

Springing into Action

Azara Care Connect in Practice



Presenters



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Program Lead
Azara Healthcare

Agenda



Network ACC Support

Michigan Primary Care Association



ACC in Action

Workflows & Best Practices



Success with ACC

Health Center Spotlight



Questions

Network ACC Support



Michigan Primary Care Association

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Supports



39 FQHCs, **2** Look-Alikes, and **3** Native American Tribal Health Service providers, serving **1 in 14** Michiganders across rural and urban communities.

Advocates



For **health policy** at the state and federal levels, fosters **collaboration** among health centers and external partners, and supports **high-quality, cost-effective, patient-centered care**.

Operates



Michigan's Health Center Controlled Network (MQIN), Clinically Integrated Network (MCHN), and VirtuALLY, a healthcare IT solutions provider.



Michigan Community Health Network (MCHN)

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MCHN is a Clinically Integrated Network (CIN) owned by MPCA and 39-member health centers.



Established in 2015, MCHN was created to facilitate group contracting with Michigan Medicaid Health Plans, focusing on value-based-care agreements.



Negotiates value-based-agreements to improve patient outcomes and share cost savings.



Current focus: Medicaid populations and Medicare ACOs REACH and MSSP.



How many of you
use Azara Care
Connect (ACC)?



Azara Care Connect

A fully integrated solution to efficiently manage and coordinate care that:

Leverages DRVS data to optimize performance.

Integrates clinical, claims, HIE, and practice management data.

Helps care teams improve productivity and efficiency.

Closes care gaps and tracks adherence to health plan contract requirements.

**How many of you are
beginning to integrate
ACC into your work?**

**Are you finding new ways
to grow with ACC and use
it to its fullest?**



Planting the Seeds of Success: Growing Implementation and Utilization



ACC Use Across the Network

ACC is used across our network to **enhance care coordination**, **track performance**, and **strengthen care team workflows**.

Programs using ACC vary based on funding sources and organizational priorities including:



VBA funded
CHW Patient
Engagement
Programs



Care
Management
Services



Accountable
Care
Organization
Programs

CHW Patient Engagement Program

Partnered with **four Medicaid health plans** through **Value Based Care Agreements** to fund CHW positions at health centers.

Highlighted the need for a **reporting structure** to track patient data, generate outreach alerts, and space for staff to document outreach.

Azara and MCHN partnered to develop a **Care Coordination framework** to support these needs.



Health Center Care Management

Health Centers across the MCHN network have implemented a **diverse range of Care Management services**, including:

- Transitional Care Management
- Chronic Care Management
- Behavioral Health Home Model

Utilizing **cohort identification** and **template building**, teams can tailor workflows, documentation, and reporting to align with their specific care models –enhancing both **efficiency** and **patient care delivery**.



Medicare ACO Programs

Partnered with an external organization to assist us in implementing the **ACO REACH** and **MSSP** program across **18 health centers**.

Highlighted the need for a system that was payer agnostic and could streamline the **multiple, fragmented workflows** that were currently being used to adhere to program requirements.

Once again partnered with Azara to develop "**ACC 2.0**" to **streamline and support a unified, payer agnostic, documentation experience**.



Blossoming Together: Cultivating Success Across Diverse Health Centers



Challenges in the Current Landscape

- ① Use of multiple documentation systems
- ② Manual entry of reportable fields with limited automation & integration
- ③ Redundancy in Health Center workflows
- ④ Utilization of 10 different EHR systems across the network
- ⑤ Diverse staff roles contributing to documentation
- ⑥ Complex data and reporting requirements

Key Limitation: No interoperability between systems led to inefficiencies and increased administrative burden on staff.

Essential System Design Elements

To support the work across our network, we need a solution that enables us to:

1. Ingest member-level data and open care gaps such as:

- High ED Utilizers
- Unmet Health Related Social Needs
- Unmet HEDIS and Clinical Quality Measure (CQM) Gaps
- Transition of Care Notifications and Details

2. Track Outreach and Care Gap Closure

- Enable documentation of outreach activities
- Capture status and resolution of care gaps

3. Identify and Stratify High Risk Members for Targeted Care Management

4. Document Comprehensive Care Plans

- Create a standardized format across all health centers

5. Create Cross-Functional and Payer Agnostic Workflows

Enhancements: One System, One View

Network health centers now receive monthly member files **directly through ACC**, which provides **timely notification** of patient needs, and allows staff to access a **comprehensive profile** – **all within a single platform.**

Outreach Directory

All Recently Viewed

Search Patients...

PATIENT [†]	GAP COUNT [†]	CONTACT REASONS [†]	LAST OUTREACH [†]	OUTREACH COUNT [†]	USER [†]	[†]
MARTIN, ANGELA	5	ED, SDOH, HEDIS, CQM	02/10/24 ▲	4	Jackie Brown	1 2
SCHINNER, ANGELO	17	HEDIS	02/25/24	3	Jackie Brown	1 2
STOKES, HILLARY	1	SDOH	03/11/24	3	Jackie Brown	1 2
O'CONNOR, BRIANA	2	ED, HRA	03/05/24	2	Jackie Brown	1 2
HARBER, JAZMIN	1	ED	03/09/24	2	Jackie Brown	1 2
JAST, HERMINIA	1	CQM	03/10/24	2	Jackie Brown	1 2
HERMAN, FRANCES	9	HEDIS, SDOH	03/11/24	1	Jackie Brown	1 2
FRITSCH, LILLIE	1	ED	03/11/24	2	Jackie Brown	1 2
DUBUQUE, DAGMAR	1	ED	03/12/24	3	Jackie Brown	1 2
O'CONNOR, HENRI	2	CQM	Never ▲	0	Jackie Brown	1 2
MONAHAN, ADRIEL	30	HEDIS, HRA, CQM	03/12/24	3	Jackie Brown	1 2
STRACKE, TIMMOTHY	2	ACCESS, SDOH	02/28/24	1	Jackie Brown	1 2
HEGMANN, OLEN	5	HEDIS	03/12/24	2	Jackie Brown	1 2
GUTKOWSKI, NELLA	9	ACCESS, HEDIS	02/28/24	2	Jackie Brown	1 2

Showing 1 to 14 of 14 entries

Demo data 1 Next

FILTERS MANAGE

NARROW RESULTS BY

- No Contact in last 90 days
- Attributed in Last 30 Days

CONTACT REASONS

6 selected -

FOLLOW UP STATUS

None selected -

PLAN

None selected -

PROVIDER (PCP)

None selected -

USERS

Jackie Brown -

APPLY FILTERS

RESET FILTERS

CONTACT REASONS

All selected (68) -

- ACCESS
- HIGH ED
- MCRD
- PRP+
- SDOH
- TOC
- CQM -
- HEDIS -

PLAN

None selected -

Q Search

CLEAR SELECTIONS

- Medicare REACH ACO
- Meridian
- Molina
- Priority Health
- UHC

Patient Landing Page

The screenshot displays a patient landing page for **Bathrick, Nicolas** (MRN: 1101313, Member Number: 1313, DOB: 6/11/76). The page is divided into several sections:

- Navigation:** Home, Patients, Tasks, Reports, Care Coordination, and a search bar for ACM Patients.
- Follow-Up Ribbon:** A red banner at the top left indicating a follow-up is due on 12/23, labeled as "OVERDUE".
- Outreach Icons:** A box containing "Attempted" and "Connected" status icons, labeled "Outreach Icons".
- Gaps Panel:** A section for Quality Improvement (CQM) metrics, including "DM A1c > 9 or Untested (CMS122v11)" and "DM A1c > 9 or Untested (All Ages)", labeled "Gaps Panel".
- Tasking:** A table of tasks with columns for Action, Summary, Due Date, Assignee, and Comments. Tasks include "Obtain discharge summary", "Call Pt 2 days after discharge for assessment", "Medication Reconciliation", and "Schedule follow-up visit with provider".
- Outreach Log:** A table of outreach activities with columns for Date, Reason, Notes, Interventions, and Performed By. Entries include a successful connection on 08/07/23 and a missed call on 08/06/23.

The page also features a "Follow-Up Ribbon" label pointing to the top navigation area and a "Demo data" label in the bottom right corner.

