

Making Data Actionable

Operational Improvement with DRVS

azara2026

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Today's Presenter

15



**Russ Kolski, RDN BSN
MSA**

**Value Based Care
Consultant**

Azara Healthcare



Operations & Value-Based Care

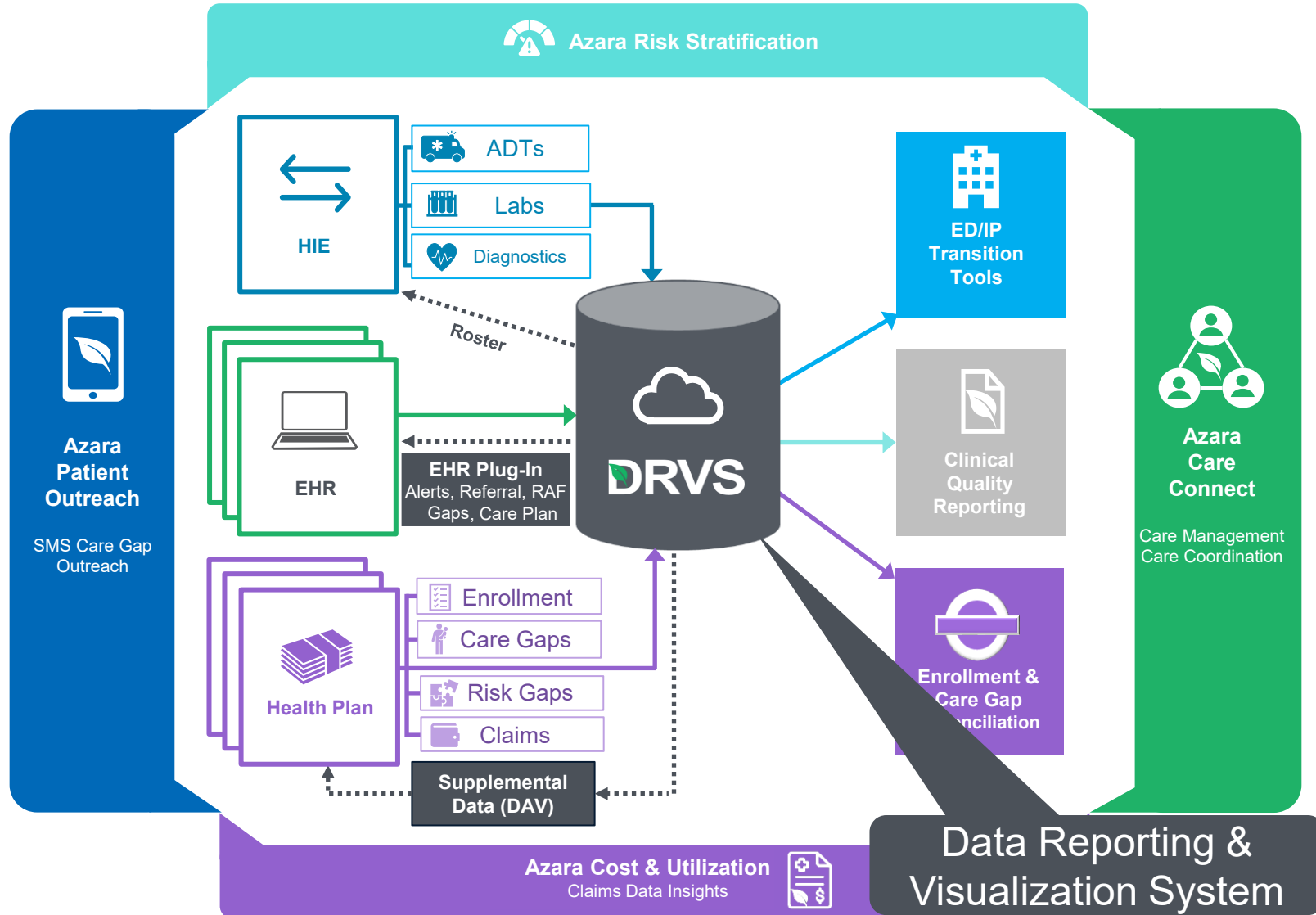


The Operations Challenge

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



Azara Platform



Model for Success – Core Domains



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)			ALERT			MESSAGE		
ASCVD	Asthma	CAD	A1c	Missing				OWNER
DM I or II	HCV	HIV	LDL	Overdue	2/14/2024			MA
HTN-NE	IVD		Foot	Missing				Provider
RISK FACTORS (6)			E/D Encounter			Occurred		
ANTICOAG	Chronic Opioid Tx	IDD	2/26/2026			St. Marys Hospital		
MSM	SMI	TOB	OPEN REFERRAL W/O RESULT					
SDOH (14)			SPECIALIST/LOCATION			ORDERED DATE		
EDU	EMPLOYMENT	FPL<200%	Open			5/30/2026		
HISP/LAT	HOMELESS	HOUSING	Open			6/27/2026		
ISOLATION	LANGUAGE	MED/CARE	Allergist			11/19/2025		
MIGRANT	RACE	SAFETY	Nutritionist			11/29/2025		
TRANSPORT-MED	VIOLENCE		Nutritionist			11/29/2025		
RAF GAP DISEASE GROUPS			Radiology			11/29/2025		
Diabetes	CNS	Infectious	Accupuncture			11/6/2025		
Cerebrovascular	Pulmonary	DD	Allergist			11/20/2025		
Cardiovascular	Substance abuse		Nutritionist			11/19/2025		
			Nutritionist			11/19/2025		



Why Use the PVP?

