

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

# Data-Driven Strategies for Managing MSSP

Establishing the Foundation



# Today's Presenters



**BreAnn Streck, RN BSN**  
Senior HCCN Project Coordinator  
Montana Primary Care Association



**Carrie Taylor**  
Director, Clinical Transformation  
Azara Healthcare

# Agenda



## Montana Health Plus

Network MSSP Journey



## Azara Ecosystem

Optimizing MSSP Performance with DRVS



## Product Update

Risk Adjustment (RAF)



## Wrap Up & Q&A

# Montana Health Plus

Network Journey to Using DRVS to Manage MSSP



# MONTANA COMMUNITY HEALTH CENTERS



MONTANA COMMUNITY HEALTH CENTERS



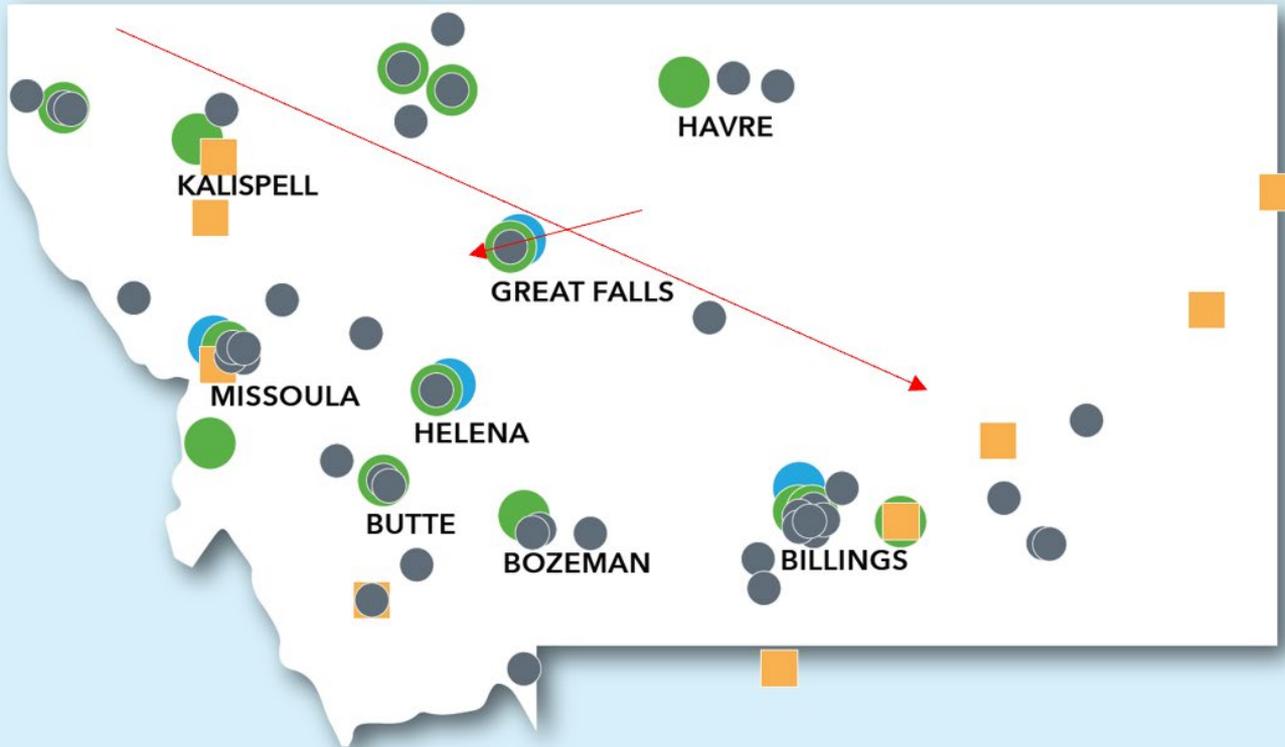
SATELLITE CLINICS



SEASONAL/MIGRANT CLINICS



URBAN INDIAN HEALTH CENTERS



# History of Value-Based Care in Montana FQHCs



Priority goal was and remains one network contract with Medicaid.

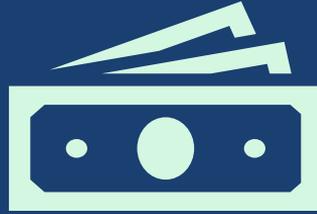
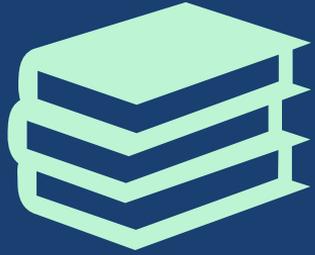


Experience with Value-Based Care started with the Medicaid Health Improvement Program.



Evolved into a PCMH Program with Medicaid, an FQHC specific version of CPC+.

# Partnership with Medicaid



**2010:**

**MT Health  
Improvement  
Program**

**2017:**

**PCMH/CPC+**

**2025:**

**Developing  
New Primary  
Care Model**

# MPCA Strategic Priorities



Getting more and better value-based contracts



Maximizing performance under existing contracts



Making good financial decisions that prepare us for the future and reward good performance