Coordination

Screening

Follow-Up Ribbon

Data Received: 10 January

FOLLOW UP

04/14 TODAY

Outreach Icons

Selected 0 Attempted Connected

OUTREACH REASONS (5)

All Open Complete

Gaps Panel

REASON DETAILS

LAST OUTREACH OUTREACHES REPORTED STATUS

CQM 2

HEDIS Cervical Cancer Screening

MW 04/14/25

1

04/07/25

Open

TOC 2

+ Add Reason

TASKS (17)

Open Completed Flagged All

ACTION	SUMMARY	DUE	ASSIGNEE	COMMENTS
Follow-up	1488983218	03/24/25	ACC Details	make sure patient went to get A1c tested
Schedule	Well Women Exam	03/31/25	ACC Details	schedule to get pap completed

Showing 1 to 2 of 2 entries

Tasking

OUTREACH LOG (3)

Last 30 Days All

DATE	REASON	NOTES	INTERVENTIONS	PERFORMED BY
04/14/2025	TOC, CQM, HEDIS		Research/Gap Found	Wack, Molly
03/24/2025	TOC		Member refused service	Maribei, Caroline

Outreach Log

Demo data

Streamlined Documentation

Granular, **gap-specific documentation** capabilities enable staff to efficiently record outreach activities, capture follow-up actions, and document gap closures—all **within a single, streamlined interface.**

Connected Outreach

Select any outreach activity that should be logged to all outreach reasons of this type

Date: 01/29/2025 | Method: Phone

Reasons	Actions	Complete
▼ CQM	None Selected	⊙
DMA1c > 9 or Untested (All Ages)	None Selected	⊙
DMA1c > 9 or Untested (CMS 122v12)	None Selected	⊙
HEDIS CDC - DM Care HbA1c Testing	None Selected	⊙

Start typing to add notes

Follow Up: Yes **No**

Submit

- Found PCP outside of Health Center
- Member refused service
- Other
- Scheduled/Connected to service at Health Center
- Scheduled/Connected to service outside of the Health Center

Attempted Outreach

Select any outreach activity that should be logged to all outreach reasons of this type

Date: 1/29/2025 | Method: Phone | Why was this person not reached?: Research/Gap Found

Reasons	Complete
▼ CQM	⊙
DMA1c > 9 or Untested (All Ages)	⊙
DMA1c > 9 or Untested (CMS 122v12)	⊙
HEDIS CDC - DM Care HbA1c Testing	⊙

Start typing to add notes

Follow Up: Yes **No**

Submit

- Research/Gap Found
- Bad phone/contact info
- No answer/no response
- Not home/no-show
- Deceased
- No longer resident
- Termed/No longer enrolled

Care Management Updates

Updated Care Plan structure offers a flexible approach, incorporating both **free text** and **structured data elements** that can be tracked and prioritized. Additionally, **built-in evidence-based resources** provide care plan development support to the care team.

The screenshot displays a user interface for a care management system. At the top, it shows patient information: 'ZzRCM Unidentified, Misc 2022', MRN: 00000103203, and DOB: 1/9/22 (26 months). Navigation tabs include Summary, Plan (selected), Screenings, Clinical, and Activity. The main content area is divided into several sections: 'FOCUS' (No focus to display), 'CARE TEAM' (Intervention Effort: Not Set; Care Manager: Unassigned; Usual Provider: Unassigned), 'MANAGEMENT PLAN' (No management plan to display), 'RECOMMENDED RESOURCES' (VIEW LIBRARY button), 'BARRIERS TO CARE' (table with columns: IDENTIFIED, BARRIER, ACTIVITY, NOTES, UPDATED, PRIORITY, OWNER), 'GOALS' (table with columns: DUE, GOAL, ACTIVITY, NOTES, UPDATED, PROGRESS, PRIORITY, OWNER), 'SELF-MANAGEMENT GOALS' (table with columns: DUE, GOAL, ACTIVITY, NOTES, UPDATED, PROGRESS, PRIORITY, OWNER), and 'EDUCATION' (table with columns: DUE, GOAL, NOTES, UPDATED, PROGRESS, PRIORITY, OWNER). Each table currently shows 'No [Category] to Display'. A blue plus sign is visible at the bottom right of the interface.

Update the assignment for Care Manager, if needed. This manual assignment will not override the EMR assignment if your org uses that information for other programs.

Free text section you can use to document. You can create templates to drop-in as well.

Elsevier content to review if you need assistance building the Care Plan.

Structured documentation section that can be independently curated or you can use Elsevier driven content.

Customized Templates

Customization is key! Templates can be created to model EHR or staff preferred documentation styles and ensure program requirements are met.

Update Management Plan Template CANCEL SAVE CHANGES

Template Name

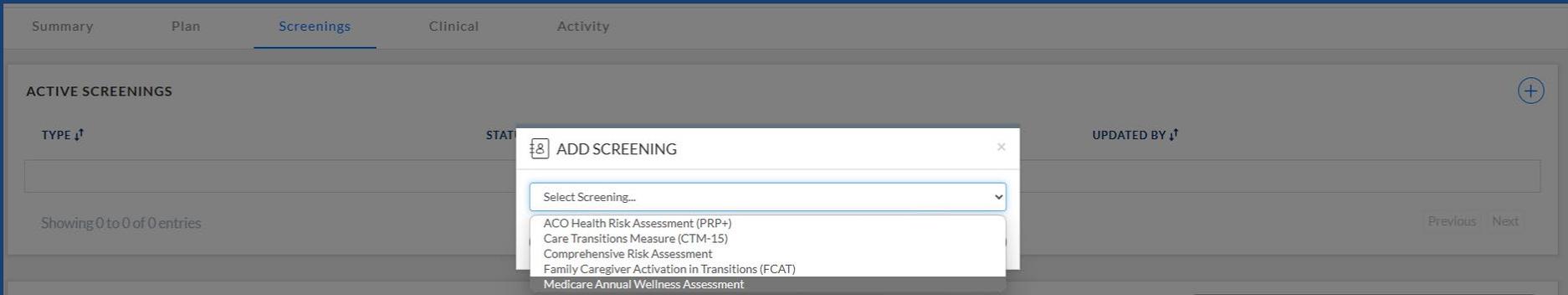
← → Bold **B** *I* U [List Icons] [Link Icon] [Code Icon] [Eye Icon]

Topic	Date	Comments	Initials
HgbA1c			
ø Current %			
ø Goal %			
Diabetes Self-Management Program			
ø Discuss/ Offer			
Medications			
ø Discuss mechanism of action			

Screenings Tab

Multiple screenings were **embedded** within the platform to capture required elements:

1. Care Transitions Measure (CTM-15)
2. ACO Health Risk Assessment (PRP+)
3. Medicare Annual Wellness Assessment
4. Comprehensive Risk Assessment
5. Family Caregiver Activation in Transitions (FCAT) Tool



The screenshot displays a software interface with a navigation bar at the top containing tabs for 'Summary', 'Plan', 'Screenings', 'Clinical', and 'Activity'. The 'Screenings' tab is currently selected. Below the navigation bar, the main content area is titled 'ACTIVE SCREENINGS' and features a table with columns for 'TYPE', 'STATUS', and 'UPDATED BY'. A modal window titled 'ADD SCREENING' is open in the center, showing a dropdown menu with the text 'Select Screening...' and a list of screening options: 'ACO Health Risk Assessment (PRP+)', 'Care Transitions Measure (CTM-15)', 'Comprehensive Risk Assessment', 'Family Caregiver Activation in Transitions (FCAT)', and 'Medicare Annual Wellness Assessment'. The table below the modal shows 'Showing 0 to 0 of 0 entries' and includes 'Previous' and 'Next' navigation links.

Coordination Activity Report

Delivers **real-time**, in-depth insights from the outreach activities staff are actively carrying out.

Date: REPORTED DATE ▾ Range: 03/07/2025 - 04/07/2025 Plan: UNITED HEALTHCARE ▾ Outreach Reason: 5 SELECTED ▾ Assigned User: ALL SELECTED (2) ▾ [RELOAD](#)

Tailored data filter options let you choose exactly the information you need—when and how you want it:

Coordination Activity 🔍 DOWNLOAD AS: [EXCEL](#) [CSV](#)

Date: OUTREACH DATE ▾ Range: 01/15/2025 - 04/14/2025 Plan: ALL SELECTED (14) ▾ Outreach Reason: ALL SELECTED (9) ▾ Assigned User: ALL SELECTED (6) ▾ [RELOAD](#)

NAME	DOB	SEX	MRN	OUTREACH REASON	REPORTED	OUTREACH ID	OUTCOME	OUTREACH	METHOD	PERFORMED BY	COMPLETED
				PRP+: ACO Health Risk Assessment	01/14/25	369346	Connected	01/21/25	Research	Kyle Guajardo	01/21/25
				PRP+: ACO Health Risk Assessment	01/14/25	369099	Connected	01/21/25	Research	Kyle Guajardo	01/21/25
				PRP+: ACO Health Risk Assessment	01/14/25	375264	Connected	01/21/25	Research	Kyle Guajardo	01/21/25
				PRP+: ACO Health Risk Assessment	01/14/25	373191	Connected	01/21/25	Research	Kyle Guajardo	01/21/25
				PRP+: ACO Health Risk Assessment	01/14/25	375086	Connected	01/21/25	Research	Kyle Guajardo	01/21/25
				PRP+: ACO Health Risk Assessment	01/14/25	1686937	Connected	03/14/25	Research	Nicole Vance	
				PRP+: ACO Health Risk Assessment	01/14/25	1683387	Connected	03/10/25	Research	Nicole Vance	
				TOC: 01/14/2025 - Munson Healthcare Cadillac Hospital - ER Visit, discharged Unknown or Blank 01/15/25 04:59 AM	01/15/25	368252	Attempted	01/15/25	Research	Nicole Vance	01/16/25
				SDOH: SDOH Screening needed	01/18/25	847687	Connected	02/17/25	Phone	Yuridia Cortez	02/17/25
				SDOH: SDOH Screening needed	01/18/25	854833	Attempted	02/28/25	Phone	Yuridia Cortez	03/4/25

From Seeds to Strategy: Gaining Buy-In

1. Shared Governance:

Health centers actively participate in decision-making, identifying needs, and prioritizing project deliverables.

