Today's Presenters

Samantha Fisher

Director of Patient Services and Engagement

Michigan Primary Care Association

Ben Struble

VP of Operations

Great Lakes Bay Community Health Center

Agenda

INTRODUCTION

Speaker and MPCA Overview

CHARTING THE COURSE TO ACC UTILIZATION

Overview of programs utilizing ACC and insights gained

NAVIGATING NEW CHANNELS: ACC 2.0 CREATION AND IMPLEMENTATION

Overview of the new build and implementation

CHANNELING OUTCOMES: INSIGHTS AND LESSONS LEARNED

Review of workflows and health center outcomes driving further enhancements

Introduction

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Michigan Primary Care Association

- MPCA represents 40 FQHCs and 4 Native American Tribal Health Service providers that are responsible for 1 in 14 Michiganders in rural and urban communities across the state.

- MPCA works to advocate, influence, and advance health policy in Lansing and Washington, D.C., foster collaboration among health centers and with external partners, and support health centers in the continuous pursuit of high-quality, patient-centered services.

- MPCA also operates Michigan's Health Center Control Network (MQIN), Clinically Integrated Network (MCHN), and VirtuALLY – a healthcare IT solutions provider.

mpca **virtu** ALLY **mqin** **mchn** SUPPORTING MICHIGAN HEALTH CENTERS

Michigan Community Health Network

Clinically Integrated Network (CIN) owned by MPCA and 39 of its member health centers

Formed in 2015 by Michigan community health centers for the purpose of group contracting with Michigan Medicaid Health Plans – creating new, sustainable funding opportunities through value-based contracting with primary focus on the triple aim

Negotiates value-based agreements on behalf of its members for the purpose of improving overall outcomes of the patients served and sharing in the resulting cost savings

Currently focused on Medicaid populations with recent diversification into Medicare ACO REACH and MSSP programs

Group Questions

By a show of hands:

How many of you use ACC currently?

How many of you think you're using it to its highest potential?

ACC Utilization Across the Network

Member Health Centers utilize ACC for a variety of programs across the state. Some of these programs are implemented and supported by participation in Value Based Agreements while others are driven by health center specific programming

Utilization currently includes:

- VBA funded CHW Patient Engagement Programs

- Care Management Programs

- Accountable Care Organization (ACO) Programs (REACH and MSSP)

CHW Patient Engagement Program

MPCA partners with 3 Medicaid health plans via Value Based Care Agreements to fund CHW positions at Health Centers

This program prompted the need to build a reporting structure to facilitate receipt of patient data from health plans, generation of outreach alerts, and space for staff to document outreach attempts

This led to Azara and MCHN partnering to form Care Coordination to meet these needs

Historical Workflows

Health centers would receive monthly excel sheets for each health plan they participated in, and they would have to fill out the reportable fields.

These sheets often contained duplicative patient information and caused staff to complete extra work to determine the patient's existing needs.

Enhanced ACC Workflows

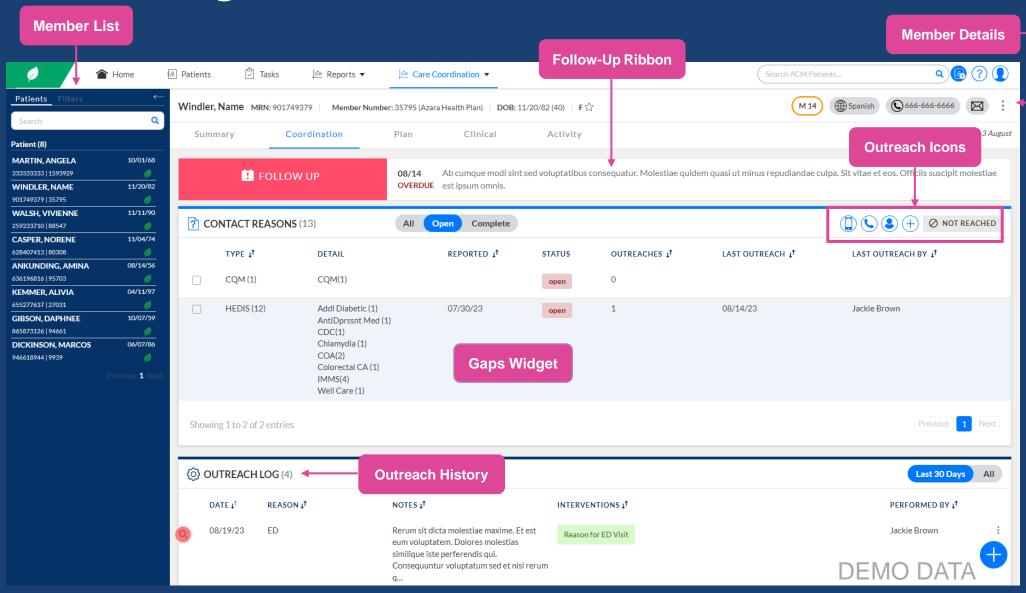Health centers receive monthly reports via ACC which captures the historical outreach completed and allows for staff to review the comprehensive patient profile without having multiple systems open.

