Lakeshore Community Health Care: Improving Quality Performance in the Era of Value-Based Transformation

LCHC uses the Azara Patient Visit Planning Report to close care gaps and improve care delivery.

THE CUSTOMER

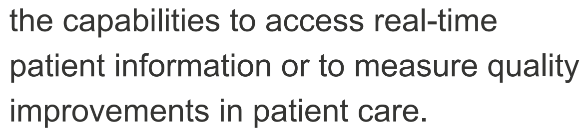
Lakeshore Community Health Care (LCHC) is a Wisconsin-based patient-centered medical home (PCMH) providing access to comprehensive care including medical, behavioral, dental and pharmacy services to address health disparities among its low-income, underserved and uninsured populations. Established in 2012, LCHC was created to address a significant unmet need for integrated, high quality care for residents in Sheboygan and Manitowoc Counties. As a federally qualified health center (FQHC), LCHC provides care for patients regardless of their ability to pay and has become a major source of dental care for residents.

LCHC has over 140 employees that support a primary medical, chiropractic, dental, behavioral health, and pharmacy practice. These services account for more than 44,000 encounters which serve nearly 13,000 annually.

THE CHALLENGE

Like many state FQHCs, LCHC was designed to meet the majority of its population's comprehensive healthcare needs through a highly collaborative, team-based approach. With a mission rooted in delivering whole-person care, LCHC's need for a modernized, data integration and patient visit planning tool grew in part to reduce the administrative burdens of its staff while demonstrating value-based care for state and federal reimbursements. Value-based care, which replaces healthcare's traditional fee-for-service model, is based on quality rather than quantity, and emphasizes the delivery of low cost, preventive care for which organizations are compensated.

To meet the objectives of value-based performance, based on population health and clinical quality measures, LCHC needed to improve its view of data across the organization and enhance existing workflows. According to LCHC's Director of Quality Improvement, Brenda Georgenson, the organization's existing reporting tool within its electronic health record lacked



the capabilities to access real-time patient information or to measure quality improvements in patient care.

As a result, quality reporting was burdensome and time consuming, and could not be collected automatically at an enterprise level to produce reliable results or identify care gaps. Further, without valid data for its patient population, LCHC's medical assistants could not address care interventions or prevention.

THE SOLUTION

LCHC desperately needed a population health and care quality improvement platform that could track and impact quality measures for reimbursements, boost patient health and satisfaction, and support cross-organizational collaboration.

To meet its clinical, administrative and financial goals, LCHC in conjunction with the Wisconsin Primary Health Care Association (WPHCA) chose Azara Healthcare's DRVS data analytics and reporting platform. The Patient Visit Planning Report (PVP) tool in DRVS or "huddle report," helps ensure that care opportunities are not missed and enables all care team members to collaborate as they perform clinical and administrative tasks.

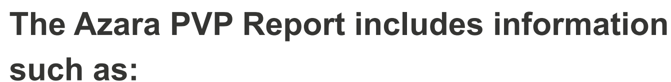
Goals of the implementation were to:

- Optimize treatment for patients and have data available to the care team at the time of visit
- Provide better patient-provider relations to engage individuals in their care
- Increase staff satisfaction to reduce administrative and workflow burdens
- Enable improved care efficiency by reducing unnecessary appointments and phone calls
- Improve performance for value-based care measures and reduce missed opportunities at the point of care
- Support LCHC's Integrated Care Model
- Create population health metrics for participating FQHC's across the state of Wisconsin.

THE RESULTS

LCHC implemented the Azara PVP reporting tool in March 2020 and was immediately able to improve participation in preventive care screenings, close care gaps, and reduce health disparities among its patients. Azara provided training, technical support, and mentorship regarding planning, preparation and final PVP rollout to implement sustainable organizational changes aimed at influencing outcomes and achieving quality benchmarks.

The Azara PVP Report provides actionable data listed by provider and patient in order of daily scheduled appointments. Medical assistants (MAs) and registered nurses (RNs) can review the report before and during their morning team huddle to address critical patient needs at the point of care.



The Azara PVP Report includes information such as:

- Patients that are due for preventive screenings;
- Condition-relevant patient alerts, such as diabetes A1c tests and blood pressure;
- Risk factors, such as smoking, obesity, and mental health.

With the PVP Report in place, LCHC was able to **boost overall alert closure by 3%** and make the following targeted improvements:

- Improve screenings and open care gaps for Body Mass Index (BMI) screening and follow-up **by 44%—from 5.9 to 50.3%**.
- Increase depression screenings and follow-ups **month over month by 12%**
- Increase targeted interventions for tobacco screening and counseling **from 20 to 53%**
- Improve blood pressure control **by 10%**

LCHC patients receive important interventions and preventive screenings to avoid missed opportunities for needed services. The PVP Report also helps LCHC providers streamline communication with care teams, unburden them of certain tasks, and increase confidence in their team's ability to provide comprehensive care to patients.

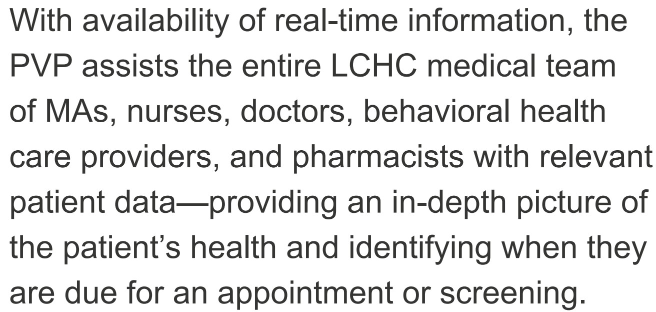
"The PVP has been integral to facilitating real world conversations across the care team so that each discipline understands what others are doing to impact outcomes and facilitate warm handoff discussions," said Georgenson. "Teams had conversations that might have been missing in the past to improve care."

> "The Azara PVP Report is a valuable part of our care management team because it aligns testing and treatment with a patient's visit to significantly decrease the likelihood of care gaps."
>
> **JENNY WENSINK | LCHC Medical Program Manager**

Additionally, providers benefit from more time spent with patients to educate and empower them to play an active role in their health and well-being.

"The PVP reporting tool has been extremely beneficial. It helps to keep us on track, gives us the ability to assign tasks, increases involvement among our care team, enhances our training process, and really demonstrates the key role we are playing in our patient's care," said Georgenson, adding that the PVP solution makes hitting benchmarks easier and more manageable.

"Quality measure data is now available to LCHC team members to promote quality awareness and direction where their efforts should be made. We take a couple measures at a time and we can all follow along to see where we are having the most impact, or identify gaps where we need to make improvements. With a clear indicator of our performance, everyone feels they are an active participant of positive change in care delivery at LCHC."



With availability of real-time information, the PVP assists the entire LCHC medical team of MAs, nurses, doctors, behavioral health care providers, and pharmacists with relevant patient data—providing an in-depth picture of the patient's health and identifying when they are due for an appointment or screening.

Wensink says LCHC now has a truly integrated program.

"For example, one of our chiropractors that uses the PVP noticed that one of his patients was overdue for a mammogram, so he sent a message to get that scheduled that same day. So it's really allowed us to see our whole patient," she said. "It's been so rewarding for our providers to not only see that all our patient's needs are being met, but that they're getting better."

To learn how Azara Healthcare can help empower your organization to improve the quality and efficiency of care for your patients, contact us at: **solutions@azarahealthcare.com.**