2. Shared Costs:

Through our shared savings, we can distribute the costs of new product development, implementation, and utilization across the network, significantly reducing or fully covering the expenses for individual centers.

3. EHR Integration and Visibility:

By integrating key elements from each health center's EHR, we enable the use of a single system, eliminating the need for multiple systems to complete tasks.

From Seeds to Strategy: Gaining Buy-In

4. Increased Insight into Outcomes:

Unified and streamlined documentation provides a single source of truth, helping the network meet program reporting requirements, track trends, and support centers in making projections and ensuring compliance.

5. Interfacing Potential:

Expansion of a platform currently used by health centers creates future opportunities for enhanced interfacing with EHR vendors, expanding capabilities across the network.

6. Network-Level Support and Oversight:

Dedicated network staff act as liaisons with external partners, allowing health center staff to focus on their work without the burden of operational design or data reporting tasks, while also ensuring the system meets the needs of all participating value-based agreements.

Key Responsibilities Within the Network

- Streamline work and programs to support payer-agnostic utilization
- Align requirements across all VBA agreements and Health Center programmatic requirements to reduce operational and administrative burden
 - Example: ACO MSSP Quality Measures align with UDS Clinical Quality Measures and MCHN VBA Focus Measures
- Assist centers in evaluating their current use of Azara modules and EHR systems to uncover opportunities for workflow enhancements and optimize platform utilization
- Establish internal support structures and communication channels to ensure consistent messaging and identify key subject matter experts

Insights Learned & Key Takeaways



Intentional Planning

Identify and address the needs across the care continuum to develop a program that is functional and effective at all stages.



Staff Involvement

- Ensure key staff members are involved in the design and development of new systems to avoid missed opportunities and prevent duplication of efforts.
- Pilot all new implementations before full release to identify and resolve any issues, minimizing disruptions and maintaining staff confidence in the system.



Training & Support

- Develop training materials and provide spaces for team collaboration, ensuring proper documentation and efficient workflow utilization.
- Establish feedback mechanisms and communication channels to quickly identify issues and implement solutions in a timely manner.

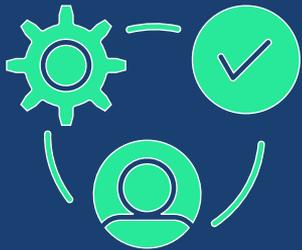
From Seeds to Flowers: Impact in Bloom

Health Center



One System, Full Visibility

Direct, real-time insight into operations and patient data—all within a single, unified platform. No more juggling multiple systems.



Role-Based Work Management

Workflows are powered by integrated EHR, DRVS, and HIE data, allowing centers to assign tasks strategically based on staff roles and responsibilities.

From Seeds to Flowers: Impact in Bloom

Network



Centralized Support with Precision

Centralized MPCA support teams, in close collaboration with Azara support, ensures fast and accurate error resolution.



Less Staff Time, More Impact

MPCA has reduced staff time spent on data processing and report creation by **70%**, freeing up resources for higher-value work.

From Seeds to Flowers: Impact in Bloom

Health System



Stronger Integration, Better Outcome

Real-time TOC alerts empower staff to take immediate action, resulting in measurable improvements in care trends.



Medicare ACO IP Events:

- **9% increase** in follow-up call completion post discharge
- **6% increase** in follow-up appointments being scheduled post-discharge

Medicare ACO ED Events:

- **10% increase** in follow-up call completion
- **3% increase** in follow-up appointments being scheduled

Next Steps & Future Planning

Workflow Support

- Reduce redundant documentation and save valuable staff time by integrating key areas in ACC with EHR documentation.
- Pull in Health-Related Social Needs (formerly SDOH) screening responses to clearly identify and address patient needs.

Feature Enhancements

- Improve current tools and introduce real-time, network-level analytics for smarter, faster decision-making.
- Refine directory filters to include more comprehensive and customizable options, making it easier to surface critical data.

Data Integration

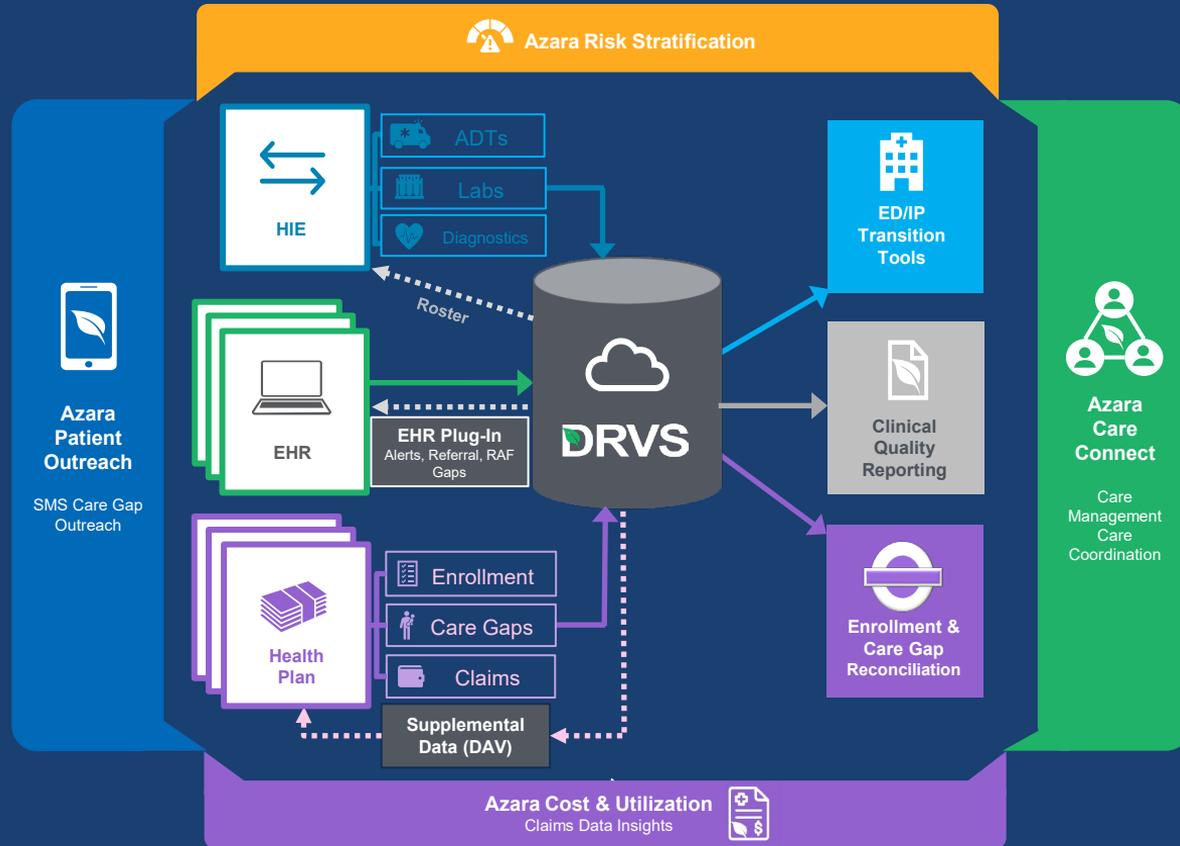
- Move beyond payer-driven lists to support a broader range of patients and care strategies.
- Integrate with communication tools like text messaging and mailing software to automatically capture off-platform staff activity—eliminating the need for double documentation.

And so much more!