CHW Program Documentation

Member List

Member Details

Follow-Up Ribbon

Outreach Icons

Gaps Widget

Outreach History

DEMO DATA
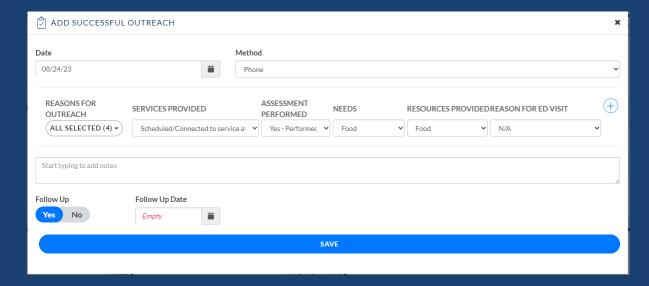
Documentation of Outreach

Successful Outreach
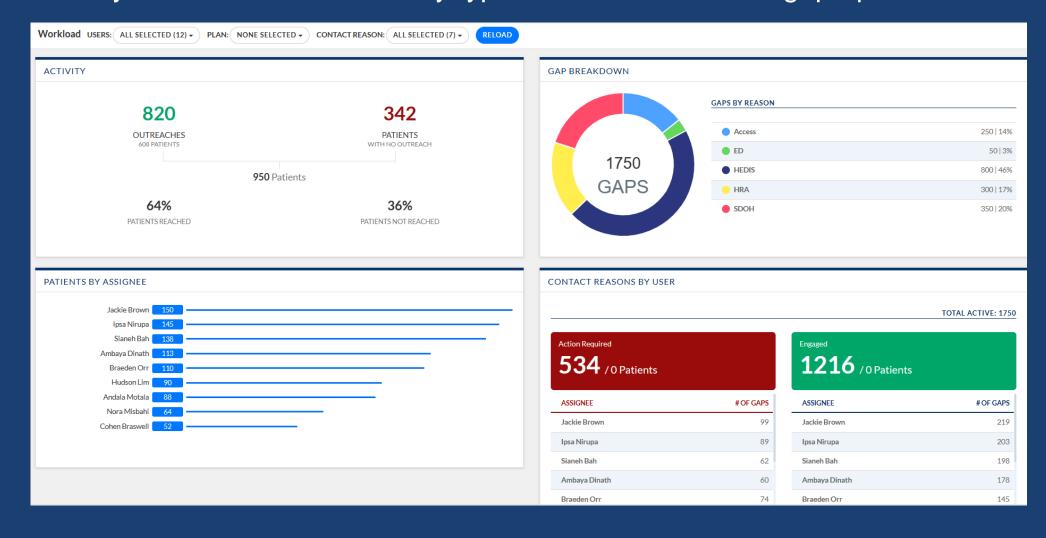
Unsuccessful Outreach

CHW Program Reporting - Workload
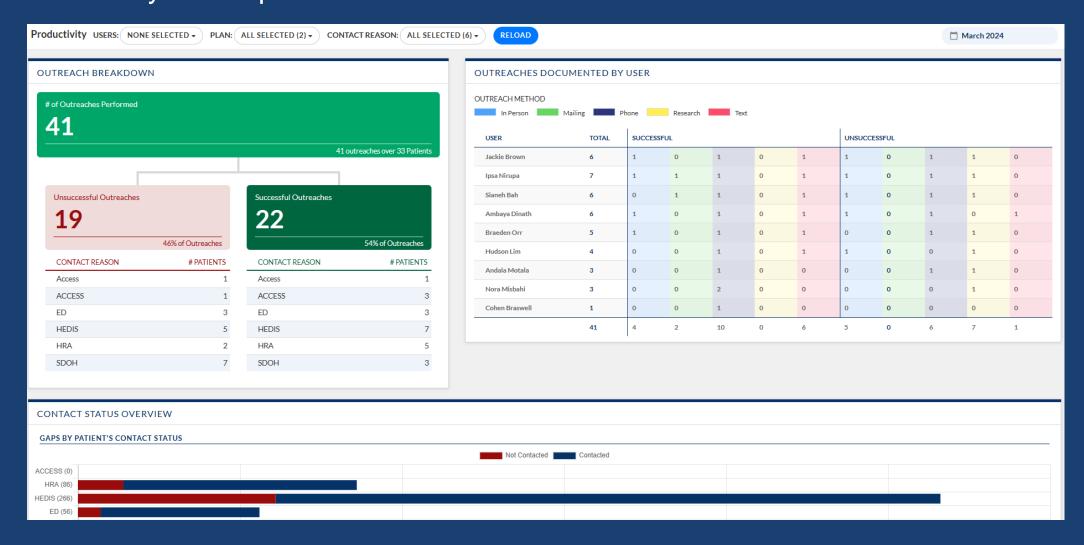
Health centers can review the work assigned to each CHW or Care Coordinator within the system and review work by type of outreach needed/gap open.

CHW Program Reporting

Health centers can review the work assigned completed by each CHW or Care Coordinator by health plan.

