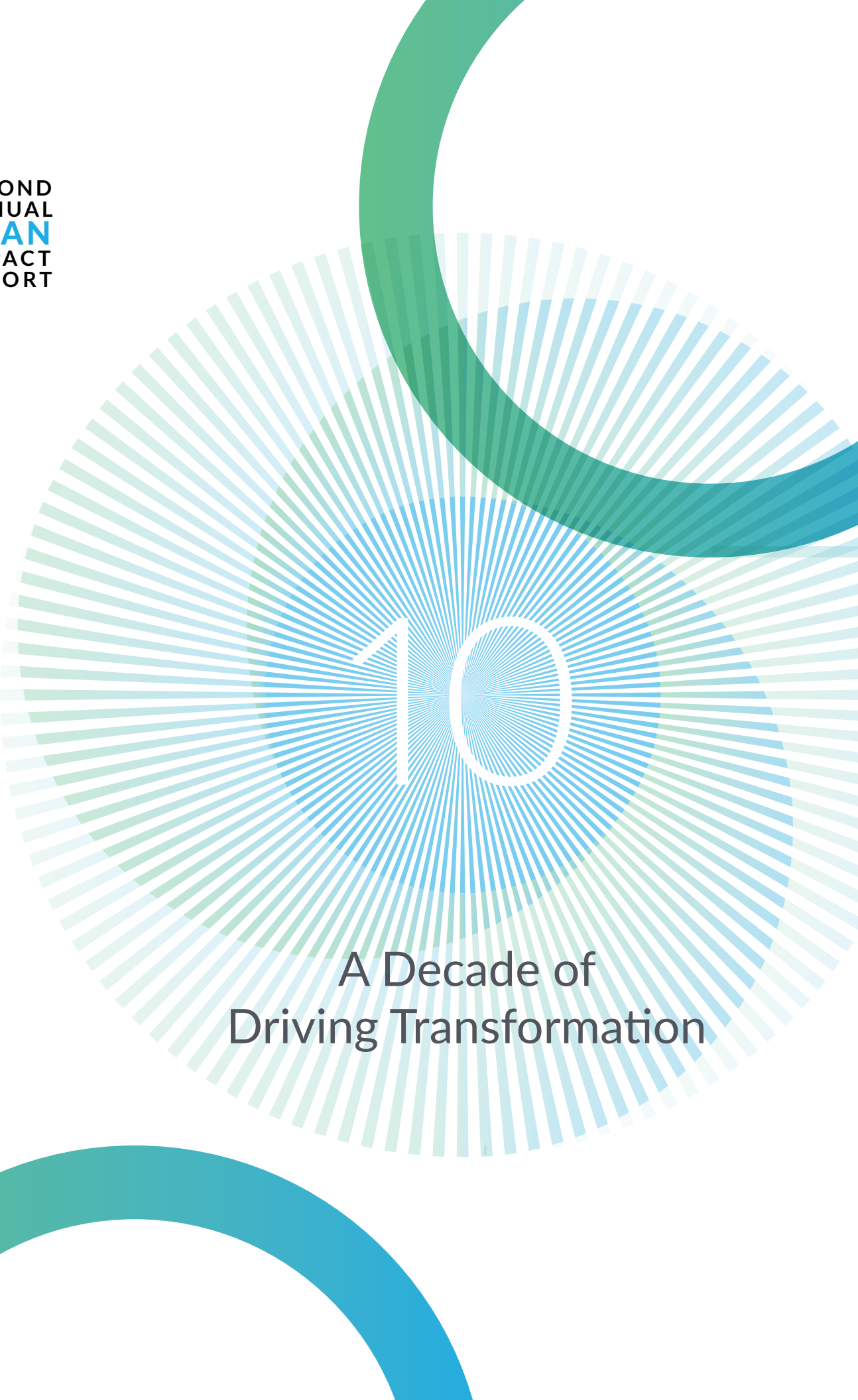


SECOND
ANNUAL
VHAN
IMPACT
REPORT



10

A Decade of
Driving Transformation



Contents

Letter to the Community	4
The Network Effect	6
Key Achievements	8
Focus Area: Utilization	12
ED Utilization and Readmissions	14
Post-Acute	16
Focus Areas: Quality and Clinical Program Development	18
Pharmacy	20
Care Management	26
Quality Improvement and Performance	30
Focus Areas: Pediatrics and Behavioral Health	34
Pediatrics	36
Behavioral Health	40
Looking Ahead	42

To Our Community,

The way we practiced health care a decade ago is barely recognizable today. But VHAN has successfully navigated this sea change over the past 10 years by keeping our eye on what matters most—improved care delivery and better outcomes.

Since 2012, VHAN members have consistently shown improved quality and cost metrics for our patients, meeting or exceeding national standards and surpassing the performance of other providers in the region. Every year, we have **outperformed the expected cost trend for our market by an average of 2.5% per year**. And most important, VHAN members consistently deliver high-quality care. Patients under VHAN management have **20% fewer ER visits and inpatient admissions** than others in the market and receive **20% more of their key wellness and preventive care**. Our quality and clinical performance has led to shared success in our financial results, and network members continue to achieve 100% performance on key quality metrics for certain payors.

These achievements have resulted in millions in shared savings and quality bonuses as part of value-based contract rewards. Over our 10 years, **VHAN has distributed nearly \$65 million to members in incentive payments with more than \$167 million in total health plan savings**.

We've produced this impact report to celebrate our achievements in 2021 leading into 2022. You'll learn more about our shared successes, especially in the areas of utilization, quality, clinical program development, and pediatric and behavioral health. You'll read individual patient stories that demonstrate the real impact of our work. And you'll see what's next for our innovative partnership.

Thank you to the providers, team members, practices, clinics and hospitals who make up this amazing network for your commitment to excellence. And thanks to all who have entrusted health care to us, including health plans, employers, brokers and, most important, our patients.


In health care, you can be affected by change, or you can be an agent of change. Together, we've chosen the latter. And that's why we look forward to the next decade of driving transformation.




David R. Posch, MS
Executive Director, VHAN
Executive Vice President, Population Health



Cynthia Powell, MD
Chief Medical Officer, VHAN
Senior Vice President, Population Health



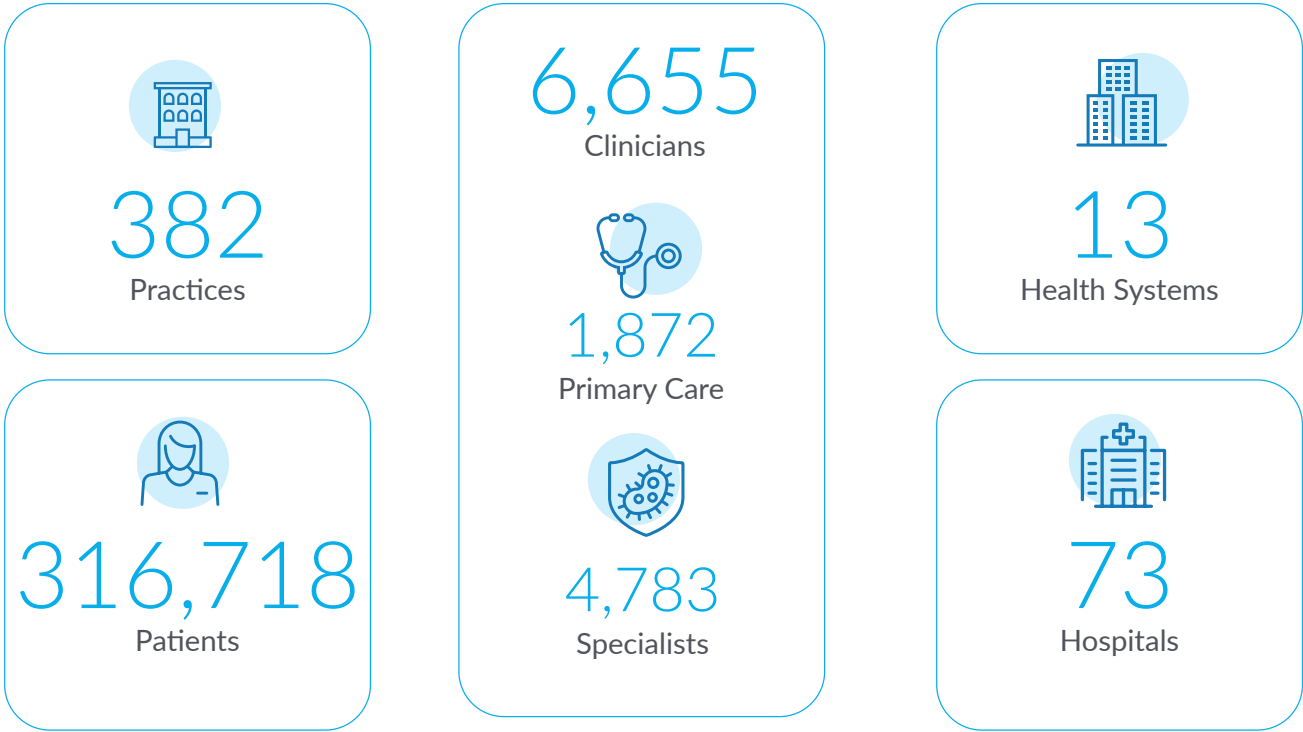
VHAN successfully navigates change by keeping our eye on what matters most—improved care delivery and better outcomes.



Thank you to everyone who makes up this amazing network for your commitment to excellence.

