azara
USER CONFERENCE
APR 29–MAY 1
BOSTON, MA
2025

Bootstrapping Value-Based Care

A Pilot Approach

Today’s Presenters

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Health Federation of Philadelphia

Health Federation of Philadelphia

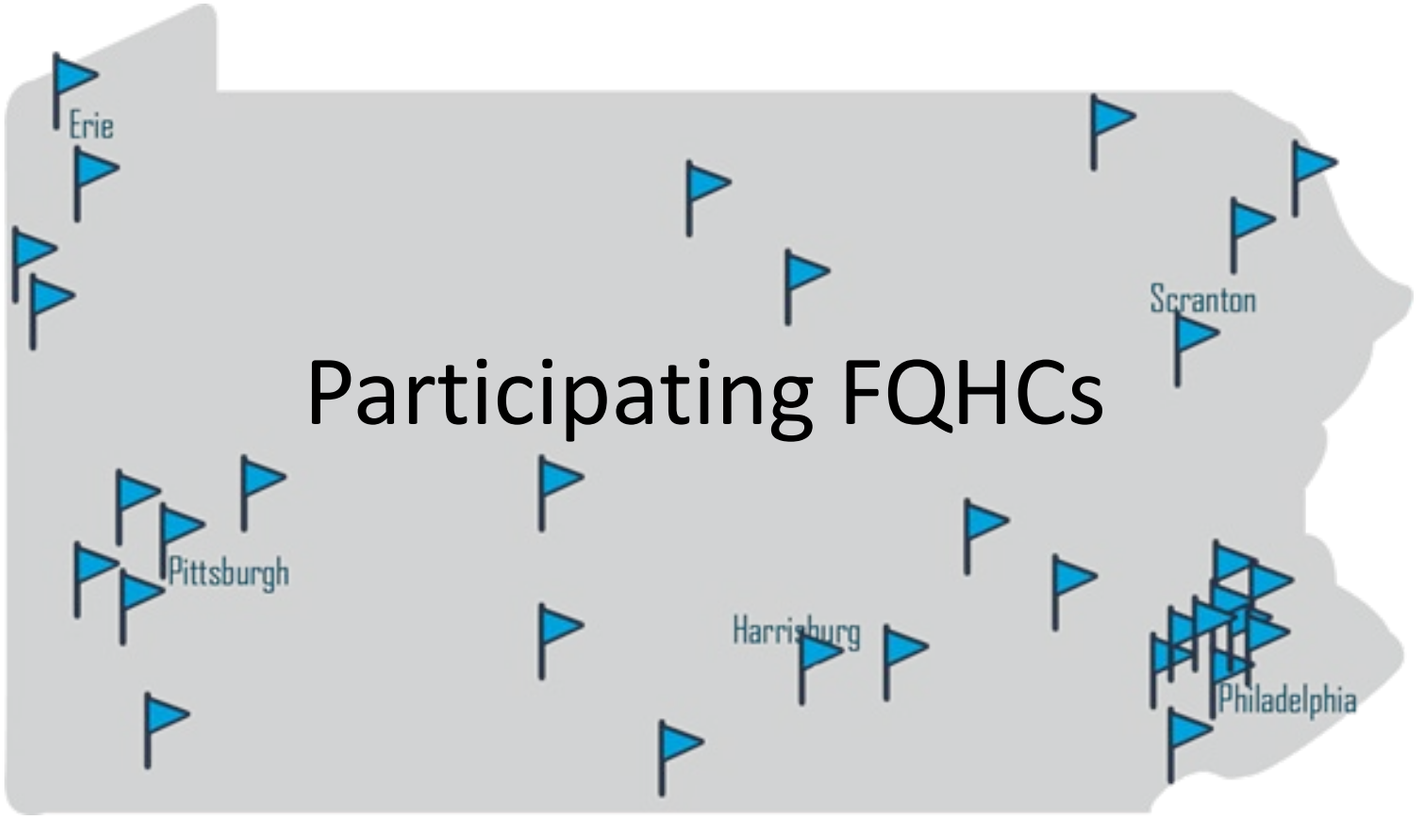
Health Federation of Philadelphia promotes health equity for marginalized communities by advancing access to high-quality, integrated, and comprehensive health and human services and serves as a keystone supporting a network of Community Health Centers as well as the broader base of public and private-sector organizations that deliver healthcare, public health and human services to vulnerable populations.

About Us

Health Center Controlled Network grantee since 2012

35 FQHCs/Look-Alikes

Statewide



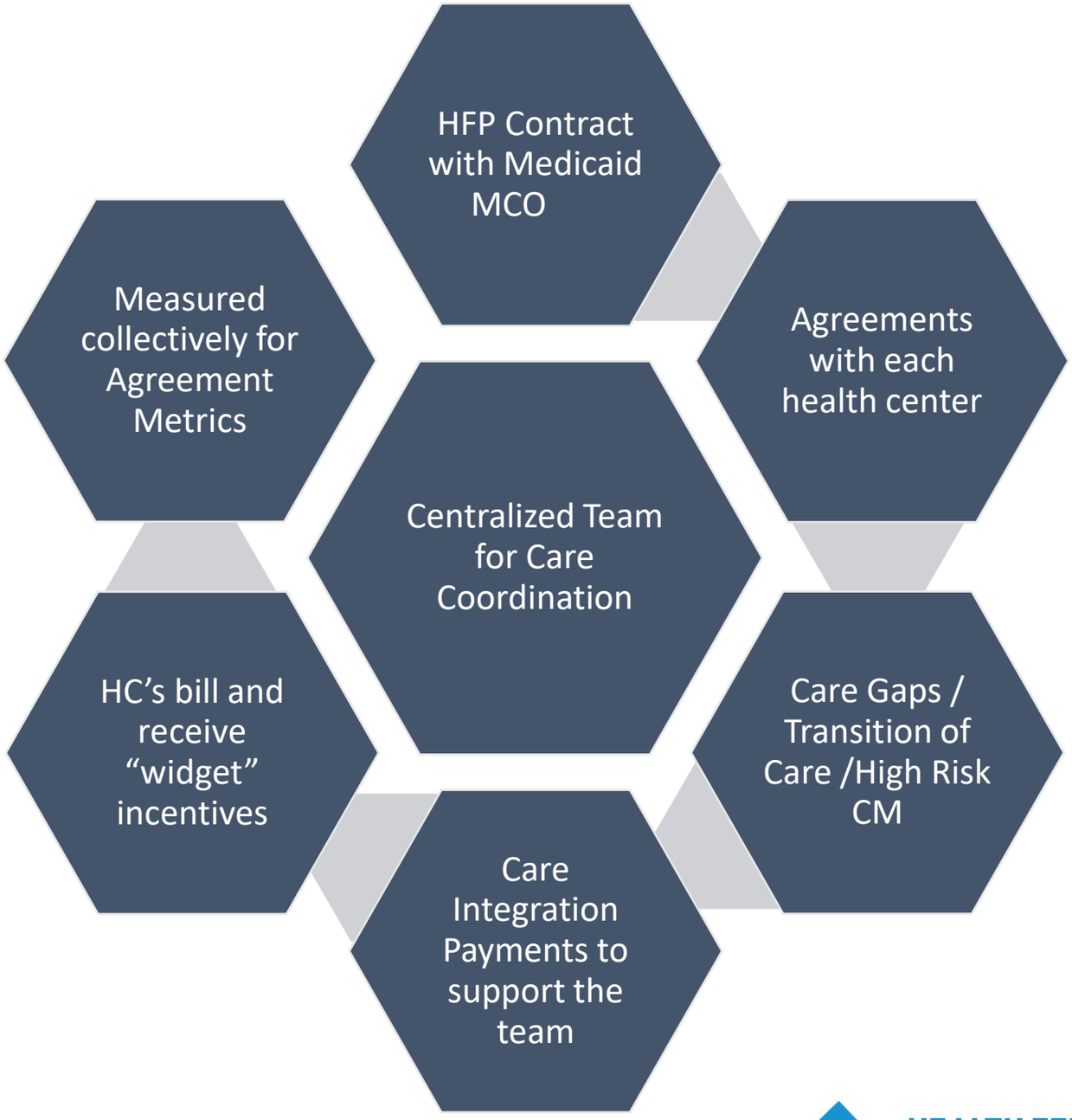
PA Value Based Care Environment

- Mature managed care (since 1995)
- State has delegated lots of decision making to MCOs
- Large health systems
- 50+ FQHCs
- Medicaid expansion/good PPS

Slow transition to VBC

So…How to Move Forward?

A Pilot



Lots of Questions

Would we be able to get access to the data?

Would patients pick up the phone?

Would health centers engage?

Would we be able to make a difference for outcomes and revenue?

The Team

Tried hiring/retaining nurses (RN or LPN) without success.

