Modernizing Chronic Care Programs with Azara Care Connect

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Today’s Presenter

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Utah Navajo Health System

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Today’s Agenda

Chronic Care Programs at Utah Navajo Health System (UNHS)

Chronic Care Management

Transitional Care Management

Behavioral Health and Diabetes Control Programs

Utah Navajo Health System

Serve approximately 15,000 Patients Annually

- Medical
- Dental
- Vision
- Pharmacy
- Behavioral Health
- Physical Therapy
- Chiropractic
- EMS Services
- Non-Emergency Transport

Multiple Chronic Care Programs

- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Behavioral Health Tasks
- Diabetes Control Program (DCP)

Needed Unified Technology Platform

Centralizes Care Management Documentation

Tracks Time and Tasks

Improves Care Coordination

Supports Billable/Unbillable Programs

Chronic Care Management

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Chronic Care Management

Identify

Potential candidates for CCM.

Patients enrolled in CCM.

Track

Track patient outreach and communications.

Track all tasks assigned to the care manager.

Task

Easy communication to care team.

Tasks assigned to nurses and care coordinators.

Document

Standardized care plan using a customized template.

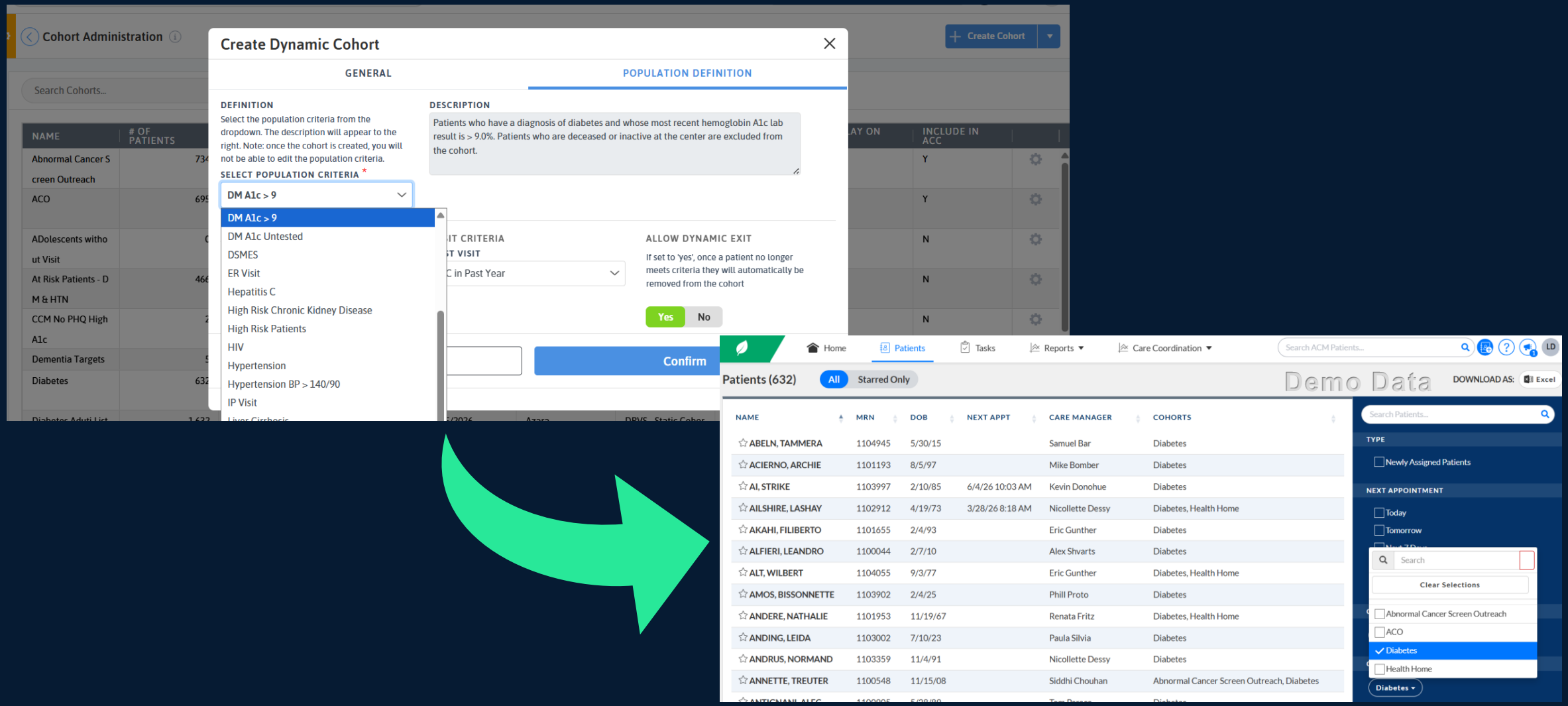
All patient communication.

Bill

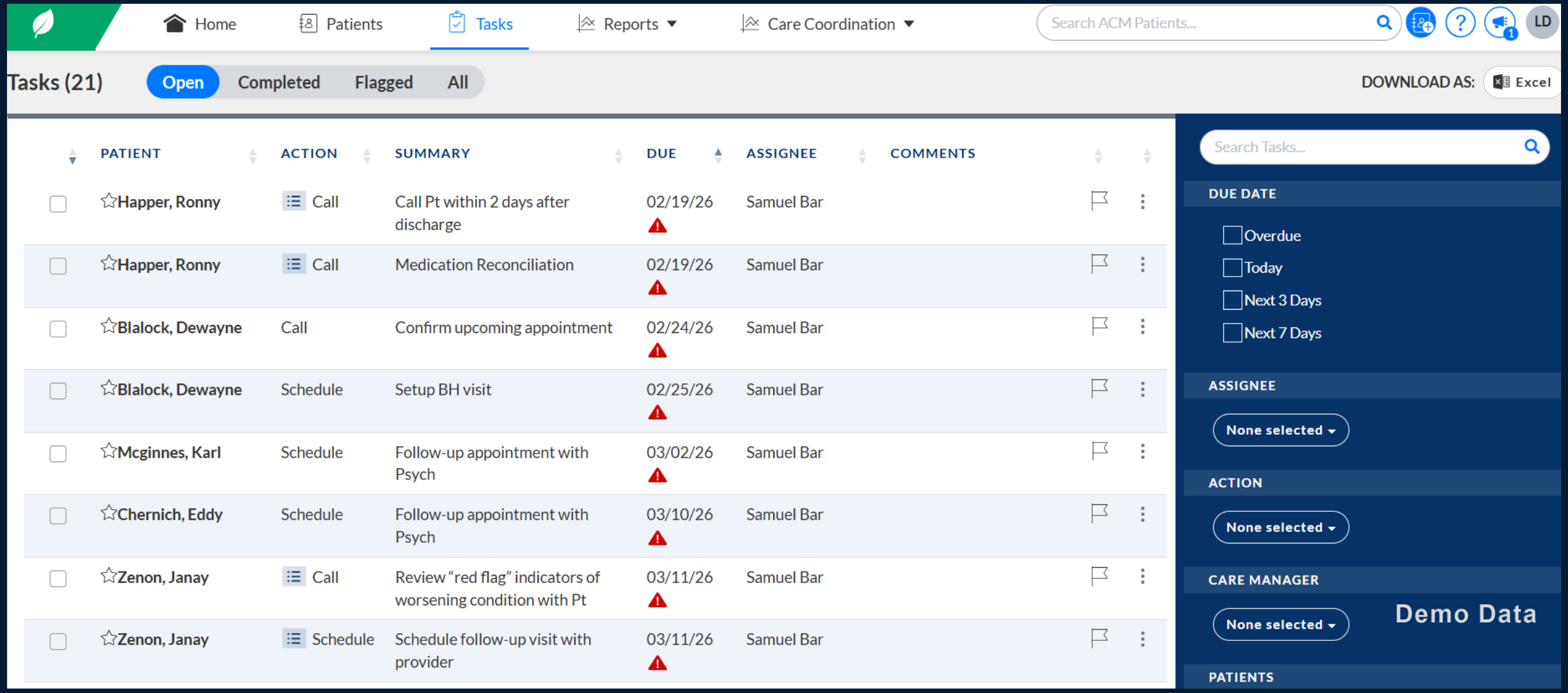
Ensure >20 minute threshold is met for billing.

