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WAIANAE COAST COMPREHENSIVE HEALTH CENTER

CASE STUDY

Care Transformation on Oahu:

A 10-Year Population Health Journey at Waianae Coast Comprehensive Health Center

Overview

As the largest Federally Qualified Health Center (FQHC) on the island of Oahu, Waianae Coast Comprehensive Health Center (WCCHC) serves one of the most diverse and vulnerable populations in Hawaii. Many communities face high rates of chronic disease, limited access to preventive care, and significant social determinants of health (SDOH) barriers.

Over the past decade, WCCHC has made substantial technical and operational strides to improve clinical and financial outcomes, while becoming a nationally recognized leader for care quality. At the heart of WCCHC's journey has been its 10-year partnership with Azara Healthcare and the adoption of its Best in KLAS population health and value-based care platform, Azara DRVS, for unified population health insights. Over the course of this decade-long collaboration, WCCHC and Azara have championed significant improvements in care delivery, from reducing chronic disease burdens to closing gaps in preventive services. Today, four of WCCHC's sites of care have earned NCQA Patient-Centered Medical Home (PCMH) recognition, while the center continues to address longstanding health disparities across its diverse communities.

Challenge

WCCHC serves more than 35,000 individuals and handles over 196,000 annual visits, making it a vital lifeline for Oahu's west coast. WCCHC's communities face some of the highest rates of chronic disease in the state, with conditions like diabetes, hypertension and asthma disproportionately impacting health and well being.

Beyond managing these chronic conditions, WCCHC is committed to providing essential preventive care services, such as immunizations and cancer screenings. The COVID-19 pandemic, however, severely disrupted these efforts, widening care gaps and placing even greater strain on the center's ability to meet value-based care goals.

In a region where geographic isolation and limited access to specialty care compound these challenges, the center needed a data-centric, population health approach to track chronic and preventive care needs more efficiently across its community sites. Moreover, WCCHC required a long-term partner that would not only help address current care gaps but ensure continued improvements across a range of clinical quality measures.

The Solution

WCCHC embarked on its data-driven journey with Azara Healthcare in 2013, adopting its award-winning population health and value-based care platform, Azara DRVS, to better meet the unique health needs of its population. As the center recognized the platform's broader potential to drive clinical, operational and financial performance, the partnership with Azara evolved tremendously, allowing the organization to address increasingly complex healthcare challenges.

Initially focused on addressing care gaps with the DRVS Patient Visit Planning (PVP) tool, WCCHC utilized the platform to automate and streamline workflows, enhance coordination across sites of care, and identify critical moments for interventions.

Leveraging the PVP or 'huddle report' allowed WCCHC to engage all care team members, from medical assistants to providers, in prioritizing interventions and making informed decisions during daily huddles. This proactive and collaborative approach drove success early on, enabling the FQHC to replicate best practices across its sites and expand the impact of the PVP across other communities.

Within the first year, WCCHC surpassed its targets for four of six key measures, driving significant improvements in critical areas such as preventive screenings, chronic disease management, and patient outcomes, including:

- **Early Care Gap Closure:** The PVP enabled WCCHC care teams to close care gaps proactively, ensuring patients received timely preventive screenings, chronic disease management, and essential follow-ups.
- **Improved Data Accessibility:** By centralizing patient data across its community sites, WCCHC empowered care teams with real-time insights, improving chronic disease management for conditions like diabetes and hypertension.
- **Strengthening Leadership and Teamwork:** Monthly performance reports and data-driven reporting cultivated a culture of continuous improvement and collaboration among leadership and clinical teams. Regular performance reviews and team-based care approaches allowed managers to track progress and respond to evolving patient needs.
- **Building for Long-Term Growth:** Establishing custom registries, alerts, and performance reports within DRVS laid a solid foundation for WCCHC to expand its capabilities and address increasingly complex healthcare challenges in the years ahead.

Over time, WCCHC expanded its use of DRVS to include custom registries, alerts and reporting tools to provide actionable insights at the point of care and enable the organization to monitor and drive key improvements across multiple measures:

- **Custom Asthma Registry Data Element:** To monitor first-line therapy for asthma patients, improving care management.
- **Care Effectiveness Report:** Used to track school days missed due to asthma, particularly impactful for the center's school-based clinics.

After 2020, WCCHC's partnership with Azara entered a new phase of transformation, as the center looked to address increasingly complex and persistent health challenges for its communities:

- **Enhanced Chronic Disease Control:** WCCHC sought to improve hypertension control rates and diabetes management through more targeted interventions.
- **Preventive Care Rebound:** Following the challenges posed by the COVID-19 pandemic, WCCHC sought to close gaps in immunizations and cancer screenings.
- **School-Based Health Innovations:** WCCHC's school-based clinics needed insights into student absences due to asthma.

Streamlining Community Health with the PVP

The DRVS Patient Visit Planning tool prepares care teams for patient encounters by providing critical data insights at the point of care:

Utilizes "huddle reports" for pre-visit planning and prioritizing interventions during daily meetings.

Identifies care gaps to ensure timely preventive screenings, chronic disease management, and follow-ups.

Presents actionable data to the clinical team, aligned with each patient's visit schedule.

Results: A Decade of Impact Across Oahu

Over the course of the past decade, WCCHC's partnership with Azara has enabled the center to leverage various data sources to streamline operational efficiencies and deliver measurable improvements in quality reporting and patient outcomes.

The impact of this decade-long collaboration has empowered WCCHC to tackle chronic conditions, close gaps and integrate behavioral and SDOH data, all while addressing the unique challenges faced by its diverse population, including:

1. **Asthma Care:**
   WCCHC increased the percentage of patients with documented asthma action plans by 40%, enabling more proactive management of asthma and reducing hospitalizations due to asthma-related complications.