Productivity USERS: NONE SELECTED ▾ PLAN: ALL SELECTED (2) ▾ CONTACT REASON: ALL SELECTED (6) ▾ RELOAD   📅 March 2024

OUTREACH BREAKDOWN

# of Outreaches Performed
41
41 outreaches over 33 Patients

Unsuccessful Outreaches
19
46% of Outreaches

Successful Outreaches
22
54% of Outreaches

CONTACT REASON	# PATIENTS
Access	1
ACCESS	1
ED	3
HEDIS	5
HRA	2
SDOH	7

CONTACT REASON	# PATIENTS
Access	1
ACCESS	3
ED	3
HEDIS	7
HRA	5
SDOH	3

OUTREACHES DOCUMENTED BY USER

OUTREACH METHOD
■ In Person ■ Mailing ■ Phone ■ Research ■ Text

USER	TOTAL	SUCCESSFUL					UNSUCCESSFUL				
Jackie Brown	6	1	0	1	0	1	1	0	1	1	0
Ipsa Nirupa	7	1	1	1	0	1	1	0	1	1	0
Sianeh Bah	6	0	1	1	0	1	1	0	1	1	0
Ambaya Dinath	6	1	0	1	0	1	1	0	1	0	1
Braeden Orr	5	1	0	1	0	1	0	0	1	1	0
Hudson Lim	4	0	0	1	0	1	1	0	0	1	0
Andala Motala	3	0	0	1	0	0	0	0	1	1	0
Nora Misbahi	3	0	0	2	0	0	0	0	0	1	0
Cohen Braswell	1	0	0	1	0	0	0	0	0	0	0
	41	4	2	10	0	6	5	0	6	7	1

CONTACT STATUS OVERVIEW

GAPS BY PATIENT'S CONTACT STATUS

■ Not Contacted ■ Contacted

ACCESS (0)
HRA (86)
HEDIS (266)
ED (56)

Program Assessment

Initial Key Insights:

Allowed for required items to be captured within structured data fields for reporting which increased our success within contract requirements

Created a space for CHWs to document that made sense for their scope of work which was not accommodated within EMRs

Allowed for documentation of incorrect demographic information or external PCP usage to be communicated with the health plans

Integrated streamlined workflows across the participating health centers

Noted Areas for Improvement:

Adding additional documentation granularity around "Gap Completion" to note the why behind the completion

Adding additional documentation granularity around the provision of resources to note the how behind the resources provided

Improving reporting capabilities around timeframe and details of outreach performed

Allowing "Not Reached" documentation to only close out intended open gaps rather than all

Increasing interfacing between ACC, DRVS, and the EMR to continue to reduce duplicative documentation

Care Management Programs

Health Centers across our network have implemented a variety of different care management programs
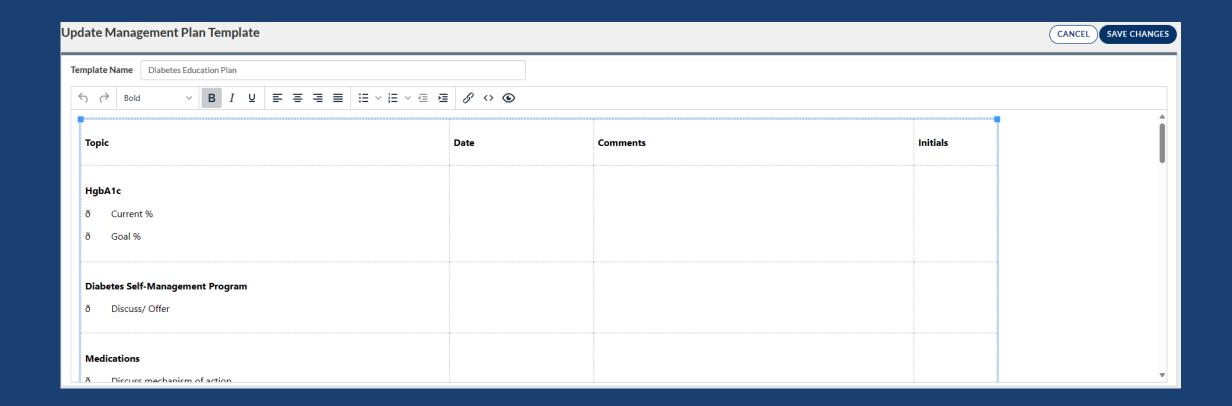
    Transitional Care Management

    Chronic Care Management

    Behavioral Health Home Model

Each of these programs and health centers have found ways to customize ACC to meet their programmatic needs utilizing cohorts and template building within the platform

Care Management Programs

ACO Programs

MCHN partnered with an external organization to assist us in implementing the ACO REACH program across eight health centers in 2023

With this partnership we received access to an external documentation tool that was limited to the Medicare population which caused Health Center staff to practice multiple workflows that were not available to their entire patient population

Due to this limitation, MCHN partnered with **Azara** to work through enhancements needed to accommodate both Medicaid and Medicare documentation

Background

MCHN highlighted critical areas of work that were required for ACO REACH and MSSP programs to be transitioned into ACC

ACO REACH and MSSP required the following to be available:

- Transition of Care alerts and documentation space for both in-patient and emergency department events
- Notification and completion of Medicare Health Risk Assessments
- Identification and grouping of individuals for High-Risk Care Management
- Documentation of comprehensive Risk Assessments
- Documentation of comprehensive Care Management Plans
- Notification and documentation of outstanding Annual Wellness visits and Clinical Quality measures

ACC Enhancements

ACC currently enables practices to organize patients into groups of high cost, risk, or other characteristics such as chronic disease and allows the Care/Case Management and Care Coordination staff to manage and monitor this panel of patients by developing care plans and tracking the day-to-day tasks and follow-up activities related to their care.