Identify patients who need additional time.

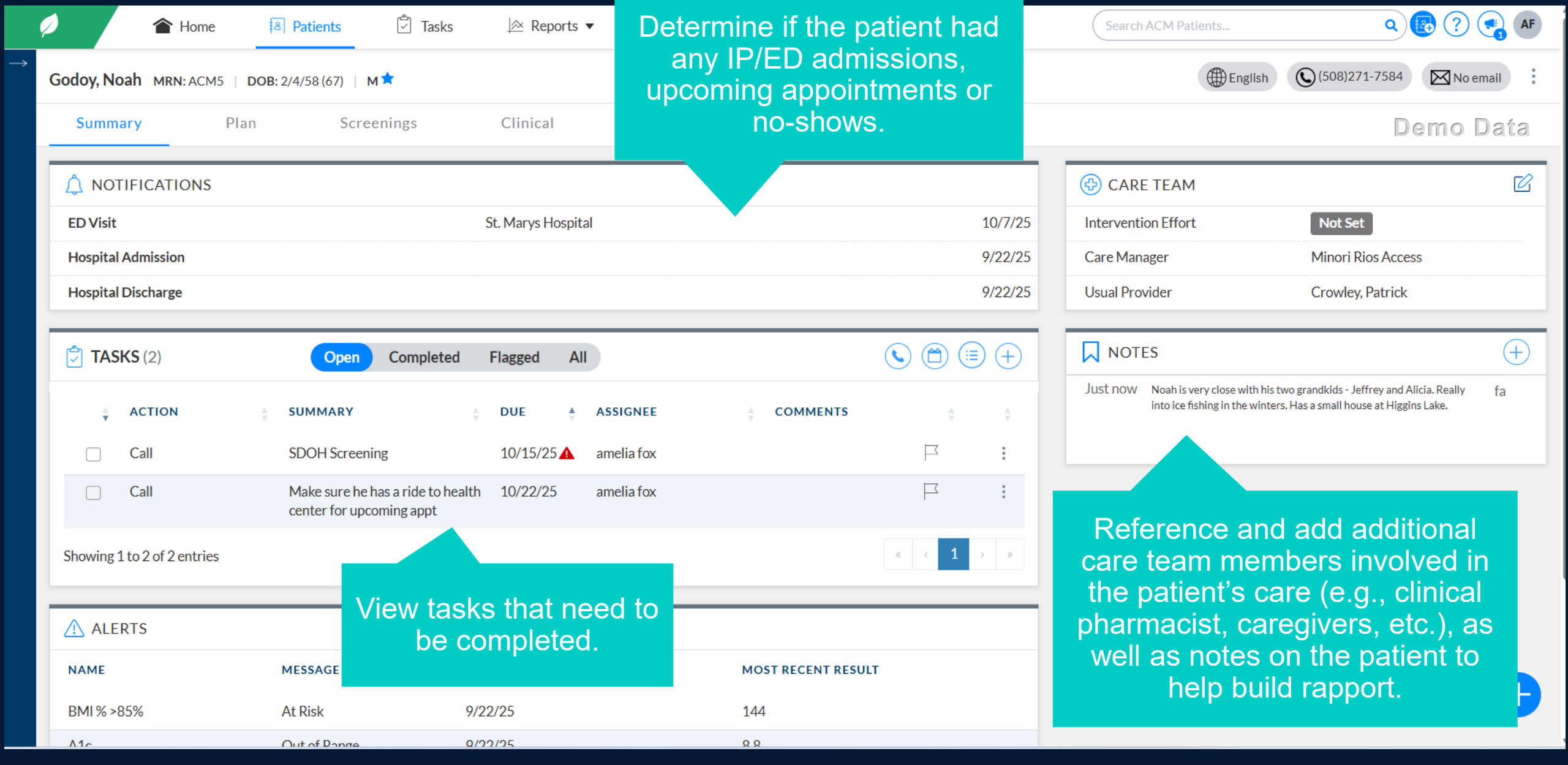
Identify CCM Patients



Track Tasks: Automate Care Manager To-Do List



Track Patients

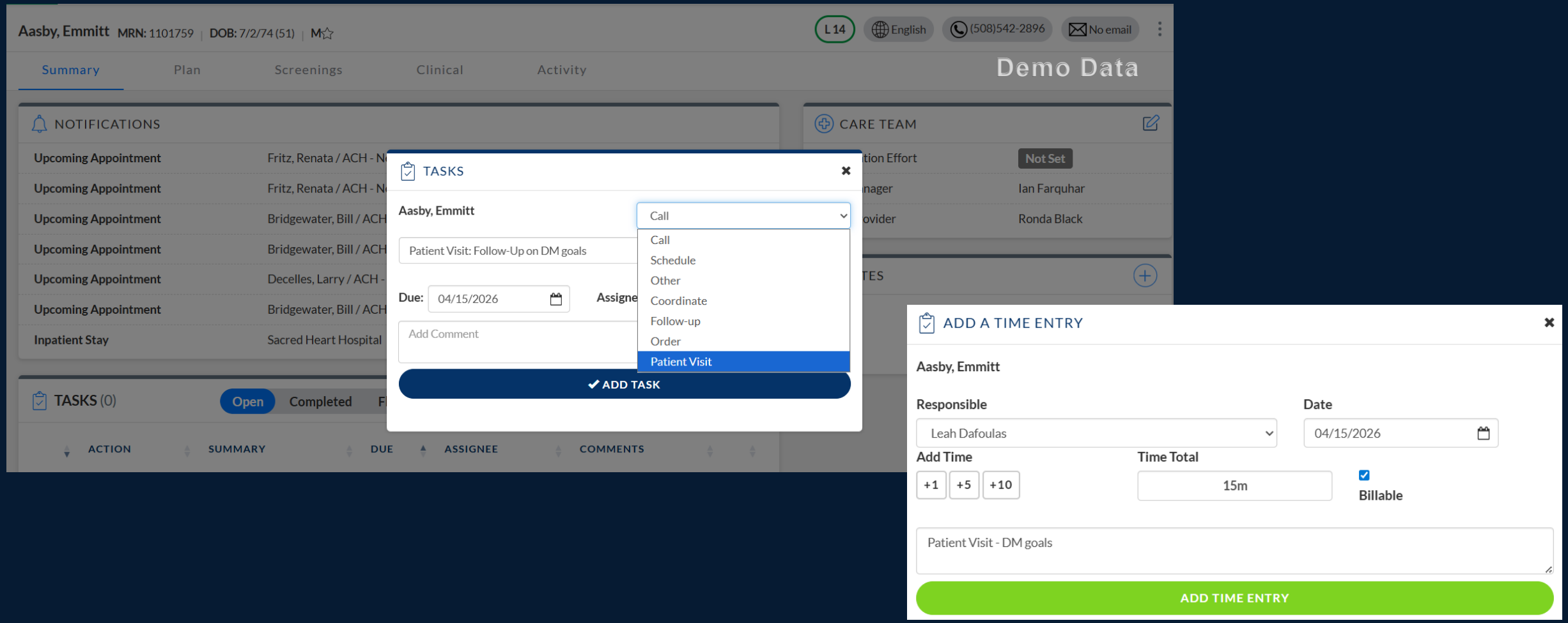


Determine if the patient had any IP/ED admissions, upcoming appointments or no-shows.