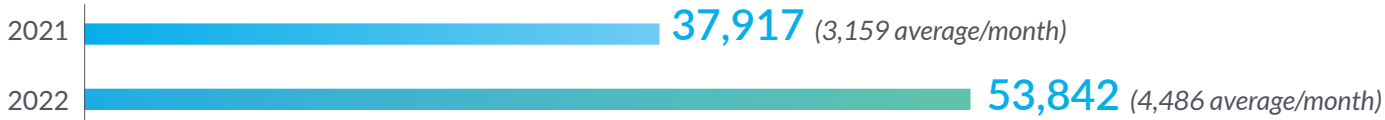
The Network Effect

Last year VHAN achieved remarkable success in quality, growth and patient engagement. At the same time, we achieved **shared savings of \$36.4 million**, the most in network history.

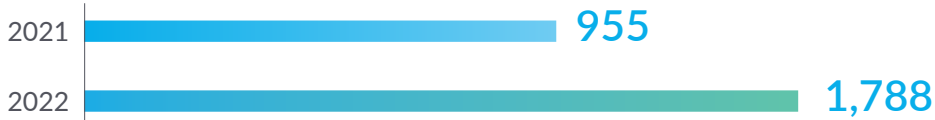


PATIENT ENGAGEMENT

Care Management *(patient outreach via calls, EMR and other connections)*



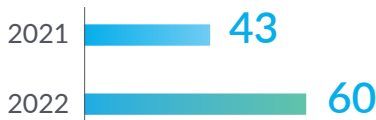
Pharmacy



Behavioral Health Consult Line Calls



Behavioral Health Face-to-Face Consults

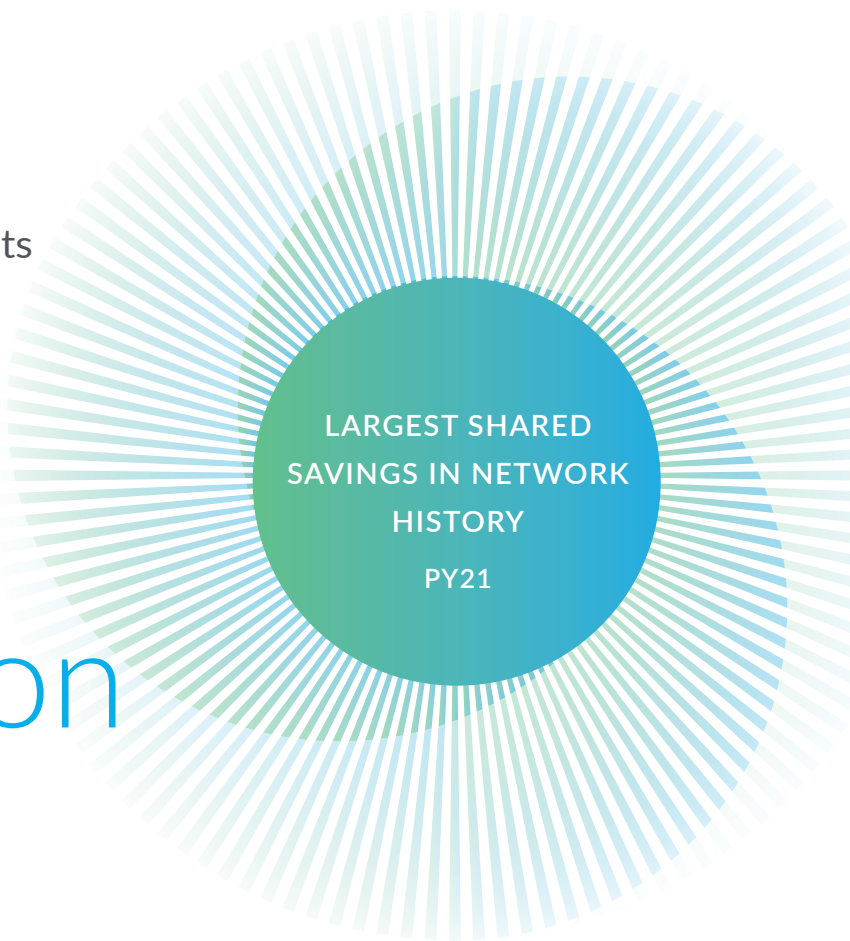


Health Plan Savings

\$36.4 Million

Member Incentive Distribution

\$17.7 Million



Key Achievements

VHAN members made a considerable impact in the past year. Here are some of our achievements together.

Improving Care Access for Maternity Patients

PAGE 10

Managing Pediatric Depression

PAGE 37

PROJECT ECHO

Helping Pediatricians Bring Hope to Patients With Depression

Depression has been on the rise among youth for at least a decade, with 4.1 million adolescents having at least one major depressive episode in the past year, 12% of whom experienced severe impairment. This depression crisis worsened significantly during the COVID-19 pandemic when young people were separated from their schools, peers and normal social routines.

At the same time, many pediatricians felt ill-equipped to treat mounting behavioral health issues such as pediatric anxiety and depression, leading to critical gaps in care. The VHAN Behavioral Health team took on the challenge of managing pediatric depression by making it the subject of the network's first Project ECHO initiative.

Greater Access to Specialty Care

Project ECHO (Extension for Community Healthcare Outcomes) addresses population health differences with low-cost, high-impact interventions. Founded in 2003 by Sanjeev Arora, MD, at the University of New Mexico, Project ECHO gives patients with complex and treatable conditions greater access to the specialty care they need—particularly in underserved or remote areas—by leveraging technology and best practices.

VHAN's first Project ECHO, "Managing Mild to Moderate Depression in Primary Care," was held in late 2022. It featured eight biweekly sessions focused on educating pediatricians about depression and giving them mental health resources tailored to young patients.

During the sessions, 20 VHAN pediatricians discussed real cases with VHAN behavioral health subject matter experts, learning from each other in an "all-teach/all-learn" environment. Topics included initial assessment and diagnosis, the stress/depression connection, medication management and risk assessment, and safety planning for depressed adolescents. Participants also discussed the social stigma around families affected by mental health challenges.



A Broad Range of Benefits

VHAN's Project ECHO yielded significant benefits: building community, fostering collaborative relationships and closing the time gap for young people to receive psychiatric help. Margaret Benningfield, MD, director of the Division of Child and Adolescent Psychiatry at Vanderbilt University Medical Center and one of the leaders of the session, cited another key takeaway.

"For many of our pediatricians, the primary intervention here is hope," she says. "When we asked them to reflect at the end of the ECHO sessions, they said they felt more confident and more comfortable talking with kids and families about depression. To be able to share with families that they're not alone and that this team is available to partner with them—that's a huge intervention in itself."

Read the Case Study

www.vhan.com/helping-patients-find-hope-vhans-first-project-echo-helps-pediatricians-manage-rising-rates-of-pediatric-depression

Key Achievements

COMMUNITY HEALTH WORKER PILOT

Improving Care Access for Obstetrics Patients


Many mothers experience a lack of support and education related to pregnancy, birth and postpartum care, which leads to an increased risk for unhealthy pregnancies and poor birth outcomes.

To help, VHAN launched its Community Health Worker (CHW) pilot in 2019 to improve access to care and resources for obstetric patients at Gallatin Women's OBGYN Center (GWC) in Gallatin, Tennessee, which has a large prenatal patient population with approximately 350 babies born annually.

The pilot helped with resource referrals and interventions for patients who need assistance with access to health care, physical and behavioral health support.


Transformative Results

After two years, the program has already produced impressive results:




73 ↓ 24

Missed prenatal appointments were reduced significantly, with just 24 in 2021, compared to 73 in 2020 and 70 in 2019.




Supported by CHW referrals and educational resources, **96%** of mothers who initially wanted to breastfeed did in fact do so.



90%

Prenatal Edinburgh Screenings **increased 90%**.



7%

ED utilization **decreased 7%** among obstetric patients.

Though the pilot already shows promising results, staff members at VHAN and GWC will continue to refine the program. They also plan to increase the number of community resources available to patients and offer consulting to help practices start their own programs.

"None of these programs and outcomes would have been possible without the marriage of the outside knowledge and support of VHAN along with the patient- and community-level responsiveness of GWC," said Richard Bennett, MD, president, chairman and co-owner of GWC. "I applaud the members of the Vanderbilt Health Affiliated Network for collaborating to find new and better ways to meet people where they are."

