Making Data Actionable

Operational Improvement with DRVS

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

Today's Presenter

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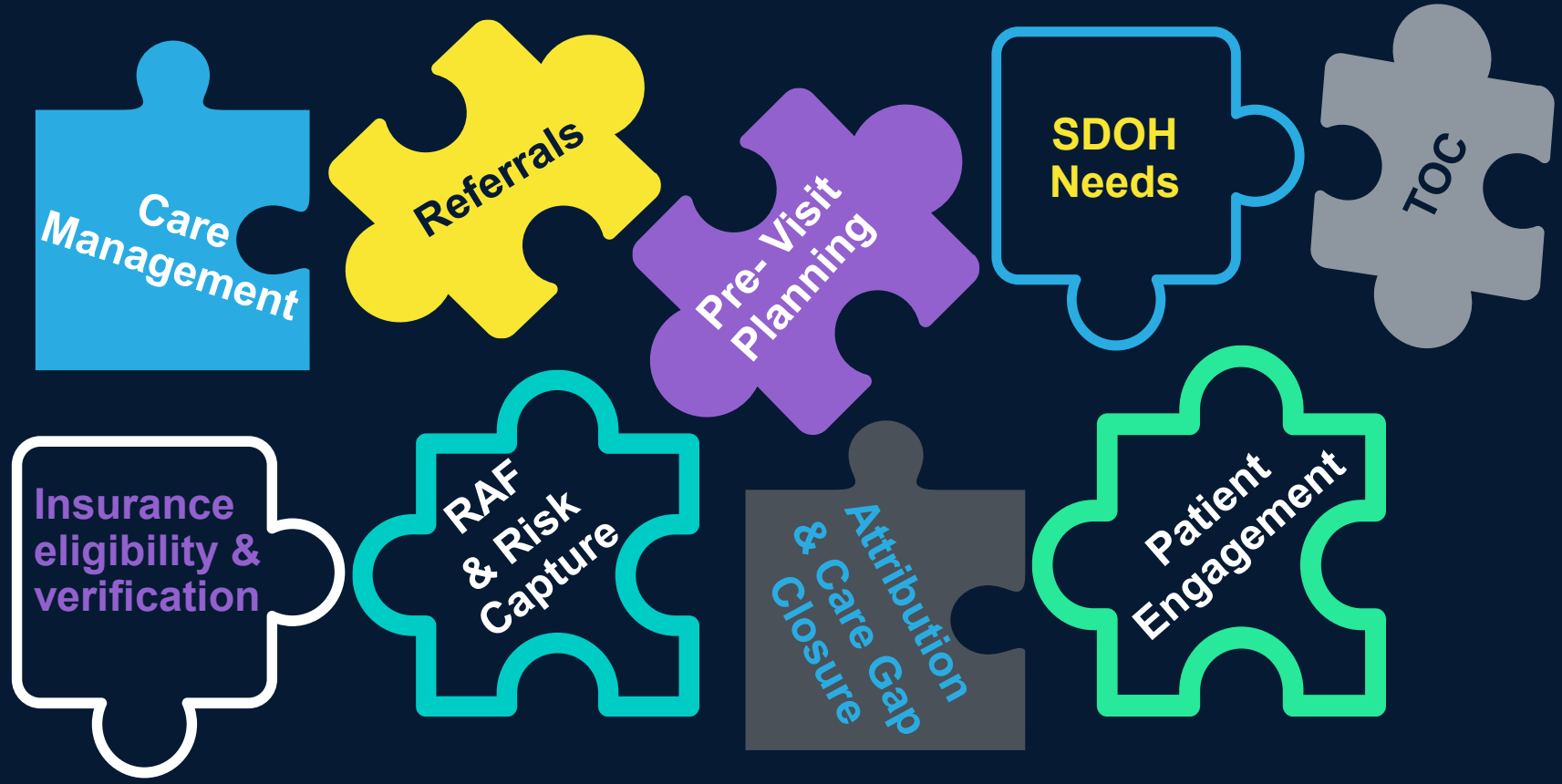
Value Based Care Consultant

Azara Healthcare

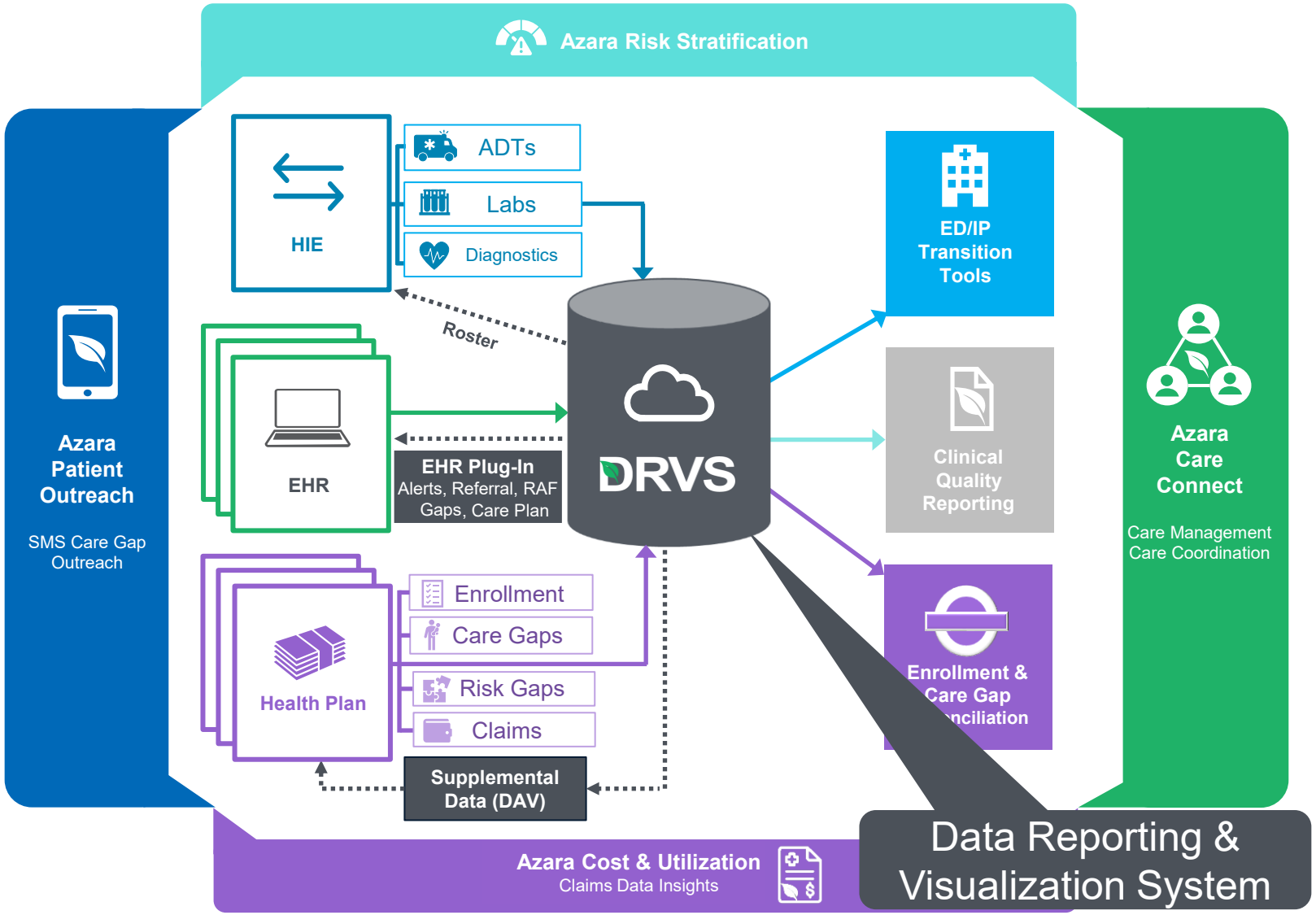
Operations & Value-Based Care

The Operations Challenge

Health centers are not lacking data – they are lacking operational consistency



Azara Platform



Model for Success – Core Domains

Before the Visit (Preparation)

During the Visit (Execution)

Between Visits (Engagement)

Population-Level Strategy
(Management & Oversight)

DRVS Before the Visit

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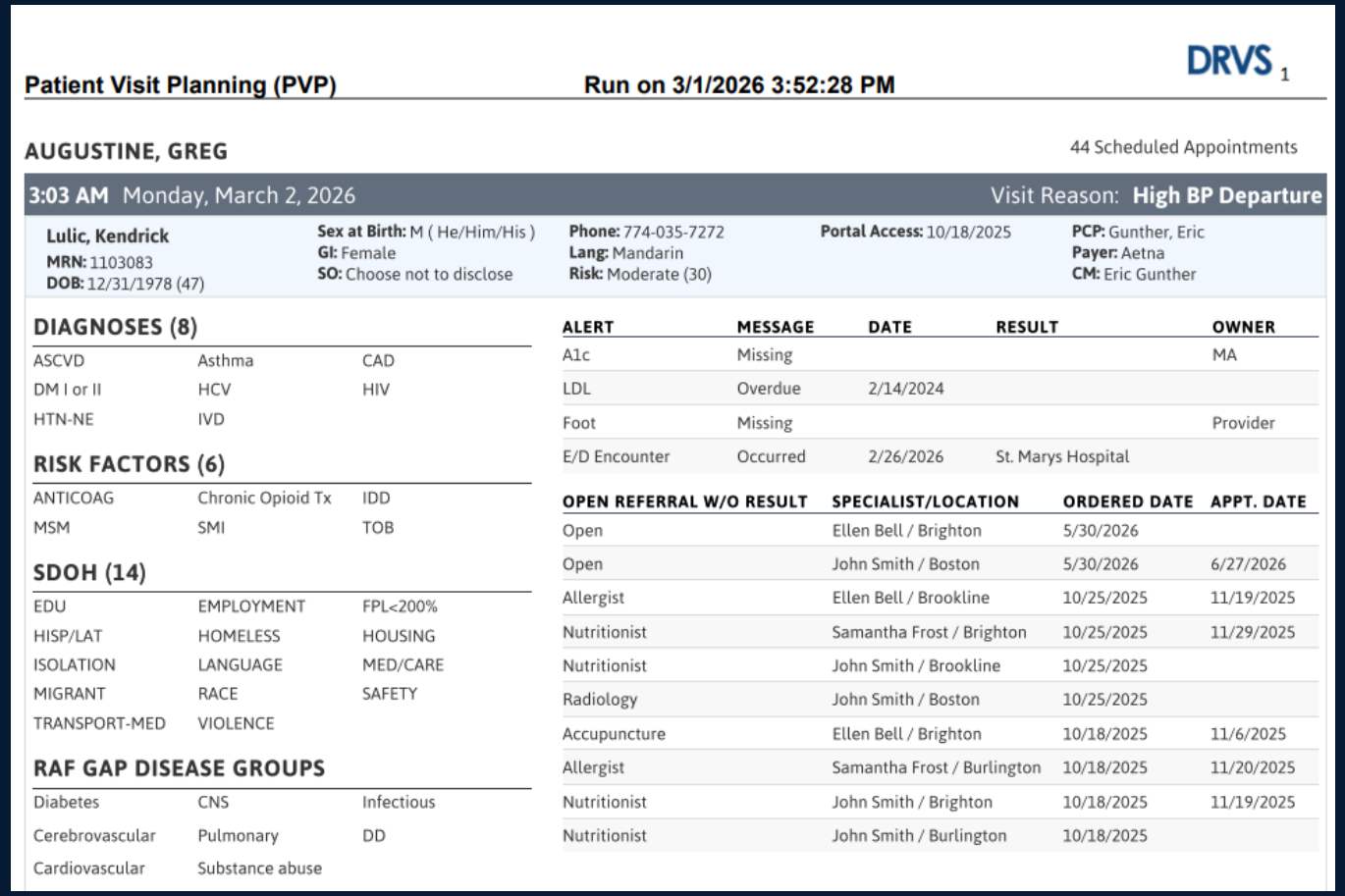
Pre-visit Planning

Insurance verification / eligibility

Identify care gaps and needed labs/referrals

Risk capture opportunities (RAF)

Identify care management candidates



Patient Visit Planning (PVP) **Run on 3/1/2026 3:52:28 PM** DRVS 1

AUGUSTINE, GREG 44 Scheduled Appointments

3:03 AM Monday, March 2, 2026 Visit Reason: **High BP Departure**

Lulic, Kendrick
MRN: 1103083
DOB: 12/31/1978 (47)

Sex at Birth: M (He/Him/His)
GI: Female
SO: Choose not to disclose

Phone: 774-035-7272
Lang: Mandarin
Risk: Moderate (30)

Portal Access: 10/18/2025

PCP: Gunther, Eric
Payer: Aetna
CM: Eric Gunther

DIAGNOSES (8)

ASCVD	Asthma	CAD
DM I or II	HCV	HIV
HTN-NE	IVD	

RISK FACTORS (6)

ANTICOAG	Chronic Opioid Tx	IDD
MSM	SMI	TOB

SDOH (14)

EDU	EMPLOYMENT	FPL<200%
HISP/LAT	HOMELESS	HOUSING
ISOLATION	LANGUAGE	MED/CARE
MIGRANT	RACE	SAFETY
TRANSPORT-MED	VIOLENCE	

RAF GAP DISEASE GROUPS

Diabetes	CNS	Infectious
Cerebrovascular	Pulmonary	DD
Cardiovascular	Substance abuse	

ALERT	MESSAGE	DATE	RESULT	OWNER
A1c	Missing			MA
LDL	Overdue	2/14/2024		
Foot	Missing			Provider
E/D Encounter	Occurred	2/26/2026	St. Marys Hospital	

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Open	Ellen Bell / Brighton	5/30/2026	
Open	John Smith / Boston	5/30/2026	6/27/2026
Allergist	Ellen Bell / Brookline	10/25/2025	11/19/2025
Nutritionist	Samantha Frost / Brighton	10/25/2025	11/29/2025
Nutritionist	John Smith / Brookline	10/25/2025	
Radiology	John Smith / Boston	10/25/2025	
Accupuncture	Ellen Bell / Brighton	10/18/2025	11/6/2025
Allergist	Samantha Frost / Burlington	10/18/2025	11/20/2025
Nutritionist	John Smith / Brighton	10/18/2025	11/19/2025
Nutritionist	John Smith / Burlington	10/18/2025	

Why Use the PVP?

In 2025, DRVS users who utilized the Patient Visit Planning Report **closed 38% more gaps in care.**

PVP users closed **>2.5M care gaps** in 2025.

Providers report **50% less time** spent chart prepping.

Organizations using the PVP **meet PCMH requirements** for huddles and team-based care.

