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

Quality and Operations Process Improvement for Success with VBC Models

Today’s Presenters

Lindsey Hollenkamp, MBA
Deputy Director of Quality and Practice Transformation
SIU Family and Community Medicine

Michal Dynda, MD
CMO/CMIO
SIU Medicine

Mission

Serving the healthcare needs of our patient and our communities in a compassionate and affordable environment

Vision

We care, you matter. Providing compassionate quality health services and leading in healthcare education

Values

- **F**amily and problem-oriented care that is comprehensive and team based
- **Q**uality care that is compassionate and affordable
- **H**ealthcare education and training that advances knowledge
- **C**ommunity based care in partnerships with organizations that share our vision

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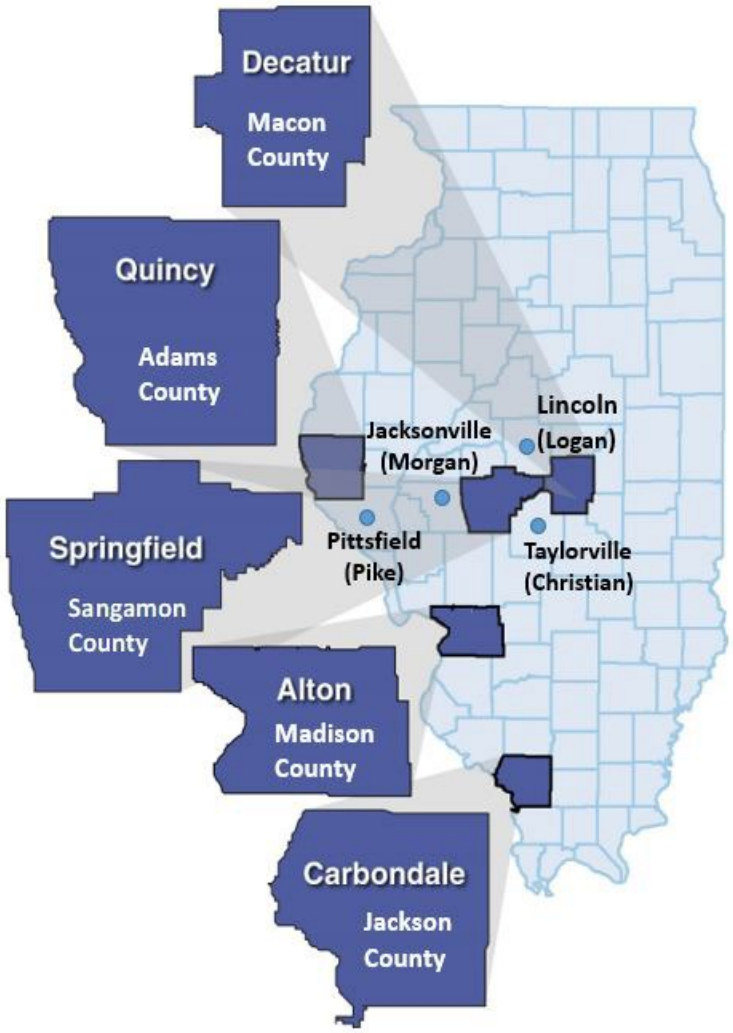

Number of visits: 151,795
Unique patients: 46,682

Residents: 147
Family Medicine: 33/year
Internal Medicine: 16/year
Sports Med Fellowships: 4/year

2 undergrad programs:
Med students: 80/year
PA students: 40/year

5 Family Medicine residencies

1 Internal Medicine residency

4 clinics integrated in mental health centers

6 outreach clinics in partnership with local health depts / Salvation Army

4 dental clinics

2 mobile Care-A-Van clinics

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Patient Population

Race	White: 69%
Black/African American: 17%	Unreported/Chose not to disclose: 11%
More than one race: 2%	Other: 1%

Payor Mix	Uninsured: 4%
Medicaid: 43%	Medicare/Dual: 23%
Commercial: 30%	

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Value Based Journey – 2021 to Present Day

No internal reporting from EHR – Q1 results in late Q2	No active MCO participation	Quality staff of 2 unfamiliar with VBC	No tracking/ reconciling of incentive dollars
Partnered with Azara in 2021, DRVS live in 2022	Participating in 14 bonus agreements and MSSP ACO	Quality staff of 5 with widespread VBC/MCO understanding	Director of Managed Care tracking contracts and payments

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SIU Specific Barriers

Shared EHR

- Altera Touchworks, minimal customization capability
- Incompatible with many vendors
- Example: DRVS has EHR overlay tool not compatible with TW

State Entity/State University System

- State procurement laws
- Competitive pay rates

Residency

- Constant and continuous education
- Resident turnover – PCP reassignment every 2 years

Academic Medicine

- Faculty in clinic only 2-4 half days a week

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Identified VBC Challenges

Variance in contract measures

- How to navigate 14 contracts with different measure sets

Attribution & exchanging data with payers

- Resolving issues with patient matching and leakage
- How to close care gaps

Provider education

- How to indicate which plan patient belongs to
- Resident turnover

MSSP ACO

- How to manage a group of patients we have no data for?

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Other Considerations

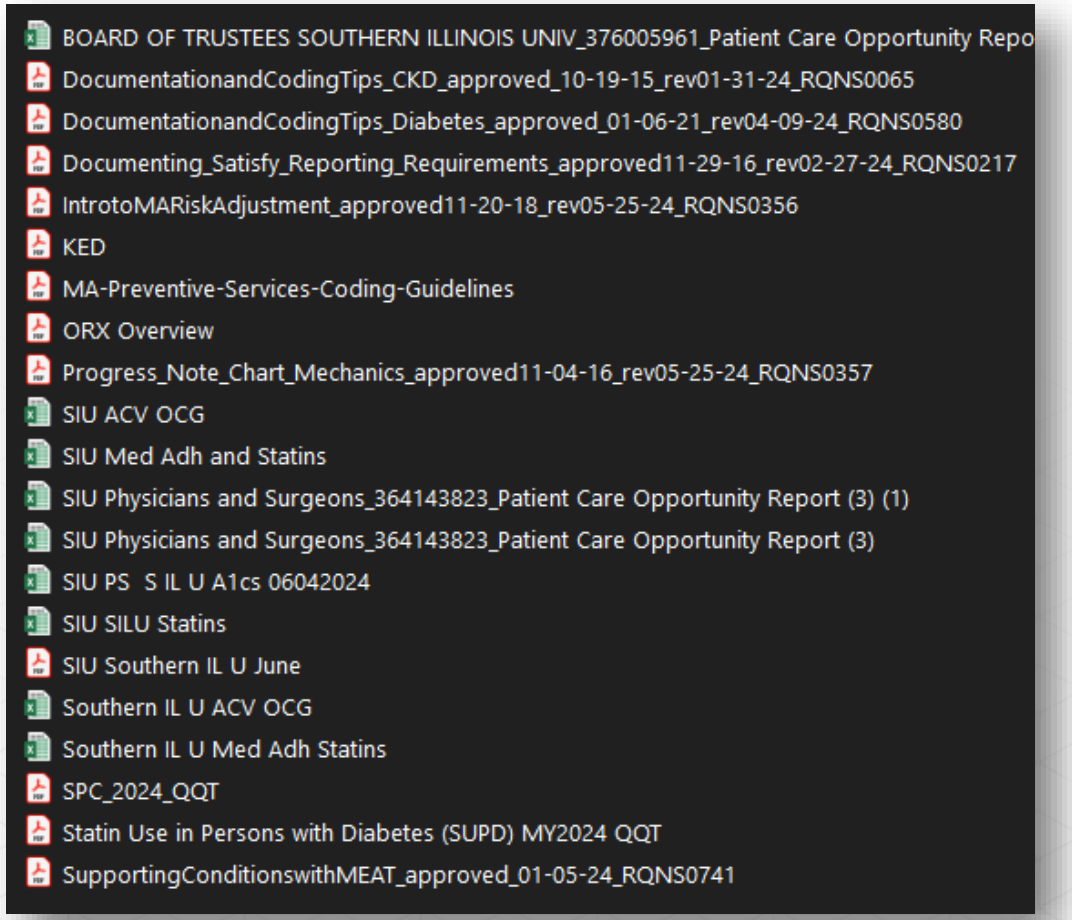
Provider and leadership buy in?

Staff for manual Care Coordination work?

Accountability?

Ability to audit?

How are you absorbing all the different reports, requirements, data elements and expectations so you can act on them?



*Files sent by a payor for a single month

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Where to Start?

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	11	21	0	6	0	7	9	13	16	6	6	13	
Measures	Aetna Medicare [PCIN]	BCBS Commercial ACO [MHP]	BCBS MMAI [MHP]	BCBS Medicaid QIP [MHP]	BCBS PHAI [MHP]	Health Alliance Commerci	Health Alliance Medicar	Humana Medicare	Meridian Medicaid [MHP]	Molina Medicaid P4Q	Molina Medicaid VBC	United Healthcare Medicar	
Breast Cancer Screening	X	X		X		X	X		X	X	X	X	9
Diabetes A1c Control <8%	X	X		X		X	X	X (<9%)				X (<9%)	7
Adult Access to Ambulatory Health Services / AWV							X	X	X	X	X	X	6
Cervical Cancer Screening		X		X					X	X	X		5
Colorectal Cancer Screening		X				X	X	X				X	5
Controlling Blood Pressure		X				X	X	X	X				5
Diabetes Care - Eye Exam	X	X					X	X				X	5
Statin Use for Persons with Diabetes	X						X	X				X	4
Medication Adherence for Cholesterol (Statins)	X							X				X	3
Medication Adherence for Diabetes Medications	X							X				X	3
Medication Adherence for Hypertension (RAS antagonists)	X							X				X	3
Prenatal and Post Partum Care		X				X			X				3

We started by organizing measures to determine low hanging fruit.

Master matrix that includes scorecards for payors, financial incentive outlines and side hustles to strategize.