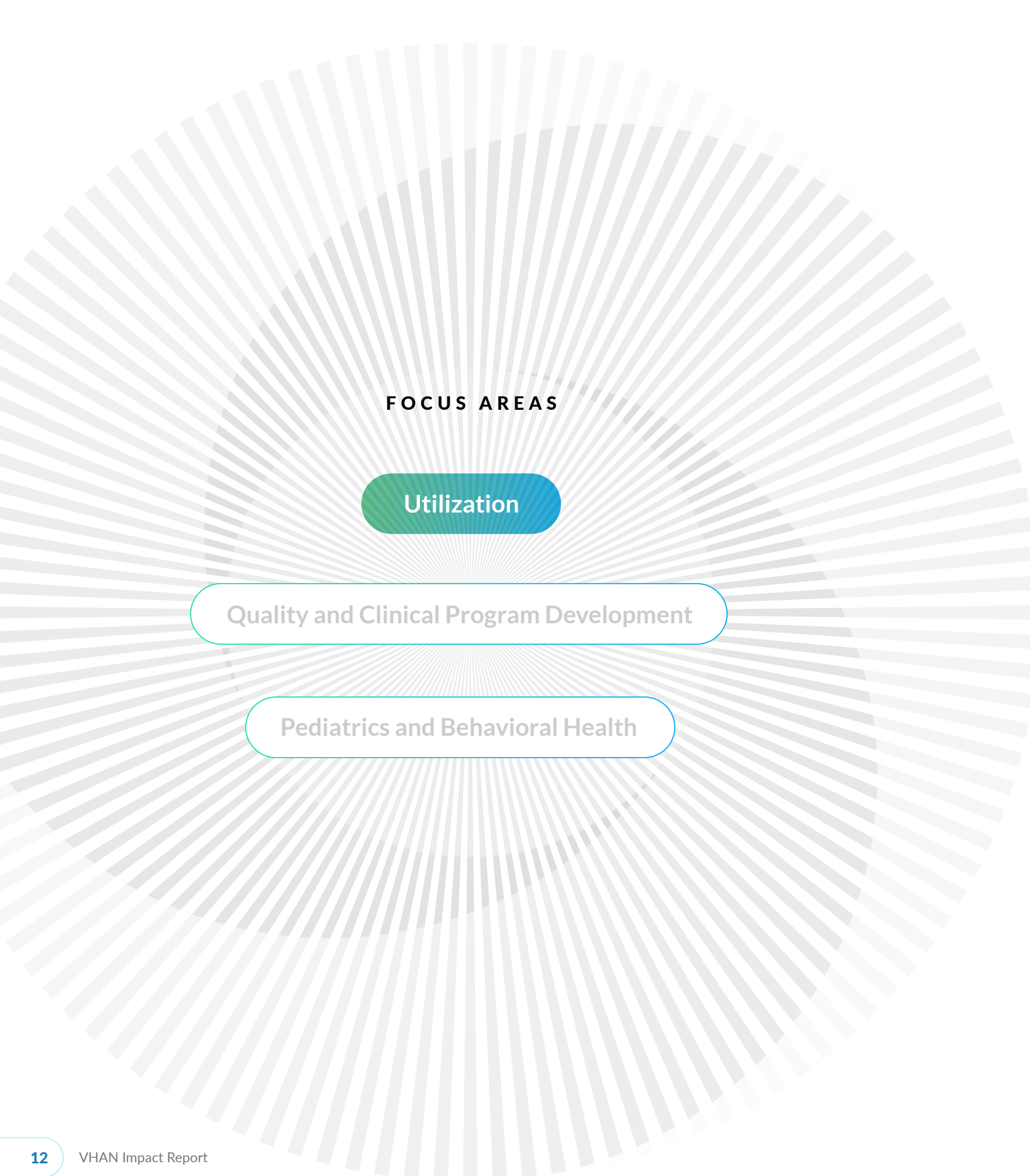
"I applaud the members of the Vanderbilt Health Affiliated Network for collaborating to find new and better ways to meet people where they are."

Richard Bennett, MD, president, chairman and co-owner of Gallatin Women's Center

A Track Record of Success

The true beauty of quality health care is that it not only leads to better outcomes, but greater cost savings as well. Here are some highlights from Performance Year 2021:

- Exceeded 9 of 10 commercial and Medicare Advantage targets in breast, colorectal and cervical cancer screenings.
- Achieved 95th percentile in breast cancer screening across all payors from the National Committee for Quality Assurance (NCQA).
- Surpassed NCQA state and national averages for colorectal cancer screenings and diabetes eye exams across multiple payors.
- Achieved 100% in Aetna Quality performance for the fourth straight year.
- VHAN members outperformed the expected cost trend for Aetna Commercial for our market by 5.1%.
- In Performance Year 2021, VHAN distributed \$17.7 million to members in incentive payments, with more than \$36.4 million in total health plan savings.



Utilization

By focusing on decreasing the unnecessary utilization of health care services, we're improving patient outcomes and driving down the total cost of care for the entire system. In the past year, we've made great strides in lowering readmissions and ensuring patients receive quality, appropriate post-acute care.

ED Utilization and Readmissions

Why It Matters

Too often, emergency departments serve as a safety net or alternative when physicians are unavailable to patients in our communities, including those who are insured and uninsured. These non-emergency visits typically result in lower quality, more expensive and wasteful care. And EDs typically can't offer preventive and education services that can reduce the need for care in the future. VHAN members are committed to developing new strategies and processes to reduce ED overutilization and improve care transitions to lower readmissions. Plus, our VHAN ER Toolkit, written for medical practices, offers resources to help patients avoid ED use.

KEY INITIATIVE

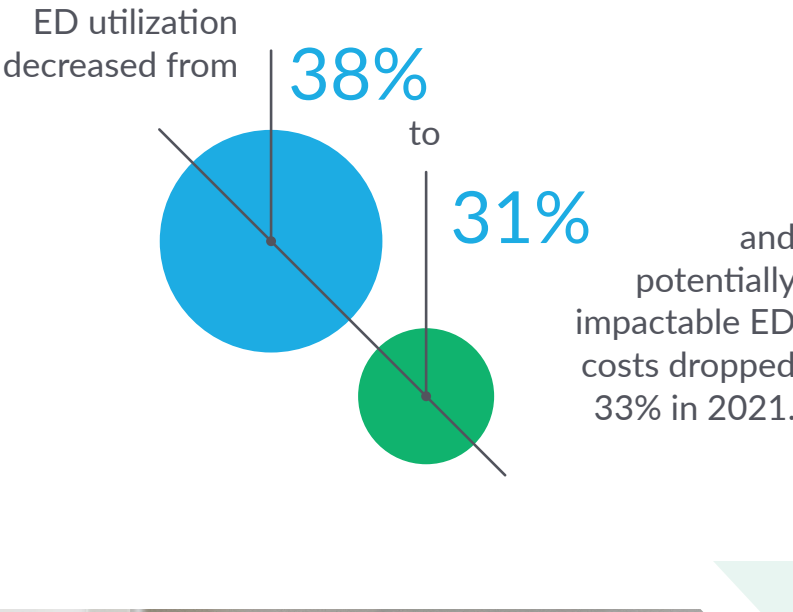
Utilization Review Directs Patients to the Right Level of Care

One of our key goals has been to develop a systematic approach to identify and review utilization patterns, trends and variation in care that impact quality outcomes and costs across VHAN. We started by assessing our current systems, defining data sources and identifying utilization trends.

Next, we developed a utilization review process for high-cost claimants and identified opportunities for clinical care standardization to give network clinicians timely insight into ED utilization. We established performance goals and a method to connect patients to needed resources and the right level of care. To help VHAN practices increase access for their patients while offering secondary options for emergent care needs, we developed the VHAN ER Toolkit, available here.

Ernie Buchanan, MD, of Upper Cumberland Family Physicians in Cookeville, TN, and VHAN Regional Medical Director, used some of the tactics from VHAN's ER Toolkit to reduce the number of total ED visits, percent impactable (PI) visits, and overall ED paid and PI paid. Through patient education, data sharing on ED visits and updated processes (including having a live person answer the phone), unnecessary ED utilization decreased from 38% in 2019 to 31% in 2021. The percentage of potentially impactable ED costs also dropped from 40% to 26% of the total ED cost for this provider.

CASE STUDY | Upper Cumberland Family Physicians



VHAN Toolkit

<https://vhanhub.com/document/er-toolkit/>



Post-Acute

Why It Matters

Post-acute care is a growing and essential health and social service, accounting for more than \$2.7 trillion spent on personal health care, according to the American Hospital Association. Ensuring appropriate utilization of post-acute services such as home health, long-term care, skilled nursing facilities and inpatient rehabilitation can lead to improved quality and an overall reduction in the total cost of care.

\$2.7
trillion

spent on personal health care



KEY INITIATIVE

Acute Care Outreach Team

In May 2022, VHAN established a new acute care outreach team for Connected Care of Middle Tennessee Medicare ACO patients. The outreach team helps increase communication between acute care teams and ambulatory care providers and care management teams. The focus is on readmission reduction and leveraging post-acute care services to help meet patient goals.

The program supports hospital-based teams regarding utilization patterns on a patient-by-patient basis. The outreach team screens patients for potential inclusion in skilled nursing facility (SNF) waivers, communicates eligibility to hospital-based teams and supports patient notification and referral processes. The program also helps move patients with emerging needs into care management programs.

Meet Our VHAN Social Work Team

Patients in need of care often face social and emotional barriers to health improvement. And sometimes these barriers don't come up during doctor visits.

VHAN's Social Work Team partners with patients, families and care teams to identify all the factors that come into play when patients are making decisions. The team, made up of licensed clinical social workers, then helps patients cope with a new diagnosis or health situation. The team can also connect patients with resources such as housing, transportation assistance, home health and caregiver support. Team members can even help guide end-of-life discussions.