15



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 p-rhutcherson1 Log out

athenaOne **Lottie SIMONIS** Contact Appointments Provider Insurance

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	Cardio-Respiratory Failure and Shock 10/14/25 Rachel Hutcherson	Dx Not Billed Add to Chg Next Visit		EHR: J80 (06/27/25)	- + ↻
Cerebrovascular	Ischemic or Unspecified Stroke 10/14/25 Rachel Hutcherson	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					

athenaOne Calendar Patients Claims Financials Reports Quality Apps Support p-rhutcherson1 Log out

Lottie SIMONIS
72yo M | 7-24-2953 | #1103603 | E#4648
ENG

10-08-2025
Office Visit | Chip Ach, MD

Home (919) 673-5676 Next

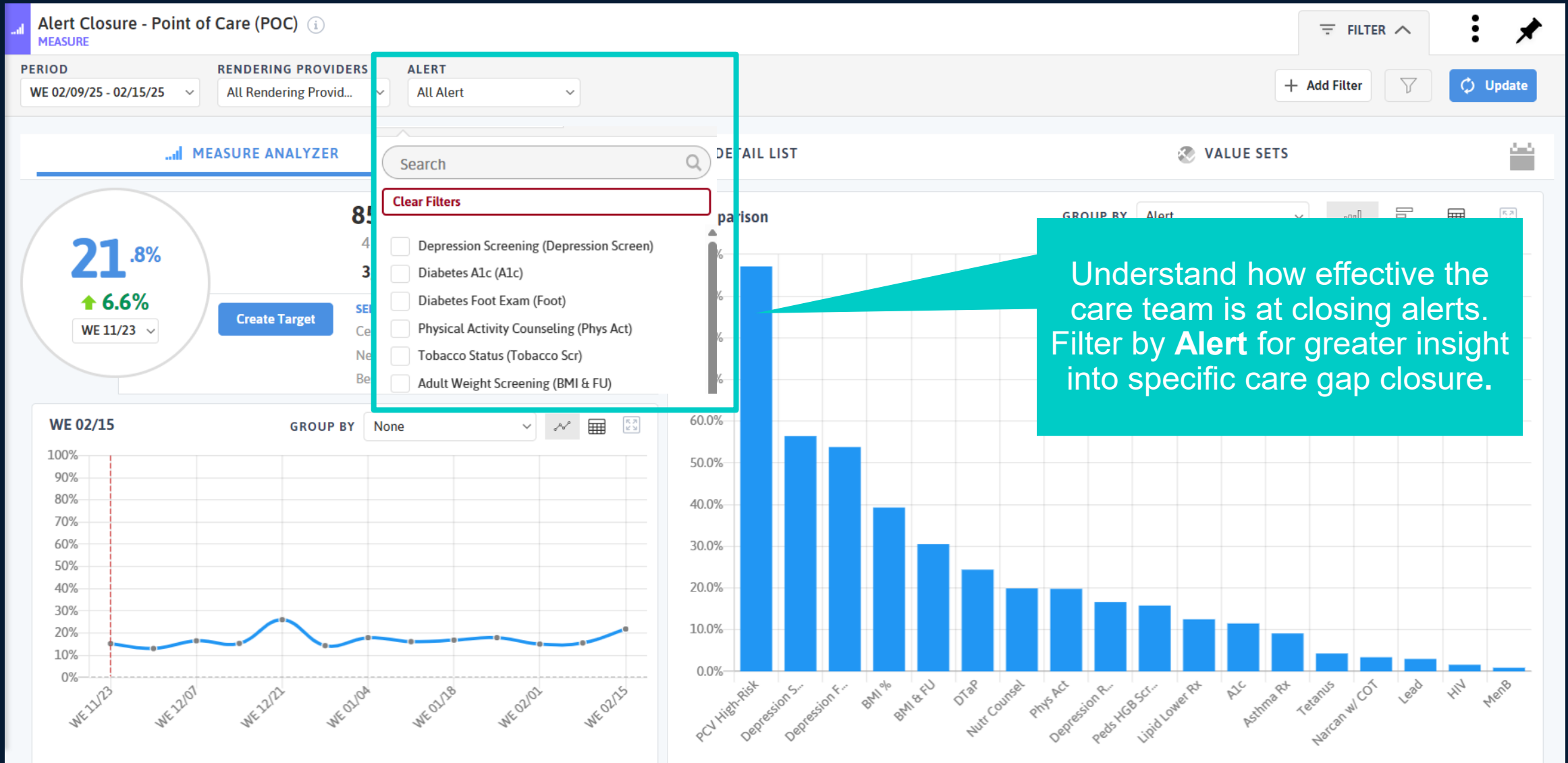
Review HPI ROS PE A/P

Assessment & Plan **DIAGNOSES & ORDERS**

cerebral palsy RAF weight 0.628



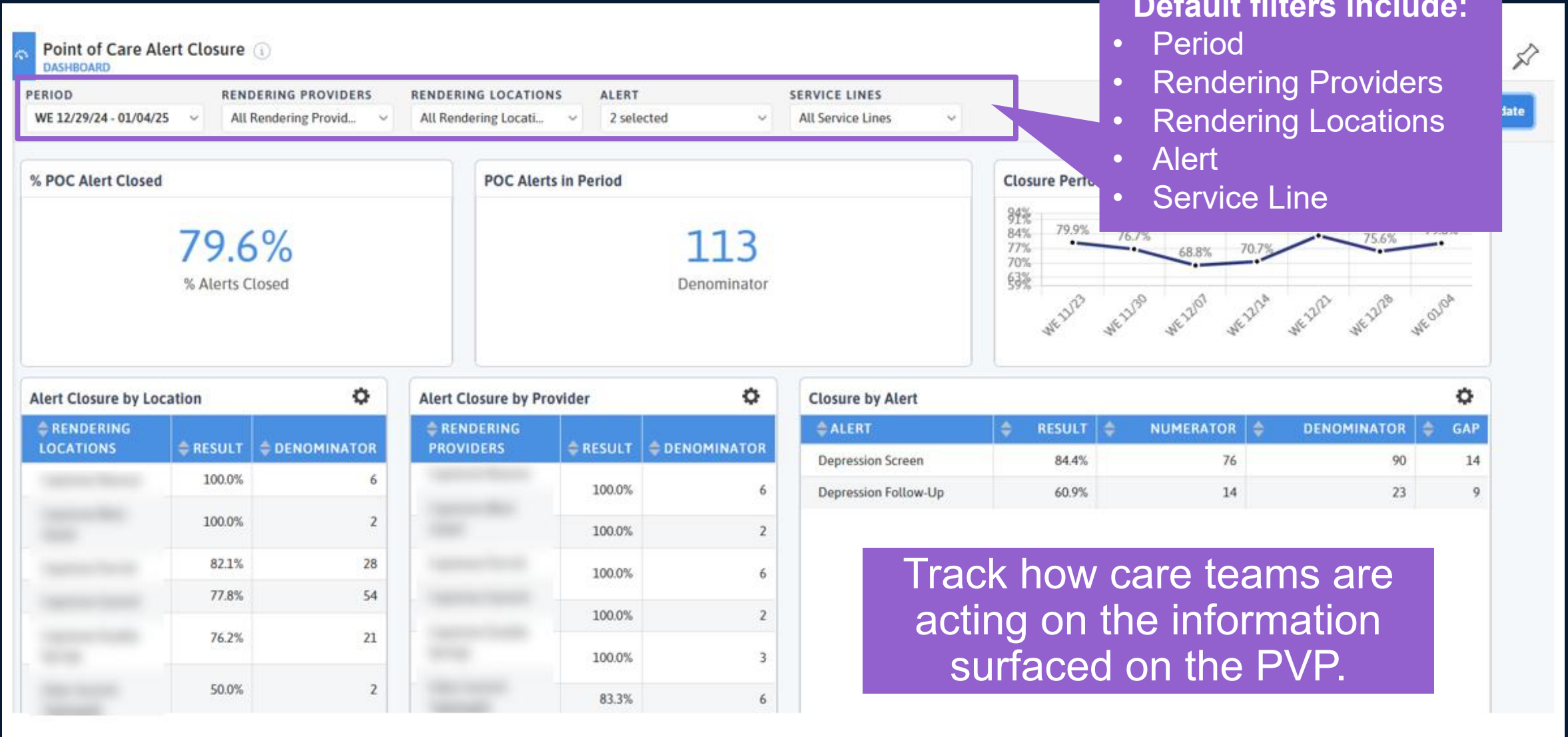
Monitoring Effectiveness | POC Alert Closure