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Insurance Payor	Bonus Opportunity Program	Bonus Opportunity Program Details	Potential Max Bonus	Current Bonus Earned	Estimated Earned Bonus Total	Missed Opportunity
Meridian	Continuity of Care Program (Appointment Agendas)	Offered bonus amount for each appointment agenda completed. Bonus amount increases as percentage of appointment agendas are completed. <50% = $100 / 50% - 80% = $200 / >80% = $300	$419,820	$209,100	$314,055 (+$104,955)	$105,765
Molina	Healthy Pregnancy Incentive Program	Offered bonus amount for two measures - prenatal visits in the first trimester ($50) and postpartum visits 7-84 days after delivery ($75). Specific coding required.	$7650 [So far this year]	$2850 Pre: 27/34 Post: 20/34	$2850 ? Pregnant patients + scheduling	$4,800
Molina	Behavioral Health Follow Up Bonus Program	Offered bonus amounts for follow up visits after mental health related hospitalization with a mental health practitioner. Offered bonus amounts for follow up visits after mental health or substance use emergency room visits. Bonus amount dependent on follow up time frame - $250 for 7 days post discharge, $150 for 30 days post discharge.	$22,000 [So far this year}	$9500 FUH 7: 11/39 30: 6/39 FUA 7: 6/26 30: 3/26 FUM 7: 15/23 30: 1/23	$9500 ? Admissions related to mental health or substance use	$12,500
United Healthcare	Medical Condition Assessment Incentive Program (MCAIP)	Bonus amounts offered for assessing diagnoses suspected by United Healthcare. Suspected diagnoses list compiled from chart information. Bonus pays $20 per assessed diagnosis or for diagnoses assessed but not diagnosed. Offers $10 per condition for fully assessed members. Offers additional bonus amounts if STAR rating of 4.0+ achieved and at least 65% of suspected diagnoses assessed. Bonus range $25-$125 PMPY.	$116,250	$4,360	$7500 (+$3,140)	$108,750

"Side hustles"

– bonus opportunities outside of the typical pay for quality performance

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Determine value/Missed Opportunity

Program	Estimated 2023	Max Opportunity	Missed Opportunity
P4Q Programs	$61,131	$581,759	$520,728
Side Hustles	$387,905	$996,425	$608,520
Totals	**$449,036 (28%)**	**$1,578,184**	**$1,129,248 (72%)**

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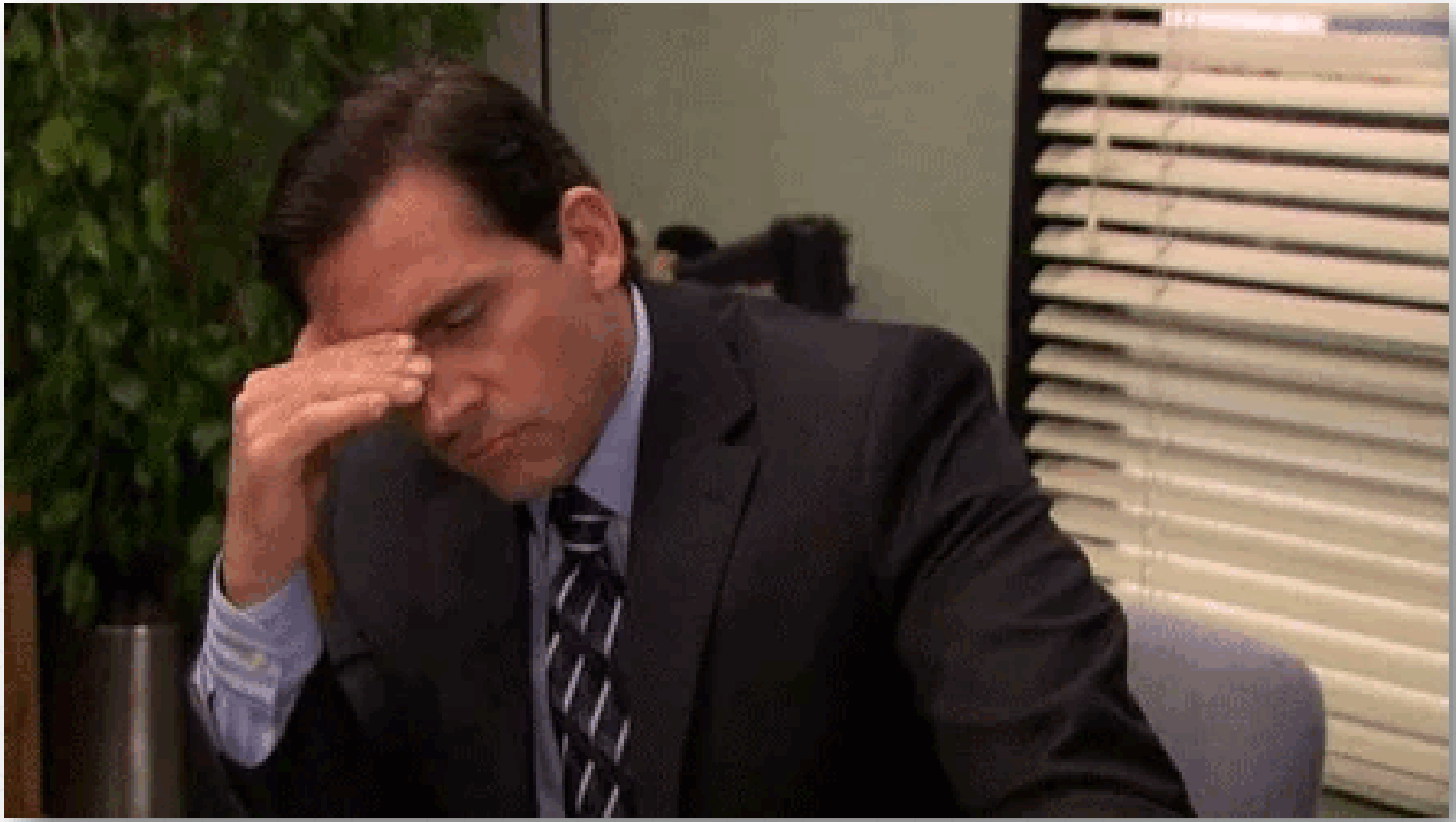
So then what?



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Challenge: Variance in Contract Measures

Started sorting measure sets by creating a Plan Calculated scorecard for each payer.

Meridian MCO
REPORT

PERIOD
2024

FILTER

Add Filter | Update

REPORT | CARE GAPS

GROUPING: No Grouping

TARGETS: Primary | Secondary | Not Met

REPORT FORMAT: Scorecard

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	GAP	TO TARGET	PAYER GAP	EHR GAP
HEDIS BCS - Breast Cancer Screening - Plan Calculated	56.4%	55.0%	602	1,068	466	0	24	133
HEDIS CBP - Controlling High Blood Pressure - Plan Calculated	38.3%	73.0%	510	1,332	822	463	272	110
HEDIS CCS - Cervical Cancer Screening - Plan Calculated	59.6%	61.8%	1,378	2,312	934	51	56	291
HEDIS GSD1 - Glycemic Status Assessment for Patients With Diabetes - Control - Plan Calculated	13.4%	61.0%	129	960	831	457	399	30
HEDIS CHL - Chlamydia Screening - Total - Plan Calculated	51.6%	50.0%	144	279	135	0	0	101
HEDIS CIS - Childhood Immunization Status - Combo 10 - Plan Calculated	22.0%	46.0%	13	59	46	15	0	4
HEDIS IMA - Immunizations for Adolescents - HPV - Plan Calculated	33.1%	49.0%	47	142	95	23	0	8
HEDIS WCV - Child and Adolescent Well-Care Visits (Total) - Plan Calculated	43.3%	62.0%	1,140	2,632	1,492	492	81	297
HEDIS AAP - Adult Access to Preventive/Ambulatory Health Services (Total) - Plan Calculated	85.6%	83.0%	2,707	3,164	457	0	25	511

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Challenge: Variance in Contract Measures

Can individually set targets for each payer based on their benchmark structure.

Meridian MCO
REPORT

PERIOD
2024

REPORT

GROUPING No Grouping

TARGETS Primary Secondary Not Met

MEASURE	RESULT	TARGET
HEDIS BCS - Breast Cancer Screening - Plan Calculated	56.4%	55.0%
HEDIS CBP - Controlling High Blood Pressure - Plan Calculated	38.3%	73.0%
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HEDIS GSD1 - Glycemic Status Assessment for Patients With Diabetes - Control - Plan Calculated	13.4%	61.0%
HEDIS CHL - Chlamydia Screening - Total - Plan Calculated	51.6%	50.0%
HEDIS CIS - Childhood Immunization Status - Combo 10 - Plan Calculated	22.0%	46.0%
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HEDIS AAP - Adult Access to Preventive/Ambulatory Health Services (Total) - Plan Calculated	85.6%	83.0%

RESULT	TARGET	
56.4%	63.0%	Meridian BCS Target
38.3%	73.0%	Meridian CBP Target
59.6%	61.8%	Meridian CCS Target
13.4%	61.0%	Meridian A1c Target
51.6%	68.0%	Meridian CHL Target
22.0%	46.0%	Meridian C-10 Target
33.1%	49.0%	Meridian IMA Target
43.3%	62.0%	Meridian WVC Target
85.6%	83.0%	Meridian AAP Target

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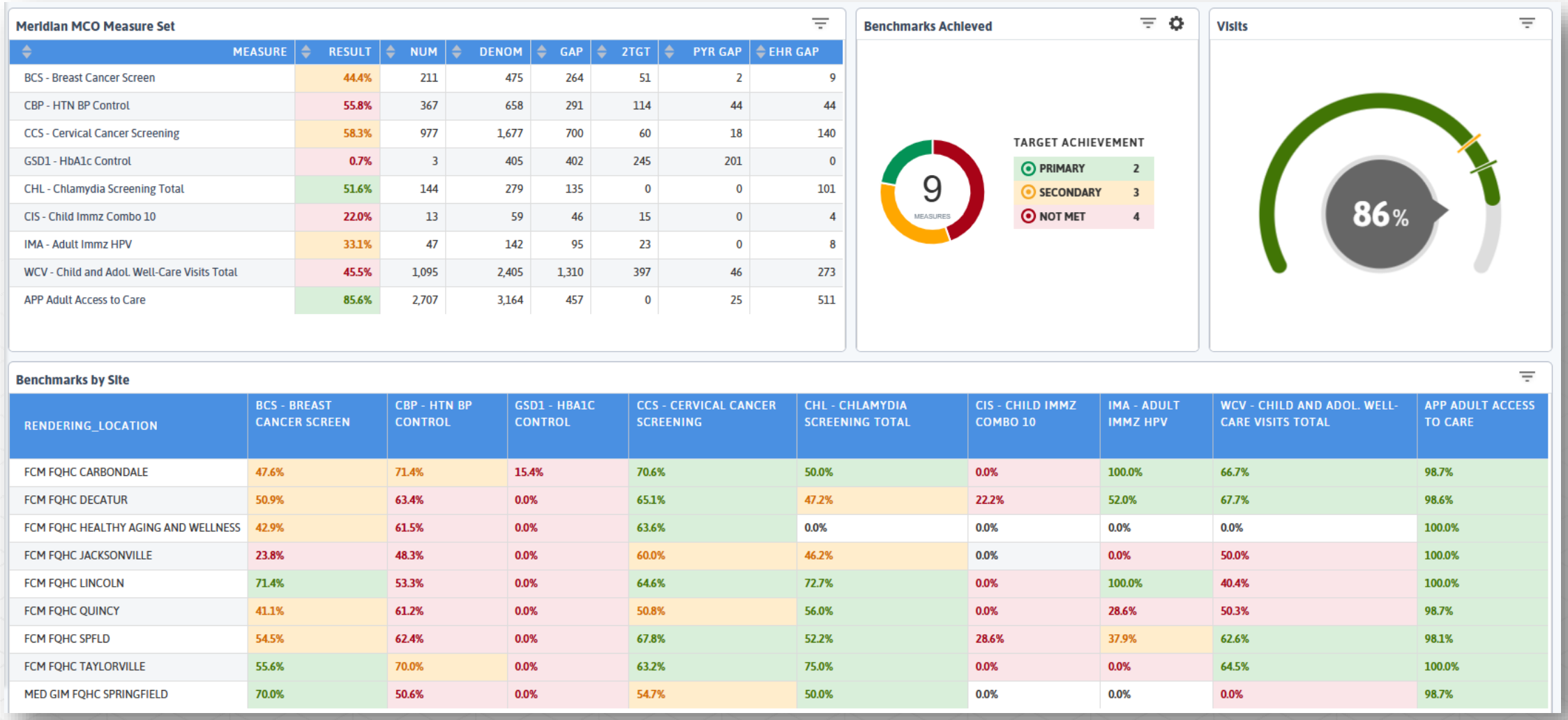
Challenge: Variance in Contract Measures



