Springing into Action

Azara Care Connect in Practice

Presenters

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Michigan Primary Care Association

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Clinical Quality Manger
Michigan Primary Care Association

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Training & Adoption 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

azara USER CONFERENCE 2025

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.

mpca virtuALLY mqin mchn

SUPPORTING MICHIGAN HEALTH CENTERS

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.

mchn

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.

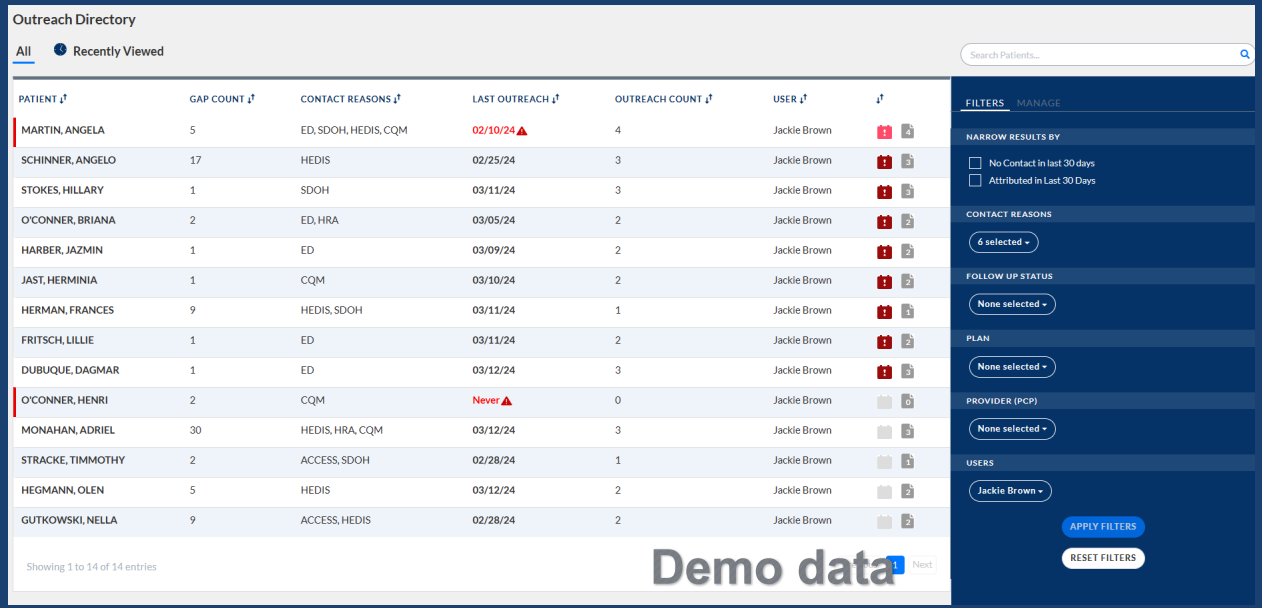
Essential System Design Elements

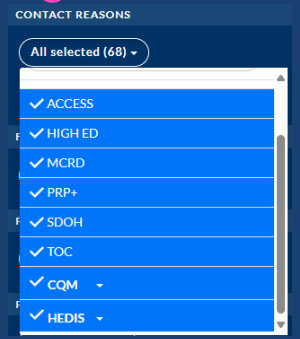
To support the work across our network, we need a solution that enables us to:

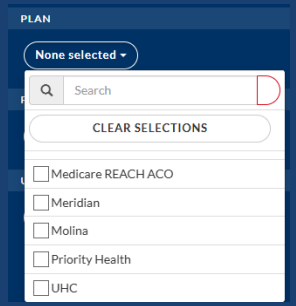
1. Ingest member-level data and open care gaps such as:
   - High ED Utilizers
   - Unmet Health Related Social Needs
   - Unmet HEDIS and Clinical Quality Measure (CQM) Gaps
   - Transition of Care Notifications and Details
2. Track Outreach and Care Gap Closure
   - Enable documentation of outreach 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

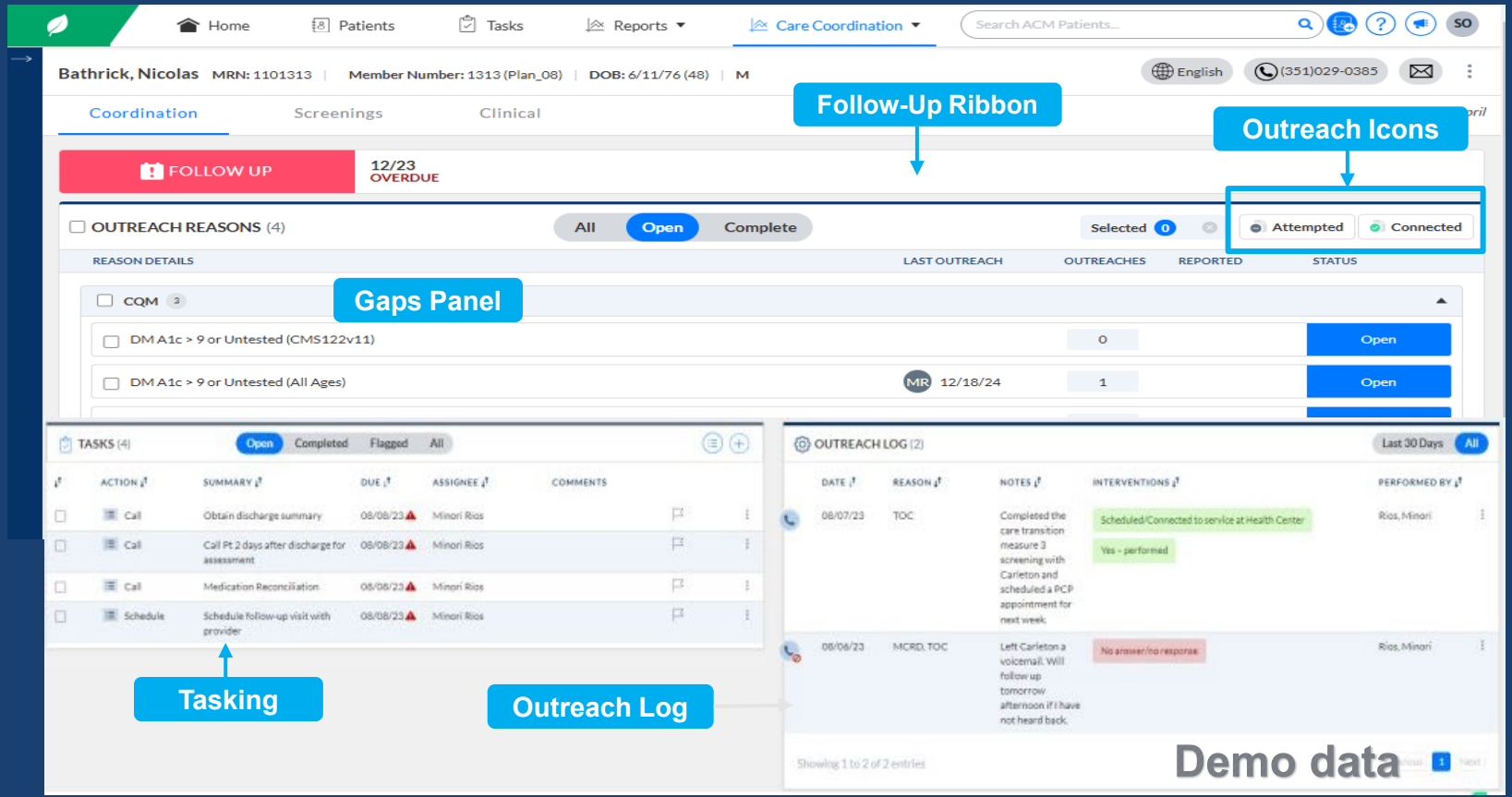
Network health centers now receive monthly member files directly through ACC, which provides timely notification of patient needs, and allows staff to access a comprehensive profile – all within a single platform.







Patient Landing Page



Munger, Dorethea MRN: 1103667 | DOB: 11/13/67 (57) | F

English (617)708-0299

Coordination Screening

Data Received: 10 January

Follow-Up Ribbon

FOLLOW UP 04/14 TODAY

Outreach Icons

OUTREACH REASONS (5) All Open Complete

Selected 0 Attempted Connected

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

« ‹ 1 2 3 4 › »

Tasking

OUTREACH LOG (3) Last 30 Days All

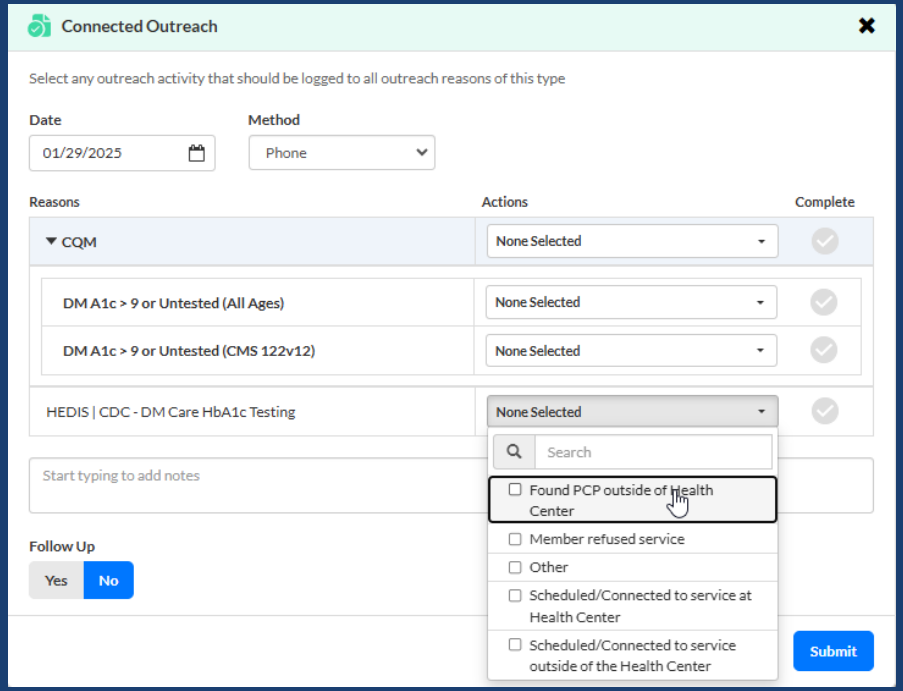
DATE	REASON	NOTES	INTERVENTIONS	PERFORMED BY
04/14/2025	TOC, CQM, HEDIS		Research/Gap Found	Wack, Molly
03/24/2025	TOC		Member refused service	Maribei, Caroline

