Azara Product Update

Tuesday, April 14, 2026

Greg Augustine

Chief Product & Technology Officer

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Agenda

- Multi-Factor Authentication
- Measure Programs
- UDS & HEDIS
- Medicaid Redetermination
- EHR Plug-In
- AI
- Smart Patient Summaries
- Maternal Care Updates
- DRVS Improvements
- Population Definition & Curation
- Application Integration
- Rural Health Transformation

Product & Engineering Leadership

Pat Crowley

Engineering

Mike Rapawy

Product Management

Phil Parker

Client Analytics

Kristi Hatchell

Product Management

Multi-Factor / 2 Factor Authentication

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Azara is rolling out a new Multi-Factor Authentication (MFA) protocol starting on **June 3rd**. In addition to your sign-in credentials, MFA requires ***additional authentication*** methods to help verify identify.

Things To Know:

- All organizations will have to set up an MFA method
- If no MFA method has been set up prior to June 2026, Email will be enabled as the default method
- Available authentication methods include SMS and Email
- Support for Google Authenticator and Microsoft Authenticator apps is undergoing final testing and should be available
- MFA will not be required for the EHR Plug-In
- If your organization chooses to use SSO, it will supersede and negate the need for MFA
- You can choose to roll out MFA sooner … even now

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UDS, eCQM, HEDIS and Other Measure Programs

UDS 2026 Released (minus the 2 new dental)

Pins
PVP
CMP
Reports
Dashboards
Measures
Registries
Admin

Reports

Search

LIBRARY
- UDS
  - UDS 2026 CQMs
  - UDS 2025 CQMs
  - UDS Legacy CQMs - 2023
  - UDS Legacy CQMs - 2024
  - Patients by Zip Code
  - Table 3a & 3b - Demographics
  - Table 4 - Patient Characteristics
  - Table 5 - Staffing and Utilization
  - Table 6a - Detail
  - Table 6a - Selected Diagnoses & Services Rendered
  - Table 6b - Quality of Care Measures
  - Table 6b - Section A & B (Prenatal Care)
  - Table 7a - Birthweight
  - Table 7b - Hypertension BP
  - Table 7c - Diabetes A1c or GMI
  - Validation of UDS Measures

Pins
PVP
CMP
Reports
Dashboards
Measures
Registries
Admin

Measures

Search

LIBRARY
- UDS 2026 CQMs
  - BMI Screen & Follow-Up 18+ (CMS 69v14)
  - Breast Cancer Screening (CMS 125v14)
  - Cervical Cancer Screening (CMS 124v14)
  - Child Weight Assessment (CMS 155v14)
  - Childhood Immz Status (CMS 117v14)
  - Colorectal Cancer Screening (CMS 130v14)
  - Depr Remission at 12 Months (CMS 159v14)
  - Depr Scrn & Follow-Up (CMS 2v15)
  - DM A1c or GMI > 9 or Untested (CMS 122v14)
  - Engagement of SUD Treatment (CMS137v14b)
  - HIV Screening (CMS 349v8)
  - HTN Controlling High BP (CMS 165v14)
  - Initiation of SUD Treatment (CMS137v14a)
  - Statin Therapy CVD (CMS 347v9)
  - Tobacco Use: Screening & Cessation (CMS 138v14)

Notable Changes and Impacts

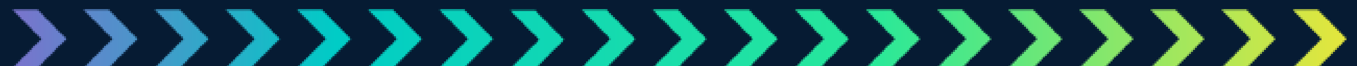
- On balance, there were no notable changes or impacts due to the version changes to the CQMs this year
- Two (2) new measures have been added to Table 6b
  - Both are dental measures and are intended to replace the legacy dental measure from 2025
  - These are measures are still in our development pipeline
- The age for the Breast cancer screening measured change from 45 to 40
  - We put out a mid-year release of a modified measure last year to help 'ease this pain'
- The Statin measure is a bit more complicated in that we are now required to use the highest ASCVD score for a patient during the year vs their score at the end of the year
- We have made modifications ensuring that we are only including Blood Pressures taken at a visit in an ambulatory / non-acute setting
  - This is most important to our hospital clients and/or their FQHC practices

What's Next for UDS 2026

- Updates to the UDS Tables are planned for early Q3
- The 2024 measures will be 'retired' at the end of June
- Scorecard and Dashboard updates in Q2
  - We will swap out the old 2025 versions of the CQMs with the new 2026 versions
- Updates to 'modified' measures (as needed) slated for Q2
- We will be holding a webinar, "Prep for UDS! Changes to Expect in 2026", May 12th at 2pm ET

HEDIS MY 2026

- Azara's primary use for HEDIS measures is for Care Gap Reconciliation
  - We receive the plan calculated versions of HEDIS measures from the plans
  - We use our HEDIS measures to find proof / evidence of measure compliance in the EHR that payers do not have
- We are developing and will release HEDIS measures to satisfiy state specific reporting (e.g., QIP in CA) that require practices to calculate the HEDIS measures for populations where VBC rosters do not exist
- MY 2026 Recertification will be complete by the end of June
- We will have a total of 43 certified measure families
- NCQA Changes for MY 2026 include
  - Retired: AMR, Asthma Medication Ratio



VBC | Care Gap Reconciliation

Care Gap Reconciliation (CGR)
REPORT

FILTER 3

FILTERS: COL - Colorectal Cancer Scree... 2022 Excellus

PAYER REPORTED SCORE

61.63 %

OPPORTUNITY +4.20 %

LEGEND

MEASURE COMPLIANCE
- Compliant
- Non-Compliant (Gap)

COMPLIANCE
- Non-Compliant (Gap)
- Data Reconciliation
- Compliant

ACTION REQUIRED
- Data Reconciliation
- Member Outreach
- No Action

DISPLAY

SHOW DETAILS Disabled Enabled

ALL MEMBERS
25,879
9,931 15,948

MATCHED MEMBERS
22,863
7,936 14,927

UNMATCHED MEMBERS
3,016
1,995 1,021

6,848
Payer EHR

With Visits	4,757
Without Visits	2,091

10,407
Payer EHR

With Visits	9,958
Without Visits	449

1,995
Payer

1,021
Payer

1,088
Payer EHR

With Visits	992
Without Visits	96

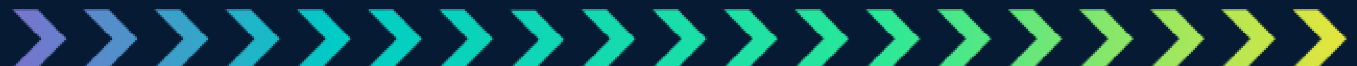
4,520
Payer EHR

With Visits	3,919
Without Visits	601

HEDIS: Reminder

Health Plans / Payers …

- Calculate and finalize prior year results into Q2
- Are just starting to provide gaps for CY 2026
- Typically upgrade and begin using new MY specs in the fall
  - CY ‘26 gaps provided are likely following MY ‘25 specs
- Often use retired measures in their contracts



MSSP Quality Measures

GJA MSSP Measures
REPORT

FILTER

PERIOD: 2024 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

REPORT | CARE GAPS

GROUPING: No Grouping | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: Scorecard

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	GAP
Diabetes A1c > 9 or Untested (CMS 122v12)	25.8%	22.0%	2,298	8,914	164	2,298
Hypertension Controlling High Blood Pressure (CMS165v12)	63.0%	67.0%	13,444	21,348	846	7,904
Screening for Depression and Follow-Up Plan (CMS 2v13)	73.6%	75.0%	58,907	80,006	5,444	21,099

GJA MSSP Measures (with MPI)
REPORT JUST GREG.AUGUSTINE@AZARAHEALTHCARE.COM

FILTER

PERIOD: 2024 | CENTERS: All Centers

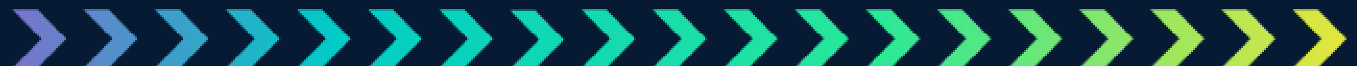
Add Filter | Update

GROUPING: No Grouping | REPORT FORMAT: Scorecard

MEASURE	RESULT	NUMERATOR	DENOMINATOR	EXCLUSIONS	GAP
Diabetes A1c > 9 or Untested (CMS 122v12) MSSP	25.6%	2,266	8,846	152	2,266
Hypertension Controlling High Blood Pressure (CMS165v12) MSSP	63.1%	13,485	21,382	814	7,897
Screening for Depression and Follow-Up Plan (CMS 2v13) MSSP	73.9%	58,463	79,142	5,411	20,679

MSSP Quality Measures

- Azara is certified to produce QRDA I files for the four (4) PY 2025 eCQMs
  - We are in the process of certifying the Colorectal Cancer Screening eCQM which was add for PY 2026
- Azara can ingest QRDA I files for non-Azara custeomers who are part of an ACO and subsequently calculate QRDA III measrure results for the ACO
- Azara is certified to produce the requisite QRDA III files for submission to CMS
  - Both are dental measures and are intended to replace the legacy dental measure from 2025
  - These are measures are still in our development pipeline



Critical Access / Rural Hospital Measures

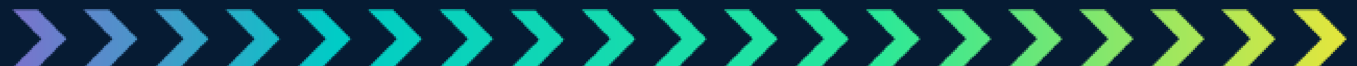
- There are a number of measures sets actively in development for the Critical Access / Rural Hospitals including:
  - IP CQMs - 15 Measures
  - CRNA - 3 Measures
  - Measure Sets As Appropriate per State

Measure Program	State	# Meas in Pgm	Reporting Deadline	Intended DRVS Delivery Date	Notes
CHIRP	TX	23	March	End of Q4 2026	
TIPPS	TX	11	March	End of Q2 2026	Ambulatory Measures
RAPPS	TX	2	March	Complete	
QIP	CA	51	June	End of Q3 2026	Includes HEDIS Measures
HTP	CO	TBD	January	TBD	
IQR	N/A	15	February	End of Q4 2026	Requires ONC Certification

Other Measure Programs

- Indian Health / GPRA
  - 2026 updates planned for mid-year with goals for more specific population filters by tribal enrollment

- PCMH
  - Continued support with updates made to eCQMs in 2025, and planned updates for 2026 standard measure versions



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Medicaid Redetermination

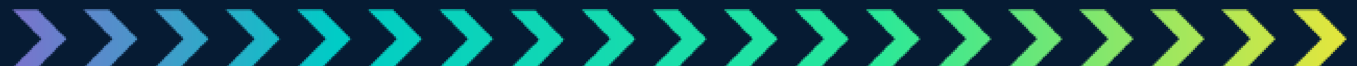
The Close of the Public Health Emergency

April May June July October

Map: Irina Ivanova
Source: Medicaid.gov

Medicaid Redetermination circa 2023

- During the pandemic, the government suspended procedures that would remove people from Medicaid
  - Medicaid enrollment to grow by 5 million between 2020 and 2022
- The Consolidated Appropriations Act instructs states to restart eligibility checks of every person currently on Medicaid
  - Medicaid agencies will redetermine enrollees' eligibility for the first time in nearly 3 yrs
  - Estimates show that 17% of enrollees (~ 15M people) will lose coverage
- Patients who lose coverage can still access care at FQHCs, who treat everyone who seeks care regardless of their ability to pay
  - As patients become uninsured, centers will face shrinking Medicaid revenue and increased costs from caring for more uninsured patients

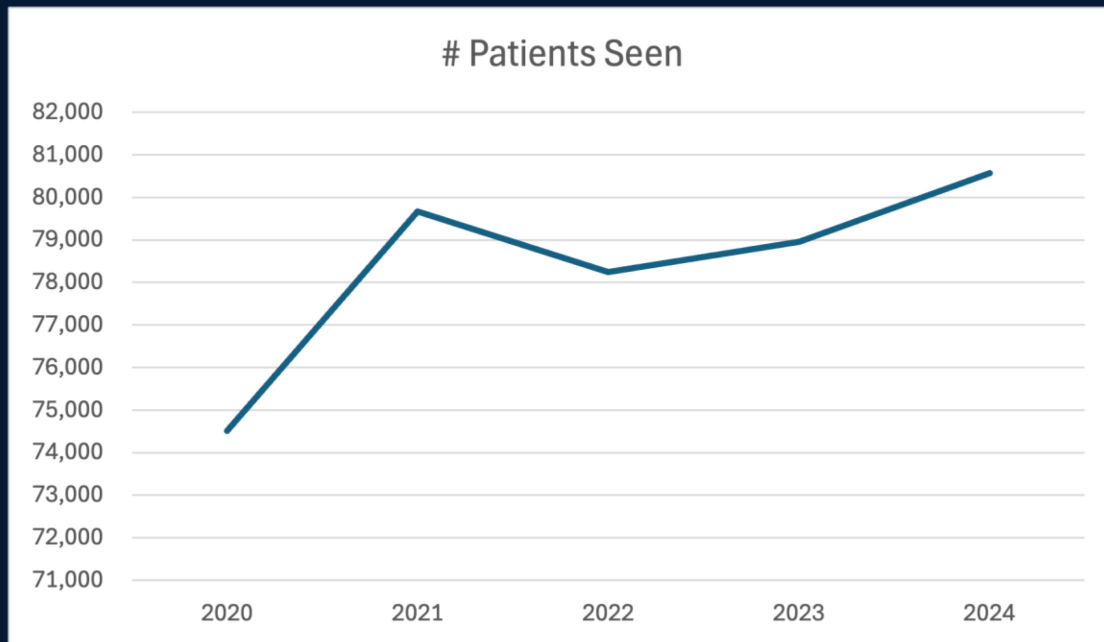


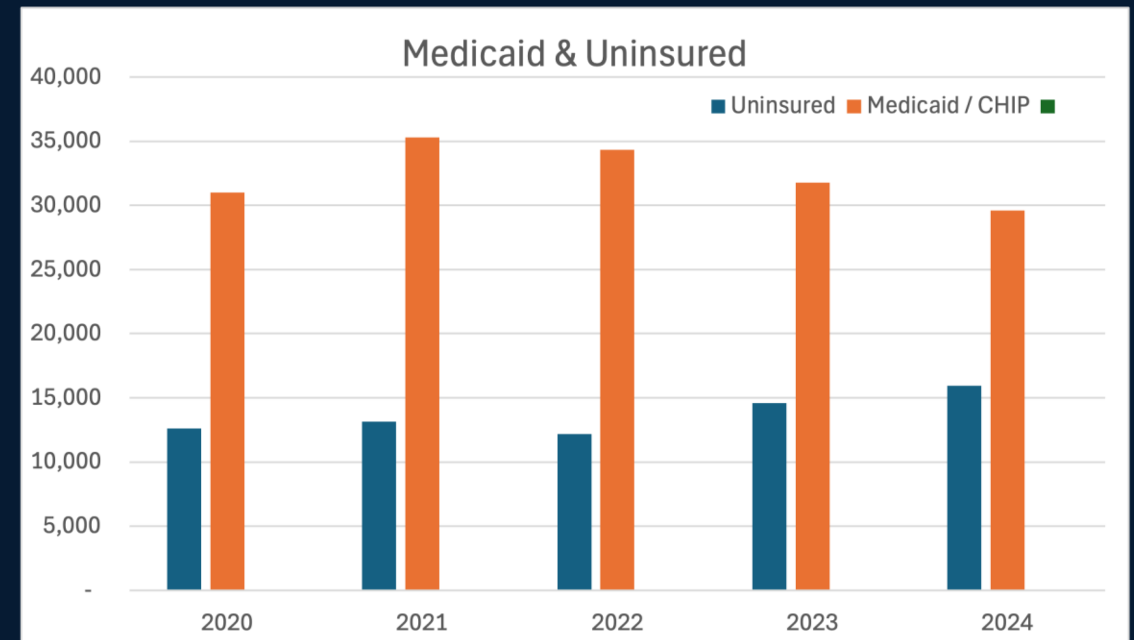
Impacts of HR1

- HR1 and the changes to Medicare and Medicaid coverage eligibility will be felt throughout the healthcare system, especially for FQHCs and safety net providers:
  - Reduction in covered lives will result in decreased reimbursement and an increase in costs for those newly without coverage who still seek care
  - Increased costs in staffing needed for redetermination and eligibility reviews at a more frequent cadence, documentation of patient status more rigorous, time intensive
  - Outreach efforts will be required to prevent disenrollment, gaps in coverage and ensure uninterrupted services for patients
  - It is anticipated that there will be a need for reporting of their patients for HRSA grant retention (via UDS or other means) on enrollment statistics and compliance with HR1 requirements
- Health Centers, Critical Access Hospitals, VBC enablers, payers will need analytic solutions to better understand the eligibility status of their patient population as well as operational tools and processes to assist in assuring all patients eligible for coverage are able to obtain it
- Health Centers, Critical Access Hospitals, VBC enablers, payers will need solutions to analyze and create actionable data at a lower cost to offset the anticipated consequences of HR1

One Client Example

- Increasing # of Patients
- Declining Medicaid
- Increasing Uninsured
- Loss of PPS
- Denials due to Eligibility
- Retroactive recapture opportunity





The Health Center / Critical Access Challenge

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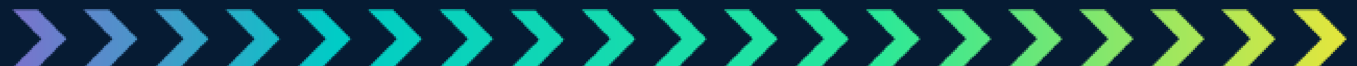
- Pain Points
  - Increased workload for centers, more frequent redetermination efforts
    - Resulting in higher costs to centers, more uninsured
  - Fragmented Medicaid renewal tracking
  - Manual processes for outreach and follow-up
  - Complexities within new work requirements, understanding exemptions
  - Policy uncertainty driving operational risk
- What FQHCs Need:
  - Systems to address increased workload: For Medicaid covered patients, outreach will need to occur 2x the total
    - Flexibility and adaptability in their product solution
    - Configurable reporting and worklists
    - Navigator-first workflows as well as point of care reminders
    - Scalable patient outreach
- Patient Enabled Solutions



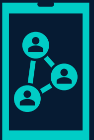
Health Center Needs

1. Regular & Ongoing Assessment of Patients Eligibility and Coverage Status
2. Active Alerts for Health Center staff to lapses in coverage and potential upcoming lapses
3. Patient engagement programs (in clinic, via phone, text, community outreach events, email) to inform and educate about coverage eligibility changes, alerting patients to actions that need to be taken for continuing coverage (redetermination, work requirements, paperwork)
4. Tools & Process for assisting patients in filling out required paperwork, gathering necessary documentation, and submitting to appropriate agency (similar for Work Requirements)
5. Reliable way of documenting and tracking patient engagement activities
6. Ability to easily see who is covered, who is not, and understand performance and effectiveness of team and programs working to assist patients in obtaining and retaining coverage
7. Coordinating efforts to ensure patients are engaged to meet quality goals of the organization

Azara Solutions By Product

DRVS

- Registries to identify patients coming due for redetermination, reenrollment and other needed services
- Identification of patients excluded / exempt from work requirements
- Alerts to ensure interventions can occur at point of care to prevent disenrollment or delay in care



ACC – Care Coordination & Care Management

- Work lists and workflow for documenting and tracking of outreach and enrollment activities sit within Azara's tool for Care Coordination and Care Management.