Meridian MCO Measure Set

MEASURE	RESULT	NUM	DENOM	GAP	2TGT	PYR GAP	EHR GAP
BCS - Breast Cancer Screen	44.4%	211	475	264	51	2	9
CBP - HTN BP Control	55.8%	367	658	291	114	44	44
CCS - Cervical Cancer Screening	58.3%	977	1,677	700	60	18	140
GSD1 - HbA1c Control	0.7%	3	405	402	245	201	0
CHL - Chlamydia Screening Total	51.6%	144	279	135	0	0	101
CIS - Child Immz Combo 10	22.0%	13	59	46	15	0	4
IMA - Adult Immz HPV	33.1%	47	142	95	23	0	8
WCV - Child and Adol. Well-Care Visits Total	45.5%	1,095	2,405	1,310	397	46	273
APP Adult Access to Care	85.6%	2,707	3,164	457	0	25	511

Benchmarks Achieved

Visits

Benchmarks by Site

RENDERING_LOCATION	BCS - BREAST CANCER SCREEN	CBP - HTN BP CONTROL	GSD1 - HBA1C CONTROL	CCS - CERVICAL CANCER SCREENING	CHL - CHLAMYDIA SCREENING TOTAL	CIS - CHILD IMMZ COMBO 10	IMA - ADULT IMMZ HPV	WCV - CHILD AND ADOL. WELL-CARE VISITS TOTAL	APP ADULT ACCESS TO CARE
FCM FQHC CARBONDALE	47.6%	71.4%	15.4%	70.6%	50.0%	0.0%	100.0%	66.7%	98.7%
FCM FQHC DECATUR	50.9%	63.4%	0.0%	65.1%	47.2%	22.2%	52.0%	67.7%	98.6%
FCM FQHC HEALTHY AGING AND WELLNESS	42.9%	61.5%	0.0%	63.6%	0.0%	0.0%	0.0%	0.0%	100.0%
FCM FQHC JACKSONVILLE	23.8%	48.3%	0.0%	60.0%	46.2%	0.0%	0.0%	50.0%	100.0%
FCM FQHC LINCOLN	71.4%	53.3%	0.0%	64.6%	72.7%	0.0%	100.0%	40.4%	100.0%
FCM FQHC QUINCY	41.1%	61.2%	0.0%	50.8%	56.0%	0.0%	28.6%	50.3%	98.7%
FCM FQHC SPFLD	54.5%	62.4%	0.0%	67.8%	52.2%	28.6%	37.9%	62.6%	98.1%
FCM FQHC TAYLORVILLE	55.6%	70.0%	0.0%	63.2%	75.0%	0.0%	0.0%	64.5%	100.0%
MED GIM FQHC SPRINGFIELD	70.0%	50.6%	0.0%	54.7%	50.0%	0.0%	0.0%	0.0%	98.7%

Created a dashboard for each payer including Plan Calc scorecard and additional widgets to help break down data.

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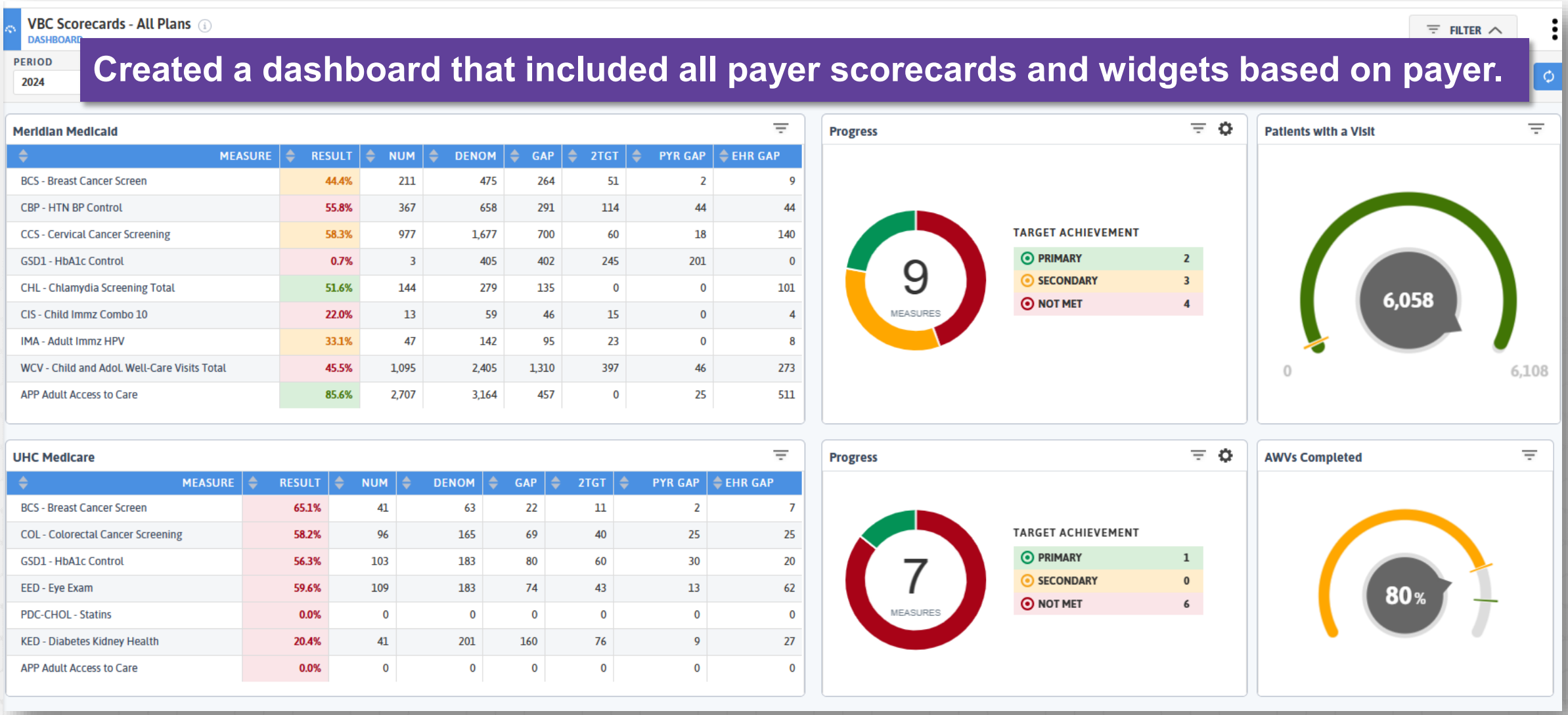
Challenge: Variance in Contract Measures



Progress on meeting scorecard measures, patient visits vs AWVs

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Challenge: Attribution

Plan Attribution

- Are patients on roster accurate?
- Medicaid plan of 6,000 – 500 patients never seen
- Providers can be auto assigned based on open panels and proximity
- Many plans require patient to call to correct PCP attribution

Provider Roster Verification

- Are affiliated providers correct?
- Plan was including providers termed >10 years ago
- Discovered issues with our credentialing department
- Need to audit process to ensure rosters being updated

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Challenge: Attribution

Soft Matching Report

Compares payer members that did not match with patients in the EHR using various match mechanisms.

Force Matching

Allows you to manually match members from payer enrollment file.

Member: IL14218463501	Plan: SIU Molina
Name:	MICHAEL G. SCOTT
DOB:	07/04/1776
Medicaid #:	314159265359
Medicare #	
Address 1:	520 N. 4th Street
Address 2:	
City:	SPRINGFIELD
State:	IL
Zipcode:	62702
Email:	
Phone 1:	217-867-5309

Demo Data

DRVS Suggested Match Reason
First, Last, DOB, Sex

Patient MRN: 130308	Find Other Patient
Name:	MICHAEL GARY SCOTT
DOB:	07/04/1776
Medicaid #:	00314159265359
Medicare #	
Address 1:	520 North Fourth
Address 2:	
City:	SPRINGFIELD
State:	IL
Zipcode:	62702
Email:	
Phone 1:	867-5309
Phone 2:	

Active Payers for this Patient			
PAYER	POLICY #	START DATE	END DATE
MEDICAID MERIDIAN HEALTH PLAN INC	0012354687	01/01/2022	

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Gap Closure and Data Exchange

Do you have a way to exchange data with payors to close gaps?

- Some plans limit methods of supplemental data exchange
- SFTP
- Manual chart scrub and portal upload
- Plan chart access
- CPT II codes on claims only
- Access to payor portals?