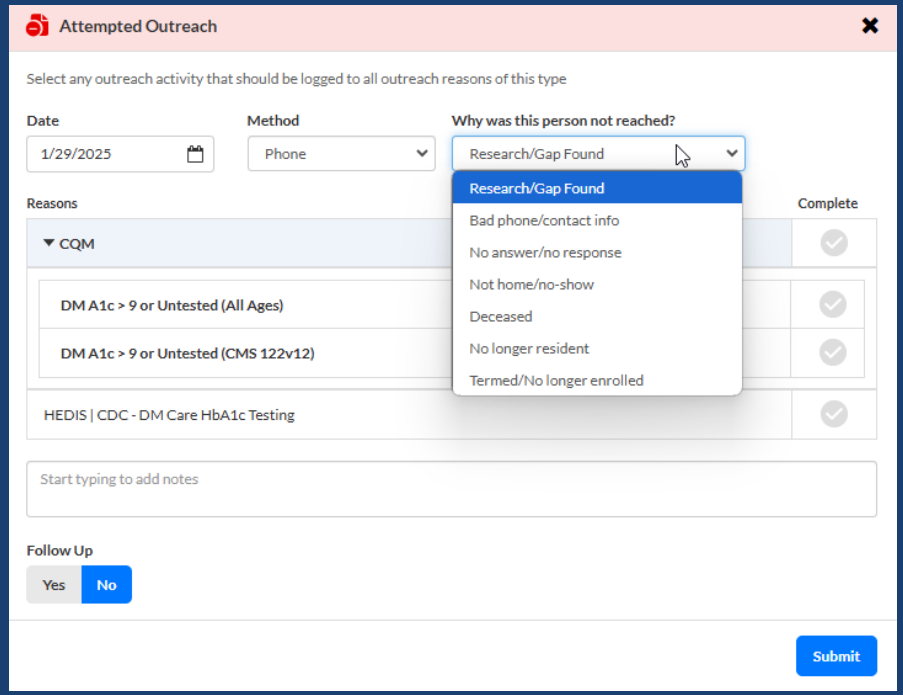
Outreach Log

Demo data

Streamlined Documentation

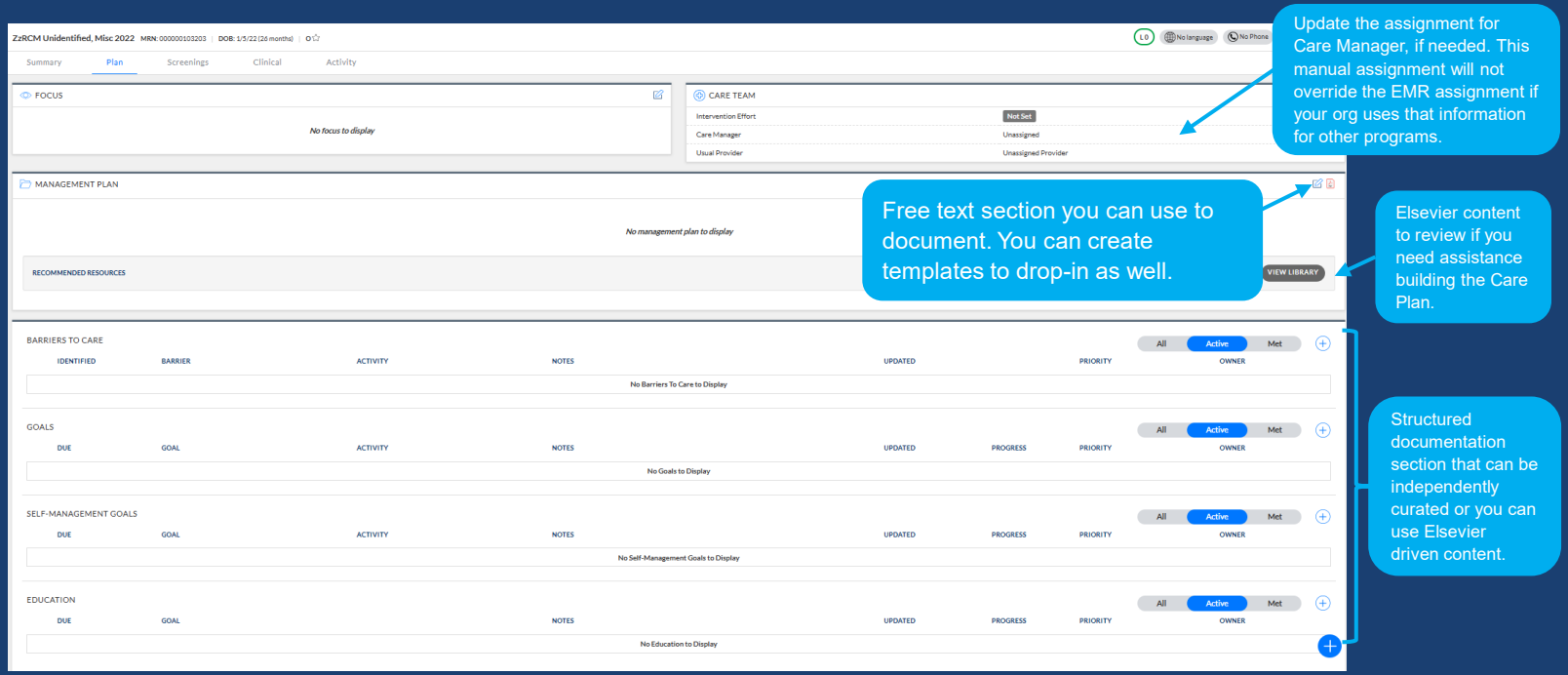
Granular, gap-specific documentation capabilities enable staff to efficiently record outreach activities, capture follow-up actions, and document gap closures—all within a single, streamlined interface.





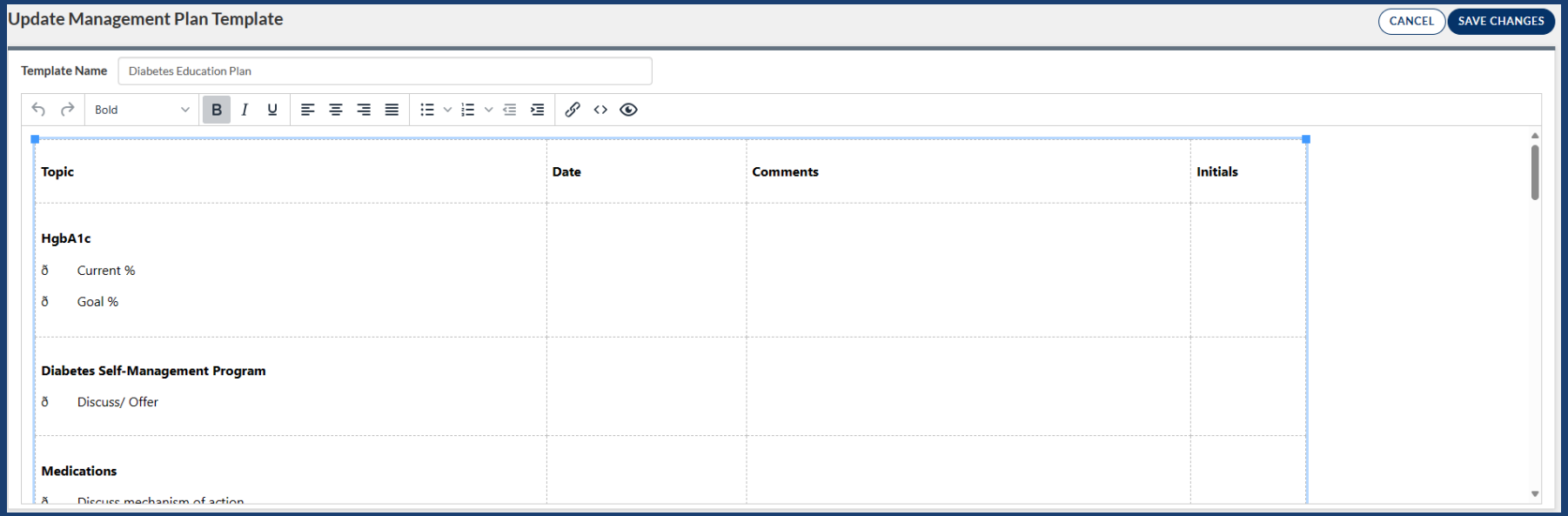
Care Management Updates

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.



Customized Templates

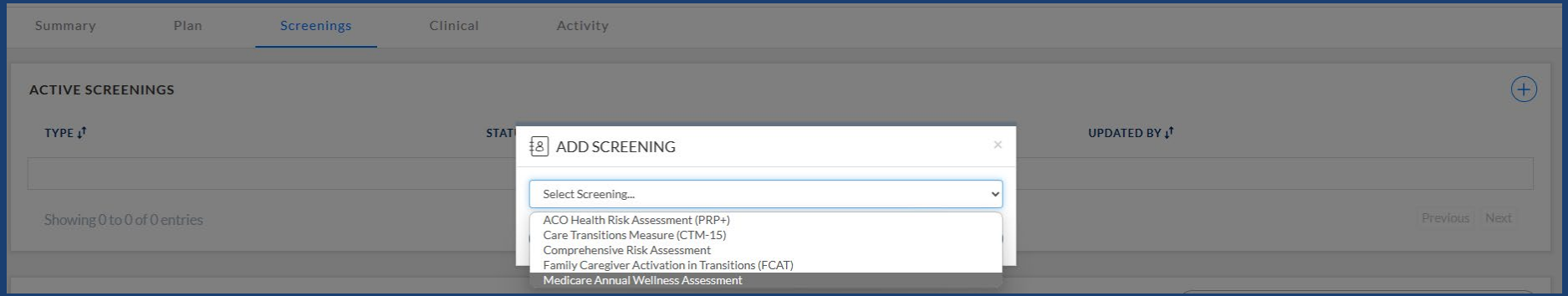
Customization is key! Templates can be created to model EHR or staff preferred documentation styles and ensure program requirements are met.