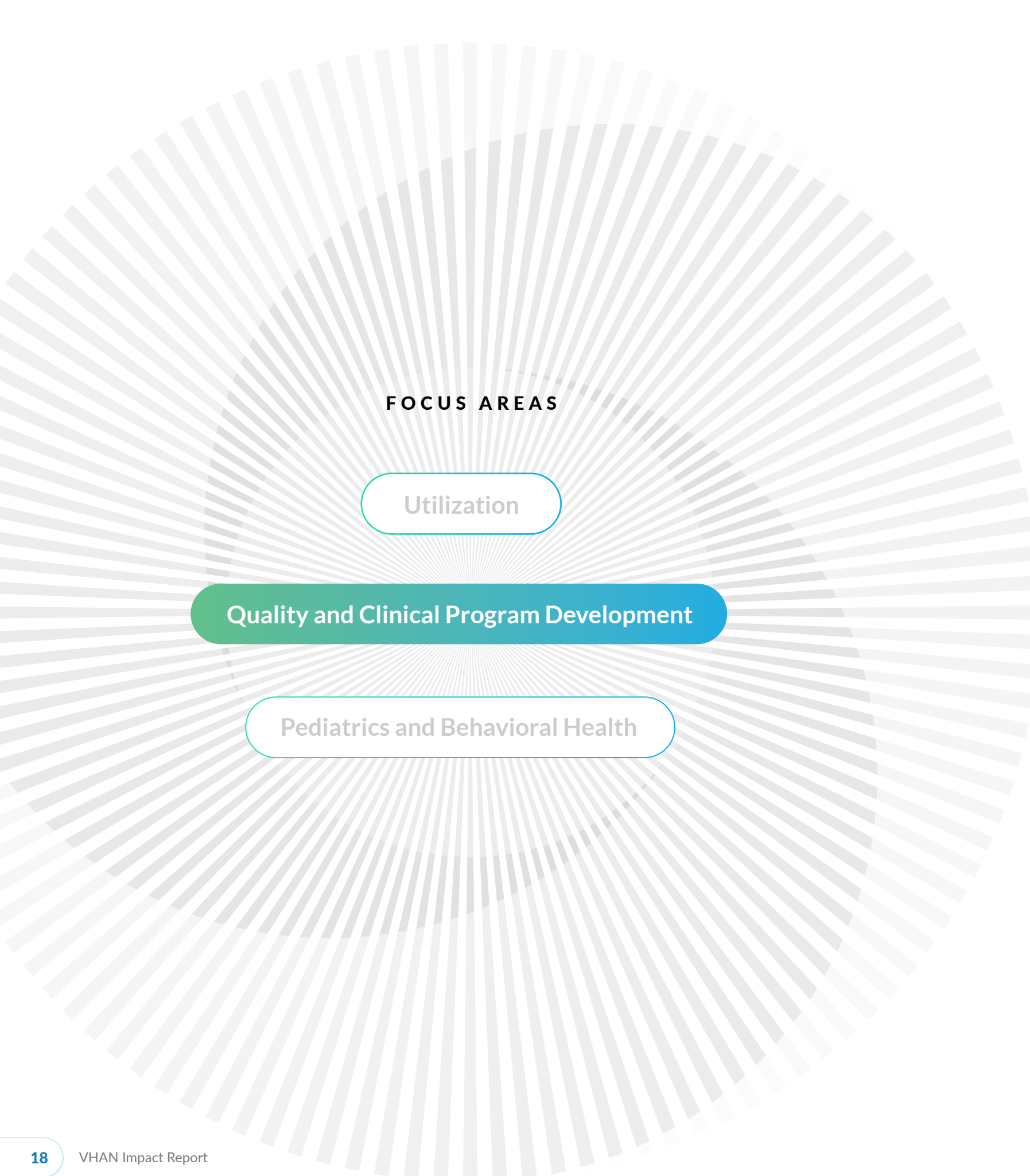
The goal is for patients to feel seen, heard and safe to bring up their concerns. [Learn more about the VHAN Social Work Team here.](#)

[Learn more in the video linked here](#)

<https://share.vidyard.com/watch/wdbd4Zrrtupaae6cs6cApS?>

OTHER SUCCESSES IN THE POST-ACUTE SPACE

- Added new SNFs as ACO and VHAN affiliates to support shared quality and utilization goals
- Received approval for a Medicare 3-day SNF for Connected Care of Middle Tennessee, launched in 2022
- Received approval for a Medicare 3-day SNF for Connected Care of West Tennessee, launched in January 2023
- Supported care management for patients in post-acute care
- Increased access to skilled nursing facility EMR and HIPAA-compliant messaging portals
- Standardized our approach for outreach to patients and SNF staff throughout the Transitions of Care program
- Participated in collaborative discharge planning with inpatient rehab facility and SNF partners
- Facilitated referrals, SNF waivers and other post-acute care needs for patients at home or receiving PAC services

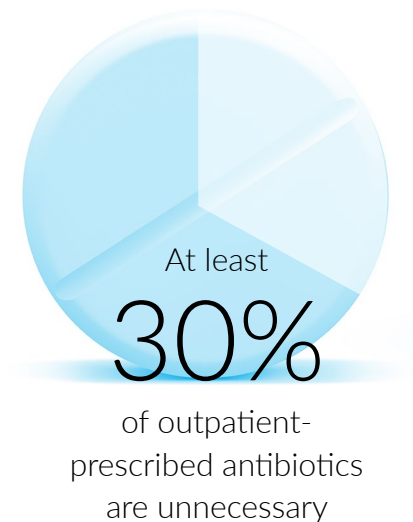


Quality and Clinical Program Development

Network members are committed to enhancing the patient care experience, improving the health of populations, reducing costs and boosting team satisfaction. VHAN's quality and clinical initiatives are evolving to best meet the needs of the patients we serve, while also supporting clinicians and caregivers.

Why It Matters

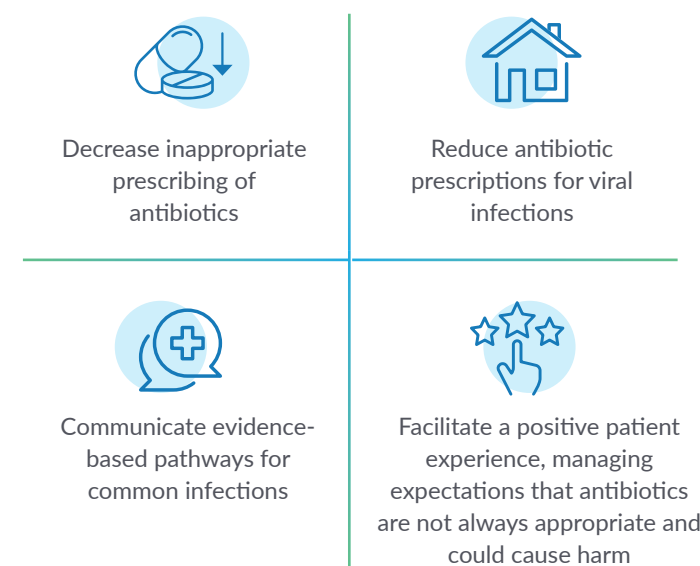
A photograph of a person's hands. The left hand holds a clear glass of water, and the right hand holds a small, white, oval-shaped pill. A circular inset in the upper left corner provides a close-up view of the pill, which is white and has a small indentation. The background is a blurred indoor setting with a wooden table and a green plant.



Antibiotic Stewardship Program Helps Ensure Appropriate Usage

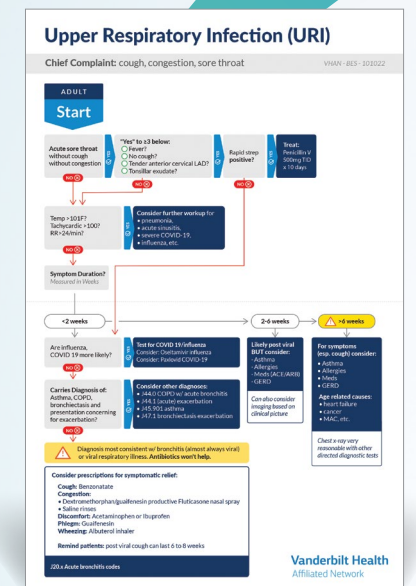
To manage the dual challenges of prescribing antibiotics appropriately and preventing unnecessary usage, VHAN launched a new Antibiotic Stewardship Program. The first phase focuses on URIs—a common reason for patient visits. Because antibiotic resistance is a critical population health issue, several VHAN value-based contracts have included appropriate antibiotic prescribing for URIs as a quality measure.

VHAN's Antibiotic Stewardship Program aims to:



As part of the program, our clinical team has developed pocket cards for VHAN members to help reduce unnecessary antibiotic prescriptions for URIs for both pediatric and adult populations, while keeping patient needs at the forefront. The cards include:

- A clinical algorithm for prescribing guidance
- Communication tips for prescribers to support appropriate use along with alternative treatment options
- Diagnostic coding tips



Patient and family engagement is equally important, particularly when it comes to URIs. Because some patients are disappointed to hear they won't be prescribed an antibiotic for their condition, VHAN's pocket cards include helpful patient messaging. Patient education tools also include a printable poster and social media graphics.

To kick off the program, VHAN conducted a virtual learning exchange to help members emphasize antibiotic stewardship, share best practices with network peers and provide tips on how to leverage VHAN's new resources.

[Learn More](#)

<https://vhanhub.com/antibiotics/>

Pharmacy

KEY INITIATIVE

Reducing ED Utilization for Migraines

Migraines are a leading reason for avoidable ED visits across VHAN commercial health plans. The American Migraine Foundation found that fewer than 5% of patients who suffer from migraines have been seen by a health care provider, received an accurate diagnosis and obtained appropriate care. Using payor data, VHAN identifies patients with migraines who could benefit from pharmacist outreach and expertise. Triptans were added to Therapeutic Alternative Program (TAP) to support cost effective prescribing of migraine therapies.

Additionally, new migraine workflows were incorporated into VHAN's care management platforms, and *My Headache Journal* was developed by VHAN in collaboration with experts at VUMC Neurology. The journal describes the causes of migraines and offers patients tips for preventing and treating them. Patients can also use the helpful resource to keep track of their headaches so they are more aware of triggers and the success of various treatments.



Debut of the miniVHAN podcast series: The five-episode series focuses on pharmacy's role in care transformation, addressing rising prescriptions costs, health policy and pharmacy's role in patient engagement. The series featuring VHAN experts debuted in March 2023.