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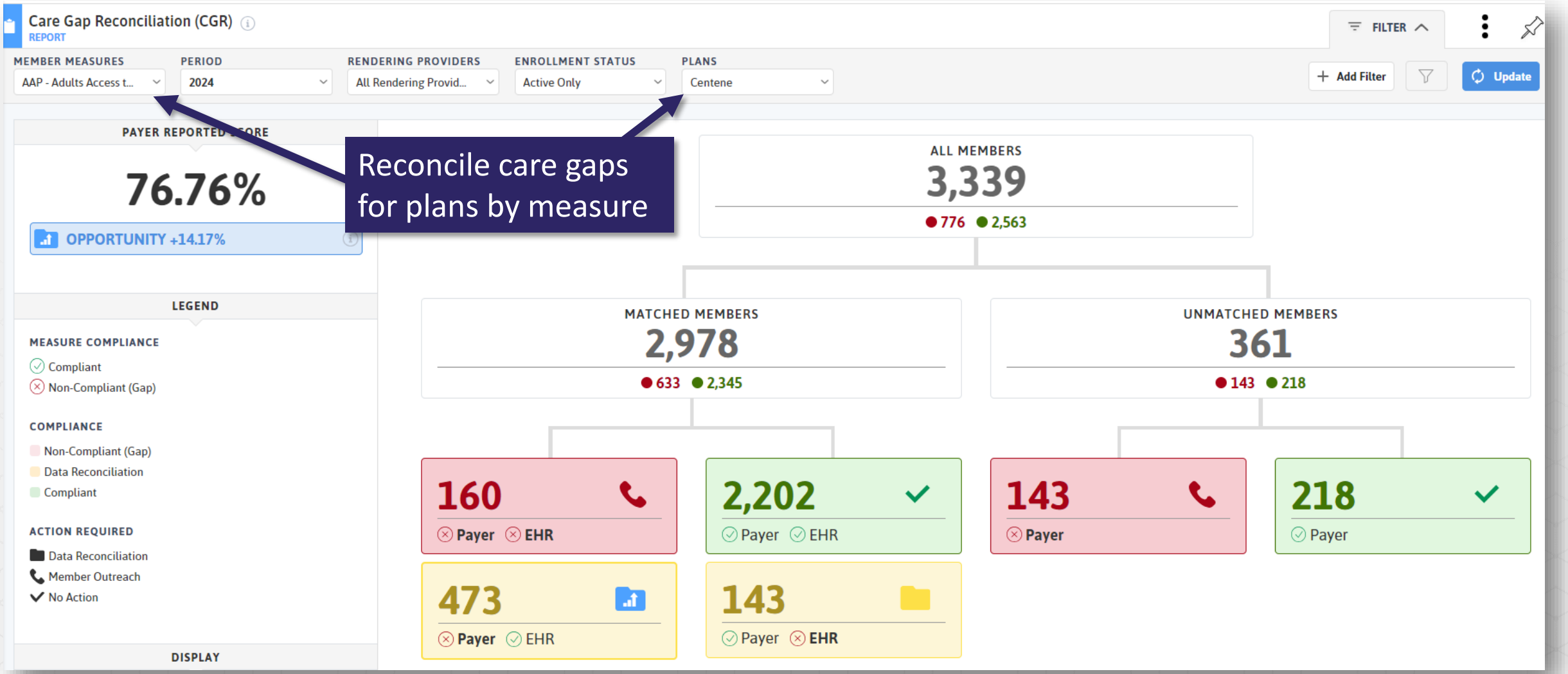
Challenge: Data Exchange



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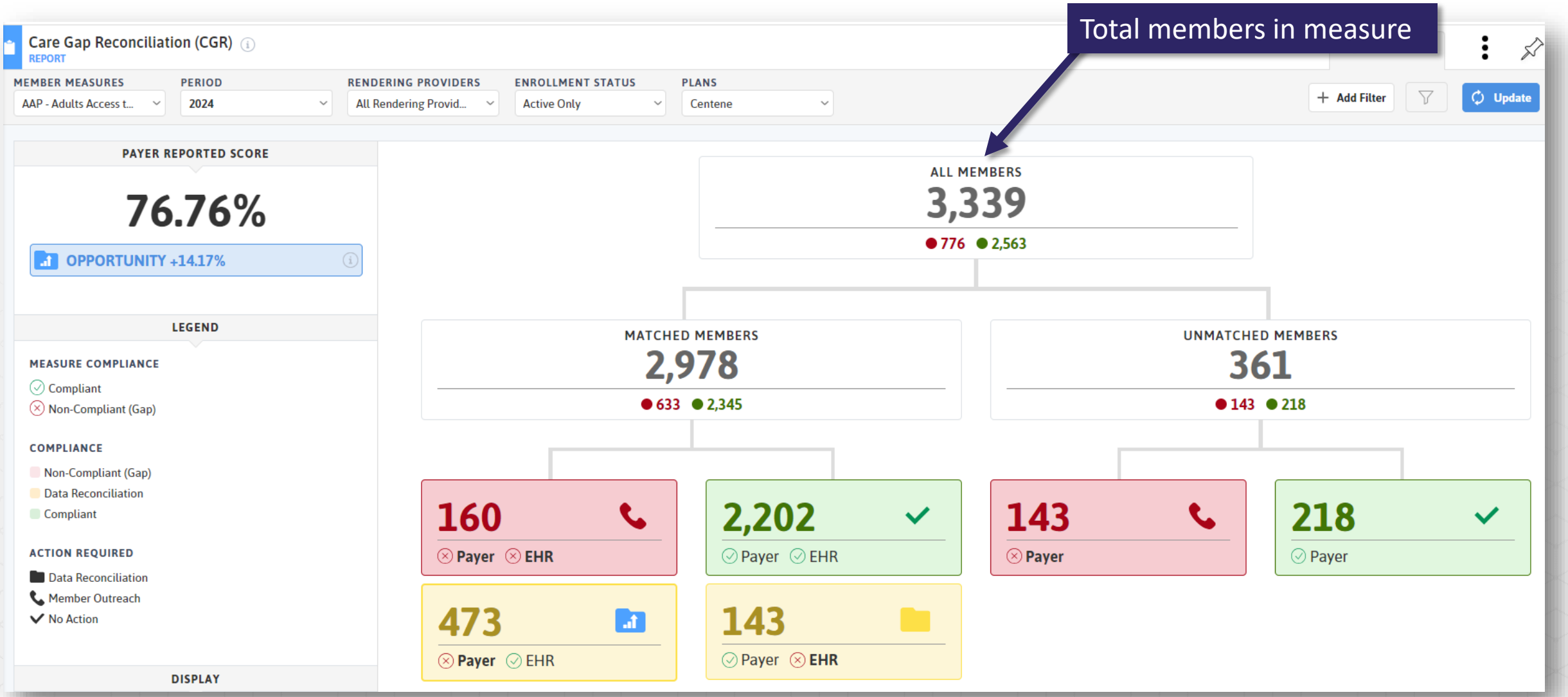

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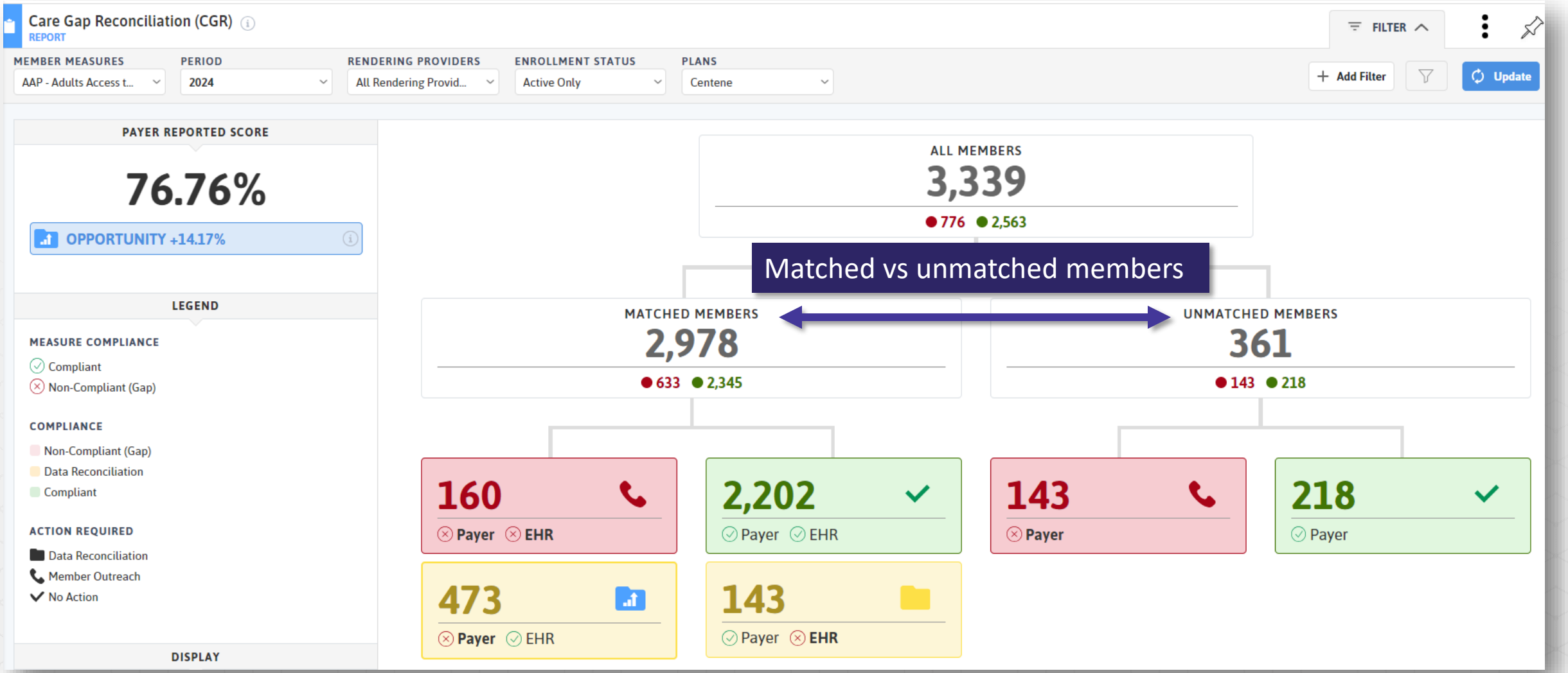

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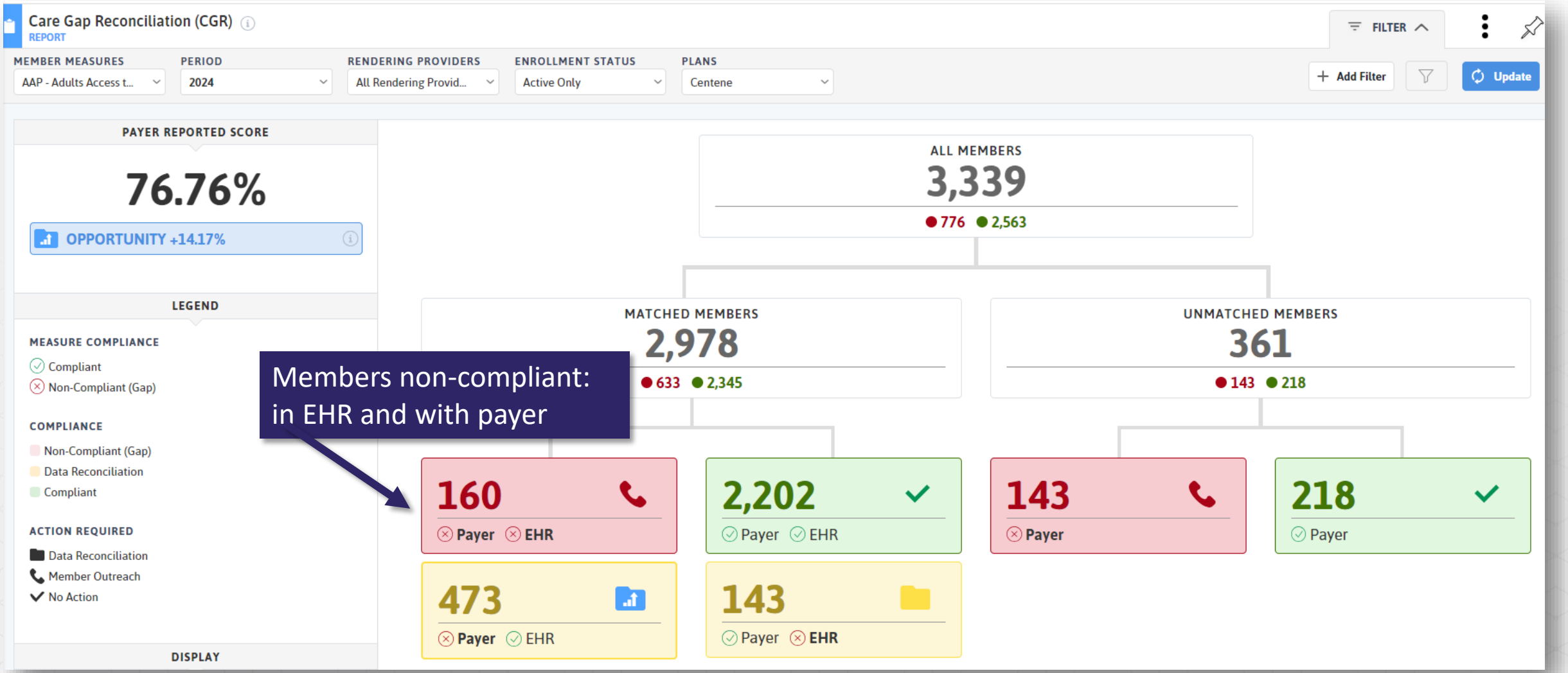