Screenings Tab

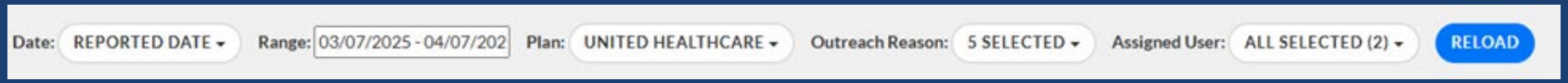
Multiple screenings were embedded within the platform to capture required elements:

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

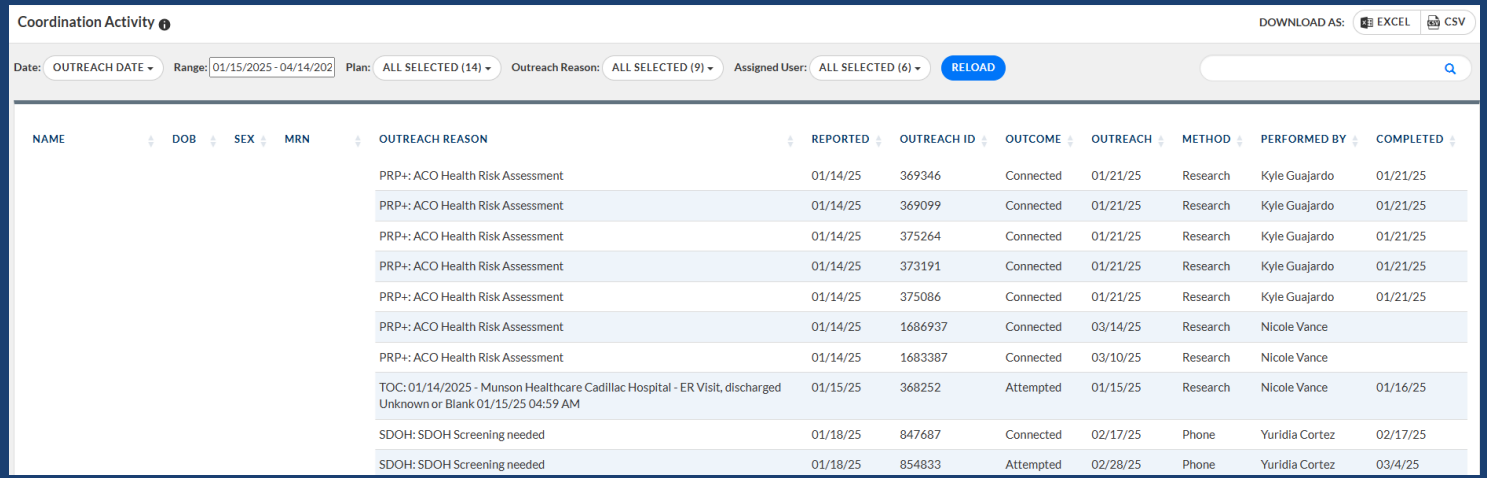


Coordination Activity Report

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



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



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

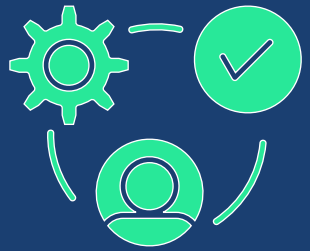
- Develop training materials and provide spaces for team collaboration, ensuring proper documentation and efficient workflow utilization.
- Establish feedback mechanisms and communication channels to quickly identify issues and implement solutions in a timely manner.

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

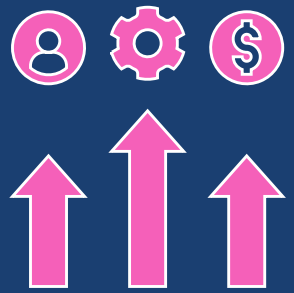
Centralized MPCA support teams, in close collaboration with Azara support, ensures fast and accurate error resolution.

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.

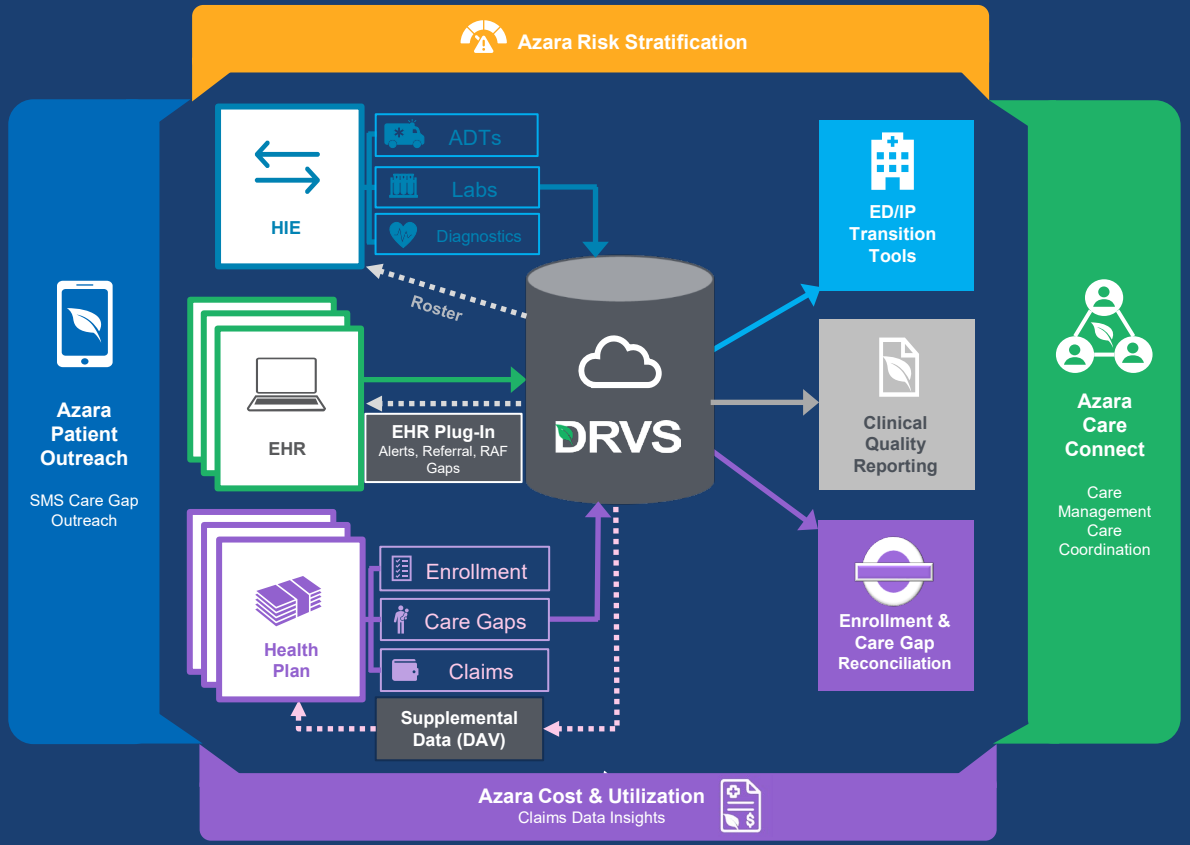
Data Integration

- 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.

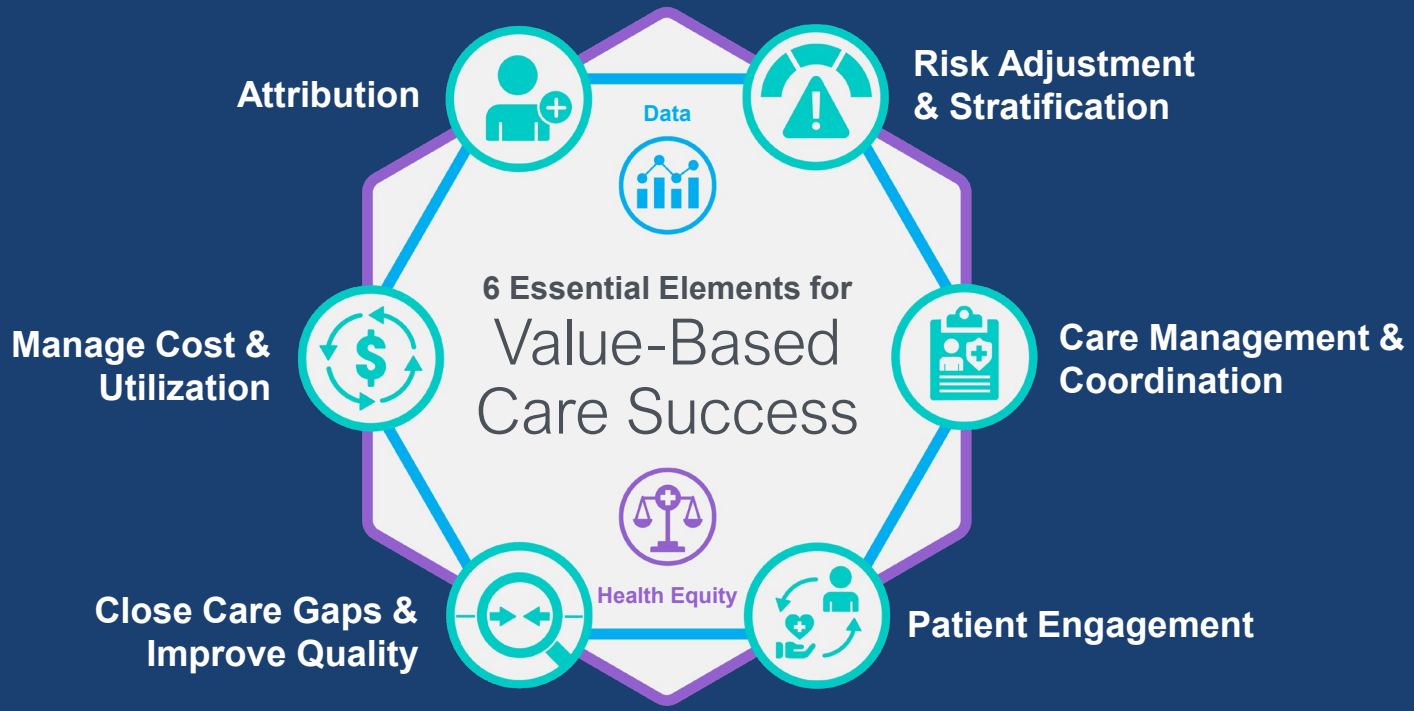
And so much more!

ACC in Action

Azara Ecosystem



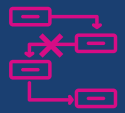
Essential Elements of VBC



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.