APO

- Engage patients for redetermination needs, care reminders in advance to prevent higher cost interventions in the future

EHR Plug-In

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PVP

15

Patient Visit Planning (PVP)
PVP PVPVIEW

FILTER

DATE RANGE: 04/13/2026-04/18/2026
RENDERING PROVIDERS: GRISWOLD, CLARK
MRN LIST:

Add Filter | Update

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Total Providers: (1)

GRISWOLD, CLARK — *1 Scheduled Appointment*

9:30 AM Monday, April 13, 2026 — Visit Reason: **ESTABLISHED PATIENT 15 MIN Having issues with sugar levels, needing checked**

Kent, Clark
MRN: 1029384756
DOB: 04/14/1959 (67)

Sex at Birth: M (he/him/his)
GI: Male
SO: Straight (not lesbian or gay)

Phone: 617-555-1212
Lang: English
Risk: High (18)

Portal Access: 02/19/2026
Plan: REACH ACO

PCP: GRISWOLD, CLARK
Payer: MEDICARE - WI
CM: Unassigned

DIAGNOSES (4)

COPD | DM I or II | HTN-E
HyLip

RISK FACTORS (2)

ASCVD High (21.20) | BMI

SDOH (2)

EMPLOYMENT | FPL<200%

RAF GAP DISEASE GROUPS

Arrest CLM | Lung | **Metabolic** CLM
Musculoskeletal CLM

ALERT	MESSAGE	DATE	RESULT
Colon CA 45+	Missing - Patient has plan data		
A1c	Out of Range	3/16/2026	8.8
HIV	Missing		
LDL	Overdue	7/7/2023	97
Nephropathy	Overdue	4/3/2024	30
Drug Screen Controlled Substance	Missing		
BP	Out of Range	3/16/2026	146/87
Foot	Overdue	2/18/2025	1

CMP

15

Care Management Passport (CMP)
CMP

Generate Summary | Patient Lookup

09:30 AM Monday, April 13, 2026 **PROVIDER:** GRISWOLRD, CLARK **VISIT REASON:** Having issues with sugar levels, needing checked

Kent, Clark
MRN: 1029384756
DOB: 4/14/1959 (67)

Sex at Birth: M
GI: Male
SO: STRAIGHT

Phone: (617) 555-1212
Language: English
Risk: High (18)

Last Phys: 9/4/2025
Portal Access: 02/19/2026
Plan: REACH ACO

PCP: GRISWOLD, CLARK
Payer: MEDICARE - WI
CM: Unassigned

Assessments (Last 10 of 20)

CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY
F51.01	Primary insomnia	3/16/26	13
E11.9	Type 2 diabetes mellitus without complications	3/16/26	5
Z79.899	Other long term (current) drug therapy	3/16/26	1
I10	Essential (primary) hypertension	2/19/26	4
G25.81	Restless legs syndrome	2/19/26	1
Z12.2	Encounter for screening for malignant neoplasm of respiratory organs	2/19/26	1
H02.059	Trichiasis without entropion unspecified eye, unspecified eyelid	12/15/25	1
H01.006	Unspecified blepharitis left eye, unspecified eyelid	12/15/25	1
H01.003	Unspecified blepharitis right eye, unspecified eyelid	12/15/25	1
E11.69	Type 2 diabetes mellitus with other specified complication	12/15/25	1

Encounters (Last 5 of 59)

DATE	PROVIDER	TYPE	REASON
3/17/26	GRISWOLRD, CLARK	Telephone	
3/17/26	SCOOP, INA	Telephone	MEDICATION ISSUES
3/16/26	GRISWOLRD, CLARK	Office Visit	3 MONTH FOLLOW UP

Active Problems (Last 10 of 23)

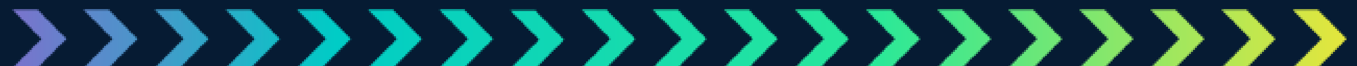
CODE	DESCRIPTION	MOST RECENT
E66.813	Obesity, class 3	3/19/26
H01.006	Unspecified blepharitis left eye, unspecified eyelid	12/15/25
H01.003	Unspecified blepharitis right eye, unspecified eyelid	12/15/25
H02.059	Trichiasis without entropion unspecified eye, unspecified eyelid	12/15/25
H43.813	Vitreous degeneration, bilateral	12/8/25
M62.838	Other muscle spasm	7/15/25
H02.834	Dermatochalasis of left upper eyelid	2/26/25
H25.813	Combined forms of age-related cataract, bilateral	2/26/25
H02.889	Meibomian gland dysfunction of unspecified eye, unspecified eyelid	2/26/25
H52.4	Presbyopia	2/26/25

The Numbers

BMI	3/16/26	**38.69** lb/m2
Systolic	3/16/26	**152** mmHg
Diastolic	3/16/26	**89** mmHg
LDL	7/7/23	**97** mg/dL

The Azara EHR Plug-In

- The EHR Plug-In enables health center care team members to access DRVS data / results from within their EHR at the point of care including:
  - Alerts / Care Gaps
  - Open Referrals
  - Risk Adjustment Factor (RAF) Gaps / Coding Gaps
  - Azara Care Management Notes and Tasks
  - ACC - EHR Plug-In Integration
  - Documents
    - Prenatal Passport
    - Care Management Plan



What's NEW | The Azara EHR Plug-In

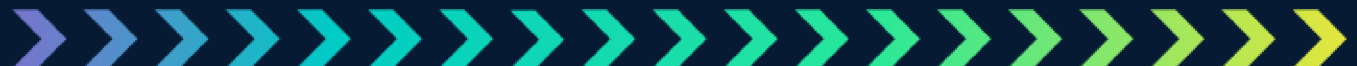
15

- SMART on FHIR integration with:
  - NextGen
  - athenaOne
  - eCW
  - Epic
- Diagnosis Coding Gap Writebacks complete for:
  - NextGen
  - athenaOne
  - eCW
  - Epic integration has been initiated

What's COMING | The Azara EHR Plug-In

15

- Alert Sticky Notes
- Enhanced Visibility to Other Items
  - Plan Calculated Care Gaps
  - Visits with other practices
  - ACC and APO outreaches
  - Medicaid Redetermination efforts
- AI Smart Patient Summaries
- Diagnosis Coding and Writeback Expansion
  - Search for and writeback related ICD10 codes when HCC Gap is insufficient
  - Visibility to Plan Calculated Suspect Conditions



EHR Plug-In | Alerts

Sallie Sue

Moderate (12)

MRN: 15303819

DOB: 10/13/1920 (104 yrs)

Plan: Medicare Advantage

- ALERTS 6
- RAF GAPS 3
- REFERRALS 7
- CARE MGMT
- PLAN CARE GAPS 3

DOCUMENTS:

- Care Mgmt Plan
- Prenatal Passport

Alert	Message	Date	Most Recent Result	Alert Owner
A1c	Overdue	3/27/23	5.4	Provider
LDL	Overdue	8/28/22	190	RN
Eye	Overdue	6/22/22	normal	Provider
Foot	Overdue	7/24/22	Y	MA/LPN
I/P Encounter	Occurred	9/30/2025	Beth Israel	Medical Records
BP High Stage 1 or 2 No Dx	Missing	6/21/23	Stage 1	RN

EHR Plug-In | Dx Coding Gaps

Sallie Sue

Moderate (12)

MRN: 15303819
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Plan: Medicare Advantage

- ALERTS 6
- RAF GAPS 3
- REFERRALS 7
- CARE MGMT
- PLAN CARE GAPS 3

DOCUMENTS:

- Care Mgmt Plan
- Prenatal Passport

Disease Group	Description	Context/Actions	Billed CY	Unbilled CY	Action
Diabetes	Diabetes with Glycemic, Unspecified, or No Complications	Dx Not Billed *Add to Chg Next Visit*		*EHR: E11.65 (01/15/24)*	
Heart	Specified Heart Arrhythmias	Dx Not Billed *Add to Chg Next Visit*		*EHR: I48.21 (05/29/24)*	
Psychiatric	Bipolar Disorders without Psychosis	Dx Not Billed *Add to Chg Next Visit*		*CLM: F31.30 (07/03/24)*	

EHR Plug-In | Dx Coding Gaps

Sallie Sue

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MRN: 15303819
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DOCUMENTS:

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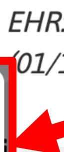
Diabetes	Diabetes with Glycemic, Unspecified, or No Complications	Dx Not Billed *Add to Chg Next*		*EHR: E11.65 (01/15/24)*	
Heart	Specified Heart A			*EHR: I48.21 (05/29/24)*	
Psychiatric	Bipolar Disorders			*CLM: F31.30 (07/03/24)*	



Confirm Acceptance ×

By Accepting this gap, last year's Highest Billed Dx Code will be written to the patient's chart:

E11.65 (TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA)

Cancel | Confirm

EHR Plug-In | Dx Coding Gaps

Sallie Sue

Moderate (12)

MRN: 15303819

DOB: 10/13/1920 (104 yrs)

Plan: Medicare Advantage

ALERTS 6

RAF GAPS 3

REFERRALS 7

CARE MGMT

PLAN CARE GAPS 3

DOCUMENTS:

Care Mgmt Plan

Prenatal Passport

Disease Group	Description	Context/Actions	Billed CY	Unbilled CY	Action
Diabetes	Diabetes with Glycemic, Unspecified, or No Complications	Dx Not Billed *Add to Chg Next*		*EHR: E11.65 (01/15/24)*	
Heart	Specified Heart A			*EHR: I48.21 03/29/24)*	
Psychiatric	Bipolar Disorders			*CLM: F31.30 07/03/24)*	

Confirm Gap Dismissal ×

Please confirm you are dismissing this gap. This action is irreversible. Choose a reason for reconciliation below. To enter a free-text reason select the "Other" option.

- (●) Dx Category no longer applies to patient
- ( ) Suggested coding does not apply
- ( ) Other

Comments (Optional):

Cancel | Confirm

EHR Plug-In | Dx Coding Gaps Expansion

Dannette Coutre

High (24)

MRN: 1104085
DOB: 6/13/1994 (31 yrs)
CM: Olive Mou
PLAN: Plan_08

- ALERTS 4
- RAF GAPS 8
- REFERRALS 7
- CARE MGMT
- PLAN CARE GAPS

DOCUMENTS:

No documents available

Smart Summary

Disease Group	Description	Context/Actions	Billed	Unbilled	Action
Cerebrovascular	Cerebrovascular, medium	Dx Not Billed *Add to Chg Next Visit*		*EHR: I63.139 (05/05/26)*	
CNS				*EHR: G47.411 (04/17/25)*	
DD				*EHR: F73 (05/05/26)*	
Diabetes			*9* *5/26)*	*EHR: E10.321 (05/05/26)*	
Infectious				*EHR: Z21 (05/05/26)*	
Pregnancy				*EHR: O03.5 (04/17/25)*	
Psychiatric				*EHR: F32.2 (02/01/26)*	
Substance abuse				*EHR: F15.951 (04/17/25)*	

Add to EHR ×

Click CONFIRM to add last year's Highest Documented DX Code to the patient's chart, or choose a different code from the list below.

UNBILLED CY: E10.321 (Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema)

ICD10 Codes *(Select one)*

lymph

	Code	Description
○	D86.1	Sarcoidosis of lymph node
○	D86.2	Sarcoidosis of lung with sarcoidosis of lymph node

SELECTED CODE:

E10.321 (Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema)

Cancel | Confirm

EHR Plug-In | Plan Care Gaps ⇨ *Q2 Delivery*

Abernathy, Colby

Moderate (12)

MRN: 000279887564
DOB: 12/18/1996 (28 yrs)
CM: Carrie Taylor
PLAN: Medicare Advantage

- ALERTS 6
- RAF GAPS 3
- REFERRALS 7
- CARE MGMT
- PLAN CARE GAPS 4

DOCUMENTS:
- Care Mgmt Plan
- Prenatal Passport

Gap	Action	Received by Plan?	Documented in EHR?
BCS - Breast Cancer Screening	Document in EHR	Y	N
BPD - Blood Pressure Control	F/U with Plan, document in EHR	N	N
CCS - Cervical Cancer Screening	Send documentation to Plan	N	Y
DSFA - Depression Screen	No action required	Y	Y

EHR Plug-In | Plan Care Gaps ⇨ *Q2 Delivery*

Abernathy, Colby

Moderate (12)

MRN: 000279887564
DOB: 12/18/1996 (28 yrs)
CM: Carrie Taylor
PLAN: Medicare Advantage

- ALERTS 6
- RAF GAPS 3
- REFERRALS 7
- CARE MGMT
- PLAN CARE GAPS 4

DOCUMENTS:
- Care Mgmt Plan
- Prenatal Passport

Gap	Action	Received by Plan?	Documented in EHR?
BCS - Breast Cancer Screening	Document in EHR	Y	N
BPD - Blood			N
CCS - Cervic			Y
DSFA - Depr			Y

Care Gap Reconciliation (CGR)
REPORT

FILTER 4

FILTERS: 2026 Access Community Health BCS - Breast Cancer Screening

PAYER REPORTED SCORE
50.00%
OPPORTUNITY +12.50%

LEGEND

MEASURE COMPLIANCE
- Compliant
- Non-Compliant (Gap)

COMPLIANCE
- Non-Compliant (Gap)
- Data Reconciliation
- Compliant

ACTION REQUIRED
- Data Reconciliation
- Member Outreach
- No Action

DISPLAY

ALL MEMBERS 40 (●20 ●20)

MATCHED MEMBERS 31 (●19 ●12)
- 14 — Payer ✗, EHR ✗
- 4 — Payer ✓, EHR ✓
- 5 — Payer ✗, EHR ✓
- 8 — Payer ✓, EHR ✗

UNMATCHED MEMBERS 9 (●1 ●8)
- 1 — Payer ✗
- 8 — Payer ✓

ACC - EHR Plug-In Integration

Home | Patients | Tasks | Reports | Care Coordination | Search ACM Patients... | GA

Godoy, Noah MRN: ACM5 | DOB: 2/4/58 (67) | M

English | (508)271-7584 | No email

Summary | Plan | Screenings | Clinical | Activity

FOCUS

No focus to display

CARE TEAM

Intervention Effort — Not Set

Care Manager — Minori Rios Access

MANAGEMENT PLAN

test template

Vitals: BMI 23.4

BP 130/76

Weight 170

HT 72 inches

VIEW LIBRARY

Updated By: Test, T</h1><h1>TEST</h1>

v. 4 *Version History*

Flag Care Plan for Provider Review

Flagging Care Plan for Provider Review triggers a notification in the Azara EHR Plug-In and will remain visible until 11/21/25 unless manually removed.