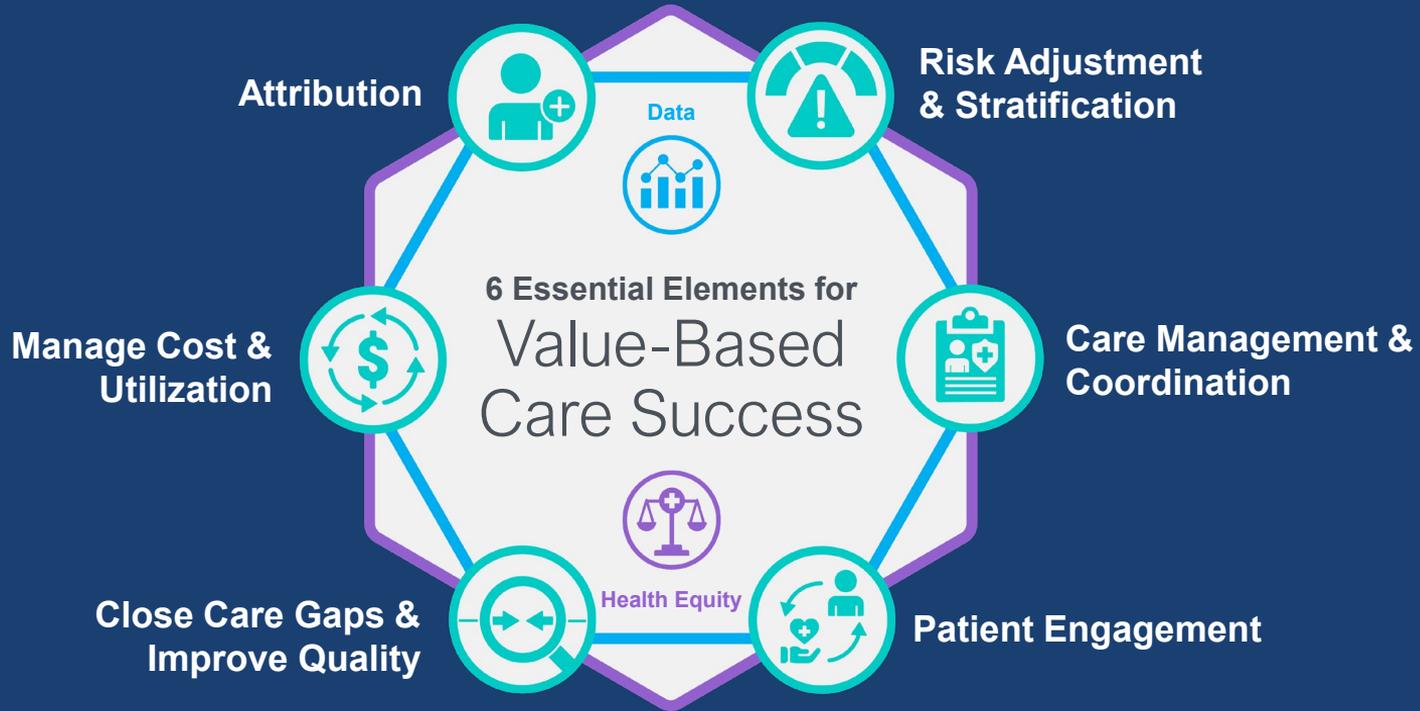
ACC in Action



Azara Ecosystem



Essential Elements of VBC



Care Management + Coordination

By proactively managing patient populations through care coordination and care management programs, healthcare providers can close care gaps, improve population health outcomes, and achieve success in value-based care models.

Key Challenges:



Ineffective processes for identification and placement of patient into the appropriate care program



Staffing shortages



Tools/technology does not align with workflows

Care Management Basics



Who is being care managed + how are they “enrolled” in your program?



What are the required activities for patients in a care management program?



What are the goals your organization has for its care management program ?

Common Methods to Identify CM Patients

Pre-defined lists

- Often provided by payers or state agencies.
- Includes list of patients who meet specific criteria, either generated by a payer or submitted by the practice for approval to a payer/program.

Clinical review process

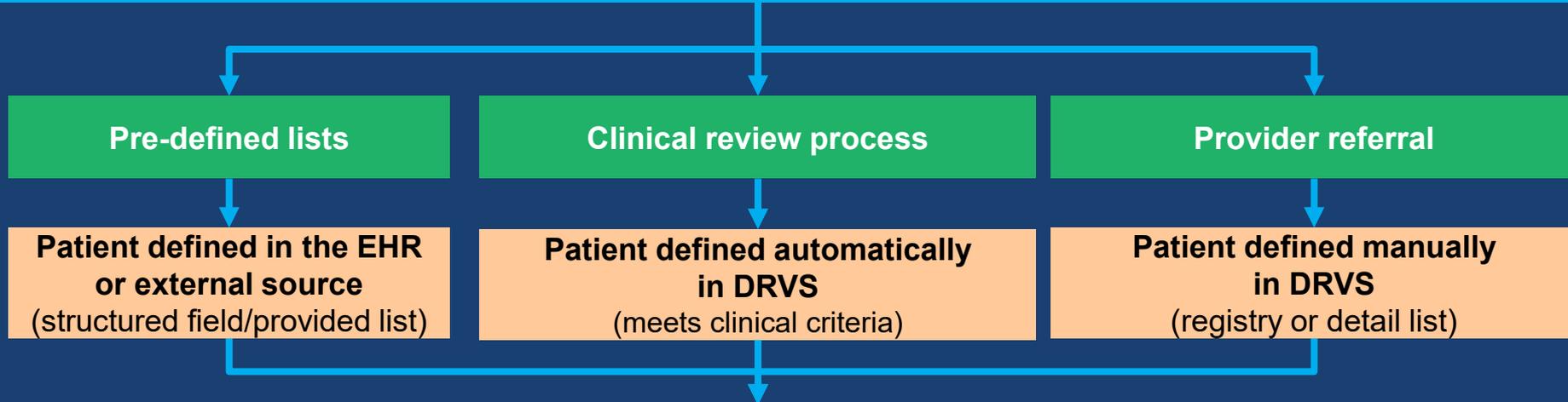
- Group of clinical and administrative staff meet regularly to review list of potential patients for care management.
- Can be a blend of those who have been referred or identified.

Provider referral (ad-hoc post-patient visit)

- Providers determine if a patient could benefit from care management services at the visit and send a referral.
- Determination for enrollment in care management plan varies.

Workflow to Enroll in CM

Identify patients for care management



Patient Assigned to Care Manager*

Patients added to cohort enabled for Care Management in DRVS

*recommended workflow via the EHR

Identification
Process

Patient Definition

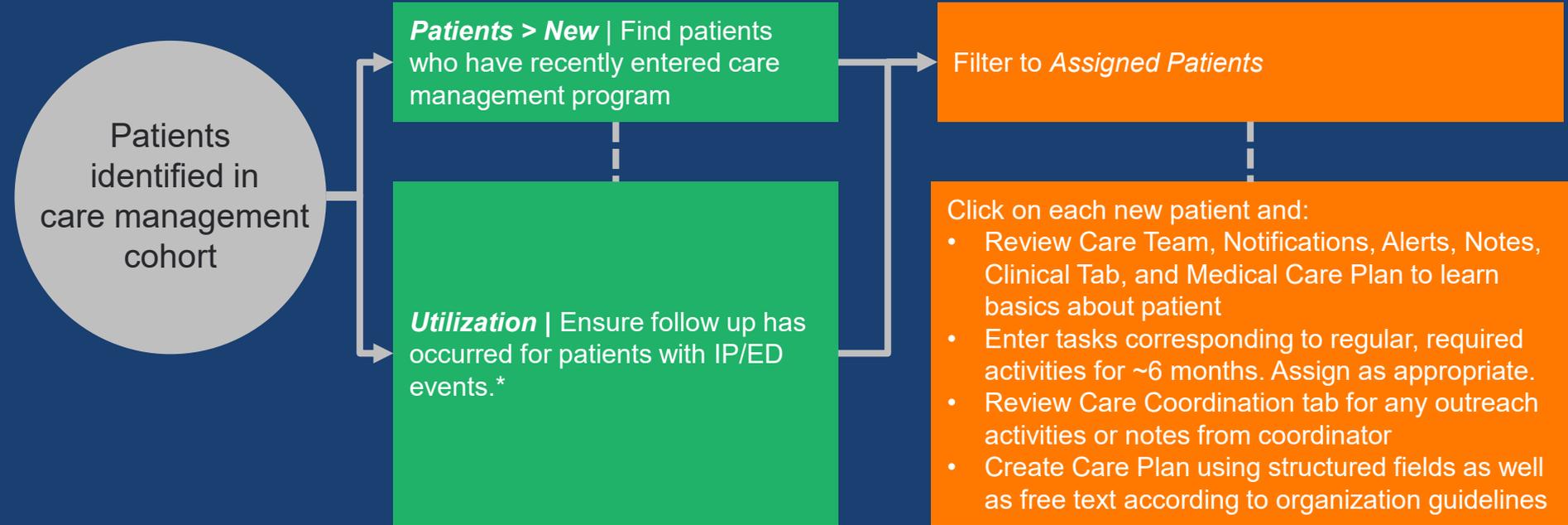
Input + Output

Common Activities of Care Management

- ✓ Creating and updating patient care plan
- ✓ Setting regular check-ins/touchpoints with the patient
- ✓ Following up on visits and provider instructions
- ✓ Helping manage specialist referrals, medications, and coordinating other services/appointments

These activities are in service of the larger goals of care management: to establish a relationship with the patient, provide support for identified needs, and ultimately improve outcomes and lower costs.

