



We also built and delivered leakage reports for practices to show the rate of patients seeking care outside of the network.

Members of the Physician Leadership Council (PLC) reviewed the reports and plan to identify additional strategic recruitment opportunities to improve access.





## The True Value

# West Tennessee Healthcare's Story

When the pandemic first hit in March of 2020, West Tennessee Healthcare (WTH) faced the same dilemma as health care organizations all across the country.

They needed to launch a telehealth program, and they needed to do it quickly.

WTH leaders immediately formed a Telehealth Governance Council made up of providers, clinic directors, nurses and administrators to develop a solution for the entire enterprise. They tapped VHAN resources for training on key issues such as coding and risk stratification. And in record time, they increased their frequency of telehealth visits by more than 1,300%.

Learn more about how WTH leveraged change management principles and rapid cycle development to implement system-wide telehealth adoption on the [miniVHAN podcast](#) or read the full story found at [www.vhan.com/west-tennessee-healthcare-takes-innovative-approach-to-telehealth](http://www.vhan.com/west-tennessee-healthcare-takes-innovative-approach-to-telehealth).

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The Vanderbilt Health Affiliated Network (VHAN) is a clinically integrated network of independent providers, health systems and hospitals across Tennessee and throughout the southeast. Driven by collaboration, data insights and continuous learning, our members provide high quality, cost-effective care to the communities we live in.

# About VHAN



**309k+**  
Managed Lives



**13**  
Health Systems



**60+**  
Hospitals



**6,450+**  
Providers



**Hundreds**  
of physician  
practices and clinics



This is the story of  
*our impact.*