Hi Care Team - I am having issues getting this patient to comply with their medication regimen. Can you please speak to them. Thank you, Greg the Care Manager

Cancel | Confirm

BARRIERS TO CARE (Active | Met)

	IDENTIFIED	BARRIER	ACTIVITY	NOTES	UPDATED	PRIORITY	OWNER
☐	8/6/2025	Food Insecurity	Connect with food bank		8/6/2025	HIGH	Alex Shvarts

GOALS (All | Active | Met)

ACC - EHR Plug-In Integration

Sallie Sue

Moderate (12)

MRN: 15303819

DOB: 10/13/1920 (104 yrs)

Plan: Medicare Advantage

ALERTS 6

RAF GAPS

REFERRALS

CARE

Alert	Message	Date	Most Recent Result	Alert Owner
A1c	Overdue	3/27/23	5.4	Provider
LDL	Overdue	8/28/22	190	RN
				Provider
				MA/LPN
				Medical Records
				RN

Name John Smith **Date** 4/13/2026

Reason Patient not regularly checking blood sugar levels

Care Mgmt Plan

Care Management Plan

BP High Stage

EHR Plug-In | Sticky Notes ⇨ *in Beta*

Clark Kent High (18)

MRN: 1029384756

DOB: 4/14/1959 (67 yrs)

CM: Unassigned

PLAN: REACH ACO

ALERTS 8

RAF GAPS 4

REFERRALS

DOCUMENTS:

No documents available

Smart Summary

Unspecified Diagnoses: Psoriasis, unspecified (Feb2025); Chronic obstructive pulmonary disease, unspecified (Oct2025); Unspecified astigmatism, bilateral (Feb2025); Unspecified blepharitis left eye, unspecified eyelid (Dec2025); Unspecified blepharitis right eye, unspecified eyelid (Dec2025); Dental caries, unspecified (Feb2025); Consider re-evaluation of diagnoses to specify severity.

Undocumented HCC RAF Diagnoses: Respiratory failure, unspecified (May2025); Chronic obstructive pulmonary disease, unspecified (Oct2025); Morbid (severe) obesity due to excess calories (Jul2025); Other psoriatic arthropathy (Dec2025)

Lab Trends: A1c increased from 6.0 (Feb2025) to 8.8 (Mar2026)

Open Referrals: N/A

TOC Events: N/A

AI-generated content may be incorrect

Alert	Message	Date	Most Recent Result	Notes
A1c	Out of Range			
BP	Out of Range			
Colon CA 45+	Missing - Patient has plan data			
Drug Screen Controlled Substance	Missing			
Foot	Overdue	2/18/25	1	

Add Sticky Note

Save

One More Thing Coming …

- The EHR Plug-In will become a standalone app that can be run on traditional workstations and laptops ***AND*** on Mobile Devices

EMILY ALMOND MRN 12345 DOB 4/8/1987 (38 yrs) CM: Unassigned

Low (3) PLAN: No plan found

DOCUMENTS: No documents available

Alerts 3 | RAF Gaps | Referrals 1

Alert	Message	Date	Most Recent Result
A1c	Missing		
Flu - Seasonal	Due Seasonal		Due Date: 2025-10-01
Pap HPV	Overdue	2/21/20	PAP 02/21/2020

Targeted / Planned EHR Integrations

- We are targeting the following EHRs for similar integration as to what we have seen:
  - MediTech
  - Oracle / Cerner CommunityWorks
  - Trubridge
  - Medent
  - Touchworks

AI

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Azara's 2026 AI Initiatives

- ✓ Incorporate **AI-generated patient summaries** within
  - DRVS on the PVP and CMP
  - The EHR Plug-In
  - ACC, specifically for Care Managers
- ✓ Develop AI assistant to explain **patient inclusion / exclusion** within a quality measure
- Release **AI Help System** bot to enhance self-service product guidance and reduce support ticket
- Develop and deploy AI/ML model to predict the **propensity** of a patient **to No Show**
- Surface **Azara Insights** for quality measures (e.g., identify primary 'offenders' of gaps)
- Expand **Azara Insights** to provide **actionable items** for meeting quality and contract goals
- Extend AI/ML to **improve mappings** for labs and structured clinical data (e.g., Mammograms)
  - Expand use of ML to codify (LOINC, SNOMED) clinical data that is not recorded in a structured manner

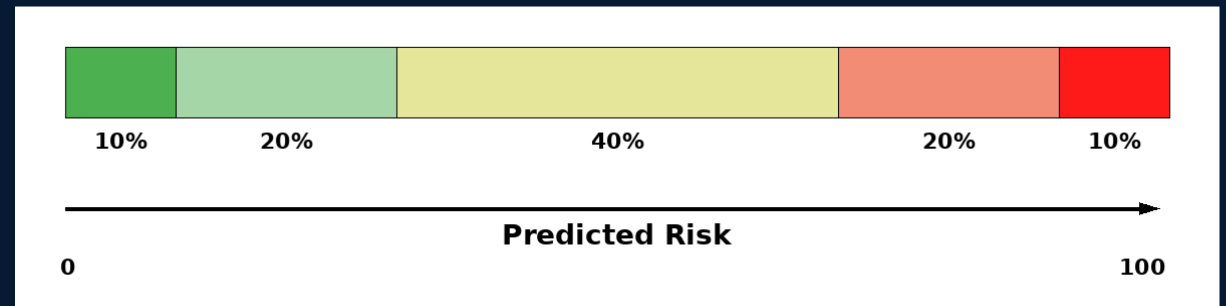
Azara's 2026 AI Initiatives

- Expand use of **ML to codify (LOINC, SNOMED) clinical data** that is not recorded in a structured manner
- Incorporate AI prioritization engine to **optimize patient outreach**, focusing efforts on high impact patients
- Identify and prioritize **free text responses** to APO campaigns that require Care Coordination follow-up via ACC
- Utilize AI/ML to provide **predictive** analytics on patient (**suspect**) **conditions**
- Integrate **AI Virtual Enrollment Agent** into Medicaid Redetermination / Work Requirements outreach solution
- Develop **Virtual Agent** to assist with Care Coordination outreach efforts in ACC

No-Show Risk Scores & Bands

The model will assign appointments to categories:

- Highest Risk (Top 10% of predicted risk)
- Higher Risk (Next 20%)
- Moderate Risk (40%)
- Lower Risk (20%)
- Lowest Risk (Bottom 10%)



Risk Scores will be on a scale from 0-100.

Azara Care Coordination

Home | Patients | Tasks | Reports | Care Coordination

Search ACM Patients...

GA

Rayos, Joe MRN: 5647382910 | Plan: 2 MSSP ACO (8UE0JK2HM11), | DOB: 8/1/52 (73) | M

M 13 | English | (617)555-1212

Summary | Coordination | Plan | Screenings | Clinical | Activity

Data Received: 4 April

OUTREACH REASONS (4)

All | Open | Complete

Selected 0 | Attempted | Connected

REASON DETAILS	LAST OUTREACH	OUTREACHES	REPORTED	STATUS
CQM 3				
MISC Other need	AV 03/20/26	7	03/18/26	Open

TASKS (1)

Open | Completed | Flagged | All

ACTION	SUMMARY	DUE	ASSIGNEE	COMMENTS
Call	December check-in	12/24/25	Greg Augustine	

Showing 1 to 1 of 1 entry

« ‹ 1 › »

OUTREACH LOG (2)

Last 30 Days | All

DATE	REASON	NOTES	INTERVENTIONS	PERFORMED BY
03/20/2026	MISC	Called Ridelink to schedule transportation for pt's 3/26 ultrasound at The Imaging Center. Ride confirmed with pickup time of 7:20am. Unsure how long ...	Other	Greg Augustine

but says it's at the same place he recently w...

Recording Outreach Log Notes

OUTREACH LOG (2)

Last 30 Days | All

DATE	REASON	NOTES	INTERVENTIONS	PERFORMED BY
03/20/2026	MISC	Called Ridelink to schedule transportation for pt's 3/26 ultrasound at The Imaging Center. Ride confirmed with pickup time of 7:20am. Unsure how long ...	Other	Greg Augustine
03/17/2026	MISC	Pt called to let me know he has another appointment coming up at the end of March - he is not sure where but says it's at the same place he recently w...	Other	Greg Augustine

Azara Care Coordination

Home | Patients | Tasks | Reports ▾ | Care Coordination ▾ | Search ACM Patients... | GA

Rayos, Joe MRN: 5647382910 | Plan: 2 MSSP ACO (8UE0JK2HM11), | DOB: 8/1/52 (73) | M ☆

M 13 | English | (617)555-1212

Summary | Coordination | Plan | Screenings | Clinical | Activity

Data Received: 4 April

OUTREACH REASONS (4) All | Open | Complete — Selected 0 | Attempted | Connected

REASON DETAILS	LAST OUTREACH	OUTREACHES	REPORTED	STATUS
CQM 3				
MISC Other need	AV 03/20/26	7	03/18/26	Open

TASKS (1) Open | Completed | Flagged | All

ACTION	SUMMARY	DUE	ASSIGNEE	COMMENTS
Call	December check-in	12/24/25 ⚠	Greg Augustine	

Showing 1 to 1 of 1 entry

OUTREACH LOG (2) Last 30 Days | All

DATE	REASON	NOTES	INTERVENTIONS	PERFORMED BY
03/20/2026	MISC	Called Ridelink to schedule transportation for pt's 3/26 ultrasound at The Imaging Center. Ride confirmed with pickup time of 7:20am. Unsure how long ...	Other	Greg Augustine

but says it's at the same place he recently w...

Complete Screenings

Rayos, Joe MRN: 5647382910 | Plan: 2 MSSP ACO (8UE0JK2HM11), | DOB: 8/1/52 (73) | M

M 13 English (617)555-1212

Summary | Coordination | Plan | Screenings | Clinical | Activity

Data Received: 4 April

ACTIVE SCREENINGS

TYPE	STATUS	UPDATED	UPDATED BY
No Screenings to Display			

Showing 0 to 0 of 0 entries

SCREENING HISTORY

Search...

TYPE	SUBMITTED	SUBMITTED BY
ACO Health Risk Assessment (PRP+)	11/10/2025	Doe, John
Comprehensive Risk Assessment	7/1/2024	Brown, Charlie
ACO Health Risk Assessment (PRP+)	4/11/2024	Smith, Susan

Showing 1 to 3 of 3 entries

Smart Patient Summaries

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

AI Smart Patient Summary | *CMP*

Care Management Passport (CMP)
CMP

Generate Summary

Patient Lookup

09:30 AM Monday, April 13, 2026 **PROVIDER:** GRISWOLRD, CLARK **VISIT REASON:** Having issues with sugar levels, needing checked

Kent, Clark
MRN: 1029384756
DOB: 4/14/1959 (67)

Sex at Birth: M
GI: Male
SO: STRAIGHT

Phone: (617) 555-1212
Language: English
Risk: High (18)

Last Phys: 9/4/2025
Portal Access: 02/19/2026
Plan: REACH ACO

PCP: GRISWOLD, CLARK
Payer: MEDICARE - WI
CM: Unassigned

Assessments (Last 10 of 20)

CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY
F51.01	Primary insomnia	3/16/26	13
E11.9	Type 2 diabetes mellitus without complications	3/16/26	5
Z79.899	Other long term (current) drug therapy	3/16/26	1
I10	Essential (primary) hypertension	2/19/26	4
G25.81	Restless legs syndrome	2/19/26	1
Z12.2	Encounter for screening for malignant neoplasm of respiratory organs	2/19/26	1
H02.059	Trichiasis without entropion unspecified eye, unspecified eyelid	12/15/25	1
H01.006	Unspecified blepharitis left eye, unspecified eyelid	12/15/25	1
H01.003	Unspecified blepharitis right eye, unspecified eyelid	12/15/25	1
E11.69	Type 2 diabetes mellitus with other specified complication	12/15/25	1

Encounters (Last 5 of 59)

DATE	PROVIDER	TYPE	REASON
3/17/26	GRISWOLRD, CLARK	Telephone	
3/17/26	SCOOP, INA	Telephone	MEDICATION ISSUES
3/16/26	GRISWOLRD, CLARK	Office Visit	3 MONTH FOLLOW UP

Active Problems (Last 10 of 23)

CODE	DESCRIPTION	MOST RECENT
E66.813	Obesity, class 3	3/19/26
H01.006	Unspecified blepharitis left eye, unspecified eyelid	12/15/25
H01.003	Unspecified blepharitis right eye, unspecified eyelid	12/15/25
H02.059	Trichiasis without entropion unspecified eye, unspecified eyelid	12/15/25
H43.813	Vitreous degeneration, bilateral	12/8/25
M62.838	Other muscle spasm	7/15/25
H02.834	Dermatochalasis of left upper eyelid	2/26/25
H25.813	Combined forms of age-related cataract, bilateral	2/26/25
H02.889	Meibomian gland dysfunction of unspecified eye, unspecified eyelid	2/26/25
H52.4	Presbyopia	2/26/25

The Numbers

BMI	3/16/26	**38.69** lb/m2
Systolic	3/16/26	**152** mmHg
Diastolic	3/16/26	**89** mmHg
LDL	7/7/23	**97** mg/dL

AI Smart Patient Summary | *CMP*

Care Management Passport (CMP)
CMP

Generate Summary | Patient Lookup

Smart Summary

This is a 67-year-old male patient with multiple chronic conditions including diabetes, hypertension, COPD, and obesity, who is at high risk and actively managed in primary care and specialty settings.

1. The patient has **poorly controlled diabetes** with a recent A1c of **8.8%** as of Mar 2026 and is on multiple diabetes medications; medication management was addressed in the last visit on Apr 13, 2026.
2. He has **hypertension with elevated blood pressure readings** (latest 152/89 mmHg on Mar 16, 2026) despite treatment, indicating suboptimal control.
3. His BMI is in the **morbidly obese range at 38.7**, contributing to his high-risk status and complicating management.
4. He has multiple eye-related diagnoses including cataracts and other ocular conditions, with recent optometry follow-ups and a comprehensive eye exam scheduled for May 7, 2026.
5. There are several overdue preventive care gaps including LDL cholesterol screening (last 97 in Jul 2023), nephropathy screening (overdue since Apr 2024), foot exam (overdue since Feb 2025), and colon cancer screening is missing.

Today's Recommended Action Items

1. Review and optimize diabetes and hypertension management during today's visit, considering the elevated A1c and blood pressure.
2. Address overdue preventive screenings: order nephropathy and LDL labs, schedule foot exam, and discuss colon cancer screening.
3. Coordinate care with optometry for upcoming eye exam and follow up on ocular diagnoses to prevent vision loss.

Modify Prompt

AI-generated content — please review for accuracy

09:30 AM Monday, April 13, 2026 **PROVIDER:** GRISWOLRD, CLARK **VISIT REASON:** Having issues with sugar levels, needing checked

Kent, Clark
MRN: 1029384756
DOB: 4/14/1959 (67)

Sex at Birth: M
GI: Male
SO: STRAIGHT

Phone: (617) 555-1212
Language: English
Risk: High (18)

Last Phys: 9/4/2025
Portal Access: 02/19/2026
Plan: REACH ACO

PCP: GRISWOLD, CLARK
Payer: MEDICARE - WI
CM: Unassigned

Assessments (Last 10 of 20)

CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY
F51.01	Primary insomnia	3/16/26	13
E11.9	Type 2 diabetes mellitus without complications	3/16/26	5
Z79.899	Other long term (current) drug therapy	3/16/26	1
I10	Essential (primary) hypertension	2/19/26	4
G25.81	Restless legs syndrome	2/19/26	1

Active Problems (Last 10 of 23)

CODE	DESCRIPTION	MOST RECENT
E66.813	Obesity, class 3	3/19/26
H01.006	Unspecified blepharitis left eye, unspecified eyelid	12/15/25
H01.003	Unspecified blepharitis right eye, unspecified eyelid	12/15/25
H02.059	Trichiasis without entropion unspecified eye, unspecified eyelid	12/15/25
H43.813	Vitreous degeneration, bilateral	12/8/25

AI Smart Patient Summary | *ACU*

Member Profile

Oct 2024 - Sep 2025 ▾ | Update

STREICH, JULIO

Summarize

Member # : 3bc1db39-e4b3-19d0-075d-d939279ca716
MRN : 000575405380
DOB : 04/26/1953 (72)

Practice : Access Community Health
Match Status : HARD
Plan & LOB : Plan 4 - Medicare

Plan Eligibility Status : Active
Attributed PCP : Buckridge - Swaniawski
Hospice Utilization : N

Review Queue Population : 3
Review Queue Status : Needs Review

Chronic Conditions

Category ↑2	Detail ↑3	Impact ↑1
Cardiovascular	Congestive heart failure	HIGH
Renal	Chronic renal failure	HIGH
Renal	ESRD	HIGH
Respiratory	Chronic respiratory failure	HIGH

High Impact Areas

Area	Value	Area	Value
Avoidable IP	4	Primary Care Leakage	0
30 Day IP Readmissions	3	Network Leakage	130
Avoidable ED	7	RUB Score	5

Total Cost
$197.2k

N/A
STOP LOSS

Risk of Pred. Hospitalization : Medium

Utilization Over Time

$ | #

	10/24	11/24	12/24	01/25	02/25	03/25	04/25	05/25	06/25	07/25	08/25	09/25	Total	% Of Total
Inpatient		$14,045	$17,587	$9,536	$9,651				$37,343			$27,432	$115,593	59%
Emergency Department	$1,843	$3,742	$193	$1,456	$2,098	$935		$3,769	$3,869	$2,153		$6,733	$26,790	14%
Pharmacy	$45	$80	$718										$843	0%
Outpatient	$782	$567		$277	$202			$155	$142	$580		$184	$2,888	1%

ED/IP Utilization

Admission	Discharge ↓	Type	Sub Type	Location	Clinical Class	Avoidable?	Planned Admission	Cost
9/25/2025	9/29/2025	Inpatient	Surgery	SWANIAWSKI - LEUSCHKE	Circulatory Diseases	No	No	$27,431.65

AI Smart Patient Summary | *ACU*

Member Profile

Jan 2025 - Dec 2025 ▾ | Update

Smart Summary

This is a 72-year-old Medicare member with a RUB 5 (Very High) risk profile, driven by extensive chronic disease burden and frequent acute care use across emergency, outpatient, and dialysis settings.