Listen here

minivhanpodcast.com



KEY INITIATIVE

Statin and Adherence Outreach Helps Maximize Medication Benefits

There is strong evidence that statin medications reduce cardiovascular risk in patients with diabetes or preexisting heart disease. However, despite recommendations for their use, statins are both under-prescribed and underutilized.

At the same time, medication nonadherence continues to be a pressing—yet preventable—problem. According to a 2017 study in *Annals of Internal Medicine*, 20-30% of medication prescriptions are never filled, and about 50% of medications for chronic disease are not taken as prescribed. This lack of adherence can be life-threatening for patients.

In response, VHAN launched a Statin and Adherence Outreach Program, which uses a population health team to identify patients, then provides support to primary care physicians and patients to improve the statin use measure as well as adherence to other drugs for chronic conditions such as diabetes and hypertension.

In 2022, the program included 209 adherence patients and 165 statin patients. The VHAN team created a statin outreach training video and patient care training materials.

Alternatives to High-cost Medications

Additionally, the team offers updates and support related to current trends in pharmacy. Recently, several drug makers announced list price increases for nearly 450 drugs, making it even more difficult for patients to afford their medications and threatening to reduce medication adherence. In response, the VHAN Pharmacy Team compiled a pocket guide for prescribers with therapeutic alternatives to high-cost medications, now available on the VHAN Hub.

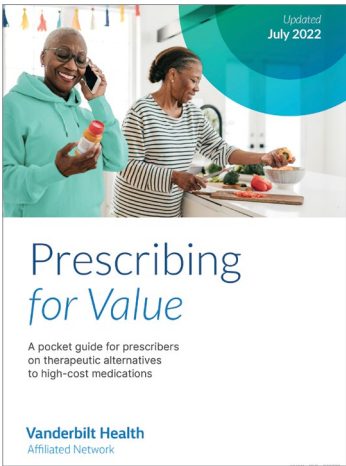
This collaborative work between pharmacists on the care team and patients has led to substantial growth of clinical pharmacy services to help manage patients with complex chronic conditions and medication-related problems. Network pharmacists can support VHAN patients and practices with chronic disease management, medication cost or access issues, comprehensive medication reviews for polypharmacy or after a transition of care, or to help solve any other medication-related problem.

20-30% of medication prescriptions are never filled



SUCCESS STORY

Updated 'Prescribing for Value' guide, with the addition of antidepressants and triptans: The update reflects the most used medications in the network. Because antidepressants are one of the top drivers on the TAP Dashboard, this class was added to the guide for clinicians to use in their initial decision-making. Triptans were also included to guide prescribers to the most cost-effective therapies first, and to ensure patients have access to effective, affordable medications for migraines.



PATIENT STORY

Reducing Risk by Managing Medications

A patient with hypertension was taking losartan with a year-to-date proportion of days covered (PDC) of 60%. The patient’s primary care physician had reduced the losartan dose to a half tablet daily. However, further review suggested that the patient’s 10-year risk for ASCVD (atherosclerotic cardiovascular disease) was still 16.2%.

To lower the risk, the pharmacy team worked with the patient’s primary care provider to update the losartan prescription and initiate a statin to lower cholesterol. When the team followed up with the patient, they were able to confirm that the patient was tolerating both medication changes well.

Care Navigators Help Patients Access Needed Medications

As the cost of prescription drugs continues to rise, patients’ inability or refusal to pay them contributes to an estimated 125,000 deaths every year, according to a Public Health Report study.

A *Journal of Clinical Oncology* study found that 67% of cancer patients did not use approved chemotherapy drugs if they had to pay \$2,000 or more out of pocket, compared to just 13% of those with a co-payment of just \$10 a month. Another study cited cost as the reason that 25% of patients with diabetes underuse their insulin. Plus, research shows a patient’s inability to purchase costly but essential drugs can increase overall health care costs over time.

Listening Actively and Collaborating With Other Providers

In addition to helping patients receive the highest level of care, VHAN’s Care Navigators are also skilled listeners who find solutions for a patient’s immediate needs as well as root causes of illness. Often, these solutions begin with a closer look at a patient’s medications.

For example, in a recent conversation with a 68-year-old female patient being treated for an atrial fibrillation and an ongoing thyroid issue, VHAN RN Care Navigator Shanika Robinson learned that the patient had been struggling to afford her essential heart medication.

After Robinson met with VHAN’s pharmacy team, they discovered that the patient’s primary care provider had prescribed the patient’s essential heart medication as “DAW-1,” or dispense brand name only. Working with her provider, the VHAN Pharmacy team was able to switch the patient’s medication to an equally effective and far less expensive generic version.

Building Trust to Address Depression

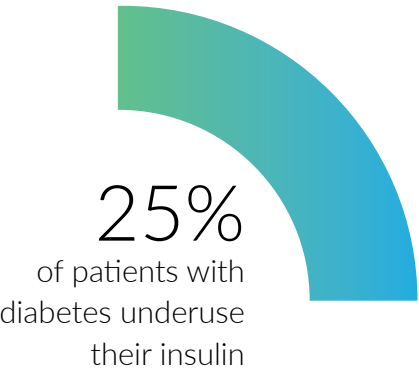
In ongoing conversations, Robinson realized the patient was also battling depression but had been hesitant to talk about it or seek therapy. After Robinson checked in periodically and built trust over several months, the patient agreed to speak with a social worker and seek additional help. With her medications properly adjusted and more affordable, the patient continued to meet with the social worker to find ways to earn extra money.



“This patient really has faith in our program. She’s been getting out of the house and having meals with her friends, and she is 110% better than when we first met—an absolute success story.”

Shanika Robinson, VHAN Care Navigator

Pharmacy



Meet Our VHAN Pharmacy Team

This group of experts helps patients find effective, affordable and safe medications and increase their understanding of these medications. Learn more about the team’s services in this video:

Watch the Video

<https://share.vidyard.com/watch/ySPfowUG7Wu7VmVxmLmvSn?>

Care Management

Why It Matters

According to the Centers for Disease Control and Prevention (CDC), Americans living with chronic physical and mental health conditions account for 90% of the \$3.3 trillion the U.S. spends each year on health care. The VHAN Care Management Program—staffed by a team of registered nurses, diabetes educators, social workers and pharmacists—supports VHAN practices by helping reduce readmissions, improving medication management and treating complex behavioral health conditions, all while keeping patient goals top of mind.



Diabetes Care Management Programs

VHAN Care Management offers focused programs to help patients better manage their diabetes and meet their health goals. This includes ongoing support of patients with complex needs and diabetes as well as a dedicated 12-week “Living Well with Diabetes” program for patients with a new diagnosis or who could benefit from education and supplement tools.

Once a provider refers a patient to the Care Management Program, that patient is connected to a dedicated care navigator, who can answer their health questions and connect them to resources available through VHAN, their physician and the community. In the past year, the program has added digital patient experiences to its toolbox of support. Each patient receives a series of emails with helpful information on preventive care and cancer screenings, details on how and where to access care, and tips for a healthier lifestyle.

The program also has a specialized subgroup supporting patients with diabetes. VHAN Care Navigators help patients self manage their condition, effectively implement their care plan and live their best life. Patients with diabetes are triaged and given added support in-between doctor visits to help ensure they have what they need to manage their diabetes, receive recommended screenings and reach therapeutic targets. The program also features digital workbooks and resources to support patients along the way.

Providers can refer patients to VHAN’s Care Management Program, including Diabetes Management Program, through a digital HIPAA-compliant referral form at [VHANReferral.org](#), or they can call (615) 936-2828.

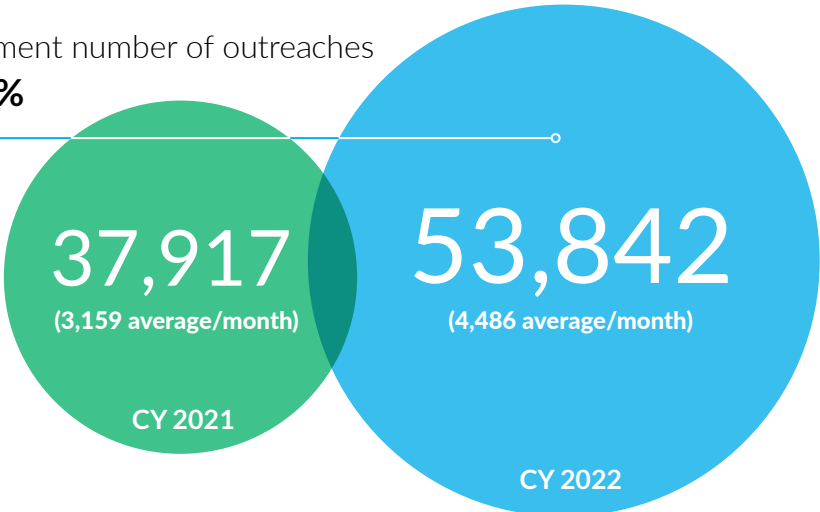
VHAN Care Management by the Numbers



Interventions (specific action items to provide services directly to a patient) increased **30% per month** for all payors, all populations



Care management number of outreaches increased **42%**



My Emergency Plan of Care

1. CHECK BLOOD SUGAR
READING MORE FREQUENTLY

- For a mild illness check every 8 hours
- For severe illness check every 2-4 hours

Never stop taking medications without discussing with your provider. Some diabetes medications may need to be stopped or adjusted when you are sick. Contact your diabetes health care team to discuss.