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

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- Proactive
- Requires structured workflows



Core Areas of Focus



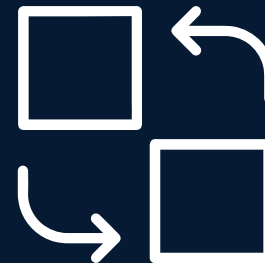
Transitions of Care
Timely follow-up after
ED/IP events



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

Transitions of Care (TOC) - ED/IP REPORT

DATE RANGE: 05/09/2024-05/09/2024 | CENTERS: All Centers | DISCHARGE STATUS: All Discharge Status | LAST VISIT: No Required Visit | TOC TYPE: IP Only | TOC STATUS: Discharge

Search ... | Clear Filters | All | No Appt | Upcoming Appt

Filter by ED or IP Type

Filter the discharge status column to identify patients discharged to a particular location. For example, all patients discharged to home (01).

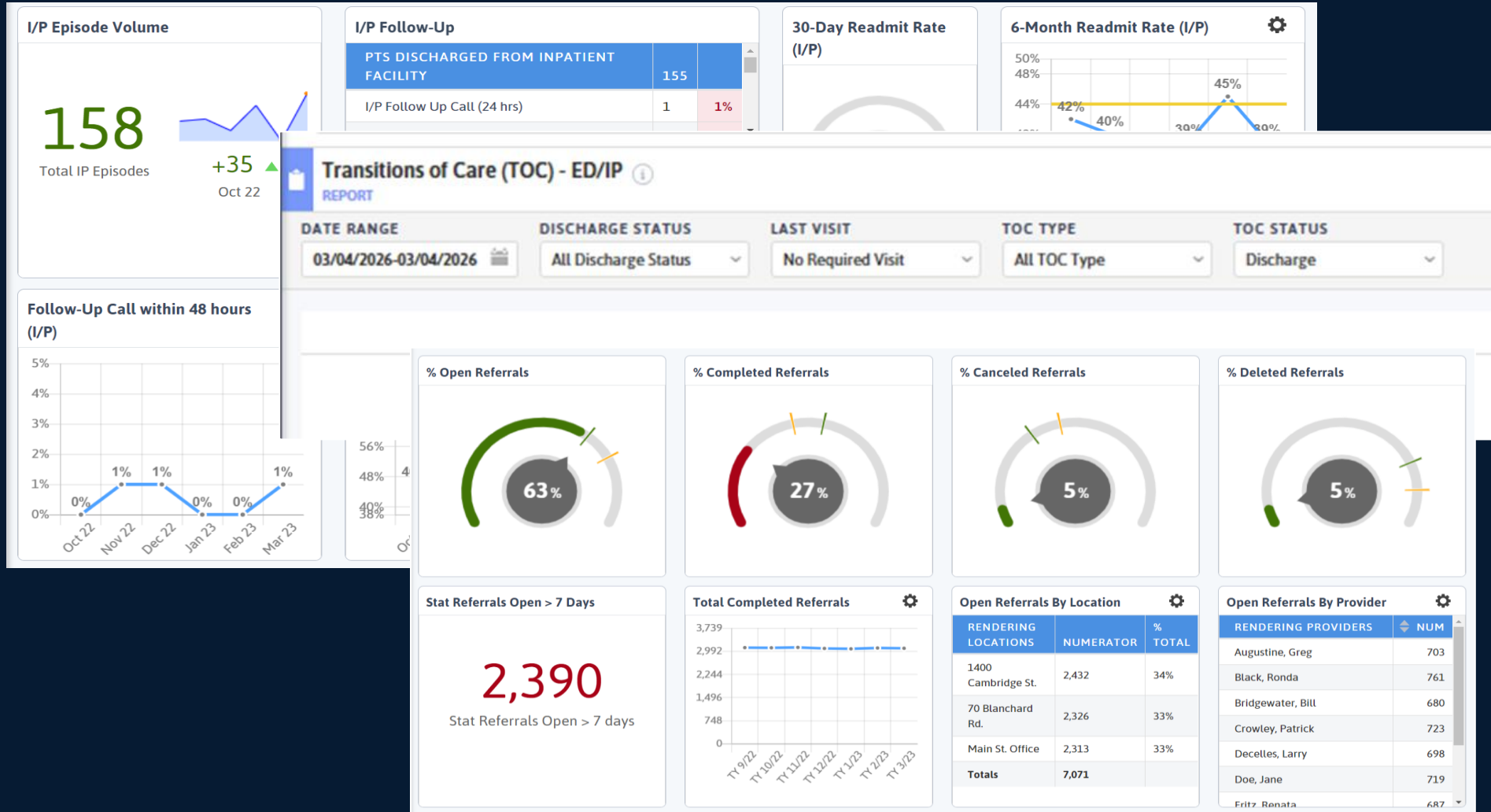
See diagnosis code & description from patient's admission