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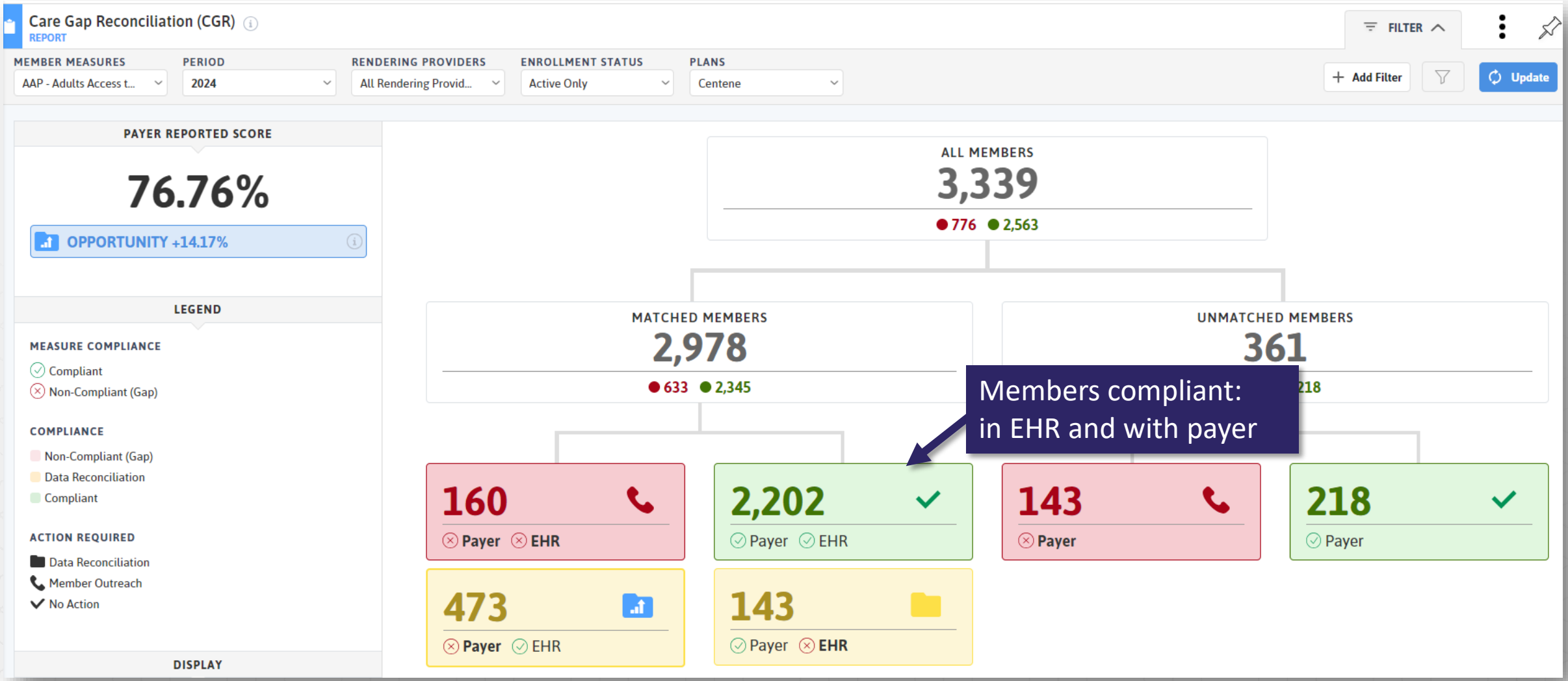

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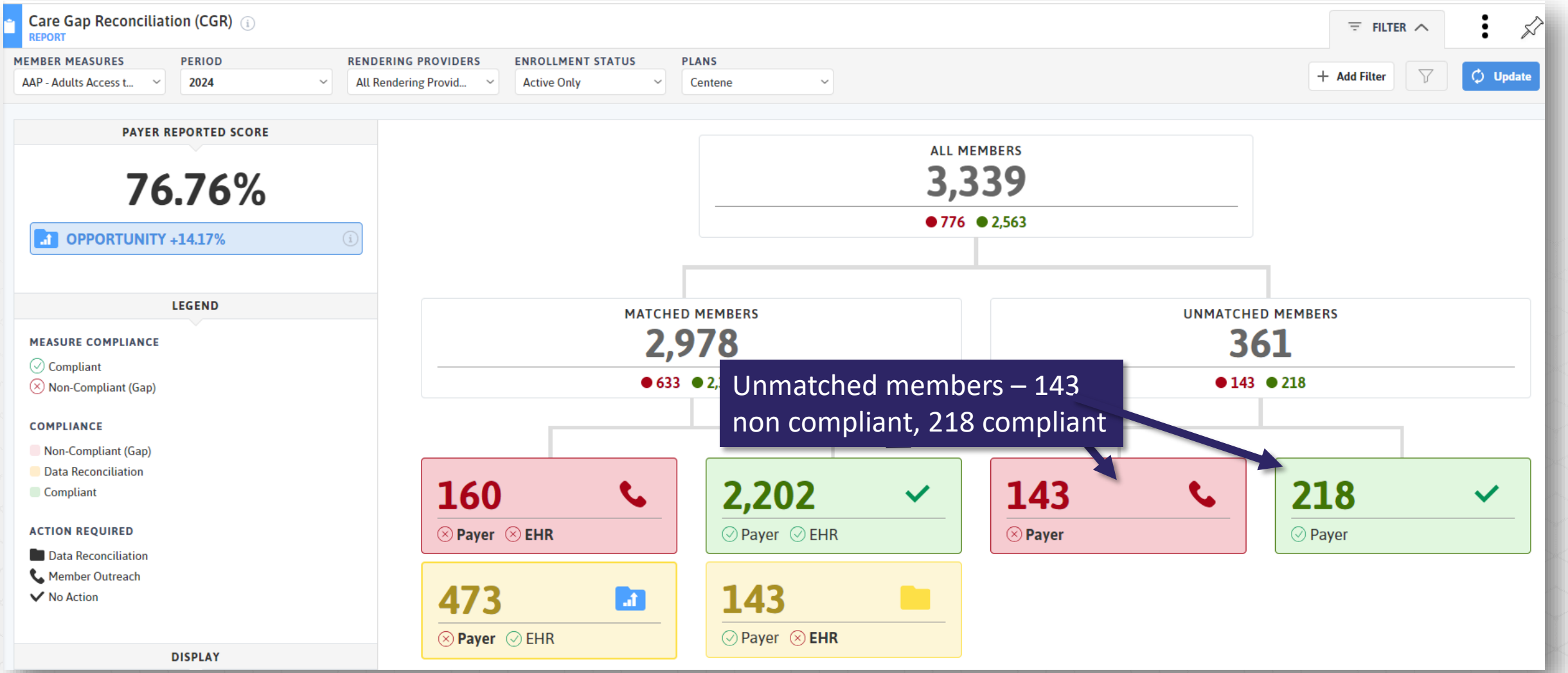
Challenge: Data Exchange



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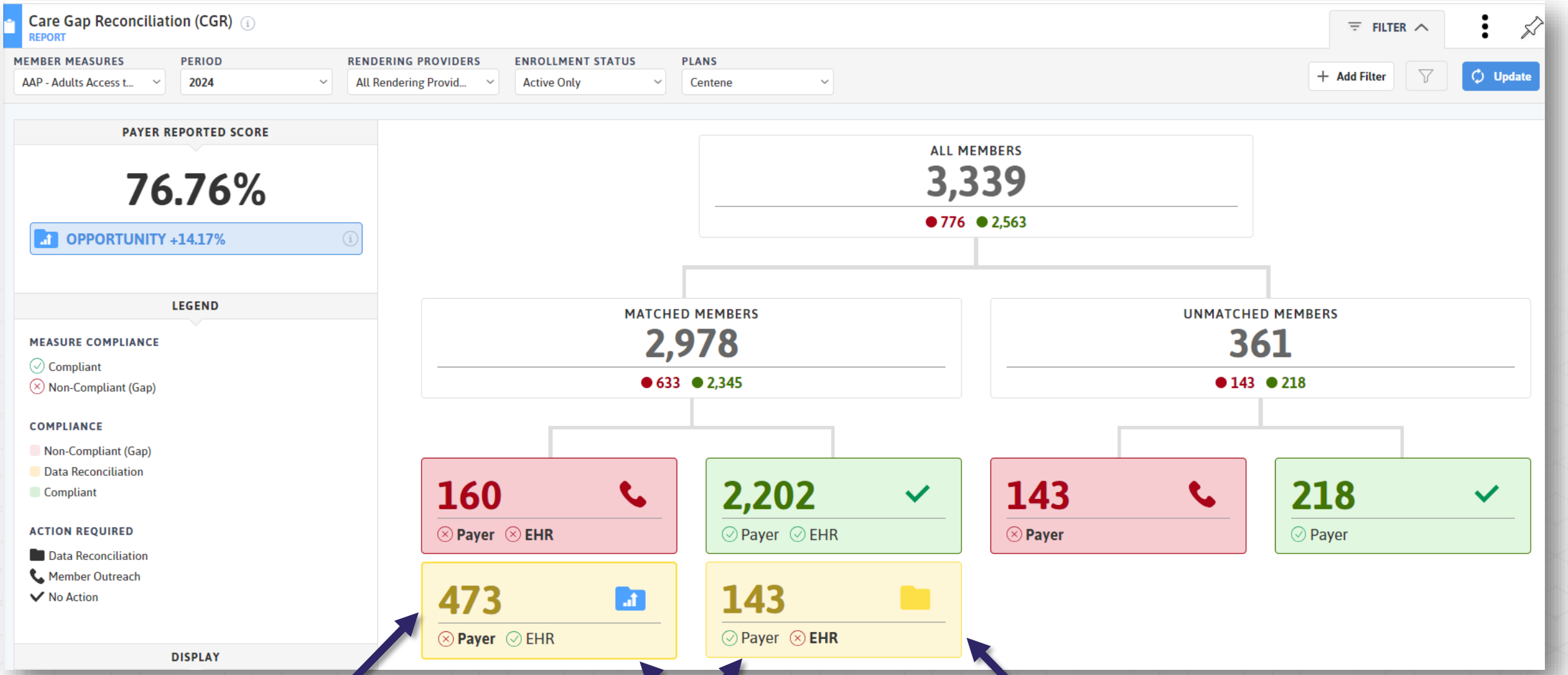