2. STICK TO YOUR MEAL PLAN
AS CLOSELY AS POSSIBLE

Eating well is important when you are sick, so try to follow your usual meal plan. You can also choose items from the healthy list below. Each item counts as 1 carbohydrate choice or 15 grams of carbs. Try to eat or drink at least 3 of these 45 grams of carbs every 3 to 4 hours:

- 1/2 cup fruit juice (like orange or apple)
- 1/2 cup regular (not sugar-free) soda pop
- 1/2 cup regular granola dessert
- 1 double ice pop
- 1 cup kefir
- 1 cup sports drink
- 1 slice toast
- 6 soda crackers

3. PREVENT DEHYDRATION

Signs of dehydration include dry mouth, thirst, decreased urination, very dark urine and dry flushed skin that does not snap back when pinched.

- Take small sips of fluid every 15 to 15 minutes.
- Consume a total of about 1 cup (8 oz.) of fluid per hour when sick.

My Insulin Pen Guide

When to Call Your Diabetes Care Team

- Your blood sugar is less than 70 mg/dL twice in one week or you experience a severe low blood sugar of less than 50
- Your blood sugar is higher than 250 mg/dL for more than 2 days
- You are vomiting or are unable to keep fluids down
- You have had a fever of 101.5 or higher for 24 hours
- You have been vomiting or having diarrhea for more than 6 hours
- You have cuts, burns or blisters that don't seem to be healing

AFTER HOURS / WEEKENDS:
Call 911 for a loss of consciousness or life-threatening emergency.

My Insulin

Name	
Supplied	
Additional info	
Storage (if not opened, avoid pen exposure to moisture)	
Dosing Schedule	
Timing Before Meals	

Reminders

Take good care of yourself. Plan ahead if you are too sick to take your medicines or stay hydrated.

Speed flow setting down the contact information of your primary care provider (PCP) and other members of your health care team, and write down the details of your after-hours plan, too. Keep this sheet near your phone and easily accessible to others.

If you need care after hours or on weekends and it's not a life-threatening emergency, call your PCP first.

If you need care after hours or on weekends and it's not a life-threatening emergency, refer to your after-hours plan for information on the closest walk-in or retail clinic.

Heading to the ER?
If this event is not life-threatening:
Have I called my primary care provider?
Have I considered my after-hours care plan?

Vanderbilt Health Affiliated Network

Learn more in this video and on this page on [VHAN.com](#), which also includes resources you can share with patients.

Watch the Video

www.vhan.com/diabetes-care-management



Care Management

PATIENT STORY

Managing Diabetes While Coping With Tragedy

Our team makes a difference, even in the most challenging situations.

After being stabilized and sent home from a hospital admission for hyperglycemia, a patient immediately suffered a tragic event that left her and her children without housing. She was faced with the daunting tasks of finding food, clothing and shelter coupled with financial burdens, all while recovering from her hospital stay.

VHAN's Care Management team sprang into action, coordinating the necessary expertise and resources to get medical, emotional and financial support to the patient as quickly as possible. Because she was a Vanderbilt Health employee, Vanderbilt's Employee Assistance Program also stepped in to provide financial assistance, while social workers from Vanderbilt Health and Aetna responded quickly to supply everyday essentials.

Care Navigators also pulled together specialists from our social work, case management and pharmacy teams, along with a Certified Diabetes Educator, to support the patient in managing her health.

'Angels From Heaven'

Now that she has been set up with a continuous blood sugar monitor, the patient is making great strides in managing her diabetes. She is receiving financial assistance and counseling and reportedly has "a fantastic outlook on life." She is working on her diet, taking medications as directed and developing a plan to reduce the cost and complexity of those medications.

The patient called the Care Management team "angels from heaven" for helping her let go of her fears and reclaim her life.



Quality Improvement
and Performance

Why It
Matters

Everyone in a health care organization has a role to play as we monitor, assess and improve the standards of our work to achieve better outcomes, including improved patient safety and quality of life and fewer adverse events and unnecessary hospital admissions. The dedication of VHAN members to continuously improve approaches to care have led to sustained and improved success in our network's performance.



SUCCESS STORY

100% Performance 2021
on Aetna Quality Measures

Our network achieved 100% performance on all Aetna Commercial quality measures in 2021. VHAN members also scored higher than Aetna's Q4 national average on several measures, including:

- Breast cancer screening
- Colorectal cancer screening
- Well-child/pediatric visits in the third, fourth, fifth and sixth years of life
- Appropriate treatment for upper respiratory infection (URI)



SUCCESS STORY

Driving Annual Wellness Visits,
Preventive Screenings and Better Health

The Annual Wellness Visit (AWV) with a patient's primary care provider can help prevent illness based on a patient's current health and risk factors. Recognizing the importance of these check-ins, our quality team can provide prioritized patient outreach and engagement rosters to practices participating in Medicare Advantage plans and the Medicare Shared Savings Program to support outreach and AWV scheduling.

For the 2022 performance year, AWV completion rates were as follows:

- Aetna Medicare Advantage: **55.1%***
(Up 15% from 2021)
- Medicare Shared Savings Program (MSSP): **48.5%**
(Up 12% from 2021)

* = Indicates final 2022 performance is pending due to claims runoff, with an expected completion date of July 2023.

We have even produced an AWV toolkit with helpful information for performing and documenting Medicare AWV patient education, including coding/documentation information, preventive services summary sheets and a sample health risk assessment.

Exceeding Screening Targets

As a result, VHAN met or exceeded nine out of 10 commercial and Medicare Advantage targets in breast, colorectal and cervical cancer screenings. For breast cancer screening, we achieved 95th percentile across all payors from the National Committee for Quality Assurance (NCQA), and we surpassed NCQA state and national averages for colorectal cancer screening across multiple payors.

Quality Improvement and Performance

How Erlanger Health System Improved Its AWV Completion Rate

Based in Chattanooga, Tennessee, Erlanger Health System (EHS) wanted to improve its AWV completion rate, maximize reimbursements and deliver vital preventive care, all while keeping patient satisfaction at the forefront. The system's quality team implemented an AWV template and clinical education program, led by MCO Quality Coordinator Kim Hullander, LPN, CPC.

The program identified and implemented several best practices:

- To improve the patient experience, Hullander educates clinical staff on the questions that are part of the AWV template and offers tips on how to prioritize “conversation over interrogation.” Her first rule: Always begin with a greeting. “We start our visit by asking how the patient is doing. Then, as we’re getting the patient’s height and weight, we start to ask required AWV questions, such as if they are having issues at home or are at risk of falling,” she explains.
- Erlanger’s AWV template and the EMG quality team education program help every member of the clinical staff obtain appropriate patient interactions, making visits as efficient as possible. For example, the clinician taking care of patient intake begins the patient’s cognitive screening by giving them three words to remember as soon as they get into a patient room. Then the clinician continues the conversation, asking required questions about patient safety, caring for themselves at home and fall risk screening before turning back to the cognitive screening. This maximizes the patient’s and provider’s time while supplying Medicare with the answers required for an AWV.
- Hullander audits all of EHS’ AWVs to ensure everything is completed and documented properly. When errors are identified, she uses them as an opportunity to help practices improve their process. “The audit tells us where to target specific education for our practices, and it gives us better results,” she says.

AWV Completions Nearly Double

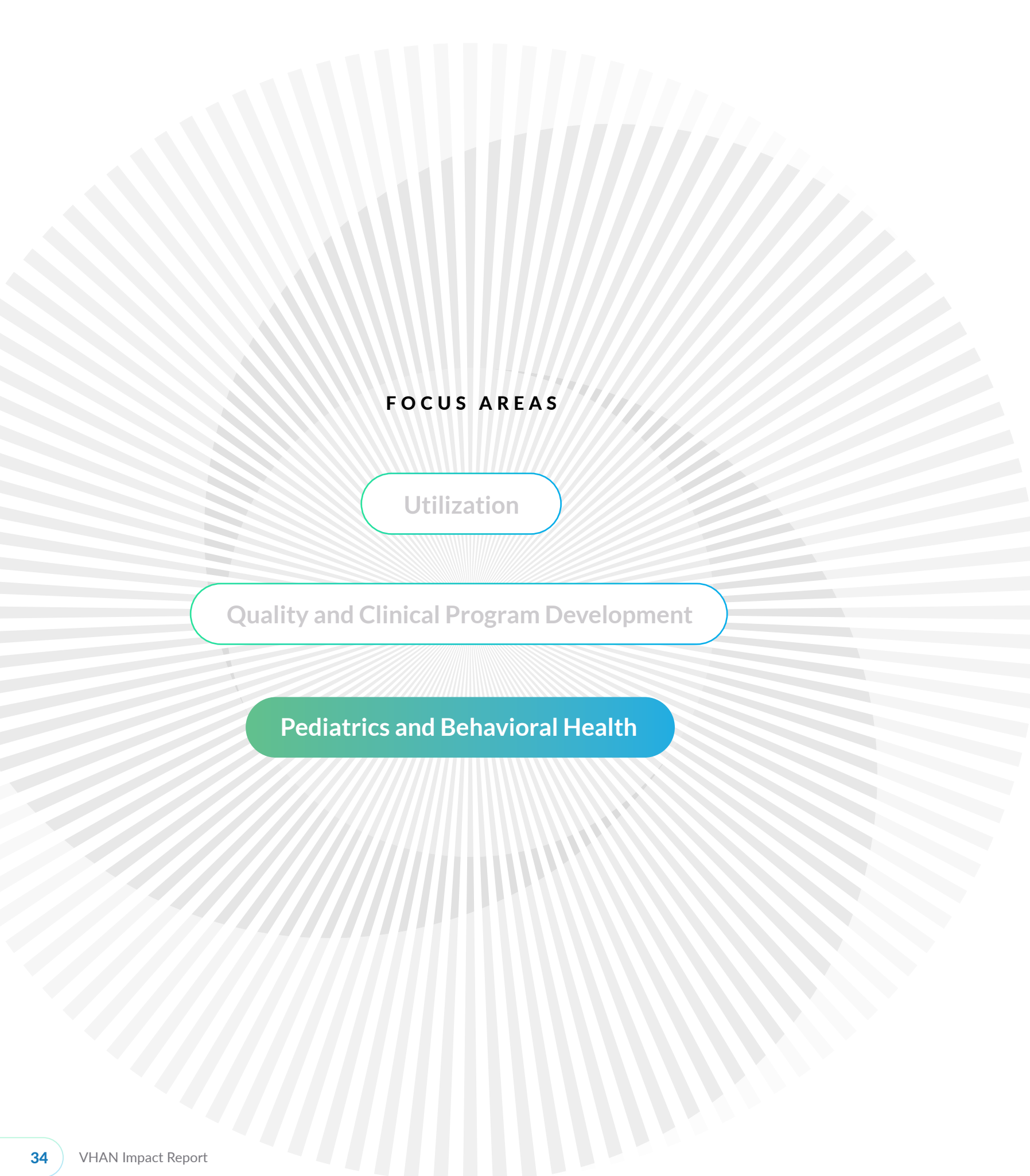
Since implementing the new template and education program in 2018, Erlanger has experienced year-over-year increases in total Medicare AWVs, including an increase of more than 800 AWVs in 2020 as compared to 2019, despite pandemic-related challenges. In 2021, EHS nearly doubled their AWV completions with 10,581 compared to 5,991 in 2020. So far, EHS is on track to grow or maintain its AWV completions in 2022.