Workflows

Transition of Care

- Visit with PCP or Specialist within 7-10 days of discharge from ER or IP

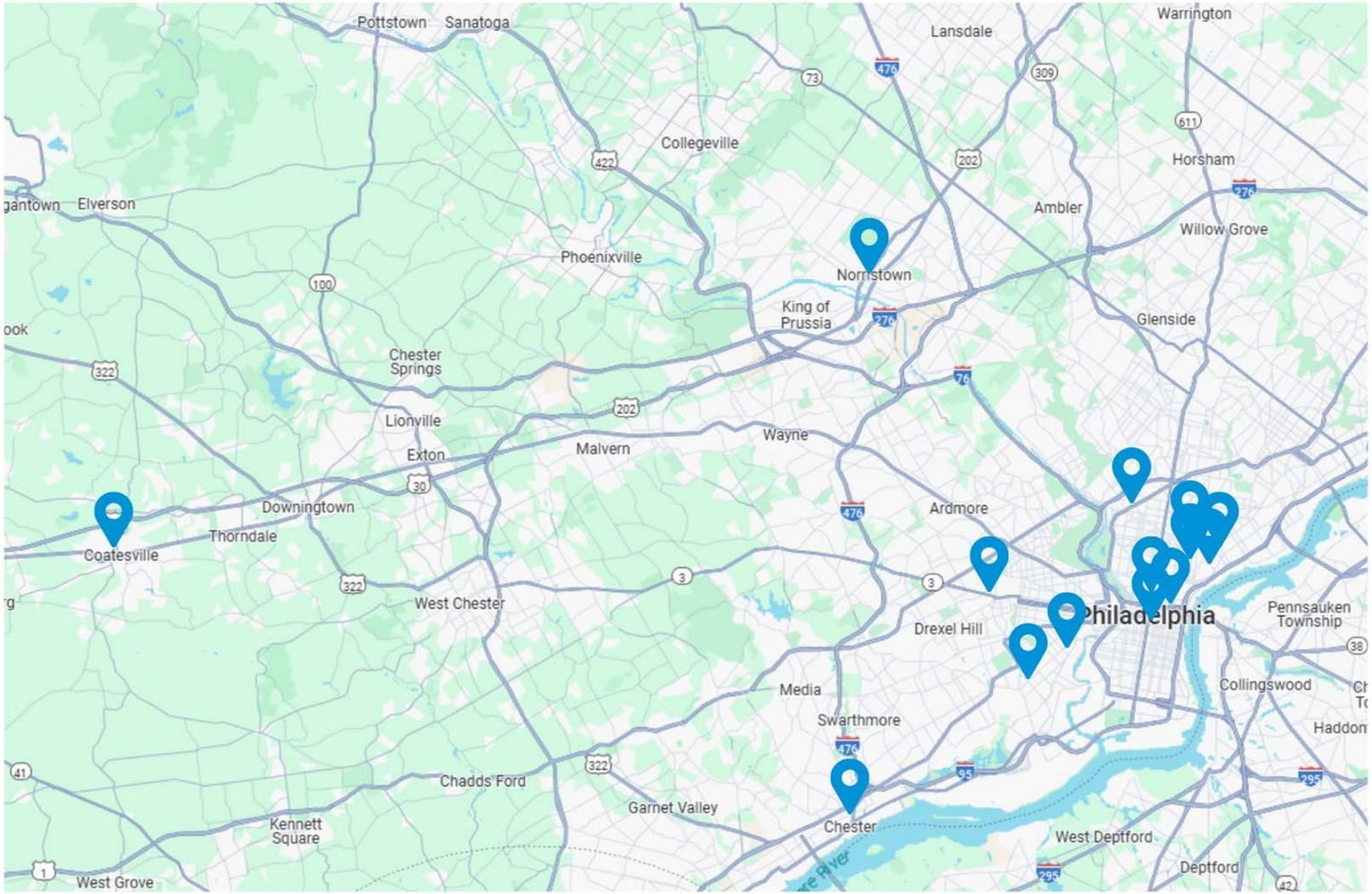
Care Gaps

- Hit benchmarks on five quality measures:
  - Lead screening
  - Well child visits (3-21)
  - Oral Evaluation Dental
  - A1c<9
  - Breast cancer screening

High Risk Care Management

- Small panel, adjusted every six months
- Engagement with PCP at least every 90 days

Geographic Reach



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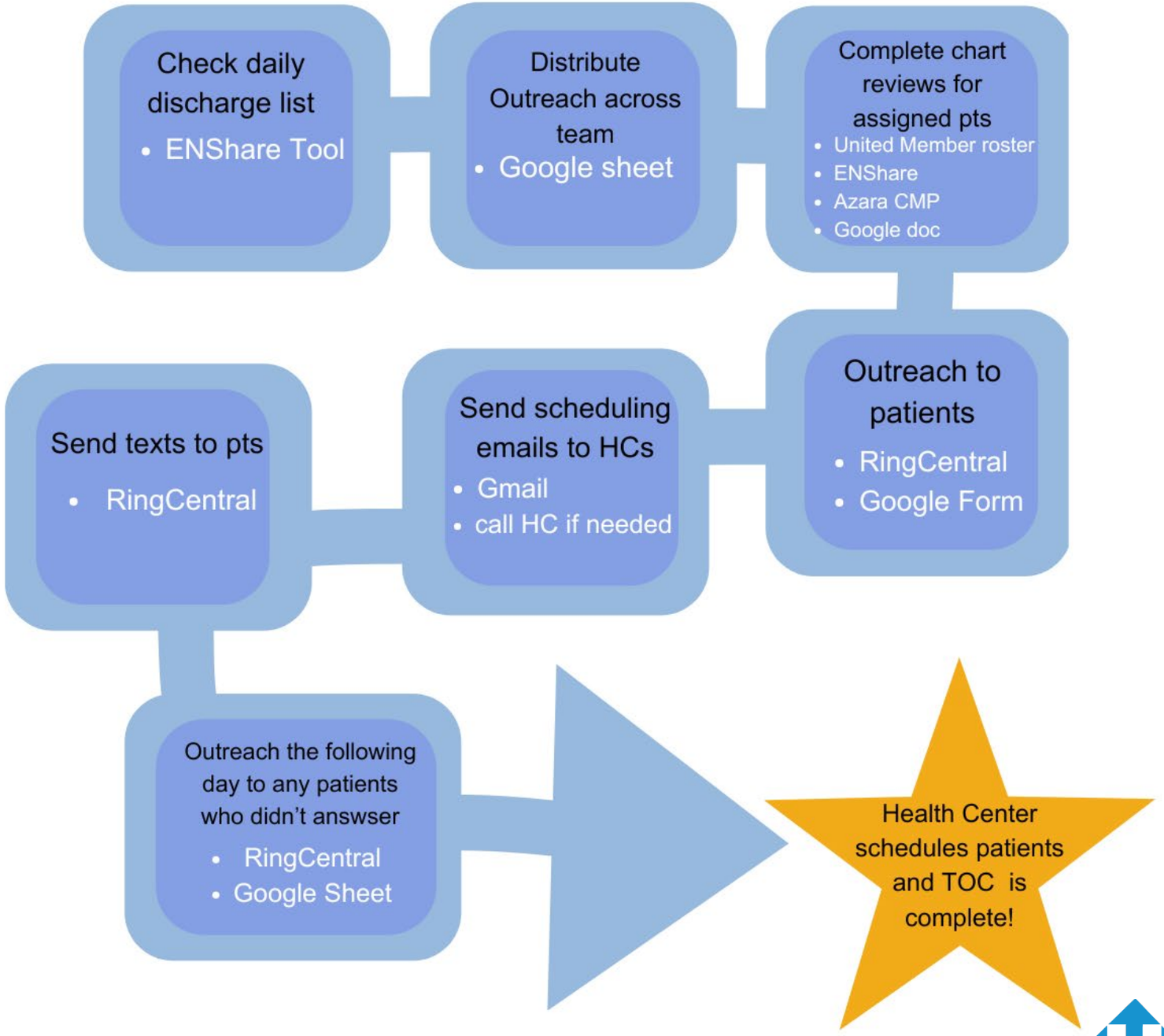
OF PHILADELPHIA
The keystone of community health since 1983

Our Technology Journey: The Beginning

From the payer	Team documentation	Real time ADT notifications	Access to patient data
So many spreadsheets!	Google sheets/forms	Through local HIE	Remote access to each health center's i2i Tracks