- The member has repeated **emergency department visits** throughout the measurement period, along with frequent outpatient encounters and a high volume of **dialysis-related services**, contributing to consistently elevated total cost of care.
- Ongoing utilization is primarily associated with **end stage renal disease, congestive heart failure, chronic respiratory failure, hypertension with complications, ischemic heart disease, and diabetes with complications**, all of which are linked to higher costs and ongoing care needs.
- Multiple emergency department encounters are documented for conditions such as **shortness of breath, fluid overload, hypertension with complications, pneumonia, and respiratory symptoms**, with several visits classified as **potentially avoidable or primary-care treatable** and no indication of planned admissions.
- Pharmacy data reflects a **high prescription volume**, including medications for cardiovascular disease (e.g., blood pressure and cholesterol management), anticoagulation, and **renal-related therapies** such as phosphate binders and calcium-regulating agents, consistent with long-term chronic disease management.
- The member has recurring touchpoints across **ED, outpatient, home health, and dialysis settings**, indicating ongoing medical needs and continued monitoring requirements based on recent utilization and condition history.

AI-generated content – please review for accuracy.

STREICH, JULIO

Summarize

Member # : 3bc1db39-e4b3-19d0-075d-d939279ca716
MRN : 000575405380
DOB : 04/26/1953 (72)

Practice : Access Community Health
Match Status : HARD
Plan & LOB : Plan 4 - Medicare

Plan Eligibility Status : Active
Attributed PCP : Buckridge - Swaniawski
Hospice Utilization : N

Review Queue Population : 3
Review Queue Status : Needs Review

Chronic Conditions

Category ↑2	Detail ↑3	Impact ↑1
Cardiovascular	Congestive heart failure	HIGH
Renal	Chronic renal failure	HIGH
Renal	ESRD	HIGH

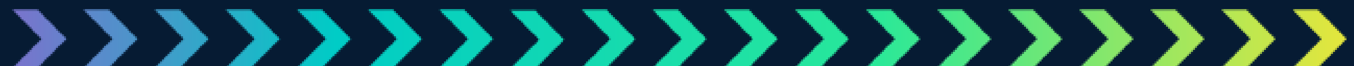
High Impact Areas

Area	Value	Area	Value
Avoidable IP	4	Primary Care Leakage	0
30 Day IP Readmissions	3	Network Leakage	130
Avoidable ED	7	RUB Score	5

Total Cost
$197.2k

N/A
STOP LOSS

Risk of Pred. Hospitalization : Medium



AI Smart Patient Summary | ACC

Home | Patients | Tasks | Reports | Care Coordination

Search ACM Patients...

STREICH, JULIO MRN:000575405380 | Plan: 1 Aetna (101116271300) | DOB: 4/26/53 (72) | M

English (617) 555-1212 No email

Summary | Plan | Clinical | Activity | Cost

NOTIFICATIONS

Upcoming Appointment	Brandes DO, Jeff	4/14/26 9:30 AM

CARE TEAM

Intervention Effort	Not Set
Care Manager	Unassigned
Usual Provider	Suzanne Stragand DO

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

AI Smart Patient Summary | ACC

Home | Patients | Tasks | Reports | Care Coordination

Search ACM Patients...

GA

STREICH, JULIO MRN:000575405380 | Plan: 1 Aetna (101116271300) | DOB: 4/26/53 (72) | M

English | (617) 555-1212 | No email

Smart Summary

This is a 72-year-old male patient with multiple chronic conditions including COPD, hypertension, coronary artery disease, kidney stones, and a history of smoking, with recent hospital discharge follow-ups and a care team including nurse practitioners, physician assistants, and specialists in pulmonary and family medicine.

1. The patient has no open or active outreach reasons and no outstanding outreaches required at this time.
2. There are no open actionable tasks currently assigned to the patient.
3. The patient's last appointment was a new patient visit with a pulmonary disease specialist on March 3, 2026. Upcoming appointments include a brief office visit with family medicine on April 14, 2026, and a follow-up appointment with pulmonary medicine on May 27, 2026. Recent hospital discharge follow-ups occurred on February 2 and February 17, 2026.
4. There are no documented social determinants of health noted for this patient.

AI-generated content — please review for accuracy

Summary | Plan | Clinical | Activity | Cost

NOTIFICATIONS

Upcoming Appointment	Brandes DO, Jeff	4/14/26 9:30 AM

CARE TEAM

Intervention Effort	Not Set
Care Manager	Unassigned
Usual Provider	Suzanne Stragand DO

AI Smart Patient Summary | *Plug-In*

Clark Kent High (18)

MRN: 1029384756

DOB: 4/14/1959 (67 yrs)

CM: Unassigned

PLAN: REACH ACO

ALERTS 8

RAF GAPS 4

REFERRALS

DOCUMENTS:

No documents available

Smart Summary

Unspecified Diagnoses: Psoriasis, unspecified (Feb2025); Chronic obstructive pulmonary disease, unspecified (Oct2025); Unspecified astigmatism, bilateral (Feb2025); Unspecified blepharitis left eye, unspecified eyelid (Dec2025); Unspecified blepharitis right eye, unspecified eyelid (Dec2025); Dental caries, unspecified (Feb2025); Consider re-evaluation of diagnoses to specify severity.

Undocumented HCC RAF Diagnoses: Respiratory failure, unspecified (May2025); Chronic obstructive pulmonary disease, unspecified (Oct2025); Morbid (severe) obesity due to excess calories (Jul2025); Other psoriatic arthropathy (Dec2025)

Lab Trends: A1c increased from 6.0 (Feb2025) to 8.8 (Mar2026)

Open Referrals: N/A

TOC Events: N/A

AI-generated content may be incorrect

Alert	Message	Date	Most Recent Result	Notes
A1c	Out of Range	3/16/26	8.8	
BP	Out of Range	3/16/26	146/87	
Colon CA 45+	Missing - Patient has plan data			
Drug Screen Controlled Substance	Missing			
Foot	Overdue	2/18/25	1	

Maternal Care

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Maternal Care PVP Alerts

Alert Administration

Create Alert

Search Alerts...

All | Enabled | Disabled

All | In POC Measure | Not in POC Measure

CATEGORY	NAME	PVP NAME	DESCRIPTION	OWNER
Screening	Maternal Care Screenings Incomplete	Maternal Care Screenings	Alert will trigger for patients that have at least one required screening with an incomplete status during the prenatal. Patients must have a record of a pregnancy episode with a start date before today, and end date after today. This alert is not configurable	
Screening	Postpartum Depression Screen	Depression Screen (Postpartum)	Alert will trigger if patient has not had a post-partum depression screening within 6 weeks after pregnancy end date. This alert is not configurable	
Screening	Postpartum Follow-Up Appointment	Postpartum Appointment	Alert will trigger for patients that do not have an appointment scheduled in the primary care or specialty service line during the postpartum period, from pregnancy end date to 12 weeks after. Patients must have a record of a pregnancy episode with an end date between tomorrow and up to 30 days after today. This alert is not configurable	
Well Visit	Prenatal Documentation	Prenatal	Alert will trigger if patient has been identified as pregnant but does not have initial visit trimester and location documented. This alert is not configurable	

Columns

Maternal Care & APO

Patient Outreach Administration

Global Campaign Status | Send Messages | Stop Messages

CAMPAIGNS | SCHEDULE SETTINGS

Search Campaigns...

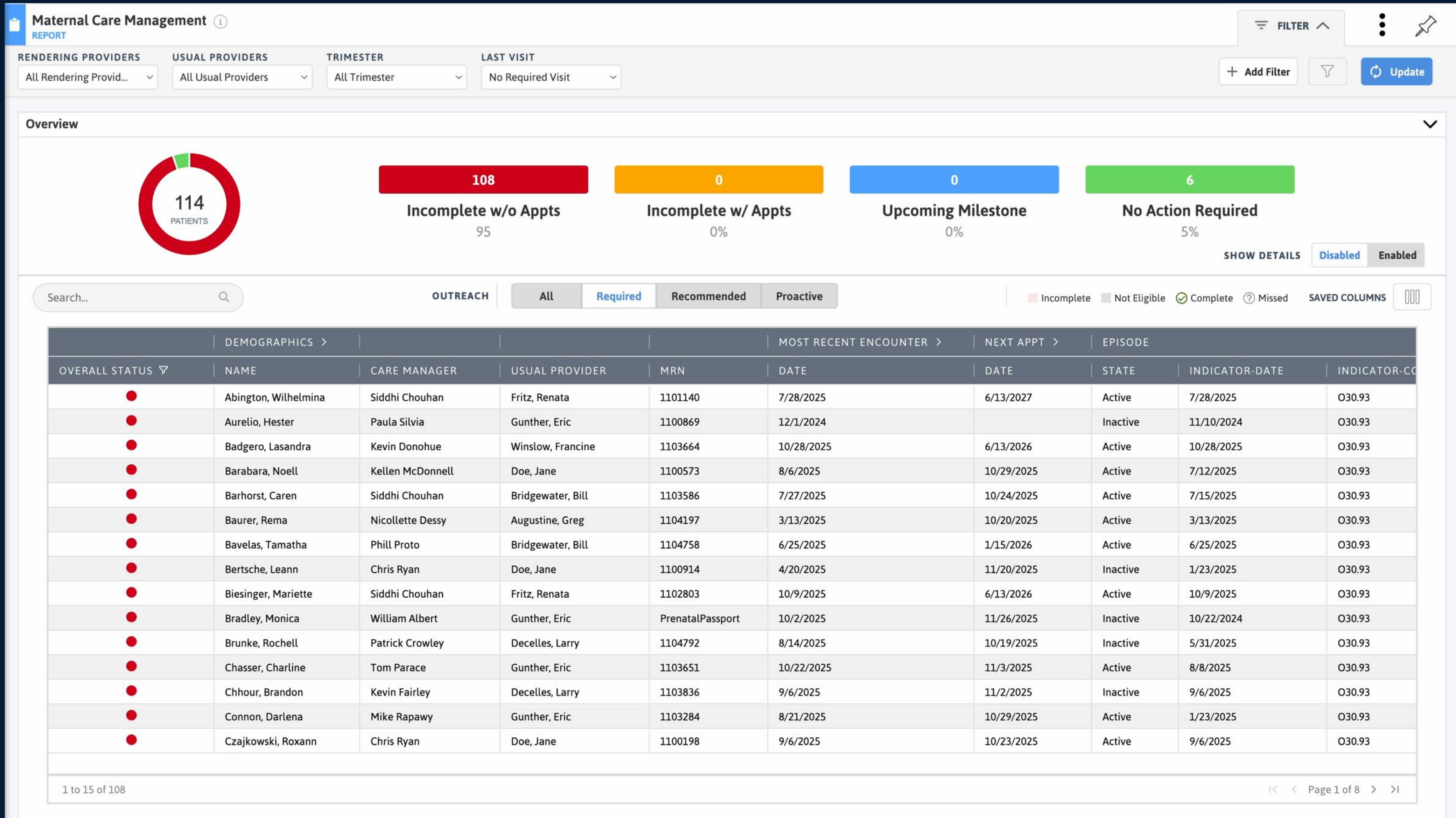
All | Enabled | Disabled

PRIORITY ORDER	CAMPAIGN	PROGRAM	PATIENTS ENTERED IN LAST 30 DAYS	EXITED IN LAST 30 DAYS	MESSAGES SENT IN LAST 30 DAYS	STATUS
41	Postpartum Follow-Up Appointment	Maternal Care	57	57	0	Enabled
42	Pregnant Patients Without Appointment	Maternal Care	4	4	0	Enabled
43	Prenatal No Show Appointments	Maternal Care	0	0	0	Enabled

Columns

Maternal Health Report

azara healthcare



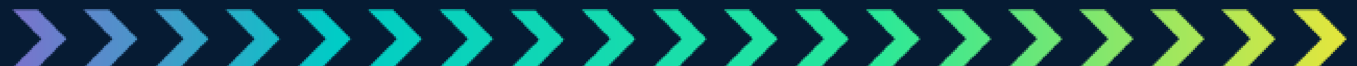
	DEMOGRAPHICS				MOST RECENT ENCOUNTER	NEXT APPT	EPISODE		
OVERALL STATUS	NAME	CARE MANAGER	USUAL PROVIDER	MRN	DATE	DATE	STATE	INDICATOR-DATE	INDICATOR-C
	Abington, Wilhelmina	Siddhi Chouhan	Fritz, Renata	1101140	7/28/2025	6/13/2027	Active	7/28/2025	O30.93
	Aurelio, Hester	Paula Silvia	Gunther, Eric	1100869	12/1/2024		Inactive	11/10/2024	O30.93
	Badgero, Lasandra	Kevin Donohue	Winslow, Francine	1103664	10/28/2025	6/13/2026	Active	10/28/2025	O30.93
	Barabara, Noell	Kellen McDonnell	Doe, Jane	1100573	8/6/2025	10/29/2025	Active	7/12/2025	O30.93
	Barhorst, Caren	Siddhi Chouhan	Bridgewater, Bill	1103586	7/27/2025	10/24/2025	Active	7/15/2025	O30.93
	Baurer, Rema	Nicollette Dessy	Augustine, Greg	1104197	3/13/2025	10/20/2025	Active	3/13/2025	O30.93
	Bavelas, Tamatha	Phill Proto	Bridgewater, Bill	1104758	6/25/2025	1/15/2026	Active	6/25/2025	O30.93
	Bertsche, Leann	Chris Ryan	Doe, Jane	1100914	4/20/2025	11/20/2025	Inactive	1/23/2025	O30.93
	Biesinger, Mariette	Siddhi Chouhan	Fritz, Renata	1102803	10/9/2025	6/13/2026	Active	10/9/2025	O30.93
	Bradley, Monica	William Albert	Gunther, Eric	PrenatalPassport	10/2/2025	11/26/2025	Inactive	10/22/2024	O30.93
	Brunke, Rochell	Patrick Crowley	Decelles, Larry	1104792	8/14/2025	10/19/2025	Inactive	5/31/2025	O30.93
	Chasser, Charline	Tom Parace	Gunther, Eric	1103651	10/22/2025	11/3/2025	Active	8/8/2025	O30.93
	Chhour, Brandon	Kevin Fairley	Decelles, Larry	1103836	9/6/2025	11/2/2025	Inactive	9/6/2025	O30.93
	Connon, Darlena	Mike Rapawy	Gunther, Eric	1103284	8/21/2025	10/29/2025	Active	1/23/2025	O30.93
	Czajkowski, Roxann	Chris Ryan	Doe, Jane	1100198	9/6/2025	10/23/2025	Active	9/6/2025	O30.93

DRVS Improvements

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

AMA MAP Blood Pressure Care Effectiveness Report 15

- **Actionable insights at the point of care**
  Designed to help care teams quickly identify patients at highest cardiovascular risk
- **Precision identification of uncontrolled hypertension**
  Flags patients with Stage 2 Hypertension, not being treated and without a scheduled follow-up
- **Equity-informed care delivery**
  Enables stratification by social determinants of health helping care teams identify and address disparities
- **Real-world impact**
  Already receiving accolades from users



Deeper Application Integration | *ACU & DRVS*

Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE

FILTER

PERIOD: TY March 2026
RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

70.9%
5.1%
TY 3/25

2,295 / 3,238
136 Exclusion(s)
943 Gaps **296** To Target

2026 FHN Targ...
80%

SELECTED	70.9%
Center Avg	70.9%
Network Avg	66.3%
Best Center	100.0%

TY 3/26 GROUP BY None

100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0%

TY 3/25, TY 5/25, TY 7/25, TY 9/25, TY 11/25, TY 1/26, TY 3/26

Comparison GROUP BY Patient Diagnosis

100.0%, 90.0%, 80.0%, 70.0%, 60.0%, 50.0%, 40.0%, 30.0%, 20.0%, 10.0%, 0.0%

Physiologica..., Severe Persi..., HIV Stage 3 ..., Glaucoma Dia..., Cirrhosis, Hemorrhagic..., Schizophrenia, HIV First Dx, Persistent A..., Bipolar Diso..., Bipolar Diag..., Coronary Art..., Ischemic Str..., Malignant De..., Coronary Art..., Moderate Per..., Diabetes Typ..., Ischemic Vas..., Cataract Age..., Arterioscler..., Diabetes (An..., Acute Myocar..., Hypothyroidism, Cirrhosis or..., Epilepsy (ac..., Severe Menta..., Prediabetes ..., Depression, Asthma, Hyperlipidemia, Immunocompro..., Prediabetes, Chronic Non-..., Anxiety, Cancer or Ma..., Chronic Obst..., Congestive H..., Post-traumat..., Osteoarthritis, Atrial Fibri..., Hypertension..., Hypertension..., Chronic K...