Other Successes in Quality Improvement and Contract Performance

- Quality attestations:** Implemented across multiple payor contracts to achieve performance targets and earn shared savings
- Improved ratings:** Many practices went from 3-star to 4- or 5-star ratings in the Medicare Advantage plan.
- Prioritized patient engagement rosters:** To aid in scheduling annual wellness visits.

Collaborative action plans: Working with practice teams, we created and maintained action plans that drive improvement in cancer screening, wellness visits and diabetes-related quality measures, as well as initiatives related to our Connected Care ACOs.





Pediatrics and Behavioral Health

Before the coronavirus pandemic, the National Association of Mental Illness (NAMI) estimated one in five adults and one in six youth ages 6-17 experienced mental illness each year. However, at the height of the pandemic in late June 2020, the CDC found that number jumped to nearly 40% of adults struggling with mental health or substance abuse. The CDC also found that from March 2020 to October 2020, mental health-related ED visits increased 24% for children ages 5 to 11 and 31% for those ages 12 to 17 compared with 2019 ED visits. Today, primary care providers are faced with increasing levels of mental health events among patients, often with limited resources. VHAN is working to change that narrative.

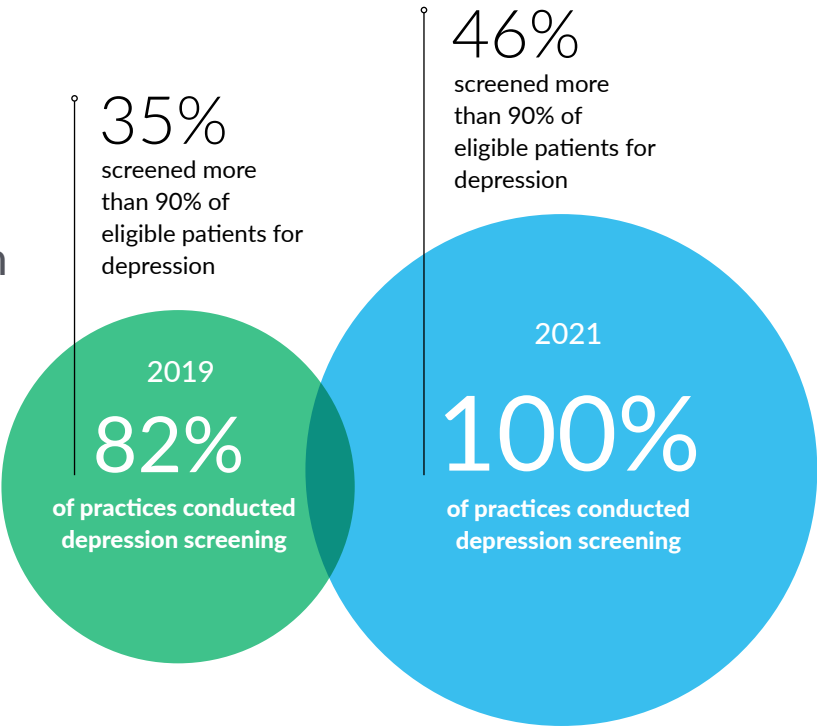
Pediatrics

Why It Matters

Pediatric patients, who make up almost 30% of the population VHAN manages, not only require quality care focusing on their unique needs, but they also need support as they move to adulthood, where they will be responsible for their own health care. VHAN helps these young patients make this transition successfully, putting them on a path to a healthier future.



VHAN practices greatly improved the percentage of patient depression screenings by 2021



SUCCESS STORY

VHAN Helps Pediatricians Improve Depression Screenings

In 2019, when we began measuring annual depression screenings for children 12 and older, 18% of practices received a score of zero for depression screening, and only 35% screened more than 90% of their eligible VHAN patients for depression.

To improve our performance, VHAN licensed clinical social workers met with practices to promote our social work program and the benefits of using the pediatric behavioral health consult line.

Dramatic Improvement in Scores

As a result, by 2021, no VHAN members received a score of zero for depression screening, and 46% of practices screened 90% of their VHAN patients for depression. Depression screenings during checkups for patients 12 and older averaged 92%.

These results showcase how our members can use VHAN tools and services to improve patient care. These include pediatric resources related to anxiety, eating disorders and ADHD; webinars and online training to assist clinicians in providing better mental health care; and information about the pediatric and adult behavioral health consult lines.

Learn More

VHANHub.com/pediatrics



Pediatrics

SPOTLIGHT

Brentwood Pediatrics Helps Demystify Care for Young Adults

Young patients who turn 18 are suddenly forced to fend for themselves in a complex health care system, which can lead to confusion, frustration and gaps in health care. Stacy Kellum, practice manager at VHAN member Brentwood Pediatrics in Brentwood, Tennessee, decided to take a proactive approach to closing the gap.

“This was an issue where we as a practice said, ‘We need to make sure that these patients transition to an adult provider,’” Kellum says. “In the past it was, ‘You need a new provider, pick one, goodbye.’ Our focus now is on making sure that we’re not just dumping these patients without any direction.”

A Comprehensive Transition Resource

Kellum and her team went to work on a comprehensive transition packet, designed to inform and educate young patients and their parents on how best to prepare for the transition to an adult PCP. The packet contains letters for both young patients and their parents outlining what to expect and how to prepare for the upcoming change.

It also includes information about taking medications, filling prescriptions, navigating health insurance, understanding HIPAA regulations and handling health emergencies. The practice pulls it all into one convenient printed resource that both patients and parents can keep on hand for reference.

An Emphasis on Conversation

Brentwood Pediatrics encourages physicians to listen to their young patients’ needs and have open conversations with them to help demystify health care.

Other Successes in the Pediatrics Space

Outstanding quality metrics: Achieved 100% of quality pediatrics metrics for Aetna in 2021

Nurse outreach: A new program targeted all children seen in the ED or discharged from the hospital with an asthma or behavioral health diagnosis in 2021. This outreach was expanded to high-cost health plan claimants starting in 2022.

SUCCESS STORY

Transitions Program Helps Pediatric Patients Move to Adult Care

The adolescent years pose many challenges, including emerging sexuality, development of personal identity and adult relationships, behavioral health issues and a high degree of risk-taking behaviors.

Amid this uncertainty and vulnerability, adolescence is the time to begin preparation for transitioning to an adult provider, when young adults take charge of their personal health care needs. Unfortunately, lack of communication, consistency and clarity around leading young patients to adult care often creates gaps in care that can lead to poor health outcomes and frustration for patients and families alike.

VHAN’s Transitions Program helps young adult patients find network primary care providers (PCPs) for their care. We’ve begun by identifying unattributed pediatric patients for our practices. In 2023, we are working to connect these patients to a network pediatrician to begin the process of moving to adult care.

Here are some helpful resources:



Quick Reference Guide:
[Transition From Pediatric to Adult Provider \(for providers\)](https://vhanhub.com/slug/quick-reference-guide-making-the-transition-from-pediatric-to-adult-provider)

<https://vhanhub.com/slug/quick-reference-guide-making-the-transition-from-pediatric-to-adult-provider>



How to Navigate the Transition From Pediatric to Adult Health Care: Packet Compiled by Brentwood Pediatrics (for patients)

<https://vhanhub.com/slug/how-to-navigate-the-transition-from-pediatric-to-adult-health-care/>



Digital Pediatric Patient Referral Card

<https://vhanhub.com/slug/pediatric-patient-referral-card-digital/>



Behavioral Health

Why It Matters

According to the CDC, more than 50% of Americans will be diagnosed with a mental illness or disorder at some point in their lifetime. It can lead to disability, family and relationship problems, social isolation, substance abuse, and legal and financial problems. What's more, a mental illness like depression increases the risk for many types of physical health problems, particularly chronic conditions such as diabetes, heart disease and stroke. Helping members address the domino effect of mental illness is one of our key priorities.

