VALLEY HEALTH TEAM

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Growing VHT's PHASE Program

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Our Desired Future for PHASE/TC3

New AIM Statement

By March 31, 2022 VHT will improve the health if patients by:

i) increasing the statin prescription rates for all VHT patients at high risk of a cardiovascular event from 58% to 68%

ii) decrease the rate of uncontrolled blood pressure rates for all VHT patient's with a minor focus on the homeless population at high risk of a cardiovascular event from 37% to 32%, by implementing 4 key changes to the chronic care delivery system at VHT's 8 medical sites;

- Care team nurses to conduct monthly telehealth visits with case managed patients
- Care team to mail out educational materials to patients regarding controlling A1c and Blood Pressure readings "know your numbers"
- Care team will communicate with (non-compliant) patients on the importance of medication compliance/BP control utilizing MTM
- The QI team will provide site specific dashboards to care teams to identify PHASE patients and monitor measures and review quarterly

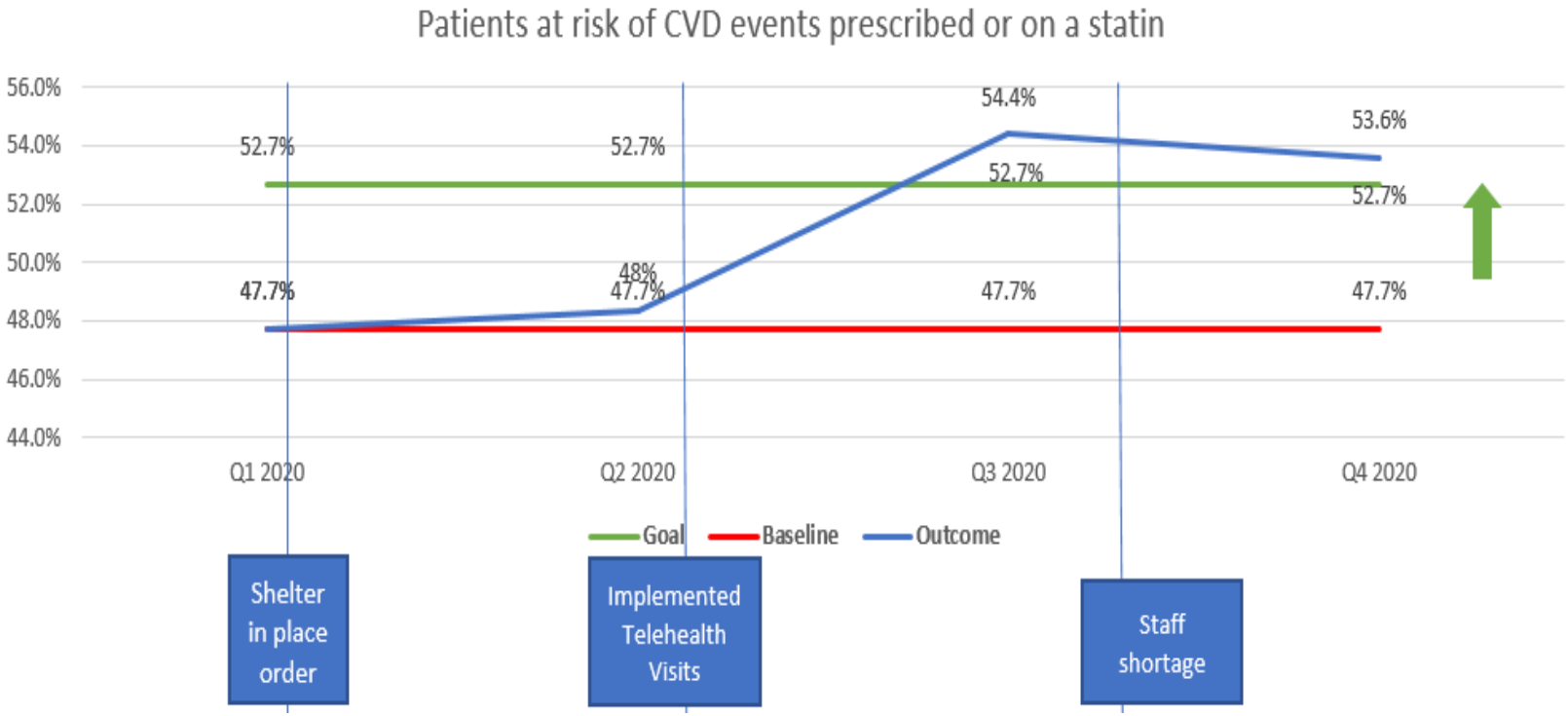
Why It's Not Possible Now