AND / OR Diagnosis Filter

Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE

FILTER

PERIOD: TY March 2026
RENDERING PROVIDERS: All Rendering Provid...
PATIENT DIAGNOSES: 2 selected (AND)

+ Add Filter | Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

70.9%
↑ 5.1%
TY 3/25
2026 FHN Targ...
80%
943

Include All (AND) | Include Any (OR)

Search

Clear Filters

- [x] Chronic Kidney Disease Stages 3 and 4
- [x] Diabetes Type I or Type II
- [ ] Actively Pregnant Patient
- [ ] Acute Myocardial Infarction
- [ ] Alcohol Disorder
- [ ] Alcohol/Substance Dependency
- [ ] Anxiety
- [ ] Arteriosclerosis/Cardiovascular Disease (ASCVD)
- [ ] Asthma
- [ ] Atrial Fibrillation/Flutter (ICD-9 codes)
- [ ] Attention-deficit hyperactivity disorders
- [ ] Autism Spectrum Disorders
- [ ] Bipolar Diagnosis
- [ ] Bipolar Disorder First Dx
- [ ] Cancer or Malignancy Active Diagnosis
- [ ] Cataract Age-Related
- [ ] Cerebral Palsy

TY 3/26

Comparison

GROUP BY: Patient Diagnosis

AND / OR Diagnosis Filter

Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE

FILTER

PERIOD	RENDERING PROVIDERS	PATIENT DIAGNOSES
TY March 2026	All Rendering Provid...	2 selected (AND)

Add Filter | Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

65.5%
0.2%
TY 3/25

76 / **116**
14 Exclusion(s)
40 Gaps **17** To Target

2026 FHN Targ...
80%

SELECTED	65.5%
Center Avg	65.5%
Network Avg	68.8%
Best Center	100.0%

TY 3/26 — GROUP BY: None

100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0%
TY 3/25, TY 5/25, TY 7/25, TY 9/25, TY 11/25, TY 1/26, TY 3/26

Comparison — GROUP BY: Patient Diagnosis

100.0%, 90.0%, 80.0%, 70.0%, 60.0%, 50.0%, 40.0%, 30.0%, 20.0%, 10.0%, 0.0%
Diabetes Typ... | Chronic Kidn...

AND / OR Diagnosis Filter

15

Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE

FILTER

PERIOD: TY March 2026
RENDERING PROVIDERS: All Rendering Provid...
PATIENT DIAGNOSES: 2 selected (OR)

Add Filter
Update

Include All (AND) | Include Any (OR)

Search

Clear Filters

- [x] Chronic Kidney Disease Stages 3 and 4
- [x] Diabetes Type I or Type II
- [ ] Actively Pregnant Patient
- [ ] Acute Myocardial Infarction
- [ ] Alcohol Disorder
- [ ] Alcohol/Substance Dependency
- [ ] Anxiety
- [ ] Arteriosclerosis/Cardiovascular Disease (ASCVD)
- [ ] Asthma
- [ ] Atrial Fibrillation/Flutter (ICD-9 codes)
- [ ] Attention-deficit hyperactivity disorders
- [ ] Autism Spectrum Disorders
- [ ] Bipolar Diagnosis
- [ ] Bipolar Disorder First Dx
- [ ] Cancer or Malignancy Active Diagnosis
- [ ] Cataract Age-Related
- [ ] Cerebral Palsy

MEASURE ANALYZER

65.5%
0.2%
TY 3/25

2026 FHN Targ...
80%

TY 3/26

100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0%

TY 3/25, TY 5/25, TY 7/25, TY 9/25, TY 11/25, TY 1/26, TY 3/26

DETAIL LIST

VALUE SETS

Comparison

GROUP BY: Patient Diagnosis

100.0%, 90.0%, 80.0%, 70.0%, 60.0%, 50.0%, 40.0%, 30.0%, 20.0%, 10.0%, 0.0%

Diabetes Typ...
Chronic Kidn...

AND / OR Diagnosis Filter

Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE

FILTER

PERIOD	RENDERING PROVIDERS	PATIENT DIAGNOSES
TY March 2026	All Rendering Provid...	2 selected (OR)

Add Filter | Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

75.4%
8.4%
TY 3/25

877 / **1,163**
63 Exclusion(s)
286 Gaps **54** To Target

2026 FHN Targ...
80%

SELECTED	75.4%
Center Avg	75.4%
Network Avg	66.7%
Best Center	88.1%

TY 3/26 — GROUP BY: None

100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0%

TY 3/25, TY 5/25, TY 7/25, TY 9/25, TY 11/25, TY 1/26, TY 3/26

Comparison — GROUP BY: Patient Diagnosis

100.0%, 90.0%, 80.0%, 70.0%, 60.0%, 50.0%, 40.0%, 30.0%, 20.0%, 10.0%, 0.0%

Diabetes Typ..., Chronic Kidn...

Patient Detail Performance Improvements

Hypertension Controlling High Blood Pressure (CMS165v12)
MEASURE

PERIOD: TY March 2026 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

MEASURE ANALYZER | DETAIL LIST | VALUE

Search Patients ... | Measure Investigation Tool | All | Gaps | Num | Excl | VIEW: Simple | Full

FILTER

- Export PDF
- Export Excel
- Export CSV
- Export QRDA III

CENTER NAME	MRN	NAME	SEX AT BIRTH	DATE OF BIRTH	NUMERATOR
Family Health Center	1103758	Locantore, Dane	M	7/5/2003	N
Family Health Center	1103759	Hallo, Sheba	M	2/5/1954	N
Family Health Center	1103760	Gudis, Shaina	F	12/6/1976	N
Family Health Center	1103765	Upadhyaya, Major	M	10/12/1948	N
Family Health Center	1103772	Buikema, Buck	M	3/12/1980	N

Patient Detail Performance Improvements

Hypertension Controlling High Blood Pressure (CMS165v12)
MEASURE

PERIOD: TY March 2026
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

MEASURE ANALYZER | DETAIL LIST | VALUE S

Search Patients ...

Measure Investigation Tool

All | Gaps | Num | Excl

VIEW: Simple | Full

		DEMOGRAPHICS >				USUAL		
CENTER NAME	MRN	NAME	SEX AT BIRTH	DATE OF BIRTH	MEDICAID-NUMBER	PROVIDER	LOCATION	INACTIVE
Family Health Center	1103758	Locantore, Dane	M	7/5/2003	9176791	Branchburg, Tom	FHC - Needs Update	N
Family Health Center	1103759	Hallo, Sheba	M	2/5/1954	6311320	House, Gregory	FHC - Needs Update	N
Family Health Center	1103760	Gudis, Shaina	F	12/6/1976	1055944	Cote, David	FHC - Needs Update	N
Family Health Center	1103765	Upadhyaya, Major	M	10/12/1948	5787061	Mejido, Daniel	FHC - Needs Update	N

FILTER

- Export Excel
  All Columns
- Export Excel
  Displayed Columns
- Export CSV
  All Columns
- Export CSV
  Displayed Columns
- Export QRDA III

Patient Detail Performance Improvements

Preferences

My Home Screen

Select the default view for your home screen. You can choose to display any of the options from the toggles below. If not set you will see the default selection chosen by your administrator.

Type: Default | **Scorecard** | Dashboard | PVP — UDS 2024 CQMs

DEMO Home Screen

Set a default home screen for this center or network. User can override this in their personal settings.

Type: **Default** | Scorecard | Dashboard — Scorecard: UDS 2024 CQMs

Details List

This setting applies only to patient-based measures. Simple View shows key columns for faster load times, while Full View displays all available columns. Azara recommends using 'Simple' as the default for optimal performance, with the option to switch to 'Full' at any time using the toggle in the Details List.

VIEW: **Simple** | Full

Cancel | Confirm

AI Summaries in the MIT

Hypertension Controlling High Blood Pressure (CMS165v12)
MEASURE

FILTER

Update

Hypertension Controlling High Blood Pressure (CMS165v12)

1102310 Search

Center: Access Community Health

Period: TY March 2026

Name: Willard Michalec

Sex at Birth: F

DOB: 2/6/1980 (46 years as of 3/31/2026)

Smart Summary

The patient is in the **exclusion** category because she has an **active pregnancy** during the measurement period, which excludes her from the hypertension controlling high blood pressure measure.

AI-generated content — please review for accuracy

Modify Prompt ▼

Patient Excluded

Age/Sex at Birth Criteria

AGE:	46 years at end of period
SEX:	F

Numerator (N)

VITALS

MULTIPLE BLOOD PRESSURE:	11/10/25 - 120/76 (Vitals)

Denominator (Y)

CHARGES DIAGNOSES ENCOUNTERS

HYPERTENSION ESSENTIAL FIRST DIAGNOSIS:	3/6/25 (I10 - Diagnosis)
NQF QUALIFYING ENCOUNTER:	5/23/25 (G0438 - Encounter)

Exclusion (Y)

Endorser: None
Steward: NCQA

Patients 18-85 years of age who had an active diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period and whose most recent blood pressure during the measurement period was adequately controlled (<140/90mmHg).

Numerator:

Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period*

- Most recent systolic blood pressure in measurement period < 140 mmHg
- Most recent diastolic blood pressure in measurement period < 90 mmHg

*If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." If multiple readings are taken on the same day, measure will look for the lowest diastolic and lowest systolic values from all readings. The Detail List includes a "Multiple BP" column that shows the lowest systolic and lowest diastolic readings. This means the final reported diastolic and systolic numbers may be a composite of values from different readings. For example, on reading of 150/95 and another of 135/100 would result in a reported value of 135/95.

Denominator:

Patients 18-85 years of age by the end of the measurement period who had a visit during the measurement period and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period.

Scorecard Enhancement | Multi-Month Select

User Conference 2026
REPORT

FILTER

PERIOD	CENTERS	RENDERING PROVIDERS
March 2026	All Centers	All Rendering Provid...

Add Filter | Update

REPORT | CARE GAPS

GROUPING: No Grouping | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: Scorecard

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Breast Cancer Screening Ages 50-74 (CMS 125v13)	57.2%	80.3%	4,457	7,786	333
Cervical Cancer Screening (CMS 124v13)	48.7%	79.2%	6,324	12,973	2,896
Colorectal Cancer Screening (CMS 130v13)	47.5%	72.8%	8,249	17,361	576

Scorecard Enhancement | Multi-Month Select

User Conference 2026 ⓘ
REPORT

FILTER

PERIOD: March 2026
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

Period options:
- Year
- Quarter
- **Month**
- Trailing Year

Months:
- [x] March 2026
- [ ] February 2026
- [ ] January 2026
- [ ] December 2025
- [ ] November 2025
- [ ] October 2025
- [ ] September 2025
- [ ] August 2025
- [ ] July 2025

...EPORT | CARE GAPS

TARGETS: Primary, Secondary, Not Met

REPORT FORMAT: Scorecard

	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
...3)	57.2%	80.3%	4,457	7,786	333
	48.7%	79.2%	6,324	12,973	2,896
Colorectal Cancer Screening (CMS 130v13)	47.5%	72.8%	8,249	17,361	576

Scorecard Enhancement | Multi-Month Select

User Conference 2026
REPORT

FILTER

PERIOD: 5 selected
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

Add Filter
Update

- Year
- Quarter
- Month
- Trailing Year

- [x] March 2026
- [x] February 2026
- [x] January 2026
- [x] December 2025
- [x] November 2025
- [ ] October 2025
- [ ] September 2025
- [ ] August 2025
- [ ] July 2025

EPORT
CARE GAPS

TARGETS: Primary, Secondary, Not Met

REPORT FORMAT: Scorecard

	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
3)	57.2%	80.3%	4,457	7,786	333
	48.7%	79.2%	6,324	12,973	2,896
Colorectal Cancer Screening (CMS 130v13)	47.5%	72.8%	8,249	17,361	576

Scorecard Enhancement | Multi-Month Select

User Conference 2026
REPORT

FILTER

PERIOD: 5 selected | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

REPORT | CARE GAPS

GROUPING: No Grouping | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: Scorecard

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Breast Cancer Screening Ages 50-74 (CMS 125v13)	53.4%	80.3%	11,314	21,201	643
Cervical Cancer Screening (CMS 124v13)	45.5%	79.2%	16,629	36,532	7,110
Colorectal Cancer Screening (CMS 130v13)	43.8%	72.8%	21,297	48,649	1,187

Population Definition & Curation

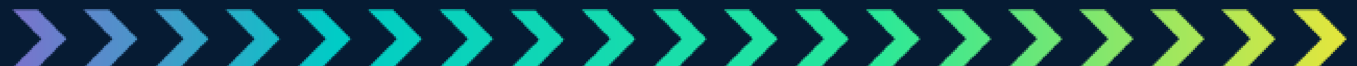
azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Patient Cohort

- A patient cohort is a specific group of individuals sharing common characteristics—such as a disease, exposure to a treatment, or demographic factors—who are tracked over time for medical research or analysis.

- They are used in observational studies to examine disease development, assess treatment outcomes, and drive evidence-based care.

- Usage Examples
  - **Disease Management**: Tracking patients with diabetes to monitor long-term outcomes.
  - Clinical Trials: Selecting a specific group, such as pregnant women or children under 5, to receive a new treatment.
  - **Epidemiology**: Following a group over time to determine the incidence of a disease.
  - **Quality Improvement**: Analyzing high-cost patients to improve efficiency and reduce costs.

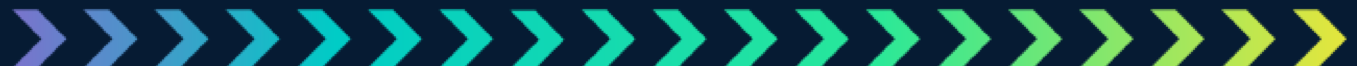


Examples of Cohorts in DRVS

- Measures and the associated patient details
- Visit Planning Alerts
- Care Effectiveness Reporting (CER)
- Patients under Care Management
- Patients requiring outreach and engagement
- Patient Outreach Campaigns
- Filters (on the Measure Analyzer)
- Registries

Population Definition

- Customizable definition of patient populations
  - Dynamic cohorts on steroids
- Use to create new cohorts for purposes of
  - Filtering DRVS measures
  - Serving as the ‘data source’ for registries
  - The ‘data source’ for patient fed to ACC for Care Management and / our Care Coordination
  - The ‘
- Aligning this population definition capability with the architecture Azara will be using to define alerts, build APO campaigns, define and pass populations to ACC



New Registry Builder

Create Registry

Cancel | Save

GENERAL

NAME: Greg User Conference 2026 Registry

CENTER: Brevard Health Alliance

DESCRIPTION: This registry was created to demonstrate the new Registry Builder functionality at the 2026 Azara User Conference.

Special thanks - and appreciate snacks and such - owed to the Product & Engineering Teams.

ACCESS SETTINGS: Brevard Health Alliance

STATUS: Enabled | Disabled

POPULATION DEFINITION

+ Create New Population Definition

POPULATION DEFINITION: Select an existing population | Edit

No Population Definition Selected

DATA ELEMENTS

Select from the options below, double click to add from the left or double click from the right to remove.

TITLE: Search

SELECTED

CATEGORIES	OPTIONS
All	Actively Pregnant Patient
Claim	Bacterial Infection
Demographics	Care Plan
Dental	Developmental Screening
Diabetes	Measles IgG Antibody presence
Diagnosis	Microalbumin in Urine
Encounter	SARS-COV-2 (COVID-19) Vaccine Booster Dose
Immunization	Tobacco Cessation Counseling
Incarceration	Tobacco Interest to Quit
Lab	

New Registry Builder

Edit Population

GENERAL | RULES AND CRITERIA

CENTER
Brevard Health Alliance

NAME*
User Conf 2026 Demo

DESCRIPTION*

DESCRIPTION*
Pts with out of control DM, out of control HTN and no CKD diagnosed.

Cancel | Confirm

New Registry Builder

Edit Population

GENERAL | **RULES AND CRITERIA**

The information entered here will determine the rules and criteria for including or excluding patients from this population.

TYPE

Select Type

Add Rule

INCLUDE ALL

Measure	DM A1C OR GMI > 9 OR UNTESTED (CMS 122V14): Numerator HTN CONTROLLING HIGH BP (CMS 165V14): Gap	Patient is in the **numerator** of the **DM A1c or GMI > 9 or Untested (CMS 122v14)** CQM measure **Anytime AND** Patient is in the **gap** of the **HTN Controlling High BP (CMS 165v14)** CQM measure **Anytime**
		AND
Demographics	AGE: Less than or equal to 120 Years	Patient is less than **120 Year(s) Old**

EXCLUDE ANY

Diagnosis	CHRONIC KIDNEY DISEASE STAGES 3 AND 4: Anytime CHRONIC KIDNEY DISEASE, STAGE 5: Anytime	Patient has a diagnosis of **Chronic Kidney Disease Stages 3 and 4 Anytime** **OR** Patient has a diagnosis of **Chronic Kidney Disease, Stage 5 Anytime**

Cancel | Confirm

New Registry Builder

Create Registry

Cancel Save

GENERAL

NAME
Greg User Conference 2026 Registry

CENTER
Brevard Health Alliance

DESCRIPTION
This registry was created to demonstrate the new Registry Builder functionality at the 2026 Azara User Conference.

Special thanks - and appreciate snacks and such - owed to the Product & Engineering Teams.

ACCESS SETTINGS
Brevard Health Alliance

STATUS Enabled Disabled

POPULATION DEFINITION

+ Create New Population Definition

POPULATION DEFINITION
User Conf 2026 Demo — Edit

POPULATION DESCRIPTION
Pts with out of control DM, out of control HTN and no CKD diagnosed.