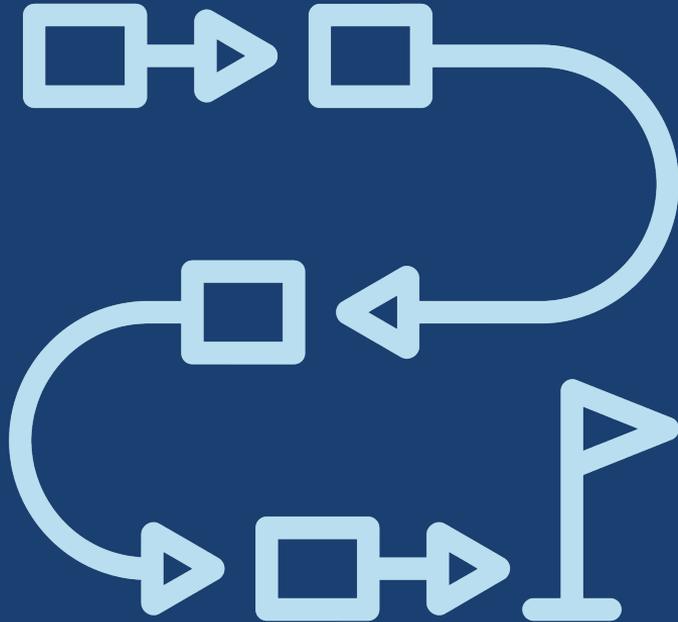


Enhancing the influence of Montana Health Plus

# How Do We Achieve Success?



# Data Strategy

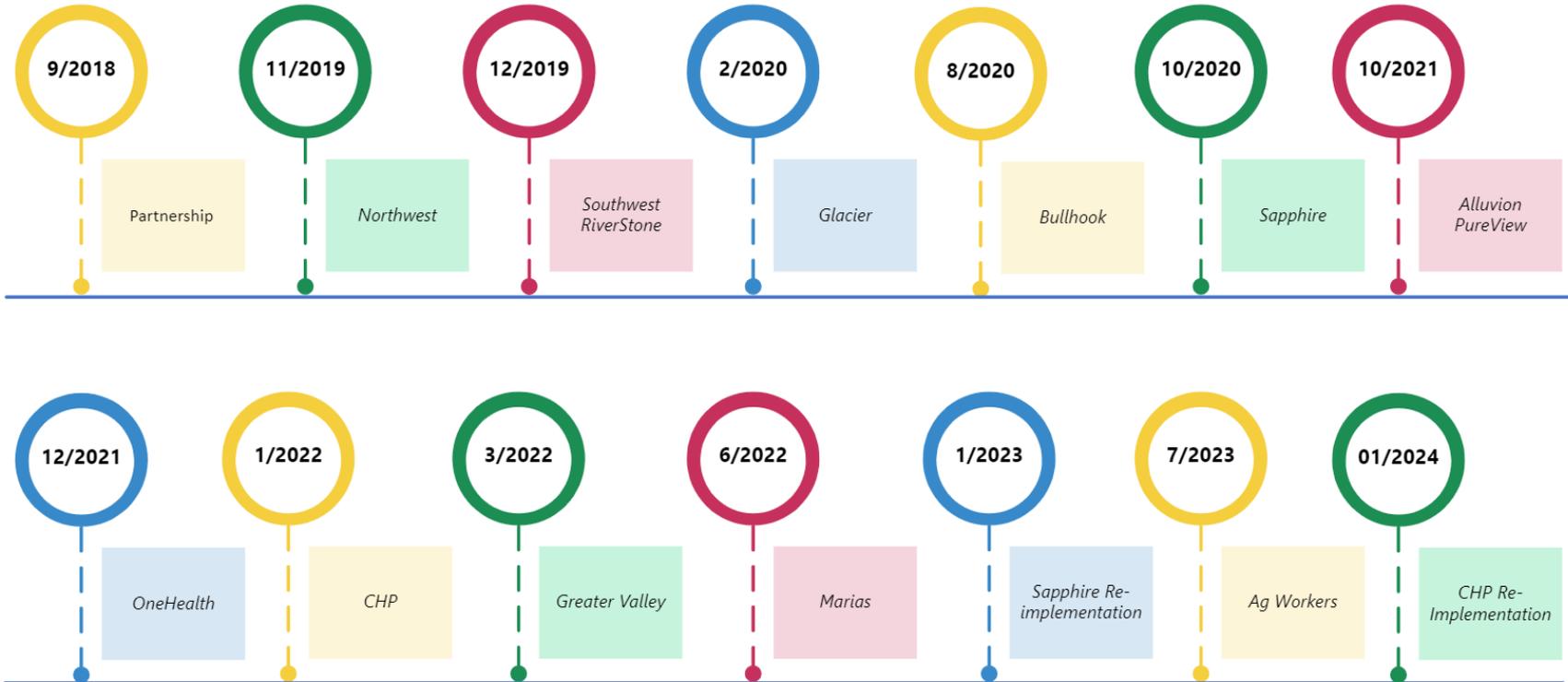


**2018:** DRVS pilot with Partnership Health Center.

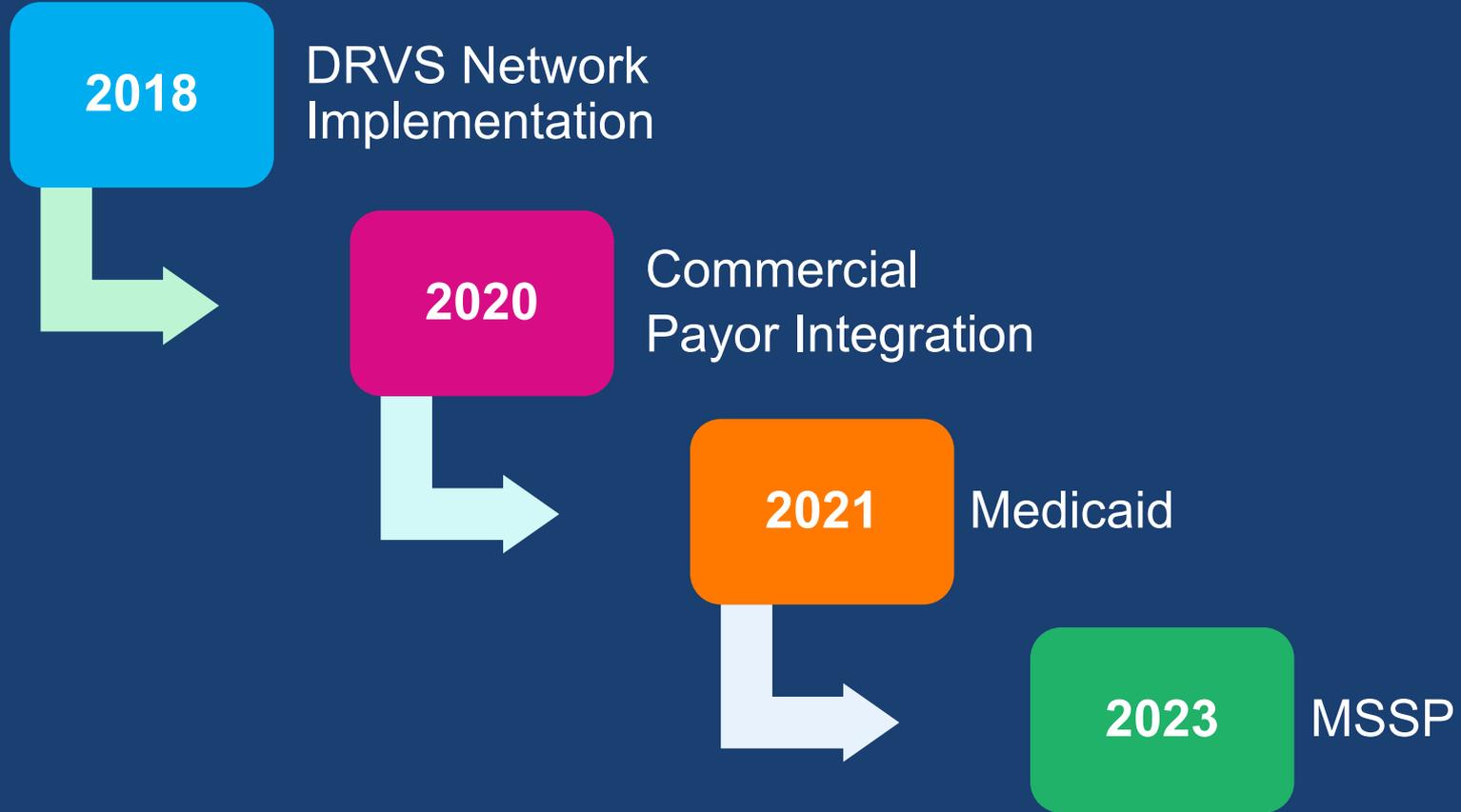


Unanimous board decision to adopt and implement DRVS at every health center in the network.

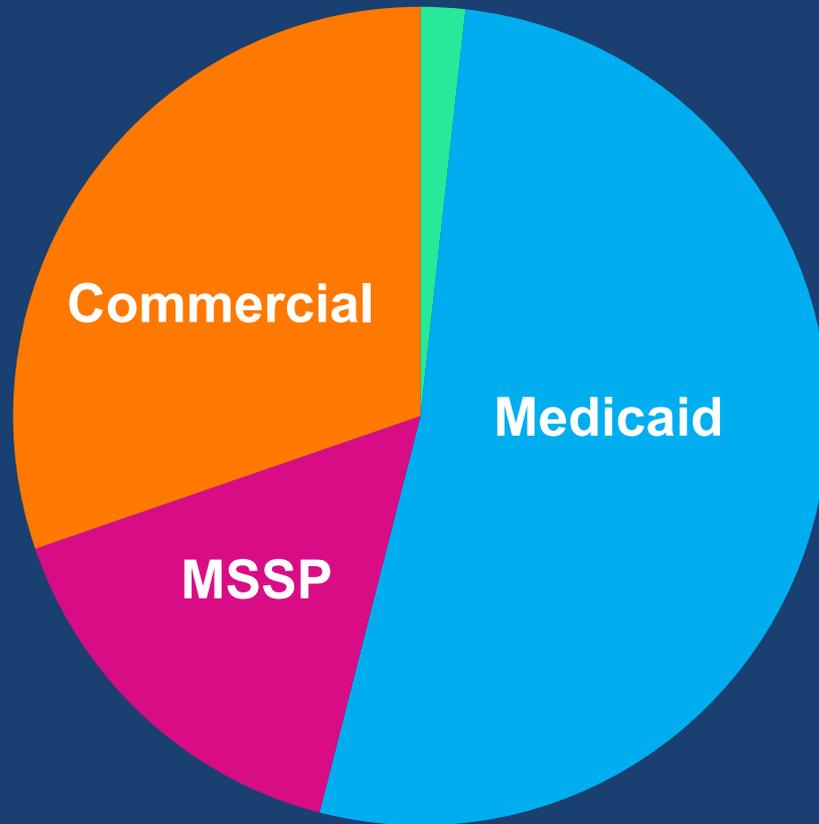
# Montana Azara DRVS Implementation Timeline



# Network Rollout



# Member Distribution



# Medicare Shared Savings Program



1<sup>st</sup> participation year 2023



CMS goal: 2030 all Medicare members are aligned with an ACO



Primary care is key – FQHC led ACO



Revenue stream for health center



Experience in payment models

# Inside Our Care Delivery Model

**PCMH  
Recognition**

**Transparent  
Sharing of Data**

**Utilization of  
Azara DRVS**

**Quality Reporting**

**Payer Integration  
Population Health**

# Turning Strategy into Action



# Network Focus & DRVS

**Care Gaps**

**Risk Adjustment  
Factors (RAF)  
Gaps**

**HCC**

**Member Reports**

**Risk Stratification**

# MSSP Quality Reporting

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All centers in ACO are connected to DRVS.

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Utilized DRVS for completing web interface for 2023/2024 MSSP quality reporting.

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2024 – QRDAIII quality report submission.