New Patient Workflow



Patients identified in care management cohort

Patients > New | Find patients who have recently entered care management program

Utilization | Ensure follow up has occurred for patients with IP/ED events.*

Filter to *Assigned Patients*

Click on each new patient and:

- Review Care Team, Notifications, Alerts, Notes, Clinical Tab, and Medical Care Plan to learn basics about patient
- Enter tasks corresponding to regular, required activities for ~6 months. Assign as appropriate.
- Review Care Coordination tab for any outreach activities or notes from coordinator
- Create Care Plan using structured fields as well as free text according to organization guidelines

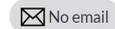
* Note: requires Transitions of Care Module. This follow up could be done through care coordination or care management, depending on established roles and workflows.

Home Page

Patients Page



Burg, Lesia MRN: ACM4 | DOB: 1/30/49 (75) | F ☆



Summary

Plan

Clinical

Activity

NOTIFICATIONS

Upcoming Appointment	Crowley, Patrick / ACH - Needs Update	7/3/24 2:19 AM
Upcoming Appointment	Gunther, Eric / ACH - Needs Update	6/21/24 9:34 AM
New to CM	Added to Abnormal Cancer Screen Outreach cohort	5/31/24

CARE TEAM

Intervention Effort	Not Set
Care Manager	Mike Rapawy
Usual Provider	Augustine, Greg

TASKS (0)

Open Completed Flagged All



↑↓ ACTION ↑↓	SUMMARY ↑↓	DUE ↑↓	ASSIGNEE ↑↓	COMMENTS
No Tasks to Display				

Showing 0 to 0 of 0 entries Previous Next

NOTES

Just now	Patient just entered care management program - needs a lot of support coordinating appointments and managing medication	HE
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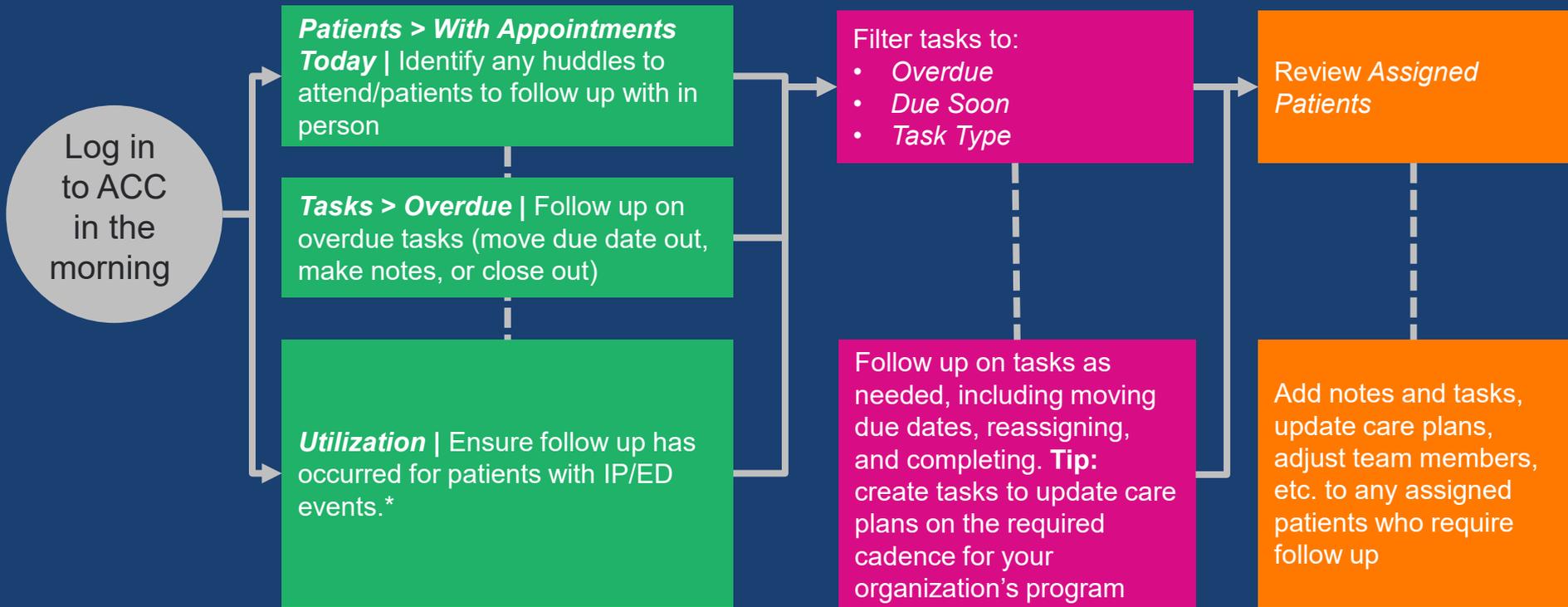
ALERTS

NAME	MESSAGE	MOST RECENT DATE	MOST RECENT RESULT
BMI & FU	Missing		
Depression Screen	Missing		
Mammo	Missing		

Demo data



Established Patient Workflow



* Note: requires Transitions of Care Module. This follow up could be done through care coordination or care management, depending on established roles and workflows

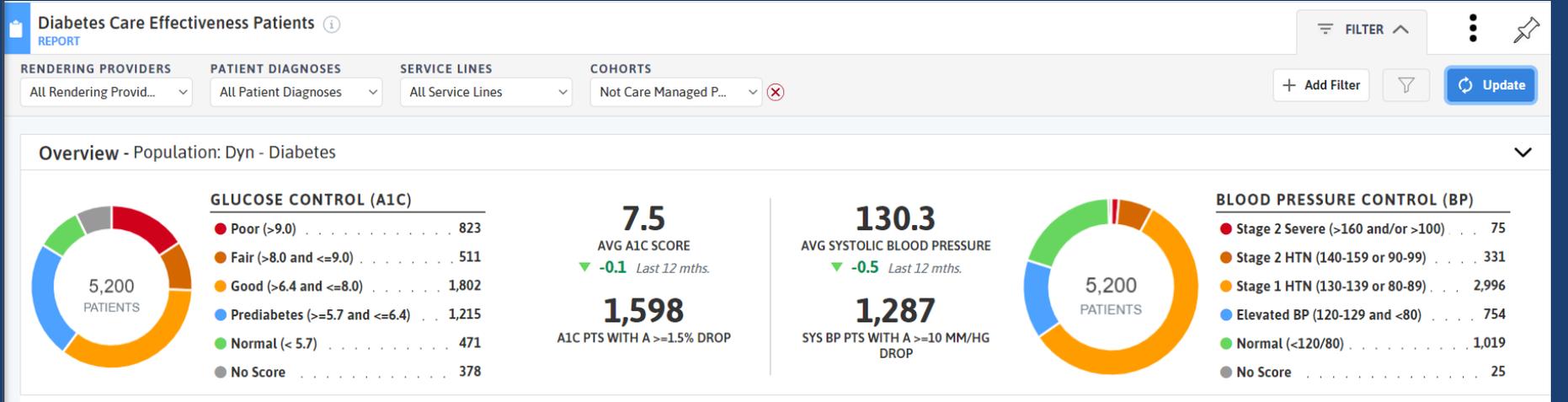
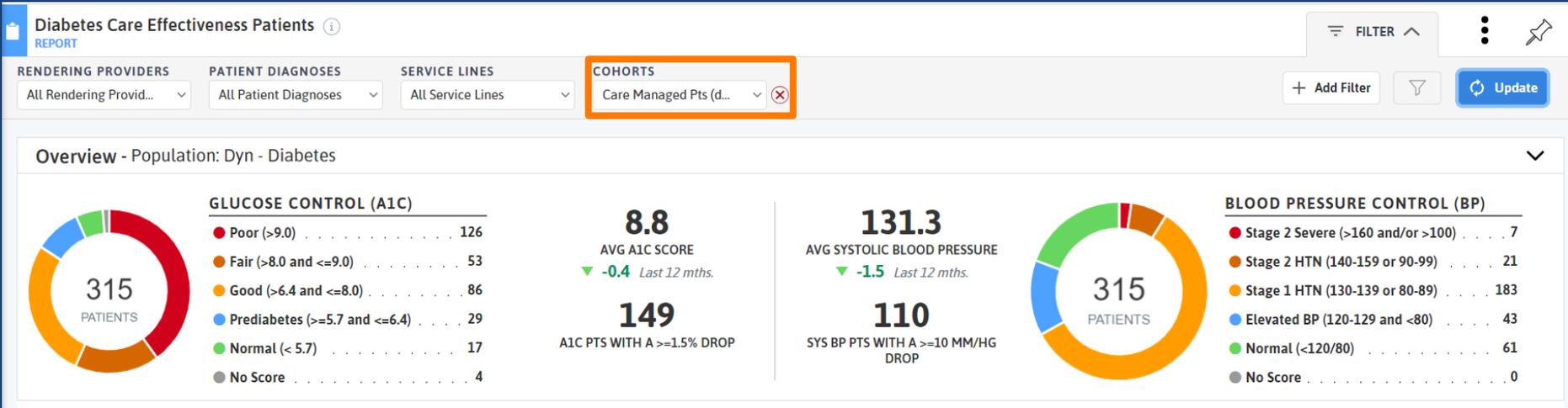
Broad Goals for CM