DRVS During the Visit

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The Visit

- Clinical care
- Quality gap closure
- Risk capture
- Patient engagement

Visit – Core Domains

Prioritized gap closure

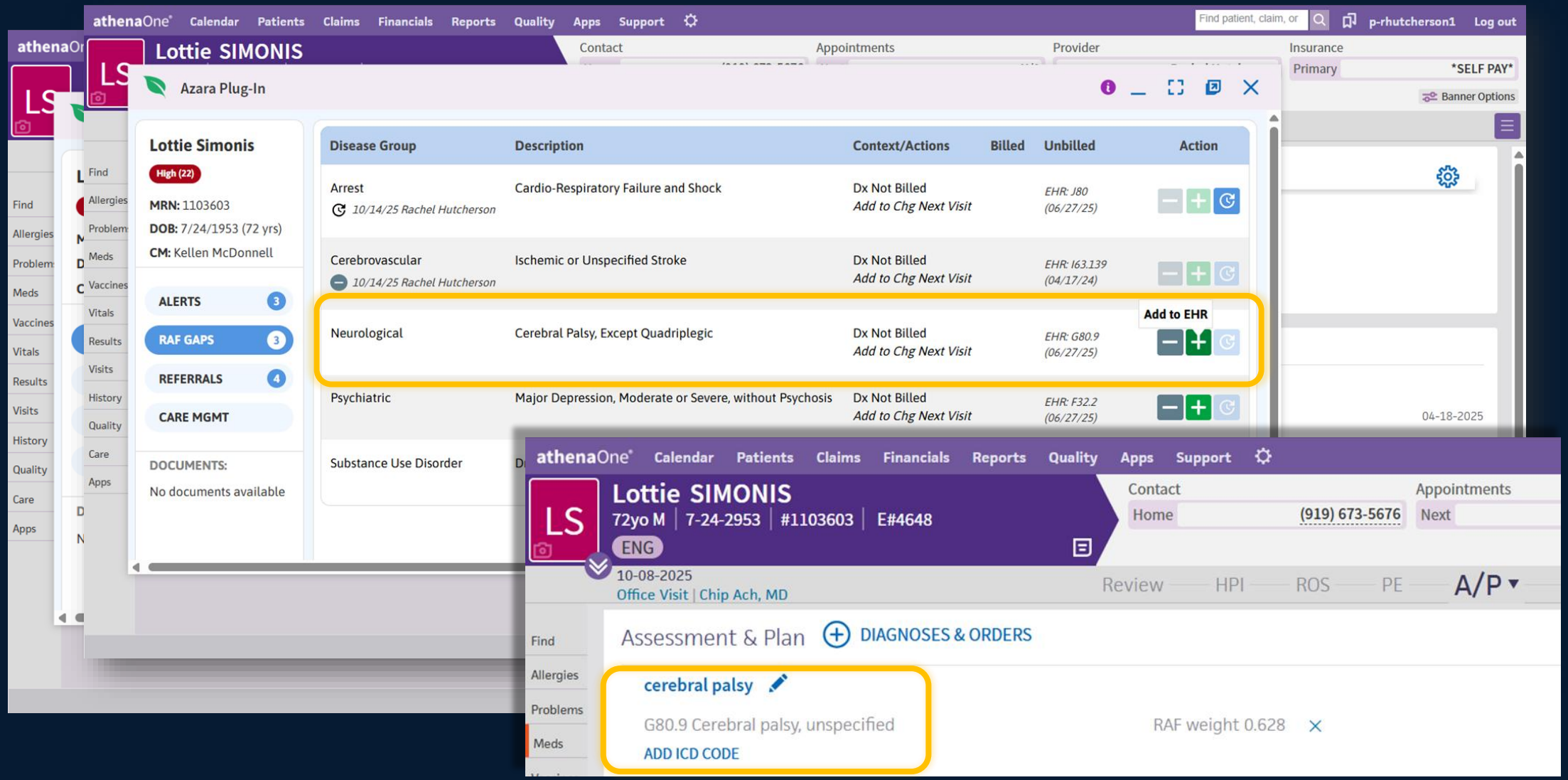
SDOH screening

Identification of care management needs

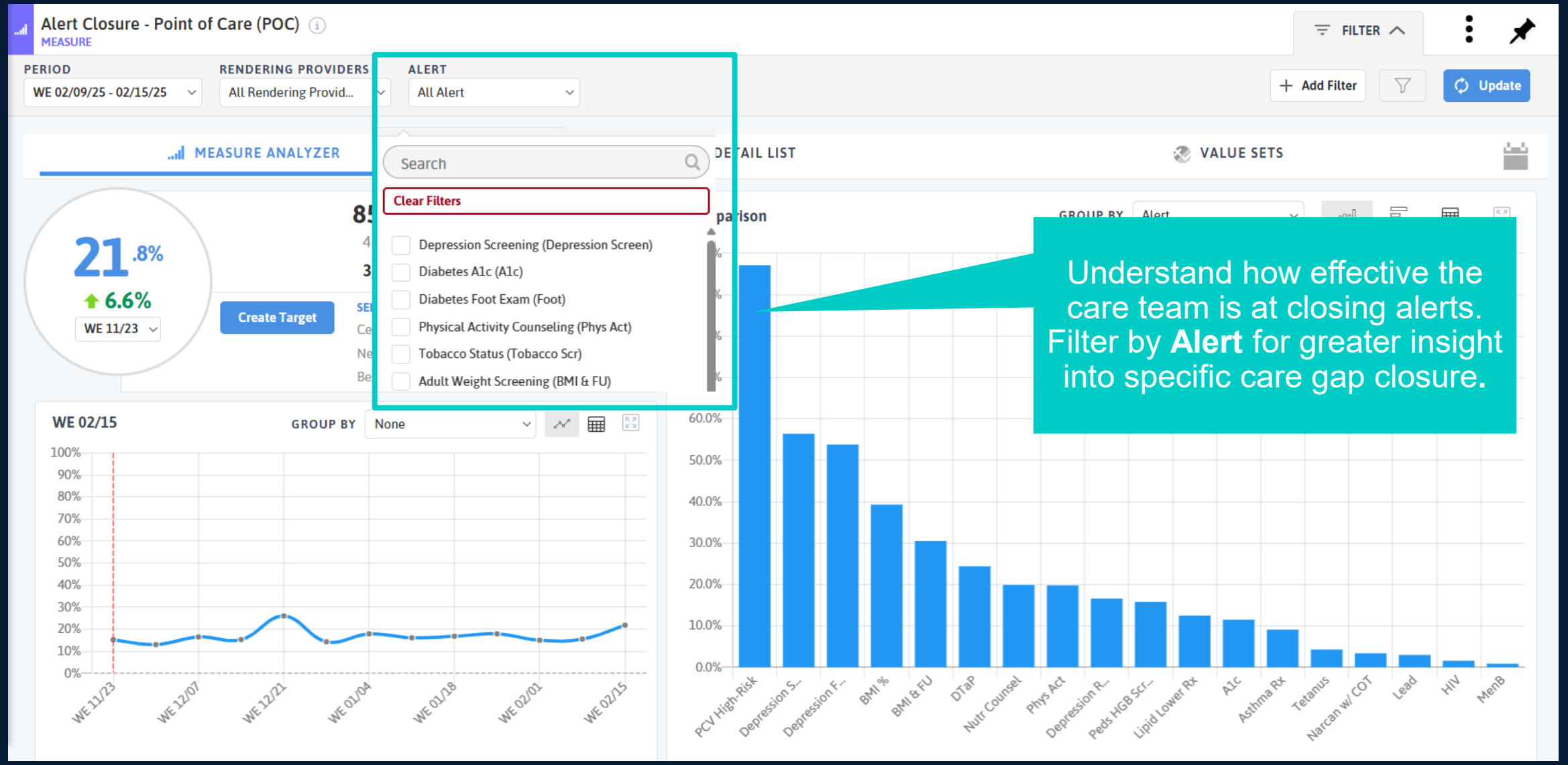
Risk adjustment documentation

Medication Adherence Discussions

EHR Plug-in


athenaOne
Calendar
Patients
Claims
Financials
Reports
Quality
Apps
Support
Lottie SIMONIS
Contact
Appointments
Provider
Insurance
Primary
SELF PAY
Banner Options
Azara Plug-In
Lottie Simonis
High (22)
MRN: 1103603
DOB: 7/24/1953 (72 yrs)
CM: Kellen McDonnell
ALERTS 3
RAF GAPS 3
REFERRALS 4
CARE MGMT
DOCUMENTS:
No documents available
Disease Group
Description
Context/Actions
Billed
Unbilled
Action
Arrest
10/14/25 Rachel Hutcherson
Cardio-Respiratory Failure and Shock
Dx Not Billed
Add to Chg Next Visit
EHR: J80 (06/27/25)
Cerebrovascular
10/14/25 Rachel Hutcherson
Ischemic or Unspecified Stroke
Dx Not Billed
Add to Chg Next Visit
EHR: I63.139 (04/17/24)
Neurological
Cerebral Palsy, Except Quadriplegic
Dx Not Billed
Add to Chg Next Visit
EHR: G80.9 (06/27/25)
Add to EHR
Psychiatric
Major Depression, Moderate or Severe, without Psychosis
Dx Not Billed
Add to Chg Next Visit
EHR: F32.2 (06/27/25)
Substance Use Disorder
04-18-2025
athenaOne
Calendar
Patients
Claims
Financials
Reports
Quality
Apps
Support
Lottie SIMONIS
72yo M | 7-24-2953 | #1103603 | E#4648
ENG
Contact
Home
(919) 673-5676
Appointments
Next
10-08-2025
Office Visit | Chip Ach, MD
Review
HPI
ROS
PE
A/P
Find
Allergies
Problems
Meds
Assessment & Plan
DIAGNOSES & ORDERS
cerebral palsy
G80.9 Cerebral palsy, unspecified
ADD ICD CODE
RAF weight 0.628

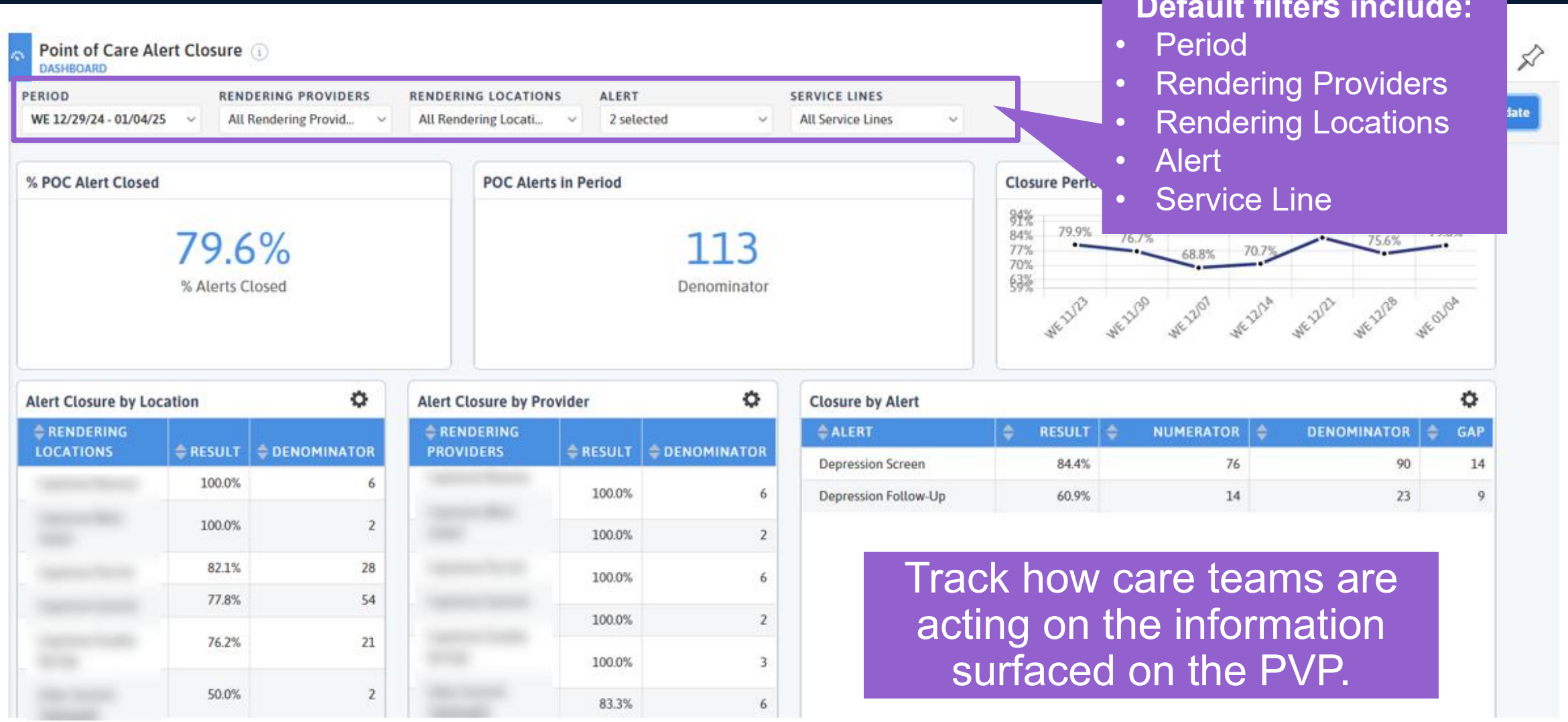
Monitoring Effectiveness | POC Alert Closure



Understand how effective the care team is at closing alerts. Filter by **Alert** for greater insight into specific care gap closure.

Point of Care Alert Closure Dashboard

Default filters include:
- Period
- Rendering Providers
- Rendering Locations
- Alert
- Service Line



Track how care teams are acting on the information surfaced on the PVP.