Areas of Enhancement to Meet ACO Requirements:

Assessments

Processing Rules

Robust Care Plan

Automated Tasks

ACO Level Access

Reporting

Care Coordination Enhancements

All patient information is from a demo environment and does not contain real PHI

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Care Coordination

Each month a patient attribution file from CMS is uploaded to the care coordination directory.
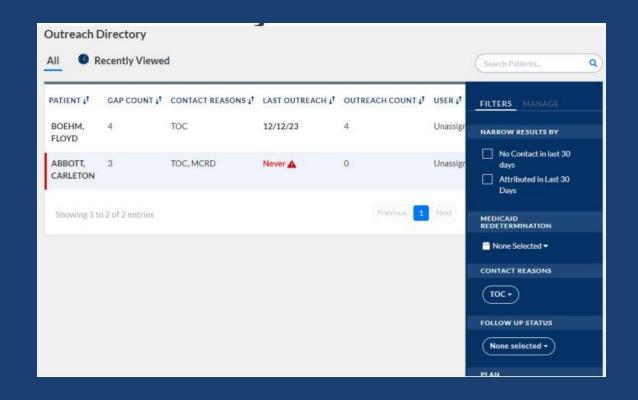
This is where staff review open care gaps and complete outreach documentation

Gaps indicated in the directory are:

Transitions of Care (TOC)
Medicare HRA (PRP+)
Clinical Quality Measures (CQM)

Staff will be able to filter patients by the following:

Assigned Care Coordinator/Care Manager
Contact Reason (Gaps)
Follow-Up Status
Assigned PCP

Transition of Care Gaps
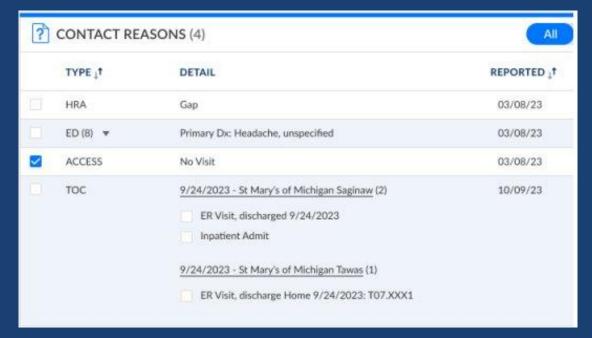
Data flows from Michigan's HIE (MiHIN) into DRVS for TOC events (Inpatient and Emergency Department) which triggers a TOC alert to pop up within Care Coordination.

Each gap is grouped by:

Admit Date

Location, including:
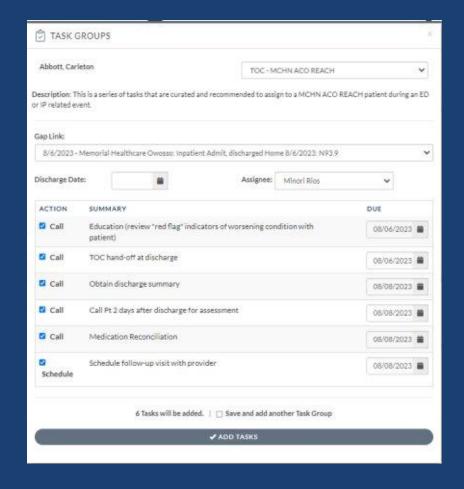
- Event Type

- Discharge Status Description

- Discharge Date

- Discharge Diagnosis
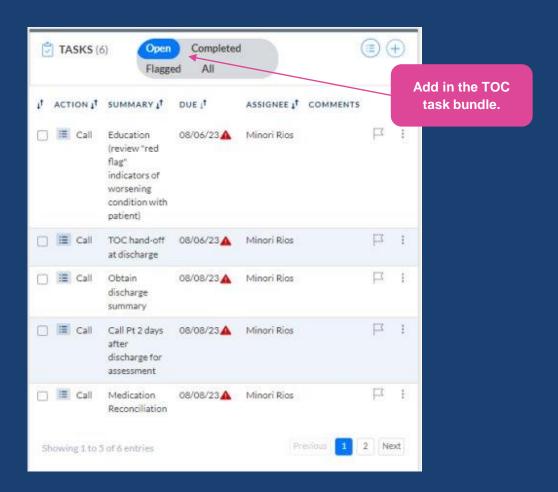
Coordination Tab – TOC Tasking

The task panel was added to the coordination tab and shows tasks created by users within the system that are either assigned to an open TOC gap or independent tasks for follow-up related to other gaps/work. Tasks created within Care Coordination will also now show up within the task panel in Care Management.

Add in the TOC task bundle.
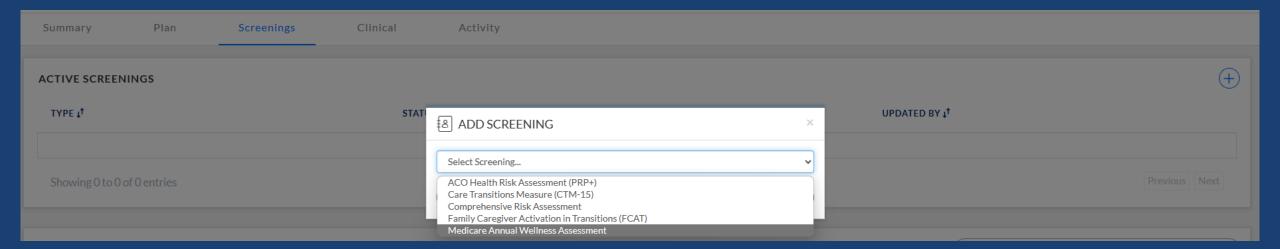
Screenings Tab

Once, in a patient's profile, an additional tab was created to house assessments pertinent to the ACO program, which includes the following options:

- Care Transitions Measure (CTM-15)
- ACO Health Risk Assessment (PRP+)
- Medicare Annual Wellness Assessment
- Comprehensive Risk Assessment
- Family Caregiver Activation in Transitions (FCAT) Tool

Screenings Tab

Screenings can be saved in a draft form if staff are unable to complete it with the patient in one sitting and can also be exported to a PDF upon completion.