Compliant in EHR, non-compliant with payer

Need to reconcile

Compliant with payer, non-compliant in EHR

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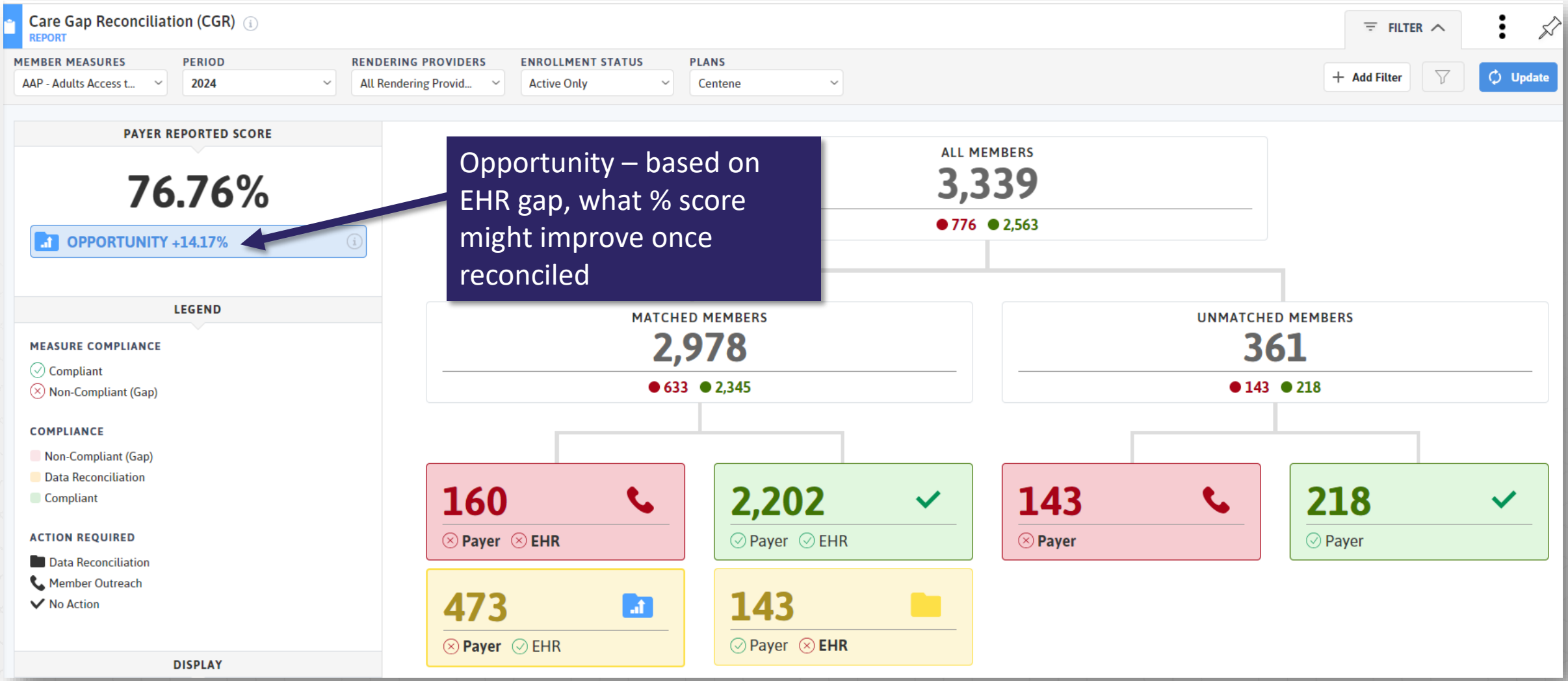
Challenge: Data Exchange



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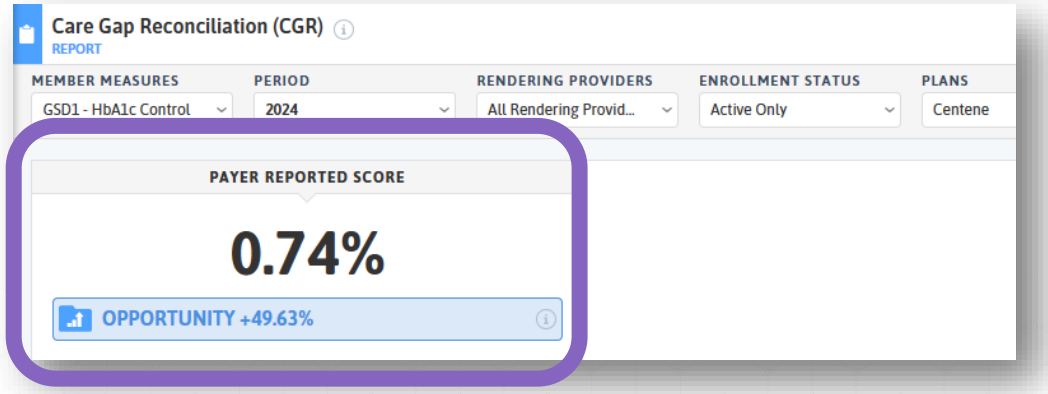
Fully Integrated with Centene Medicaid



Completely automated increase of 27%

2023 Earnings: $2,800

2023 Potential: $214,430

Missed Opportunity: $211,630

98.7%

Measure	09/24	CY 24	Difference
Adults Access to Care	80.31%	86.32%	6.01%
Breast Cancer Screening	39.50%	44.42%	4.92%
Controlling Blood Pressure	47.64%	68.39%	20.75%
Cervical Cancer Screening	56.12%	59.21%	3.09%
Diabetes HbA1c <8	7.60%	52.63%	45.03%
Child + Adolescent WCV	47.92%	52.68%	4.76%
Childhood Imm - Combo 10	46.67%	43.75%	-2.92%
Imm for Adolescents - Combo 2	18.18%	36.36%	18.18%
Well Child Counseling – BMI	46.81%	64.79%	17.98%
Well Child Counseling - Nutrition	13.83%	27.70%	13.87%

2024 Earnings: $70,560

2024 Potential: $246,660

Missed Opportunity: $176,100

71.4%

Improvement of 27.3%

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Benefits of Payer Integration

Patient Matching	Compares enrollment data to EHR data Can force match patients Helps with patient leakage
Care Gap Reconciliation	Compares EHR care gap data to insurance plan care gap data
Detailed Member Reports	Includes data on membership, recent ED and IP admits, risk related diagnoses, RAF scores and RAF gaps

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Challenge: Provider and Resident Education

8:20 AM Thursday, August 22, 2024 — Visit Reason: **DYNDA/BP ISSUES**

KNOPE, LESLIE
MRN: 123456
DOB: 01/07/1975

Sex at Birth: F
GI: WOMAN/GIRL
SO: straight or heterosexual

Phone:
Lang: English

Portal Access: Y
Plan: Centene
Cohorts: Meridian Medicaid MCO Patients

PCP: DYNDA, MICHAL
Payer: MEDICAID MERIDIAN HEALTHCHOICE ILLINOIS
CM: Unassigned

DIAGNOSES (5)

Anxiety	Depression	DM I or II
HTN-E	HyLip	

RISK FACTORS (1)

BMI

SDOH (2)

INSURANCE

Demo Data

Plan and Cohort on PVP indicate insurance type to providers, residents and clinical staff

ALERT	MESSAGE	DATE	RESULT	OWNER
Colon CA 45+	Missing			
BMI F/U Documentation	Missing Follow-up	8/22/2024	Highest BMI: 37.46 (08/22/2024)	Provider
Flu - Seasonal	Missing			
CV High-Risk	Missing			
Tetanus	Due 1		Due Date: 1997-07-28 | Most Recent: None	
Eye	Missing			
Foot Exam	Missing			Provider
Well Visit 19+	Overdue	1/12/2022		

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Outpatient | FQHC Cardiology Clinic	Cheema MD, Amir N. /	7/11/2024	8/14/2024

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Challenge: Provider and Resident Education

2024 DRVS conference gave us ideas on how to make quality education more fun

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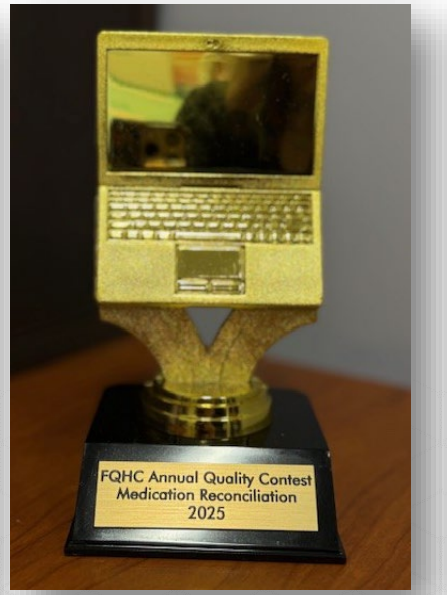
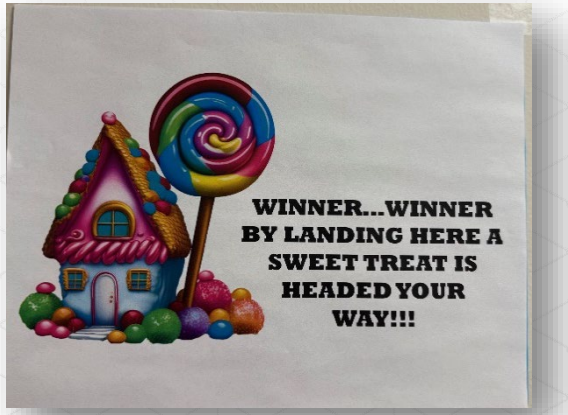
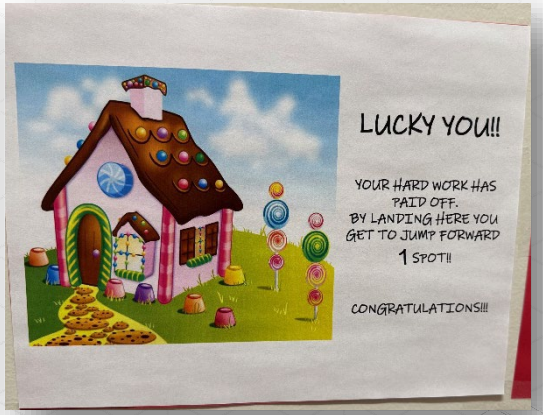
Challenge: Provider and Resident Education