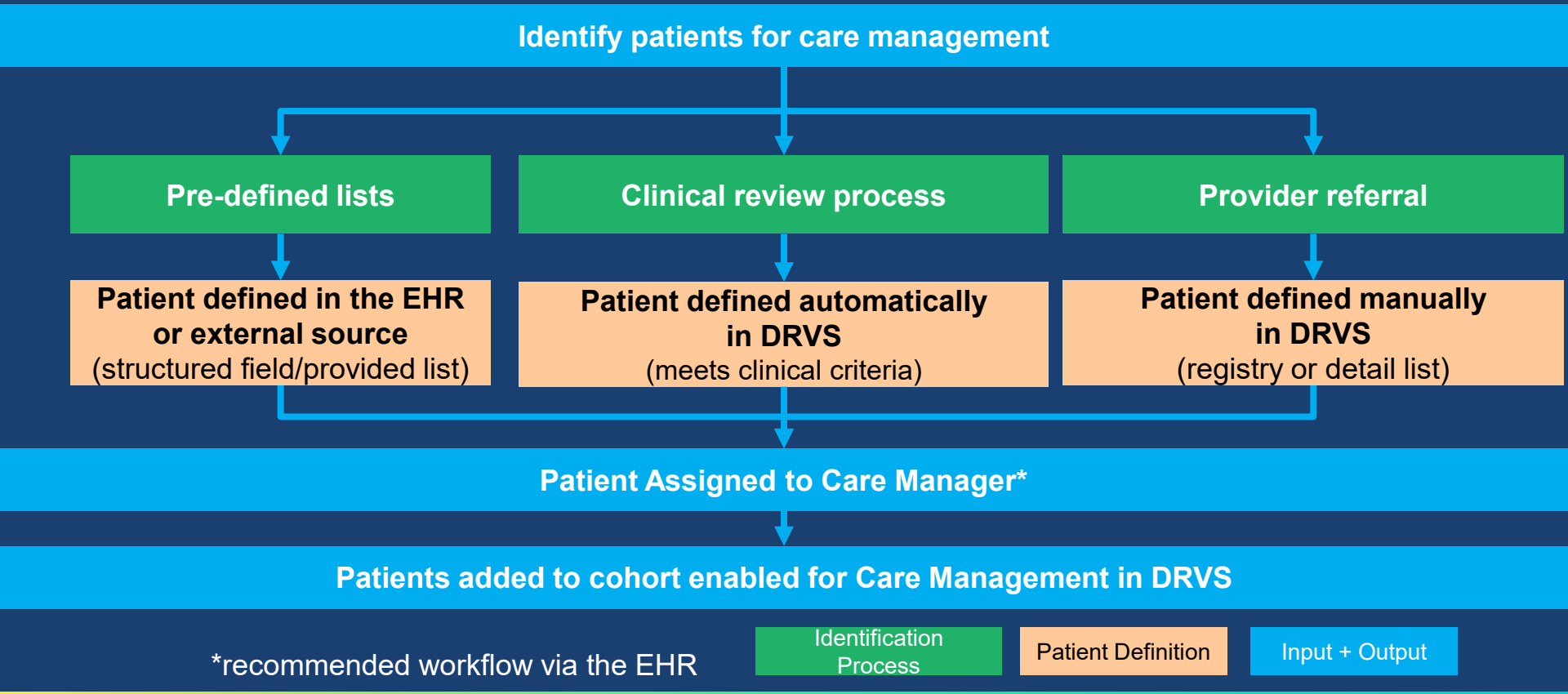
Clinical review process

- 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

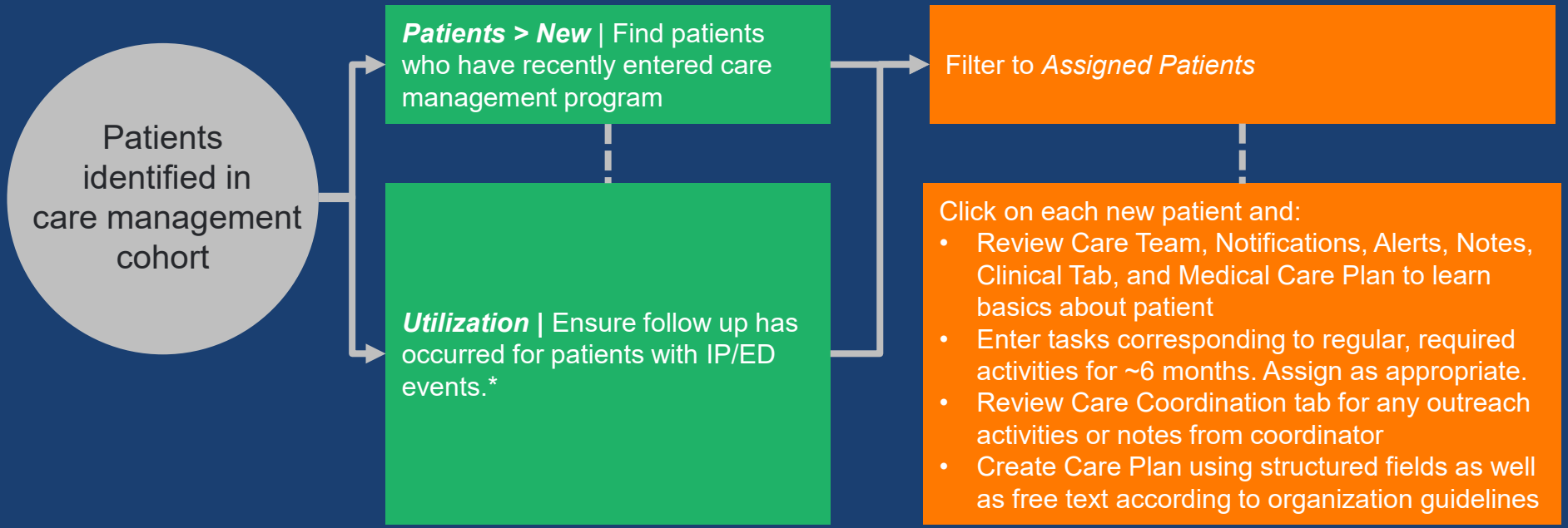


Common Activities of Care Management

- ☑ 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

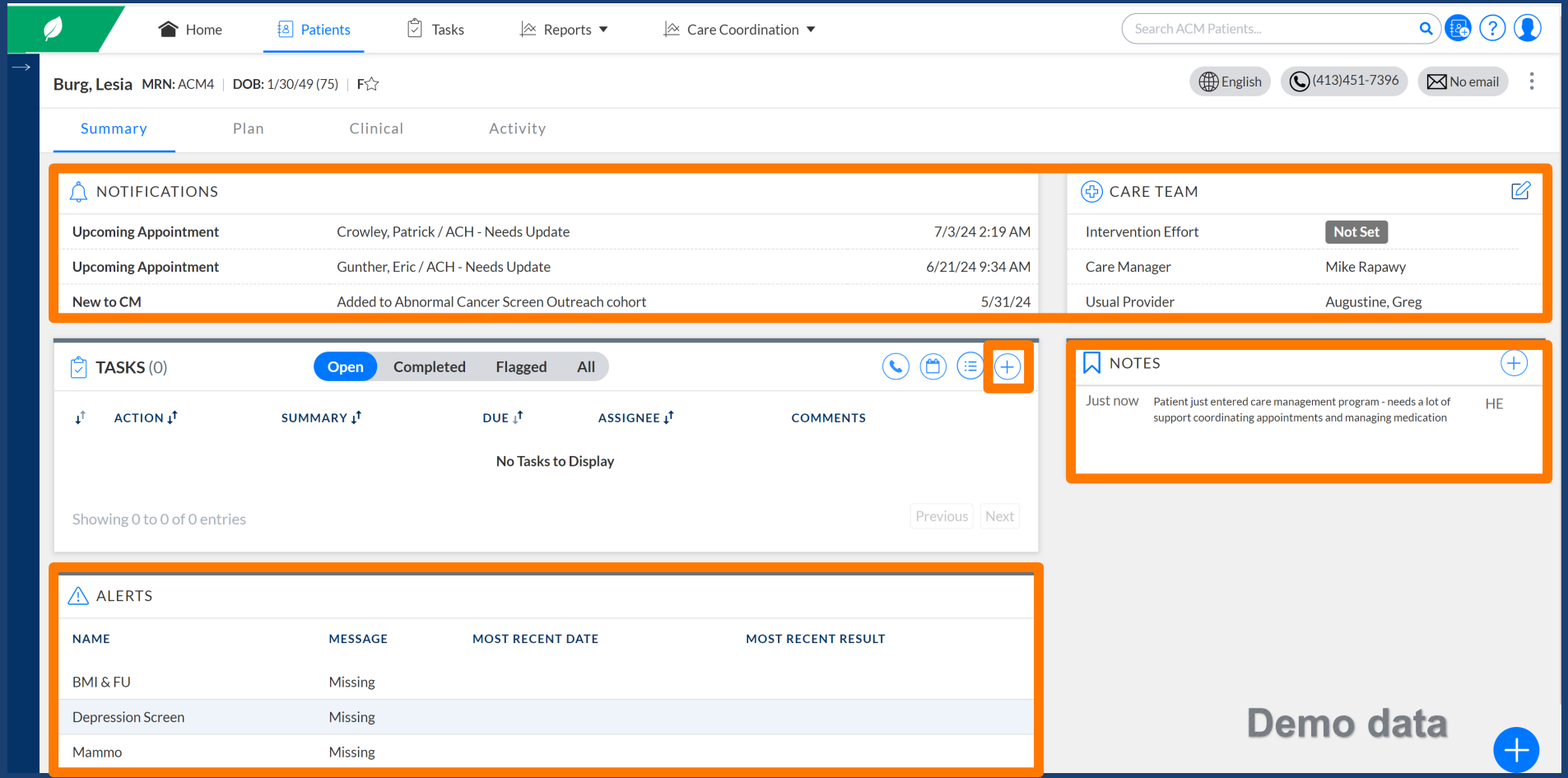
These activities are in service of the larger goals of care management: to establish a relationship with the patient, provide support for identified needs, and ultimately improve outcomes and lower costs.

New Patient Workflow

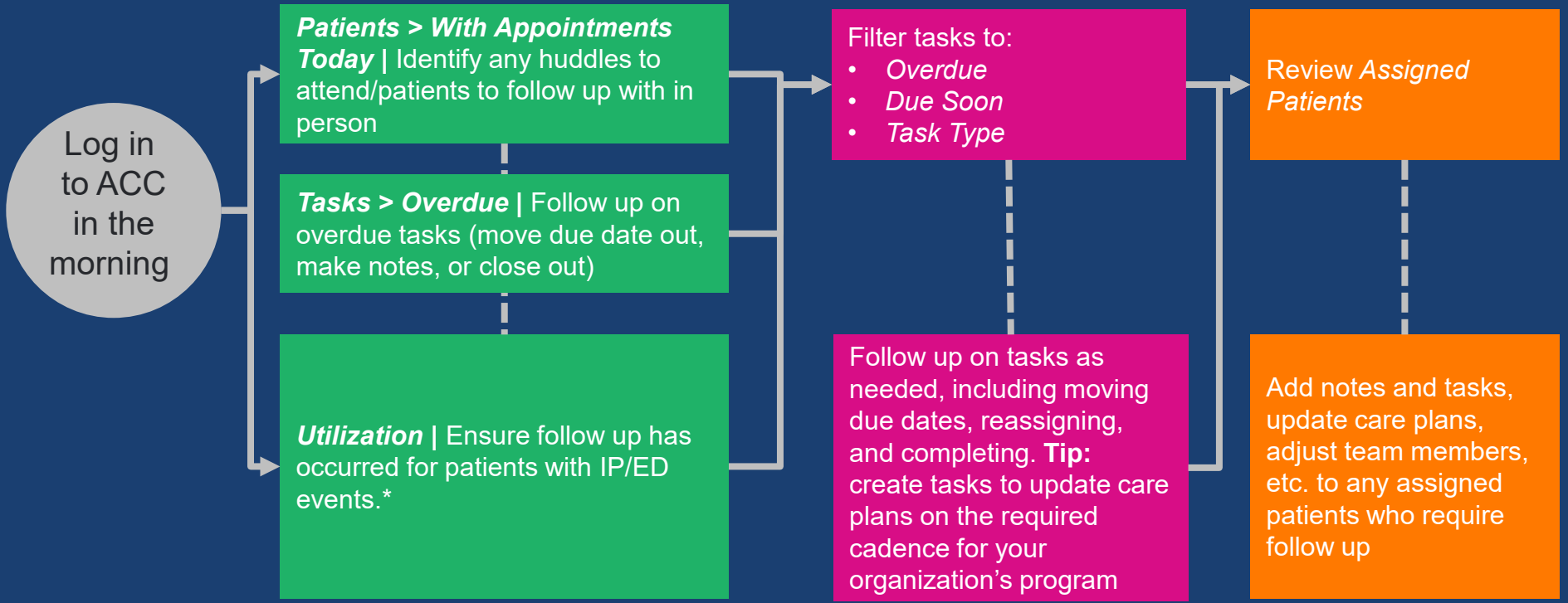


* Note: requires Transitions of Care Module. This follow up could be done through care coordination or care management, depending on established roles and workflows.