NAME	MRN	DATE OF BIRTH	PA (Y/N)	CHARGE	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS	DISCHARGE STATUS CODE	DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
			Y	ER Visit	2/2/23 3:05 am	2/2/23 6:06 am	Home (Self-Care Only)		
			Y	ER Visit	2/2/23 3:05 am	2/2/23 6:06 am			
			Y	ER Visit	2/2/23 11:47 am	2/2/23 1:32 pm	Home (Self-Care Only)		
			Y	ER Visit	2/2/23 10:52 am	2/2/23 12:23 pm			
			Y	Inpatient Stay	12/12/22 2:00 pm	2/2/23 1:25 pm	HOME		
			Y	ER Visit	2/1/23 10:24 pm	2/2/23 1:18 am	1		
			Y	Inpatient Stay	1/31/23 11:04 am	2/2/23 11:13 am	HOMHLTH	Z96.652	Presence of left artificial knee joint

DEMOGRAPHICS	NEXT APPOINTMENT	LAST APPOINTMENT	HIE	RISK	RISKSCORE				
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
Undiagnosed Measure
Patient Risk Stratification Dashboard

PERIOD: March 2026

Timeline Trend: 100%, 80%, 60%, 40%, 20%, 0% (Mar 25)

Members Group: COST GROUP >\$100K, \$50-100K, \$25-50K, \$10-25K, \$5-10K, \$0-5K, No Cost Data

PERIOD: TY January 2026

RENDERING PROVIDERS: All Rendering Provid...

SERVICE LINES: Primary Care

Filter, 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

103 Pts w/ qualifying encounter

Total Patients: 1,355 Pts w/ qualifying encounter

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

Risk Score Distribution

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

Predominant Conditions DASHBOARD

PERIOD: TY March 2021 | RENDERING PROVIDER: All Rendering Provid...

Primary Care Encounters In Period
8,817
Count of Pts with Primary Care Encounter in period

Predominant Conditions

Risk Distribution

Ethnicity

ETHNICITY	NUMERATOR	% TOTAL
Hispanic/Latino	1,252	14.2%
Non-Hispanic/Latino	7,343	83.3%
Unreported/Refused to Report Ethnicity	222	2.5%
Totals	8,817	

Predom Cond based on Primary Care Visits

PATIENT DIAGNOSES	NUMERATOR	% TOTAL
Actively Pregnant Patient	1	0.0%
Acute Myocardial Infarction	4	0.0%
Alcohol Disorder	139	0.5%
Alcohol/Substance Dependency	396	1.6%
Anxiety	2,270	8.9%
ASCVD	325	1.3%
Asthma	759	3.0%
Atrial Fibrillation/Flutter (ICD-9 codes)	124	0.5%
Attention-deficit hyperactivity disorders	421	1.7%
Autism Spectrum Disorders	49	0.2%
Bipolar Diagnosis	300	1.2%
Bipolar Disorder	308	1.2%
Cancer or Malignant Diagnosis	181	0.7%
Cerebral Palsy	10	0.0%
Cervical Cytology Result Only	392	1.5%
CHF	130	0.5%
Chronic Hepatitis C	88	0.3%
Chronic Kidney Disease Stages 3 and 4	114	0.4%
Chronic Kidney Disease, Stage 5	11	0.0%
Chronic Non-malignant Pain	1,157	4.6%
Cirrhosis	20	0.1%

Could be as simple as picking the top 5 conditions

■ Hypertension
 ■ Hypertension - Essential
 ■ Anxiety
 ■ Severe Mental Illness and Psychosis
■ Depression
 ■ Hypertlipidemia
 ■ Chronic Non-malignant Pain
 ■ Diabetes
■ Morbid (Severe) Obesity
 ■ Severe Emotional Disturbance (SED)



Care Gap Reconciliation



Care Gap Reconciliation (CGR) REPORT

FILTERS: BCS - Breast Cancer Screening 2024 Wellcare

FILTER 4

PAYER REPORTED SCORE

37.38%

OPPORTUNITY +1.35%

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

6,814

● 4,267 ● 2,547

MATCHED MEMBERS

2,609

● 1,536 ● 1,073

UNMATCHED MEMBERS

4,205

● 2,731 ● 1,474

1,444

✘ Payer ✘ EHR

With Visits	740
Without Visits	704

880

✔ Payer ✔ EHR

With Visits	551
Without Visits	329

2,731

✘ Payer

1,474

✔ Payer

92

✘ Payer ✔ EHR

With Visits	61
Without Visits	31

193

✔ Payer ✘ EHR

With Visits	83
Without Visits	110

Payer Performance

Legend & Action Steps

EHR data can be sent back to the plan to close the gap

Patients' records can be updated with results from location where claim was filed

Visit Info looks for a UDS QE 12 months from period end e.g., If period = CY 2024, appointment must be in 2024



Azara Care Connect



Smith, Andrea MRN: 111111111 | DOB: 1/1/66 (55) | F ★

Summary **Plan** Clinical Activity

FOCUS

Change focus to: Select a focus

- Blood Glucose Mgmt
- ER/Admit Prevention
- Exercise
- Hepatitis C
- HIV
- Hypertension Mgmt

CARE TEAM

Intervention Effort	Not Set
Care Manager	Jackie Brown
Usual Provider	Reynolds, Burt

MANAGEMENT

She has been known to have trouble caring for herself, including managing her Diabetes because she has complications of a history of HIV and hypertension. She has had multiple hospitalizations due to mental confusion and difficulty remembering to take medications and managing blood sugar. Need to...