# Azara Ecosystem

Optimizing MSSP Performance with DRVS



# How DRVS Supports Our Work

PVP/CMP

Raf Gaps Per Patient Measure

RAF Gaps Medicare Report

Custom MSSP Dashboard

Other Tools Used

- Member Report
- Rising Risk Measure
- Newly Assigned Member Measure
- Transition of Care – ED/IP Dashboard and Report
- Care Reconciliation Report
- Medicare Annual Well Visit Member Based Measure
- Azara Patient Outreach (APO) Medicare AWW without appointment campaign

# Managing RAF Gaps in VBC



**Understand RAF Scores**



**Identify RAF Gaps**



**Improve Documentation and Coding**

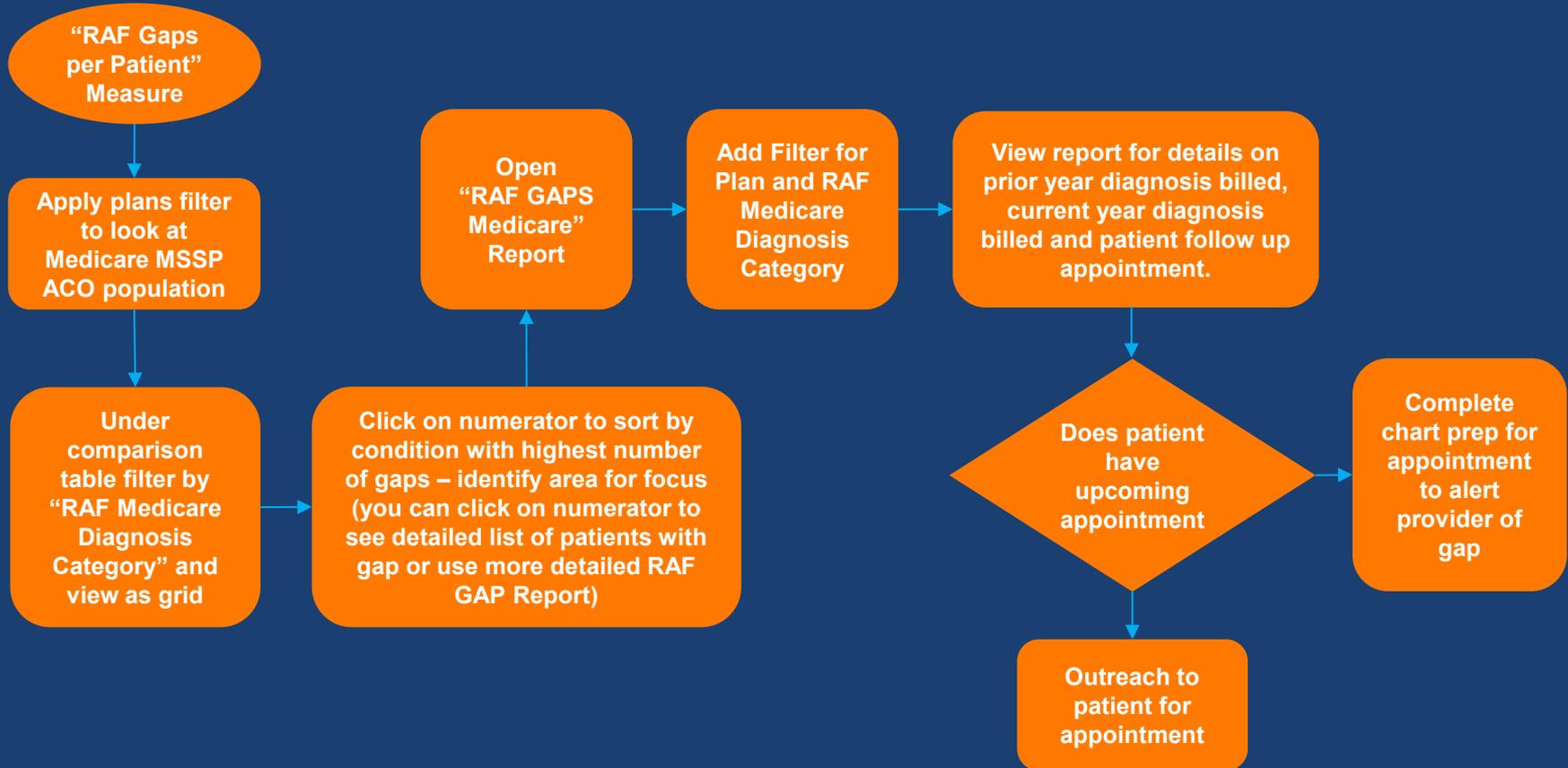


**Enhance patient engagement**



**Collaborate across teams**

# RAF Workflow



# RAF on The PVP & CMP

2:16 AM Wednesday, April 16, 2025 Demo data

**Barcelo, Andrea**  
 MRN: 1100994  
 DOB: 7/19/1996 (28)

Sex at Birth: M  
 GI: Male  
 SO: Don't know

**DIAGNOSES (10)**  
 ASCVD Asthma  
 CAD/No MI Cancer  
 HCV HIV  
 IVD

**RISK FACTORS (5)**  
 ANTICOAG Chronic Opioid Tx  
 SMI TOB

**SDOH (9)**  
 CHILDCARE EDU  
 LANGUAGE MED/CARE  
 SAFETY TRANSPORT-NONMED

**RAF GAPS DIAGNOSIS CATEGORIES (2)**  
 Diabetes Pulmonary

Team-based huddles

Coordination of care

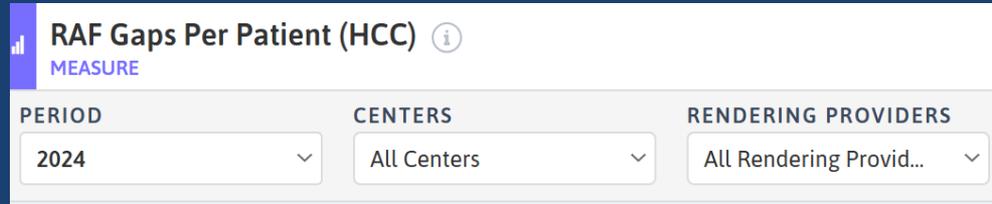
Identify RAF gaps

RAF Gaps (2)				
DIAGNOSIS CATEGORY	CONTEXT	BILLED CY	UNBILLED CY	ACTIONS TO CONSIDER
Diabetes	Dx Not Billed		CHG: E11.9 (05/04/24)	Add to Chg Next Visit
Pulmonary	Dx Not Billed		EHR: J45.30 (05/04/24)	Add to Chg Next Visit
<b>Total RAF Risk Score</b>				
MAX TOTAL SCORE		GAP SCORE		ACTUAL SCORE
0.809		0.809		0

# DRVS RAF GAPS

## RAF Gaps Per Patient (HHC) Measure

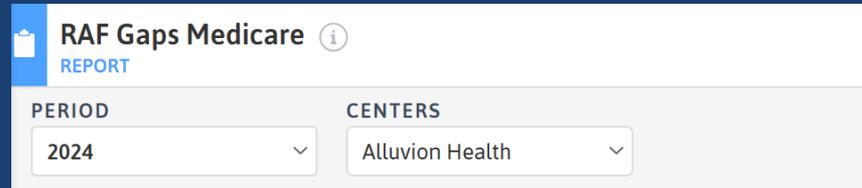
Allows for sorting and analytics to identify focus.



The screenshot shows a web interface for the 'RAF Gaps Per Patient (HCC) MEASURE'. It features a title bar with a signal strength icon, the title 'RAF Gaps Per Patient (HCC)', and an information icon. Below the title bar, there are three filter sections: 'PERIOD' with a dropdown menu set to '2024', 'CENTERS' with a dropdown menu set to 'All Centers', and 'RENDERING PROVIDERS' with a dropdown menu set to 'All Rendering Provid...'. Each dropdown menu has a downward arrow icon.