TOC Workflow



Scripting

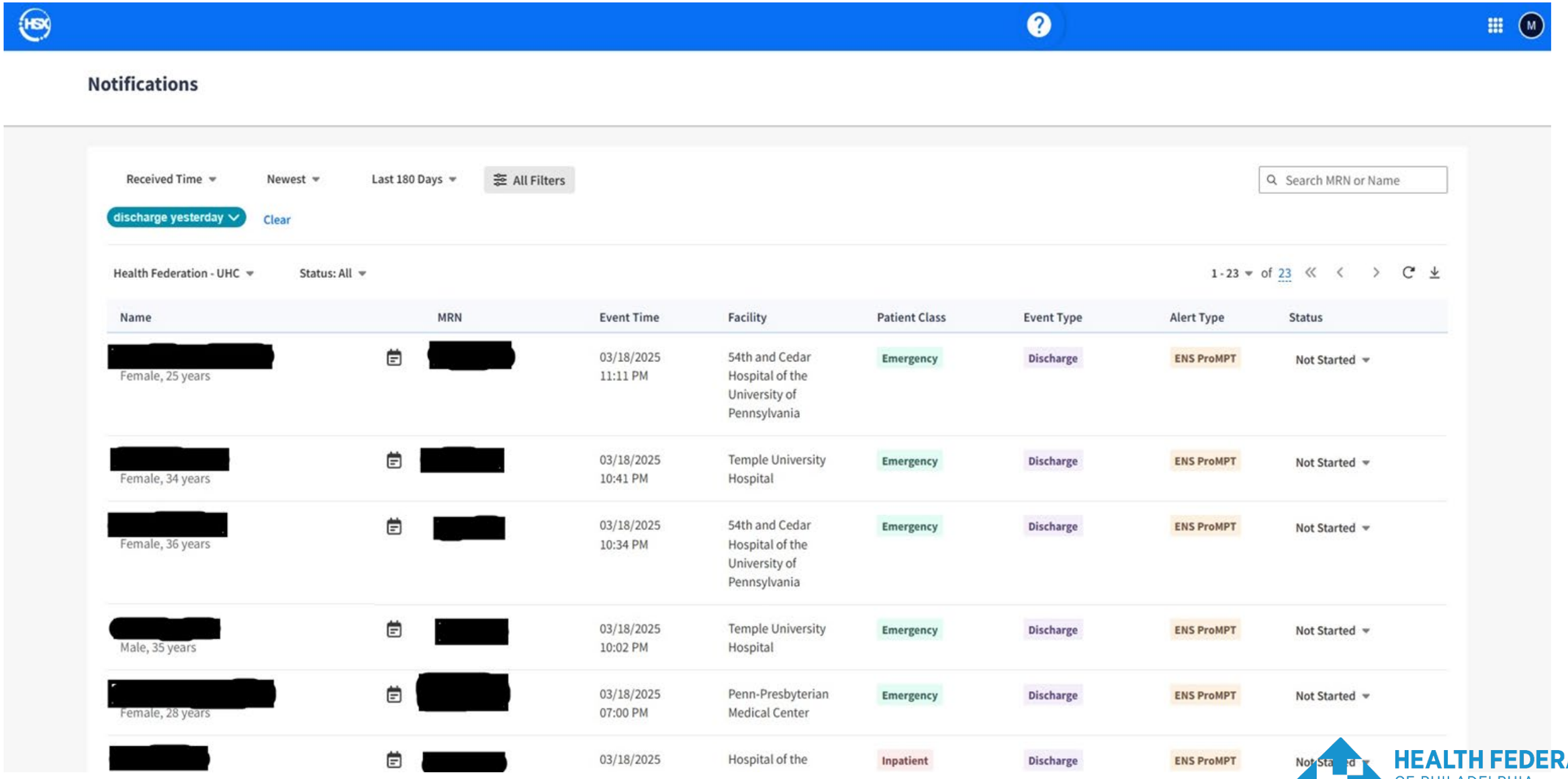
Phone Call intro script:
Hi, I'm looking for [patient first name]
(patient confirms)
My name is Maggie, I'm a Community Health Worker calling on behalf of United Healthcare Community Plan. I'm calling to see how you're feeling after your hospital visit (and to see if you want to make a follow up appointment with your primary care doctor).

Text:
Hello, this is Maggie reaching out on behalf of United Healthcare Community Plan. I'm hoping to assist you in connecting you with your primary care provider after your recent hospital visit. Please call me when you get a chance.

Phone Call Outreach Considerations

- Listen for the patient's needs
- What brought you into the hospital?
- Med reconciliation - were you able to pick up your medications, do you know how to take them?
- Transportation - can you get to your appointment?
- Specialists

ENShare Tool



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Outreach Documentation

TOC Patient Outreach

mgreen@healthfederation.org Switch account

* Indicates required question

Email *

Record mgreen@healthfederation.org as the email to be included with my response

Name of Patient (F, L) *

Your answer

Health Center assigned to? *

Choose

Date of contact *

Date

mm/dd/yyyy

Time *

Time

Who did you speak to? *

Choose

Date of discharge *

Date

mm/dd/yyyy

Nature of visit: *

Choose

What was patients explanation for what brought them to the hospital?

Your answer

Did patient mention medications were changed during their visit?

Choose

Who was identified as patient's primary care/family doctor?

Your answer

If any, what benefits of following up with ones PCP regularly did you discuss?

- [ ] Prescription management (timely, consisting refills, med reconciliation)
- [ ] Referrals and resources
- [ ] Preventative care (vaccines & health counseling)
- [ ] Early identification of health conditions (blood pressure readings, mammograms, labwork,etc.)
- [ ] One physician who knows all of your medical and family history
- [ ] Review of IP or ED discharge instructions to prevent future readmissions
- [ ] Other:

If any, what barriers were addressed to attending PCP visits?

- [ ] Transportation
- [ ] Challenges with scheduling w/ office
- [ ] Challenges with scheduling personal life
- [ ] Cost concern
- [ ] Too many appointments
- [ ] Don't understand the need
- [ ] No barriers identified
- [ ] Other:

If any, what community resources/education were provided to patient?

Your answer

More Outreach Documentation…

March '25 Assignment

File Edit View Insert Format Data Tools Extensions Help Accessibility

Share

Menus 100% $ % .0 .00 123 Defaul... 10 B I

F271 fx LVM

Summarize this table

	A	B	C	D	E	F	G	H	I	J	K	L
1	CMT Numbers	Patient	Staff	High Risk?	Needs Manna	Outcome #1	Appt status	Follow up Plan	Date (create calendar reminder)	#2 Attempt Outcome	Letter?	Answered/Xf
2	List of Outside PCPs	TOC form; HR Form	HC contacts							TEXT MESSAGE SCRIPTING		
3	3/3/2025											
4	[redacted]	[redacted]	BF	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025			
5			BF	NO	☐	Chart Review Only	Recent Appt Completed/Scheduled	None				
6			BF	NO	☐	Chart Review Only	Recent Appt Completed/Scheduled	None				
7			BF	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	unable to lvm		
8			BF	NO	☐	Spoke with PT/ Caregiver	Recent Appt Completed/Scheduled	None				
9			BF	NO	☐	Unable to LVM	No follow up needed	None				
10			MG	NO	☐	NOR	NOR	NOR				
11			MG	NO	☐	Outside PCP	No follow up needed	None				
12			MG	NO	☐	Chart Review Only	No follow up needed	None				
13			MG	NO	☐	Unable to LVM	No follow up needed	None				
14			MG	NO	☐	NOR	NOR	NOR				
15			MG	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	LVM		
16					☐							
17		[redacted]	BF	NO	☑	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	LVM		
18			BF	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	LVM		
19			BF	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	LVM		
20			BF	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	pt refused toc		
21			BF	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	LVM		
22			BF	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	LVM		
23			MG	NO	☐	Chart Review Only	Recent Appt Completed/Scheduled	None				
24			MG	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	BF outreached		
25			MG	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	LVM		
26			MG	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/5/2025	LVM		
27			MG	NO	☐	Unable to LVM	No follow up needed	None				
28					☐							
29		[redacted]	BF	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/6/2025			
30			BF	NO	☐	LVM	Needs f/u for appt scheduling	Did not reach-Call back	3/6/2025			
31			BF	NO	☐	Unable to LVM	No follow up needed	None				

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High Risk Tracking

	A	B	C	D	E	F	G	H	I	J	K	L	
1	Health center	Full Name	DOB	NOT on roster	Manna qualified	Staff	Outreach 1	Outreach 2	Goal Status	Appt status	Letter?	Notes	Date
2	[redacted]	[redacted]	[redacted]	☐	☑	JG	2/7/2025		In progress w/ goals	Recent Appt	SENT 6/26/2024	CRO ON 2/7/2025 - APPT SCHEDULED FOR 2/1	
3				☑	☑	JG			In progress w/ goals	Recent Appt	SENT 6/26/2024	NO WORKING NUMBERS AS OF 8/28	
4				☐	☐	JG	2/7/2025		In progress w/ goals	Needs f/u for	YES	NO WORKING NUMBERS AS OF 2/7/2025	
5				☐	☐	JG	2/7/2025		In progress w/ goals	Needs f/u for		LVM AND TEXT ON 2/7/2025	
6				☐	☑	JG	2/7/2025		In progress w/ goals	Needs f/u for	SENT 6/26/2024	TRANSPLANT PATIENT - NO WORKING NUMBE	
7				☑	☐	JG			In progress w/ goals	Emailed cont			
8				☐	☑	JG	2/7/2025		In progress w/ goals	Needs f/u for		LVM AND TEXT ON 2/7/2025	
9				☐	☐	JG	2/7/2025		In progress w/ goals	Emailed cont		REQUESTED APPT ON 2/7/2025	
10				☐	☐	JG	2/7/2025		In progress w/ goals	Needs f/u for	SENT 6/26/2024	LVM AND TEXT ON 2/7/2025	
11				☐	☐	JG	2/7/2025		In progress w/ goals	Emailed cont		REQUESTED APPT ON 2/7/2025	
12				☐	☐	JG	2/7/2025		In progress w/ goals	Needs f/u for		CRO ON 2/7/2025 - APPT SCHEDULED FOR	
13				☑	☐	JG			In progress w/ goals	Recent Appt		CRO - APPT COMPLETED 9/30/2024	
14				☐	☐	JG	2/7/2025		In progress w/ goals	Needs f/u for		OUTSIDE PCP	
15				☑	☐	JG			In progress w/ goals	No follow up			
16				☑	☑	JG			In progress w/ goals	Recent Appt		SPOKE TO MOTHER ON 5/1/2024- APPT COMPI	
17				☐	☑	JG	2/7/2025		In progress w/ goals	Needs f/u for		DOES NOT NEED APPT, BUT REQUESTED UBE	
18				☐	☐	JG	2/13/2025		In progress w/ goals	Recent Appt		CRO ON 2/13/2025- APPT SCHEDULED FOR 5/7/2025	
19				☐	☑	JG	2/13/2025		In progress w/ goals	Recent Appt		CRO ON 2/13/2025- APPT SCHEDULED FOR 2/20/202	
20				☐	☑	JG	2/13/2025		In progress w/ goals	Needs f/u for		OUTSIDE PCP	
21				☑	☑	JG			In Need of f/u	Needs f/u for	SENT 6/26/2024	NO WORKING NUMBERS	
22				☐	☐	JG	2/13/2025		In progress w/ goals	Needs f/u for	YES	NO WORKING NUMBERS AS OF 2/13	
23				☐	☐	JG	2/13/2025		In progress w/ goals	Recent Appt		CRO ON 2/13/2025- APPT COMPLETED 12/11/2(	
24				☐	☐	JG	2/13/2025		In progress w/ goals	Needs f/u for		NEED IPCA DATA	
25				☑	☐	JG	2/13/2025						
26				☑	☐	JG	2/13/2025						
27				☐	☐	JG	2/13/2025		In progress w/ goals	Recent Appt		CRO ON 2/13/2025 - APPT SCHEDULED FOR 2/	