Goals

1. Reduce ER visits to <2 per month
2. Provide blood sugar management education
3. Provide medication education- how to take which pills and when, and insulin guidance
4. Get BH consult

Considerations for the Case

1. Understand why emergency room visits are happening (medication, education, blood sugar, cognitive or BH concerns, substance use?)
2. Consider SBIRT screen
3. Consider close weight monitoring at home for edema management and skilled nursing to check BP weekly

Updated By: Unknown User Updated Date: 7/30/2021

MEDICAL CARE PLAN (EHR)

Andrea is a 55-year-old female patient with poorly manage Diabetes and a history of excessive emergency room usage. Multiple chronic diseases complicated by a combination of improved blood sugar management and medication adherence. She may also benefit from care management and behavioral health interventions.

Self-management goal: improved blood sugar management-A1c<7 If patient calls for refill requests-please assist with refill.

* 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: [redacted] SO: don't know Risk: Moderate (14) (MEDI) [redacted] 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

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

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)

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	Dictofenac Sodium 75 MG Delayed Release Oral Tablet
1/4/21	Chantix Starting Month PAK

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.

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		

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



Care Management Passport (CMP) ⓘ

Generate Summary ✦

Patient Lookup 🔍



05:18 AM Friday, April 17, 2026

PROVIDER: Bridgewater, Bill VISIT REASON: Departure

Smart Summary

This is a 37-year-old transgender female patient with complex medical and social needs, including multiple chronic conditions and recent behavioral health encounters.

1. The patient has significant chronic respiratory issues including persistent asthma and COPD, with recent diagnoses of pneumonia and acute respiratory infections as of Feb 2026.
2. She has a history of diabetes with an **HbA1c of 3.3%** recorded in Dec 2024, and HIV infection, both contributing to her complex care needs.
3. Behavioral health concerns are prominent, including depression and severe mental illness, with recent low PHQ-9 depression scores indicating possible improvement or underreporting.
4. Social determinants of health are significant: the patient is homeless (street status), has poverty-level income, language barriers (Portuguese speaker), and exposure to violence, all impacting care coordination.
5. Recent utilization includes multiple inpatient stays and ER visits for respiratory and psychiatric issues, with an urgent allergist referral scheduled for Mar 22 2026; next appointment is a sick visit on Mar 31 2026, and several future appointments through 2026 are scheduled.

Today's Recommended Action Items

1. Confirm and support attendance for the upcoming allergist appointment on Mar 22 2026 and coordinate follow-up care post-visit.
2. Address social needs by connecting the patient with housing resources and language support services to improve engagement and adherence.
3. Review and update behavioral health support plans given the history of severe mental illness and recent low depression screening scores, ensuring crisis resources are accessible.

AI-generated content — please review for accuracy

05:18 AM Friday, April 17, 2026

PROVIDER: Bridgewater, Bill VISIT REASON: Departure

Priscilla, Cryan

Sex at Birth: M

Phone: (617) 338-8912

Last Phys: 2/18/2026

PCP: Brid

MRN: 1102735

GI: Transgender Female/ Male-to-Female

Language: Portuguese

Portal Access: 02/18/2026

Payer: Co

DOB: 3/4/1989 (37)

SO: Bisexual

Risk:

Cohorts: Diabetes Aduti List 2026

CM: Rena

Generate relevant insights & surface recommended action items.

079.53	Human immunodeficiency virus, type 2 [HIV-2]	2/18/26	1	J06.0	Acute laryngopharyngitis
296.24	Major depressive affective disorder, single episode, severe, specified as with psychotic behavior	2/18/26	1	O30.93	Multiple gestation, unspecified, thi



DRVS for Strategy and Compliance

Population Level Management

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- Leadership decisions
- Resource allocation
- Performance accountability