Patients that are at a higher risk for cardiovascular events have challenges accessing chronic care management. These factors were further exacerbated due to the current COVID-19 pandemic:

- Decrease in access & utilization of primary care
  - Shelter in place mandate
  - Fear/Anxiety to seek care
  - Patient transportation challenges
- Not all sites have a pharmacy/pharmacist
- Decreased monitoring of chronic care indicators
  - Essential labs (LDL/blood panel/A1c etc..)
  - Updated vitals
  - Lack of data transparency

Learnings that Will Inform Our Desired Future: Accomplishments

- Engaging patients by using patient input/feedback to modify care plans (monthly patient experience feedback interviews)
- Chronic care tools adapted to assist with Telehealth visits
- Successful increase in Statin prescription rate, utilizing medication provider dashboards

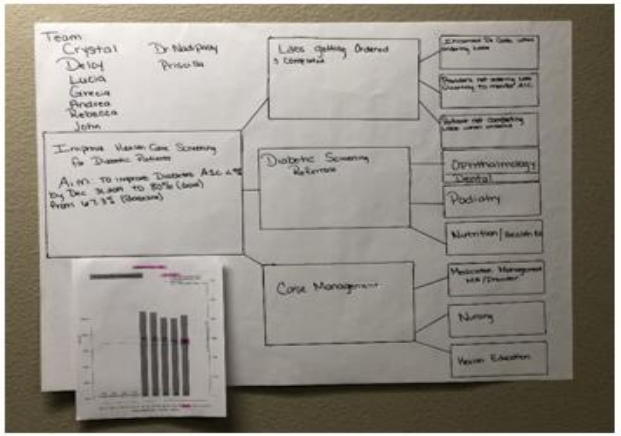


Learnings that Will Inform Our Desired Future: Staff/Patient Feedback

"I like that we made a change in our patients life, help them understand about their disease process."- Medical Assistant

" I didn't really think I needed medication, I don't like taking medicine, but Dr. P was really sure that I did." "I got on line and tried to find out as much as I could about high blood pressure, and now I'm glad he made me start taking it." – Patient