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Challenge: Provider and Resident Education

Created scorecard subscription that sends providers monthly UDS scorecards for their patient panel

Edit

SELECTED REPORT: UDS 2024 CQMs

CENTER NAME: SIU Center For Family Medicine

EMAIL SUBSCRIPTION NAME: 2025 UDS Scorecard - Panel

EMAIL SUBJECT: Monthly UDS Scorecard

STATUS: Enabled | Disabled

EMAIL SUBSCRIPTION FREQUENCY

START DATE: 2/28/2025

START TIME: 06:00 AM

REPEAT: Monthly

DATES: First Monday

FILTER SETTINGS *(must be shared filter)*

SELECTED FILTER: 2025 Usual Provider Scorecard

RECIPIENTS

TYPE: Usual Provider

PROVIDERS

PROVIDER	EMAIL
ABDULFATTAH, OMAR	oabdulf
ACTIVE, PT TERMINATION	noemail
AGAR, SAMANTHA A	sagar98
AGGARWAL, SACHIN	saggarw

CC LIST

From: noreply@azarahealthcare.com <noreply@azarahealthcare.com>
Sent: Monday, April 7, 2025 1:03 AM
To: Michal Dynda <mdynda@siumed.edu>
Subject: Monthly UDS Scorecard (2025)

azara healthcare

DRVS

Please find attached your Azara Healthcare **UDS 2024 CQMs** for 2025. This automated email was scheduled by lhollenkamp82@siumed.edu

Visit DRVS

SUBSCRIPTION NAME	REPORT NAME	FREQUENCY	NEXT SEND (LOCAL)	LAST SENT (LOCAL)	LAST STATUS
2025 UDS Scorecard - Panel		Monthly	04/07/2025 01:00 AM	04/07/2025 01:00 AM	Successful

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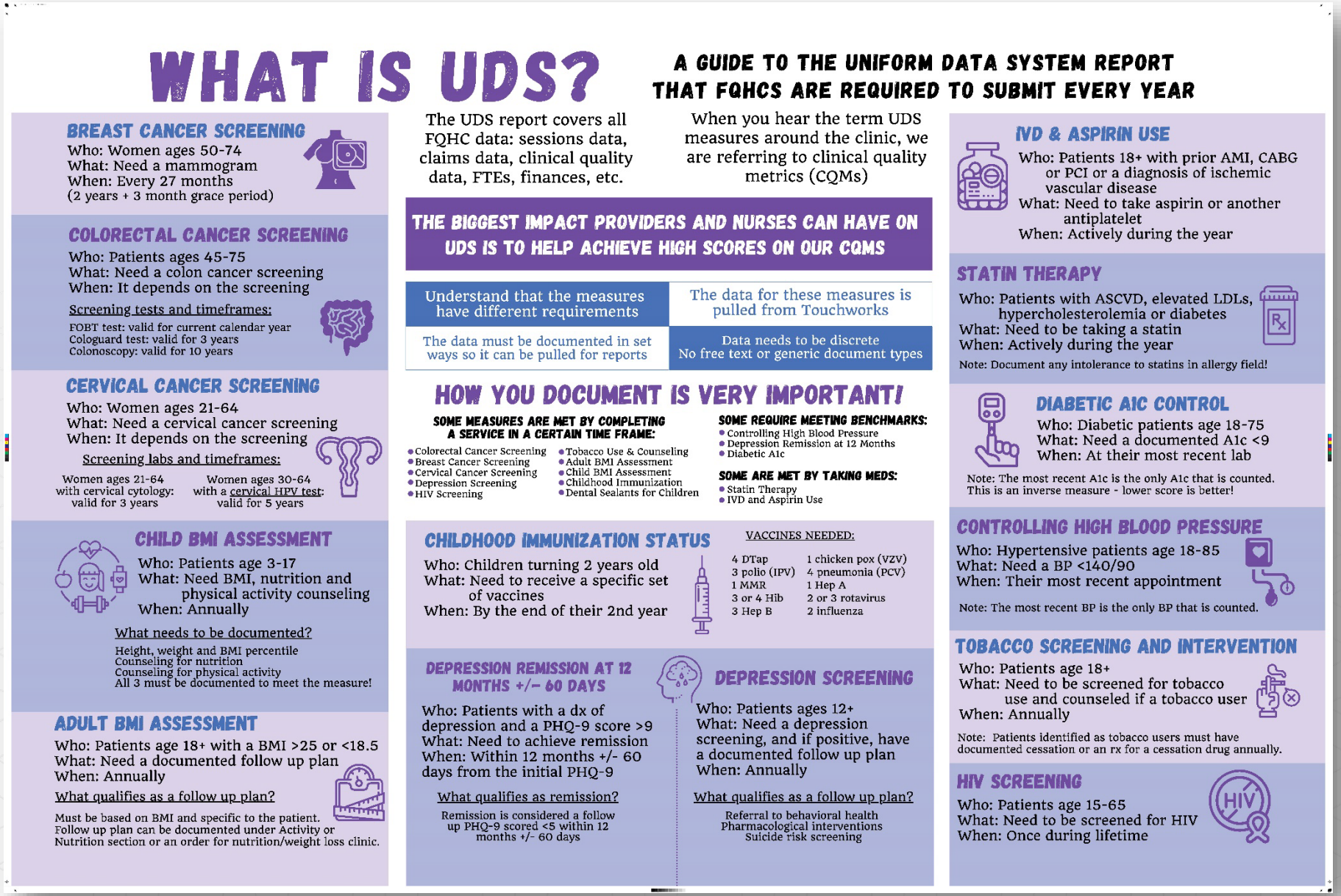
Challenge: Provider and Resident Education



Created a 4ft by 6ft UDS poster explaining what UDS is, measure species and how different clinical staff can help.

Hung in main clinical hallways and breakrooms.

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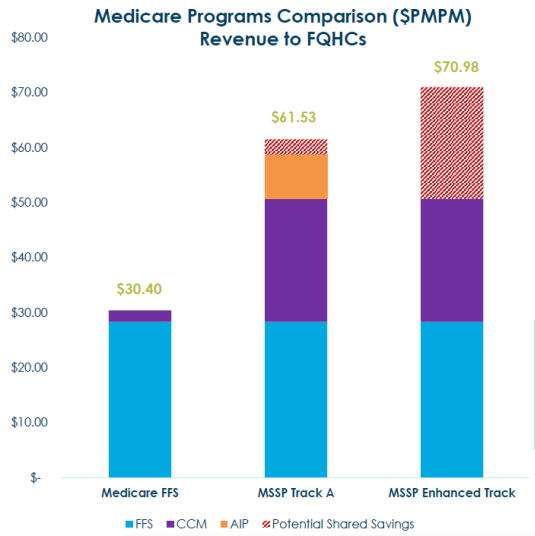
MSSP ACO

Approached by Medical Home Network and invited to participate in the new Medicare Shared Savings Program ACO they were forming

Financial Modeling: MSSP A serves as a glidepath for risk expansion



Per 1,000 patients	Medicare FFS	MSSP Track A	MSSP Enhanced Track
Fee-for-service (FFS)* Total Revenue	$340,000 *$28.33 PMPM*	$340,000 *$28.33 PMPM*	$340,000 *$28.33 PMPM*
Chronic Care Management (CCM)* *Assume 90 patients at $23 PMPM*	$24,840 *$2.07 PMPM*	$268,800 *$22.40 PMPM*	$268,800 *$22.40 PMPM*
Advanced Investment Payment (AIP)	-	$96,000 *$8.00 PMPM*	-
Potential Shared Savings Revenue	-	$33,600** *$2.80 PMPM*	$243,000** *$20.25 PMPM*
Estimated Revenue for 10K Patients	$3,648,400	$7,384,000	$8,518,000
Difference from FFS		+ $3,735,000	+ $4,869,600

MSSP Track A Assumptions
SS to FQHCs: 30% out of 40% of shared savings
Savings Rate: 4%
AIP: $8.00 PMPM (60%)

MSSP Enhanced Track Assumptions
SS to FQHCs: 38% out of 75% of shared savings
Savings Rate: 6%

Proven Model & Results: Medicaid and Medicare Outcomes

- ↓42% Admissions per 1,000
- ↓11% Readmissions
- 100% Quality Score* *Predominantly P4R with 1 measure P4P in 2022
- 60% Health Risk Assessment Completion Rate (Year 1)
- ↑82% Post-ER follow-up within 7 days
- ↓37% Social Drivers of Health
- 69% SDOH resolved
- ↓10% 1-year Medical Expenses Reduction 1 market
- 84% Health Risk Assessment Completion Rate
- $120M Shared Savings over 6 Years
- $10M Shared Savings for Y2022

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Target 3 -7% savings rate with care transformation activities

MSSP Track A P&L modeling Assumptions		Notes
Lives	4,205	
FFS Revenue (PMPM)	$ 28	*assume 3 visits in a year*
Benchmark	$ 1,337	*modeling using CMS claims data*
Qualifying AIP	$ 13	*MHN Historical MSSP A experience*
MSSP Track A model assumptions		
CCM Qualified Population	40%	*40% of Medicare population meets multiple chronic conditions billable criteria*
Available Shared Savings	40%	*Available Shared Savings Track A*
Shared Savings to FQHC	55%	
AIP to FQHC	60%	*60% of qualified Advanced Investment Payments; AIP is netted out of Shared Savings*

FQHC or CIN P&L

PMPM				*$ Dollars*		
Savings Rate	3%	5%	7%	3%	5%	7%
FFS Revenue	$ 28.3	$ 28.3	$ 28.3	$ 1,429,700	$ 1,429,700	$ 1,429,700
CCM Enhanced Payments	$ 22.4	$ 22.4	$ 22.4	$ 1,130,304	$ 1,130,304	$ 1,130,304
Shared Savings PMPM (including AIP)	$ 8.8	$ 14.7	$ 20.6	$ 445,269	$ 742,115	$ 1,038,961
TOTAL FQHC P&L for Medicare FFS	$ 59.6	$ 65.4	$ 71.3	$ 3,005,273	$ 3,302,119	$ 3,598,965
INCREMENTAL MSSP Value	$ 31.2	$ 37.1	$ 43.0	$ 1,575,573	$ 1,872,419	$ 2,169,265

ACO Reported Measures (CQMs)	40th Percentile*	Top Decile*
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	60.00%	≤10%
Screening for Depression and Follow-Up Plan	96.65%	100%
Controlling High Blood Pressure	40.00%	≥90%

CMS Calculated Metrics
Hospital-wide, 30-day, all-cause unplanned readmissions
Risk standardized, all-cause unplanned admissions for multiple chronic conditions

CAHPS Patient Engagement and Experience Survey

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MSSP ACO

Created a static cohort using alignment file provided by partner Medical Home Network