Core Capabilities



Scorecards and performance tracking



Peer comparison & benchmarking/variation



Strategic planning & work plans



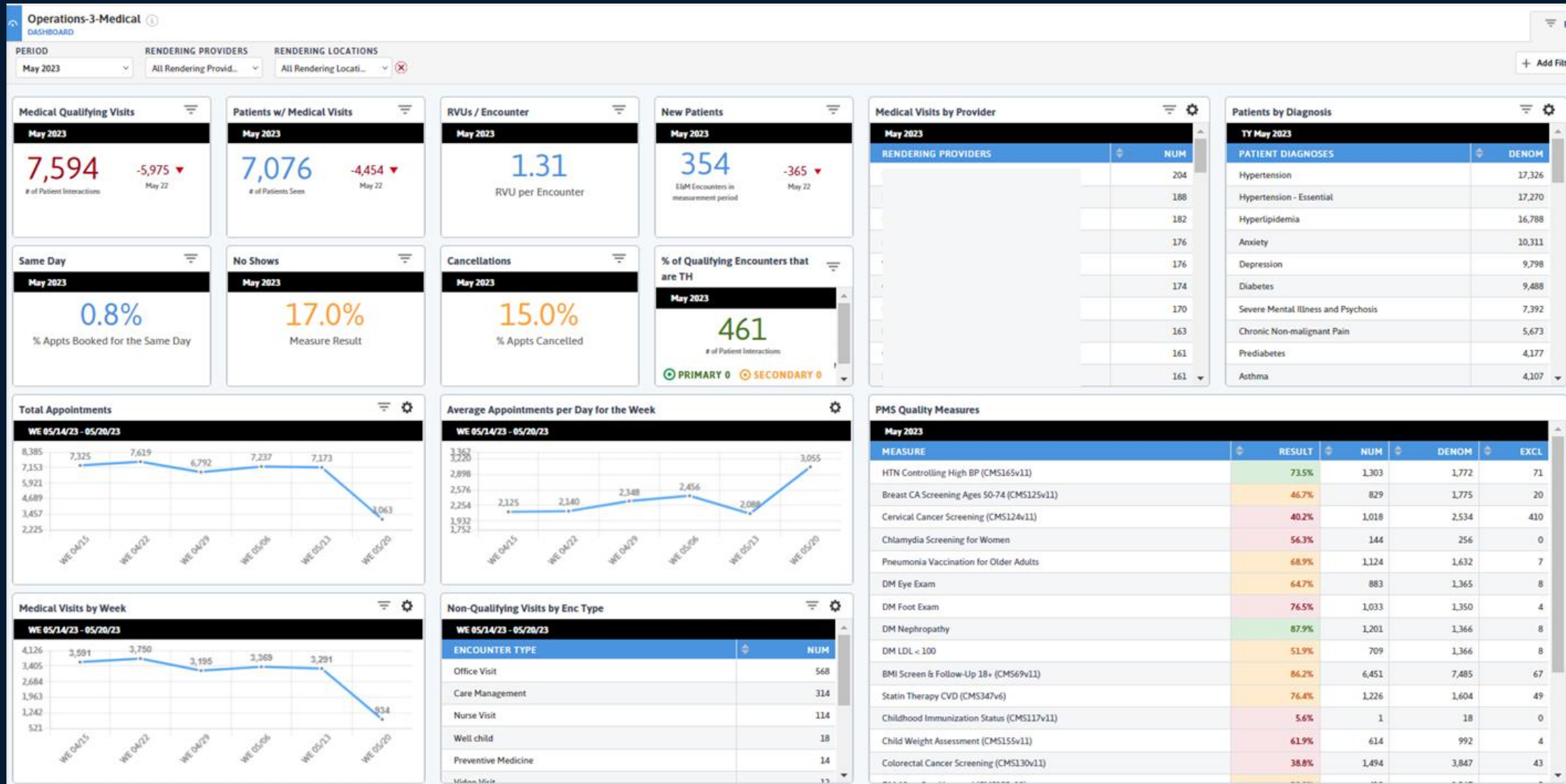
ROI & effectiveness evaluation



UDS Reporting



Scorecards and Performance Tracking



Benchmarking / Variation



UDS 2022 CQMs REPORT

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

REPORT | CARE GAPS

GROUPING: Rendering Providers | TARGETS: Primary (Green), Secondary (Yellow), Not Met (Red) | 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%



Strategic Evaluation



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

Financial Operations DASHBOARD

PERIOD: November 2024 | RENDERING PROVIDERS: All Rendering Provid...

Encounters w/POS Collection

RENDERING LOCATIONS	RESULT
Socorro School Based Health Center	36%
Veguita Family Health Center	8%
Pecos Valley Medical Center	7%
Quay County Family Health Center	5%
Catron County Medical Center	3%

Days to Close Encounter: 0.62 (Average Days To Complete)

Days to Submit Charge: 7 (Average Billing Days)

Days to File Claim: 9 (Average Days to File Claim)

Days to First Payment: 31 (Average Charge Lag Days)

First Pass Payment Rate: 60.7% (Result)

- PRIMARY 75%
- SECONDARY 7%

Days to Close Encounter

RENDERING PROVIDERS	RESULT
Allsop, Dana	0.00
Anaya LMFT, Jacqueline	0.00
Aranda RDH, Melanie	0.00
Baca RDH, Wendy	0.00

Days to Submit Charge

RENDERING LOCATIONS	DAYS
SF Community Guidance Center	799
IHS Clinics	148
Valley Community Health Center	19

Days to File Claim

RENDERING LOCATIONS	DAYS TO FILE
Cuba Ambulance	44
Sacramento Mountain Medical	16
Valley Community Health Center	16

Days to First Payment

RENDERING LOCATIONS	DAYS
Deming High School Wildcat Health Center	3,981
SF Community Guidance Center	812
Counselor Clinic	78

First Pass Payment Rate

RENDERING LOCATIONS	RESULT
Teen Health Center	91.2%
Capital High School	89.7%
Cuba Ambulance	89.7%
Socorro School Based Health Center	87.5%

Charges per Encounter: \$312

Payments per Encounter: \$133

Adjustments per Encounter: \$160

Denials per Encounter: \$165

% of Claim Denials: 0.61

Encounters Missing Charges: 2.81%

Charges Per Encounter

INTERACTIONS GROUP	RESULT
OB	\$760
ACT	\$390
Office Visit	\$366
BH Family Therapy	\$295

Payments per Encounter

INTERACTIONS GROUP	RESULT
ACT	\$202
Respite	\$202
BH Family Therapy	\$185
OB	\$170

Adjustments per Encounter

INTERACTIONS GROUP	RESULT
OB	\$275
ACT	\$189
MST	\$175
Office Visit	\$156

Denials Per Encounter

DENIAL CODE GROUP	RESULT
ALERT	\$225
BENEFIT MAX	\$220
NON COVERED	\$207
EOB NEEDED	\$202

% of Claim Denials

DENIAL CODE GROUP	RESULT
AUTH	0.00
BENEFIT MAX	0.00
BUNDLED	0.00
CLAIM SERVICE LACKS	0.00

Encounters Missing Charges

INTERACTIONS GROUP	RESULT
ACT	0.00%
BH Group Therapy	1.94%
Office Visit	1.97%

**Financial Operations Module Required



UDS 2025 CQMs REPORT

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

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



Unmatched Members MEASURE
FILTER 1

FILTERS: March 2026
MEASURE ANALYZER
DETAIL LIST
VALUE SETS

MEMBER			
MRN	PL...	NUMBER	LAST NAME
1100279	AZR Healt...	4040	Mattioli
1100288	AZR Healt...	1094	Capri
1104585	AZR Healt...	3478	Karjala
1104587	AZR Healt...	4819	Troutner
1104589	AZR Healt...	905	Pochatko
1100185	AZR Healt...	416	Peale
1100198	AZR Healt...	4848	Nerney
1100273	AZR Healt...	4963	Eylicio
1100225	AZR Healt...	555	Keitt
1100216	AZR Healt...	3476	Wolanin
9999694	AZR Healt...	95	Goos