High Risk Tracking

When was the patients last visit with health center?
Skip if patient has outside PCP

Date

mm/dd/yyyy

Does patient have outside PCP? *

- ◯ Yes
- ◯ No

Based on detailed chart review, consideration of diagnoses, and phone call questions, how is the patient managing their overall health at this time?

	1	2	3	4	5	
Poorly	◯	◯	◯	◯	◯	Excellent

List any support patient mentioned that would help improve their health at this time

Your answer

Does patient have goals to work toward?

- ◯ Yes
- ◯ No

CHW Support and Health Education

Which of the following benefits of having a PCP were discussed?

- ☐ Preventative care and early detection of health conditions
- ☐ Prescription mangement
- ☐ One provider knowing medical history
- ☐ Referrals and resources
- ☐ Recent hospitalization (TOC)

Were any of the following barriers to primary care discussed?

- ☐ Transportation
- ☐ Health center communication
- ☐ Personal issues
- ☐ Technical issues
- ☐ Cost
- ☐ Other:

Use the below space to detail parts of the call that were not captured in the above questions

Your answer

Was an appointment scheduled during this call? *

- ◯ Yes

Our Technology Journey: The Middle

2022	HCCN decided to move from i2i to Azara, mostly due to greater capacity to integrate data from external sources (payers, HIE)
2024	20+ health centers implemented on DRVS, including 5 out of 6 of health centers in this contract • Started to implement TOC Module in Southeast PA • Started to use CareMessage (Not APO)

Initial use of Azara to support this work

Specific center group for this contract

- Only HFP group with PHI access
- Allows team to use DRVS to access individual patient data, replacing i2i.
- Ease of login

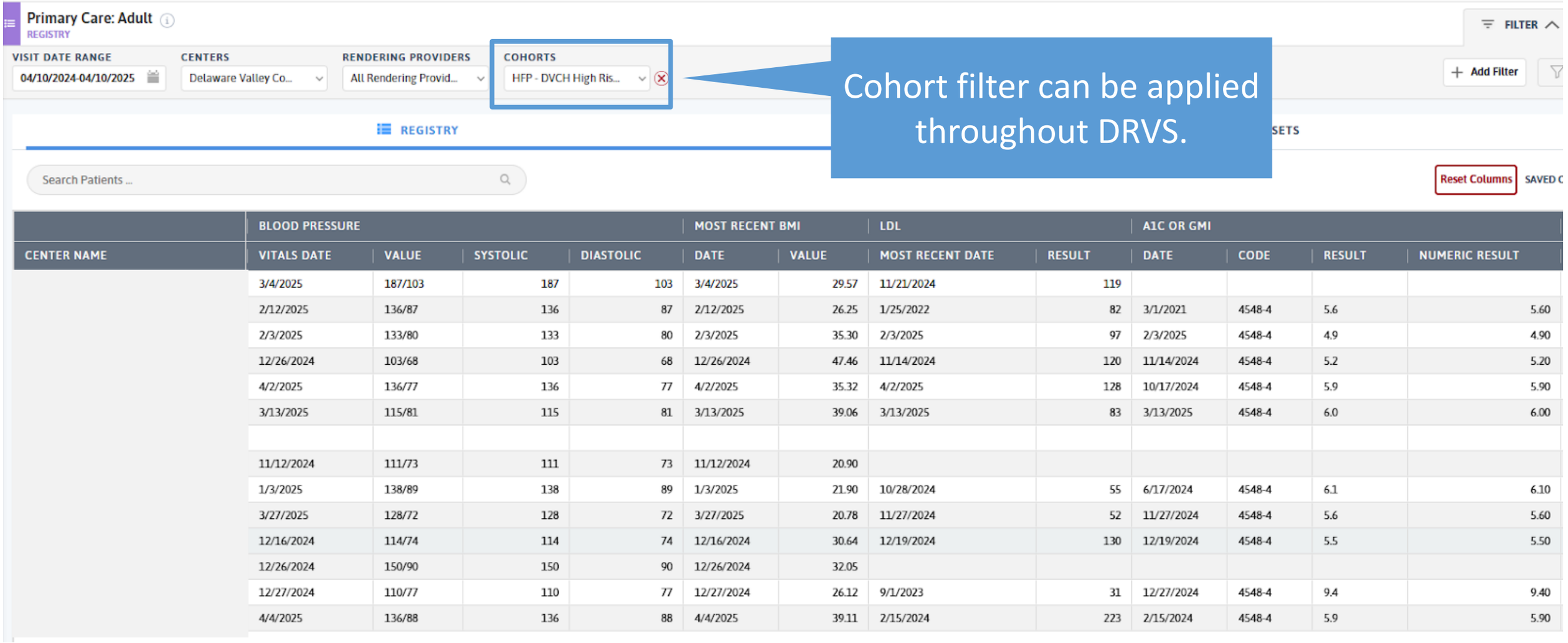
One-way "payer integration"

- Payer not interested
- HFP paid for the module and uploading rosters and care gaps manually
- No sharing of supplemental clinical data back to payer

Other tools

- Using cohorts for high risk panels
- Measure scorecard/dashboard
- Pulling lists for texting outreach

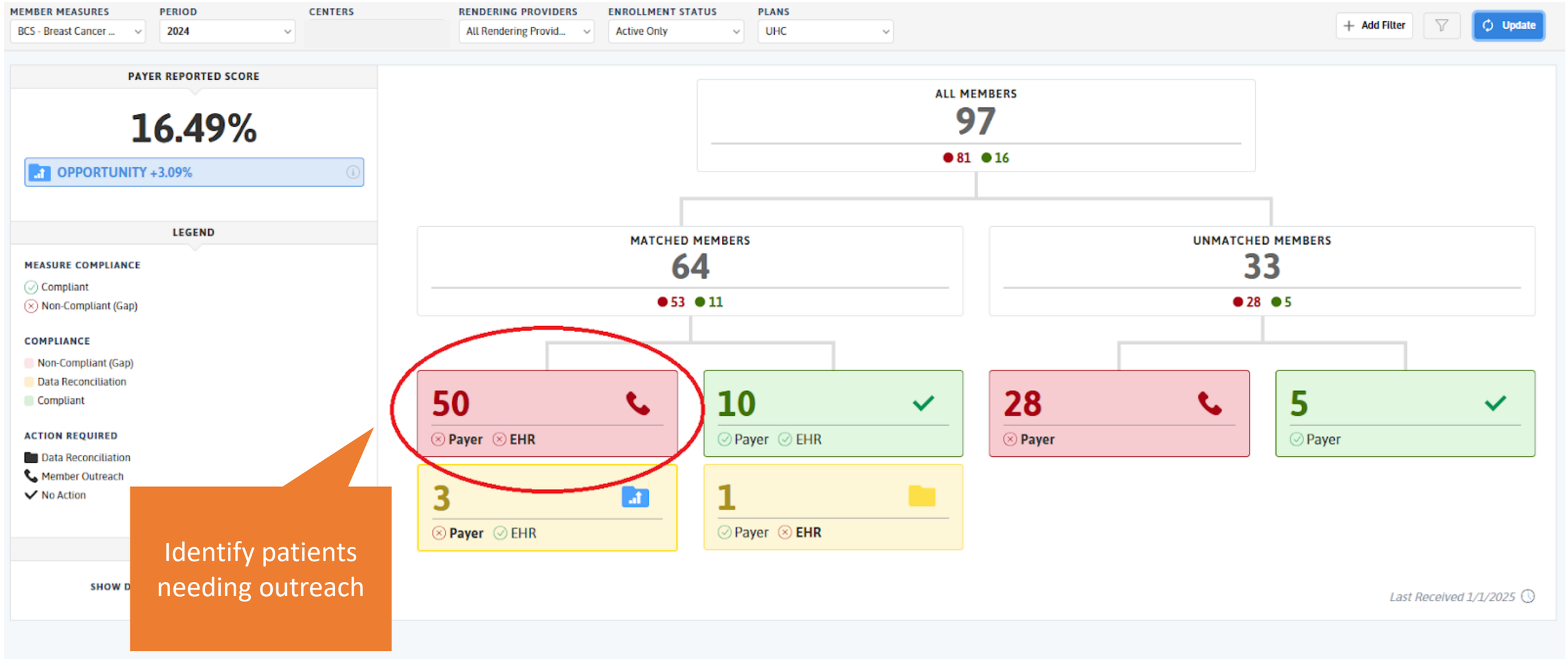
High Risk Cohort in DRVS



Cohort filter can be applied throughout DRVS.