**Identify + reduce
risks for patients**

**Improve patient
outcomes**

**Improve patient
experience +
engagement with
care team**

Lower costs



Care Management Dashboard

Care Management Overview (LKK) ①

DASHBOARD

FILTER 1

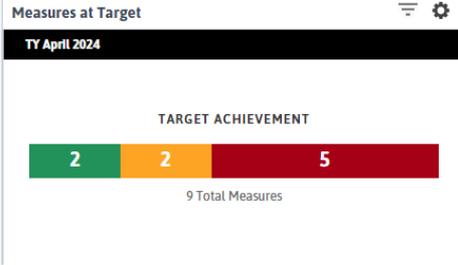
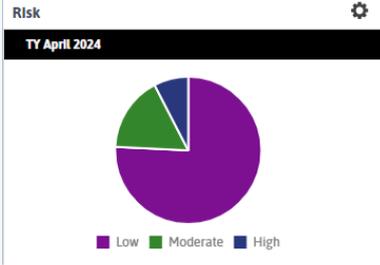


FILTERS: April 2024

CM Enrollees

TY April 2024

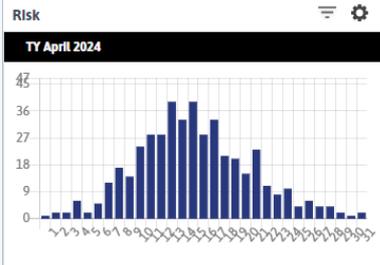
448 +7 ▲
Count of Unique Patients w/ Encounter
TY 11/23



CM Enrollee w/Primary Care Encounters

TY April 2024

99.6% +0.7% ▲
% Patient w/ Primary Encounter
TY 3/24



CM Assignments

TY April 2024

CARE MANAGERS	DENOMINATOR
Unassigned	71,092
KRISTIE BOETTCHER RN	82
AMANDA SCHULTE RN	63
RACHEL JOHNSON RN	50
KAYLA HEITZIG RN	49
JACKSON_RN_TAREYA	43
TANIESHA BOWEN RN	42
THERESA SERAZIO RN	36
JAMIE MCMULLEN RN	35
SARAH MEINEMA RN	24
CALLIE DICK RN	24
JENNIFER DIETRICH RN	1
MEGAN ANDERSON CHW	1

Quality Metrics

TY April 2024

MEASURE	RESULT	NUM	DENOM	EXCL
HTN Controlling High BP (CMS165v12)	69.4%	229	330	27
DM A1c > 9 or Untested (CMS 122v12)	42.7%	138	323	6
DM A1c Tested (1 yr)	96.9%	313	323	6
HTN BP Recorded	100.0%	330	330	27
DM A1c Tested (6 mo)	89.8%	290	323	6
DM Foot Exam	54.8%	178	325	2
Diabetes: Eye Exam (CMS 131v9)	57.9%	187	323	6
Depression Screening & Follow-Up (CMS 2v13)	60.4%	223	369	70
Depression Remission at Twelve Months (CMS 159v12)	4.5%	3	66	26
ED Readmission (30	24.0%	164	683	0

Diabetes Data

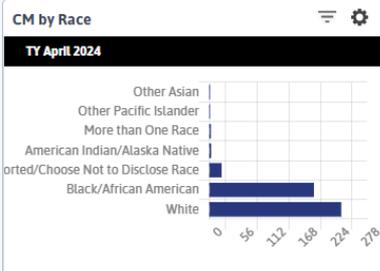
TY April 2024

PTS W/ DIABETES	323	
DM A1c < 7	75	23%
DM A1c >= 7 and A1c <= 8	58	18.0%
DM A1c > 8 and A1c <= 9	52	16.1%
DM A1c > 9	128	40%
DM A1c does not exist	4	1.2%

CM No Show Rate

April 2024

6.4% -4.8% ▼
Measure Result
Mar 24



Example Comparison



Care Coordination



Care Coordination Considerations



What services are being coordinated?



What is the primary method of intervention?



What staff do you have available?

Populations for Care Coordination

Contact Reason	Use Case	Considerations
CQM	Close measure-specific gaps for the entire population	<ul style="list-style-type: none">• Population(s) can be very large• Workflows can vary by gap
Plan-Calculated HEDIS	Close measure-specific gaps for enrolled populations	<ul style="list-style-type: none">• Only includes data for enrolled members on care gap files• Care gap file data can conflict with EHR
Transitions of Care	Complete follow up for patients with ED or IP events	Must have Transitions of Care module in DRVS to use this contact reason

Note: for other contact reasons, please contact your Client Success Manager or Support.

Identifying the TOC Population

Transitions of Care (TOC) - ED/IP REPORT

FILTERS: 06/17/2024-06/20/2024 Discharge; Admission

Search ...

NEXT APPT: All No Appt Upcoming Appt

Reset Columns SAVED COLUMNS

ADMISSION EVENT						
TYPE	ADMISSION	DISCHARGE	FACILITY	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS	IP
Inpatient Stay	6/13/24 10:44 am	6/17/24 3:53 pm	MEDICAL	0	1	N
ER Visit	6/18/24 2:32 pm	6/18/24 6:10 pm	M Health	1	0	N
ER Visit	6/17/24 3:37 pm	6/17/24 9:15 pm	Emergency Department	3	0	N
ER Visit	6/18/24 12:26 pm	6/18/24 7:07 pm	Emergency Department	3	0	N
ER Visit	6/17/24 3:37 pm	6/17/24 9:15 pm	Emergency Department	3	0	N
ER Visit	6/18/24 12:26 pm	6/18/24 7:07 pm	Emergency Department	3	0	N
Inpatient Stay	6/8/24 9:40 pm	6/17/24 11:29 am	SURGICAL UNIT	0	1	N
ER Visit	6/18/24 3:23 am	6/18/24 6:23 am	M Health	1	0	N
ER Visit	6/17/24 12:31 am	6/17/24 11:18 am		1	0	N

Demo data

1. The Transitions of Care (TOC) – ED/IP report in DRVS filtered to the last 3 days provides an estimate how many patients will flow into ACC.
2. Users can view the quality of TOC data, particularly discharge diagnosis and status on the TOC report. If the data is not in DRVS, it will not be in ACC.

Identifying the Population | CQMs

Care Coordination CQM Gaps REPORT

FILTERS: 2024

REPORT CARE GAP

Search ... GAPS Gaps Present All Has Appt No Appt

GAP		MEASURES		
COUNT	DESCRIPTION	COLORECTAL CANCER SCREENING (CMS 130V12)	CERVICAL CANCER SCREENING (CMS 124V12)	
5	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
2	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
6	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
6	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
3	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
3	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
7	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
7	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
9	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
1	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
1	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
1	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
1	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
1	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
1	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap
1	4 Colo, Pap HPV, Mammo, DM A1C	gap	gap	gap

1 to 15 of 2,728

Review gaps on a custom CQM scorecard and assess:

- Do you have the staff to reach even 50% of patients with gaps?
- Can you remove lower-impact, point of care focused measures like tobacco screening, BMI, etc.