DRVS Outside the Visit

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Between Visits

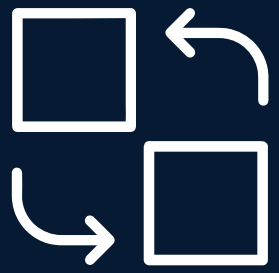
- Proactive
- Requires structured workflows

Core Areas of Focus

Transitions of Care
Timely follow-up after ED/IP events

Care Management
High-risk / rising-risk patients

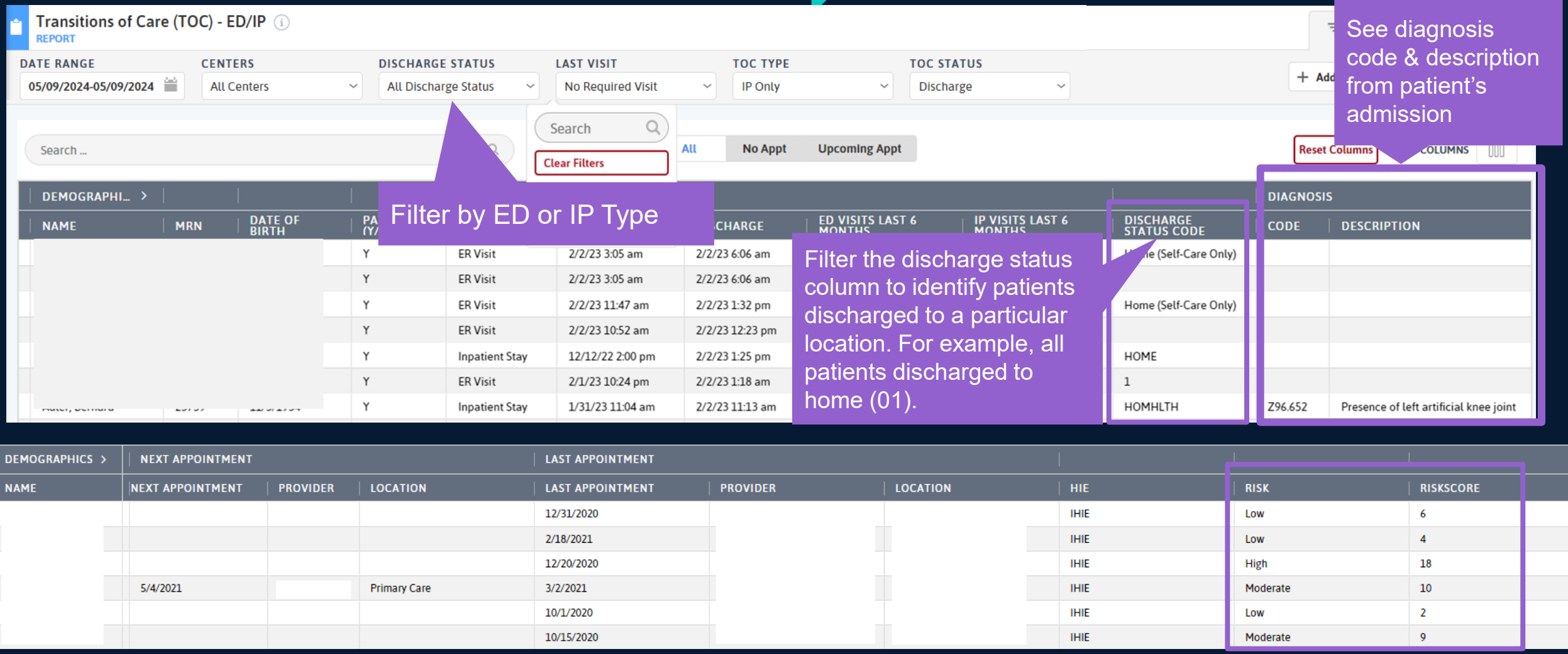
Outreach
Patients with gaps and no upcoming visit



Care Gap Reconciliation
Aligning payer vs. clinical data

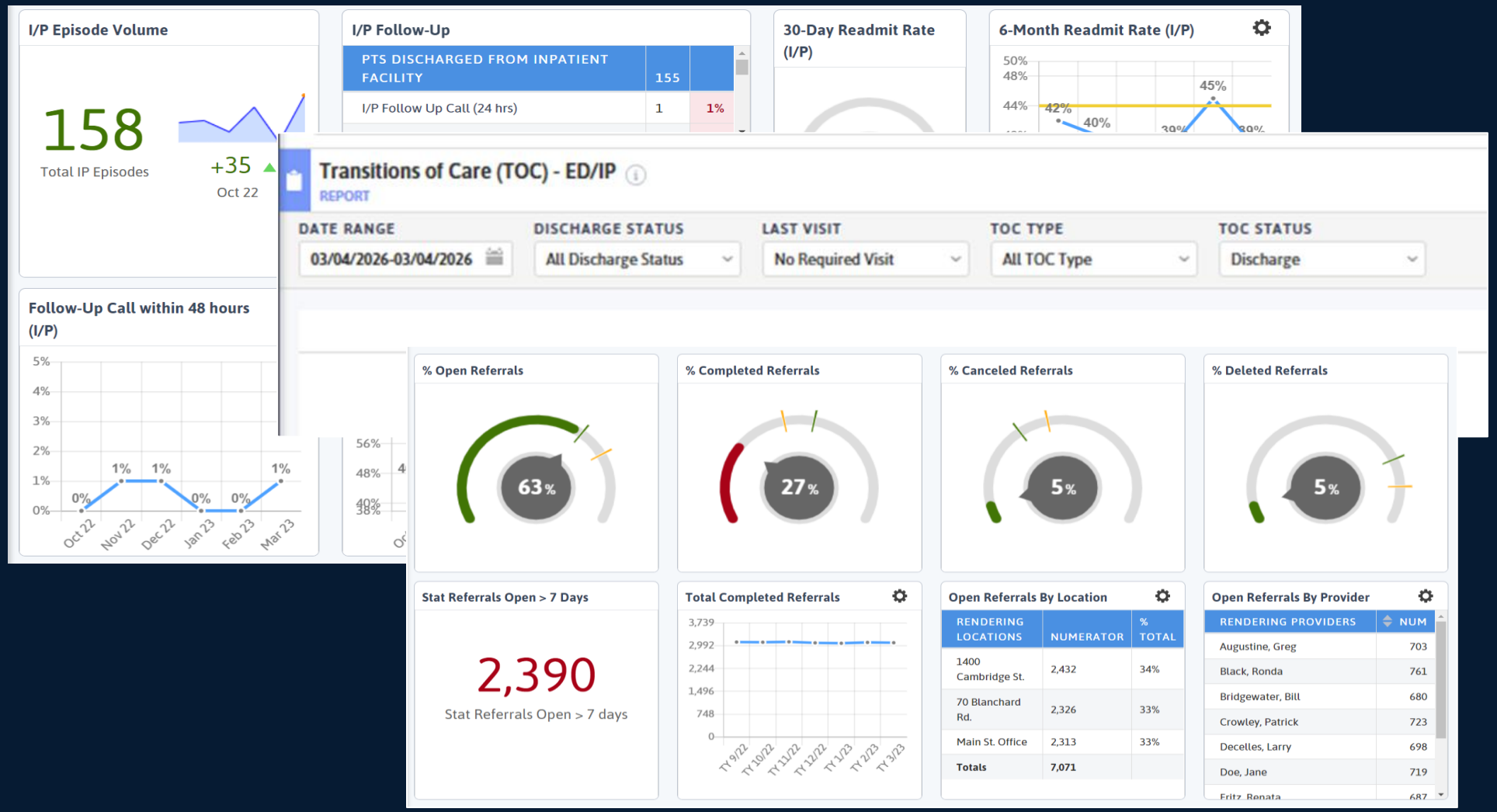
Transitions of Care (TOC) – ED/IP

Run the ED/IP Report by Discharge Date



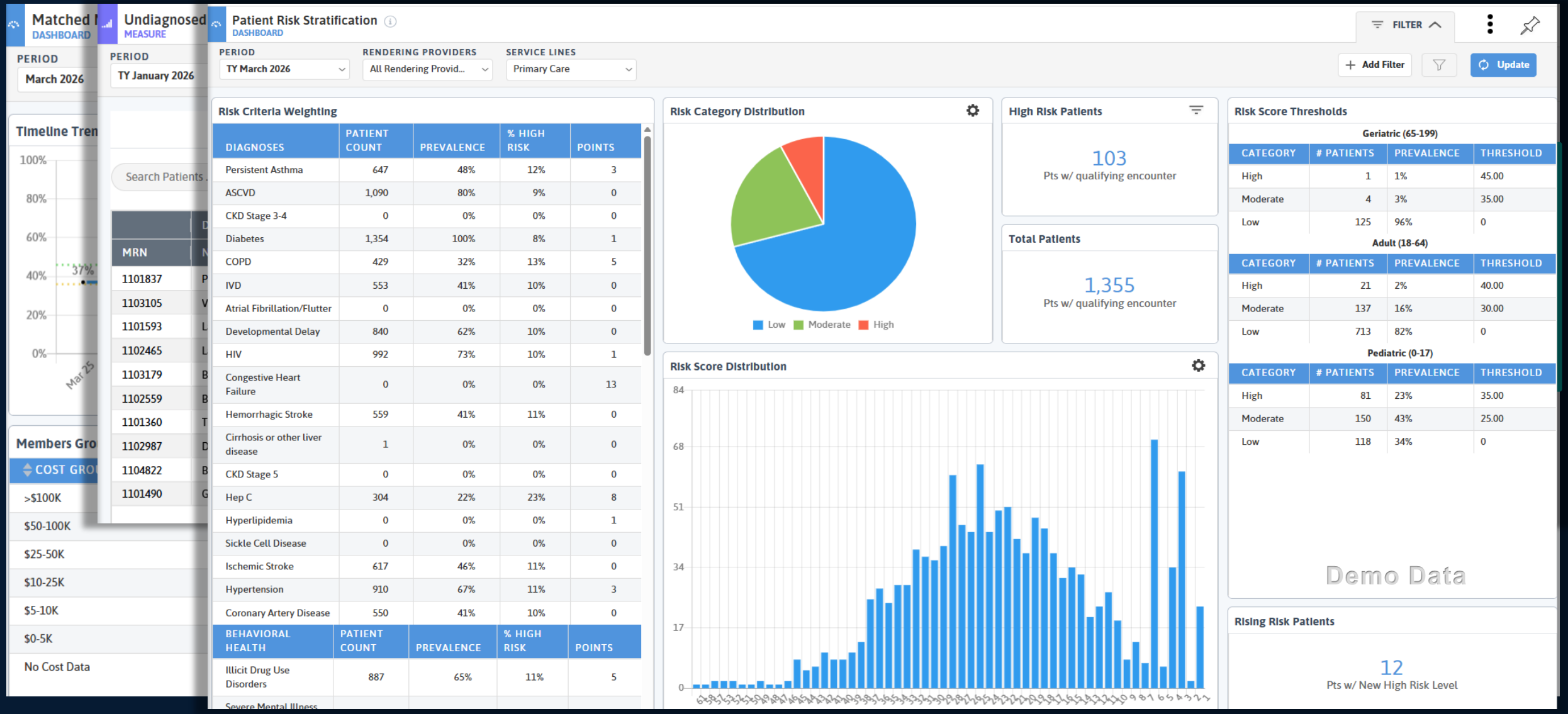
DEMOGRAPHICS	NEXT APPOINTMENT			LAST APPOINTMENT					
NAME	NEXT APPOINTMENT	PROVIDER	LOCATION	LAST APPOINTMENT	PROVIDER	LOCATION	HIE	RISK	RISKSCORE
				12/31/2020			IHIE	Low	6
				2/18/2021			IHIE	Low	4
				12/20/2020			IHIE	High	18
	5/4/2021		Primary Care	3/2/2021			IHIE	Moderate	10
				10/1/2020			IHIE	Low	2
				10/15/2020			IHIE	Moderate	9

Managing Utilization of Services



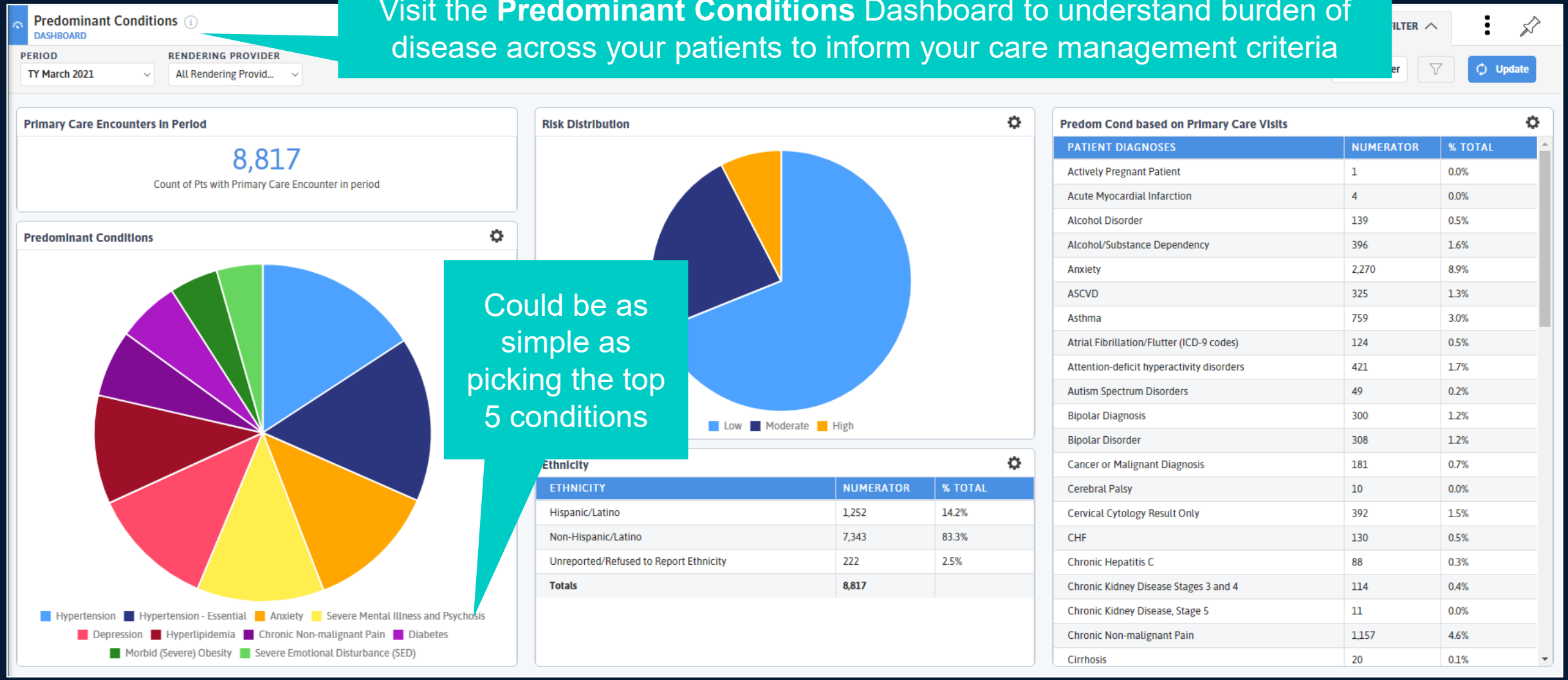
The Referral and Transition of Care functionality require add on modules in DRVS.