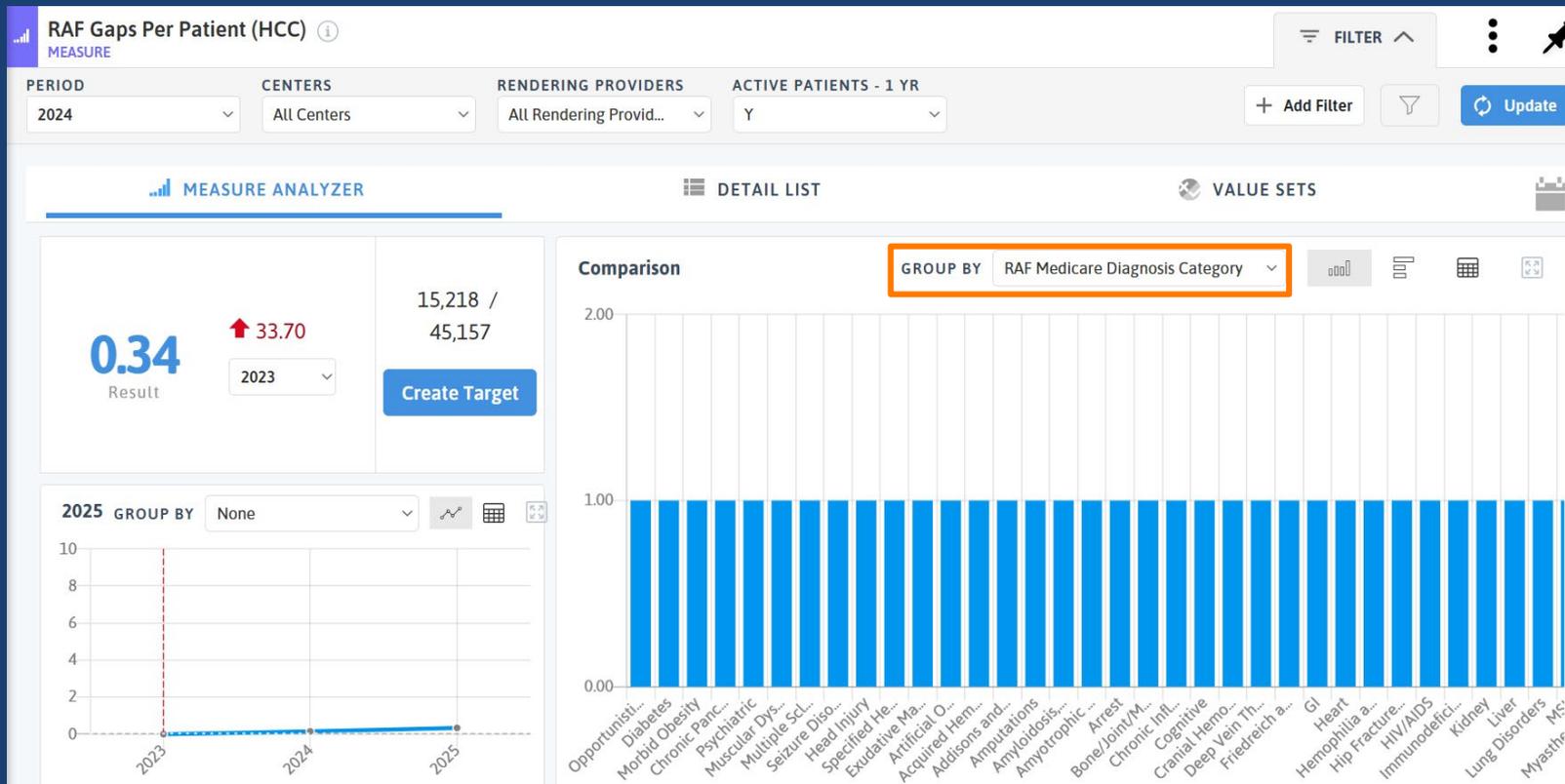
## RAF GAPS Medicare Report

Detailed list to identify gaps, prioritize, and drive outreach.



The screenshot shows a web interface for the 'RAF Gaps Medicare REPORT'. It features a title bar with a clipboard icon, the title 'RAF Gaps Medicare', and an information icon. Below the title bar, there are two filter sections: 'PERIOD' with a dropdown menu set to '2024' and 'CENTERS' with a dropdown menu set to 'Alluvion Health'. Each dropdown menu has a downward arrow icon.

# RAF Gaps Per Patient Measure



# RAF Gaps Medicare Report

RAF Gaps Medicare <sup>1</sup>  
REPORT

PERIOD: 2025 CENTERS: All Centers LAST VISIT CY: Current Year

FILTER ^

+ Add Filter Update

REPORTS VALUE SETS

Search ...

NEXT APPT: All No Appt Upcoming Appt

Reset Columns SAVED COLUMNS

TOTAL HCC MEDICARE RISK			GAP SUMMARY				CURRENT YR EHR				PRIOR
MAX	GAP	ACTUAL	HCC GROUP	GAP DESCRIPTION	MAX RISK ↓	RISK GAP	FACTOR	CODE	RISK	DATE	FACTO
1.76	1.306	0.454	Kidney	No code has been billed yet this year	0.815	0.815	HCC Chronic Kidney Disease Stage 5	I13.11	0.815	1/11/2025	
1.76	1.306	0.454	Kidney	No code has been billed yet this year	0.815	0.815	HCC Chronic Kidney Disease Stage 5	I13.11	0.815	1/11/2025	
1.76	1.306	0.454	Kidney	No code has been billed yet this year	0.815	0.815	HCC Chronic Kidney Disease Stage 5	I13.11	0.815	1/11/2025	
1.259	1.093	0.166	Psychiatric	No code has been billed yet this year	0.484	0.484					HCC Ps
1.492	1.214	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484	HCC Major Depression Moderate or Severe without Psychosis	F32.2	0.299	3/30/2025	HCC Ps
2.155	1.877	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484	HCC Psychosis Except Schizophrenia	F22	0.484	6/12/2025	
1.122	0.844	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484	HCC Psychosis Except Schizophrenia	F22	0.484	4/22/2025	
2.348	2.07	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484					HCC Ps
2.456	2.178	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484					HCC Ps
2.456	2.178	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484	HCC Psychosis Except Schizophrenia	F22	0.484	2/8/2025	HCC Ps
2.662	2.384	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484					HCC Ps
1.492	1.214	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484					HCC Ps
0.65	0.484	0.166	Psychiatric	No code has been billed yet this year	0.484	0.484	HCC Psychosis Except Schizophrenia	F22	0.484	1/28/2025	
1.912	1.634	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484	HCC Psychosis Except Schizophrenia	F22	0.484	3/28/2025	
1.002	0.724	0.278	Psychiatric	No code has been billed yet this year	0.484	0.484	HCC Psychosis Except Schizophrenia	F22	0.484	4/9/2025	

1 to 15 of 6,004

< > Page 1 of 401 > |

# CY Filter on RAF Gaps

New Default Filter on RAF Reports and Measures ✕

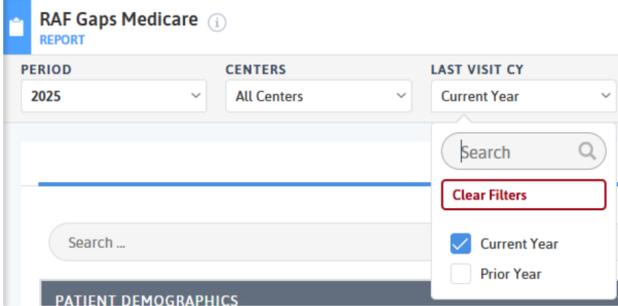
ANNOUNCEMENT

## Last Visit CY Filter on RAF Gaps in DRVS

A new default filter **Last Visit CY** (where CY means current year) has been added to each RAF Gap report and measure.

This filter will allow you to see all patient RAF Gaps at the start of each calendar year, by filtering to "**Last Visit CY = Prior Year**". Filtering like this will show you all patients whose last visit was in the Prior calendar year, aka showing you RAF Gaps for all of your patients who were seen last year.

You can also choose to filter by "**Last Visit CY = Current Year**". This will scope to your patients who have been seen in this calendar year only. One use case for this is to help identify patients who have been seen this year but *still* have open RAF Gaps. Gather those opportunities for RAF Gap closure by filtering to patients who have upcoming appointments where you know you can focus on closing those gaps.



**RAF Gaps Medicare** ⓘ  
REPORT

PERIOD: 2025 | CENTERS: All Centers | LAST VISIT CY: Current Year

Search ...

PATIENT DEMOGRAPHICS

Search

Clear Filters

Current Year

Prior Year

*This filter is a default filter on all RAF Gap reporting objects (measures and reports).*

CREATED BY: Azara PUBLISHED ON: 03/06/2025



# Understanding Attribution

Member Report offers data necessary for a comprehensive understanding of the members attributed to your organization.