POPULATION CRITERIA RULES SUMMARY

INCLUDE ALL

Patient is in the **numerator** of the **DM A1c or GMI > 9 or Untested (CMS 122v14)** CQM measure **Anytime**
AND Patient is in the **gap** of the **HTN Controlling High BP (CMS 165v14)** CQM measure **Anytime**

AND

Patient is less than **120 Year(s) Old**

AND

EXCLUDE ANY

Patient has a diagnosis of **Chronic Kidney Disease Stages 3 and 4 Anytime**
OR Patient has a diagnosis of **Chronic Kidney Disease, Stage 5 Anytime**

DATA ELEMENTS

Select from the options below, double click to add from the left or double click from the right to remove.

TITLE
Search

CATEGORIES
- Demographics
- Dental
- Diabetes
- Diagnosis
- Encounter
- Immunization
- Incarceration
- Lab
- Laboratory
- Medication

OPTIONS
- In Person Encounter
- Medicare Annual Well Visit
- Missed Appointment Rate
- Next Appointment Time
- Next Appointment Type
- Next Behavioral Health Appointment
- Next Dental Appointment
- Next Dental Appointment Type
- Next Primary Care Appointment
- Next Primary Care Appointment Type

SELECTED
- Medical Record Number
- Age
- Transportation
- Transportation Services
- SDOH Transportation Intervention
- Numeric A1c
- Blood Pressure
- Estimated Glomerular Filtration Rate (eGFR) Result
- 2nd Estimated Glomerular Filtration Rate (eGFR) Result
- Next Appointment

Example #2

Edit Population

GENERAL | RULES AND CRITERIA

The information entered here will determine the rules and criteria for including or excluding patients from this population.

TYPE
Select Type

Add Rule

INCLUDE ALL

Demographics	POVERTY LEVEL HHS: 4 selected AGE: Less than or equal to 120 Years	Patient Poverty Level HHS is **100% and below, 101-138%, 139-150%,** or **151-200%** **AND** Patient is less than **120 Year(s) Old**

INCLUDE ANY

Medication	INSULIN MEDICATION EPINEPHRINE AUTO-INJECTION RX	Patient has been prescribed **Insulin Medication** **OR** Patient has been prescribed **Epinephrine Auto-Injection Rx**

EXCLUDE ALL

Primary Payer	Medicaid 87 selected	Patient primary payer is one of the **87** selected **Medicaid** payers

Cancel | Confirm

Example #3

Edit Population

GENERAL | RULES AND CRITERIA

The information entered here will determine the rules and criteria for including or excluding patients from this population.

TYPE
Select Type

Add Rule

INCLUDE ALL

Demographics	AGE: Less than or equal to · 120 · Years	Patient is less than **120 Year(s) Old**

INCLUDE ANY

Measure	HTN >=140/90 AND NO MEDICATION: Numerator HTN >=140/90 ON MONOTHERAPY: Numerator	Patient is in the **numerator** of the **HTN >=140/90 and No Medication** CQM measure **Anytime** **OR** Patient is in the **numerator** of the **HTN >=140/90 on Monotherapy** CQM measure **Anytime**

Cancel | Confirm

Results Curated for Your Population

NAME	# OF PATIENTS
340B Epi & Insulin not Medicaid	463
ConferMed	662

Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE

PERIOD: TY March 2026
RENDERING PROVIDERS: All Rendering Provid...
COHORTS: All Cohorts

MEASURE ANALYZER

70.3%
4.5%
TY 3/25

2,265 / 3,224
133 Exclusion(s)
959 Gaps 315 To Target

2026 FHN Targ...
80%

SELECTED
Center Avg
Network Avg
Best Center

Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE

PERIOD: TY March 2026
RENDERING PROVIDERS: All Rendering Provid...
COHORTS: 340B Epi & Insulin n...

MEASURE ANALYZER

78.0%

149 / 191
15 Exclusion(s)
42 Gaps 4 To Target

Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE

PERIOD: TY March 2026
RENDERING PROVIDERS: All Rendering Provid...
COHORTS: ConferMed

MEASURE ANALYZER

11.3%

70 / 617
2 Exclusion(s)
547 Gaps 424 To Target

Application Integration

azara2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Azara's Solution Suite

EHR Plug-in

Value-Based Care Reporting & Payer Data Exchange

Azara Care Connect

Azara Patient Outreach

Azara Cost and Utilization

Risk Stratification

Referral Management

HIV & HEP C

Transitions of Care

Substance Use

Patient Surveys

OB, Family Planning, & Title X

Dental

Clinical Quality Measurement

Normalized & Validated Data

Registry Reporting

Dashboard & Performance Trending

Patient Visit Planning

Centralized Reporting & Analytics

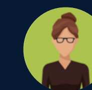
DRVS

Azara DRVS is an AI/ML-enhanced centralized data reporting and analytics solution that facilitates care transformation, drives quality improvement, aids in cost reduction and simplifies mandated reporting

Key Features & Functionality

Feature	Description
Centralized Reporting & Analytics	▪ Comprehensive reporting with multi-level drill down capabilities from network-level to patient detail
Dashboards & Performance Trending	▪ Provide insight into UDS, HEDIS, managed care contracts and other clinical quality initiatives
Normalized & Validated Data	▪ Ensure accurate benchmarking, comparative analytics, best practices and adoption monitoring
Health Equity	▪ Visualize and compare disease burden and SDoH thru a population lens
Patient Visit Planning	▪ Identify care gaps and provide critical data at the point of care, in advance of patient visits
Clinical Quality Measurement	▪ Evaluate clinical data with a comprehensive library of clinical quality measures (CQMs)
Registry Reporting	▪ Track specific populations of patients by chronic disease, co-morbidities and/or health disparities

Provider



Care Coordinator

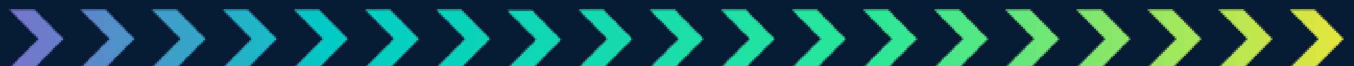
Chief Medical Officer

VBC / Payer Relations

Clinical Quality Director

Deeper Application Integration

- ACU and DRVS
  - It has always been possible to see current progress against quality metrics and targets which are a part of your VBC contracts
  - Now it is possible to view VBC cost details and trends calculcated by ACU on DRVS Dashboards
- DRVS and ACU
  - Review and filter ACU results by matched vs unmatched members
  - Review and filter by SDOH in ACU
- APO and ACC
  - Outreaches made via text and APO are now visible in the Care Coordination Outreach Log
  - Have had a tab available in ACC to view all texts sent via APO but could not easily tied these to initiatives to close care gaps
- ACU and ACC
  - Review the ACU Member Profile inside of ACC Care Management
- Pass candidates for Care Management from the ACU Member Review Queue to ACC for Triage



Deeper Application Integration | *ACU & DRVS*

Test - ACU Measures
DASHBOARD

FILTER

PERIOD: June 2025
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

Add Filter
Update

PMPM

$522

PRIMARY 500

PMPM Over Time

$592
$576
$540
$504
$468
$432
$412

Jun 24 $479
Jul 24 $476
Aug 24 $481
Sep 24 $496
Oct 24 $500
Nov 24 $497
Dec 24 $486
Jan 25 $512
Feb 25 $514
Mar 25 $536
Apr 25 $537
May 25 $474
Jun 25 $522

ED Visits/1k

19.35%

PRIMARY 18%

ED Visits/1k Over Time

27%
26%
24%
22%
20%
18%
17%

Jun 24 20.56%
Jul 24 21.04%
Aug 24 21.45%
Sep 24 21.97%
Oct 24 22.35%
Nov 24 22.57%
Dec 24 22.65%
Jan 25 21.29%
Feb 25 20.84%
Mar 25 20.68%
Apr 25 21.04%
May 25 20.30%
Jun 25 19.35%

Member Months

129,442

Member Months Over Time

148,402
136,889
125,376
113,863
102,350
90,837

Jun 24 110,168
Jul 24 111,239
Aug 24 112,315
Sep 24 108,179
Oct 24 111,426
Nov 24 111,914
Dec 24 105,677
Jan 25 124,665
Feb 25 130,211
Mar 25 134,908
Apr 25 132,062
May 25 130,292
Jun 25 129,442

IP Admits/1k

5.29%

PRIMARY 8%

IP Admits/1k Over Time

9%
8%
7%
6%
5%
4%

Jun 24 5.95%
Jul 24 6.21%
Aug 24 6.40%
Sep 24 6.52%
Oct 24 6.51%
Nov 24 6.59%
Dec 24 6.47%
Jan 25 6.06%
Feb 25 5.90%
Mar 25 6.01%
Apr 25 5.97%
May 25 5.67%
Jun 25 5.29%

Deeper Application Integration | *DRVS & ACU*

Executive Dashboard

CY 2025 | Filters 2 | Update

Fidelis ⊗ Medicaid ⊗

Med Claim Status: Sufficient, Semi-Sufficient, Insufficient, Not Loaded

Cost Per Member Per Month

Target: $370

$337 ▼$54

Emergency Utilization

ED Visits/1K	Avoidable ED Visits	ED Cost/Visit
542 ▼6%	67% ▲1%	$536 ▲$22

VISITS/1K | AVOIDABLE ED VISITS | COST/VISIT

Member Months

644k ▼36.9k

10/25: 52,793

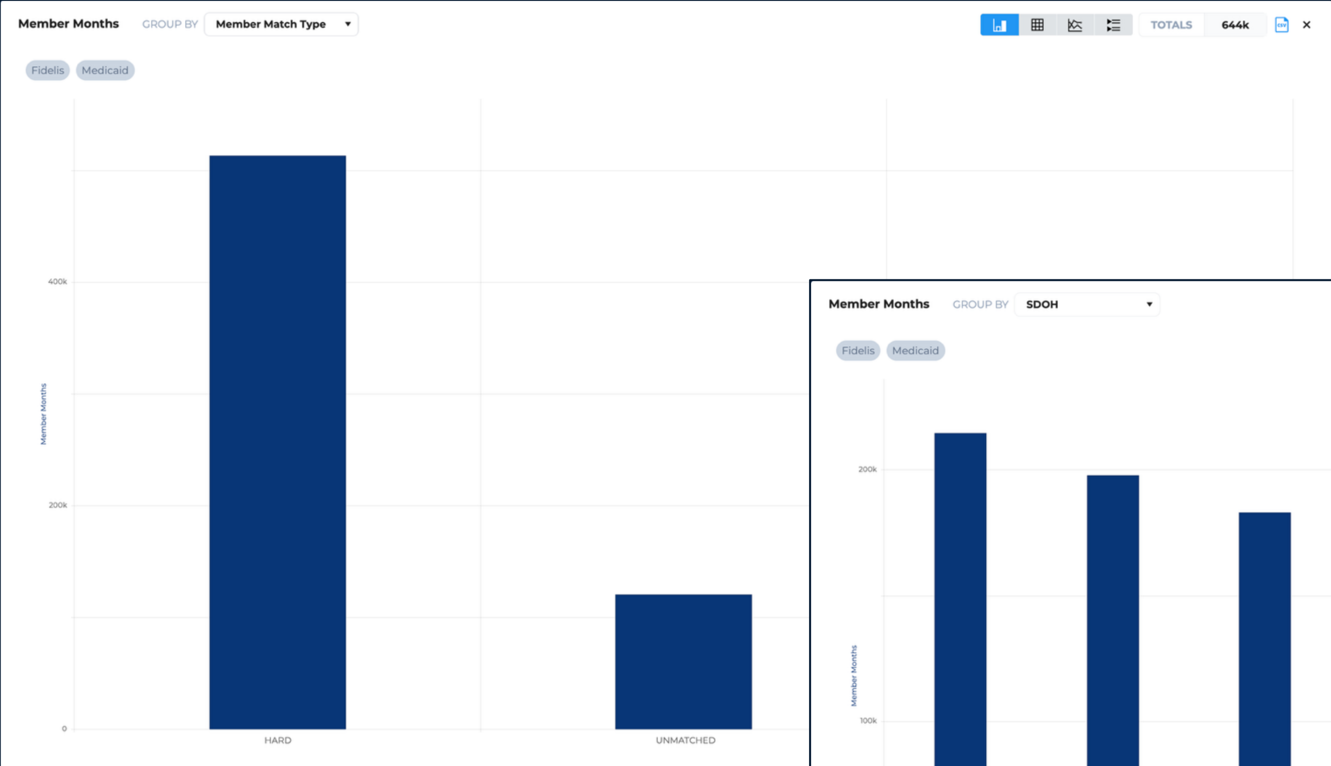
Inpatient Utilization

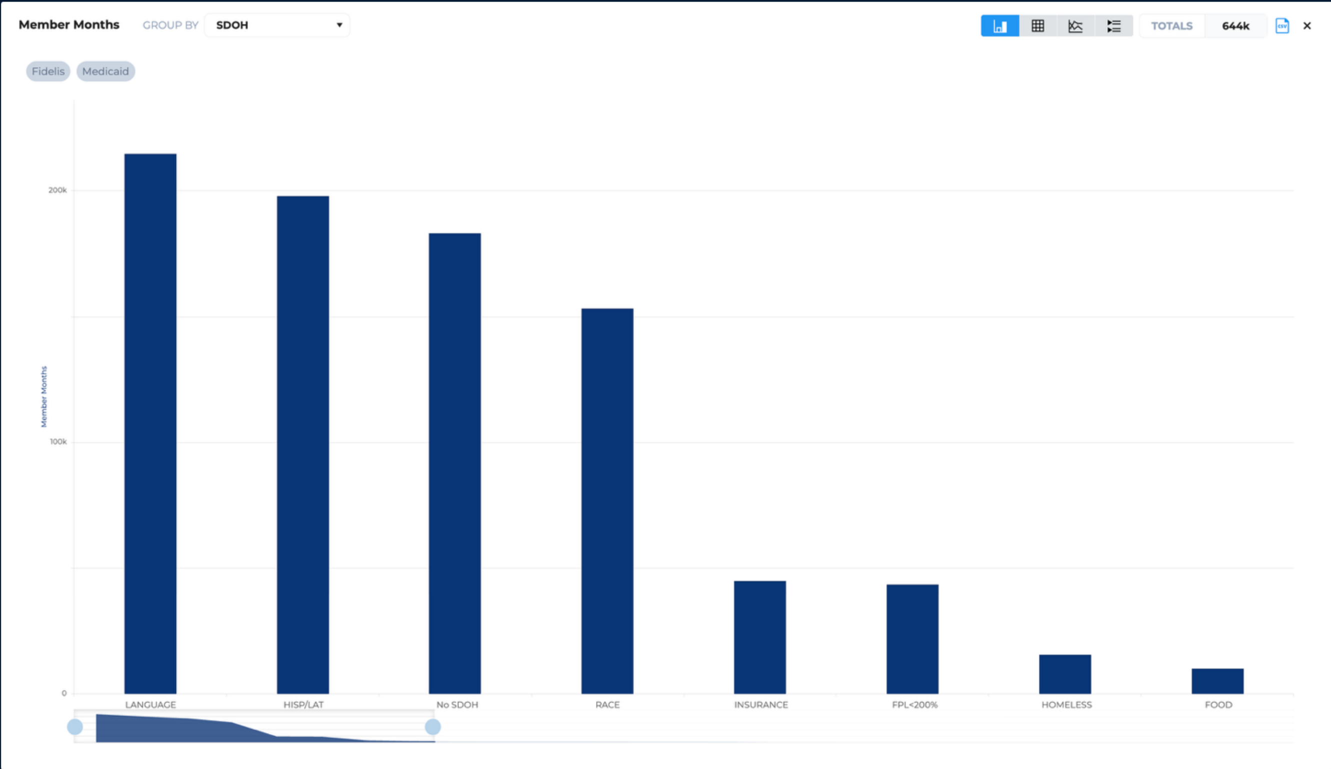
IP Admits/1K	Avoidable IP Admits	IP Cost/Admit
74 ▼28%	20% ▲2%	$13k ▼$1.7k

ADMITS/1K | AVOIDABLE IP ADMITS | COST/ADMIT

Resource Utilization Bands (RUBs)

Filter by Match Type and SDOH From DRVS





Deeper Application Integration | *APO & ACC*

Deeper Application Integration | *ACU & ACC*

Home | Patients | Tasks | Reports ▾ | Care Coordination ▾ | Search ACM Patients... | GA

STREICH, JULIO MRN:000575405380 | Plan: 1 Aetna (101116271300) | DOB: 4/26/53 (72) | M ☆

English | (617) 555-1212 | No email

Summary | Plan | Clinical | Activity | Cost

STREICH, JULIO

Summarize

Member # : 3bc1db39-e4b3-19d0-075d-d939279ca716
MRN : 000575405380
DOB : 04/26/1953 (72)

Practice : Access Community Health
Match Status : HARD
Plan & LOB : Plan 4 - Medicare

Plan Eligibility Status : Active
Attributed PCP : Buckridge - Swaniawski
Hospice Utilization : N

Review Queue Population : 3
Review Queue Status : Needs Review

Chronic Conditions

Category ↑2	Detail ↑3	Impact ↑1
Cardiovascular	Congestive heart failure	HIGH
Renal	Chronic renal failure	HIGH
Renal	ESRD	HIGH

High Impact Areas

Area	Value	Area	Value
Avoidable IP	4	Primary Care Leakage	0
30 Day IP Readmissions	3	Network Leakage	130
Avoidable ED	7	RUB Score	5