Outreach


Matched
DASHBOARD
PERIOD
March 2026
Timeline Tren
100%
80%
60%
40%
20%
0%
37%
Mar 25
Members Gro
COST GRO
>$100K
$50-100K
$25-50K
$10-25K
$5-10K
$0-5K
No Cost Data
Undiagnosed
MEASURE
PERIOD
TY January 2026
Search Patients
MRN
1101837
1103105
1101593
1102465
1103179
1102559
1101360
1102987
1104822
1101490
Patient Risk Stratification
DASHBOARD
FILTER
PERIOD
TY March 2026
RENDERING PROVIDERS
All Rendering Provid...
SERVICE LINES
Primary Care
Add Filter
Update
Risk Criteria Weighting
DIAGNOSES | PATIENT COUNT | PREVALENCE | % HIGH RISK | POINTS
Persistent Asthma | 647 | 48% | 12% | 3
ASCVD | 1,090 | 80% | 9% | 0
CKD Stage 3-4 | 0 | 0% | 0% | 0
Diabetes | 1,354 | 100% | 8% | 1
COPD | 429 | 32% | 13% | 5
IVD | 553 | 41% | 10% | 0
Atrial Fibrillation/Flutter | 0 | 0% | 0% | 0
Developmental Delay | 840 | 62% | 10% | 0
HIV | 992 | 73% | 10% | 1
Congestive Heart Failure | 0 | 0% | 0% | 13
Hemorrhagic Stroke | 559 | 41% | 11% | 0
Cirrhosis or other liver disease | 1 | 0% | 0% | 0
CKD Stage 5 | 0 | 0% | 0% | 0
Hep C | 304 | 22% | 23% | 8
Hyperlipidemia | 0 | 0% | 0% | 1
Sickle Cell Disease | 0 | 0% | 0% | 0
Ischemic Stroke | 617 | 46% | 11% | 0
Hypertension | 910 | 67% | 11% | 3
Coronary Artery Disease | 550 | 41% | 10% | 0
BEHAVIORAL HEALTH | PATIENT COUNT | PREVALENCE | % HIGH RISK | POINTS
Illicit Drug Use Disorders | 887 | 65% | 11% | 5
Severe Mental Illness
Risk Category Distribution
Low
Moderate
High
High Risk Patients
103
Pts w/ qualifying encounter
Total Patients
1,355
Pts w/ qualifying encounter
Risk Score Distribution
84
68
51
34
17
0
Risk Score Thresholds
Geriatric (65-199)
CATEGORY | # PATIENTS | PREVALENCE | THRESHOLD
High | 1 | 1% | 45.00
Moderate | 4 | 3% | 35.00
Low | 125 | 96% | 0
Adult (18-64)
CATEGORY | # PATIENTS | PREVALENCE | THRESHOLD
High | 21 | 2% | 40.00
Moderate | 137 | 16% | 30.00
Low | 713 | 82% | 0
Pediatric (0-17)
CATEGORY | # PATIENTS | PREVALENCE | THRESHOLD
High | 81 | 23% | 35.00
Moderate | 150 | 43% | 25.00
Low | 118 | 34% | 0
Demo Data
Rising Risk Patients
12
Pts w/ New High Risk Level

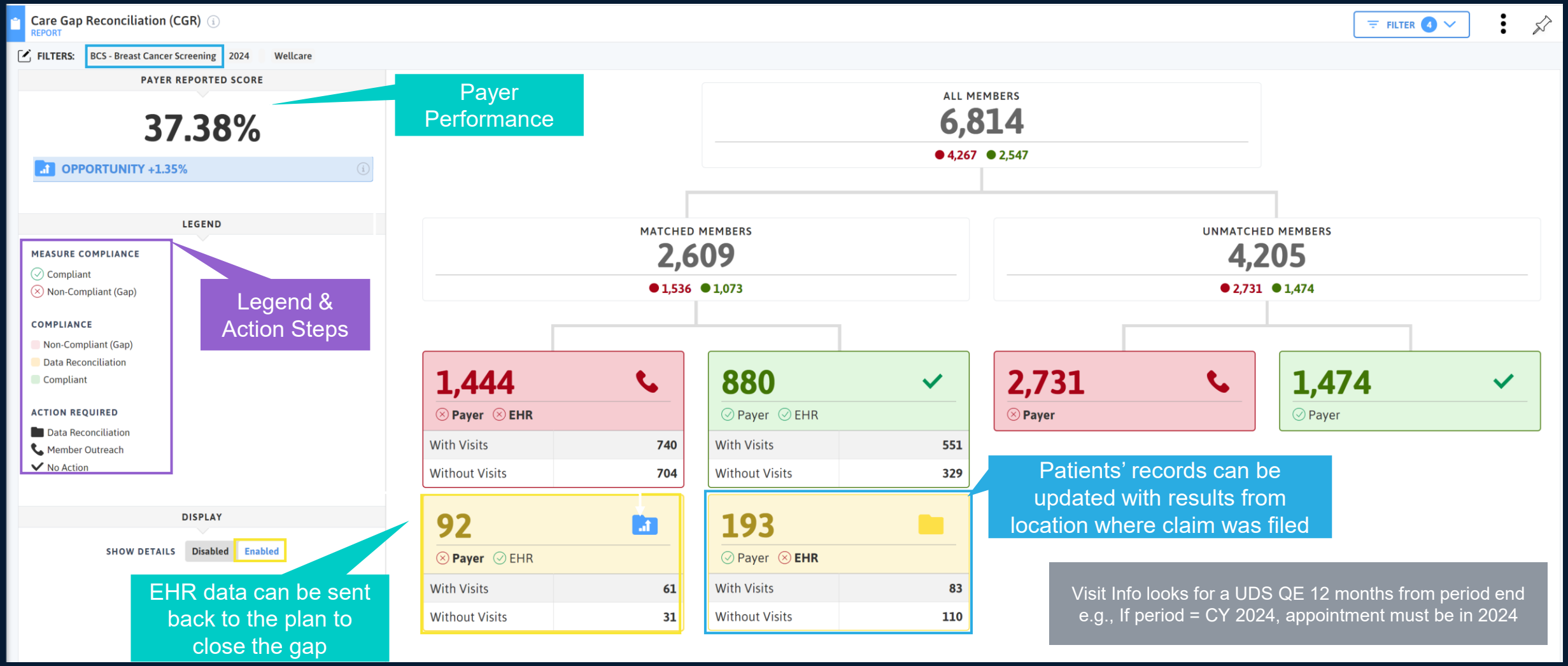
Determine Care Management Criteria

Visit the **Predominant Conditions** Dashboard to understand burden of disease across your patients to inform your care management criteria

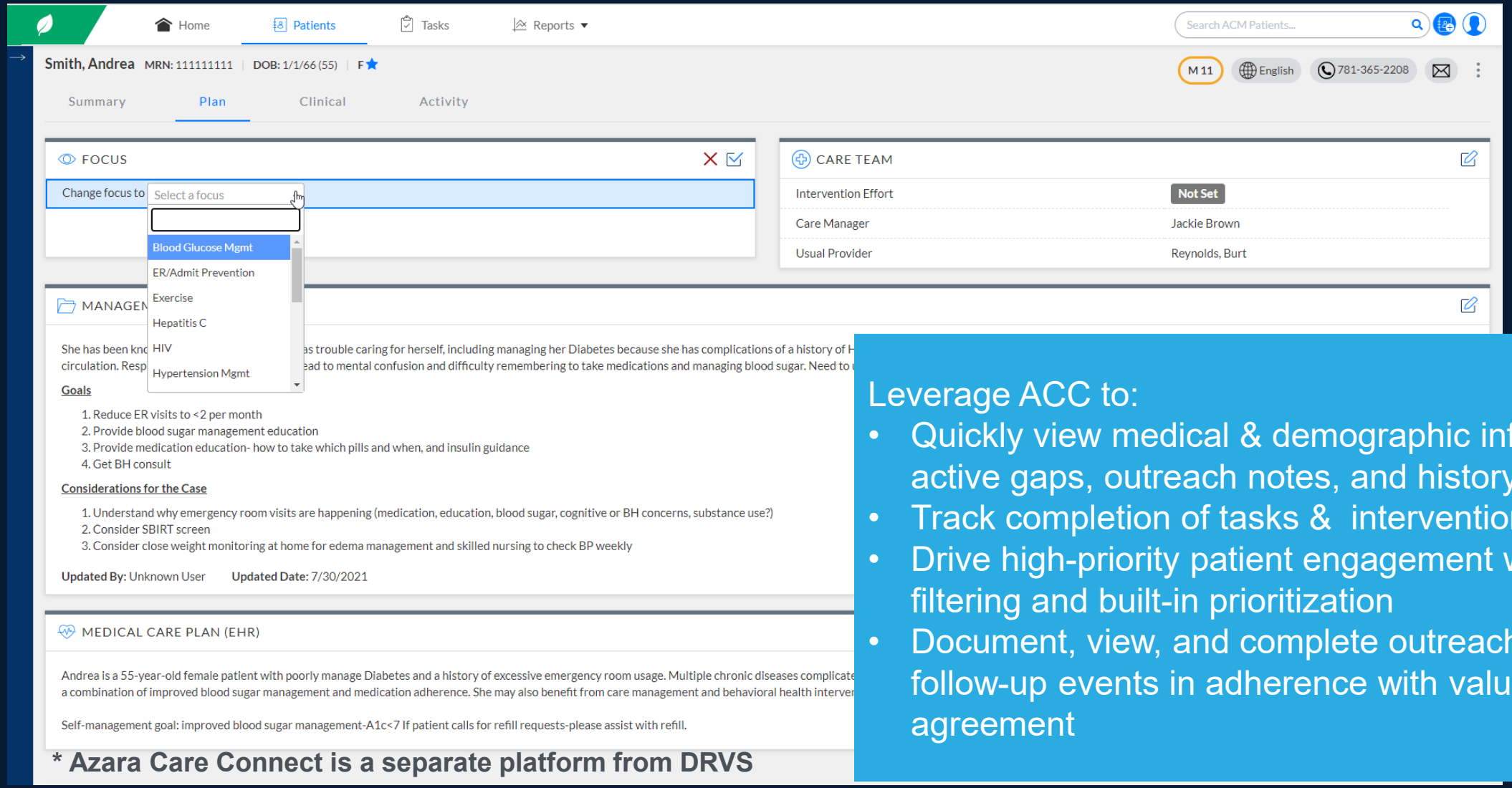


Could be as simple as picking the top 5 conditions

Care Gap Reconciliation



Azara Care Connect



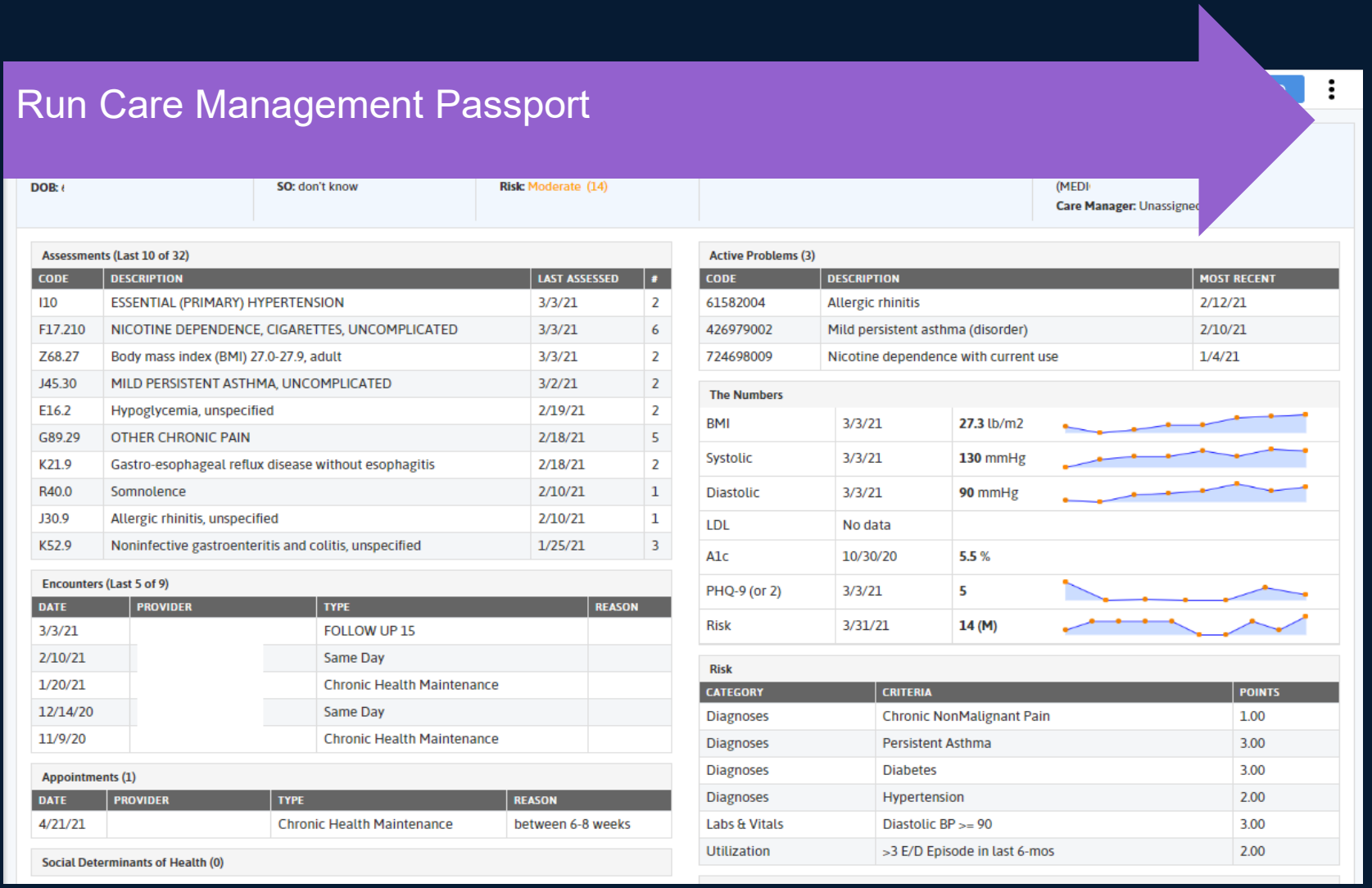
*** Azara Care Connect is a separate platform from DRVS**

Leverage ACC to:

- Quickly view medical & demographic information, active gaps, outreach notes, and history
- Track completion of tasks & interventions
- Drive high-priority patient engagement with flexible filtering and built-in prioritization
- Document, view, and complete outreach efforts. Set follow-up events in adherence with value-based agreement

Care Management Passport (CMP)

Run Care Management Passport



DOB: ‹ SO: don't know Risk: Moderate (14) (MEDI Care Manager: Unassigned

Assessments (Last 10 of 32)

CODE	DESCRIPTION	LAST ASSESSED	#
I10	ESSENTIAL (PRIMARY) HYPERTENSION	3/3/21	2
F17.210	NICOTINE DEPENDENCE, CIGARETTES, UNCOMPLICATED	3/3/21	6
Z68.27	Body mass index (BMI) 27.0-27.9, adult	3/3/21	2
J45.30	MILD PERSISTENT ASTHMA, UNCOMPLICATED	3/2/21	2
E16.2	Hypoglycemia, unspecified	2/19/21	2
G89.29	OTHER CHRONIC PAIN	2/18/21	5
K21.9	Gastro-esophageal reflux disease without esophagitis	2/18/21	2
R40.0	Somnolence	2/10/21	1
J30.9	Allergic rhinitis, unspecified	2/10/21	1
K52.9	Noninfective gastroenteritis and colitis, unspecified	1/25/21	3

Encounters (Last 5 of 9)

DATE	PROVIDER	TYPE	REASON
3/3/21		FOLLOW UP 15	
2/10/21		Same Day	
1/20/21		Chronic Health Maintenance	
12/14/20		Same Day	
11/9/20		Chronic Health Maintenance	

Appointments (1)

DATE	PROVIDER	TYPE	REASON
4/21/21		Chronic Health Maintenance	between 6-8 weeks

Social Determinants of Health (0)

Active Problems (3)

CODE	DESCRIPTION	MOST RECENT
61582004	Allergic rhinitis	2/12/21
426979002	Mild persistent asthma (disorder)	2/10/21
724698009	Nicotine dependence with current use	1/4/21

The Numbers

BMI	3/3/21	**27.3** lb/m2
Systolic	3/3/21	**130** mmHg
Diastolic	3/3/21	**90** mmHg
LDL	No data	
A1c	10/30/20	**5.5** %
PHQ-9 (or 2)	3/3/21	**5**
Risk	3/31/21	**14 (M)**

Risk

CATEGORY	CRITERIA	POINTS
Diagnoses	Chronic NonMalignant Pain	1.00
Diagnoses	Persistent Asthma	3.00
Diagnoses	Diabetes	3.00
Diagnoses	Hypertension	2.00
Labs & Vitals	Diastolic BP >= 90	3.00
Utilization	>3 E/D Episode in last 6-mos	2.00

Use the CMP to understand the patient story.