Care Management Enhancements

All patient information is from a demo environment and does not contain real PHI

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Promoting Patients to Care Management
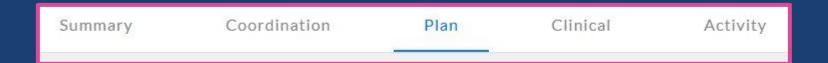
All patients added into ACC from the BAR file are added to Care Coordination. Upon review from health center staff, if appropriate, they will be promoted to care management to be included in the high-risk care management cohort.

Once a patient has been identified to promote to care management, within their profile in care coordination staff will complete the following steps:

1. Navigating to the three dots in the upper right-hand corner, staff will select "Add Patient to CM"
2. Staff will then select the cohort "ACO Program CM" from the drop-down menu.

3. Once the patient has been added to the cohort, they will have "Plan" added to their tab selection at the top.

Plan Tab Enhancements

Enhanced the documentation options by adding structured data fields and providing resources for plan building via Elsevier content.

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Update the assignment for Care Manager, if needed. This manual assignment will not override the EMR assignment if your org uses that information for other programs.

Free text section you can use to document. You can create templates to drop in as well.

Elsevier content to review if you need assistance building the Care Plan.

Structured documentation section that can be independently curated or you can use Elsevier driven content.

ZzRCM Unidentified, Misc 2022   MRN: 000000103203 | DOB: 1/5/22 (26 months) | O☆

Summary   Plan   Screenings   Clinical   Activity

FOCUS
No focus to display

CARE TEAM
Intervention Effort	Not Set
Care Manager	Unassigned
Usual Provider	Unassigned Provider

MANAGEMENT PLAN
No management plan to display

RECOMMENDED RESOURCES   VIEW LIBRARY

BARRIERS TO CARE   All | Active | Met | ⊕
IDENTIFIED	BARRIER	ACTIVITY	NOTES	UPDATED	PRIORITY	OWNER
			No Barriers To Care to Display			

GOALS   All | Active | Met | ⊕
DUE	GOAL	ACTIVITY	NOTES	UPDATED	PROGRESS	PRIORITY	OWNER
			No Goals to Display				

SELF-MANAGEMENT GOALS   All | Active | Met | ⊕
DUE	GOAL	ACTIVITY	NOTES	UPDATED	PROGRESS	PRIORITY	OWNER
			No Self-Management Goals to Display				

EDUCATION   All | Active | Met | ⊕
DUE	GOAL		NOTES	UPDATED	PROGRESS	PRIORITY	OWNER
			No Education to Display				

Plan Tab Enhancements

Allowed for structured data fields to minimize the need for free text and to streamline the key items included within the larger care plan

Plan Tab Enhancements

You can export the care plan as a PDF summary to add into your EMR or provide the patient.

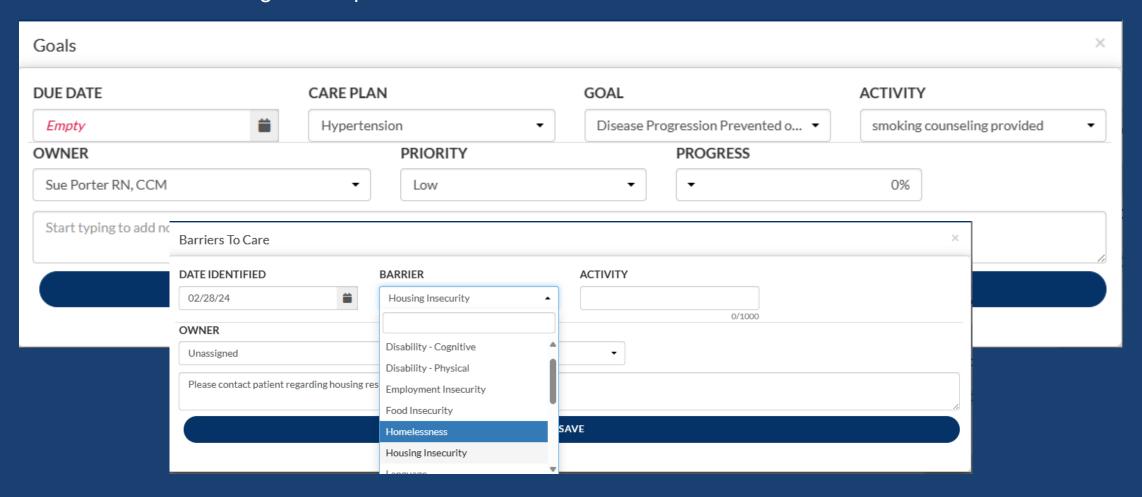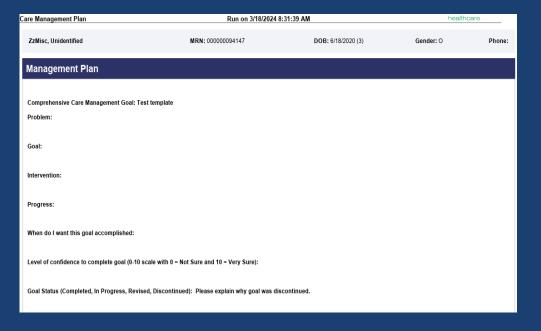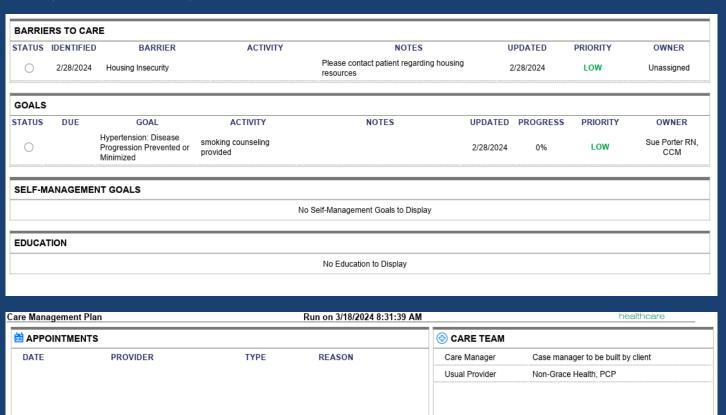| Care Management Plan	Run on 3/18/2024 8:31:39 AM	healthcare