	BLOOD PRESSURE				MOST RECENT BMI		LDL		A1C OR GMI			
CENTER NAME	VITALS DATE	VALUE	SYSTOLIC	DIASTOLIC	DATE	VALUE	MOST RECENT DATE	RESULT	DATE	CODE	RESULT	NUMERIC RESULT
	3/4/2025	187/103	187	103	3/4/2025	29.57	11/21/2024	119				
	2/12/2025	136/87	136	87	2/12/2025	26.25	1/25/2022	82	3/1/2021	4548-4	5.6	5.60
	2/3/2025	133/80	133	80	2/3/2025	35.30	2/3/2025	97	2/3/2025	4548-4	4.9	4.90
	12/26/2024	103/68	103	68	12/26/2024	47.46	11/14/2024	120	11/14/2024	4548-4	5.2	5.20
	4/2/2025	136/77	136	77	4/2/2025	35.32	4/2/2025	128	10/17/2024	4548-4	5.9	5.90
	3/13/2025	115/81	115	81	3/13/2025	39.06	3/13/2025	83	3/13/2025	4548-4	6.0	6.00
	11/12/2024	111/73	111	73	11/12/2024	20.90						
	1/3/2025	138/89	138	89	1/3/2025	21.90	10/28/2024	55	6/17/2024	4548-4	6.1	6.10
	3/27/2025	128/72	128	72	3/27/2025	20.78	11/27/2024	52	11/27/2024	4548-4	5.6	5.60
	12/16/2024	114/74	114	74	12/16/2024	30.64	12/19/2024	130	12/19/2024	4548-4	5.5	5.50
	12/26/2024	150/90	150	90	12/26/2024	32.05						
	12/27/2024	110/77	110	77	12/27/2024	26.12	9/1/2023	31	12/27/2024	4548-4	9.4	9.40
	4/4/2025	136/88	136	88	4/4/2025	39.11	2/15/2024	223	2/15/2024	4548-4	5.9	5.90

Care Gap Outreach

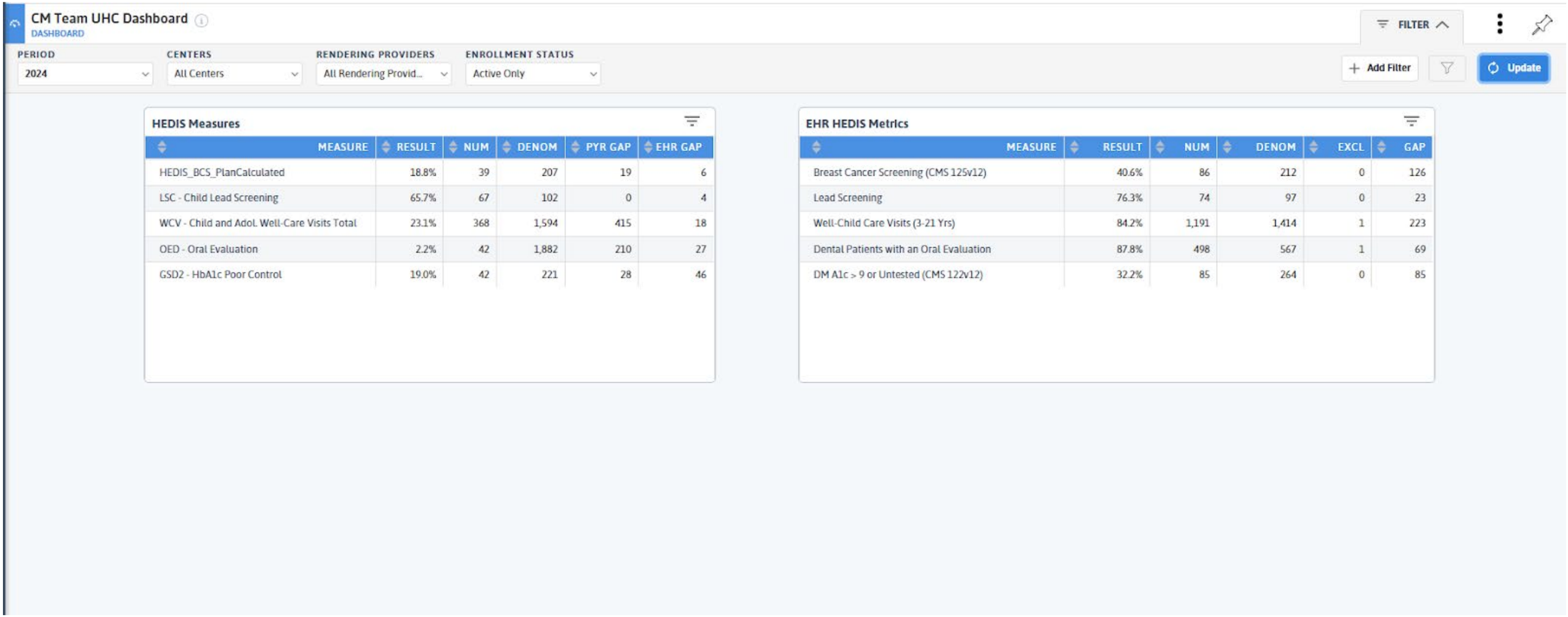


Identify patients needing outreach

Text Messaging

Date & Time	Outreach Title	Status	Patients	Response %
02/27/2025 11:30 AM		COMPLETED	100	2%
02/20/2025 12:00 PM		COMPLETED	57	7%
10/31/2024 01:00 PM		COMPLETED	27	0%
10/24/2024 12:00 PM		COMPLETED	43	7%
07/31/2024 11:00 AM		COMPLETED	1228	9%
05/28/2024 03:00 PM		COMPLETED	277	6%

HEDIS Tracking Dashboard



Future Use of Azara – ACC!

TOC

- Expanding TOC roster to include unregistered members
- Using ACC Care Coordination to set daily work lists and track outreach