SUCCESS STORY

VHAN Tools Provide Critical Post-Pandemic Behavioral Health Support

To help our members connect patients with the behavioral health support they need, VHAN continues to provide new tools and connections to community resources.

Our first Project ECHO, "Managing Mild to Moderate Depression in Primary Care," focused on educating pediatricians about depression and giving them mental health resources tailored to young patients. (See story on Page x.) Plans call for another Project ECHO program on a similar topic in 2023.

More Consults for Providers

Our Pediatric Behavioral Health Consult Line fielded more than 1,500 calls in 2021-2022, and our Behavioral Health face-to-face consults grew from 43 in 2021 to 60 in 2022. Calls to the consult line help providers prescribe medications and shorten psychiatric evaluation wait times for pediatric patients who need immediate assistance.

Pediatric Behavioral Health Consult Line:
(615) 205-9367, available Monday-Friday, 8 a.m.-5 p.m. CT

<https://vhanhub.com/slug/pediatric-behavioral-consult-line/>
[Learn more](#)

Our Adult Behavioral Health Consult Line launched its pilot in 2022 with more than 35 consults completed to date. Our staff helps develop behavioral health care plans, assists with level-of-care determinations, helps with safety planning, navigates strategic resources and referrals, and conducts direct follow-up and care coordination with families. We can also schedule medication and diagnostic consultations with an adult psychiatrist as needed.

Face-to-face
consults grew from
43 in 2021 to
60 in 2022

PATIENT STORY

VHAN Support Helps Patient Cope with Multiple Conditions

Facing multiple medical conditions can cause patients to experience depression, hampering their ability to manage their health. For one patient, a nimble response from VHAN's Care Management team recently made a huge difference.

The patient, a 70-year-old male, was suffering from multiple comorbidities and experiencing associated depression and anxiety, along with what he described as a "short fuse." While his cardiologist had prescribed an antidepressant, the patient was confused over the name of that medication and how to get the prescription filled.

A VHAN RN Care Navigator stepped in to offer comfort and counsel as well as to assess the patient's complex situation. After seeing signs of depression, the nurse made a referral to a social worker trained in behavioral health interventions, who worked with the patient to address his psychological areas of concern.

Reconnecting to Needed Care

The social worker helped the patient resume care with his past psychiatric provider. A follow-up letter was sent to the patient with steps for reconnecting with a pharmacist. Over several weeks the social worker offered counseling and anger management, talking through specific situations that triggered an anger response and offering coping methods.

Not Signed Up
for the VHAN Hub?

Members can visit the Registration page to create a profile and gain access to hundreds of practice tools and resources, including the behavioral health content mentioned on this page. Visit [VHANHub.com/member-registration](https://vhanhub.com/member-registration) to get started.

Other Successes
in the Behavioral
Health Space

New Well Moment resources:
In this dedicated online space, patients and families can learn from and talk directly to health experts about pressing health and wellness issues. In 2021, Well Moment hosted webinars related to anxiety and mood disorders in children, cyberbullying and internet security, and more. Find previous Well Moment content at wellmoment.org.

Care management support:
Acting as an extension of a practice, the Care Management Team alleviates burdens on staff by freeing up their time for other important tasks. Care Navigators can reach out to patients with complex needs and help them find care in between visits.

Addressing physician burnout:
VHAN supports our exhausted, overextended health care provider members with programs and coping strategies to ease pressures and boost mental health.

New behavioral health section on the VHAN Hub:
Members can find all VHAN's behavioral health resources in one place on the VHAN Hub, including webinars, pediatric behavioral health resources and online behavioral health training.

Pediatric behavioral health community resources:
These resources, which can be found here on the VHAN Hub, are organized by county and patient need, from ADHD and anxiety to eating disorders and substance abuse. Plans call for similar resources for adults to be available.

Looking Ahead

As we work together to provide high-quality, cost-effective care, VHAN is constantly looking for new ways to build connections, improve outcomes, enhance value and provide support to our practices and our patients, leveraging network data and member feedback to identify priorities. Here are some of our new initiatives on the horizon.

ONEPOINT

A Clearer View Into Patient Health Needs

Members have told us they often struggle to access and organize patient data from seemingly endless sources. So, in 2023 we are implementing One Point, our new population health management platform that puts actionable quality and performance metrics at their fingertips, providing a clearer, more up-to-date view into a patient's health needs. It helps our providers aggregate, analyze and act to drive transformative, value-based care.

OnePoint connects to your EHR with added functionality to operate in the background, with "no touch" pop-up notifications that yield helpful intelligence without additional clicks. It improves insights at the point of care, eliminates clinician pre-work and provides a full patient view that a singular EHR may not.

A Round-the-Clock Tool to Improve Care

The system gives around-the-clock access to timely patient information. Our desktop app shows when and where patients received care, including ER visits and hospital admissions. Smart alerts pinpoint areas to improve patient care and identify patients with gaps in care, including those who need follow-up and care

management programs. It also enables more patients to receive preventive care at affordable costs. Pop-up notifications improve patient communications.

OnePoint gives members customized automated progress reports, PCP scorecards and performance benchmarks, including data insights on the individual patient and comprehensive levels. It optimizes performance in value-based contracts, increasing opportunities for shared savings by improving performance.

Boosting Efficiency for Practices

What's more, OnePoint reduces work for staff through more effective workflows and greater team efficiencies, aligning everyone across the continuum of care. It allows team members to spend less time on administration and more time on higher-value patient care tasks.

Our dedicated success team supports platform implementation, from EHR integration to training, with the least amount of disruption possible. OnePoint delivers the data our members need on demand to meet and exceed quality and performance goals.

Introducing OnePoint

Watch the Video

<https://share.vidyard.com/watch/Uc9XhHiE3iNm5KQXHkGrGW?>



Looking Ahead

THE GRACE GERIATRIC PROGRAM

Improving Care, Controlling Costs

Older adults ages 85 and up have the highest per capita utilization of health services, and this population is expected to rise to 9 million by 2030 according to the National Institutes of Health. To manage utilization while maintaining quality of care, VHAN is introducing the Geriatric Resources for the Assessment and Care of Elders (GRACE) Program, an evidence-based model to improve quality while controlling costs for older patients with complex care needs.

The GRACE model, which deploys a multidisciplinary team to meet health and social needs, works best under value-based payment arrangements. Every patient is assigned a support team, including an RN or NP and social worker, who work closely with the patient, caregivers and the patient's primary care physician.



OLDER POPULATION GROWING DRAMATICALLY

Ages 85 and up have the highest per capita utilization of health services, and this population is expected to rise to **9 million** by 2030

Assessments, Care Plans and Other Support

Support from the team includes:

- Performing an in-home geriatric assessment of health and social needs of each patient
- Developing an individualized care plan, based on evidence-based care protocols, with input from a larger interdisciplinary team that includes a geriatrician, pharmacist and mental health social worker
- Collaborating with the primary care physician to review and implement the care plan
- Improving proactive coordination across specialty providers and care settings, including transitional care from a hospital or SNF to home
- Using integrated EHR documentation and communication with physicians
- Connecting patients and caregivers with community resources

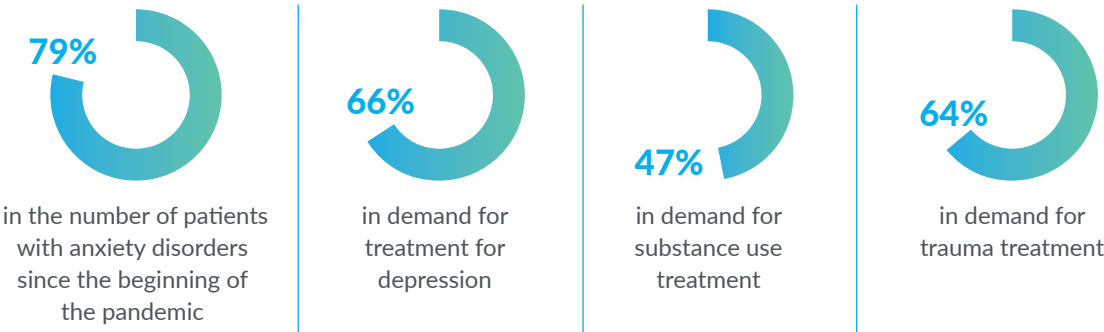
The GRACE program has a proven track record of success. Among high-risk patients, those enrolled in GRACE compared to typical care had fewer emergency department visits, decreased number of hospitalizations, fewer hospital readmissions and reduced hospital costs.

BEHAVIORAL HEALTH

Expanding Our Reach



According on an American Psychological Association survey with psychologists in 2022, the demand for mental health treatment continues to rise, with increases of:




Additionally, two-thirds of psychologists reported seeing an increase in the severity of symptoms among patients.

In response, VHAN will increase our focus on behavioral health. We are expanding our consult line from pediatric to adult behavioral health, offering real-time clinical guidance including behavioral health care plan development, assistance with level-of-care determinations, help with safety planning, navigating referrals and care coordination with patients and families. Licensed Clinical Social Workers and psychiatrists will collaborate on medication and diagnostic consultation as needed.

An Emphasis on Education

At the same time, we will continue to provide valuable educational opportunities. Our miniVHAN podcast series in Fall 2023 will be dedicated to behavioral health. We'll continue to host quarterly pediatric behavioral health webinars and plan to add adult behavioral health learning opportunities in the future.

And after the successful launch of Project ECHO in fall 2022 (see story on [page 9](#)), VHAN will host a second session on pediatric depression in Fall 2023.



If you have questions or would like to engage in programs or opportunities discussed in this report, please reach out to your network contact or email us at info@vhan.com

Vanderbilt Health

Affiliated Network