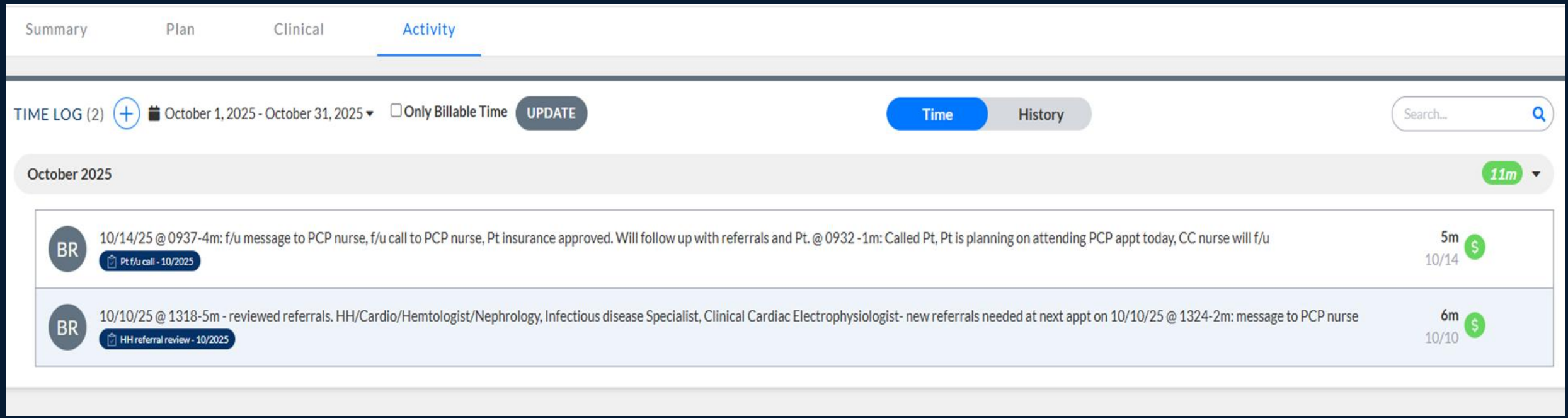
View tasks that need to be completed.

Reference and add additional care team members involved in the patient's care (e.g., clinical pharmacist, caregivers, etc.), as well as notes on the patient to help build rapport.

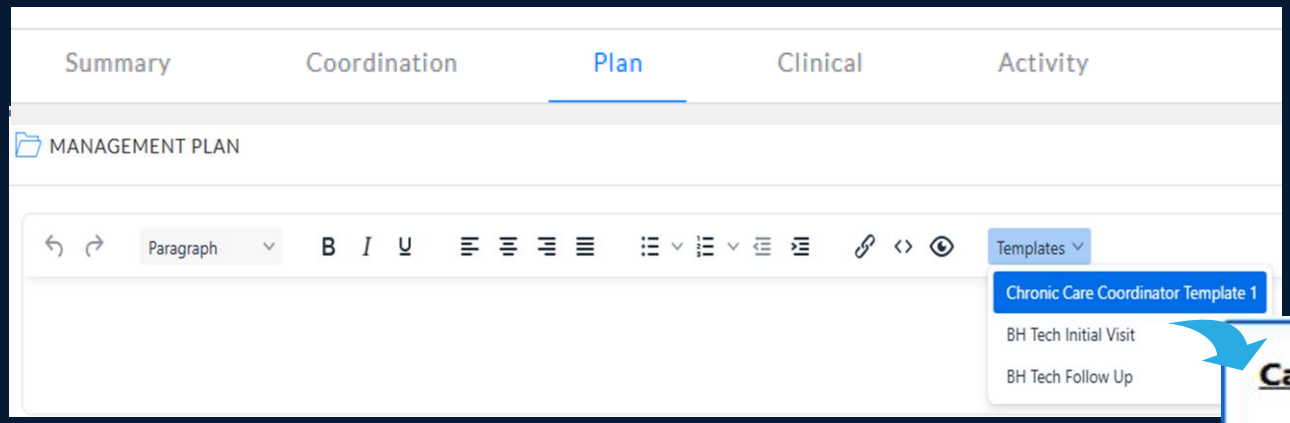
Tasks & Time Tracking



Review Time Spent with Patient



Document the Care Plan



Care Coordinator Plan of Care

Total Time: minutes

Where the appointment took place:

Describe:
Patient Others present

Describe:
Patient Assessment:

Disease state and other chronic condition: See AP section.

Medications: Reviewed with patient.

Trends in labs/outcomes: Pertinent labs reviewed.

Orders and referrals:

Billing Requirements for CCM

Two or More Chronic Conditions

Patients must have two or more chronic conditions.

20+ Minutes of Care Management

At least 20 minutes of clinical staff time per month.

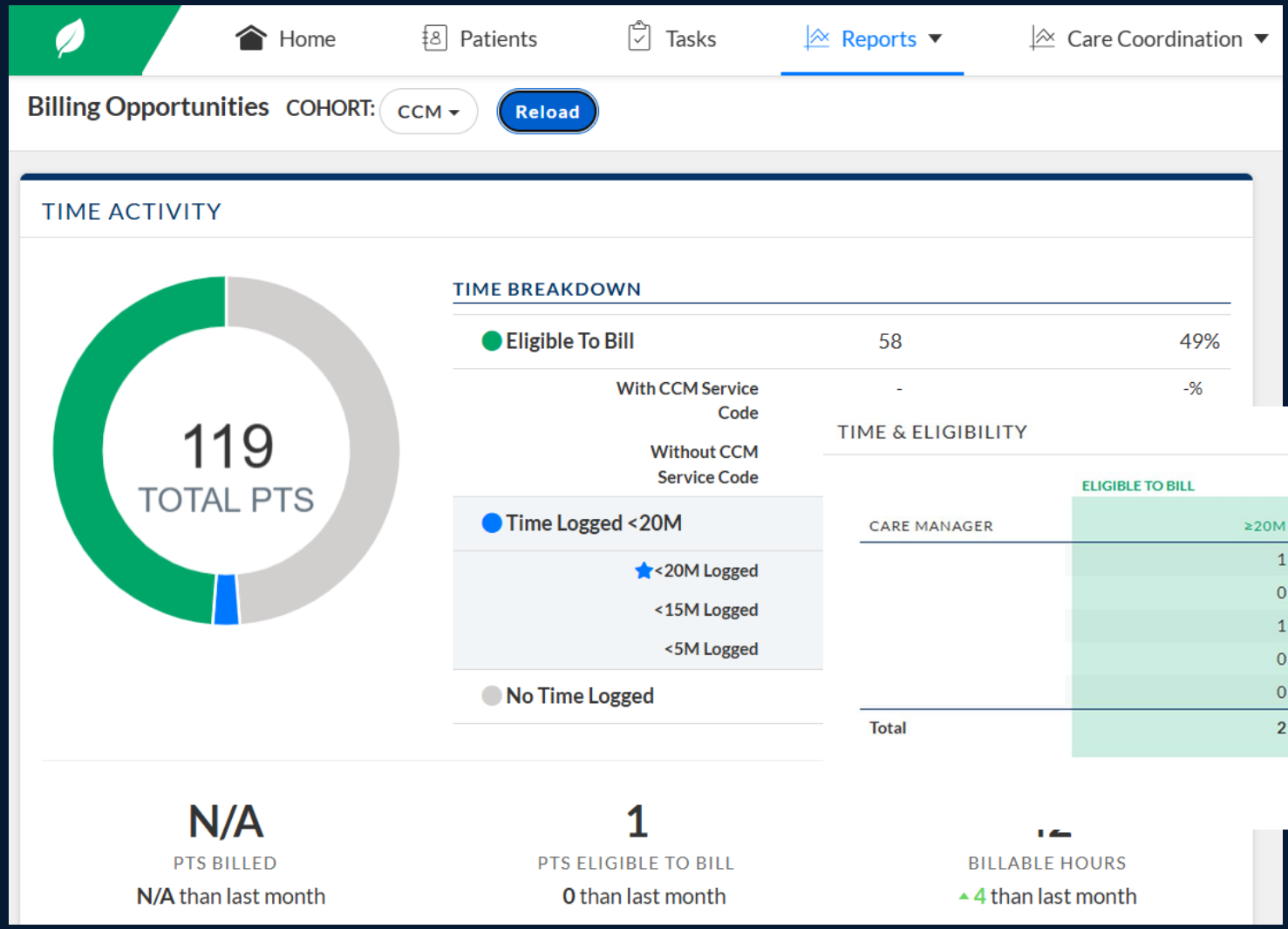
Comprehensive Care Plan

Personalized, patient-centered care plan required.

Documentation & Reporting

Detailed timely records.