Identifying the Population | Plan-Calc

P4P UHC Scorecard REPORT FILTER 2

FILTERS: 2024 United Healthcare

REPORT + CARE GAPS

Search ...

MEASURE COMPLIANCE

- MEASURE COMPLIANCE
- Non-Compliant (Gap)
- Compliant

ACTION REQUIRED

- Member Outreach
- Data Reconciliation

NO ACTION REQUIRED

- Compliant

Reset Columns

DATA RECONCILIATION REQUIRED

PLAN	MATCHED >	GAP	MEASURES		
PLAN	MATCH	COUNT	DESCRIPTION	W30A - WELL-CHILD VISITS IN THE 1ST 15 MONTHS	WCV - CHILD AND ADOL. WELL-CARE VISITS TOTAL
United Healthcare	✓	2	WCV, CIS COMBO10		☎
United Healthcare	✓	2	WCV, CIS COMBO10		☎
United Healthcare	✓	2	WCV, CIS COMBO10		☎
United Healthcare	✓	2	WCV, CIS COMBO10		☎
United Healthcare	✓	2	WCV, CIS COMBO10		☎
United Healthcare	✓	2	WCV, CIS COMBO10		☎
United Healthcare	✓	2	WCV, CIS COMBO10		☎
United Healthcare	✓	1	WCV		☎
United Healthcare	✓	1	WCV		☎
United Healthcare	✓	1	WCV		☎

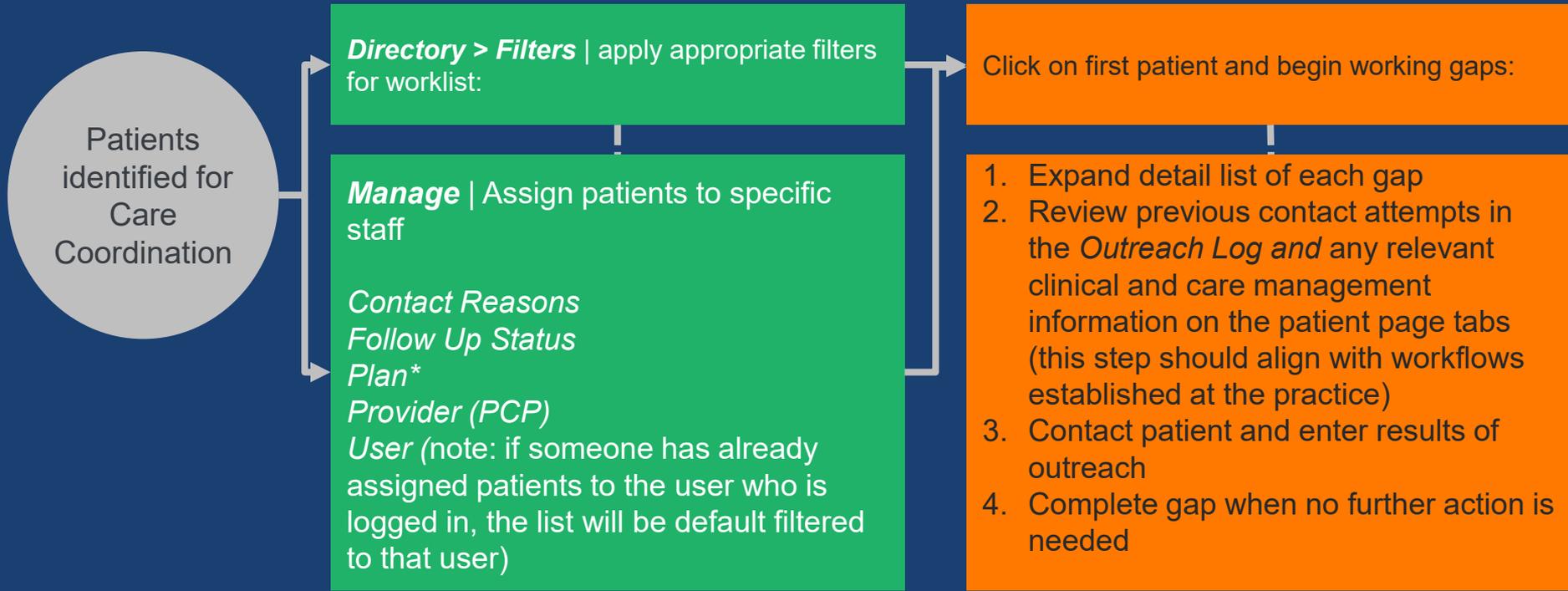
1 to 10 of 272

Review plan-calc scorecards in DRVS and assess:

- Gaps in context of value-based care contract payments – which gaps are prioritized for quality gates and incentive payments?
- If an equivalent CQM can be used

Azara does not recommend loading both CQM and plan-calc measures into ACC, as the measure logic and source data differs and gaps may be difficult to interpret.

Care Coordination General Workflow

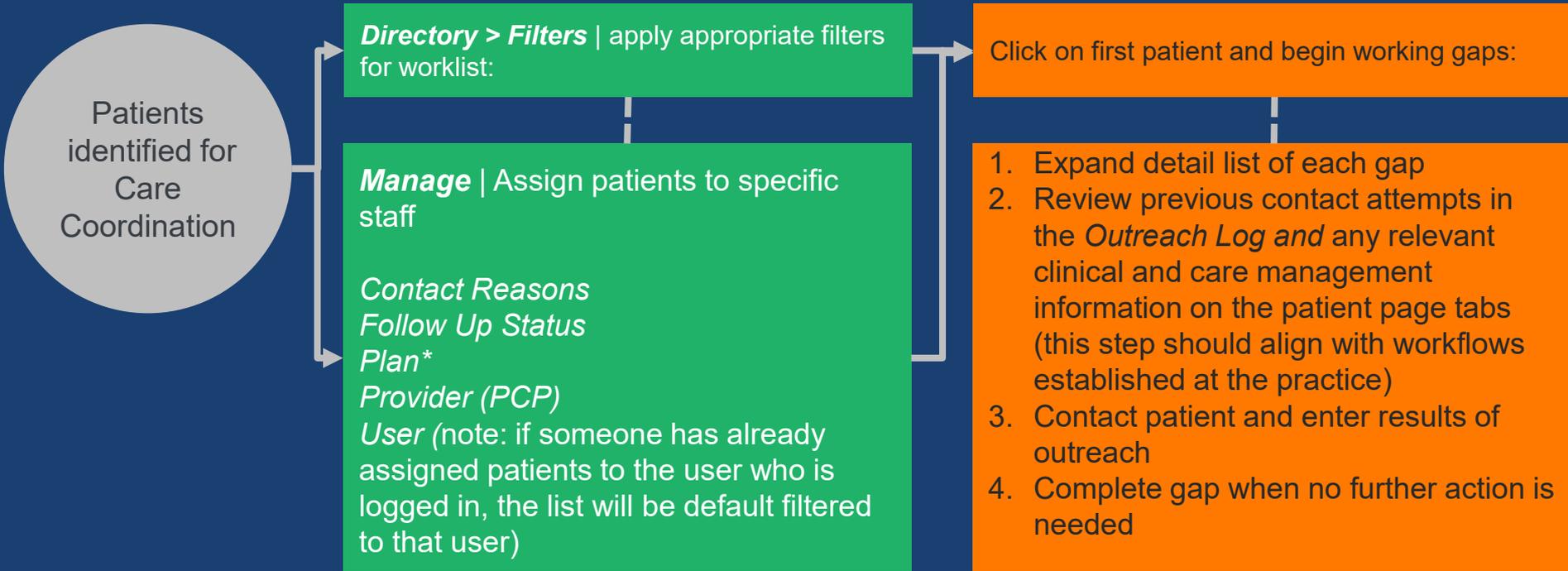


Directory

Patient Page

* Note: requires Enrollment integration in DRVS

Care Coordination General Workflow



* Note: requires Enrollment integration in DRVS

Directory

Patient Page

Transitions of Care Workflow

Patients identified for TOC Care Coordination

Directory > Filters | apply appropriate filters for worklist:

Contact Reason | TOC

Apply additional filters depending on team and allocation of work

Consider: Do the staff doing transitions of care work also close other gaps?

