Patients Ahoy!

Functionality and Features of DRVS Cohorts

PRESENTED BY:

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Today's Presenters





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Agenda



BACKGROUND INFORMATION

WHAT ARE COHORTS?

TYPES & USES OF COHORTS

ADVANTAGES & CHALLENGES

NEXT STEPS FOR COHORTS AT AHL







To Set The Scene













Services Lines:

- Primary Care
- Behavioral Health
- Dental

- Podiatry
- Cardiology
- Nephrology



Why Does AHL Use Cohorts?





Focus

Create a subset of patients from both a clinical and population health perspective.



Care

Increase enrollment in care management programs & monitor progress and outcomes.



Alert

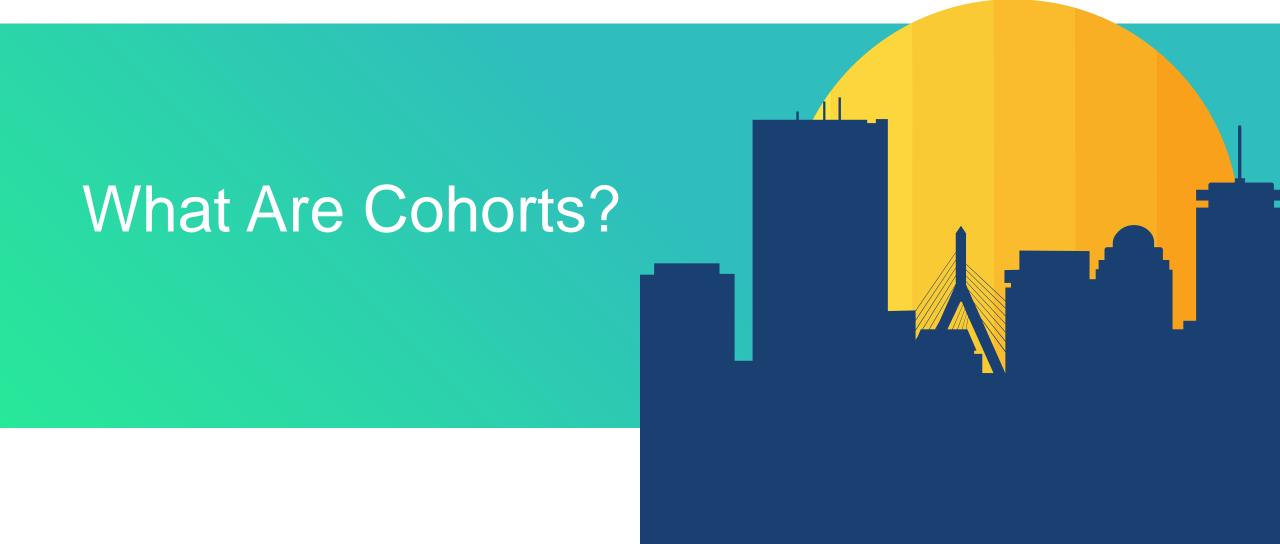
Make clinic staff aware of patients in different groups & ensure patients have appropriate forms completed.



Compare

Track performance of care managed patients compared to the general patient population.