Total Cost **$197.2k**

N/A STOP LOSS

Risk of Pred. Hospitalization : Medium

Utilization Over Time

$ | #

	10/24	11/24	12/24	01/25	02/25	03/25	04/25	05/25	06/25	07/25	08/25	09/25	Total	% Of Total
Inpatient		$14,045	$17,587	$9,536	$9,651				$37,343			$27,432	$115,593	59%
Emergency Department	$1,843	$3,742	$193	$1,456	$2,098	$935		$3,769	$3,869	$2,153		$6,733	$26,790	14%
Pharmacy	$45	$80	$718										$843	0%
Outpatient	$782	$567		$277	$202			$155	$142	$580		$184	$2,888	1%

Deeper Application Integration | *ACU & ACC*

Member Review

Oct 2024 - Sep 2025 | Filters 0 | Update

78 Members | Needs Review 70 | Pending Engagement 3 | Engaged 2 | Not Engaged 3

Mark as Needs Review (0) | Mark as Pending Engagement (0) | Mark as Not Engaged (0)

All | Needs Review | Pending Engagement | Engaged | Not Engaged

Status	Sub Status	Status Date	Population	Member Name	Alerts	Plan	LOB	Age	RUB	Chronic Cond.	Eps.	ED Eps.	IP Eps.	Rx Cost	Total Cost
	No Action Needed	01/06/2026	High Cost	BAILEY, DELORES	0	Centene	Medicaid	58	4	1	105	0	0	$9,192.62	$11,023.42
	No Action Needed	01/06/2026	High Cost	KING, C											
	No Action Needed	01/06/2026	High Cost	FAHEY,											
	Graduated from CM	01/05/2026	High Cost	HEIDEN											
	Enrolled in CM	01/06/2026	2	GREEN											

OUTREACH REASONS (7) — All | Open | Complete — Selected 0 | Attempted | Connected

REASON DETAILS	LAST OUTREACH	OUTREACHES	REPORTED	STATUS
Triage 3				
High Cost ($144K)		0	11/19/25	Open
High ED Utilization (1)		0	11/19/25	Open
High IP Utilization (5)		0	11/19/25	Open
HEDIS 4				

+ Add Reason

Rural Health Transformation

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Sample State RHTP Initiatives

1. Growing Care Coordination: Medical Operations Coordination Center (MOCC) and Alternate Payment Model Feasibility Study
2. Growing Community Connections through Indiana 211
3. Growing Improved Patient Outcomes Through Enhanced Interoperability and Technology
4. Growing Pediatric & Obstetric Readiness in Rural Emergency Departments
5. Growing Cardiometabolic Health Standards of Care in Rural Indiana
6. Growing Access to Hospital Post-Discharge Medications
7. Growing Specialty Provider Access through Expanded Teleconsult Capabilities
8. Growing Telehealth Access and Infrastructure
9. Growing our Rural Health Paraprofessional Workforce
10. Growing Clinical Training and Readiness
11. Growing our Rural Behavioral Health Workforce
12. Growing Rural Opportunities for Well-being (GROW) Regional Grants

Typical Organizations & Users

Today typically find there are three (3) typical 'types' of organizations using our solutions

Type of Organization	Retrospective Aggregate Monitoring & Mgmt	Point of Care
Public Entity (e.g., Dept of Health)	X	
Network Entity (e.g., PCA, BH Council, etc.)	X	
Individual Practices	X	X

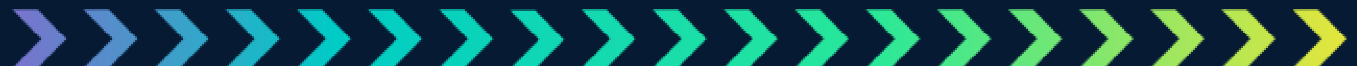
- Point of Care Users are found across all 'care' settings:
  - Primary Care Clinical Teams (Providers, Nurses, MAs, Front Desk, etc.)
  - BH Care Teams
  - Dental Care Teams
  - Patient Outreach & Engagement Specialists
  - Care Managers
  - Care Coordinators

Making Data Accurate, Timely and Actionable

15

- Source data from the EHRs of individual practices which we marry up to additional data from Health Plans, HIEs (including IHIE) and Health Plans
  - We are in the process of connecting to one of national laboratory vendors
- Support more than 50 million patients in out platform across more than 1000 entities
- In <State>, 28 of the 43 FQHCs are on the Azara platform
  - Some of which are also a CMHC / CCBHC
- More than 1M patients with visits in past 3 years

- Sounds a bit cliched, but for Azara it really is about taking this data and making it actionable
  - Sharing it across care settings and dimensions
  - Promoting efficiency
  - Curating the data to for ease of use and understanding
  - Embedding data in the workflow



Predominant Conditions Dashboard

azara healthcare

Predominant Conditions
DASHBOARD

FILTER

PERIOD: TY March 2026
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

Primary Care Encounters in Period

550,089
Count of Pts with Primary Care Encounter in period

Predominant Conditions

PATIENT DIAGNOSES	NUM	% TOTAL
Anxiety	129,124	8.1%
Hypertension (all types)	127,952	8.0%
Hypertension - Essential	126,459	7.9%
Hyperlipidemia	116,765	7.3%
Depression	106,652	6.7%
Severe Mental Illness and Psychosis	89,109	5.6%
Severe Emotional Disturbance (SED)	67,205	4.2%
Diabetes Type I or Type II	65,074	4.1%
Prediabetes First Dx	58,784	3.7%
Asthma	52,929	3.3%
Chronic Non-malignant Pain	46,097	2.9%
Prediabetes	44,557	2.8%
Attention-deficit hyperactivity disorders	41,232	2.6%
Diabetes (Any Type) With Complications	31,912	2.0%
Hypothyroidism	25,836	1.6%
Alcohol/Substance Dependency	25,372	1.6%
Osteoarthritis	23,898	1.5%
Post-traumatic stress disorder (PTSD)	21,213	1.3%
Chronic Obstructive Pulmonary Disease (COPD)	19,813	1.2%
Cirrhosis or other liver disease	19,742	1.2%

Predom Cond based on Primary Care Visits

PATIENT DIAGNOSES	NUM	% TOTAL
Actively Pregnant Patient	6,654	0.4%
Acute Myocardial Infarction	885	0.1%
Alcohol Disorder	12,247	0.8%
Alcohol/Substance Dependency	25,372	1.6%
Anxiety	129,124	8.1%
Arteriosclerosis/Cardiovascular Disease (ASCVD)	18,341	1.1%
Asthma	52,929	3.3%
Atrial Fibrillation/Flutter (ICD-9 codes)	5,691	0.4%
Attention-deficit hyperactivity disorders	41,232	2.6%

Ethnicity

ETHNICITIES	NUM	% TOTAL
Another Hispanic, Latino/a, or Spanish Origin	51,536	9.4%
Cuban	173	0.0%
Hispanic, Latino/a, or Spanish Origin Combined	25,931	4.7%
Mexican, Mexican American, Chicano/a	10,519	1.9%
Not Hispanic, Latino/a, or Spanish Origin	366,887	66.7%
Puerto Rican	709	0.1%
Unmapped	31	0.0%

Risk Distribution

Low | Moderate | High

Azara Risk Stratification

azara healthcare

Patient Risk Stratification
DASHBOARD

FILTER

PERIOD	CENTERS	RENDERING PROVIDERS	SERVICE LINES
TY March 2026	All Centers	All Rendering Provid...	Primary Care

Add Filter · Update

Risk Criteria Weighting

DIAGNOSES	PATIENT COUNT	PREVALENCE	% HIGH RISK	POINTS
Diabetes	64,944	12%	24%	3
Hypertension	127,599	23%	17%	2
Hyperlipidemia	116,484	21%	15%	1
ASCVD	18,278	3%	35%	1
CHF	8,869	2%	43%	2
CAD	12,629	2%	39%	2
Ischemic Stroke	3,848	1%	35%	1
Hemorrhagic Stroke	520	0%	27%	1
IVD	15,225	3%	36%	1
Afib	5,673	1%	40%	3
Persistent Asthma	15,963	3%	30%	3
COPD	19,766	4%	29%	1
Chronic NonMalignant Pain	45,774	8%	20%	1
Cirrhosis	19,686	4%	26%	2
CKD Stages 3&4	9,011	2%	25%	1
CKD Stage 5	523	0%	39%	1
ESRD	938	0%	36%	1
HIV	1,662	0%	28%	3
Chronic Hepatitis C	3,946	1%	36%	1
Cerebral Palsy	1,142	0%	16%	1
Physiological Developmental Delay	13,408	2%	13%	2
Newborn Extreme Immaturity	1,088	0%	4%	1
Sickle Cell Disease	481	0%	19%	3

Risk Category Distribution

High Risk Patients

41,260
Pts w/ qualifying encounter

Total Patients

548,806
Pts w/ qualifying encounter

Risk Score Distribution

Risk Score Thresholds

CATEGORY	# PATIENTS	PREVALENCE	THRESHOLD
Geriatric (65-149)			
High	4,239	8%	17.00
Moderate	9,321	18%	12.00
Low	37,279	73%	0
Adult (22-64)			
High	19,865	7%	15.00
Moderate	56,598	21%	9.00
Low	195,461	72%	0
Pediatric (0-21)			
High	17,448	8%	7.00
Moderate	35,449	16%	4.00
Low	173,763	77%	0

Rising Risk Patients

2,853
Pts w/ New High Risk Level

Hypertension Dashboard

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AMA MAP™ Hypertension
DASHBOARD

FILTER

PERIOD: TY March 2026 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

Hypertension Control

63.8%
% HTN Pts with BP <140/90
PRIMARY 70%
SECONDARY 60%
+0.4%
TY 2/26

AMA MAP™ Confirmatory BP

40%
Result
PRIMARY 70%
SECONDARY 60%
0%
TY 2/26

AMA MAP™ Med Intensification

44%
Result
PRIMARY 30%
SECONDARY 20%
0%
TY 2/26

AMA MAP™ Hypertension Scorecard

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
HTN Controlling High BP (CMS 165v13)	63.8%	68,816	107,914	6,246	39,098	21,293
Improvement in Blood Pressure	31.8%	5,921	18,608	499	12,687	
AMA MAP Confirm BP	40.2%	80,166	199,514	0	119,348	
AMA MAP Med Intens.	43.8%	35,652	81,417	4,412	45,765	
AMA MAP Follow-up	28.4%	47,096	165,928	8,304	118,832	
AMA MAP SBP Reduction	61.2%	14,159	23,117	910	8,958	

Hypertension Improvement

Hypertension Improvement

32%
% HTN w/ BP Improvement
-1%
TY 2/26

AMA MAP™ Follow-up

28%
Result
PRIMARY 50%
SECONDARY 40%
0%
TY 2/26

AMA MAP™ SBP Reduction

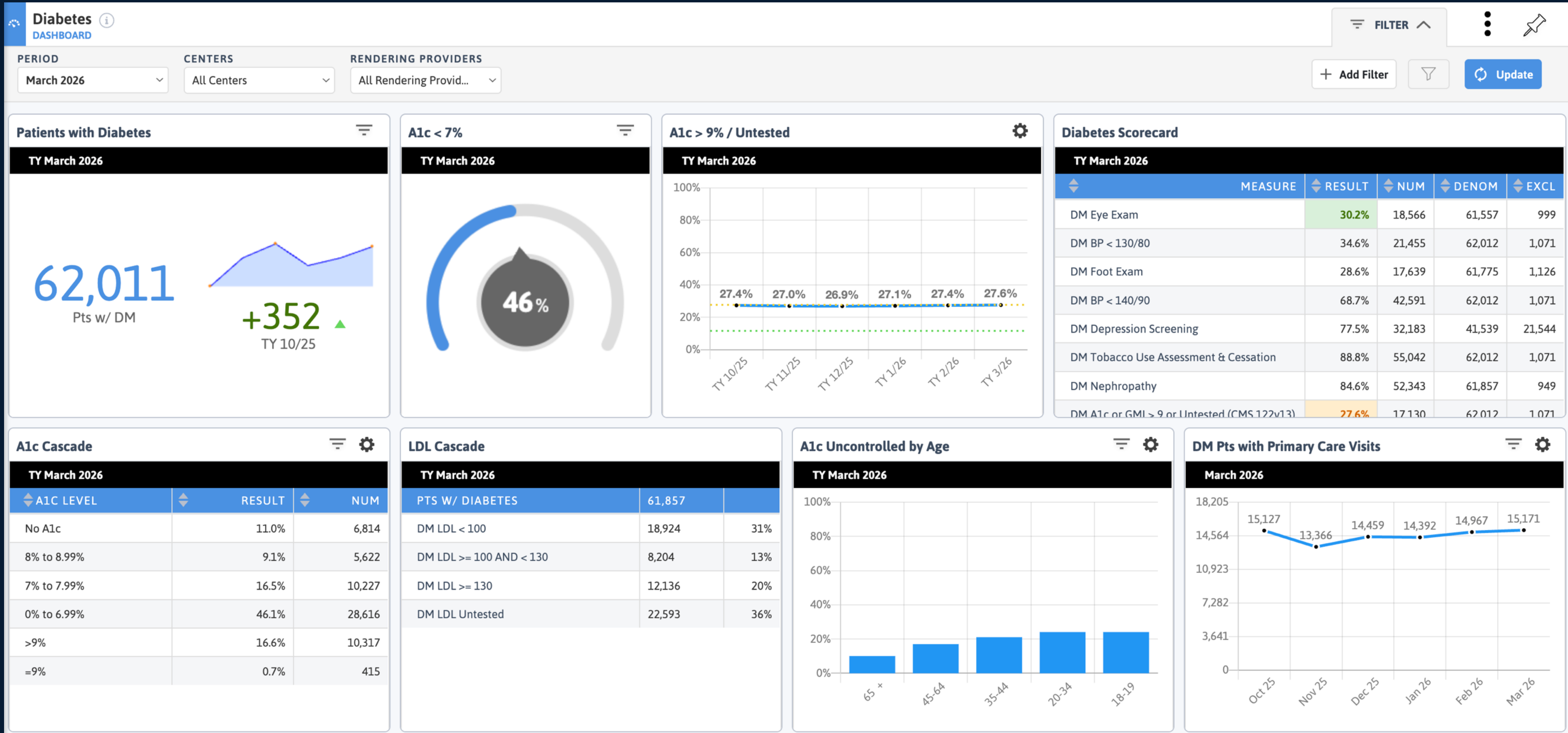
61%
Result
PRIMARY 70%
SECONDARY 60%
0%
TY 2/26

Hypertension Prescribing Scorecard

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Adult HTN Guideline Recommended Therapy	52.3%	63,207	120,840	6,775	57,633	
Uncontrolled HTN Guideline Recommended Therapy	59.8%	19,626	32,804	1,793	13,178	
HTN >=140/90 and No Medication	19.5%	6,405	32,804	1,793	6,405	
HTN >=140/90 on Monotherapy	31.3%	10,278	32,804	1,793	10,278	
AMA MAP SBP Reduction	61.2%	14,159	23,117	910	8,958	
AMA MAP Follow-up	28.4%	47,096	165,928	8,304	118,832	

Diabetes Dashboard

azara healthcare



Practice Comparison

azara healthcare

AMA MAP™ Cholesterol Scorecard
REPORT

FILTER

PERIOD: 2026 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

Baseline filter is not supported for multi month period types.