Billing for CCM Monthly: Generate Revenue



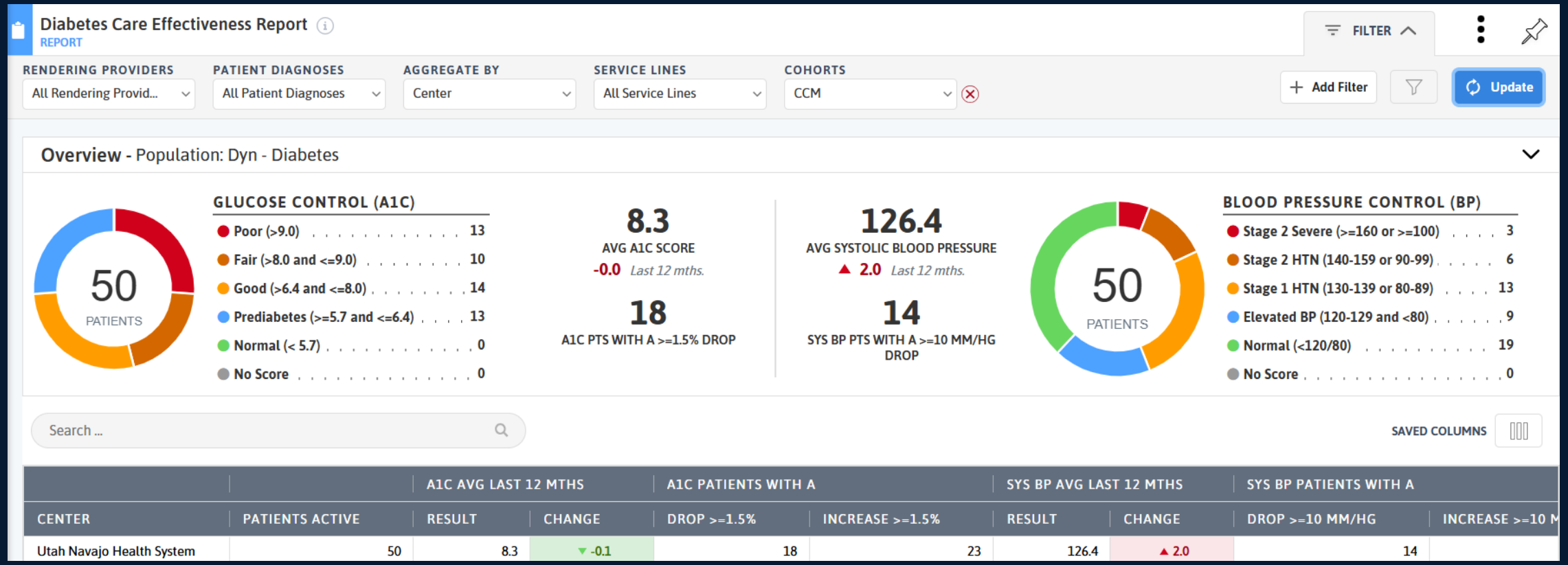
TIME & ELIGIBILITY

	ELIGIBLE TO BILL	PTS WITH TIME LOGGED			NO TIME	
CARE MANAGER	≥20M	<20M	<15M	<5M	0	TOTAL
	1	0	0	0	3078	3079
	0	2	6	1	36	45
	1	0	0	0	40	41
	0	0	0	0	14	14
	0	0	4	3	2	9
Total	2	2	10	4	3170	3188

Pts Opportunities
< 5m required to bill

Tracking Outcomes

Care Effectiveness reports are used to track A1C and Blood Pressure control for patients enrolled in CCM.



Transitional Care Management

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Transitional Care Management

Clinical staff must contact the patient or their caregiver by phone, by email, or face-to-face **within 2 business days after the patient's discharge** from the inpatient or partial hospitalization setting.

Needs of the TCM Program

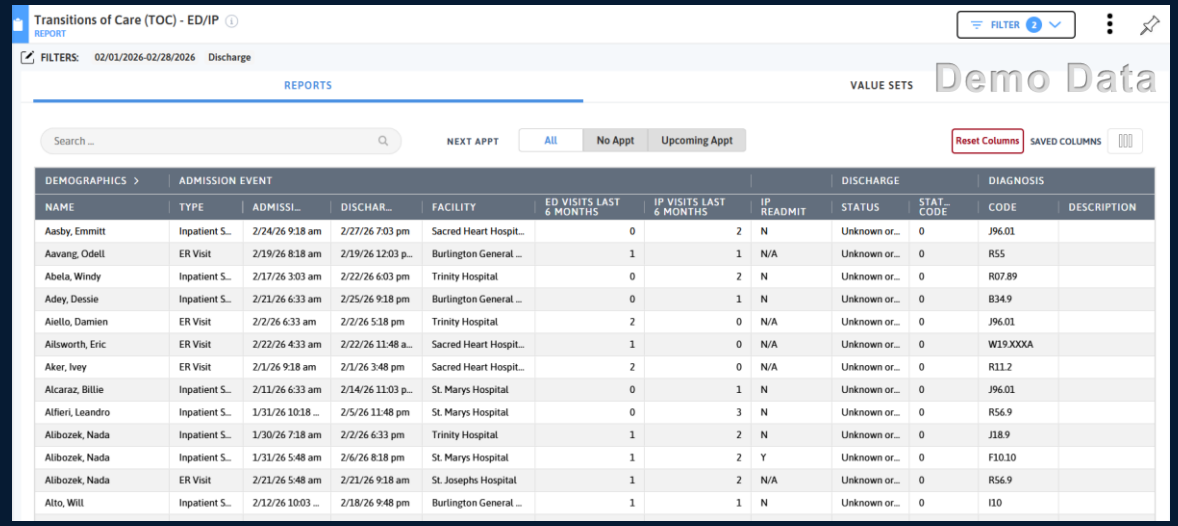
Timely identification of discharged patients

Standardized post-discharge follow-up

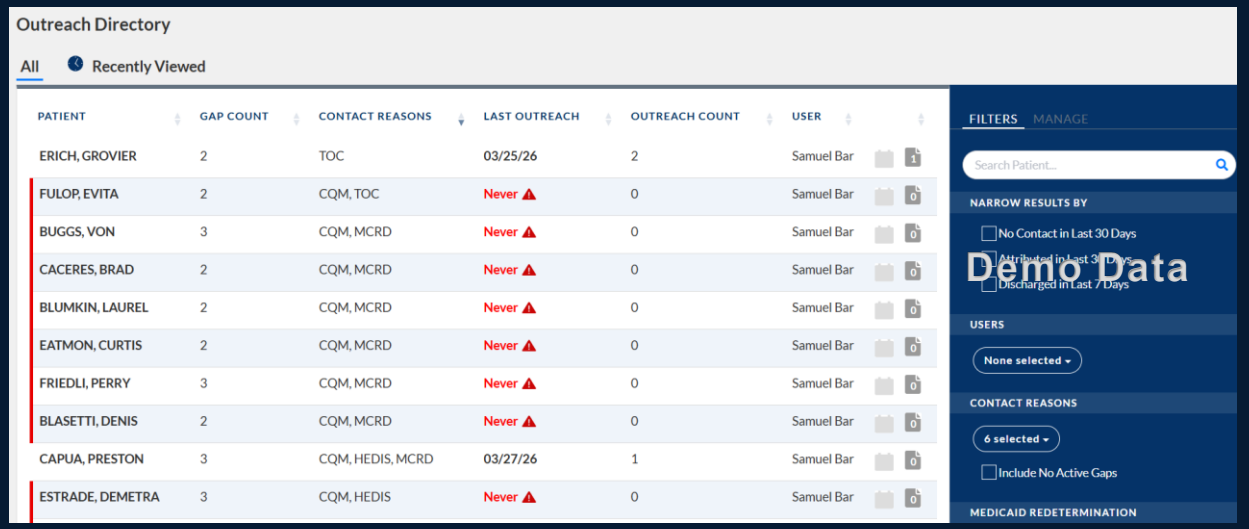
Documentation of activities

Track Outcomes (Clinical & Operational)