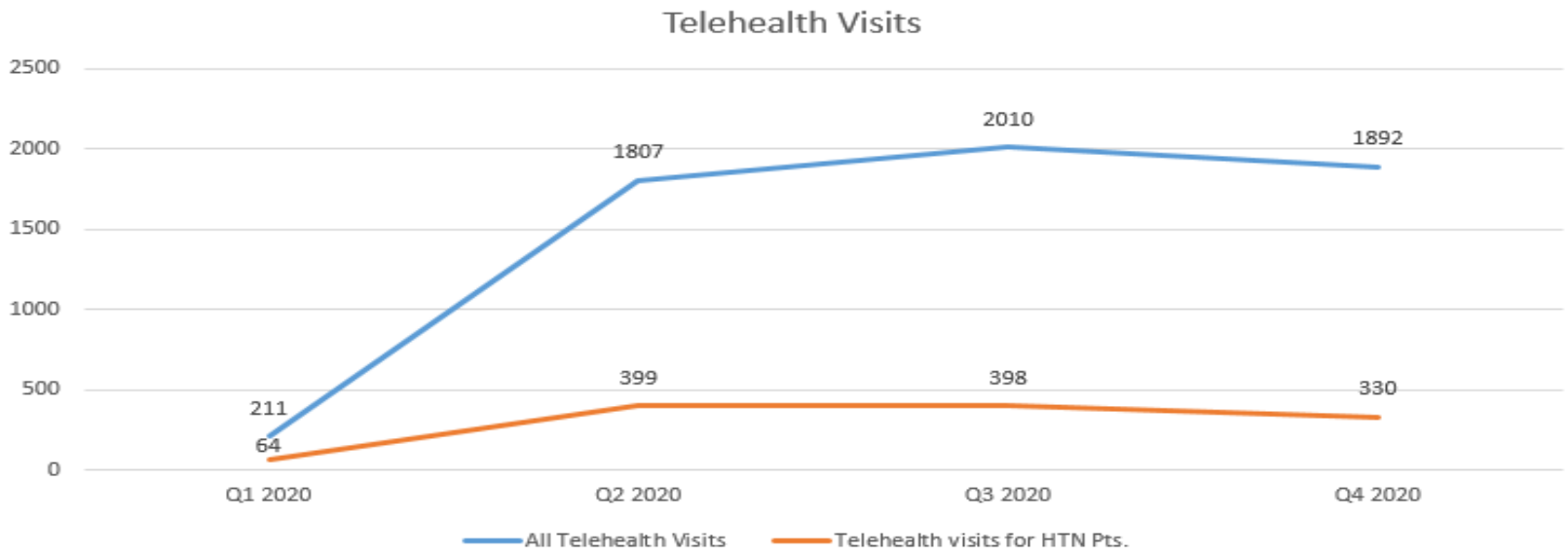
"My doctor has taken really great care of me with medication and have been managing it well"- Patient



Meet the team: Crystal, Delcy, Lucia

Learnings that Will Inform Our Desired Future: Continued Activities

- Medication focused interventions. Statin, ACE/ARB prescription rate for patients at risk of cardiovascular events
- Addressing patient needs by extending services to outside the clinic setting. Outdoor screenings /testing/immunization events.
- Leveraging remote monitoring and telehealth visits to engage patients in chronic care management



What Else is Possible?

- Leveraging a Self Monitoring Blood Pressure (SMBP) program for patients at risk of a cardiovascular event, to further enhance VHT's remote case management program.

- Additional clinical pharmacist staff to provide MTM services to all patients at risk of a cardiovascular event.

- Virtual telehealth group visits, will provide patients at risk of a cardiovascular event, with important community support resources/tools to assist the patient with disease self-management.

Benefits of Achieving Desired Future

- Reduce heart attack/strokes hospitalizations events
- Improve patient health outcomes
  - Increase medication compliance
  - Improve blood pressure control
  - Improve patient experience
- Decrease burden on chronic care management teams
- Reduce utilization of specialty care services
- Enhance P4P measures & associated health plan funding

Challenges if We Don't Move Forward with Solution

What if VHT didn't have a PHASE program…..

- The most vulnerable populations would continue to experience challenges in managing their chronic conditions & place extra burden on safety net resources:
  - Leading to decrease patient outcomes
    - Decrease access to primary care services
    - Over utilization of chronic care management team
  - Increase patient hospitalizations
  - Decrease access to specialty care services
  - Reduction in P4P supplemental dollars

What We Need from Our Leaders to Make it Happen

- Time & resources to train additional care team members (RN,LVN, Lead MA's) at all medical sites in telehealth case management visits. (1hr/site)
  - Incorporate new workflows for case management
  - Develop P&P's
  - Add duties to job description and develop skill competencies
- Time & resources to train care team members at all medical sites to identify and engage patients struggling with medication/Bp control, utilizing system generated care panel reports. (0.5hr/site)
  - Expand use of site level patient reports to highlight non-complaint patients

What We Need from Our Leaders to Make it Happen

- QI to develop site specific dashboards that will be posted to each clinic site hub; add dashboard to monthly leadership meetings and quarterly Continuous Quality Improvement Committee meetings to increase transparency/sustain improvement efforts. Dashboard measures:
  - % Uncontrolled blood pressure for patients at high risk of a cardiovascular event
  - % Uncontrolled blood pressure for all homeless patients at high risk of a cardiovascular event
  - % Statin prescription rates for patients at high risk of a cardiovascular event

QUESTIONS

Thank you for your time!

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