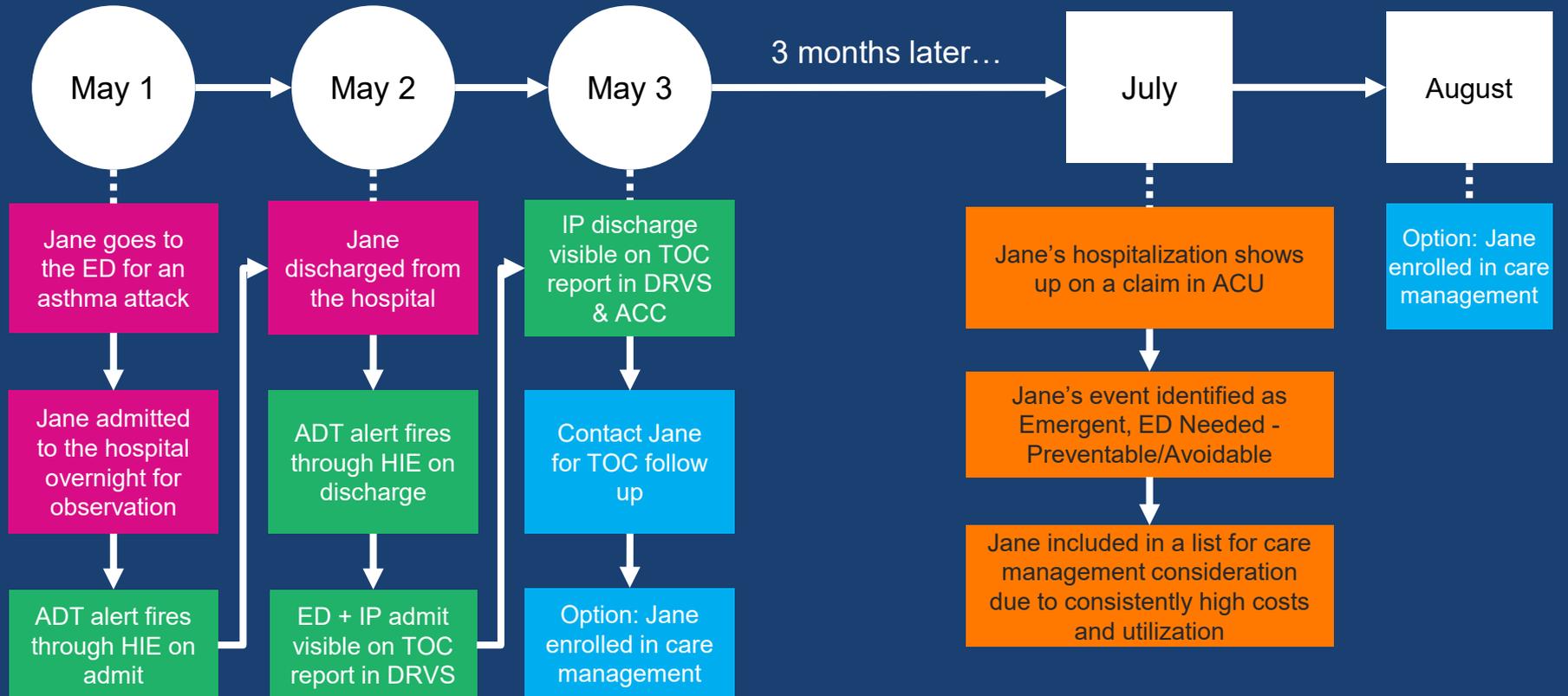
Click on first patient and begin working gaps:

1. Conduct any necessary review required by protocol (see General Workflow)
2. Expand TOC gap and evaluate next steps.
Consider: does your team outreach when a patient is still in the hospital or only after discharge?
3. Add TOC task group using the stacked list icon and link TOC gap. Remove any unnecessary tasks from list.
4. Record outreach according to General Workflow. For TOC outreaches, recommendation is to set follow ups to 1 day to ensure timely coordination of care.

Directory

Patient Page

Transitions of Care



Patient journey

ADT + DRVS data

Claims data

ACC

Summary

Coordination

Plan

Clinical

Activity

NOTIFICATIONS

Inpatient Stay	UNIVERSITY MEDICAL CENTER	4/21/25
ED Visit	UNIVERSITY MEDICAL CENTER	4/21/25
ED Visit	UNIVERSITY MEDICAL CENTER	4/16/25
ED Visit	UNIVERSITY MEDICAL CENTER	4/16/25

TASKS (0)

Open Completed Flagged All



ACTION SUMMARY DUE ASSIGNEE COMMENTS

No Tasks to Display

Showing 0 to 0 of 0 entries



CARE TEAM



Intervention Effort	Not Set
Care Manager	Unassigned
Usual Provider	AUGUSTINE, GREG
Coordinator	Unassigned

NOTES



No notes to display

Demo data

Summary **Coordination** Plan Clinical Activity

OUTREACH REASONS (10)

All **Open** Complete

Selected 0

Attempted

Connected

REASON DETAILS	LAST OUTREACH	OUTREACHES	REPORTED	STATUS
<input type="checkbox"/> TOC 10				
<input type="checkbox"/> 04/16/2025 12:00 AM UNIVERSITY MEDICAL CENTER - Inpatient Admit		0	04/18/25	Open
<input type="checkbox"/> 03/15/2025 12:00 AM UNIVERSITY MEDICAL CENTER - Inpatient Admit, discharged 03/19/2025 10:02 PM Nursing Facility: B95.3		0	03/16/25	Open
<input type="checkbox"/> 01/01/2025 12:00 AM State University Hospital - ER Visit, discharged 01/01/2025 8:51 PM HOME		0	01/03/25	Open

Demo data

TASK GROUPS

Smith, Donna Transition of Care Abbrev

Description: The abbreviated TOC is a shortened series of tasks that are curated and recommended to assign to a patient following an ED or IP related event based on The Care Transitions Program by Dr. Eric Coleman.

Gap Link: None Selected

Discharge Date: 04/21/2025 Assignee: Molly Wack

ACTION	SUMMARY	DUE
<input checked="" type="checkbox"/> Call	Call Pt within 2 days after discharge	<input type="text"/>
<input checked="" type="checkbox"/> Call	Review "red flag" indicators of worsening condition with Pt	<input type="text"/>
<input checked="" type="checkbox"/> Call	Medication Reconciliation	<input type="text"/>
<input checked="" type="checkbox"/> Schedule	Schedule follow-up visit with provider	<input type="text"/>

4 Tasks will be added. | Save and add another Task Group

ADD TASKS

REASON DETAILS

TOC ¹⁰

04/16/2025 12:00 AM UNIVERSITY MED

03/15/2025 12:00 AM UNIVERSITY MED B95.3

01/01/2025 12:00 AM State University Ho

TASKS (0)

ACTION

Showing 0 to 0 of 0 entries

ACTION	REPORTED	STATUS
	04/18/25	Open
	03/16/25	Open
	01/03/25	Open

Utilization Widget vs. TOC Gaps in CC

UTILIZATION	
Inpatient Last 7 Days	1
Emergency Last 7 Days	2

TASKS

- Overdue
- Flagged
- Due Today
- Assigned

Utilization Widget

- Flows in based on **discharge event**
- Identified patients already part of care management

TOC Gaps

- Gaps flow in based on **admit date**
- Admit date must be **within the last 3 days**

TYPE	DETAIL	REPORTED	STATUS	OUT
<input type="checkbox"/> CQM (3)	CQM (3)		open	0
<input checked="" type="checkbox"/> TOC (1)	6/1/2024 - Blodgett Hospital (1)	06/03/24	open	0

Showing 1 to 2 of 2 entries

Broad Goals for Care Coordination

**Identify patients
needing care**

**Coordinate care
for patients**

**Improve patient's
ability to access
and utilize
healthcare
services**

Lower costs

ACC Take-Aways



You must define your population of patients for care management & care coordination in a **repeatable, structured way**.



ACC can help **replace spreadsheets** and other difficult-to-share documentation.



Aligning required activities for your care management & coordination program to **measure performance improvement** will streamline use of ACC.

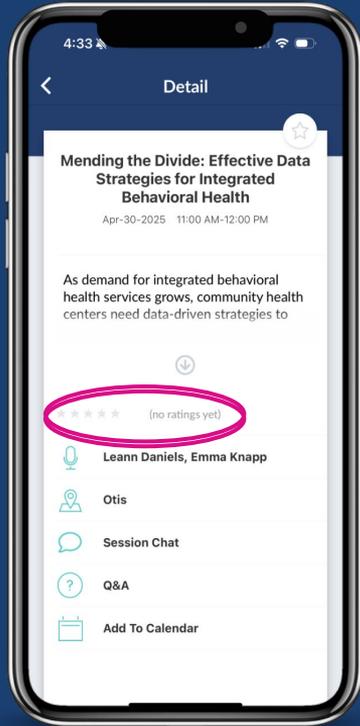
Questions?



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)



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