- Identify problems, assessments
- View most recent encounters, upcoming appointments
- Understand key vitals and lab trends
- View the components contributing to the risk score

CMP Continued

Allergies (0)

No active allergies

Medications (Last 10 of 28)

ACTIVE AS OF	NAME
3/3/21	amlodipine 5 MG Oral Tablet
2/19/21	isopropyl alcohol 70 % Topical Swab
2/19/21	ACCU-CHEK GUIDE (GLUCOSE) TEST STRIP
2/18/21	Naproxen 500 MG Oral Tablet
2/18/21	Omeprazole 40 MG Delayed Release Oral Capsule
2/10/21	Zyrtec 10 MG Oral Tablet
2/10/21	Advair Diskus 250/50 Dry Powder Inhaler, 60 ACTUAT
2/10/21	gabapentin 600 MG Oral Tablet
1/8/21	Diclofenac Sodium 75 MG Delayed Release Oral Tablet
1/4/21	Chantix Starting Month PAK

Alerts (5)

ALERT	MESSAGE	MOST RECENT DATE	MOST RECENT RESULT
LDL	Missing		
Depr Follow-Up	Missing Follow-up		
BP	Out of Range	3/3/21	130/90
Foot	Missing		
E/D Encounter	Occurred	3/2/21	IU Health

Open Referrals w/o Result (4)

TYPE	SPECIALIST/LOCATION	ORDER DATE	APPT DATE
Z12.11 - GASTROENTEROLOGY REFERRAL	IU HEALTH PHYSICIANS GASTROENTEROLOGY / IU HEALTH PHYSICIANS GASTROENTEROLOGY	1/25/21	
M79.605 - PODIATRY REFERRAL	TOD S REED DPM / TOD S REED DPM	8/11/20	
M79.605 - PHYSICAL THERAPY REFERRAL	IU HEALTH BALL MEMORIAL REHABILITATION CENTER / IU HEALTH BALL MEMORIAL REHABILITATION CENTER	8/11/20	
R55 - NEUROLOGY REFERRAL	IU HEALTH BALL MEMORIAL PHYSICIANS NEUROLOGY- ALAN SCHMITT / IU HEALTH BALL MEMORIAL PHYSICIANS NEUROLOGY- ALAN SCHMITT	6/9/20	

I/P & E/D Utilizations (Last 10 of 35)

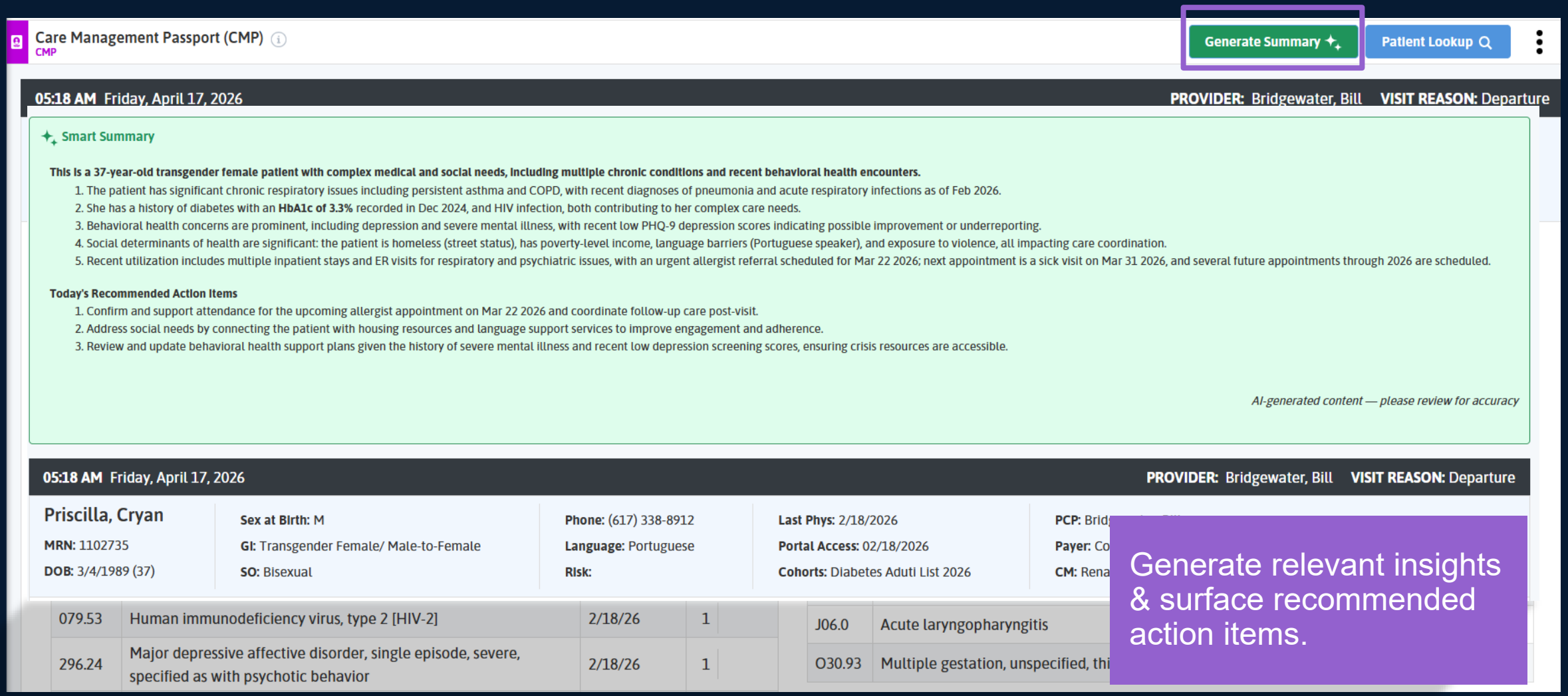
SOURCE	TYPE	ADMIT DATE	DISCHARGE DATE	LOCATION	DIAGNOSIS	DESCRIPTION
IHIE	ER Visit	3/2/21	3/2/21	IU Health		
IHIE	ER Visit	3/1/21	3/1/21	IU Health		
IHIE	ER Visit	2/25/21	2/26/21	IU Health		
EHR	Hospital Discharge	2/11/21	2/11/21			
IHIE	ER Visit	2/9/21	2/9/21	IU Health		
IHIE	ER Visit	1/17/21	1/17/21	IU Health		
EHR	Hospital Discharge	1/12/21	1/12/21			
IHIE	ER Visit	1/10/21	1/10/21	IU Health		
IHIE	ER Visit	1/8/21	1/8/21	IU Health		
IHIE	ER Visit	1/7/21		Reid Hospital		

The **Care Management Passport** will help the Care Coordinators, RN Care Managers, and other care team members prepare prior to their communication with the patient.

Follow up on open referrals to improve coordination of care efforts.

Identify each ER Visit and Hospital Discharge based on the HIE data.

CMP | Smart Summary



DRVS for Strategy and Compliance

Population Level Management

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Leadership and Performance Management

- Leadership decisions
- Resource allocation
- Performance accountability

Core Capabilities

Scorecards and performance tracking

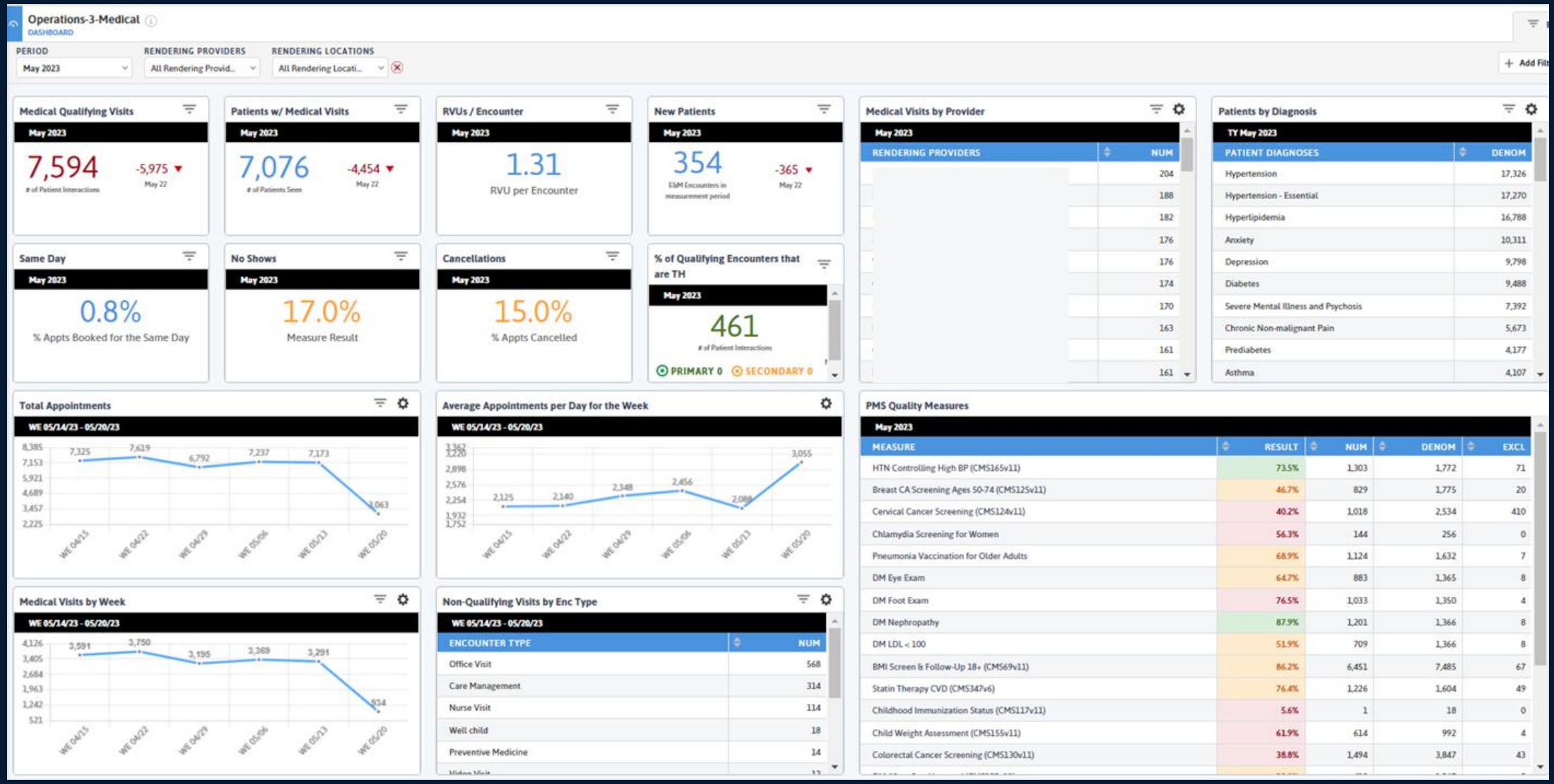
Peer comparison & benchmarking/variation

Strategic planning & work plans

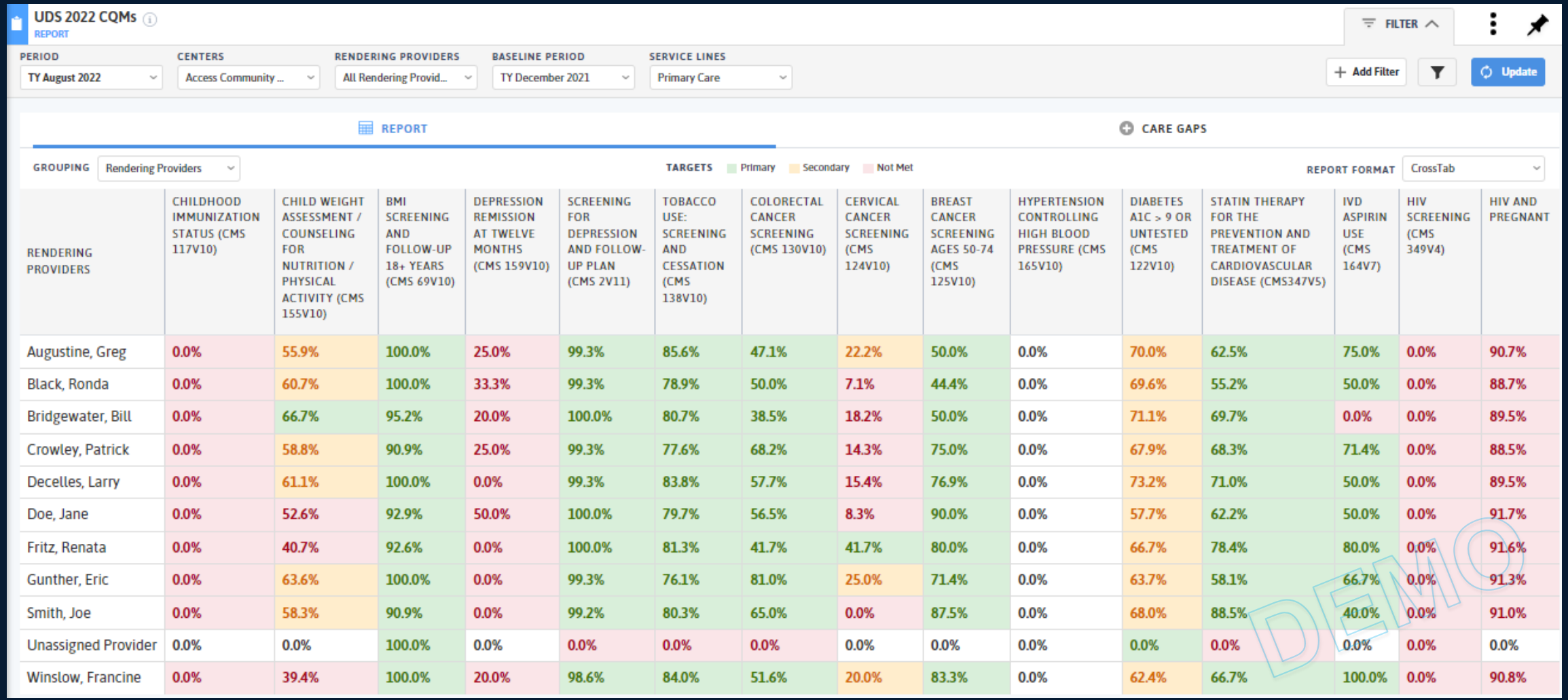
ROI & effectiveness evaluation

UDS Reporting

Scorecards and Performance Tracking



Benchmarking / Variation



UDS 2022 CQMs
REPORT

FILTER

PERIOD: TY August 2022 | CENTERS: Access Community ... | RENDERING PROVIDERS: All Rendering Provid... | BASELINE PERIOD: TY December 2021 | SERVICE LINES: Primary Care