Home Page **Patients Page**


Home
Patients
Tasks
Reports
Care Coordination
Search ACM Patients...
Burg, Lesia MRN: ACM4 | DOB: 1/30/49 (75) | F
English
(413)451-7396
No email
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
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

Task Page **Home Page** **Patient Page**

Broad Goals for CM

- Identify + reduce risks for patients
- Improve patient outcomes
- Improve patient experience + engagement with care team
- Lower costs

Diabetes Care Effectiveness Patients

REPORT

FILTER

RENDERING PROVIDERS: All Rendering Provid...

PATIENT DIAGNOSES: All Patient Diagnoses

SERVICE LINES: All Service Lines

COHORTS: Care Managed Pts (d...

Add Filter | Update

Overview - Population: Dyn - Diabetes

GLUCOSE CONTROL (A1C)

Poor (>9.0)	126
Fair (>8.0 and <=9.0)	53
Good (>6.4 and <=8.0)	86
Prediabetes (>=5.7 and <=6.4)	29
Normal (< 5.7)	17
No Score	4

8.8
AVG A1C SCORE
▼ -0.4 *Last 12 mths.*

149
A1C PTS WITH A >=1.5% DROP

131.3
AVG SYSTOLIC BLOOD PRESSURE
▼ -1.5 *Last 12 mths.*

110
SYS BP PTS WITH A >=10 MM/HG DROP

BLOOD PRESSURE CONTROL (BP)

Stage 2 Severe (>160 and/or >100)	7
Stage 2 HTN (140-159 or 90-99)	21
Stage 1 HTN (130-139 or 80-89)	183
Elevated BP (120-129 and <80)	43
Normal (<120/80)	61
No Score	0

Diabetes Care Effectiveness Patients

REPORT

FILTER

RENDERING PROVIDERS: All Rendering Provid...

PATIENT DIAGNOSES: All Patient Diagnoses

SERVICE LINES: All Service Lines

COHORTS: Not Care Managed P...

Add Filter | Update

Overview - Population: Dyn - Diabetes

GLUCOSE CONTROL (A1C)

Poor (>9.0)	823
Fair (>8.0 and <=9.0)	511
Good (>6.4 and <=8.0)	1,802
Prediabetes (>=5.7 and <=6.4)	1,215
Normal (< 5.7)	471
No Score	378

7.5
AVG A1C SCORE
▼ -0.1 *Last 12 mths.*

1,598
A1C PTS WITH A >=1.5% DROP

130.3
AVG SYSTOLIC BLOOD PRESSURE
▼ -0.5 *Last 12 mths.*

1,287
SYS BP PTS WITH A >=10 MM/HG DROP

BLOOD PRESSURE CONTROL (BP)

Stage 2 Severe (>160 and/or >100)	75
Stage 2 HTN (140-159 or 90-99)	331
Stage 1 HTN (130-139 or 80-89)	2,996
Elevated BP (120-129 and <80)	754
Normal (<120/80)	1,019
No Score	25

Care Management Dashboard

Care Managment Overview (LKK)
DASHBOARD

FILTER 1

FILTERS: April 2024

CM Enrollees

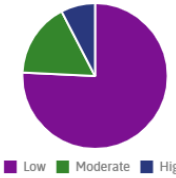
TY April 2024

448
Count of Unique Patients w/ Encounter

+7 ▲
TY 11/23

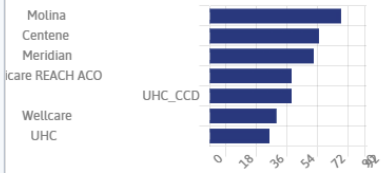
Risk

TY April 2024



In Care Management by Plan

TY April 2024



Measures at Target

TY April 2024

TARGET ACHIEVEMENT

2 | 2 | 5

9 Total Measures

CM Enrollee w/Primary Care Encounters

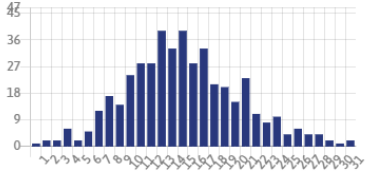
TY April 2024

99.6%
% Patient w/ Primary Encounter

+0.7% ▲
TY 3/24

Risk

TY April 2024



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				

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

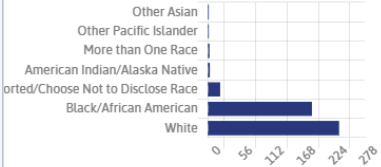
April 2024

6.4%
Measure Result

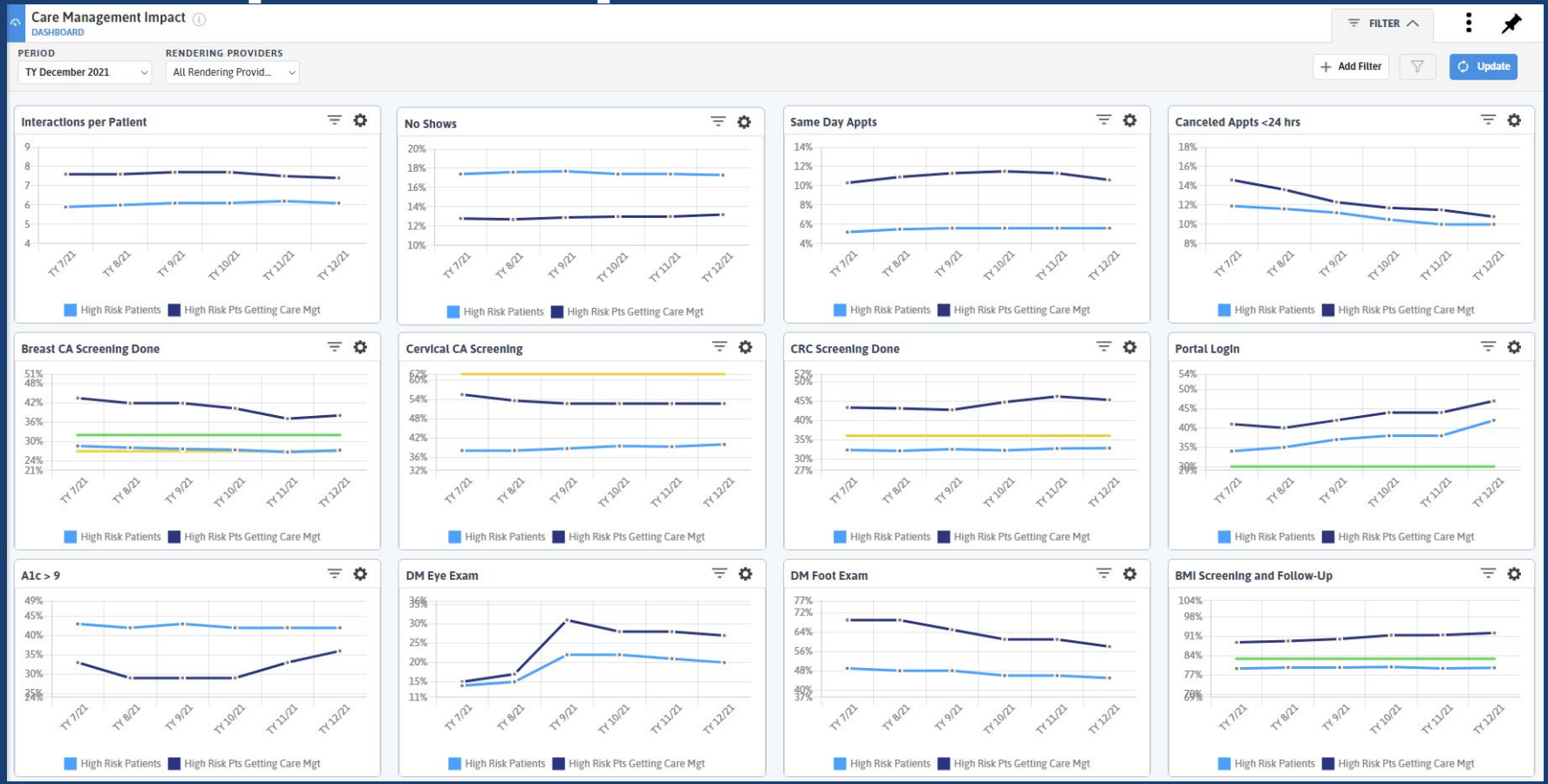
-4.8% ▼
Mar 24

CM by Race

TY April 2024



Example Comparison



Care Coordination

Care Coordination Considerations

What services are being coordinated?

What is the primary method of intervention?

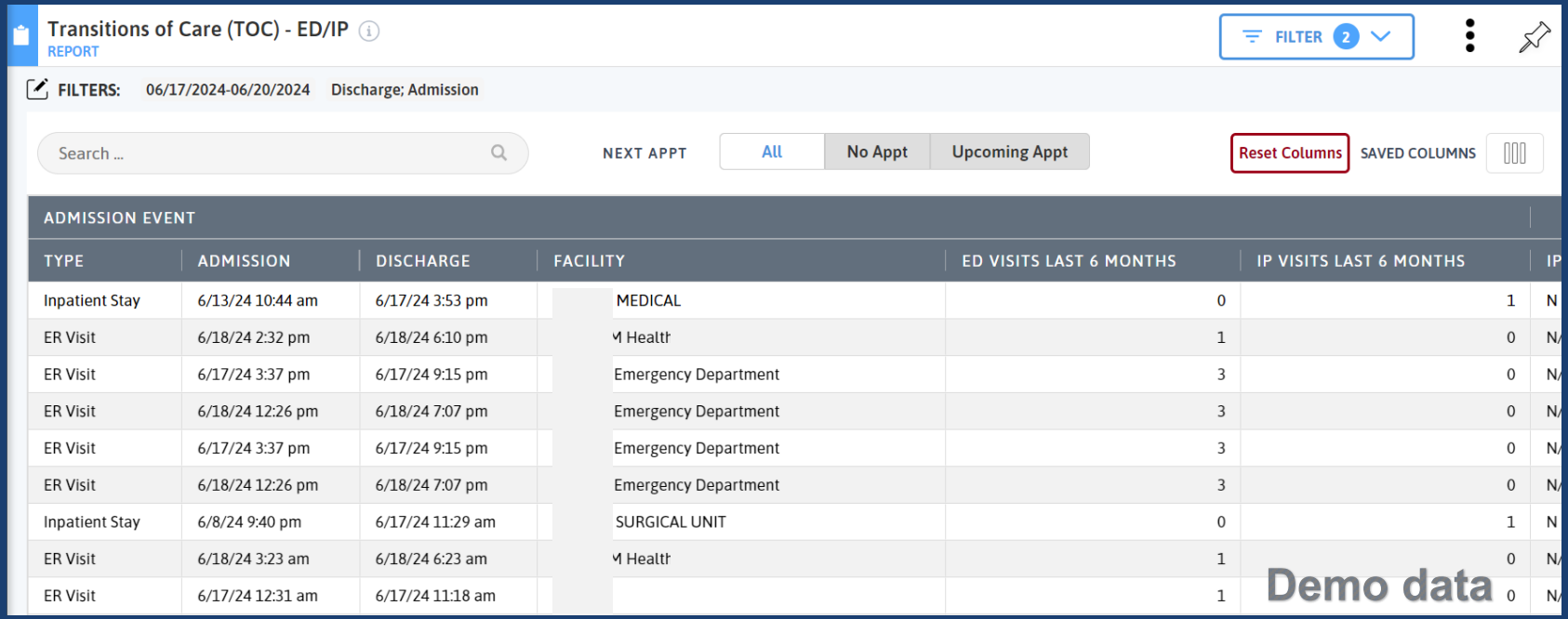
What staff do you have available?