Cohort Basics

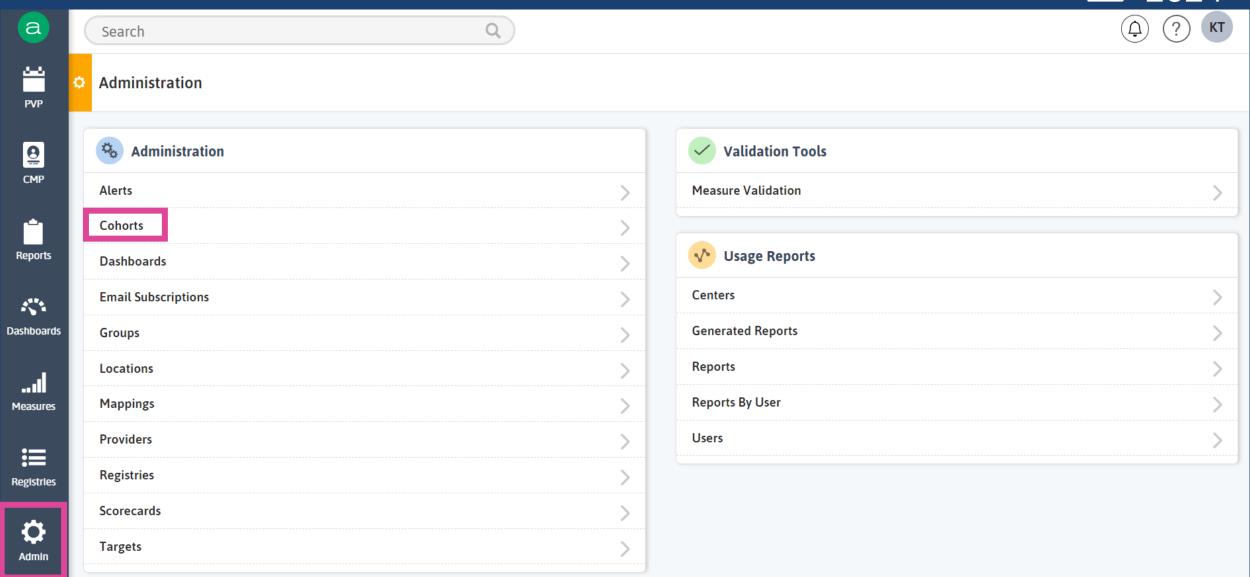


- What: A group of patients with a shared characteristic
- Who: Defined by YOUR criteria all you need is a patient list
- How: Created in the cohort administration

 Dynamic Cohorts: Azara defined populations, updated nightly

 Static Cohorts: Created by the practice, manually maintained
- Where: Displayed on the PVP, in ACC, and anywhere you find the Cohort filter









Search

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Cohort Administration (i) + Create Cohort

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	Q	Q All	Q All Enabled	Q All Enabled Disabled

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Create Static Cohort	×
NAME*	CENTER
Name of Cohort	Access Health Louisiana
DESCRIPTION	
Description of Cohort	
STATUS Enabled Disabled DISPLAY ON PV	Yes No
ADD PATIENTS TO COHORT	
Upload a text file of MRNs into this box. Each MRN should have its own <i>Download Sample File</i>	Choose File
Cancel	Confirm













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Search







PVP











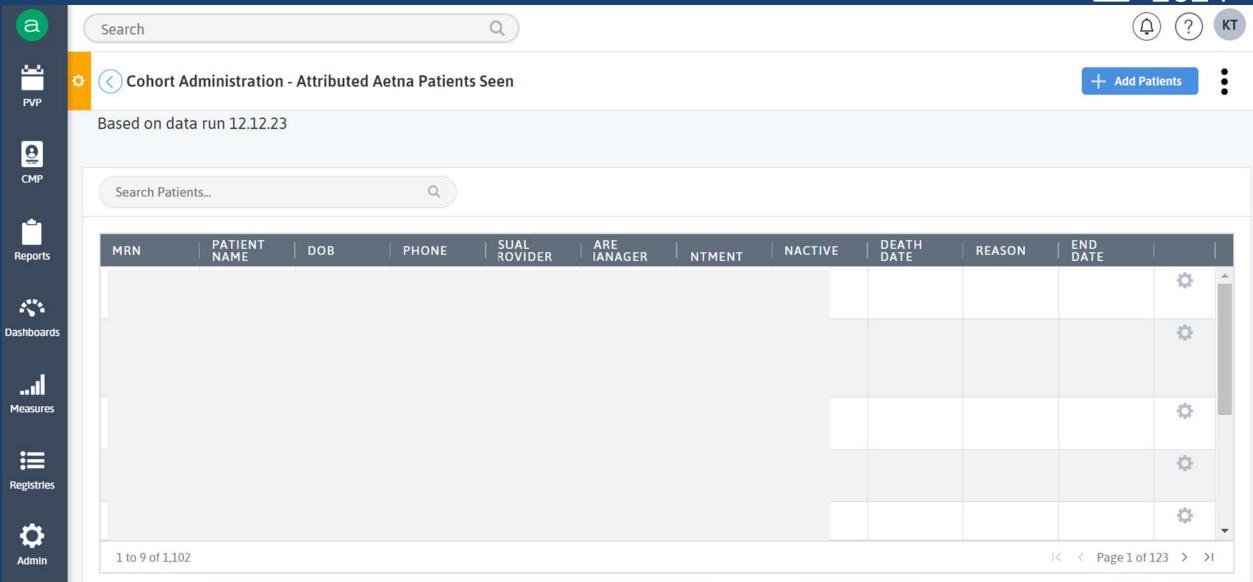


Cohort Administration (i)

Search Cohorts... Q All Enabled Disabled

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Cohort vs. Registry



Cohort

- Completely customizable to meet your needs
- Must be created/updated manually (if static)
- Only has a time component if you establish one
- Can appear on the PVP & ACC
- Essentially a patient list

Both

- Focus on a specific population
- Can be used to filter key patients
- Tools for population health management

Registry

- Bound by the available DRVS data elements
- Automatically updates with EHR data
- Has a date range built into it
- Will not appear on the PVP or in ACC
- Patient list with various data points



Types & Uses of Cohorts



Why Use Cohorts?