Identifying Patients In Need of Follow-Up



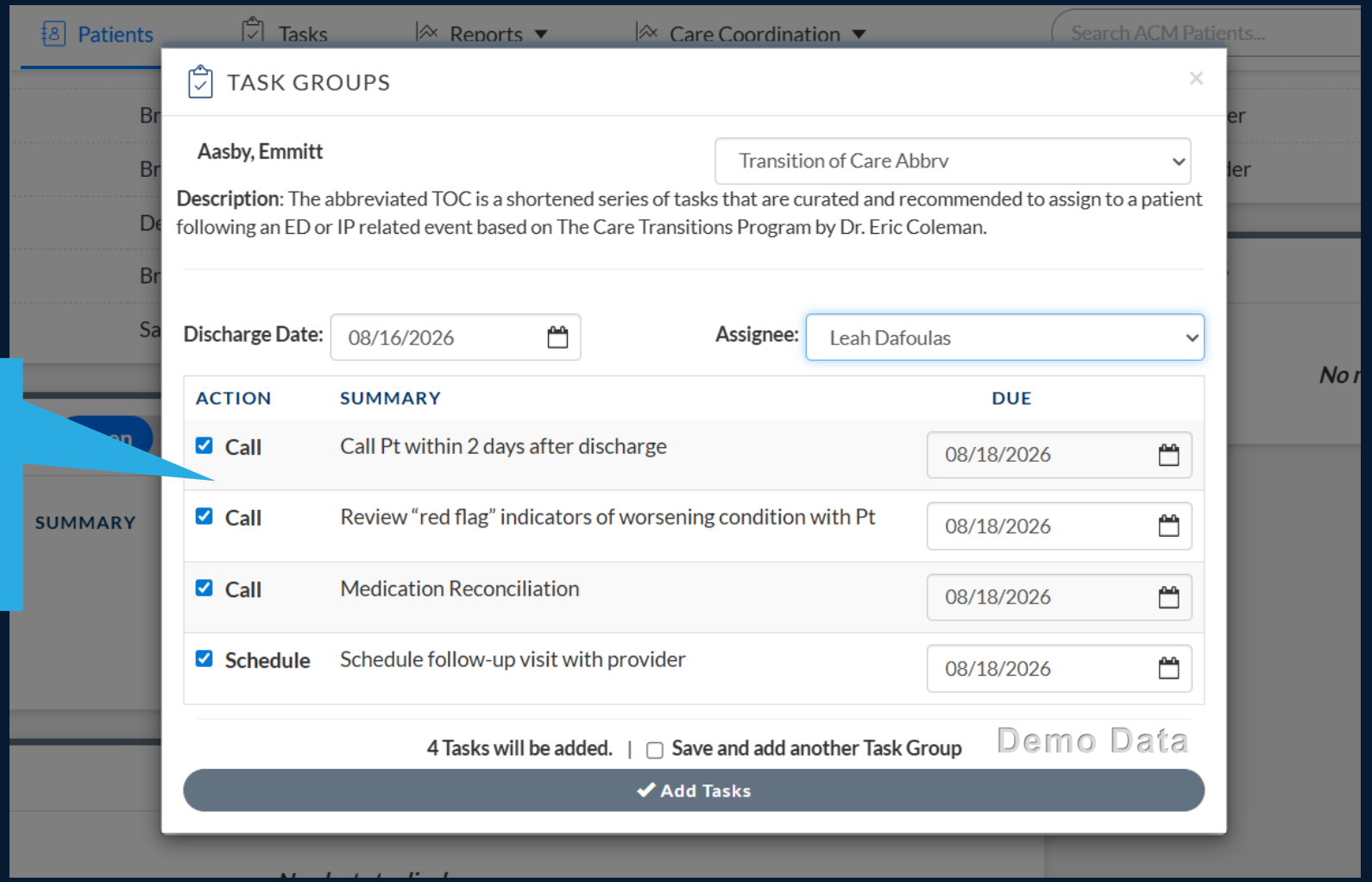
ACC automates the lists of patients for outreach and tracks progress on outreach goals.



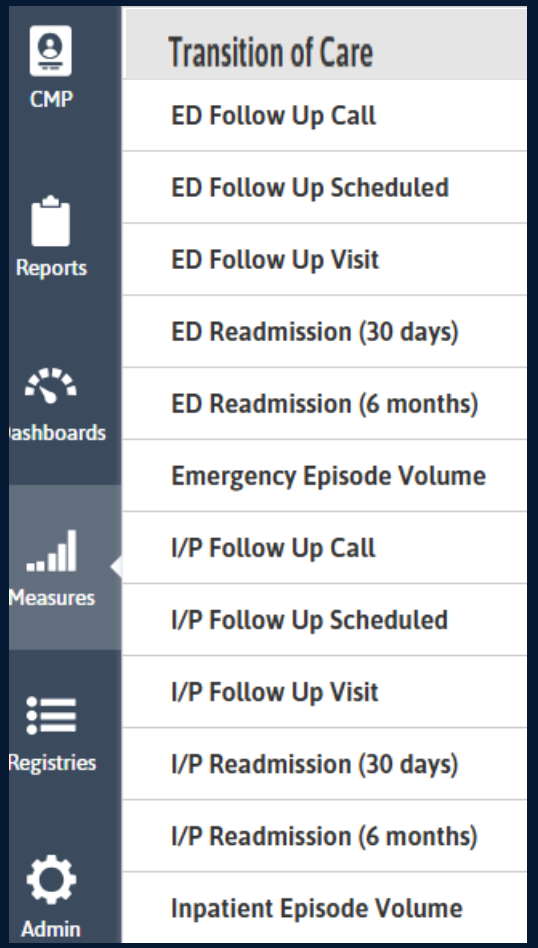
The **DRVS TOC ED/IP Report** generates a list of patients with recent hospital utilization.

Standarized Post-Discharge Follow Up

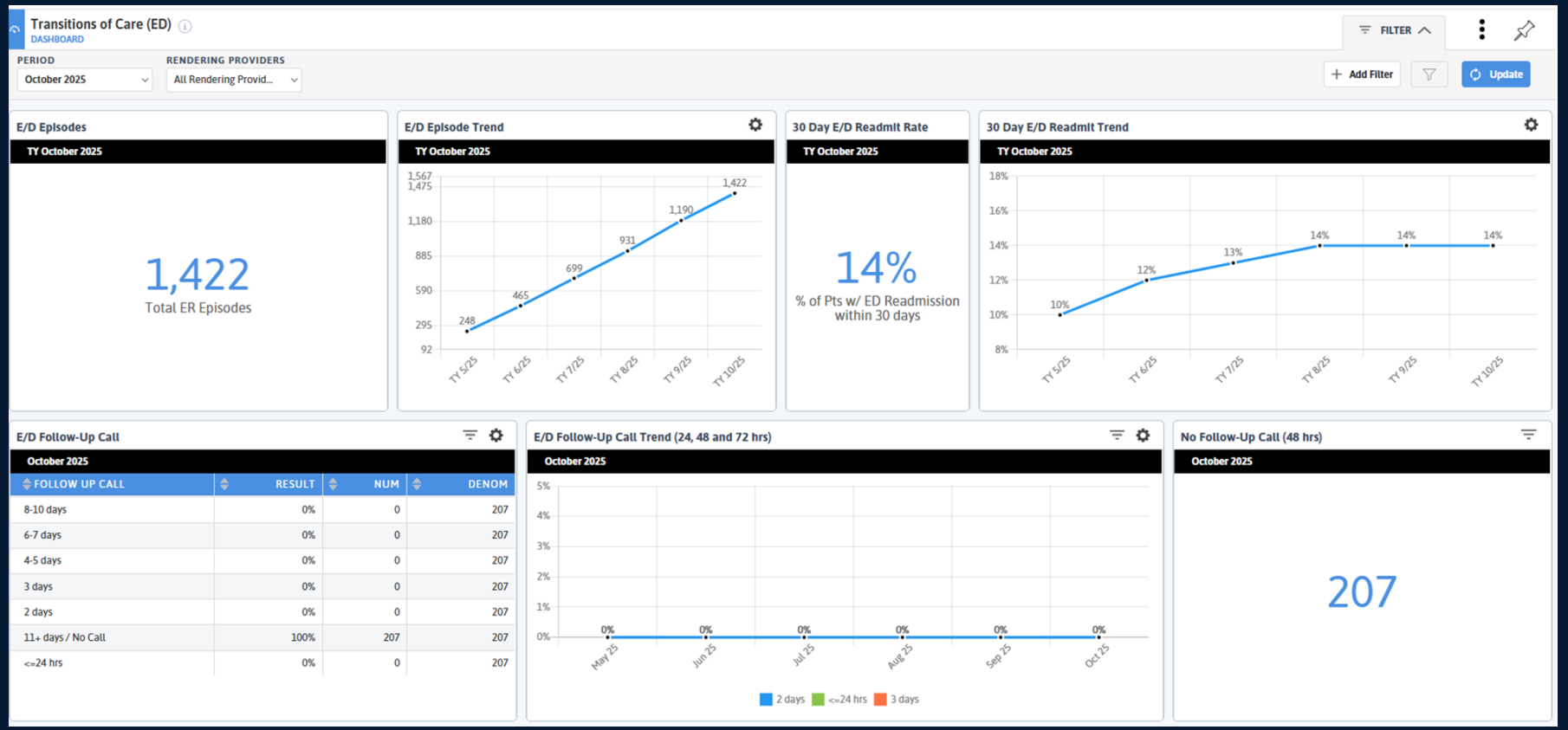
Task groups standardize evidence-based workflows.