Populations for Care Coordination

Contact Reason	Use Case	Considerations
CQM	Close measure-specific gaps for the entire population	• Population(s) can be very large • Workflows can vary by gap
Plan-Calculated HEDIS	Close measure-specific gaps for enrolled populations	• 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

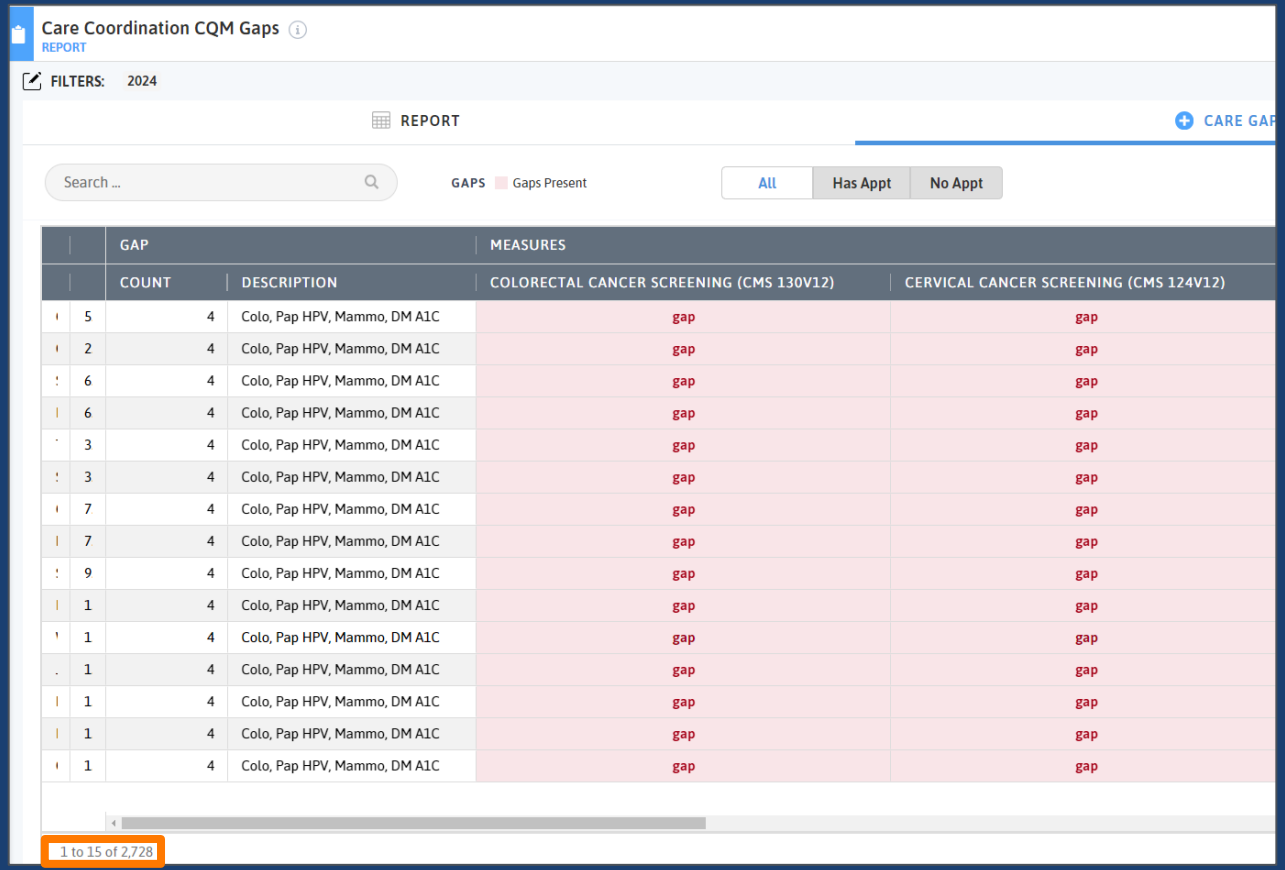
Note: for other contact reasons, please contact your Client Success Manager or Support.

Identifying the TOC Population



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.

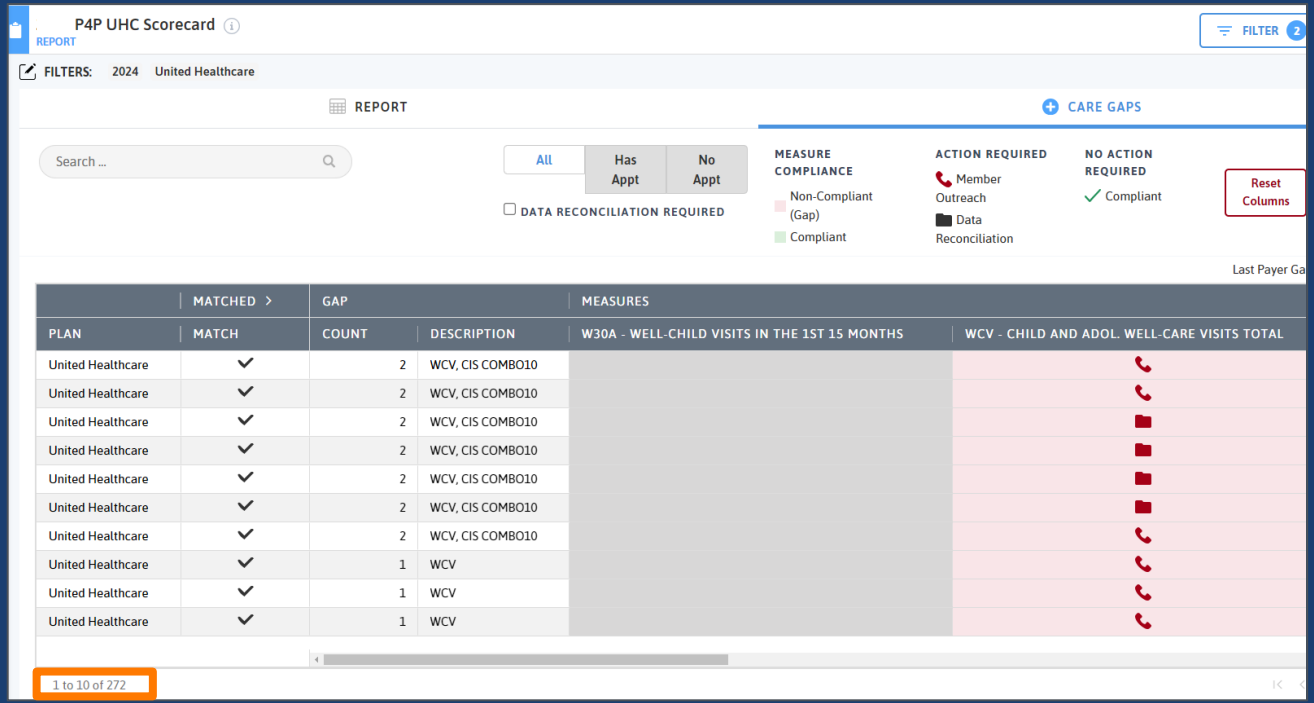
Identifying the Population | CQMs



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

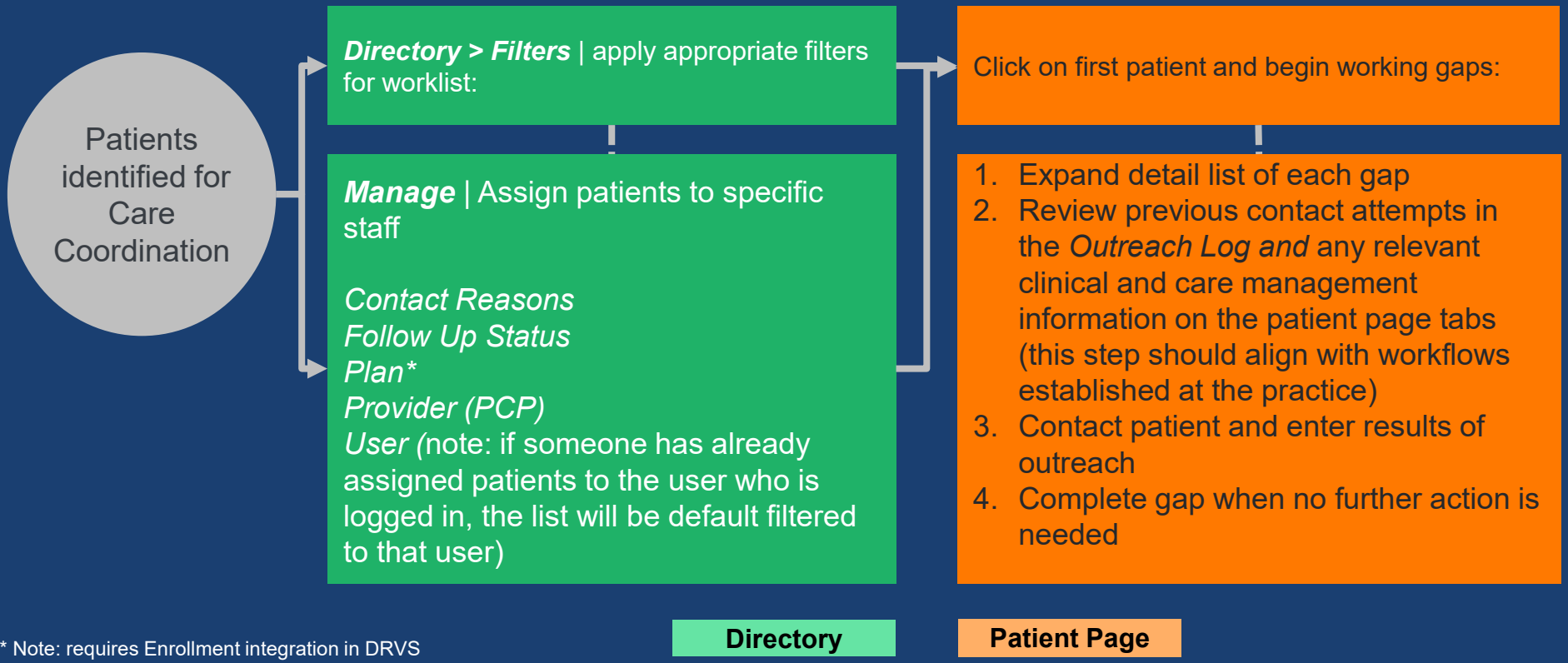


Review plan-calc scorecards in DRVS and assess:

- 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

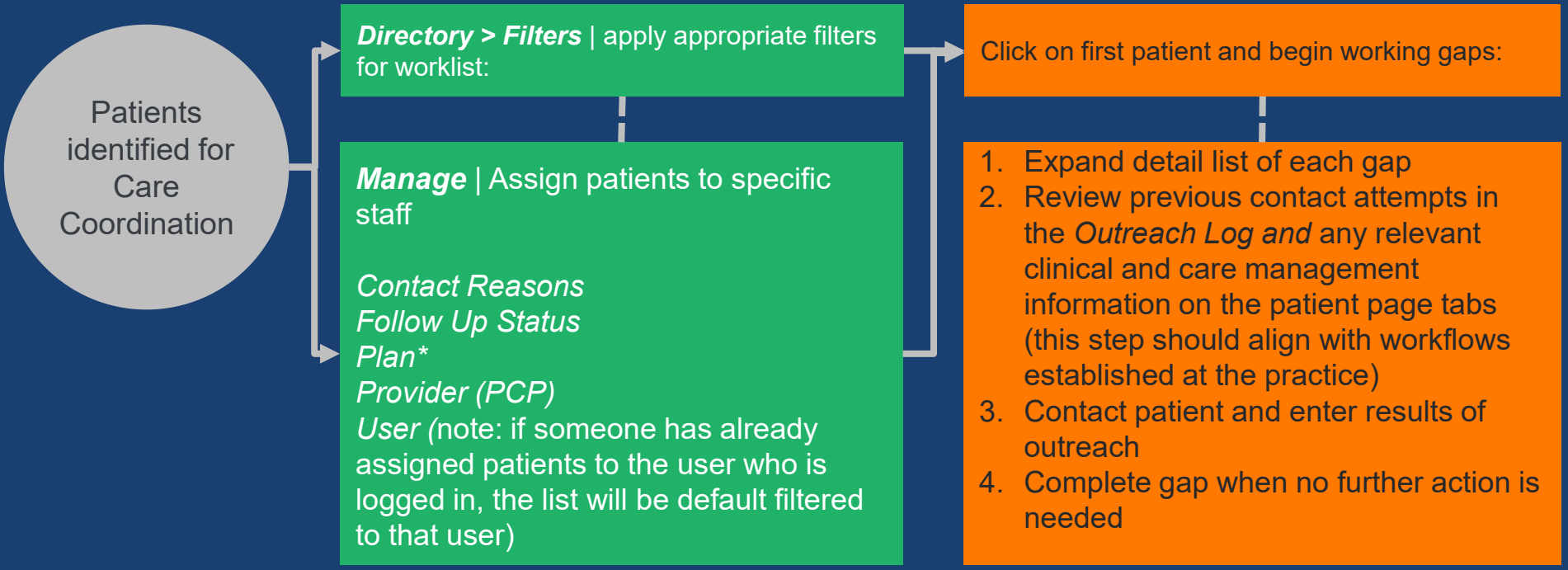
Azara **does not recommend loading both CQM and plan-calc measures into ACC**, as the measure logic and source data differs and gaps may be difficult to interpret.

Care Coordination General Workflow



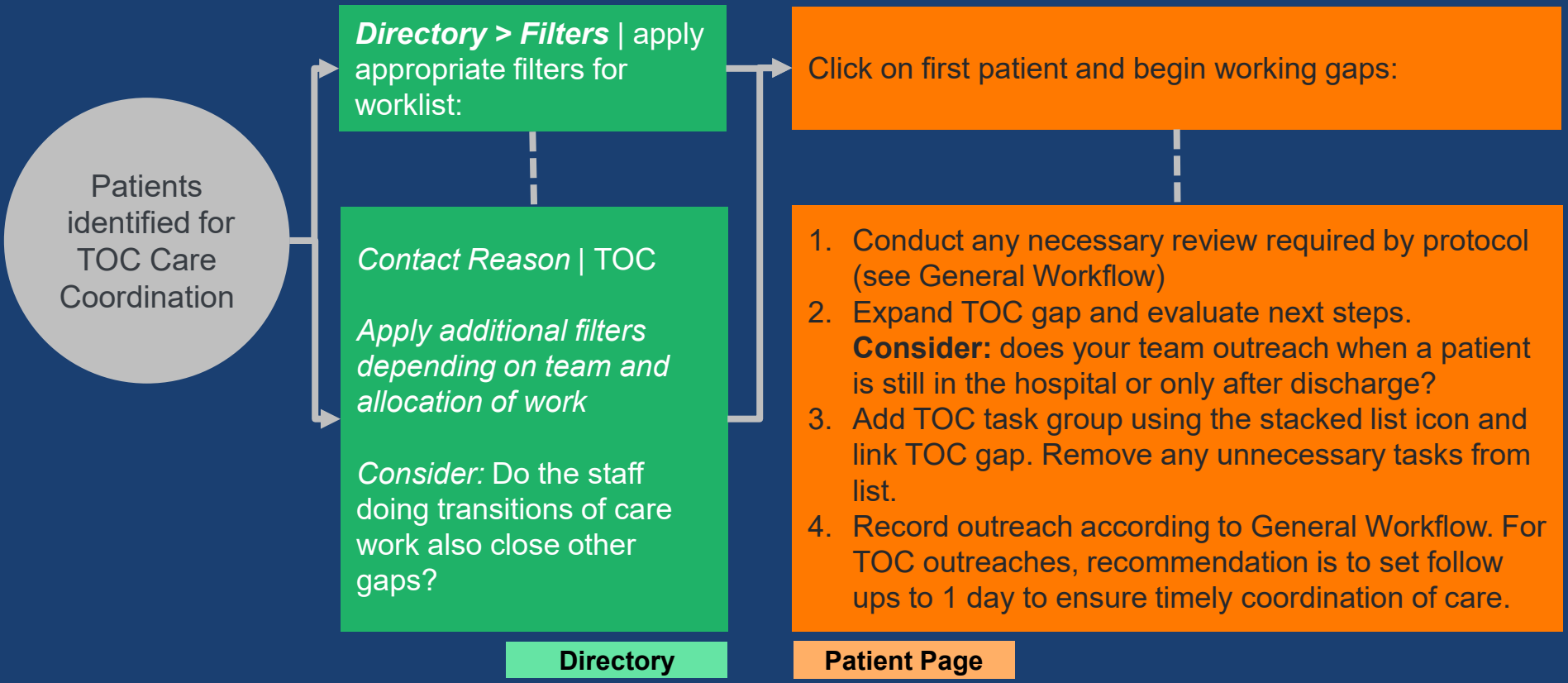
* Note: requires Enrollment integration in DRVS

Care Coordination General Workflow

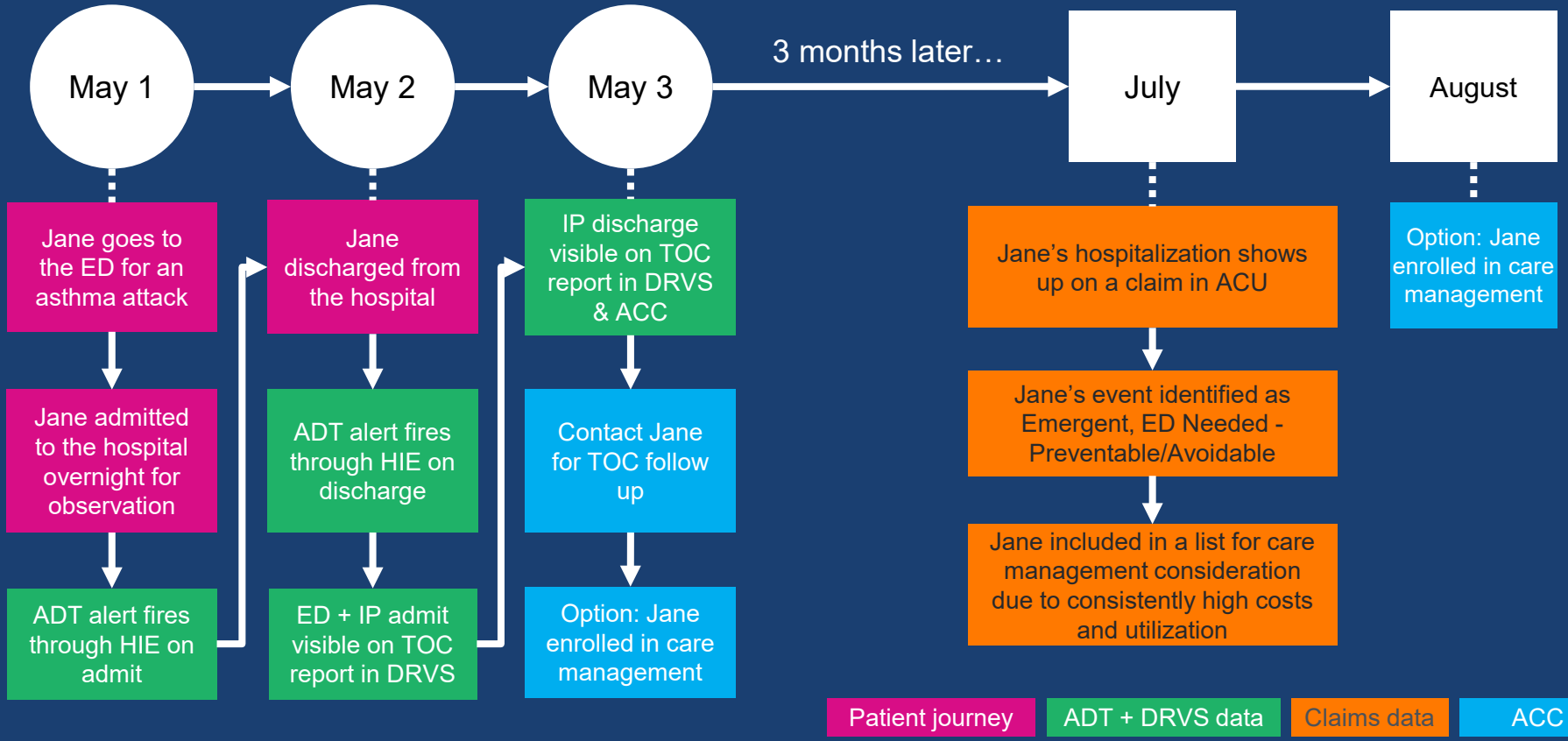


* Note: requires Enrollment integration in DRVS

Transitions of Care Workflow



Transitions of Care



Smith, Donna MRN: 645307 | DOB: 3/17/63 (62) | F ☆

H 19 | English | (123)-456-78990 | No email

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

CARE TEAM

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

TASKS (0)