ZzMisc, Unidentified	MRN: 000000094147	DOB: 6/18/2020 (3)	Gender: O	Phone:

Management Plan

Comprehensive Care Management Goal: Test template

Problem:

Goal:

Intervention:

Progress:

When do I want this goal accomplished:

Level of confidence to complete goal (0-10 scale with 0 = Not Sure and 10 = Very Sure):

Goal Status (Completed, In Progress, Revised, Discontinued): Please explain why goal was discontinued.

BARRIERS TO CARE

STATUS	IDENTIFIED	BARRIER	ACTIVITY	NOTES	UPDATED	PRIORITY	OWNER
○	2/28/2024	Housing Insecurity		Please contact patient regarding housing resources	2/28/2024	LOW	Unassigned

GOALS

STATUS	DUE	GOAL	ACTIVITY	NOTES	UPDATED	PROGRESS	PRIORITY	OWNER
○		Hypertension: Disease Progression Prevented or Minimized	smoking counseling provided		2/28/2024	0%	LOW	Sue Porter RN, CCM

SELF-MANAGEMENT GOALS

No Self-Management Goals to Display

EDUCATION

No Education to Display

Care Management Plan	Run on 3/18/2024 8:31:39 AM	healthcare

📅 APPOINTMENTS				⊕ CARE TEAM	
DATE	PROVIDER	TYPE	REASON	Care Manager	Case manager to be built by client
				Usual Provider	Non-Grace Health, PCP

Elsevier Content

Selecting "View Library" from within the Plan tab will take you to a listing of 60 conditions for you to select from.

Care Plan Library	
TITLE	**LAST UPDA**
Anxiety	11/16/23
Anxiety Peds	11/16/23
Asthma	11/16/23
Asthma Peds	11/16/23
Atrial Fibrillation	11/16/23
Autism	11/16/23
Autism Peds	11/16/23
Bronchiolitis Peds	11/16/23
Cancer Posttreatment Phase	11/16/23
Cancer Posttreatment Phase Peds	11/16/23
Cancer Treatment Phase	11/16/23
Cancer Treatment Phase Peds	11/16/23
Chronic Kidney	11/16/23
Chronic Kidney Peds	11/16/23
Chronic Pain	11/16/23
Chronic Pain Peds	11/16/23
COPD	11/16/23
Coronary Artery Disease	11/16/23
Cystic Fibrosis	11/16/23

Elsevier Content

Once you have selected the condition you would like to review, you will be provided with a PDF of a care plan guide that offers recommendations for goals, assessments, and interventions along with the resources behind the recommendations.

Care Planning

Care Plan Guide
Anxiety
Setting: Ambulatory
Target Population: Adult

Clinical Description

Care of the ambulatory/primary care patient experiencing persistent and excessive anxiety or worry characterized by restlessness, feeling keyed-up or on edge, becoming easily fatigued, having difficulty concentrating or "mind going blank", or experiencing irritability, muscle tension and sleep disturbances.

Key Information

- Once a person's stress response begins to interfere with his or her ability to function, an anxiety diagnosis should be considered.
- Obsessive-compulsive disorder and posttraumatic stress disorder are closely related to anxiety disorders, which some may experience at the same time.
- Early treatment may reduce functional limitations, disability, health care utilization costs, physical complications and comorbidities.
- Anxiety increases risk for suicide.
- There is conflicting opinion regarding an increase in suicidality with the use of selective-serotonin-reuptake inhibitors in adults.
- Suicidal ideation with access to lethal means constitutes a psychiatric emergency.
- Medication side effects and effects of intoxication or substance withdrawal must be considered during diagnosis. Medications, medical comorbidities and other psychiatric conditions often overlap anxiety.