Soft Matching REPORT

PERIOD: January 2026
RENDERING PROVIDERS: All Rendering Provid...
PLANS: All Plans

REPORTS

PLAN	MEMBER NUMBER	MATCH RANK	SOFT MATCHED METHOD
Medicare REACH ACO		3	First, Last, DOB, Sex
Medicare REACH ACO		3	First, Last, DOB, Sex
Medicare REACH ACO		3	First, Last, DOB, Sex
Medicare REACH ACO		3	First, Last, DOB, Sex
Medicare REACH ACO		3	First, Last, DOB, Sex
Medicare REACH ACO		15	Member Medicaid Medicare Policy Number, DOB



Health Plan Performance Dashboard



Health Plan Performance CY 2023 Filters 0 Update

Cost & Utilization | Plans | Executive | Leakage | Utilization | Claim Completeness | Member Review

Plan and Line of Business Summary

Expand All

PLAN	LOB	Membership	Total Cost	PMPM	ED Visits/1k	IP Admit/1k	30d Readmit	Quality
- Plan 2	Medicaid	7,000	\$29,619,730	\$350	479	175	14%	1 Green, 0 Yellow, 9 Red
Resource Utilization Band		Cost Group		Quality				
- Plan 1	Medicaid	3,275	\$9,823,120	\$479	375	100	18%	1 Green, 1 Yellow, 1 Red
Resource Utilization Band		Cost Group		Quality				
- Plan 1	Commercial	1,200	\$1,632,247	\$175	185	19	9%	2 Green, 1 Yellow, 7 Red
Resource Utilization Band		Cost Group		Quality				



Cost and Utilization - Executive Dashboard

Identify focus areas for further drill down.

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

Executive Dashboard | CY 2024 | Filter | Update

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: **55.6k** ▼ 9%

Avg RUB: **2.9** ▼ 0.1

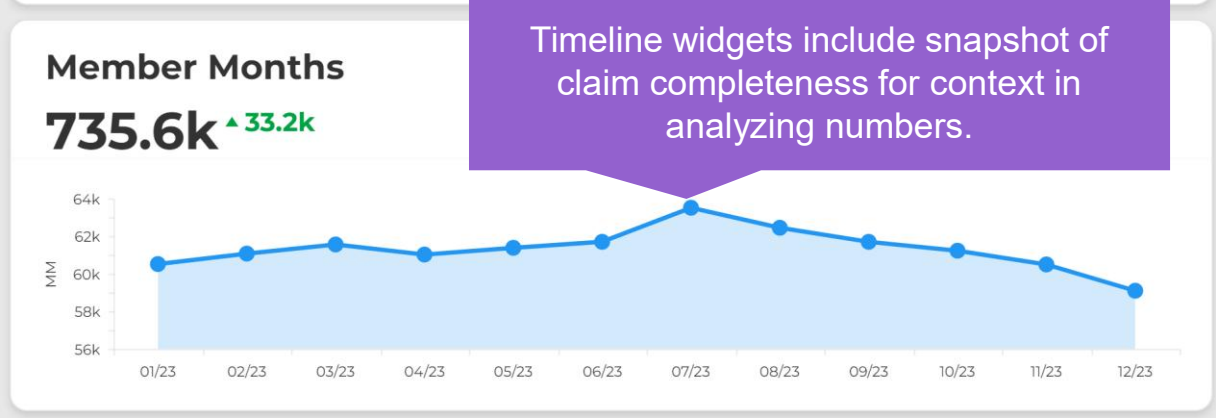
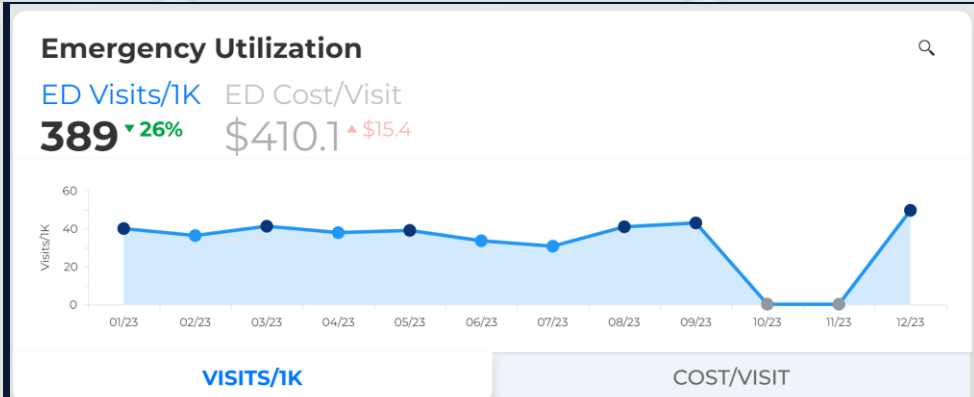
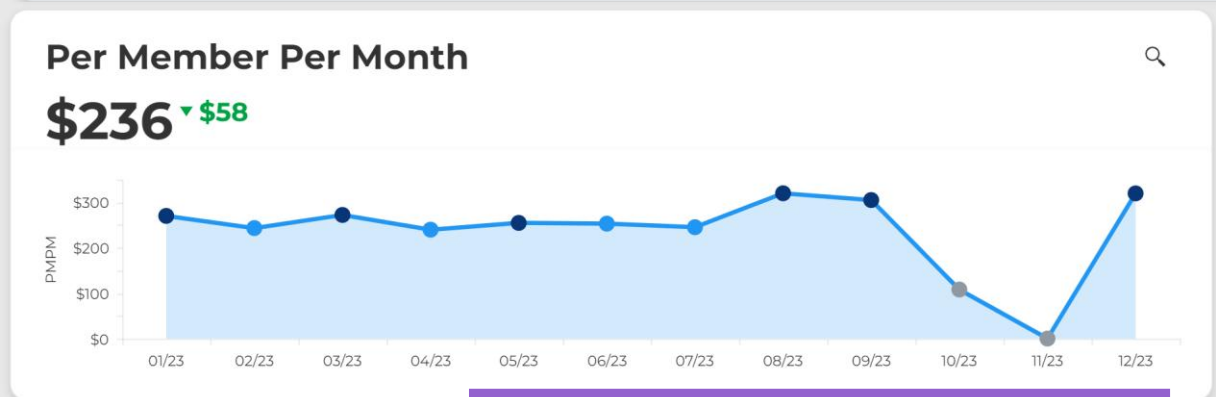
Total Claims Paid: **\$6.7m** ▼ \$166.9m