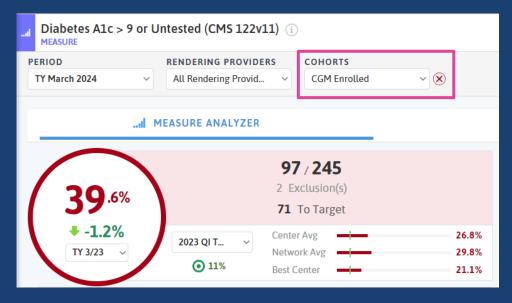
Identify

- Call out specific populations of patients
- Communicate with care teams via the PVP

Visit Reason: BH FU Telemed 30 f/u med mgmt Portal Access: 08/11/2020 PCP: KENT. CLARK Payer: UNITED Cohorts: CGM Enrolled, Diabetic **Pharmacy Patients HEALTHCARE COMMUNITY PLAN CM:** Unassigned MESSAGE DATE RESULT Overdue 11/27/2023 6.6 Refused 11/27/2023 Missing

Track

- Review and track outcomes for a specific group
- Compare outcomes between groups



Succeed

- Monitor performance for value-based contracts
- Compare members attributed vs. not attributed

COHORTS						
Attribute	Attributed Aetna Pat V					
90.4%	+ 11.8% 🔺	86.0%				
54.9%	+ 8.9% 🔺	53.0%				
41.7%	+ 6.0% 🔺	59.0%				
59.1%	+ 9.9% 🔺	65.0%				
66.7%	+ 4.2% 🔺	75.0%				
17.9%	- 0.5% ▼	11.0%				

Cohort "Buckets" at AHL





Clinical

Used to alert care team members using the PVP



Quality

Used to track and monitor outcomes for defined groups



Value-Based

Used to track attributed & non attributed members for valuebased contracts

Clinical Cohorts



Cohort Name(s)	Details	Workflow
CCM Enrolled & CCM Eligible	Medicare with 2+ chronic conditions	Identify patients & discuss CCM program/refer eligible patients
CGM Enrolled & CGM Eligible	Diagnosis of diabetes & prescribed insulin (enrolled if using CGM)	Identify patients & discuss CGM/place order for eligible
Diabetic Pharmacy Patients	Prescribed one of several diabetic medications and not using our in-house pharmacy	Identify patients & discuss using AHL Pharmacy/send prescriptions if patient agrees
ICCM Enrolled & ICCM Eligible	Diagnosis of depression/anxiety, (+) PHQ-9 or GAD-7, not currently seeing AHL for BH	Identify patients & discuss ICCM program/refer eligible patients
RPM Patients	Have one of our RPM kits	Identify patients & discuss RPM
MAT Enrolled & MAT Eligible	F11 diagnosis and/or prescribed Narcan and/or Naloxone	Identify patients & discuss MAT program as well as (+) CAGE-AID/refer eligible patients
Medicaid Benefits Expired/Expiring	Medicaid with recently expired or soon to expire benefits	Identify patients & connect patient with Medicaid enroller
REACH Patients & REACH Eligible Patients	Traditional Medicare aligned to AHL/not aligned & had PC visit	Identify patients & perform MAWV as well as discuss SDOH needs/submit form for eligible

Quality/Analytics Cohorts



Cohort Name	Details	Use Case
Dyn – Depression/Anxiety	Diagnosis of depression/anxiety	Use as a filter for measures or export and use for other reporting
Dyn – Diabetes	Diagnosis of diabetes	Use as a filter for measures or export and use for other reporting
Dyn – ER Visit	ER visit in the last 14 days discharged home with no follow up scheduled	Outreach patients and schedule follow up with AHL
Dyn – HIV	Diagnosis of HIV	Use as a filter for measures or export and use for other reporting
Dyn – Hypertension	Diagnosis of hypertension	Use as a filter for measures or export and use for other reporting
Dyn – IP Visit	IP visit in the last 14 days discharged home with no follow up scheduled	Outreach patients and schedule follow up with AHL
Dyn – Uncontrolled Hypertension	Diagnosis of hypertension with most recent BP >140/90	Use as a filter for measures or export and use for other reporting & determine if need clinical change
PC & BH Integrated Patients	Had both a PC & BH visit in the last 12 months	Use as a filter for measures or export and use for other reporting