Tracking Outcomes

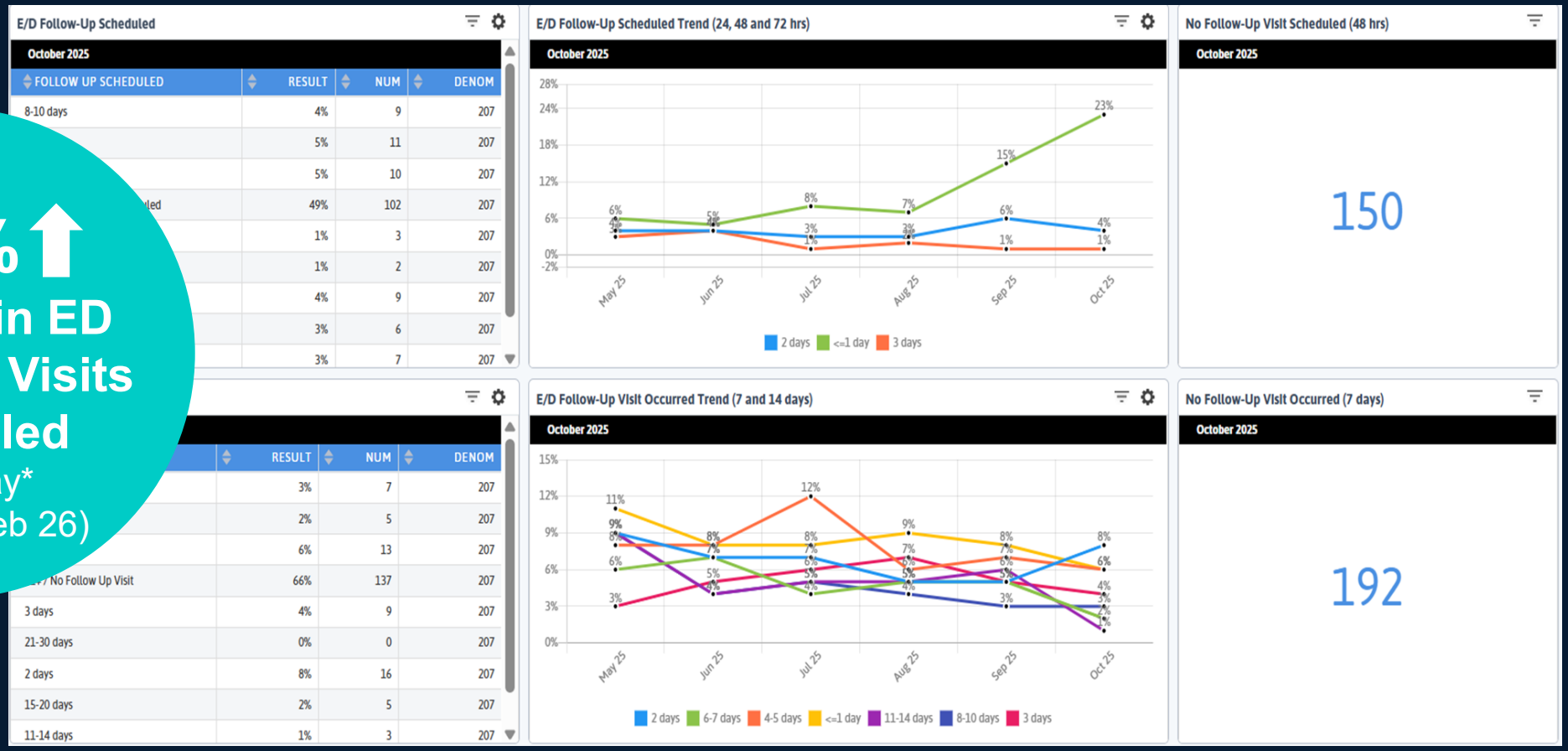


Using the measures in DRVS, we can evaluate both the clinical and operational outcomes of the TCM program.



More Efficient Post Discharge Scheduling

73% ⬆
Increase in ED Follow-Up Visits Scheduled
in <=1day*
(Aug 25 - Feb 26)



*Baseline (Aug 25) = 8%
Current (Feb 26) = 31%

Behavioral Health & Diabetes Control Program

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Populations for Behavioral Health Techs

Newly Diagnosed Depression

Monthly Follow-Up

Documentation: BH Tech Tasks

1. Follow-ups
2. Support Activities
3. Coordination

Log patient interactions and time spent.

Behavioral Health Care Plans

Time of service:
Minutes spent:
Patient contact made: face to face|by phone|by mail
Systematic Assessment used: PHQ9|CSSRS|SBIRT|GAD7|Other
Description of service:
Referring provider:

Verbal consent was given by ____ to receive collaborative care services through UNHS. This consent allows for communication about the plan of treatment between the behavioral health technician, the medical provider, and if applicable, members of the behavioral health staff. Records about the treatment and communications will not be released without the patient's written authorization except if ordered by a court to do so.
The patient verbalizes understanding that the behavioral health technician is a mandated reporter and that confidentiality does not extend to reports of being a threat to themselves or others and in cases of child or elder abuse and neglect.
The patient verbalizes understanding that they are voluntarily participating in this service, that it is a billable service, and that they may discontinue their participation at any time.

Multiple care plan templates in ACC provide flexibility for different programs

Care Plan

Patients care goal:
Patients self management tools:
Team goals:
Patients barriers to care:
Patient personal support team:

Date of service:

Time of service:
Minutes spent:
Patient contact made: face to face|by phone|by mail
Update on systematic assessment:
Description of service:

Progress/ Update to Care Plan:

Value of Standardized Workflows

Supports	Workflow documentation and supervision
Improves	Visibility, accountability and reporting

Diabetes Control Program: Non-billable Work

Prediabetes

Document

- ✓ Staff Outreach
- ✓ Coaching: Education and Lifestyle Support

Why Document Non-Billable Programs?