Eligibility Dates

Plan Usual  
Provider

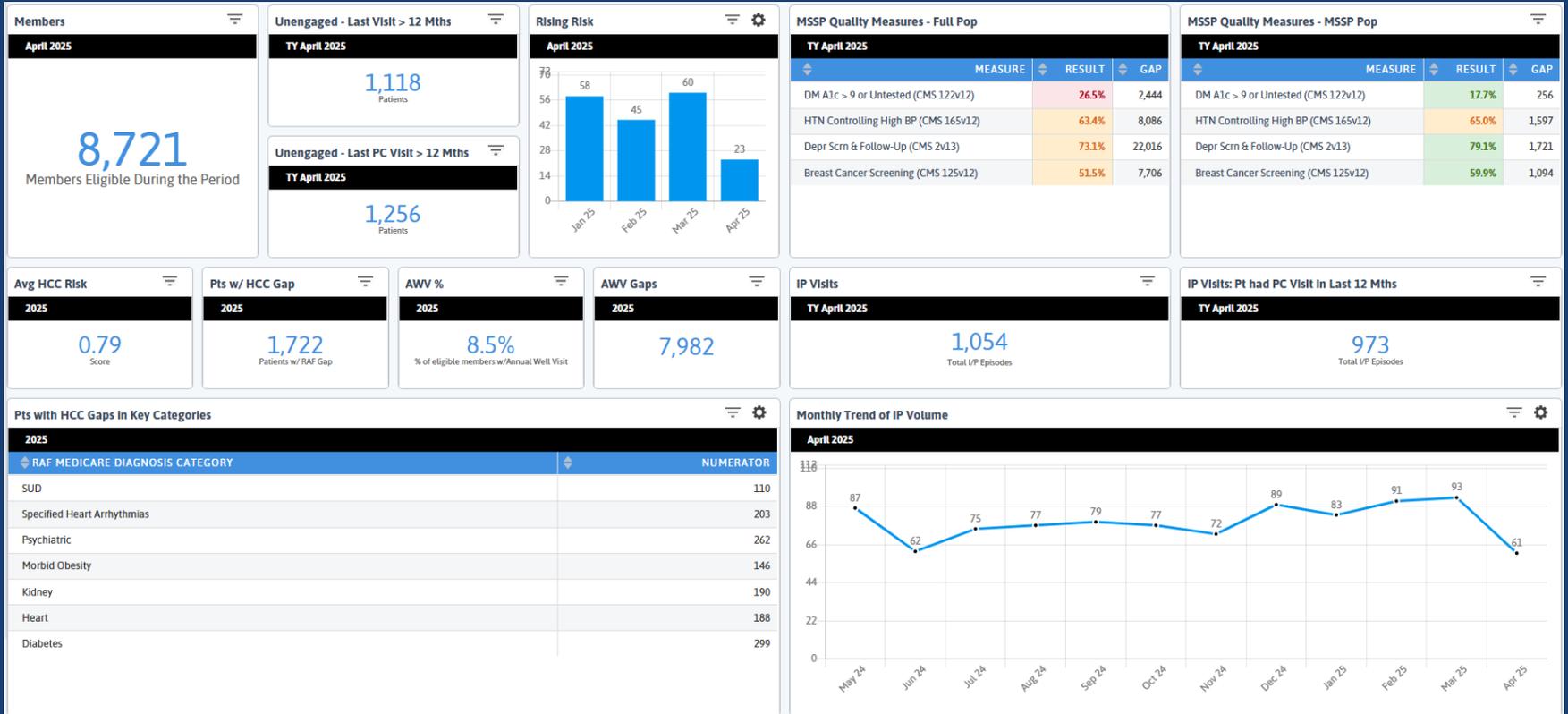
Patient Risk

Last and Next  
Appointment

Chronic  
Conditions

IP/ED Visits

# Custom MSSP Dashboard



# Custom Dashboard Breakdown

## Member Report

Members Report is a tool that can be used to analyze the members attributed to the CHC.

## Unengaged Members

Members who have not been seen in over 12 months and unengaged members who have not been seen in over 12 months by primary care at HC.

## Rising Risk

Patients with a risk level calculated in the previous month period as low or moderate, with a high risk in the current period.

## MSSP Quality Measures

Targeted quality measures looking at the entire patient population vs. the MSSP population.

## Average HCC Risk Score

Calculates the average HCC by applying the HCC Medicare Risk algorithm to all patients with a qualifying encounter.

## Patients with HCC Gap

Number of patients with HCC GAPS.

## Annual Wellness Visits (AWV)

Pulls data from the Annual Wellness Visit Member-Based Report.

## Patients with RAF Gap in Key Categories

Number of patients with RAF gaps in key Medicare categories.

## Inpatient Visits

Patients with an inpatient visit in the last 12 months, had a PCP visit in the previous 12 months, with a monthly trend of IP visits.

# Transitions of Care IP Report

Transitions of Care (TOC) - ED/IP <sup>1</sup>

REPORT

FILTER ^

DATE RANGE: 04/17/2025-04/17/2025

CENTERS: All Centers

DISCHARGE STATUS: All Discharge Status

LAST VISIT: Any visit in past 1 year

TOC TYPE: IP Only

TOC STATUS: Discharge

PLANS: Medicare MSSP ACO

+ Add Filter

Update

REPORTS

VALUE SETS

Search ...

NEXT APPT: All No Appt Upcoming Appt

Reset Columns

SAVED COLUMNS

PATIENT (Y/N)	ADMISSION EVENT				ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS	IP READMIT	DISCHARGE		DIAGNOSIS	
	TYPE	ADMISSION	DISCHARGE	FACILITY				STATUS	STATUS CODE	CODE	DESCRIPTION
Y	Inpatient Stay	4/15/25 5:05 am	4/17/25 1:13 pm		0	1	N	Home	01 Home or Self Care		
Y	Inpatient Stay	4/14/25 6:00 pm	4/17/25 3:14 pm		0	1	N	Home	HOME	I10	ESSENTIAL (PRIMARY) HYPERTENSION
Y	Inpatient Stay	4/14/25 7:57 am	4/17/25 10:48 am		0	1	N	Home	01 Home or Self Care		
Y	Inpatient Stay	4/14/25 11:36 am	4/17/25 11:30 am		0	1	N	Home	HOM		

# Transitions of Care (I/P) Dashboard

### I/P Episodes

April 2025

136

Pts Discharged from Inpatient Facility

### I/P Episode Trend

TY April 2025

Date	Value
11/24	3,443
12/24	3,585
1/25	3,738
2/25	3,850
3/25	3,936
4/25	3,875

### 30 Day I/P Readmit Rate

TY April 2025

14%

% of Pts w/ Readmission within 30 days

### 30 Day I/P Readmit Trend

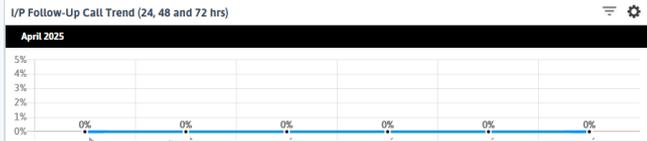
TY April 2025

Date	Value
11/24	16%
12/24	16%
1/25	15%
2/25	15%
3/25	14%
4/25	14%

### I/P Follow Up Call

April 2025

FOLLOW UP CALL	RESULT	NUMERATOR	DENOMINATOR
8-10 days	0%	0	104
6-7 days	0%	0	104
4-5 days	1%	1	104
3 days	0%	0	104
2 days	0%	0	104
11+ days / No Call	99%	103	104



### No Follow-Up Call (48 hrs)

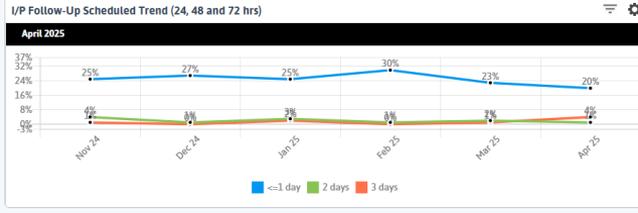
April 2025

104

### I/P Follow Up Scheduled

April 2025

FOLLOW UP SCHEDULED	RESULT	NUMERATOR	DENOMINATOR
8-10 days	0%	0	104
6-7 days	0%	0	104
4-5 days	3%	3	104
31+ / No Follow Up Scheduled	72%	75	104
3 days	4%	4	104



### No Follow-Up Visit Scheduled (48 hrs)

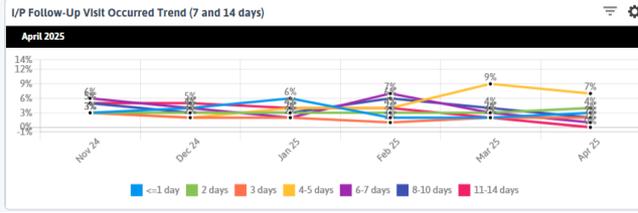
April 2025

82

### I/P Follow Up Visit

April 2025

FOLLOW UP VISIT	RESULT	NUMERATOR	DENOMINATOR
8-10 days	2%	2	104
6-7 days	1%	1	104
4-5 days	7%	7	104
31+ / No Follow Up Visit	82%	85	104
3 days	2%	2	104



### No Follow-Up Visit Occurred (7 days)

April 2025

2

Pts w/ Follow-Up visit after Discharge

# Benefits of Transitions of Care

Interface with HIE or hospitals to get daily patient updates in DRVS.

Run daily TOC Registry Reports for IP/ED admissions and discharges.

Add IP/ED alerts to pre-visit planning reports (PVP).

Improve follow-up by requesting discharge summaries and med recs.

Monitor TOC processes with DRVS Dashboards and quality measures.

Use Care Management Passport for detailed IP/ED history and outcomes.

Track readmission rates to manage costs.

Identify frequent utilizers for targeted care management.