Value-Based Contract Cohorts



Cohort Name	Details	Use Case
Attributed Patients Seen (for each Medicaid plan)	Patients attributed to AHL on the plan rosters and have had an encounter with AHL in the last 12 months	Monitor how attributed patients are doing with various contract measures
Non-Attributed Patients Seen (for each Medicaid plan)	Patients not attributed to AHL (so not on the plan rosters) that have that insurance plan and have had an encounter with AHL in the last 12 months	Monitor how non-attributed patients are doing with various contract measures, especially compared to attributed patients/provide the plans a list of patients with that insurance who are seeing AHL

Cohorts & Reporting



- Use cohorts as a filter for measures/reports
- Much easier & faster to see this information in DRVS versus pulling multiple reports out of the EHR and comparing everything in Excel
- Can monitor performance of various cohorts
- Compare performance of different cohorts or even various cohorts to the overall population
- Look at if your interventions are working for different groups
- Export the cohorts to use as a reference point for reporting outside of DRVS





The Advantages





Customizable

- Customizable to your own criteria
- Only need MRNs to start



Analysis

- Can be used in every other aspect of DRVS
- Easily exported to Excel



Simplicity

- Easy to narrow down a patient population
- All housed in one location



Maintenance

- Update as needed
- Dynamic cohorts connect to the EHR

The Challenges





Manual

- Can only upload 100 patients at a time
- Remove patients individually



Definitions

Keeping all of the criteria straight for each cohort



Buy In

Getting clinic staff on board



Maintenance

Updating static cohorts to have up-to-date information

Overcoming the Challenges





Manual

- Create a text file & upload as many patients as needed
- Create a new cohort



Definitions

Refer to the cohort "cheat sheet" or other documentation



Buy In

"Cheat sheet" explaining purpose and care team member's role for each cohort



Maintenance

Create calendar reminders for yourself to update cohorts



Future of Cohorts at AHL



What's Next?



More specific integrated care cohorts

- Patients with 2+ BH visits and 1+ PC visit in a 12-month period
- Separate cohorts based on that visit criteria by diagnosis:
 - Depression/Anxiety
 - Hypertension
 - Diabetes
- For each diagnosis, three cohorts will be created:
 - Behavioral Health patients only
 - Primary Care patients only
 - Integrated patients (based on the visit criteria above)

Cohorts by visit count

- Separate cohorts for only 1 visit and 2+ visits in a 12-month period
- Will primarily focus on Primary Care

Why These Next Cohorts?



More specific integrated care cohorts

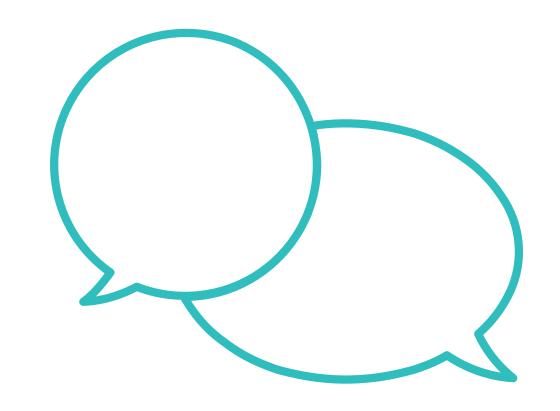
 Look at outcomes (A1c, BP, PHQ, etc.) for patients with depression/anxiety, hypertension, and diabetes to see if integrated patients have better outcomes

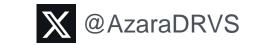
Cohorts by visit count

- Look at measures for patients who are more active with AHL versus patients who may have had a one-off visit to see if they more accurately reflect how we are managing our patient population
- Compare patients with 1 versus 2+ visits to see if more visits correspond to better outcomes

Questions?







Achieve, Celebrate, Engage!



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

Show your organization has used DRVS to Achieve measurable results, Celebrate improvement in patient health outcomes, and effectively Engage 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 at this link or scan our QR code:

See this year's ACE posters in the Ballroom Foyer!

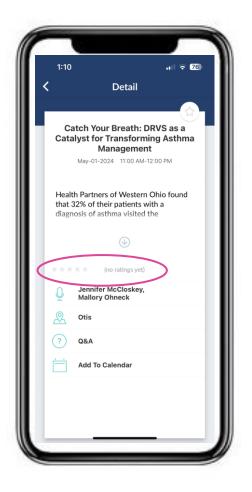


We Want to Hear From You!

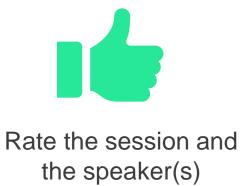


Click on the session from your agenda in the conference app.

Click the stars in the center of your screen to rate and provide feedback.













Thanks for attending!