Add Filter | Update

REPORT | CARE GAPS

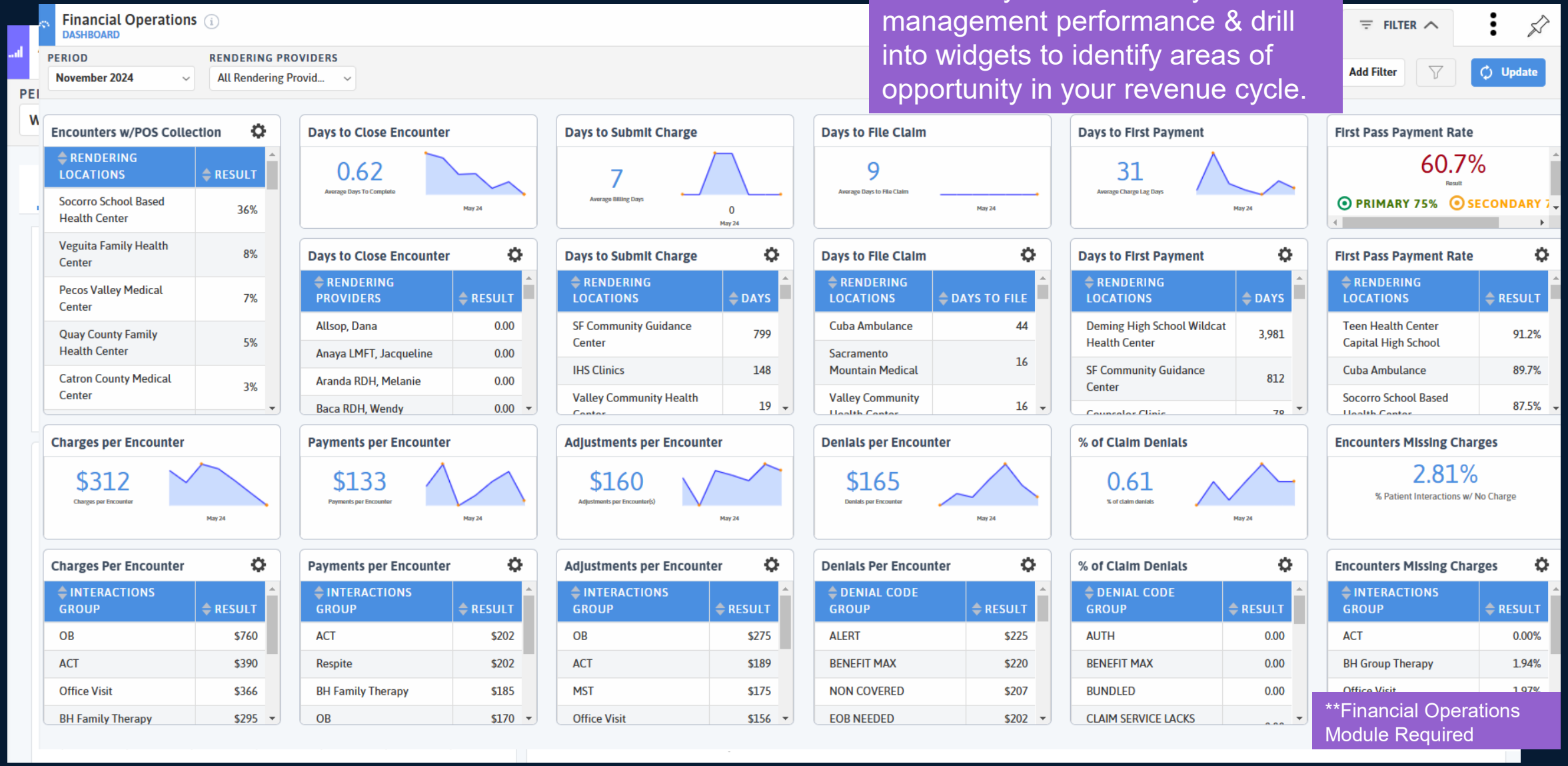
GROUPING: Rendering Providers | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: CrossTab

RENDERING PROVIDERS	CHILDHOOD IMMUNIZATION STATUS (CMS 117V10)	CHILD WEIGHT ASSESSMENT / COUNSELING FOR NUTRITION / PHYSICAL ACTIVITY (CMS 155V10)	BMI SCREENING AND FOLLOW-UP 18+ YEARS (CMS 69V10)	DEPRESSION REMISSION AT TWELVE MONTHS (CMS 159V10)	SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN (CMS 2V11)	TOBACCO USE: SCREENING AND CESSATION (CMS 138V10)	COLORECTAL CANCER SCREENING (CMS 130V10)	CERVICAL CANCER SCREENING (CMS 124V10)	BREAST CANCER SCREENING AGES 50-74 (CMS 125V10)	HYPERTENSION CONTROLLING HIGH BLOOD PRESSURE (CMS 165V10)	DIABETES A1C > 9 OR UNTESTED (CMS 122V10)	STATIN THERAPY FOR THE PREVENTION AND TREATMENT OF CARDIOVASCULAR DISEASE (CMS347V5)	IVD ASPIRIN USE (CMS 164V7)	HIV SCREENING (CMS 349V4)	HIV AND PREGNANT
Augustine, Greg	0.0%	55.9%	100.0%	25.0%	99.3%	85.6%	47.1%	22.2%	50.0%	0.0%	70.0%	62.5%	75.0%	0.0%	90.7%
Black, Ronda	0.0%	60.7%	100.0%	33.3%	99.3%	78.9%	50.0%	7.1%	44.4%	0.0%	69.6%	55.2%	50.0%	0.0%	88.7%
Bridgewater, Bill	0.0%	66.7%	95.2%	20.0%	100.0%	80.7%	38.5%	18.2%	50.0%	0.0%	71.1%	69.7%	0.0%	0.0%	89.5%
Crowley, Patrick	0.0%	58.8%	90.9%	25.0%	99.3%	77.6%	68.2%	14.3%	75.0%	0.0%	67.9%	68.3%	71.4%	0.0%	88.5%
Decelles, Larry	0.0%	61.1%	100.0%	0.0%	99.3%	83.8%	57.7%	15.4%	76.9%	0.0%	73.2%	71.0%	50.0%	0.0%	89.5%
Doe, Jane	0.0%	52.6%	92.9%	50.0%	100.0%	79.7%	56.5%	8.3%	90.0%	0.0%	57.7%	62.2%	50.0%	0.0%	91.7%
Fritz, Renata	0.0%	40.7%	92.6%	0.0%	100.0%	81.3%	41.7%	41.7%	80.0%	0.0%	66.7%	78.4%	80.0%	0.0%	91.6%
Gunther, Eric	0.0%	63.6%	100.0%	0.0%	99.3%	76.1%	81.0%	25.0%	71.4%	0.0%	63.7%	58.1%	66.7%	0.0%	91.3%
Smith, Joe	0.0%	58.3%	90.9%	0.0%	99.2%	80.3%	65.0%	0.0%	87.5%	0.0%	68.0%	88.5%	40.0%	0.0%	91.0%
Unassigned Provider	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Winslow, Francine	0.0%	39.4%	100.0%	20.0%	98.6%	84.0%	51.6%	20.0%	83.3%	0.0%	62.4%	66.7%	100.0%	0.0%	90.8%

DEMO

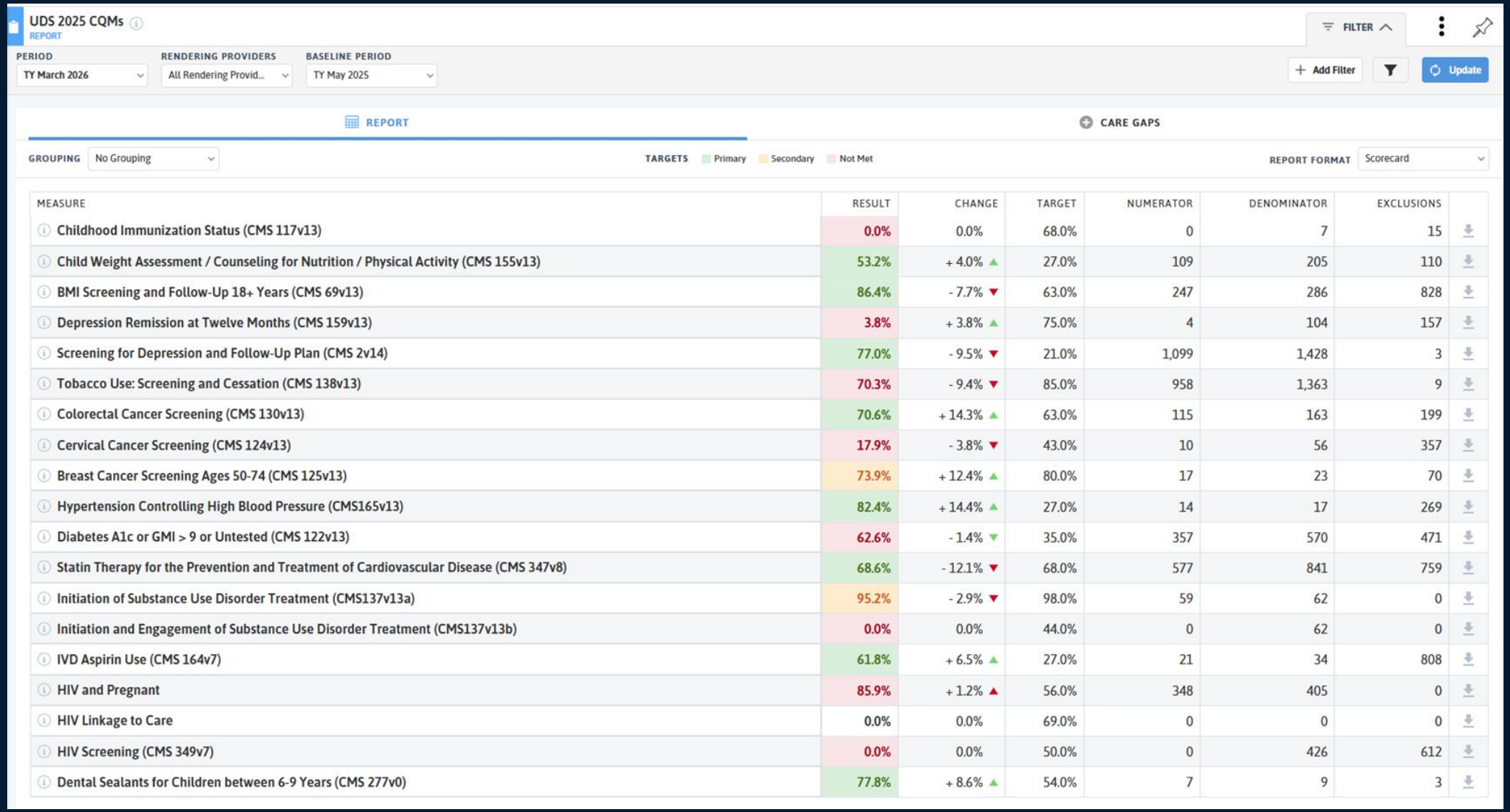
Strategic Evaluation

Visualize your revenue cycle management performance & drill into widgets to identify areas of opportunity in your revenue cycle.