# Medicare Annual Well Visit Member Based Measure

Medicare Annual Well Visit Member Based MEASURE

PERIOD: 2025 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid... | PLANS: Medicare MSSP ACO | PRODUCTS: All Products

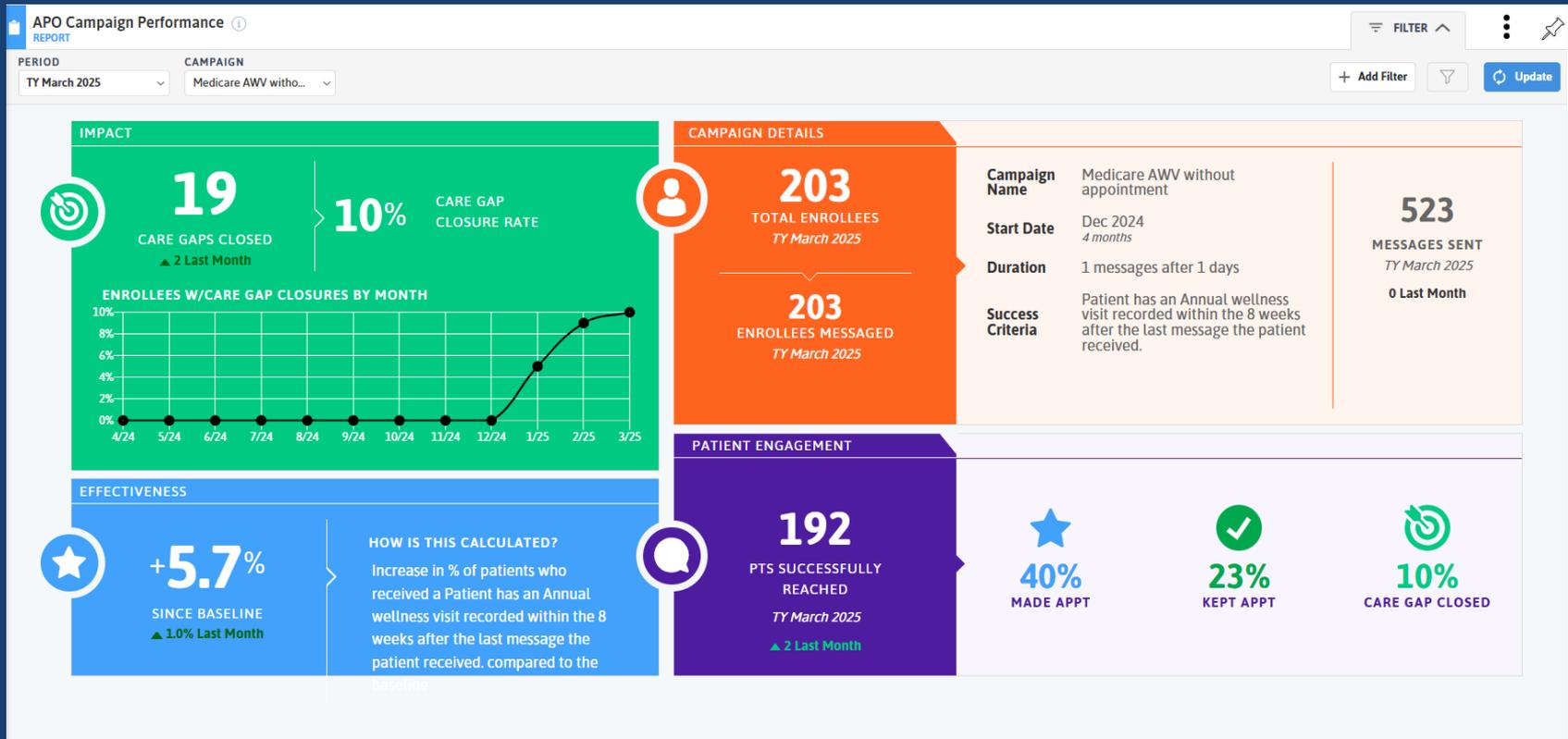
MEASURE ANALYZER | **DETAIL LIST** | VALUE SETS

Search Patients ... | All | Gaps | Num | Excl | Reset Columns | SAVED COLUMNS

PLAN	MOST RECENT ENCOUNTER DATE	TOTAL COST PAST YR	COST GROUP	ELIGIBILITY		ASSIGNMENT		ANNUAL WELLCARE VISIT				ANNUAL WELLCARE	
				START DATE	END DATE	START DATE	END DATE	DATE	PROVIDER	LOCATION	CODE	DATE	REN
Medicare MSSP ACO	3/24/2025	1143.5	\$0-5K	1/1/2025	12/31/2025	1/1/2025	12/31/2025	4/29/2024			G0439		
Medicare MSSP ACO	12/27/2024	220.96	\$0-5K	1/1/2025	12/31/2025	1/1/2025	12/31/2025	8/29/2022			G0439		
Medicare MSSP ACO	11/20/2024	78.48	\$0-5K	1/1/2023	12/31/2025	1/1/2023	12/31/2025	3/26/2024			G0439		
Medicare MSSP ACO	1/23/2025	327.89	\$0-5K	1/1/2023	12/31/2025	1/1/2024	12/31/2025	8/31/2021			G0439		
Medicare MSSP ACO	9/13/2024		No Cost Data	1/1/2025	12/31/2025	1/1/2025	12/31/2025	9/13/2024			G0439		
Medicare MSSP ACO	3/6/2025	2015.5	\$0-5K	1/1/2024	12/31/2025	1/1/2024	12/31/2025	8/4/2022			G0439		
Medicare MSSP ACO	11/8/2024		No Cost Data	1/1/2023	12/31/2025	1/1/2023	12/31/2025	8/19/2024			G0439		
Medicare MSSP ACO	9/3/2024		No Cost Data	1/1/2023	12/31/2025	1/1/2023	12/31/2025	5/8/2024			G0439		
Medicare MSSP ACO	2/19/2025	430.39	\$0-5K	1/1/2024	12/31/2025	1/1/2024	12/31/2025	4/26/2024			G0439		
Medicare MSSP ACO	12/12/2024	8440.89	\$5-10K	1/1/2024	12/31/2025	1/1/2024	12/31/2025	12/29/2023			G0439		
Medicare MSSP ACO	6/27/2024	0	\$0-5K	1/1/2023	12/31/2025	1/1/2023	12/31/2025	12/22/2023			G0439		
Medicare MSSP ACO	8/26/2024	4.8	\$0-5K	1/1/2023	12/31/2025	1/1/2023	12/31/2025						
Medicare MSSP ACO		2426.77	\$0-5K	1/1/2023	12/31/2025	1/1/2023	12/31/2025						
Medicare MSSP ACO		4456.83	\$0-5K	1/1/2024	12/31/2025	1/1/2024	12/31/2025						

# Azara Patient Outreach (APO)

## Medicare AWW without appointment campaign.



# Recommended Report Cadence

- MHP providing tools and suggestion to centers on cadence for running reports.
- Education for centers on utilizing DRVS for VBC.

## Value Based Care in DRVS:

The below is a list of Measures/Reports/Dashboards that are available in DRVS to support health centers work in [value based care](#):

DRVS	Recommended Action	Frequency
<b>Member Report</b>	Utilize to view member attribution for each payer.	Monthly
<b>Force Match Administration</b>	All payers – review members who were not able to be automatically matched by DRVS	Monthly
<b><u>Newly Assigned Members</u></b>	The detailed list in this measure can be used to identify members to outreach to establish care with your practice	Monthly
<b>GJA MSSP Dashboard</b>	MSSP PRIORITY: <ol style="list-style-type: none"> <li>1. HCC Gaps – utilize report to outreach to members with GAPS</li> <li>2. AWV –recall members due for AWV</li> <li>3. Inpatient Visit – schedule patients for follow up.</li> <li>4. Rising Risk – identify patients with increasing risk who may need care management or outreach</li> <li>5. Unengaged – identify members who need outreach to schedule</li> </ol>	Monthly
<b>RAF Gaps Medicare</b>	<ol style="list-style-type: none"> <li>1. Filter to MSSP</li> <li>2. Sort by patient to identify gaps for each patient.</li> <li>3. ACTION – outreach to schedule or pre visit plan if patient has upcoming appointment.</li> </ol>	Recommended weekly
<b>PVP/CMP</b>	Use at point of care to identify RAF gaps and pre-visit plan.	Daily
<b>Transition of Care IP/ED Report</b>	Identify IP/ED admissions to outreach after discharge and	Daily

# Strategic Priorities



## RAF Gaps – Recall Patients

- Reminder at start of year RAF scores reset.
- Need to recapture chronic conditions from year to year.