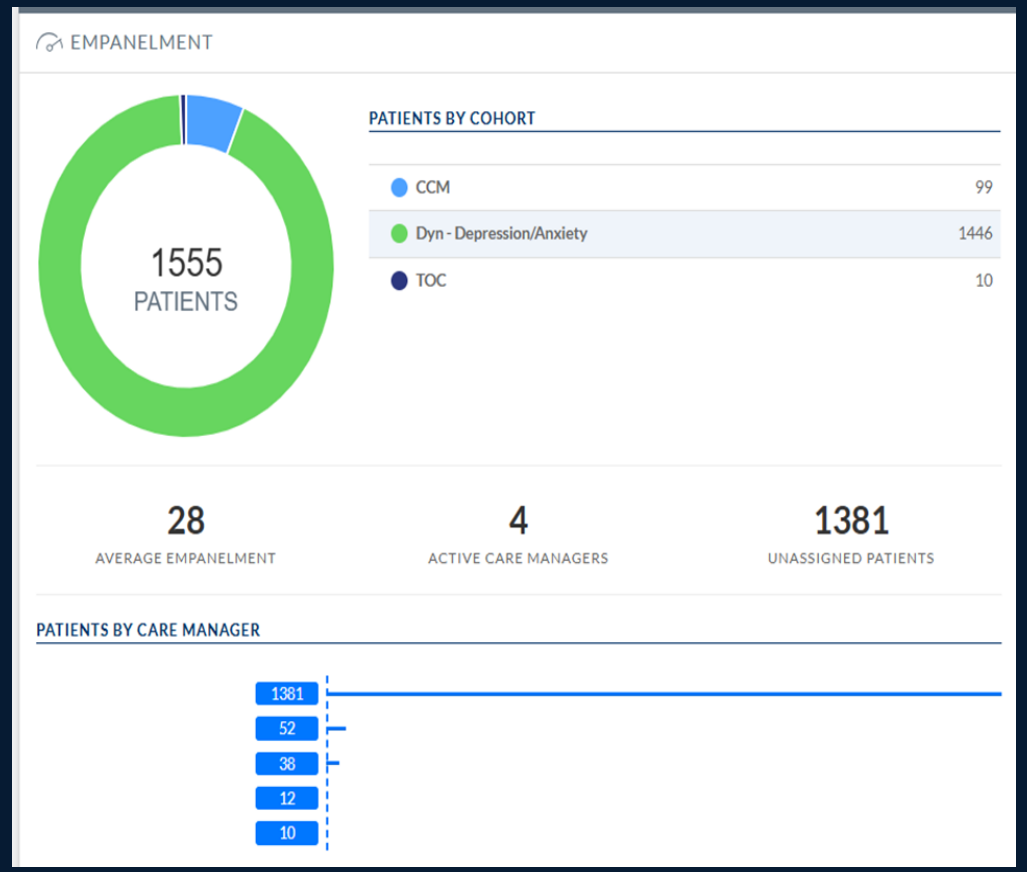
Track staff workload

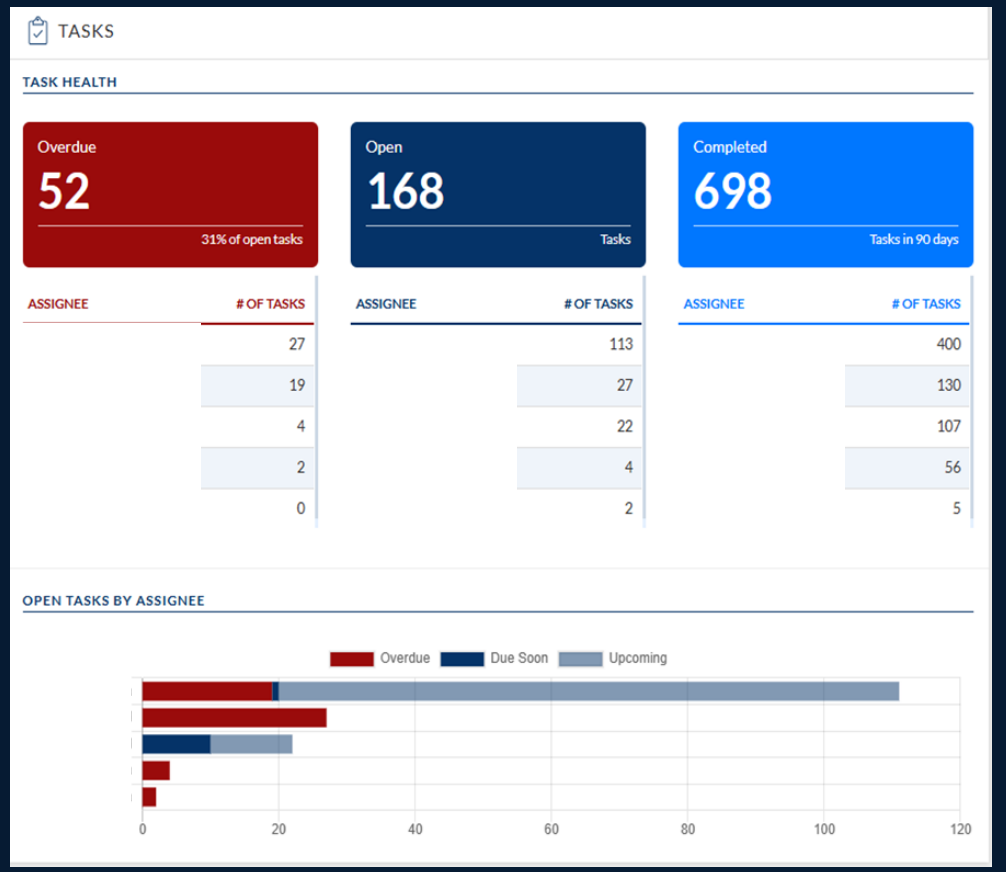
Population health reporting

Demonstrate value of outreach

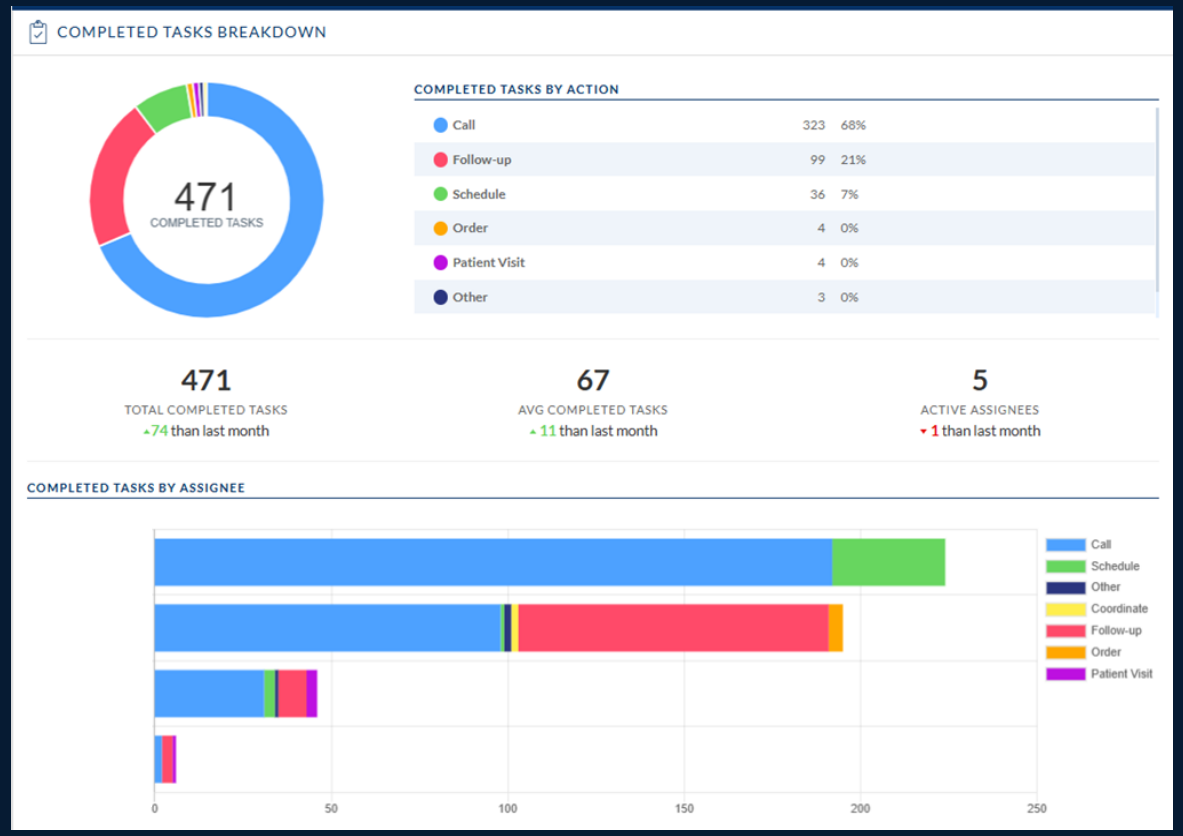
Program evaluation

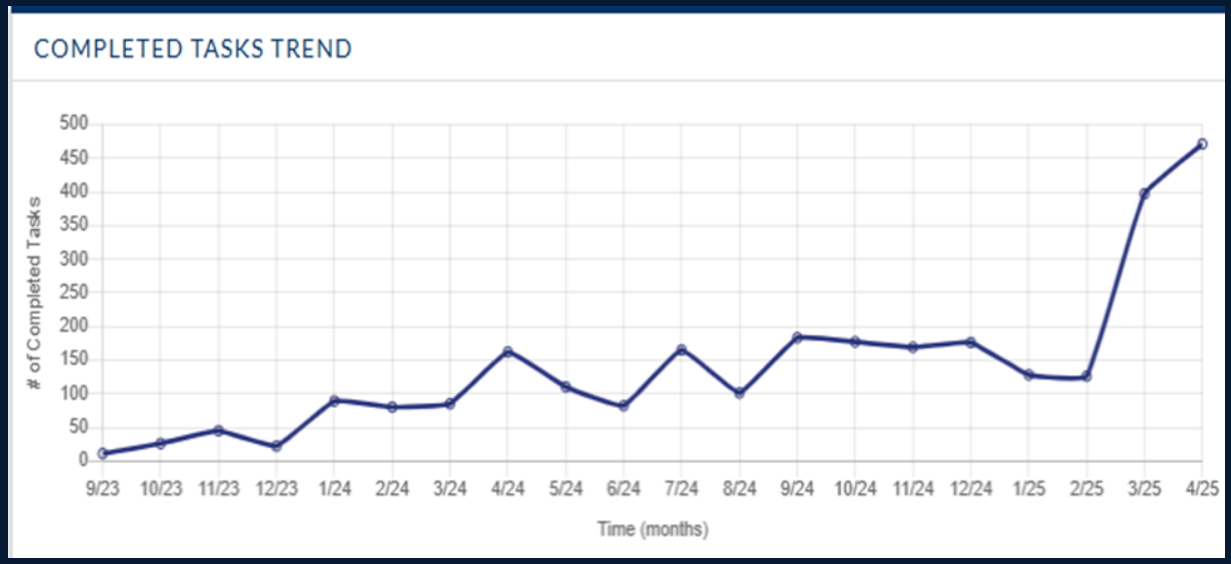
Data Across All Programs: Workload





Data Across All Program: Productivity





Wrap-Up & Questions

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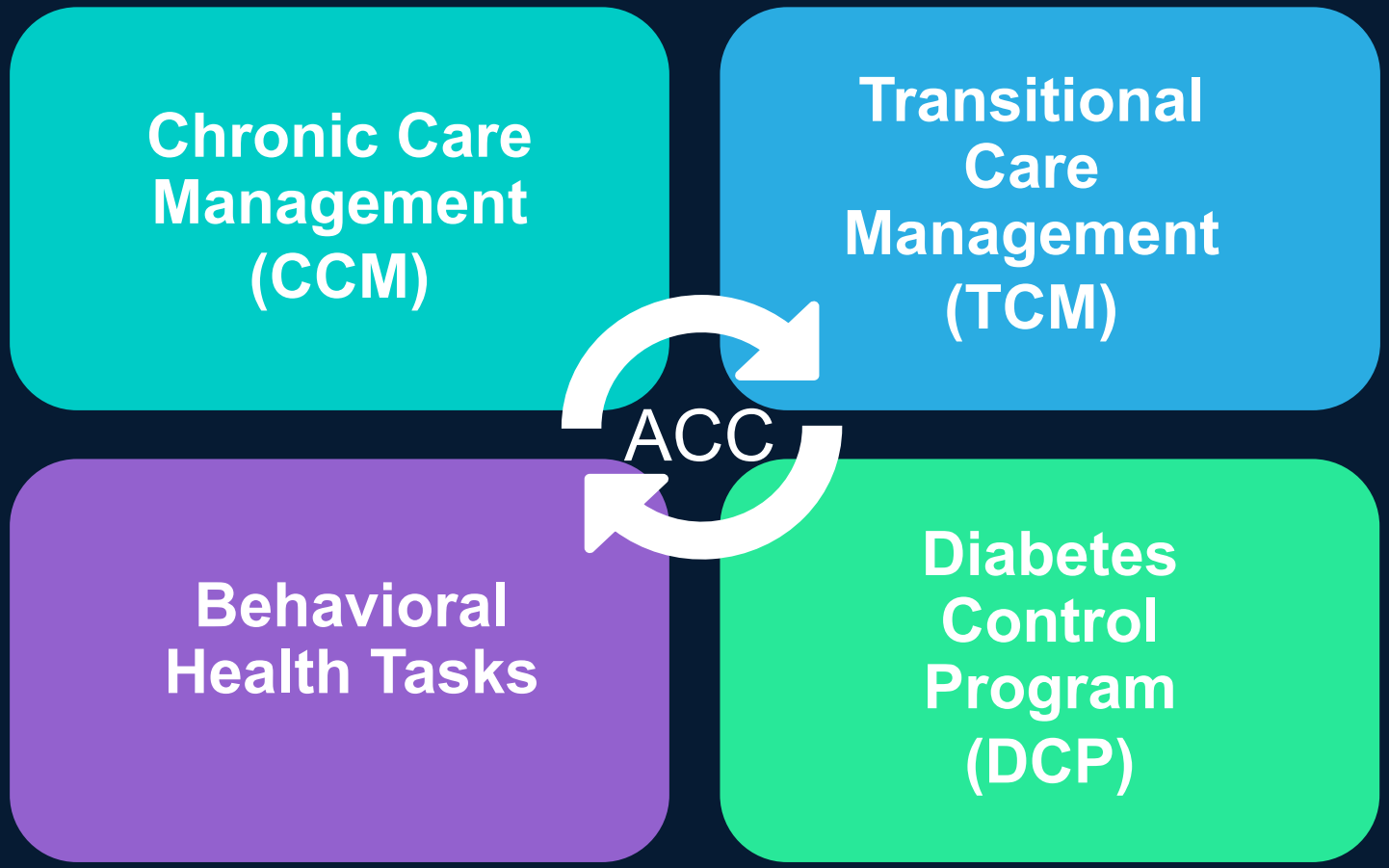