**Financial Operations Module Required

UDS



UDS 2025 CQMs
REPORT

FILTER

PERIOD: TY March 2026 | RENDERING PROVIDERS: All Rendering Provid... | BASELINE PERIOD: TY May 2025

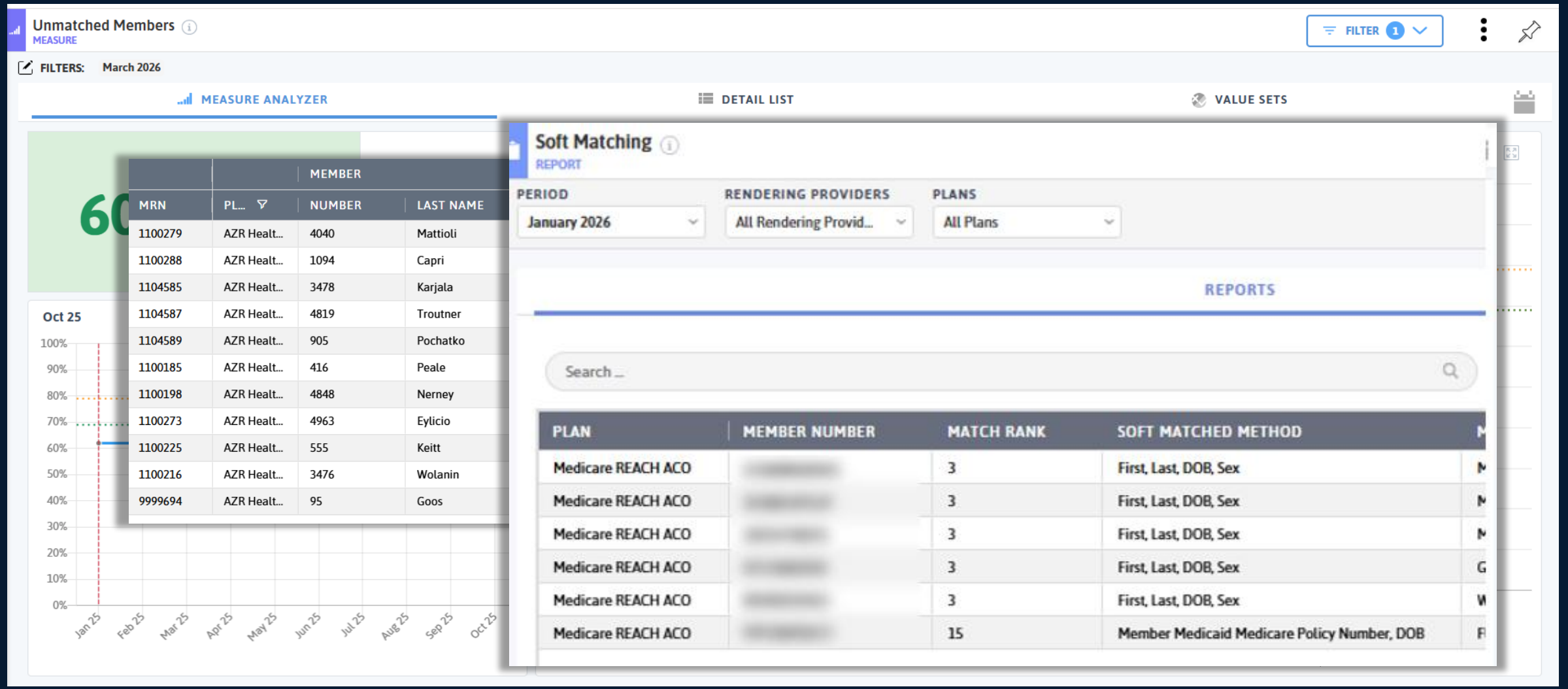
Add Filter | Update

REPORT | CARE GAPS

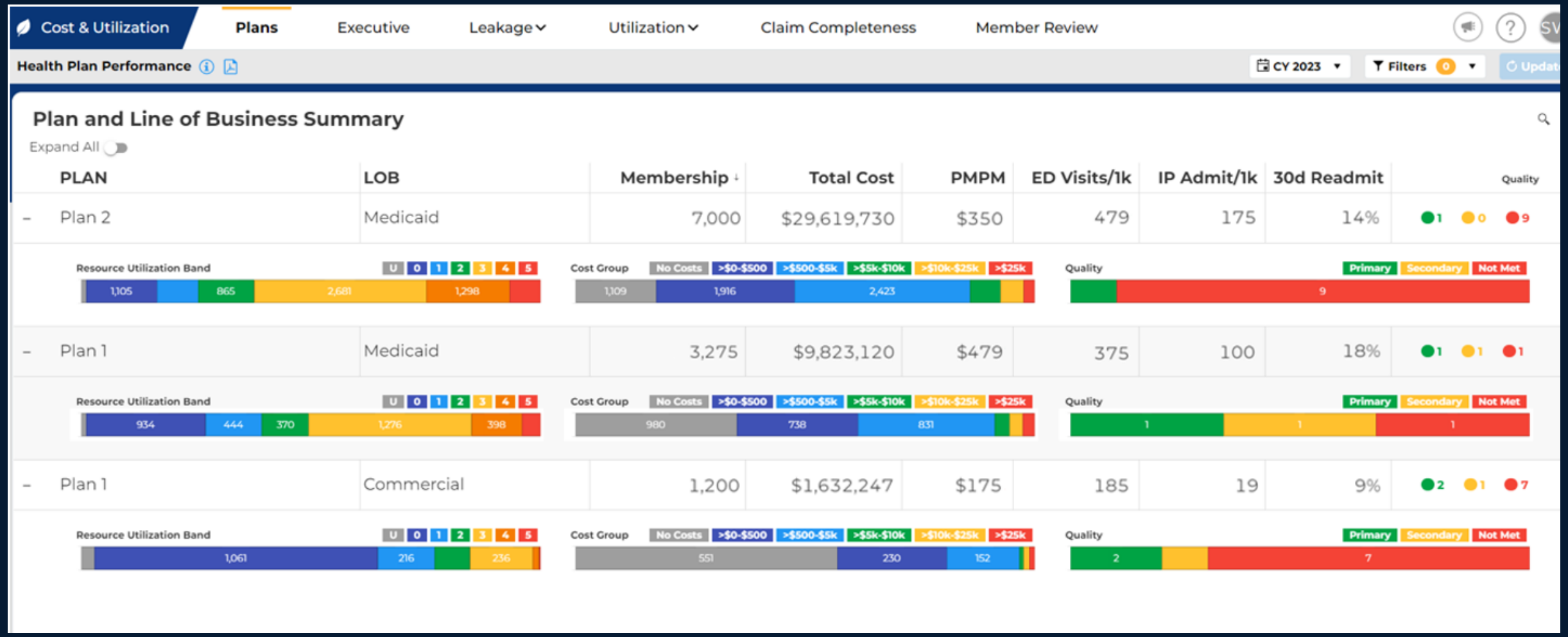
GROUPING: No Grouping | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: Scorecard

MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Childhood Immunization Status (CMS 117v13)	0.0%	0.0%	68.0%	0	7	15
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v13)	53.2%	+ 4.0% ▲	27.0%	109	205	110
BMI Screening and Follow-Up 18+ Years (CMS 69v13)	86.4%	- 7.7% ▼	63.0%	247	286	828
Depression Remission at Twelve Months (CMS 159v13)	3.8%	+ 3.8% ▲	75.0%	4	104	157
Screening for Depression and Follow-Up Plan (CMS 2v14)	77.0%	- 9.5% ▼	21.0%	1,099	1,428	3
Tobacco Use: Screening and Cessation (CMS 138v13)	70.3%	- 9.4% ▼	85.0%	958	1,363	9
Colorectal Cancer Screening (CMS 130v13)	70.6%	+ 14.3% ▲	63.0%	115	163	199
Cervical Cancer Screening (CMS 124v13)	17.9%	- 3.8% ▼	43.0%	10	56	357
Breast Cancer Screening Ages 50-74 (CMS 125v13)	73.9%	+ 12.4% ▲	80.0%	17	23	70
Hypertension Controlling High Blood Pressure (CMS165v13)	82.4%	+ 14.4% ▲	27.0%	14	17	269
Diabetes A1c or GMI > 9 or Untested (CMS 122v13)	62.6%	- 1.4% ▼	35.0%	357	570	471
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS 347v8)	68.6%	- 12.1% ▼	68.0%	577	841	759
Initiation of Substance Use Disorder Treatment (CMS137v13a)	95.2%	- 2.9% ▼	98.0%	59	62	0
Initiation and Engagement of Substance Use Disorder Treatment (CMS137v13b)	0.0%	0.0%	44.0%	0	62	0
IVD Aspirin Use (CMS 164v7)	61.8%	+ 6.5% ▲	27.0%	21	34	808
HIV and Pregnant	85.9%	+ 1.2% ▲	56.0%	348	405	0
HIV Linkage to Care	0.0%	0.0%	69.0%	0	0	0
HIV Screening (CMS 349v7)	0.0%	0.0%	50.0%	0	426	612
Dental Sealants for Children between 6-9 Years (CMS 277v0)	77.8%	+ 8.6% ▲	54.0%	7	9	3

Attribution



Health Plan Performance Dashboard



Cost and Utilization - Executive Dashboard

Identify focus areas for further drill down.

Cost & Utilization | Plans | **Executive** | Leakage | Member Review

Executive Dashboard

CY 2024

Centene | Medicaid

View of paid amount from claims for selected period.

Flags the top 10% of members WITH COST to compare to total population of members with and without costs.

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

Avg Members	Avg RUB	Total Claims Paid	Cost per Member
55.6k ▼ 9%	2.9 ▼ 0.1	$6.7m ▼ $166.9m	$121.3 ▼ $2.7k

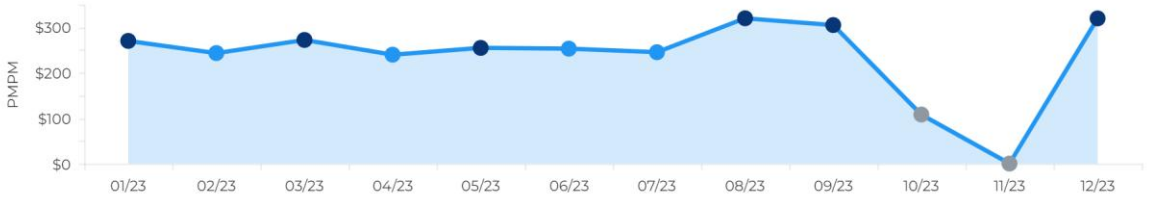
76.9% of Cost
2.7% of Members

2024

Primary	0
Secondary	0
Not Met	6
Total Measures	6

Per Member Per Month

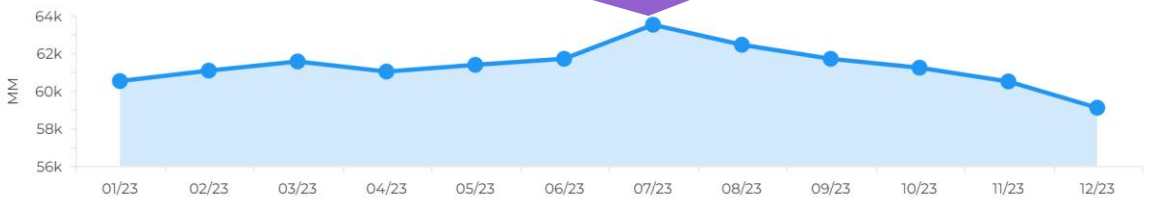
$236 ▼ $58



Member Months

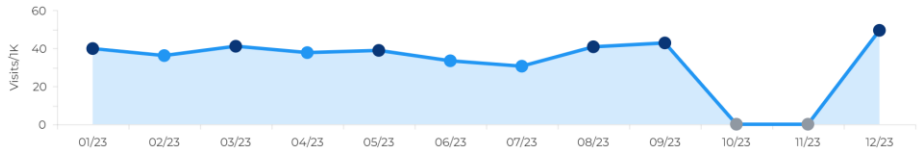
735.6k ▲ 33.2k

Timeline widgets include snapshot of claim completeness for context in analyzing numbers.



Emergency Utilization

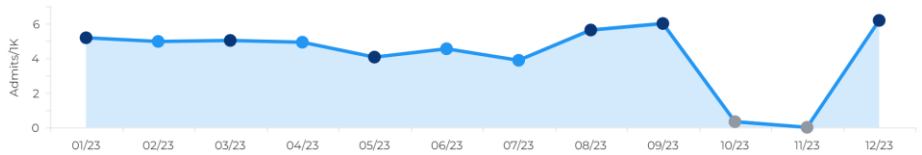
ED Visits/1K: 389 ▼ 26%
ED Cost/Visit: $410.1 ▲ $15.4



VISITS/1K | COST/VISIT

Inpatient Utilization

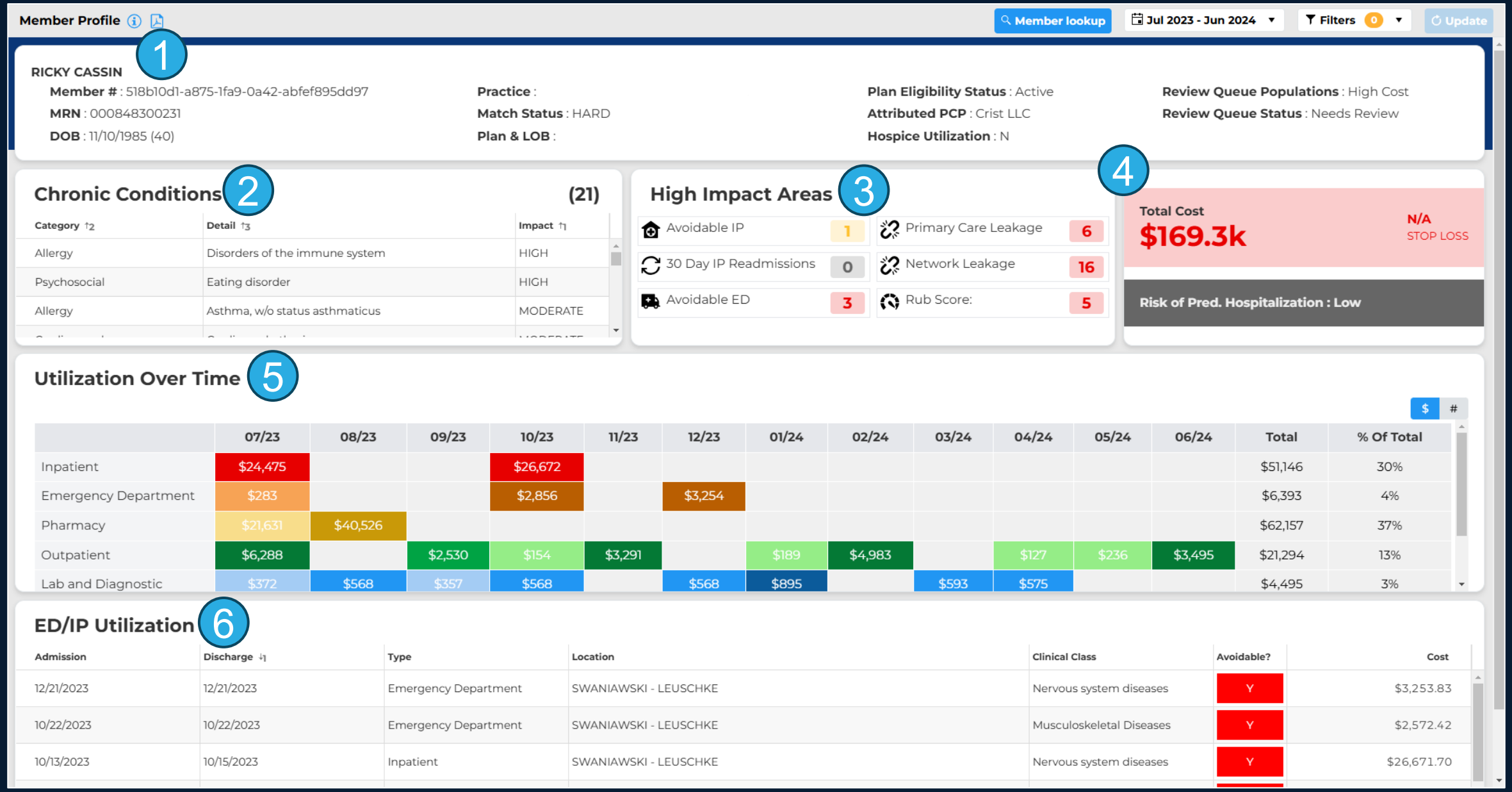
IP Admits/1K: 51 ▼ 34%
IP Cost/Admit: $8.7k ▼ $1.3k