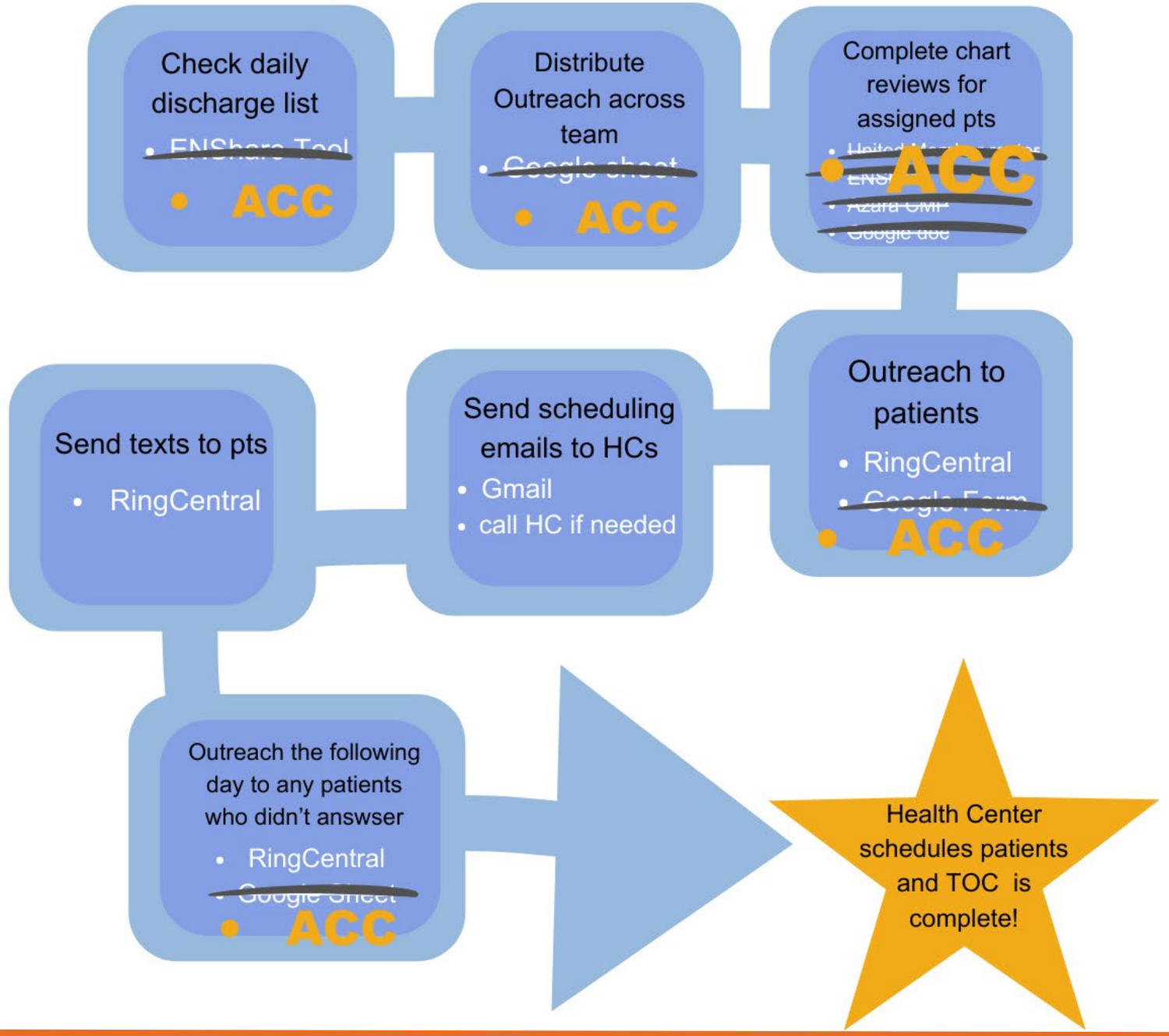
Care Gaps

- Target care gaps informing care coordination outreach in ACC

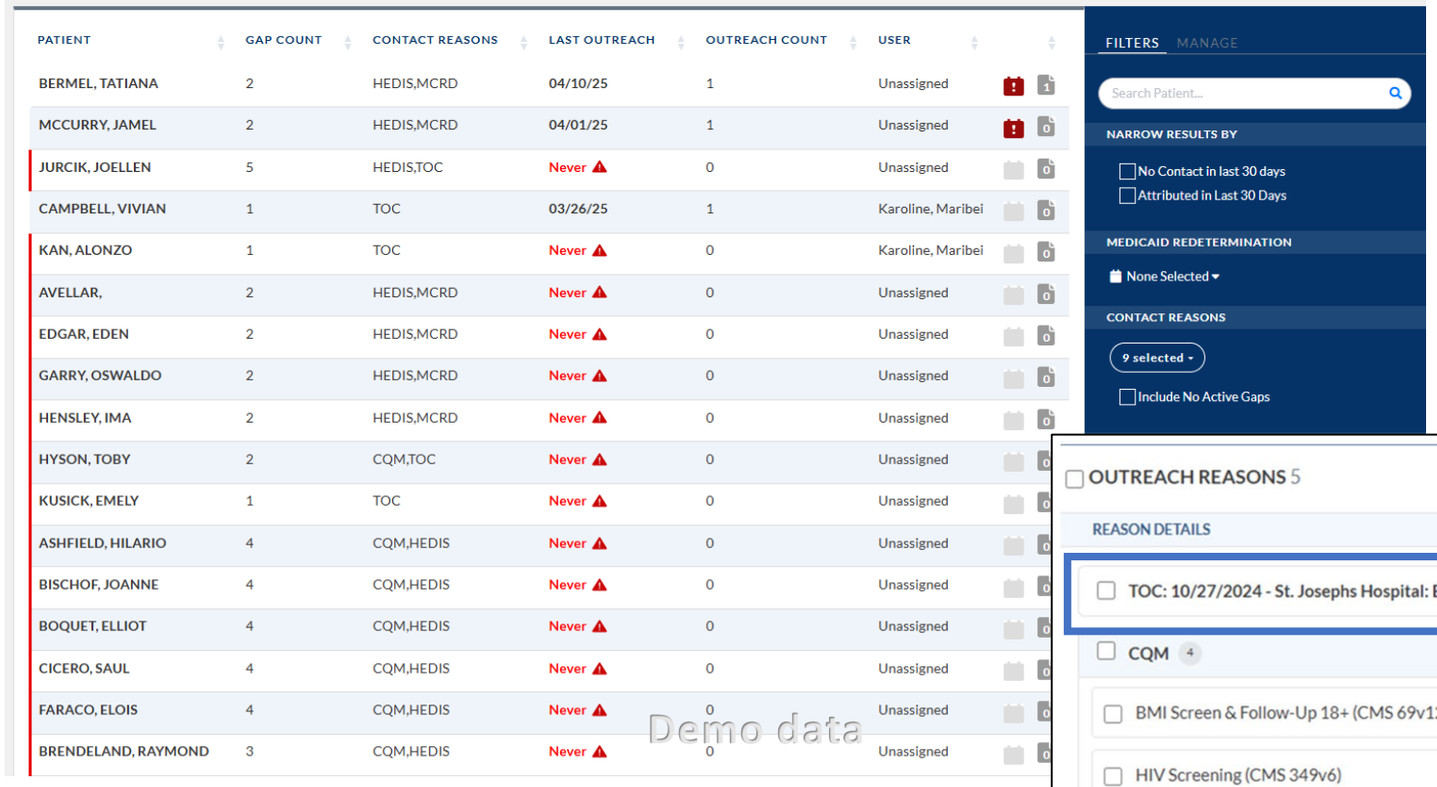
High Risk

- Pushing high risk cohorts into ACC Care Management
- Using ACC Care Management for documentation and task management

Future TOC Workflow



Future of TOC Workflow and Documentation



PATIENT	GAP COUNT	CONTACT REASONS	LAST OUTREACH	OUTREACH COUNT	USER
BERMEL, TATIANA	2	HEDIS,MCRD	04/10/25	1	Unassigned
MCCURRY, JAMEL	2	HEDIS,MCRD	04/01/25	1	Unassigned
JURCIK, JOELLEN	5	HEDIS,TOC	Never	0	Unassigned
CAMPBELL, VIVIAN	1	TOC	03/26/25	1	Karoline, Maribei
KAN, ALONZO	1	TOC	Never	0	Karoline, Maribei
AVELLAR,	2	HEDIS,MCRD	Never	0	Unassigned
EDGAR, EDEN	2	HEDIS,MCRD	Never	0	Unassigned
GARRY, OSWALDO	2	HEDIS,MCRD	Never	0	Unassigned
HENSLEY, IMA	2	HEDIS,MCRD	Never	0	Unassigned
HYSON, TOBY	2	CQM,TOC	Never	0	Unassigned
KUSICK, EMELY	1	TOC	Never	0	Unassigned
ASHFIELD, HILARIO	4	CQM,HEDIS	Never	0	Unassigned
BISCHOF, JOANNE	4	CQM,HEDIS	Never	0	Unassigned
BOQUET, ELLIOT	4	CQM,HEDIS	Never	0	Unassigned
CICERO, SAUL	4	CQM,HEDIS	Never	0	Unassigned
FARACO, ELOIS	4	CQM,HEDIS	Never	0	Unassigned
BRENDELAND, RAYMOND	3	CQM,HEDIS	Never	0	Unassigned

Demo data

FILTERS MANAGE

Search Patient...

NARROW RESULTS BY

No Contact in last 30 days

Attributed in Last 30 Days

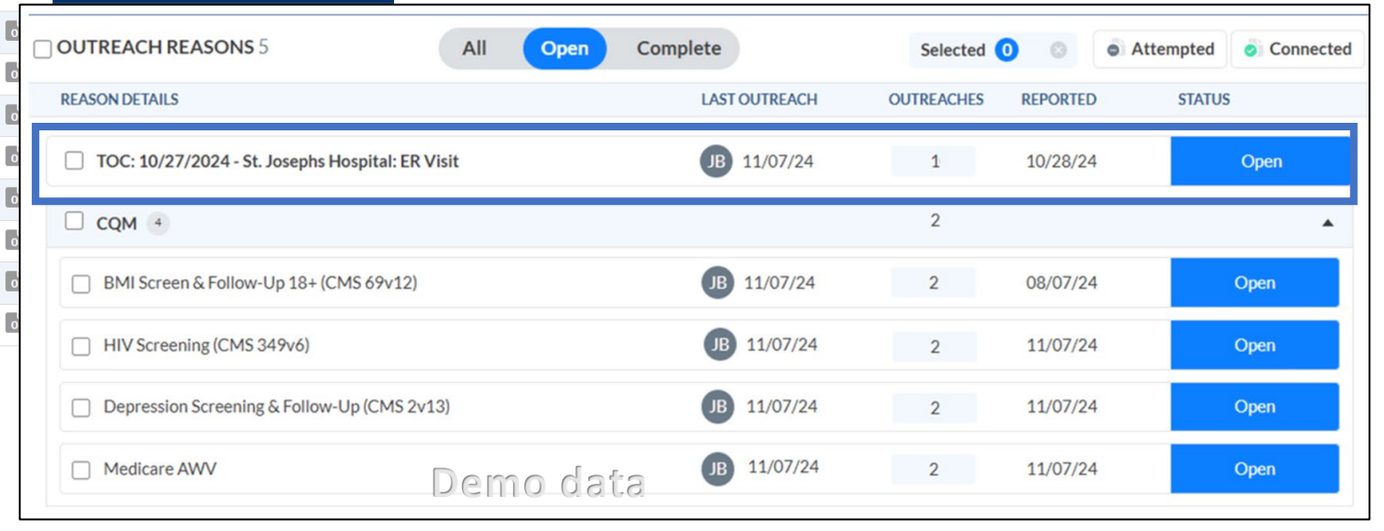
MEDICAID REDETERMINATION

None Selected

CONTACT REASONS

9 selected

Include No Active Gaps



OUTREACH REASONS 5 | All | Open | Complete | Selected 0 | Attempted | Connected

REASON DETAILS	LAST OUTREACH	OUTREACHES	REPORTED	STATUS
TOC: 10/27/2024 - St. Josephs Hospital: ER Visit	JB 11/07/24	1	10/28/24	Open
CQM 4		2		
BMI Screen & Follow-Up 18+ (CMS 69v12)	JB 11/07/24	2	08/07/24	Open
HIV Screening (CMS 349v6)	JB 11/07/24	2	11/07/24	Open
Depression Screening & Follow-Up (CMS 2v13)	JB 11/07/24	2	11/07/24	Open
Medicare AWV	JB 11/07/24	2	11/07/24	Open