Cost per Member: **\$121.3** ▼ \$2.7k

76.9% of Cost, 2.7% of Members

2024

- Primary: 0
- Secondary: 0
- Not Met: 6
- Total Measures: 6



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

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

Cost and Utilization - Member Profile



Member Profile

Member lookup

Jul 2023 - Jun 2024

Filters 0

Update

RICKY CASSIN

Member # : 518b10d1-a875-1fa9-0a42-abfef895dd97
 MRN : 000848300231
 DOB : 11/10/1985 (40)

Practice :
 Match Status : HARD
 Plan & LOB :

Plan Eligibility Status : Active
 Attributed PCP : Crist LLC
 Hospice Utilization : N

Review Queue Populations : High Cost
 Review Queue Status : Needs Review

Chronic Conditions (21)

Category	Detail	Impact
Allergy	Disorders of the immune system	HIGH
Psychosocial	Eating disorder	HIGH
Allergy	Asthma, w/o status asthmaticus	MODERATE

High Impact Areas

Avoidable IP	1	Primary Care Leakage	6
30 Day IP Readmissions	0	Network Leakage	16
Avoidable ED	3	Rub Score:	5

Total Cost
\$169.3k

N/A
STOP LOSS

Risk of Pred. Hospitalization : Low

Utilization Over Time

	07/23	08/23	09/23	10/23	11/23	12/23	01/24	02/24	03/24	04/24	05/24	06/24	Total	% Of Total
Inpatient	\$24,475			\$26,672									\$51,146	30%
Emergency Department	\$283			\$2,856		\$3,254							\$6,393	4%
Pharmacy	\$21,631	\$40,526											\$62,157	37%
Outpatient	\$6,288		\$2,530	\$154	\$3,291		\$189	\$4,983		\$127	\$236	\$3,495	\$21,294	13%
Lab and Diagnostic	\$372	\$568	\$357	\$568		\$568	\$895		\$593	\$575			\$4,495	3%

ED/IP Utilization

Admission	Discharge	Type	Location	Clinical Class	Avoidable?	Cost
12/21/2023	12/21/2023	Emergency Department	SWANIAWSKI - LEUSCHKE	Nervous system diseases	Y	\$3,253.83
10/22/2023	10/22/2023	Emergency Department	SWANIAWSKI - LEUSCHKE	Musculoskeletal Diseases	Y	\$2,572.42
10/13/2023	10/15/2023	Inpatient	SWANIAWSKI - LEUSCHKE	Nervous system diseases	Y	\$26,671.70

RAF Gaps



8:30 AM Wednesday, January 10, 2024

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	SOURCE
9/20/23	atorvastatin 40 MG C	
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 (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

Open Referrals w/o Result (3)

TYPE	SPECIALIST/LOCATION	ORDER DATE	APPT DATE
Dermatology	University Hospital, 47 Blanchard	9/20/23	

RAF Gaps surfaced at point of care



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

Potential Duplicate Patients 1
REPORT

Search Patients ...

AZARA ID	NAME	MATCH REASON	PATIENT MATCHES
		SSN, DOB	2
		SSN, DOB	2
		SSN, DOB	2
		SSN, DOB	2
		SSN, DOB	2
		SSN, DOB	2
		First, Last, DOB, Sex	2
		First, Last, DOB, Sex; SSN, DOB	2
		SSN, DOB	2
		First, Last, DOB, Sex; SSN, DOB	2
		First, Last, DOB, Sex; SSN, DOB	2
		SSN, DOB	2
		SSN, DOB	2
		SSN, DOB	2
		SSN, DOB	2

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?



Contact Us



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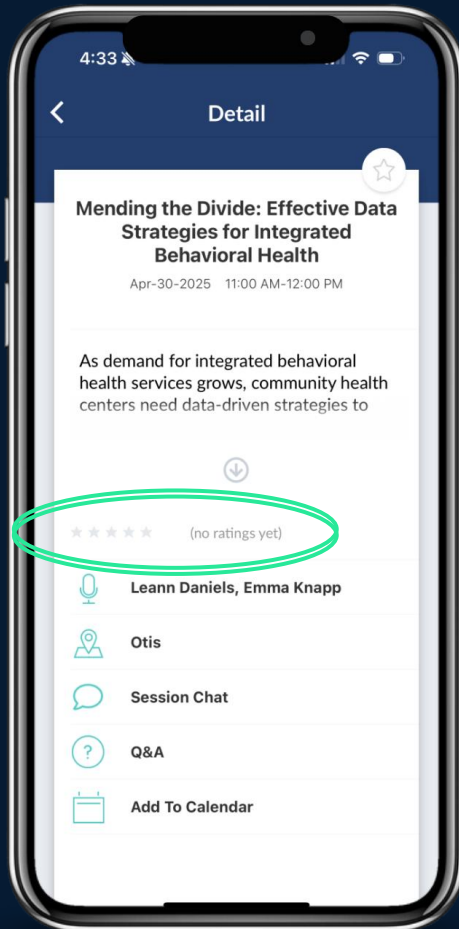
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15

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