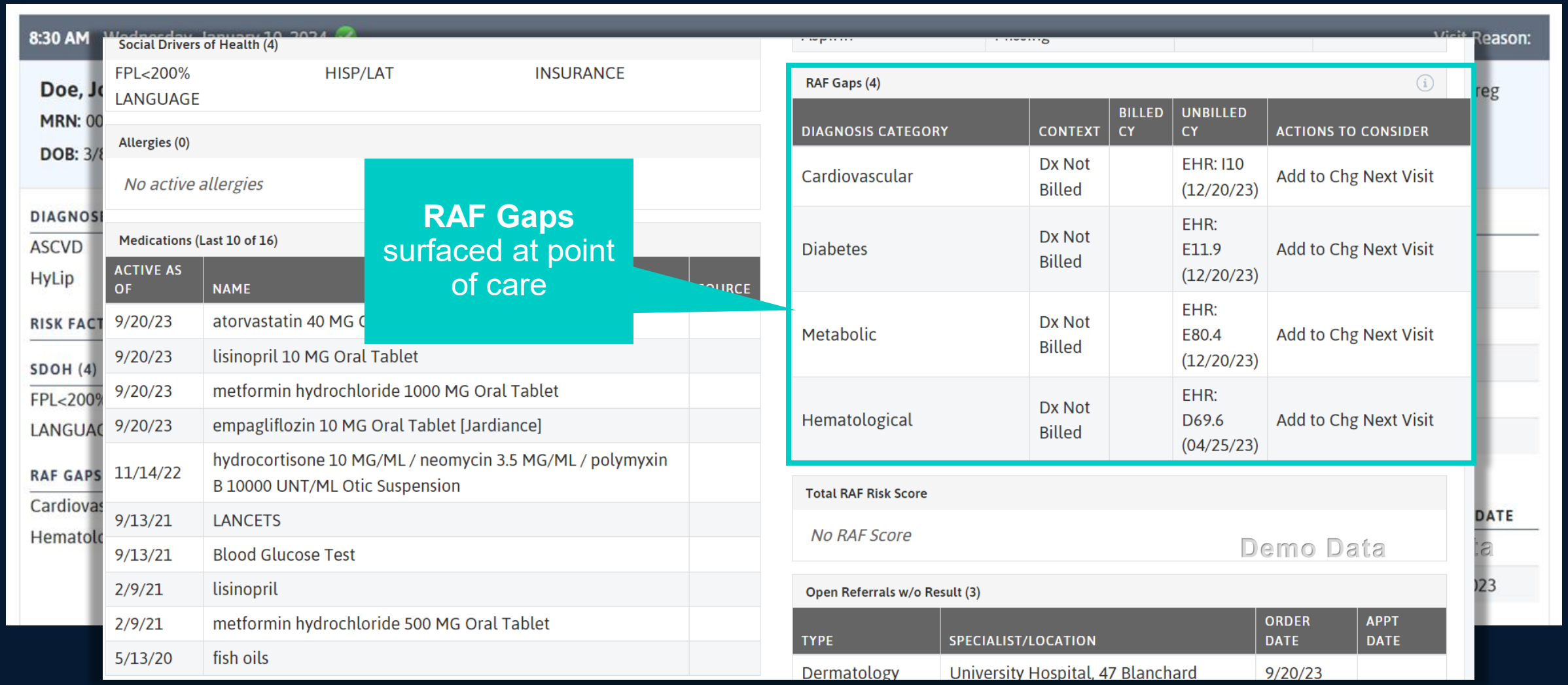
ADMITS/1K | COST/ADMIT

Shows overall ED and IP utilization and costs/visit and admit.

Cost and Utilization - Member Profile

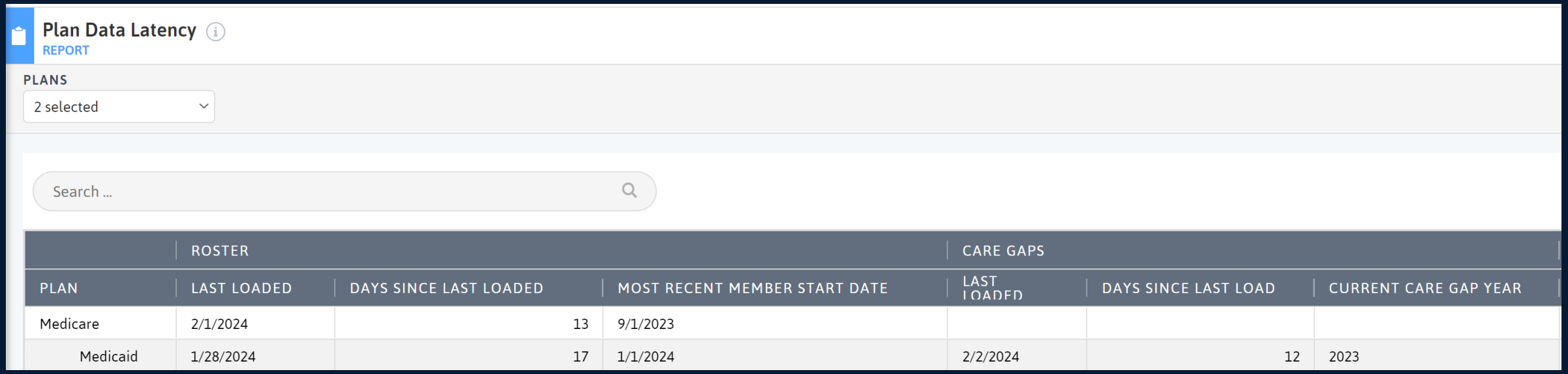


RAF Gaps


8:30 AM
Visit Reason:
Social Drivers of Health (4)
FPL<200%
HISP/LAT
INSURANCE
LANGUAGE
Allergies (0)
No active allergies
Medications (Last 10 of 16)
ACTIVE AS OF
NAME
9/20/23 atorvastatin 40 MG
9/20/23 lisinopril 10 MG Oral Tablet
9/20/23 metformin hydrochloride 1000 MG Oral Tablet
9/20/23 empagliflozin 10 MG Oral Tablet [Jardiance]
11/14/22 hydrocortisone 10 MG/ML / neomycin 3.5 MG/ML / polymyxin B 10000 UNT/ML Otic Suspension
9/13/21 LANCETS
9/13/21 Blood Glucose Test
2/9/21 lisinopril
2/9/21 metformin hydrochloride 500 MG Oral Tablet
5/13/20 fish oils
RAF Gaps surfaced at point of care
RAF Gaps (4)
DIAGNOSIS CATEGORY
CONTEXT
BILLED CY
UNBILLED CY
ACTIONS TO CONSIDER
Cardiovascular
Dx Not Billed
EHR: I10 (12/20/23)
Add to Chg Next Visit
Diabetes
Dx Not Billed
EHR: E11.9 (12/20/23)
Add to Chg Next Visit
Metabolic
Dx Not Billed
EHR: E80.4 (12/20/23)
Add to Chg Next Visit
Hematological
Dx Not Billed
EHR: D69.6 (04/25/23)
Add to Chg Next Visit
Total RAF Risk Score
No RAF Score
Demo Data
Open Referrals w/o Result (3)
TYPE
SPECIALIST/LOCATION
ORDER DATE
APPT DATE
Dermatology
University Hospital, 47 Blanchard
9/20/23

Plan Data Latency Report in DRVS

- Use to understand when data has been received from plan and uploaded into DRVS.
- Data is updated in DRVS 1-2 days after received from the plan.



Plan Data Latency
REPORT

PLANS
2 selected

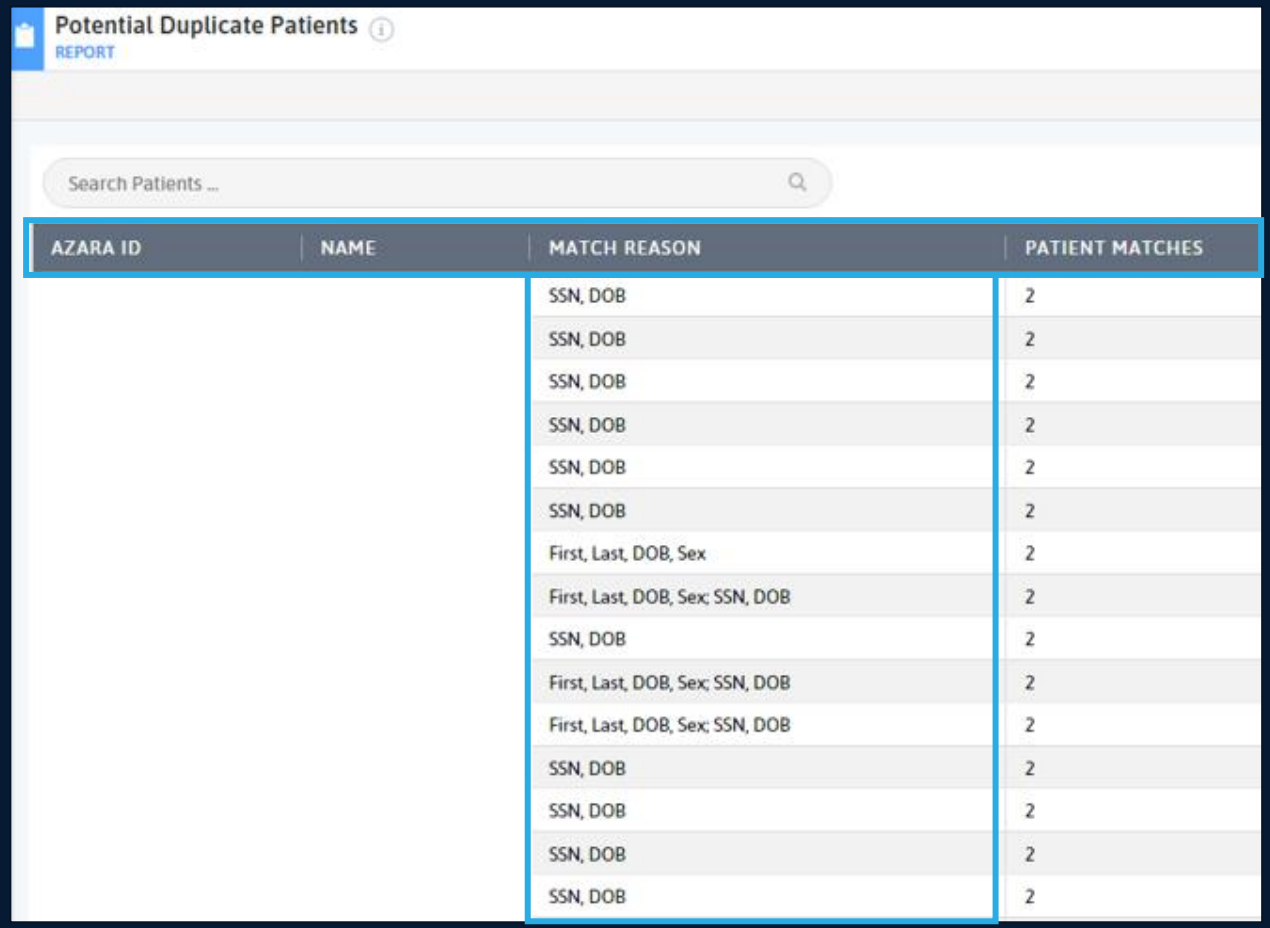
Search ...

	ROSTER			CARE GAPS		
PLAN	LAST LOADED	DAYS SINCE LAST LOADED	MOST RECENT MEMBER START DATE	LAST LOADED	DAYS SINCE LAST LOAD	CURRENT CARE GAP YEAR
Medicare	2/1/2024	13	9/1/2023			
Medicaid	1/28/2024	17	1/1/2024	2/2/2024	12	2023

CLAIMS					
DATA AVAILABLE	LAST LOADED	EARLIEST DATE OF SERVICE	DATE OF SERVICE (MOST RECENT)	IP VISIT (MOST RECENT)	ER VISIT (MOST RECENT)
Y	1/29/2024	12/29/2014	12/19/2023	12/3/2023	12/14/2023
Y	12/24/2023	7/1/2018	12/7/2023	12/7/2023	12/3/2023

Potential Duplicate Patients

How Data Health Starts with Registration



These patients have two or more records with similar or exact matches on demographic information across records.

Thinking about your organization:

- Are we verifying if patients have an account within the health record prior to starting a new registration?
- No Shows
- Patients who have not been in over the last several years
- Seen across other service lines

Where to Start

Standardize Pre-Visit Planning

- Pick 1 or 2 conditions
- Standardize expectations
- Standardize workflow

Transitions of Care

- Define who
- Define outreach timeframe
- Standardize workflow

Care Management

- Define care management criteria
- Limit panel size
- Track outcomes

Where to Start (Cont.)

Data Transparency & Reporting

- Simple scorecard
- Share

Outreach

- Start with calls to existing patients
- Utilize texting

Attribution

- Start with internal PCP management

Questions?

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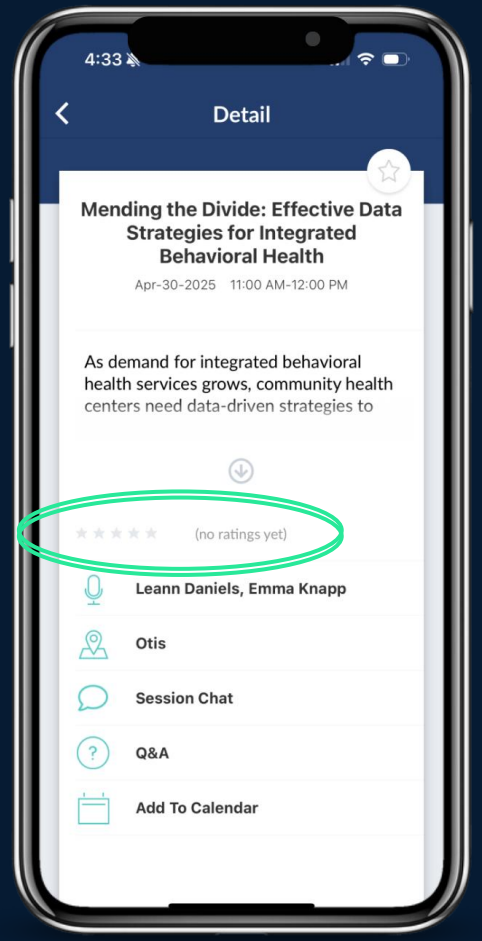
Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy

Provide brief feedback or ideas

Rate the session and the speaker(s)

Help us continue to improve

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