2. **Depression Screening:**
   WCCHC achieved a significant increase in depression screening rates, rising from around 25% in 2014 to nearly 60% by 2023. This improvement reflects the center's focus on integrating behavioral health into primary care and addressing mental health needs at the point of care.

3. **Diabetes Management (A1c Control):**
   While A1c levels remained relatively stable from 2013 to 2023, WCCHC continues to focus on improving diabetes management through care coordination and targeted interventions. Despite the challenges of maintaining control over A1c levels, the center remains committed to refining its diabetes care strategies.

4. **Hypertension Control:**
   WCCHC saw a steady improvement in hypertension control rates, increasing from 45% in 2014 to 60% in 2022. This improvement highlights the success of their efforts in managing cardiovascular health, particularly among high-risk populations.

5. **Childhood Immunizations:**
   Although childhood immunization rates declined during the COVID-19 pandemic, WCCHC continues to lead in statewide immunization performance, particularly for pediatrics. The center is actively working to regain ground by engaging parents and addressing vaccine hesitancy.

6. **Dental Sealants and Preventive Care:**
   WCCHC experienced a fluctuating performance in dental sealants, particularly after transitioning to a new system. However, efforts are underway to address data mapping issues and ensure the continued provision of preventive dental services to children.

> "It really takes a village and strong leadership to drive improvement. But without the data and reporting, we wouldn't be able to track progress or make the changes we need," said Kay Degal, Director of Quality at WCCHC. "Azara has been instrumental in providing our teams with meaningful insights, from weekly reports to monthly performance checks, to hit our quality metrics effectively."

Sustained Success and Future Innovations

Building on its initial success, WCCHC continues to leverage Azara DRVS to maintain and improve patient outcomes. The health center's commitment to data-driven care has enabled it to achieve sustained improvements in asthma care, depression screening, and hypertension control over the past decade.

Looking ahead, WCCHC plans to:

- **Expand Use of SDOH Data:** Integrating behavioral and social data into care planning will help WCCHC provide more holistic, patient-centered care, particularly for its underserved populations.
- **Enhance Management of Chronic Disease:** By refining custom registries and improving workflow processes, the center aims to further reduce the burden of chronic conditions like COPD, hypertension and diabetes.
- **Improve Preventive Care:** WCCHC will continue to focus on improving childhood immunizations, cancer screenings and other preventive services that saw declines during the pandemic.

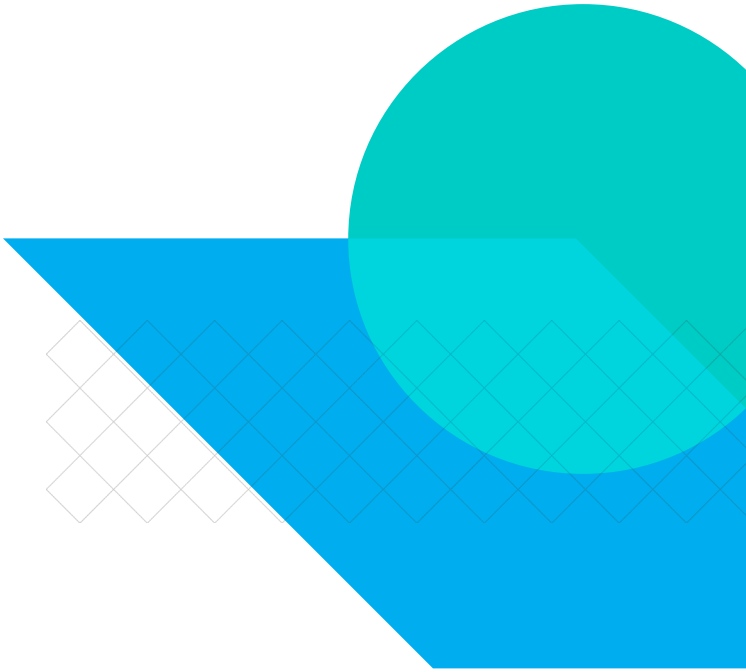
WCCHC's decade-long partnership with Azara DRVS has been a cornerstone in driving sustained advancements in population health outcomes. With NCQA Patient-Centered Medical Home (PCMH) recognition across four of its sites, WCCHC has solidified its role as a leader in care coordination and continuous quality improvement.

Azara DRVS proved to be an indispensable tool following WCCHC's first NCQA audit in 2023. With only 14 days to submit a comprehensive set of data, the platform's real-time data access and customizable reporting capabilities allowed WCCHC to quickly pull and modify the necessary reports. This enabled the center to meet all NCQA requirements efficiently.

"Azara was instrumental in the audit process. Its ability to pull accurate reports and make real-time adjustments ensured we met all NCQA requirements and passed the audit on the first submission without any complications," said Degal.

As the FQHC continues to innovate and refine its use of population health data, WCCHC is well-equipped to meet the evolving needs of value-based care and position itself as a national leader in population health success.

"Our 10-year partnership with Azara and use of DRVS have been transformative in helping us close gaps, reduce hospitalizations, improve quality reporting, and make data-driven decisions that truly impact our communities," said Kay Degal. "Whether we're refining our approach to chronic disease management or navigating new challenges like the pandemic, Azara has been there every step of the way, providing us with the insights and flexibility we need to improve care for our patients. Value-based, population-focused care is not just about implementing technologies—it's about having a real partner that understands and supports your mission."



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Learn more about how Azara Healthcare can support your organization by exploring the resources available in the DRVS Help section, contacting the Azara support team, or reaching out to your client success manager.

We at Azara can't wait to see what you will do!

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