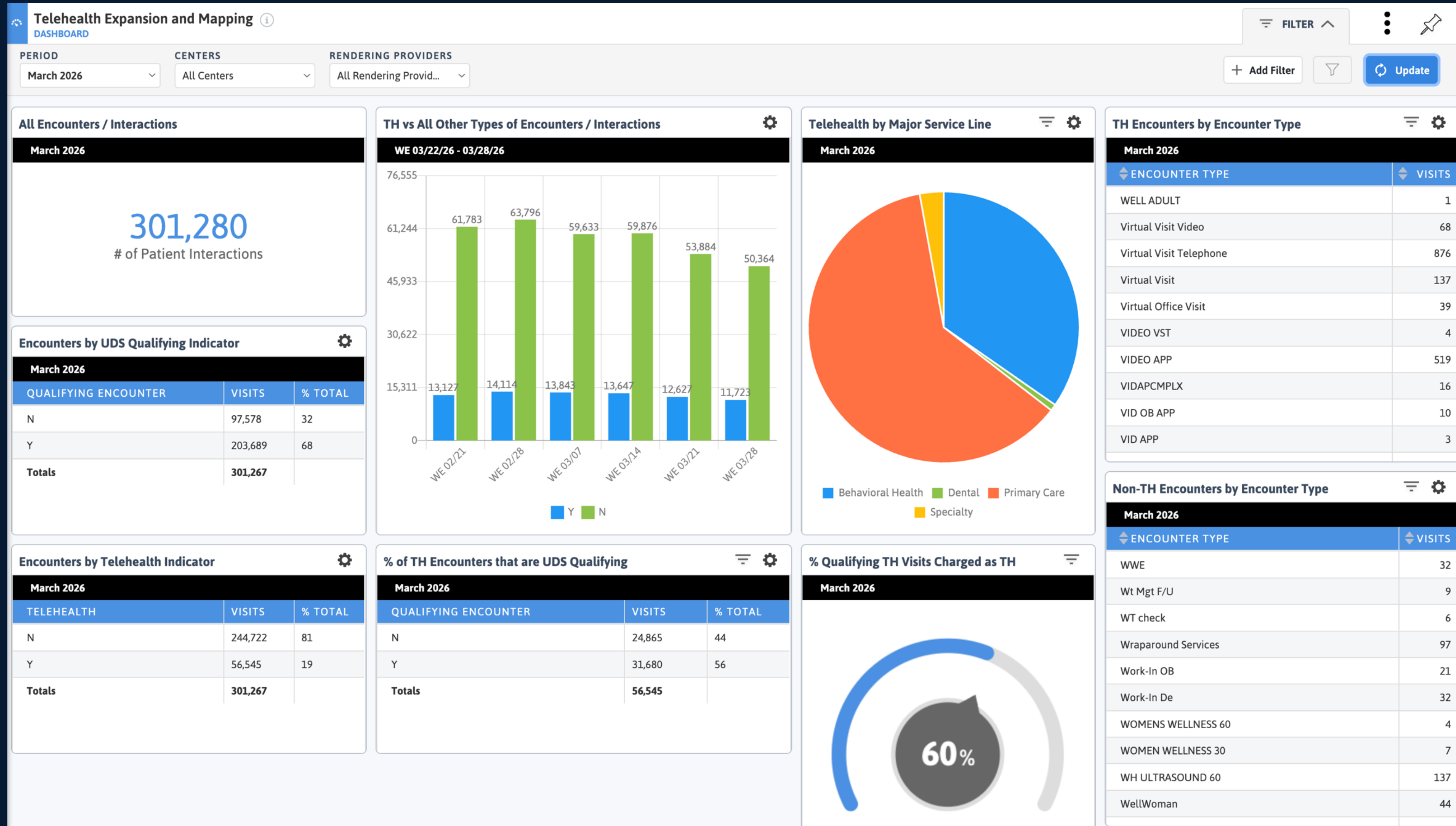
REPORT | CARE GAPS

GROUPING: Center | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: CrossTab

CENTER	STATIN THERAPY CVD (CMS 347V8)	AMA MAP RECOMMENDED CHOL TX INTENSITY	AMA MAP LDL-C SCREENING
Adult and Child Health	69.6%	57.9%	78.7%
Aspire Indiana Health	79.2%	64.1%	66.6%
Community HealthNet	86.7%	75.7%	93.8%
Edgewater Health	57.5%	46.8%	74.1%
Eskenazi Health	58.9%	40.4%	89.2%
HealthLinc Community Health Center	87.0%	74.6%	88.5%
HealthNet Inc	86.9%	75.8%	85.8%
Heart City Health Center	85.9%	70.6%	93.4%

Telehealth Usage and Adoption

azara healthcare



Transition of Care (ToC) Dashboard

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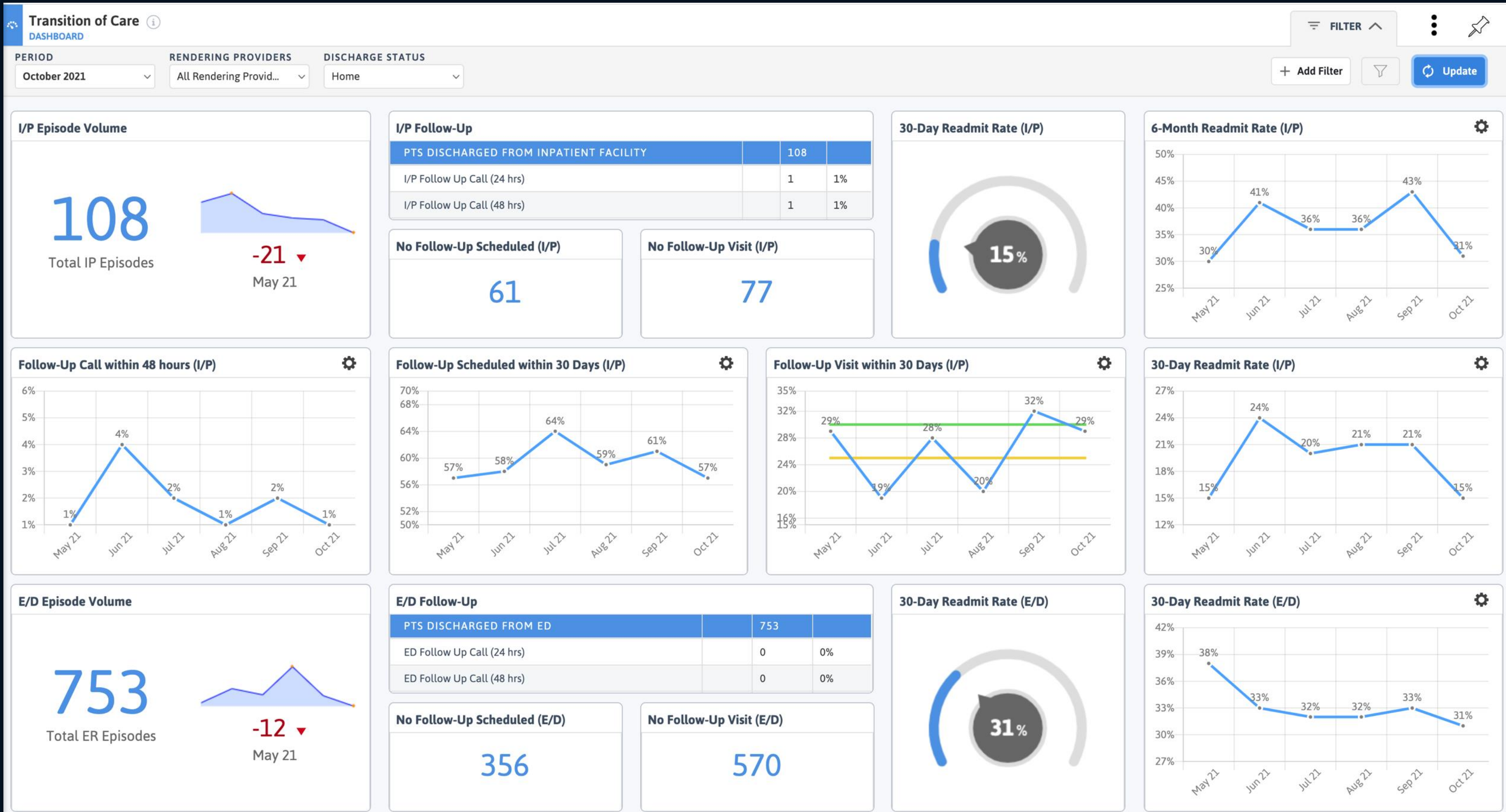


What is Care Effectiveness ?

It’s not just about meeting the measure !

- Reporting that allows you to:
  - Look at how a group of patients are doing
  - Evaluate the effectiveness of a program to help improve the care of a specific group of patients

Are my patients improving?

How is this group of patients doing?

Is our program working?

Care Effectiveness: Hypertension - Pt Detail

azara healthcare

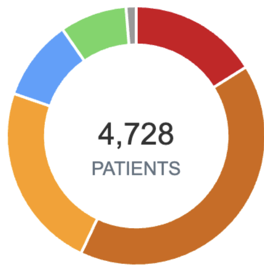
AMA MAP Hypertension Care Effectiveness Patients
REPORT

FILTER

DATE RANGE: 03/29/2026-04/05/2026
RENDERING PROVIDERS: All Rendering Provid...
PATIENT DIAGNOSES: All Patient Diagnoses
SERVICE LINES: All Service Lines

Add Filter | Update

Overview - Population: Dyn - OOC Blood Pressure



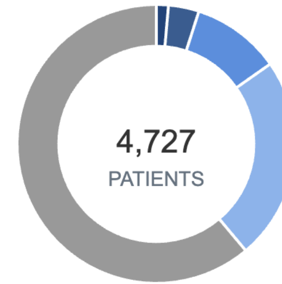
BLOOD PRESSURE CONTROL (BP)

Category	Count
Stage 2 Severe (>=160 or >=100)	761
Stage 2 HTN (140-159 or 90-99)	1,934
Stage 1 HTN (130-139 or 80-89)	1,101
Elevated BP (120-129 and <80)	476
Normal (<120/80)	396
No Score	60

140.5
AVG SYSTOLIC BLOOD PRESSURE
▼ -0.6 *Last 12 mths.*

1,199
SYS BP PTS WITH A >=10 MM/HG DROP

0.6
AVG Class Count
▲ 0.1 *Last 12 mths.*



ANTIHYPERTENSIVE MEDICATION CLASS COUNT

Class Count	Patients
>5	0
4-5	66
3	168
2	488
1	1,116
0	2,889

Search Patients ...

SAVED COLUMNS

		BP CONTROL STATUS	FIRST SYSTOLIC BP IN LAST 12 MTHS		FIRST DIASTOLIC BP IN LAST 12 MTHS		MOST RECENT SYSTOLIC BP LAST 12 MTHS			MOST RECENT DIASTOLIC BP LAST 12 MTHS	
NAME	MRN	BP CONTROL STATUS	DATE	RESULT	DATE	RESULT	DATE	RESULT	CHANGE	DATE	RESULT
First, Patent	42952	●	4/24/2025	130	4/24/2025	89	7/25/2025	146	▲ 16	7/25/2025	10
Second, Patient	95915	●	8/14/2025	150	8/14/2025	70	3/19/2026	158	▲ 8	3/19/2026	7
Third, Patient	79897	●	11/20/2025	157	11/20/2025	90	11/20/2025	157	0	11/20/2025	9

Sharing Data Across a Network

15

- A *Network* is an arrangement in which like-minded hospitals and/or independent providers *share* performance improvement, quality, value, and efficiency goals that result in improved quality and coordinated care at a lower cost.
- The Azara Solution Suite can facilitate this sharing of data now.
- Point of Care tools such as the PVP and CMP are examples of what exists.
    - Quick caveat … data use / data sharing agreements must be in place
- Data that can be shared on the PVP and CMP today includes:
    - Diagnoses & Risk Factors
    - SDOH
    - Dates and locations of most recent visits to other organizations in the network
- Even greater level of data sharing is available within Azara Care Management
- Feature adds in

Sharing Data on the PVP

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Patient Visit Planning (PVP)
PVP PVPVIEW

FILTER

DATE RANGE: 04/27/2022-04/27/2022
RENDERING PROVIDERS: All Rendering Provid...
MRN LIST:

Add Filter | Update

Augustine, Greg — *9 Scheduled Appointments*

5:02 AM Wednesday, April 27, 2022 — **DATA FROM MULTIPLE PRACTICES** — Visit Reason: **Canceled High BP**

Brackney, Roman
MRN: 6194604
DOB: 1/16/1996 (26)

Sex at Birth: M
GI: Other
SO: Choose not to disclose

Phone: 774-352-0030
Lang: English
Risk: Low (23)

Portal Access: Y

PCP: Fritz, Renata
Payer:
CM: Kevin Donohue

DIAGNOSES (12)

AMI FHC	ASCVD	Asthma
CAD	COPD	CP
Depression	HIV	HTN-E
HTN-NE	IVD	Pre-DM

RISK FACTORS (8)

ANTICOAG	Chronic Opioid Tx	HDU
IDD FHC	Pre-DM	SMI
SUD	**TOB** FHC	

SDOH (12)

CHILDCARE	CLOTHING	FOOD
HOMELESS	MED/CARE	MIGRANT
PHONE	RACE	STRESS
TRANSPORT-NONMED	UTILITY	**VIOLENCE** FHC

ALERT	MESSAGE	MOST RECENT DATE	MOST RECENT RESULT
LDL	Overdue	4/17/2020	143
Tobacco Scr	Overdue	12/13/2020	N
BMI & FU	Missing		
BP	Overdue	12/13/2020	116/74
Asth Severity	Overdue	12/13/2020	
E/D Encounter	Occurred	1/16/2022	

VISITS AT OTHER PRACTICES	PROVIDER	VISIT DATE	LOCATION
Family Health Center	Jones, James	6/18/2022	1st St. Clinic

The Azara EHR Plug-In | Alerts & Care Gaps

Sallie Sue

Moderate (12)

MRN: 15303819

DOB: 10/13/1920 (104 yrs)

Plan: Medicare Advantage

- ALERTS 6
- RAF GAPS 3
- REFERRALS 7
- CARE MGMT
- PLAN CARE GAPS 3

DOCUMENTS:

- Care Mgmt Plan
- Prenatal Passport

Alert	Message	Date	Most Recent Result	Alert Owner
A1c	Overdue	3/27/23	5.4	Provider
LDL	Overdue	8/28/22	190	RN
Eye	Overdue	6/22/22	normal	Provider
Foot	Overdue	7/24/22	Y	MA/LPN
I/P Encounter	Occurred	9/30/2025	Beth Israel	Medical Records
BP High Stage 1 or 2 No Dx	Missing	6/21/23	Stage 1	RN

The Azara Platform

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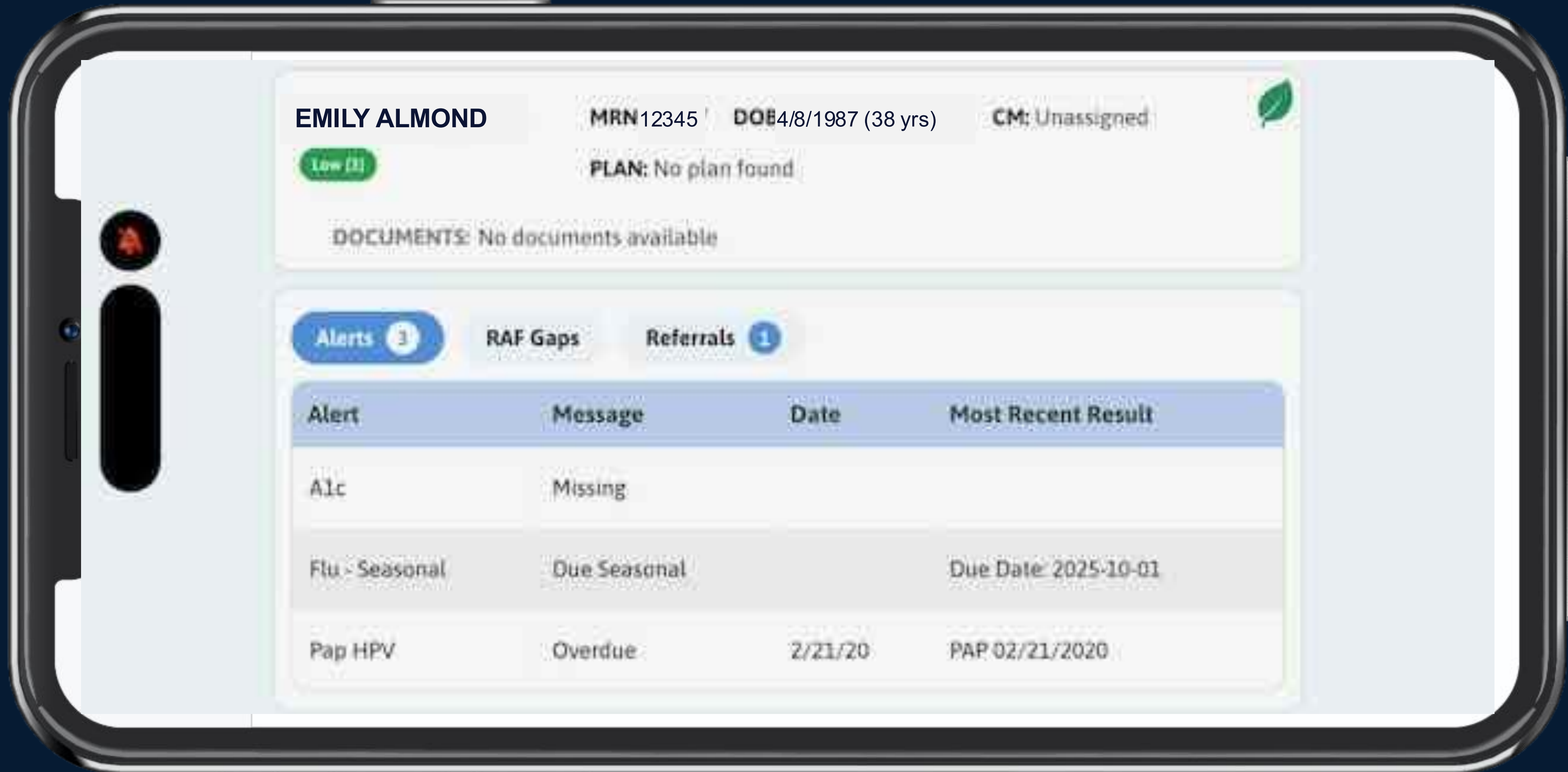

We Are Shovel Ready

We Are Shovel Ready

Sallie Sue
Moderate (12)
MRN: 15303819
DOB: 10/13/1920 (104 yrs)
Plan: Medicare Advantage

ALERTS 6
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BP High Stage 1 or 2 No Dx	Missing	6/21/23	Stage 1	RN

EMILY ALMON
MRN 12345 DOB 4/8/1987 (38 yrs) CM: Unassigned
PLAN: No plan found
DOCUMENTS: No documents available

Alerts 3 RAF Gaps Referrals 1

Alert	Message	Date	Most Recent Result
A1c	Missing		
Flu - Seasonal	Due Seasonal		Due Date: 2025-10-01
Pap HPV	Overdue	2/21/20	PAP 02/21/2020

We Are Shovel Ready

- Curated, Normalized Data
- Proven MPI technology
- Focus on sharing data at the point of care
- Imagine …
  - EMS personnel reviewing the PNP or CMP from the ambulance
  - Clinics sharing data and avoid adverse drug-drug interactions that exacerbate problems
  - Imagine ‘writing & requesting’ eConsults from within the EHR Plug-In
  - Imagine State Medicaid and DoH’s having timely, accurate & normalized aggregated data
  - Organizations coordinating on Medicaid Redetermination efforts
  - Patients having better health outcomes because we share data