Goals

Within a mutually determined timeframe or by transition of care:

A. The patient will achieve the following:
- Anxiety Symptoms Identified
- Anxiety Symptoms Monitored and Managed
- Harm or Injury Prevented

B. Patient, family or significant other will teach back or demonstrate education topics and points:
- Anxiety: Overview
- Self-Management
- When to Seek Medical Attention

Assessment

Potential Problem or Focus of Care:
- Anxiety Identification
- Anxiety Symptoms
- Harm or Injury

Intervention

Correlate health status to:
- history, comorbidity
- age, developmental level
- sex, gender identity
- baseline assessment data
- physiologic status
- response to medication and interventions
- psychosocial status, social determinants of health
- barriers to accessing care and services
- health literacy
- cultural and spiritual preferences
- safety risks
- family interaction
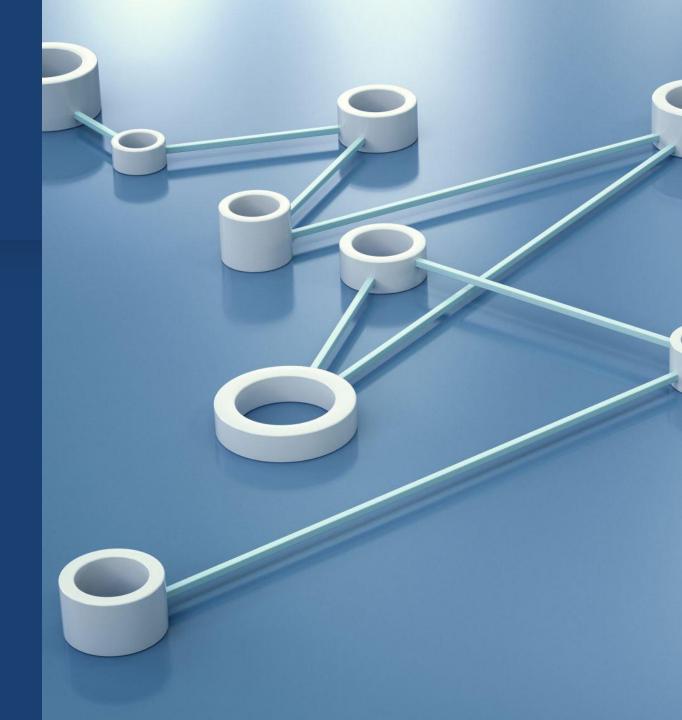
Lessons Learned:

Ensure worked is mapped out and considered from a staff role perspective to ensure workflows are comprehensive of different task types

Streamline nomenclature utilized

Include cross-functional teams in the updates to effectively communicate changes to the system

Verify data mapping and interface opportunities being utilized

Insights and Next Steps:

Separation of transition of care alerts to indicate ED vs. In-Patient to improve the staff assignment and workflow

Implementing reporting within Azara for Health Centers to access to review work completed and opportunities for improvement
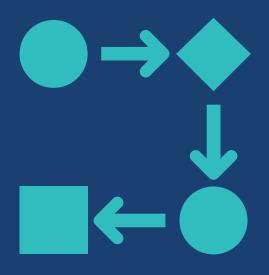
Implementing more structured documentation opportunities to capture detailed outreach outcome information

Enhancing visualization of the structured care plan

Key Takeaways

Successful implementation takes time!
- Identify the key performance indicators you have for any program you're looking to implement
- Work to customize the system and workflows to fit your needs
- Pilot implementation to identify any missing components

Staff input and commitment is crucial to success

Ensure **mapping with your EMR** is correct and that structured data fields are utilized as much as possible

Documentation resources and auditing are important pieces to ensure **streamlined workflows and accuracy**

Great Lakes Bay Health Centers

Servicing 16-country region in Mid-Michigan

56,411 patients (2023 UDS)
232,926 visits (2023 UDS)

Services: Primary Care, OB/GYN, Integrated and Traditional Behavioral Health, Substance Use Disorder, Dental, Migrant Health Care, Pharmacy, Optometry, School-Based Health, Physical Therapy, HIV Prevention and treatment, X-Ray, Mammography, Transportation, Doula Services, Hepatitis C Treatment.. and much more!

Transitioned from Athena Practice to AthenaOne in October 2023

Azara Products: DRVS, Azara Care Connect, Risk Stratification, Referral Management, Controlled Substance, Transitions of Care

Then and Now, an ACC Story

- Spreadsheets→ Single Source Solution (ACC)

- Care Management notes in chart → meaningful template (ACC)

The Beginning

Health Plan Community Health Worker Program

Funding FTE allocation for CHW:
- Meridian
- United Health
- Molina

Each month files were manipulated and combined by hand!

The Evolution

PATIENT ↓↑	GAP COUNT ↓↑	CONTACT REASONS ↓↑	LAST OUTREACH ↓↑	OUTREACH COUNT ↓↑	USER ↓↑	↓↑
MARTIN, ANGELA	5	ED, SDOH, HEDIS, CQM	03/16/24 ⚠	4	Jackie Brown	📅! 4
ROGAHN, KENTON	2	ACCESS, CQM	04/11/24	2	Jackie Brown	📅! 2
LOWE, TATUM	17	HEDIS	04/14/24	3	Jackie Brown	📅! 3
ANDERSON, CAYLA	3	ED, CQM	04/16/24	3	Jackie Brown	📅! 3
LYNCH, LETHA	1	ED	Never ⚠	0	Jackie Brown	📅 0
HOWE, OMER	1	HRA	04/07/24	3	Jackie Brown	📅 3