ACC Facilitates Multiple Chronic Care Programs



The Value of ACC at UNHS

- Centralized tracking for CCM, TCM, BH, DPP services.
- Improves care coordination and team communication.
- Supports billing, compliance, and documentation.
- Enhances overall patient follow-up and outcomes.

Questions?

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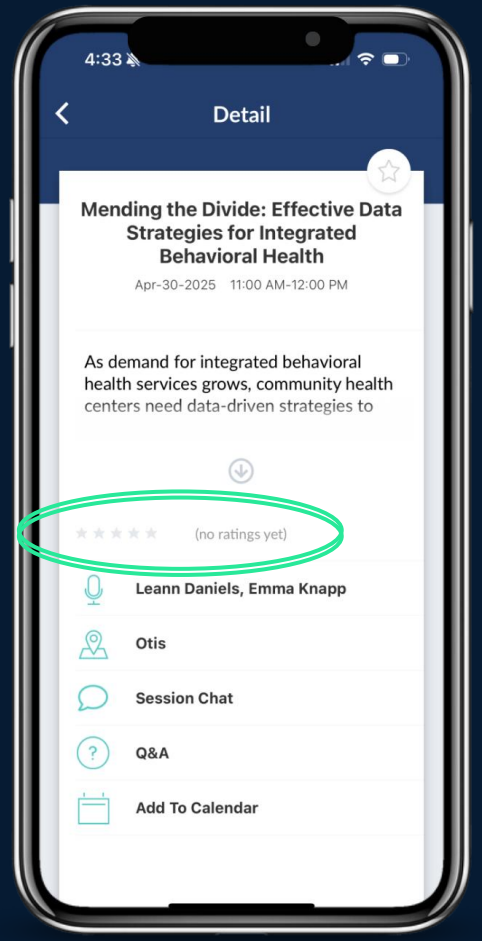

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