September 8, 2020

About VHAN & Overview of Transitions of Care Program

Medicare Advantage Learning Collaborative

AMGA™
Advancing High Performance Health

Vanderbilt Health
Affiliated Network

About
Vanderbilt Health Affiliated Network

AdVHANtage

VHAN's provider members are aligned to these strategic aims, ensuring VHAN remains the region's preferred clinically integrated network consistently delivering market-leading performance and growth

Achieving/Exceeding Contractual Quality Metrics

By equipping provider members with valuable insights that enable them to proactively engage with their patients.

Reducing the Total Cost of Care

By transforming care delivery, improving health and productivity, and driving innovation.

Growing Managed Lives

By bringing together the region's most preferred, high-performing providers to deliver high-value, cost effective care

Our Commitment to High-Value Care – Since 2012

Phase 1:

Building a Robust Network for Statewide Coverage

70 Hospitals

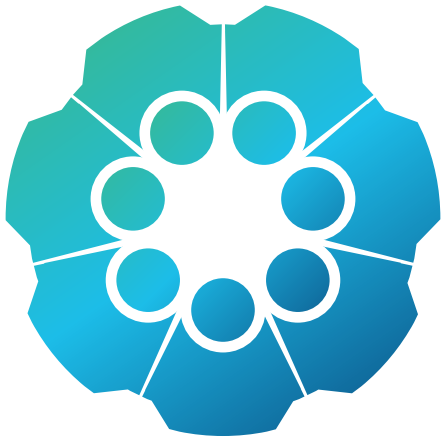
13 Health Systems

Hundreds of Physician Practices and Clinics

More Than 6,200 Clinicians

Phase 2:

Creating a Performance Engine for Value + Quality



Phase 3:

Executing with Accountability

In The Last Two Years, We Have…

- Updated provider-led operating model to focus on shared aims and accountability, regional governance and member engagement
- Established robust annual strategic planning process aligned to VHAN's strategic imperatives
- Expanded centralized Performance Improvement team to work with members on key VHAN priorities
- Developed new cross-payer, standardized quality measures and attribution reports
- Rolled out standardized, evidence-based Care Pathways
- Completed CMS-sponsored Transforming Clinical Practice Initiative
- Built digital engagement, education and member feedback infrastructure
- Operationalized data and reports to enhance care management and equip provider members to proactively engage and manage their patients
- Enhanced behavioral health resources and support for Pediatricians
- Leveraged pharmacy expertise with network-wide outpatient formulary impacting unnecessary drug spend
- Developed and launched clinical toolkits focusing on ER Utilization, Quality Measures, Transitions of Care and Coding and Documentation
- Supported COVID-19 efforts through best practice sharing and content development for clinical, practice and financial operations
- Participation and performance in managing new and emerging risk-based models

Our Future Plan is Executing with Accountability…

- Apply key learnings from shared savings and Medicare ACO work
- Seek relationships and partnership with increasing upside and downside risk
- Access through keepage and network adequacy
- Increase covered lives under economic management
- Develop an analytics roadmap to support VHANs institutional goals
- Maximize VHAN Care Paths to drive down unwarranted variation and improved outcomes while reducing costs
- Establish and standardize change management for network engagement

- Develop a behavioral health strategy
- Improve the control of VHAN patients with diabetes by 5%
- Reduce the 30 day all cause readmission rate for VHAN patients by 2%
- Improve screening rates for breast, cervical, and colorectal cancers by an average of 5% among VHAN patients
- Improve age appropriate wellness visits across our population by 5%
- Improve documentation standardization on clinical severity to at least 75% HCC recapture rate across VHAN Medicare populations
- Include voice of patient in all initiatives

The Results Have Been Rewarding

Performance Year	Quality % of Goals Attained	Financial Results Savings as % of Target Expense	Incentive Payments
2013	N/A	2.4%	$3,090,000
2014	50%	6.4%	$1,320,000
2015	80%	1.5%	$4,050,000
2016	95%	3.7%	$3,500,000
2017	83%	2.5%	$7,090,000
2018	100%	2.7%	$8,300,000
2019	**100%**	**3.9%**	**Est. $20,770,000***
			Total $48,130,000**

* Includes anticipated Medicare performance of $2.7M
** Total payment does not reflect retained funds for building reserves.

The Results Have Been Rewarding

Clinical Performance

Annual Wellness Visits

16,683 completed AWVs for Medicare Shared Savings Program (**40% of the attributed population**) in past year

Readmission Rates

Reduced readmission rates from **19.6% to 12.9**% for Medicare Shared Savings Program

Medication Management

277 engaged patients in Medicare Shared Savings Program medication management

Pediatric Behavioral Health

700+ consults conducted with network pediatricians and **200** ER discharge follow-ups from Vanderbilt Children's Hospital

Appropriate Care

Reduced unnecessary hospitalization by over **20,000** visits and avoided **17,000** unnecessary tests and procedures*

*Reflects 4-year time period during CMS Transforming Clinical Practice Initiative

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VHAN Care Management
Transitions of Care Program

Care Management Overview

- VHAN Care Management Services are based on a holistic population health management model prioritizing effort on wellness, chronic disease management, and safe transitions of care support.