## Code to Highest Specificity

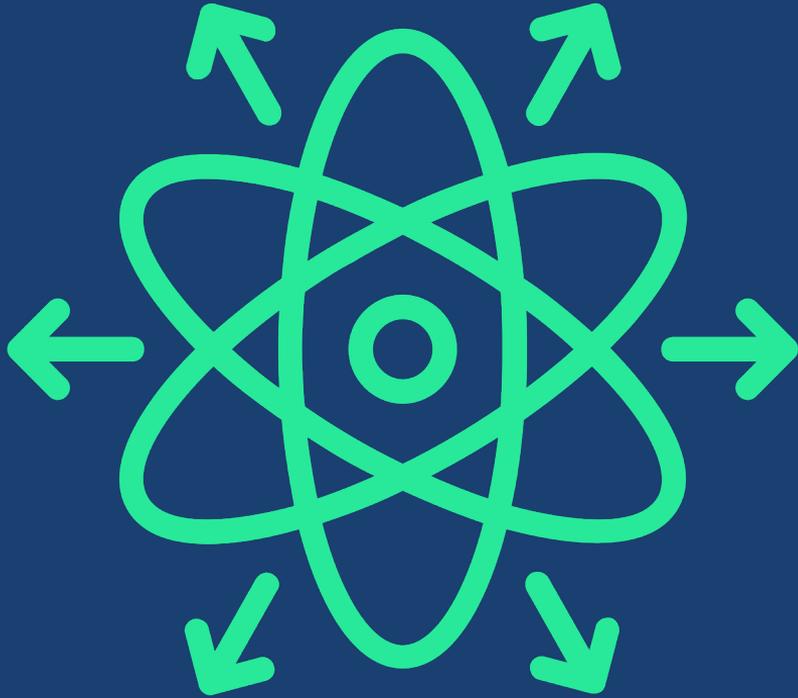
- Identify codes that are not coded to the highest specificity.
- Use of DRVS CMP/RAF.



## Medicare Wellness Visits

- Drill down by month when patient is due and recall.
- Focus on the start of the year on members who didn't have a completed AWV in 2024.

# Challenges



Mapping of ICD-10 Codes between EHR and DRVS

Coding education and EMR tool adoption

Staff turnover at health center sites

Repetition of education

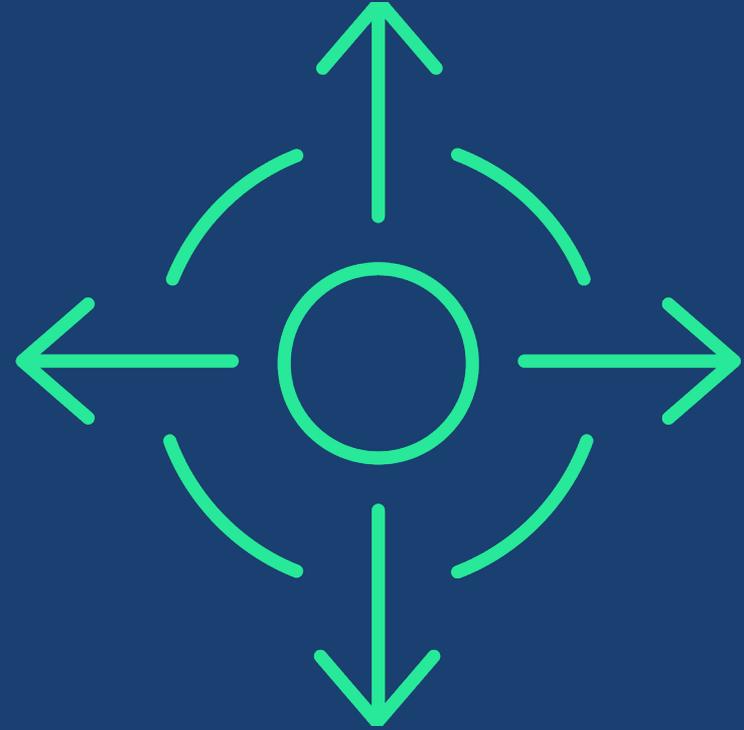
Priority fatigue

# ACU

**Next Frontier** – Center-facing tool to manage attributed population.

**Stratify patients** by cost and risk and further modify and develop population health strategies utilizing ACU.

**Develop strategies** for how the network and centers work together to identify and care manage high-risk patients.



# Celebrating Our Wins!

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**Established a Strong PCMH Foundation**

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**Achieved Full DRVS Adoption Across All Clinics**

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**Cultivated Strategic Relationships**

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**Embraced Repetition as a Strategy**

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**Implemented Population Stratification for Targeted Interventions**

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**Optimized Resource Utilization**

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# Product Update

Risk Adjustment Factors (RAF)



# Azara and HCC RAF

## Where are we in our RAF Product Journey?

1. HCC RAF v28 Upgrade
2. Plug-In RAF Dismissals
3. New Measure
4. Coming soon... **More Plug-In RAF Actions**

# NEW! Dismissing RAF Gaps in the EHR Plug-In

**Abernathy, Colby**  
Moderate (12)  
MRN: 000279887564  
DOB: 12/18/1996  
(28 yrs)

**ALERTS** 6

**RAF GAPS** 3

**REFERRALS** 7

**CARE MGMT**

**DOCUMENTS:**

- Care Mgmt Plan
- Prenatal Passport

Diagnosis Category	Context/Actions	Billed CY	Unbilled CY	Action
Cardiovascular	Dx Not Billed Add to Chg Next Visit		EHR: I10 (10/10/24)	Dismiss
Diabetes	Dx Not Billed Add to Chg Next Visit		EHR: E11.9 (07/09/24)	Dismiss
Psychiatric	Dx Not Billed Add to Chg Next Visit		EHR: F43.10 (01/24/24)	Dismiss

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Available now for ALL centers who have the EHR Plug-in

# How are RAF Gaps Closed?

A RAF gap is when a code has been billed in the past, but not the current year.

To close a RAF Gap, a diagnosis code must be documented that fits a patient's RAF Diagnosis Category from last years' billed diagnosis codes.

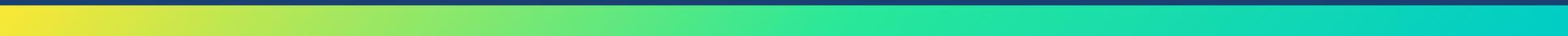
**Abernathy, Colby**  
Moderate (L2)  
MRN: 000279887564  
DOB: 12/18/1996  
(28 yrs)

ALERTS 6  
RAF GAPS 3  
REFERRALS 7  
CARE MGMT

DOCUMENTS:  
Care Mgmt Plan  
Prenatal Passport

Diagnosis Category	Context/Actions	Billed CY	Unbilled CY	Action
Cardiovascular	Dx Not Billed Add to Chg Next Visit		EHR: I10 (10/10/24)	Dismiss
Diabetes	Dx Not Billed Add to Chg Next Visit		EHR: E11.9 (07/09/24)	Dismiss
Psychiatric	Dx Not Billed Add to Chg Next Visit		EHR: F43.10 (01/24/24)	Dismiss

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# Where do “Dismissals” Come Into Play?

Currently, providers have no way to identify those RAF Gaps that no longer apply.

This means the gap stays open all year, adding to a center/organization’s RAF Gap Scores in DRVS and falsely inflating the number of *true* gaps that require action.

The screenshot displays a patient dashboard for Abernathy, Colby. On the left, there are navigation tabs for Alerts (6), RAF Gaps (3), Referrals (7), and Care Mgmt. Below these are document links for 'Care Mgmt Plan' and 'Prenatal Passport'. The main area features a table of unbillable diagnoses:

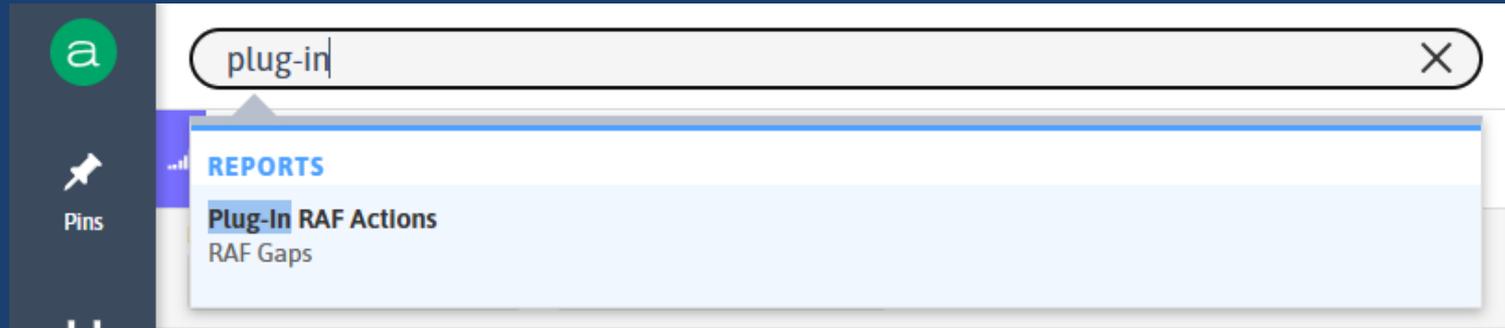
Diagnosis Category	Context/Actions	Billed CY	Unbilled CY	Action
Cardiovascular	Dx Not Billed Add to Chg Next Visit		EHR: 110 (10/10/24)	Dismiss
Diabetes	Dx Not Billed Add to Chg Next Visit		EHR: E11.9 (07/09/24)	Dismiss
Psychiatric	Dx Not Billed Add to Chg Next Visit		EHR: F43.10 (01/24/24)	Dismiss

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# How do Dismissals Affect RAF and DRVS?