DEMO DATA

FILTERS   MANAGE

NARROW RESULTS BY

☐ No Contact in last 30 days
☐ Attributed in Last 30 Days

CONTACT REASONS

6 selected ▾

FOLLOW UP STATUS

None selected ▾

PLAN

None selected ▾

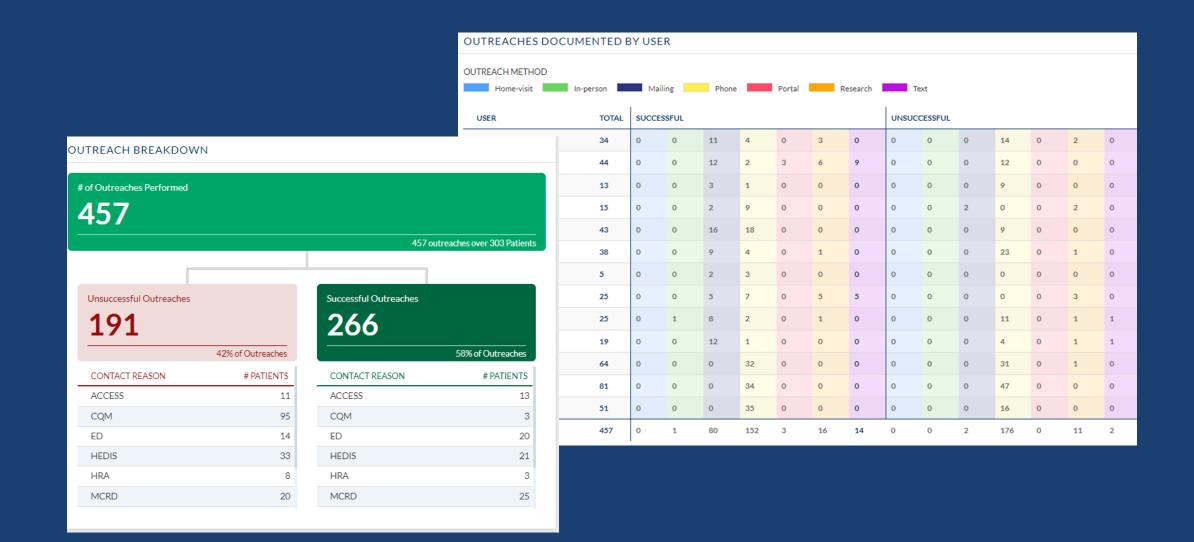Patient lists are managed within ACC with record of outreach type (letter, call, text)

ACC Tasking

Tasks and lists created to remind CHWs of upcoming actions needed

Productivity Tracking

Care Management and ACC

Before Azara Care Management and EHR Plug In:

Does the patient have a Care Plan?

Where is this documented?

Does it satisfy PCMH-NCQA criteria?

GLBHC Care Plan

- Patient consent to participate in Care Management Services-
- Assessment of patient current status
  - Disease state- uncontrolled type 2 DM, obesity
  - Trends in labs/outcomes- A1C 11.1, BMI 46.28
  - Orders and Referrals
  - Patient understanding of disease state- good
  - Gaps in care have been addressed- yes
- Screenings completed and needs identified- yes
- Engagement
  - Readiness for change- 10/10
- Goals
  - Treatment goal
  - Self Management Goal
  - Lifestyle Goal- To lose 10lb by December, 2023 (starting weight 322.6lb)
- Interventions
- 1. Eat less sweets and snacks
- 2. Continue to work on portion control, especially with carbohydrates
- 3. To use the pedal machine or free weights while watching television
- 4. Increase and take Lantus daily
- Care Plan update
- Barriers- back pain
- Solutions- focus on dietary changes as physical activity is not a good option
- Support System- Bayside care team
- Follow up plans
  - Next appointment/contact
  - Review Call Me First- yes
- Care Team Contacts- given

Accountable Care Organization (ACO).. The Journey

January 2023, Great Lakes Bay Health Centers joined an ACO (REACH Model)

Process:
1. Complete Health Risk Assessment (HRA).
2. Patient given a score based on HRA and ADT information (High, Medium, Low)
3. High Risk patients are care managed

Barriers and Solutions

Separate portal with another vendor

Redundancy! Risk scoring, double document (EHR and vendor portal)

Basic information (ADT, SDOH) based on CMS data (old data)

Documentation is not readily available to care team

In February 2024, ACO documentation moved to ACC 2.0. All documentation is included in Azara!

Questions?

Azara healthcare

@AzaraDRVS
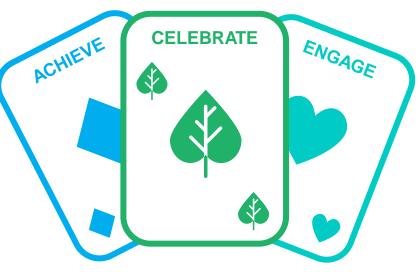
Achieve, Celebrate, Engage!

ACE'd it? Share your DRVS success story and become an Azara ACE!

Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

Benefits:
- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Win Azara swag!

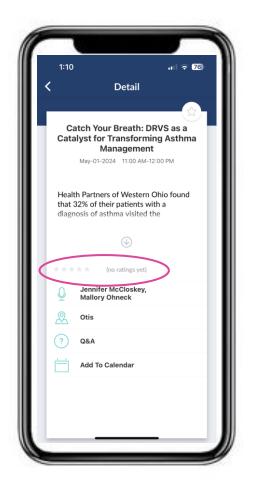**Submit your success story by completing the form <u>at this link</u> or scan our QR code:**
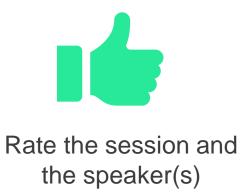
See this year's ACE posters in the Ballroom Foyer!

We Want to Hear From You!

Click on the session from your agenda in the conference app.
Click the stars in the center of your screen to rate and provide feedback.

Quick and Easy

Provide brief feedback or ideas

Rate the session and the speaker(s)

Help us continue to improve