- By applying an interdisciplinary approach, the VHAN care management team can engage patients where they are and continue to provide support throughout the continuum of care.

- Populations served include:
  - High Cost, High Risk patients typically with multiple complex illnesses resulting in increased utilization of ED and inpatient services and have the greatest care needs, including psychosocial needs

  - Rising Risk patients including patients who often have one or several stable chronic conditions or risk factors that if successfully managed may prevent the patient from moving into the High Cost/High Risk category

  - Low Risk patients include patients who are stable and healthy. These patients have minor conditions that can be easily managed.

Transitions of Care Program

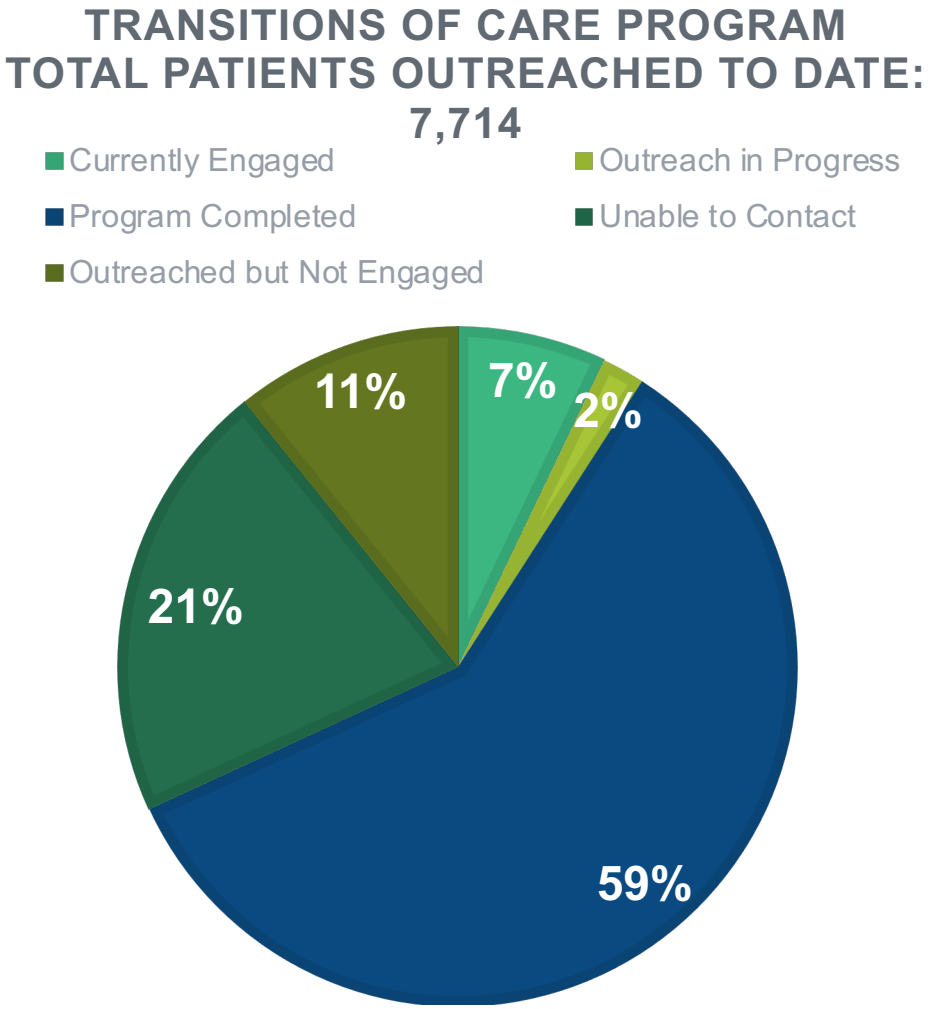
- The Transitions of Care program is a patient-centric approach that helps patients transition out of the hospital following an acute event.
- The goals of the program are to:
  - Improve care coordination for patients discharged from the hospital
  - Educate patients about diagnoses and self-management
  - Assist with medication management
  - Address patient/caregiver needs such as adequate support and resources at home
  - Improve adherence to hospital discharge care plan for patients discharged to home
  - Prevent readmissions