Predominant Conditions
DASHBOARD

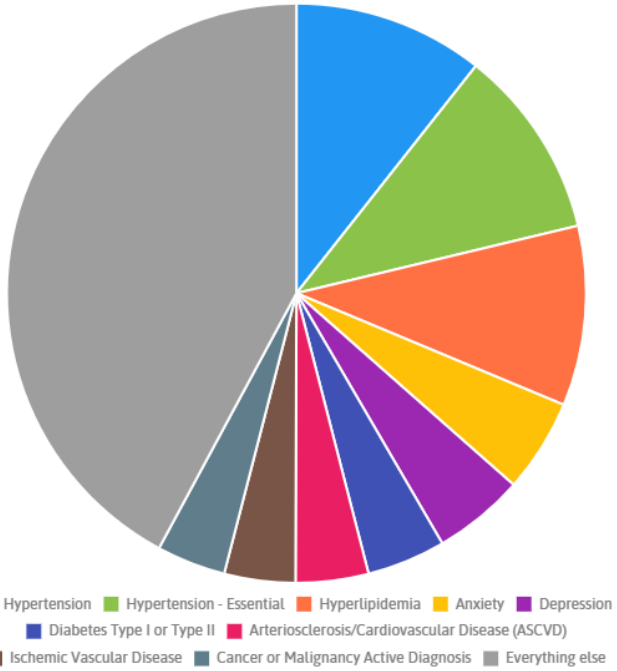
PERIOD: TY March 2025 | RENDERING PROVIDERS: All Rendering Provid... | COHORTS: Medicare ACO

FILTER | Add Filter | Update

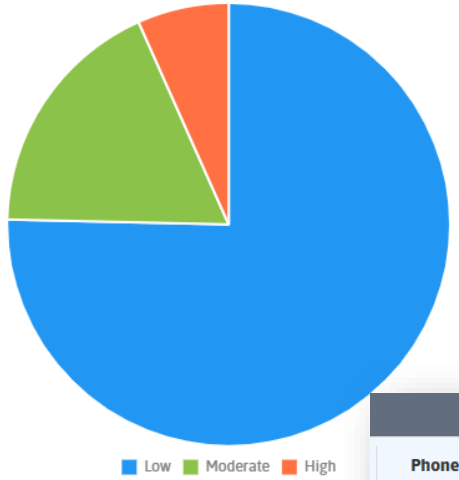
Primary Care Encounters in Period

3,388

Predominant Conditions



Risk Distribution



Ethnicity

ETHNICITIES	NUME
Another Hispanic, Latino/a, or Spanish Origin	5
Hispanic, Latino/a, or Spanish Origin Combined	5
Mexican, Mexican American, Chicano/a	2
Not Hispanic, Latino/a, or Spanish Origin	3,103
Unreported/Choose Not to Disclose Ethnicity	273
Totals	**3,388**

Predom Cond based on Primary Care Visits

PATIENT DIAGNOSES	NUMERATOR	% TOTAL
Acute Myocardial Infarction	58	0.2%
Alcohol Disorder	64	0.3%
Alcohol/Substance Dependency	183	0.7%
Anxiety	1,279	5.2%
Arteriosclerosis/Cardiovascular Disease (ASCVD)	997	4.1%
Asthma	497	2.0%
Atrial Fibrillation/Flutter (ICD-9 codes)	474	1.9%
Attention-deficit hyperactivity disorders	57	0.2%
Autism Spe		
Bipolar Di		

Shows up on PVP – helpful for providers

Visit Reason: **LONG APPOINTMENT Mirocha/Med refill**

Phone:
Lang: English
Risk: Low (9)

Portal Access: N
Cohorts: Medicare ACO

PCP: MIROCHA, NICHOLE JOY
Payer: MEDICARE PART B
CM: Unassigned

ALERT	MESSAGE	DATE	RESULT	OWNER
Colon CA 45+	Overdue	4/17/2023	Negative	
A1c Order	Due Soon	5/3/2024	6.2	Provider
Hep C	Missing			
HIV Order	Missing			Provider
LDL	Overdue	3/29/2023	107	
CKD Screening - DM	Overdue	3/30/2023	Low Risk	
Depression Screen	Overdue	12/1/2023	Positive	MA/LPN/RN
Tobacco Counseling	Overdue	6/16/2023		Provider
Eye	Missing			
Foot Exam	Overdue	6/16/2023		Provider
Well Visit 19+	Overdue	3/28/2023		

MSSP ACO

Created a custom dashboard focused on ACO specifics

Encounters and AWVs

CQMs and completed targets

Patient visits with focus area dxs

Scorecard grouped by location

ACO wide hospital encounters and focus dx hospital encounters

MSSP ACO Dashboard

DASHBOARD

PERIOD: March 2025

RENDERING PROVIDERS: All Rendering Provid...

FILTER

Quality Measures Scorecard

2025

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Breast Cancer Screening (CMS 125v12)	58.3%	287	492	49	205	9
DM A1c > 9 or Untested (CMS 122v12)	49.8%	202	406	34	202	81
HTN Controlling High BP (CMS 165v12)	66.9%	719	1,075	169	356	34
Depr Scrn & Follow-Up (CMS 2v13)	80.3%	1,399	1,742	119	343	0

Medicare CQMs

2025

TARGET ACHIEVEMENT

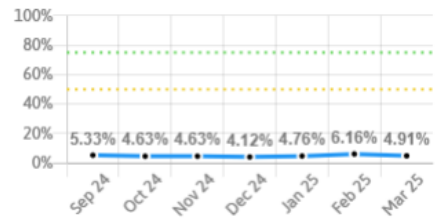
PRIMARY	1
SECONDARY	2
NOT MET	1

Qualifying Encounters

March 2025

Completed AWVs

March 2025



Scorecard by Site

2025

RENDERING_LOCATION	BREAST CANCER SCREENING (CMS 125V12)	DM A1C > 9 OR UNTESTED (CMS 122V12)	HTN CONTROLLING HIGH BP (CMS 165V12)	DEPR SCRN & FOLLOW-UP (CMS 2V13)
FCM FQHC CARBONDALE	65.2%	38.5%	77.4%	96.9%
FCM FQHC DECATUR	56.2%	44.3%	55.6%	83.6%
FCM FQHC HEALTHY AGING AND WELLNESS	33.3%	50.0%	61.9%	20.7%
FCM FQHC JACKSONVILLE	33.3%	28.6%	59.1%	92.6%
FCM FQHC LINCOLN	66.7%	42.9%	75.0%	13.6%
FCM FQHC QUINCY	50.7%	42.6%	68.4%	79.9%
FCM FQHC SPFLD	62.6%	54.1%	69.3%	79.7%
FCM FQHC TAYLORVILLE	52.9%	70.6%	71.1%	94.2%
FCM FQHC-INTEGRATED WELLNESS CENTER	38.9%	52.2%	74.4%	94.4%
MED GIM FQHC SPRINGFIELD	63.5%	58.6%	64.4%	91.2%

Visits - Heart Failure

2025

Visits - COPD

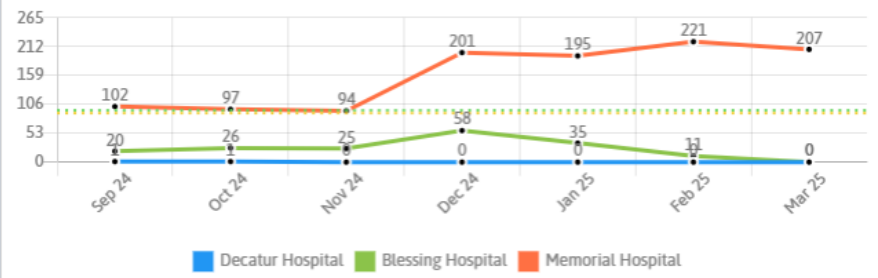
2025

Visits - CKD

2025

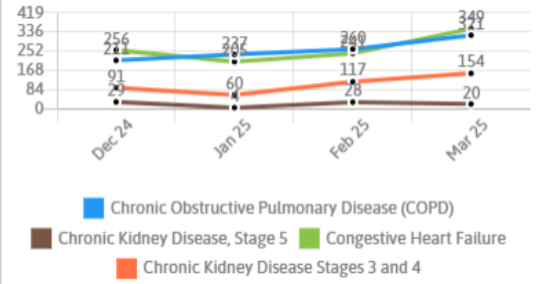
Patients with Hospital Encounters

March 2025



spital Encounters - Focus Diagnoses

March 2025



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Then and Now

Reports from EHR calendar quarter at a time, requiring manual manipulation in Excel	→	Standard and customizable scorecards to track progress, refreshed daily
Patient level detail available in Excel, but manual review and calculation of measure compliance	→	Patient level detail for all reports and measures
Any customizations done manually in Excel, tons of pivots and formulas	→	Options to customize dashboards and reports by provider, locations, plan + more
Document upload in portal or manual chart scrub	→	Automated options to close care gaps with payers
Lack of cohesive quality education, resources or accountability options	→	FQHC-wide standardized quality education, access to data and easy accountability

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What's next?

- Azara Patient Outreach
  - Tech complications related to accessing data for patients who declined texting
  - Operational complications related to having multiple sites with their own phone number
- Working with local hospitals to map their lab data to DRVS
  - Opened an Express Care – more patients seen without primary care related data
  - Help with UDS and VBC related care gaps
  - Helps prevent repeat labs or screenings
- Tracking and reconciling payments
  - Have no existing process to track payments and reconcile payment amounts with expected reimbursement
- Annual wellness visits, coding opportunities, chronic care management program
- Inclusion of revenue as part of our mission and strategy

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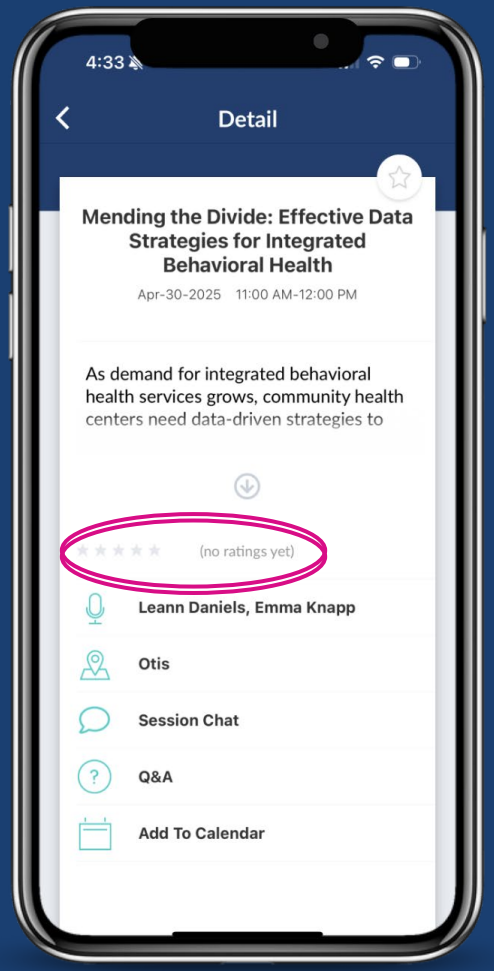
USER CONFERENCE APR 29–MAY 1 | BOSTON, MA

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!