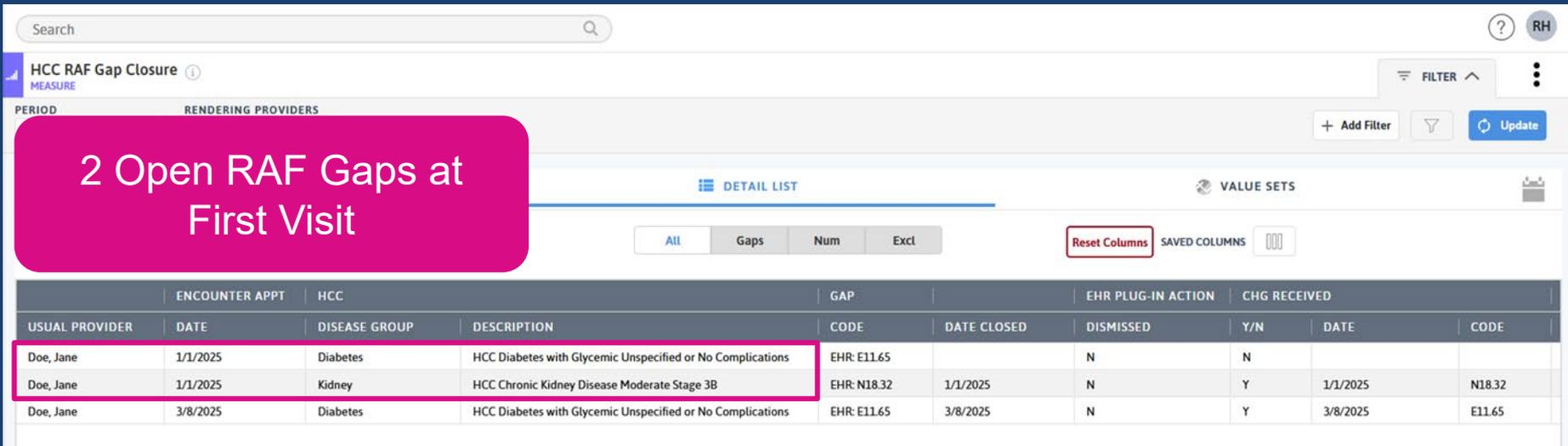
Dismissed RAF gaps flow downstream to DRVS in a few different ways...

1. Dismissed gaps are **excluded** from RAF Gap measure calculations
2. Dismissed gaps are **hidden** from the CMP RAF Gap table
3. The action of dismissing a gap is **logged in a new report**, Plug-In RAF Actions, available for those with the EHR Plug-In. This includes the user who took the action, when, and the reason why.



# New Measure: HCC RAF Gap Closure

Review patients who had gaps at the time of their visit and whether the gap was closed at the point-of-care.



Search

HCC RAF Gap Closure MEASURE

PERIOD RENDERING PROVIDERS

2 Open RAF Gaps at First Visit

DETAIL LIST VALUE SETS

All Gaps Num Excl Reset Columns SAVED COLUMNS

USUAL PROVIDER	ENCOUNTER APPT DATE	HCC DISEASE GROUP	DESCRIPTION	GAP CODE	DATE CLOSED	EHR PLUG-IN ACTION DISMISSED	CHG RECEIVED Y/N	DATE	CODE
Doe, Jane	1/1/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65		N	N		
Doe, Jane	1/1/2025	Kidney	HCC Chronic Kidney Disease Moderate Stage 3B	EHR: N18.32	1/1/2025	N	Y	1/1/2025	N18.32
Doe, Jane	3/8/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65	3/8/2025	N	Y	3/8/2025	E11.65

# New Measure: HCC RAF Gap Closure

Includes columns for encounter type, usual provider, rendering provider, and encounter location.

Search

HCC RAF Gap Closure MEASURE

PERIOD RENDERING PROVIDERS

+ Add Filter FILTER Update

DETAIL LIST VALUE SETS

All Gaps Num Excl Reset Columns SAVED COLUMNS

USUAL PROVIDER	ENCOUNTER APPT	HCC		GAP		EHR PLUG-IN ACTION	CHG RECEIVED		
USUAL PROVIDER	DATE	DISEASE GROUP	DESCRIPTION	CODE	DATE CLOSED	DISMISSED	Y/N	DATE	CODE
Doe, Jane	1/1/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65		N	N		
Doe, Jane	1/1/2025	Kidney	HCC Chronic Kidney Disease Moderate Stage 3B	EHR: N18.32	1/1/2025	N	Y	1/1/2025	N18.32
Doe, Jane	3/8/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65	3/8/2025	N	Y	3/8/2025	E11.65

# New Measure: HCC RAF Gap Closure

Search ? RH

HCC RAF Gap Closure MEASURE FILTER + Add Filter Update

PERIOD RENDERING PROVIDERS

DETAIL LIST VALUE SETS

All Gaps Num Excl Reset Columns SAVED COLUMNS

ENCOUNTER APPT		HCC		GAP		EHR PLUG-IN ACTION		CHG RECEIVED	
USUAL PROVIDER	DATE	DISEASE GROUP	DESCRIPTION	CODE	DATE CLOSED	DISMISSED	Y/N	DATE	CODE
Doe, Jane	1/1/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65		N	N		
Doe, Jane	1/1/2025	Kidney	HCC Chronic Kidney Disease Moderate Stage 3B	EHR: N18.32	1/1/2025	N	Y	1/1/2025	N18.32
Doe, Jane	3/8/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65	3/8/2025	N	Y	3/8/2025	E11.65

One Open RAF Gap at Second Visit

# New Measure: HCC RAF Gap Closure

Search ? RH

HCC RAF Gap Closure MEASURE FILTER

PERIOD RENDERING PROVIDERS + Add Filter Update

**One RAF Gap Closed at Second Visit**

DETAIL LIST VALUE SETS

All Gaps Num Excl Reset Columns SAVED COLUMNS

ENCOUNTER APPT		HCC		GAP		EHR PLUG-IN ACTION		CHG RECEIVED	
USUAL PROVIDER	DATE	DISEASE GROUP	DESCRIPTION	CODE	DATE CLOSED	DISMISSED	Y/N	DATE	CODE
Doe, Jane	1/1/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65		N	N		
Doe, Jane	1/1/2025	Kidney	HCC Chronic Kidney Disease Moderate Stage 3B	EHR: N18.32	1/1/2025	N	Y	1/1/2025	N18.32
Doe, Jane	3/8/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65	3/8/2025	N	Y	3/8/2025	E11.65

# Coming Soon...

## Add Dx Codes to your EHR from the Plug-In

**Abernathy, Colby**  
Moderate (12)  
MRN: 000279887564  
DOB: 12/18/1996  
(28 yrs)

**ALERTS** 6  
**RAF GAPS** 3  
**REFERRALS** 7  
**CARE MGMT**

**DOCUMENTS:**  
Care Mgmt Plan  
Prenatal Passport

Diagnosis Category	Context/Actions	Billed CY	Unbilled CY	Action
Cardiovascular	Dx Not Billed Add to Chg Next Visit		EHR: I10 (10/10/24) Type 2 diabetes mellitus without complications	Dismiss + Add to EHR
Diabetes	Dx Not Billed Add to Chg Next Visit		EHR: E11.9 (07/09/24)	Dismiss + Add to EHR
Psychiatric	Dx Not Billed Add to Chg Next Visit		EHR: F43.10 (01/24/24)	Dismiss + Add to EHR

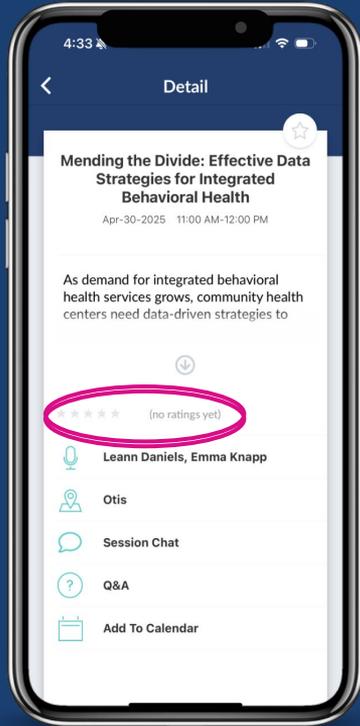
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Rate the session and the speaker(s)



Help us continue to improve

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## 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
- 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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**ACE Program**



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# Thanks for attending!