Demo data

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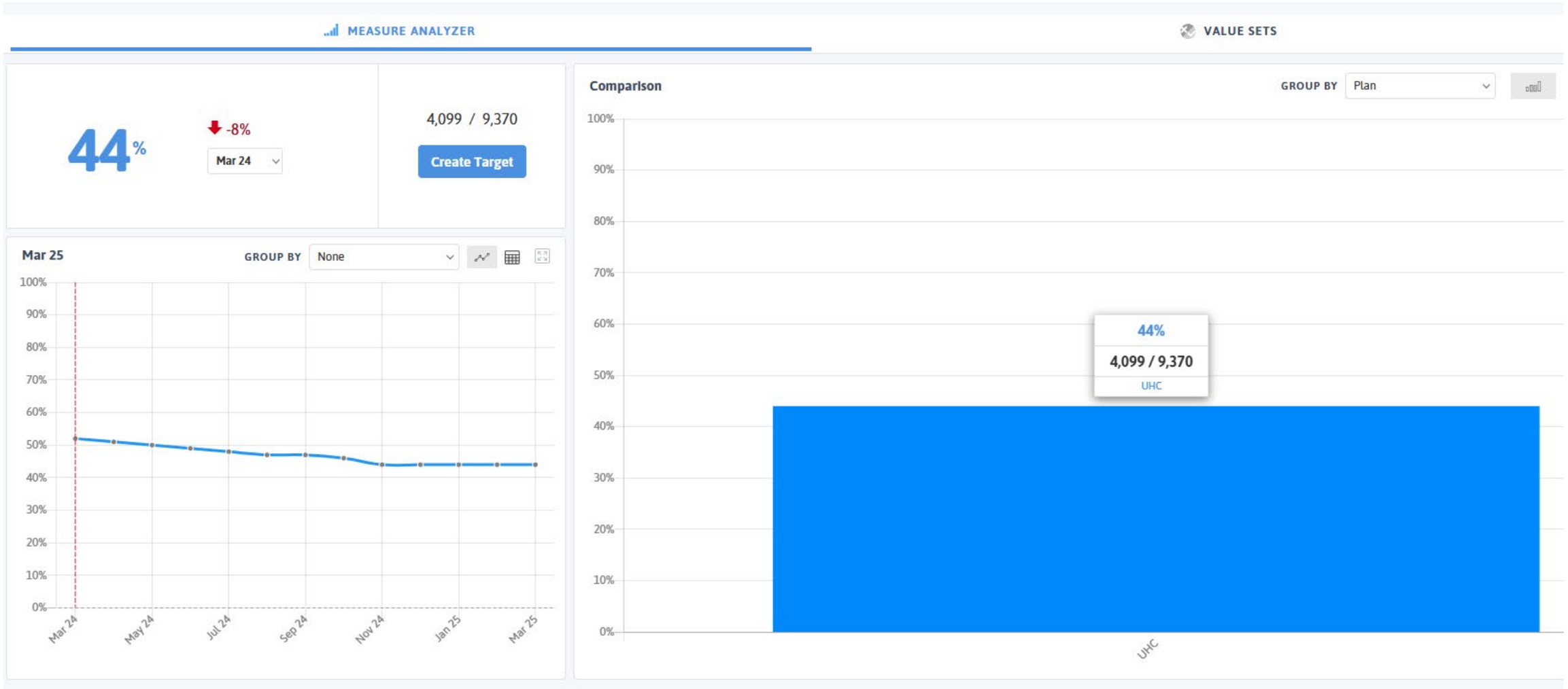
The keystone of community health since 1983

Challenges

Really low member matching

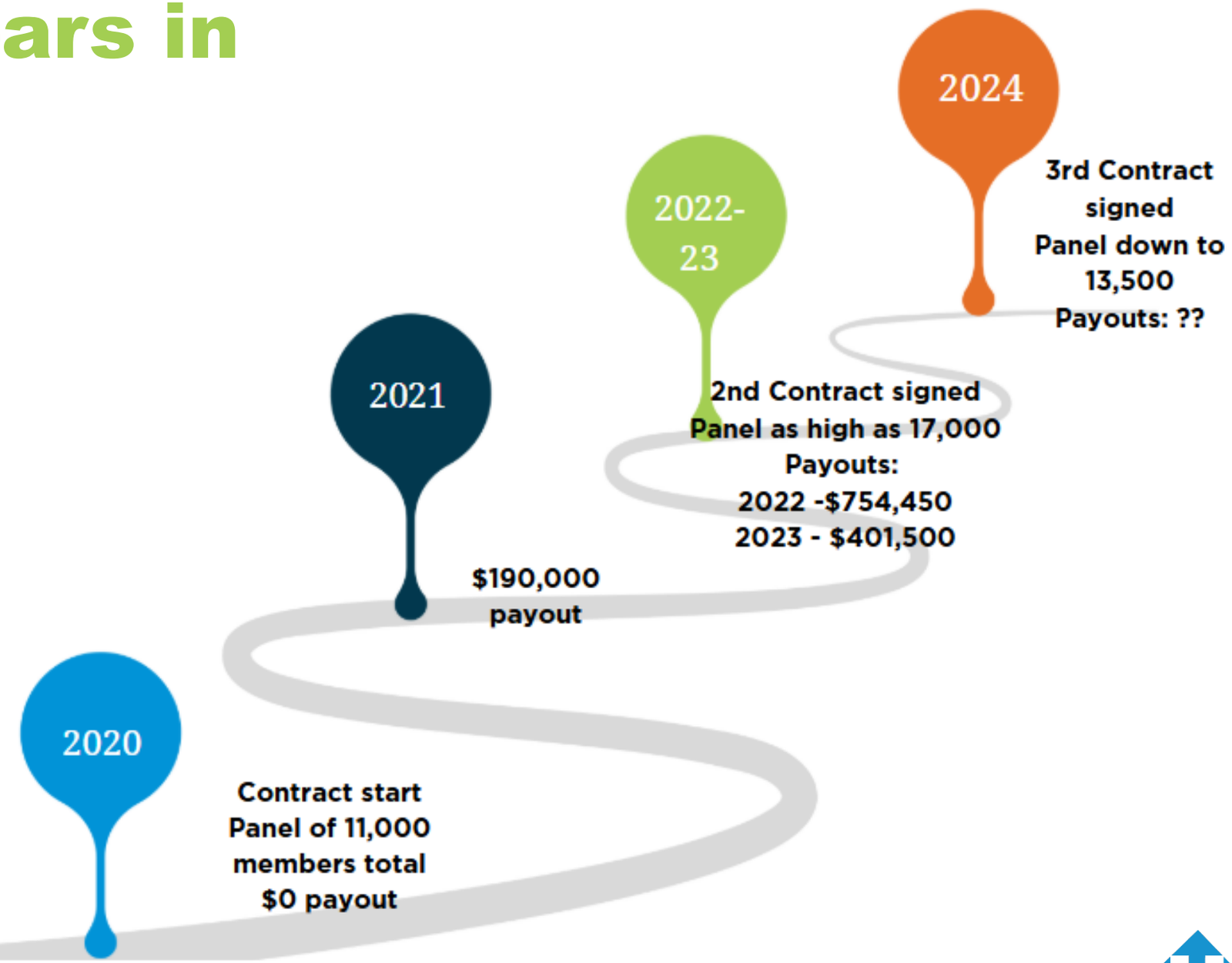


Effective Communication/Collaboration with Payer Team

- Mistakes in site assignments
- Still no movement on engaging them directly with Azara
- Care gap lists have been wonky