Open | Completed | Flagged | All

ACTION	SUMMARY	DUE	ASSIGNEE	COMMENTS

No Tasks to Display

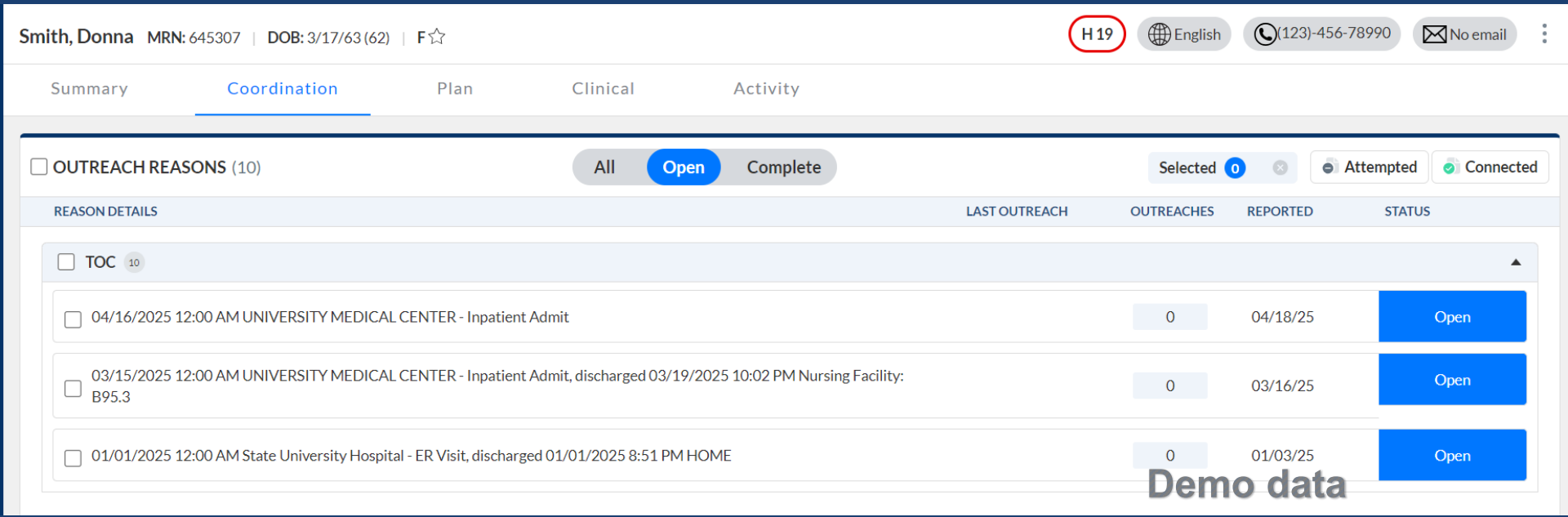
Showing 0 to 0 of 0 entries

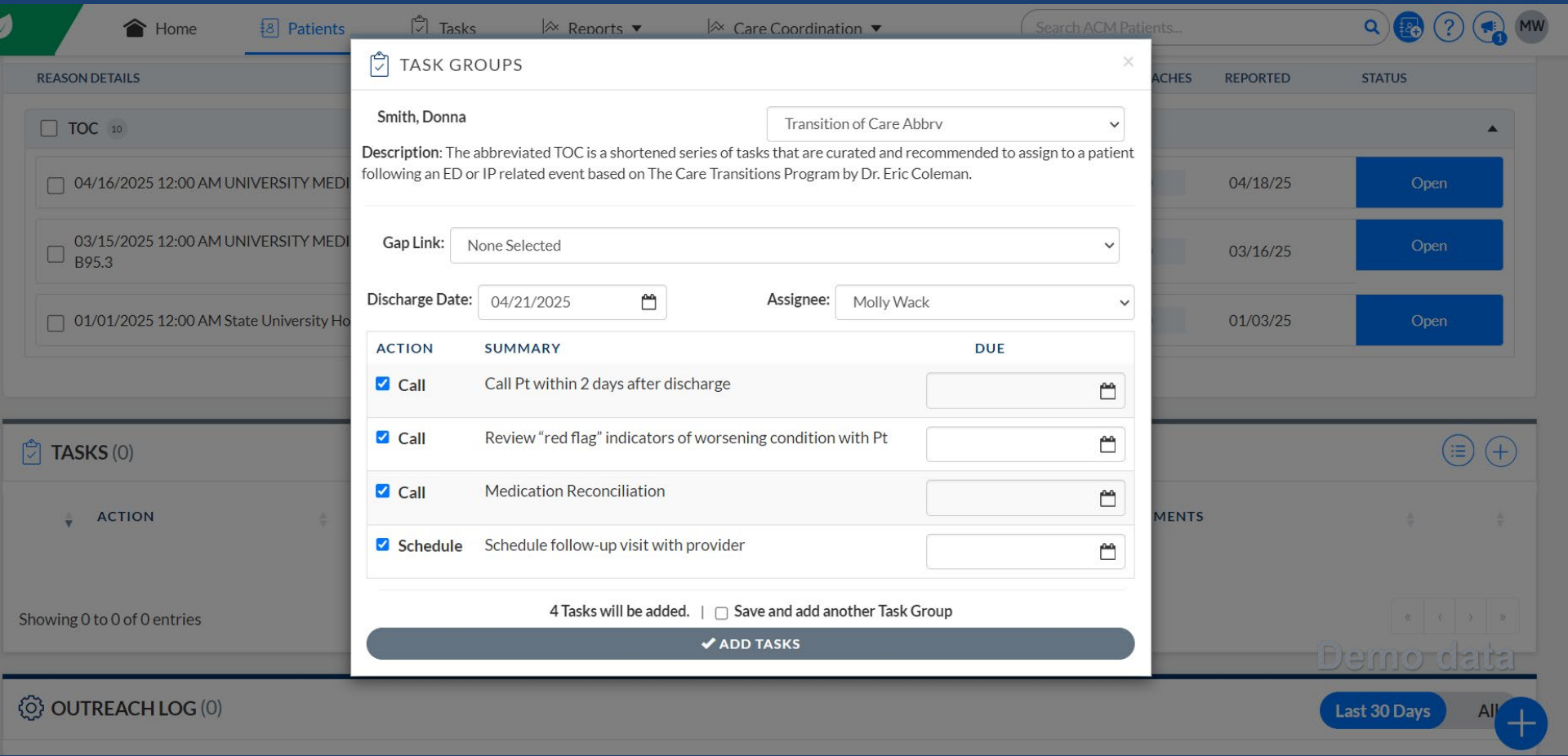
« ‹ › »

NOTES

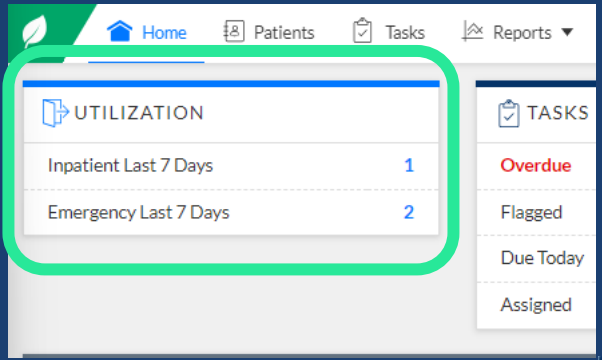
No notes to display

Demo data


Smith, Donna MRN: 645307 | DOB: 3/17/63 (62) | F
H 19
English
(123)-456-78990
No email
Summary
Coordination
Plan
Clinical
Activity
OUTREACH REASONS (10)
All
Open
Complete
Selected 0
Attempted
Connected
REASON DETAILS
LAST OUTREACH
OUTREACHES
REPORTED
STATUS
TOC 10
04/16/2025 12:00 AM UNIVERSITY MEDICAL CENTER - Inpatient Admit
0
04/18/25
Open
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
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


Home
Patients
Tasks
Reports
Care Coordination
Search ACM Patients...
MW
REASON DETAILS
REPORTED
STATUS
TOC 10
04/16/2025 12:00 AM UNIVERSITY MEDI
04/18/25
Open
03/15/2025 12:00 AM UNIVERSITY MEDI
B95.3
03/16/25
Open
01/01/2025 12:00 AM State University Ho
01/03/25
Open
TASK GROUPS
Smith, Donna
Transition of Care Abbrv
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
Call
Call Pt within 2 days after discharge
Call
Review "red flag" indicators of worsening condition with Pt
Call
Medication Reconciliation
Schedule
Schedule follow-up visit with provider
4 Tasks will be added.
Save and add another Task Group
ADD TASKS
TASKS (0)
ACTION
Showing 0 to 0 of 0 entries
Demo data
OUTREACH LOG (0)
Last 30 Days

Utilization Widget vs. TOC Gaps in CC

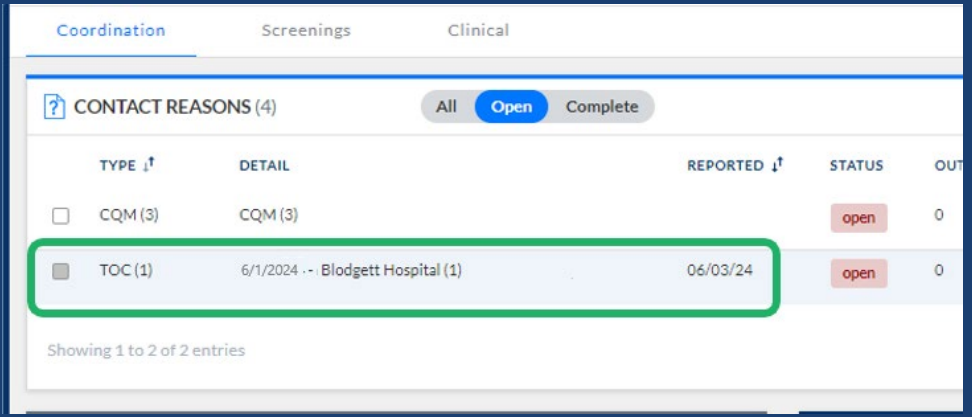


Utilization Widget

- 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**

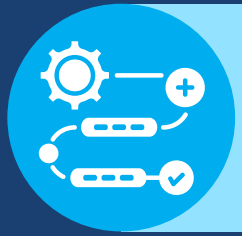


Broad Goals for Care Coordination

- 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.

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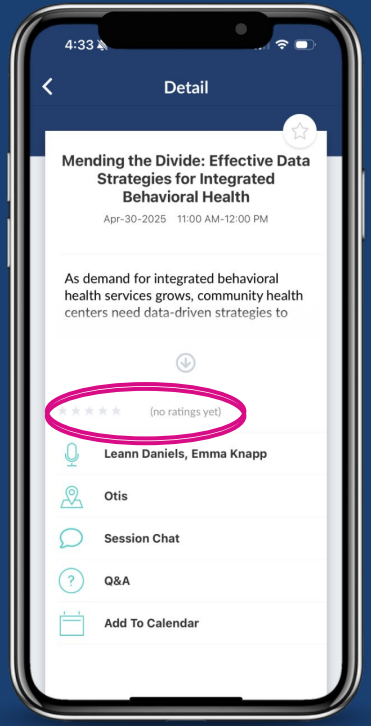
Questions?

We want to hear from you!

Click on the session from your agenda in the conference app.
Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy

Provide brief feedback or ideas

Rate the session and the speaker(s)

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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
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