Tennessee Hospital Association Partnership

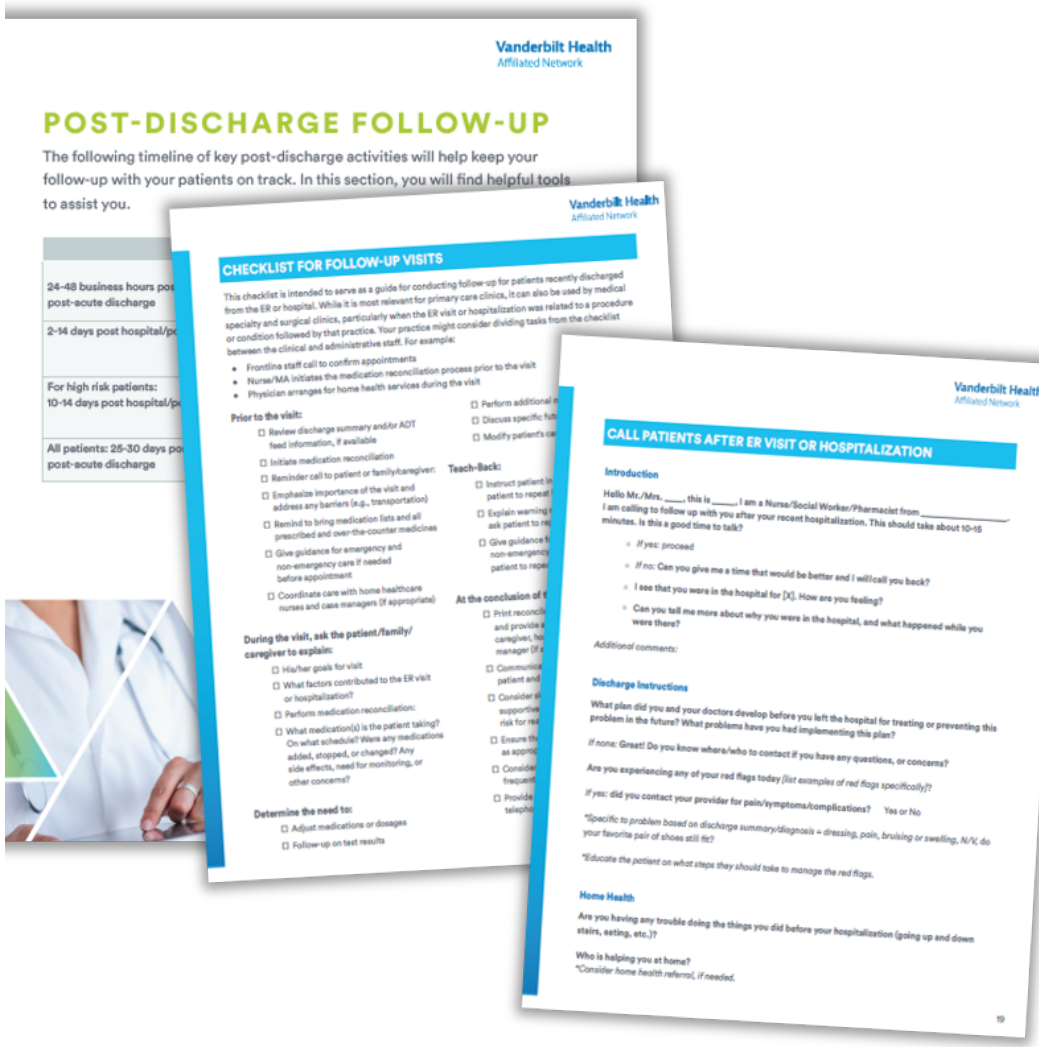
- ADT feeds from over 120 Tennessee Hospital Association member facilities across Tennessee for VHAN attributed patients
- Receiving real-time notifications of patient movement across acute settings
- Patient roster driven data
- Access to web portal with actionable patient data

Transitions of Care Program Start-up Summary

- Real-time ADT notifications became available September 2019
- Consistent outreach to approximately 200-300 new transitions patients each week
- Engaged patients are called an average of 2.5 times within the 30 days post-discharge
- Social Work and Pharmacy support available as necessary
- When necessary, patients remain enrolled in complex care support for additional 60-180 days



Transitions of Care 7-14 Day Office Visits Best Practices



- Dedicated resource to manage follow-up with post-discharge patients
- Outreach to patients in first 24-48 hours post-discharge
- Scheduling template enhancements
- Script and checklist for follow-up phone calls and visits

Transitions of Care Patient Success Story

- 77 year old patient with a history of HTN and high cholesterol hospitalized due to shortness of breath and lower extremity edema
- Standard transition assessment identified barriers and complications, including lack of medication adherence
- Team-based approach to coordinating care across providers, including home health, PCP, and cardiologist
- Positive patient outcome, including compliance with sodium restrictions and medication adherence

Transitions of Care Patient Success Story

- 44 year old woman admitted through the ER for stroke like symptoms and headache, which she began experiencing at work
- Patient did not regularly follow-up with a PCP
- Patient established care with a PCP and was provided counseling on stress reducers and lack of sleep concerns
- Additional counseling and psychosocial support provided through network social worker

“I am so grateful someone called me this soon.”

- Patient

“Thank you for notifying our office…we would have never known.”

- *Physician*

“I would have stopped that medication had you not called to explain why I need to keep taking it…”

- Patient

“I appreciate you letting us know Mr. Smith isn’t feeling better after his discharge…we’ll get him in right away.”

- *Clinic Nurse*

Questions?

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