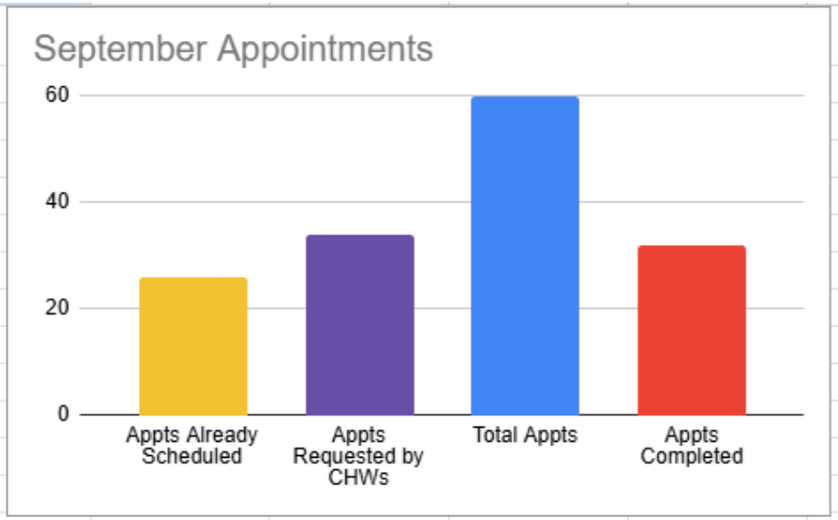
Successes

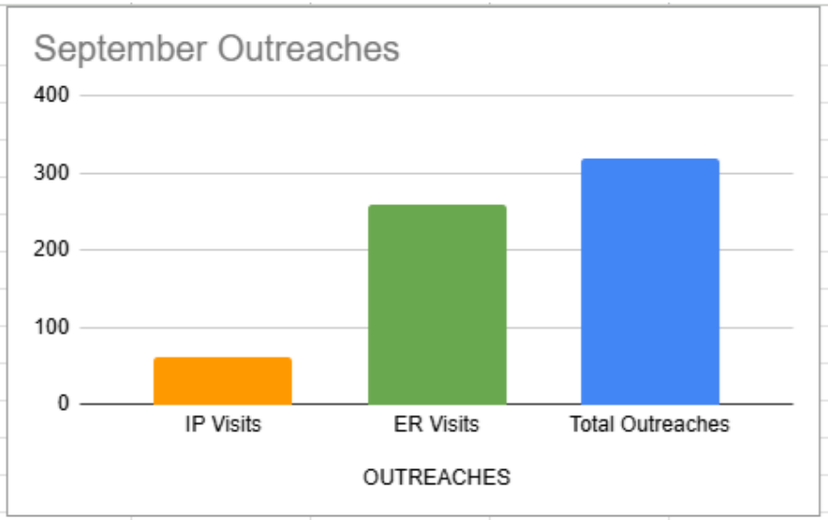
Five years in



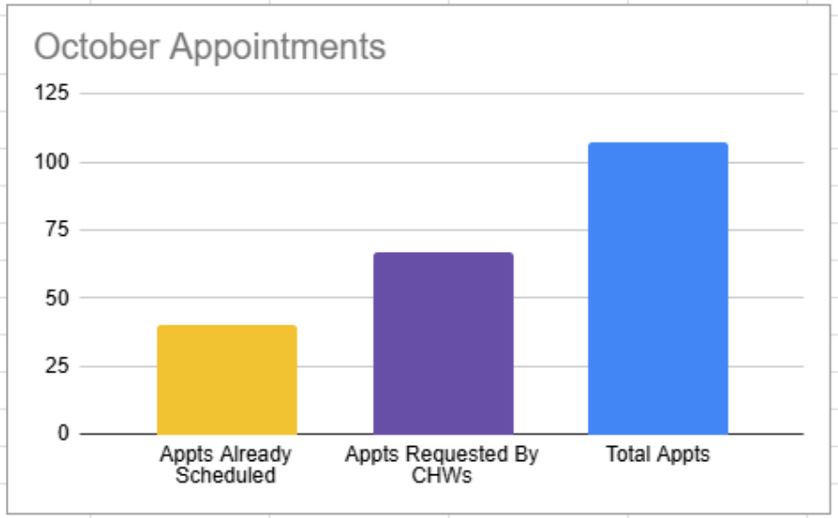
Outreach Results

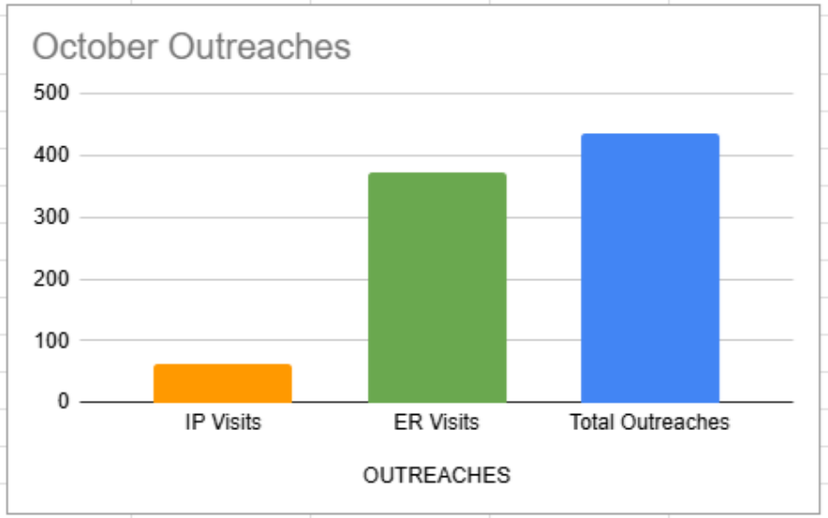
SEPTEMBER	
Appts Already Scheduled	26
Appts Requested by CHWs	34
Total Appts	60
Appts Completed	32
OUTREACHES	
IP Visits	61
ER Visits	259
Total Outreaches	320





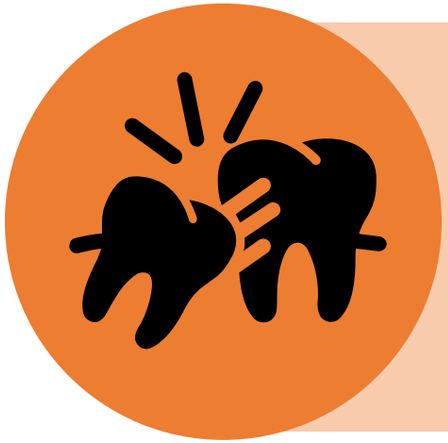
OCTOBER	
Appts Already Scheduled	40
Appts Requested By CHWs	67
Total Appts	107
OUTREACHES	
IP Visits	62
ER Visits	374
Total Outreaches	436





Patient Stories – Avoiding ER/Hospital Use

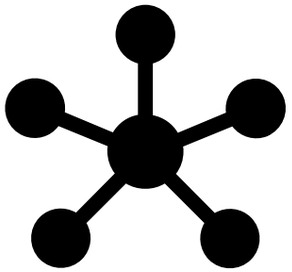
Provided transportation for a patient to travel to specialist appointments.



Connected patient with an oral surgeon who accepts insurance for wisdom tooth surgery.

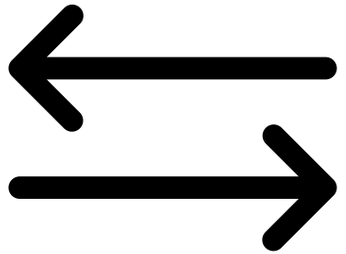
Parent of a patient was unable to reach health center and said she would need to take her baby back to the ER. Health center was immediately contacted and made an appointment for the following day, keeping the patient out of the ER.

No new payer contracts yet, but….



Centralized services for a cancer screening / navigation infrastructure funded by Merck

- We proposed it because we knew it was possible



Amerihealth's bidirectional data integration with Azara

- New opportunities?

The Health Federation of Philadelphia is continually developing new programs in response to both the needs of underserved communities and the availability of data indicating improved approaches to health care and behavioral support.

For more information on our initiatives, please visit:
www.healthfederation.org

company/health-federation-of-philadelphia

@HealthFederationofPhiladelphia

HEALTH FEDERATION
OF PHILADELPHIA
The keystone of community health since 1983

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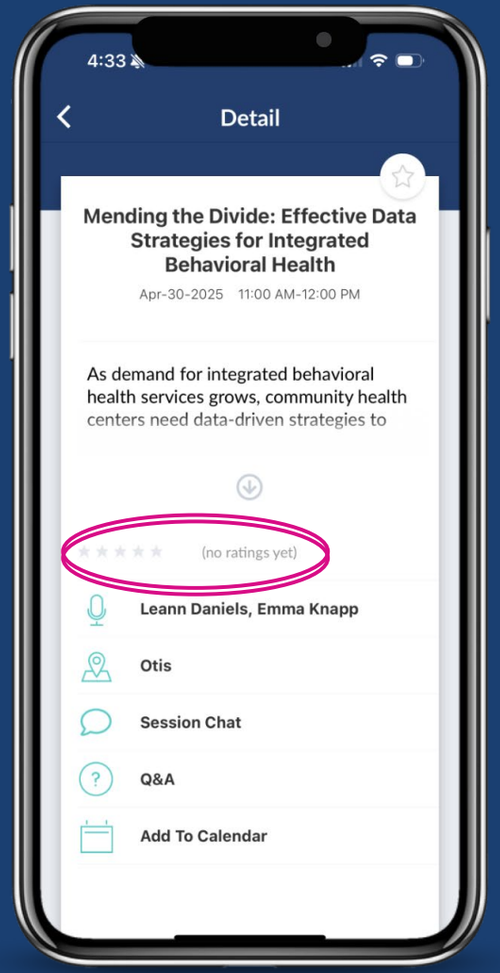
Questions?

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

Achieve, Celebrate, Engage!

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

azara healthcare

ACE Program

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
- Potential to be featured at next year's Azara User Conference
- Win Azara swag!

Submit your success story by completing the form at this link.

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Thanks for attending!