

Modernizing Chronic Care Programs with Azara Care Connect

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Today's Presenter



Heidi Riphenburg, MPH

Director of Quality
Improvement

Utah Navajo Health System

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Today's Agenda

15



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

15

Serve approximately 15,000 Patients Annually

Medical

Dental

Vision

Pharmacy

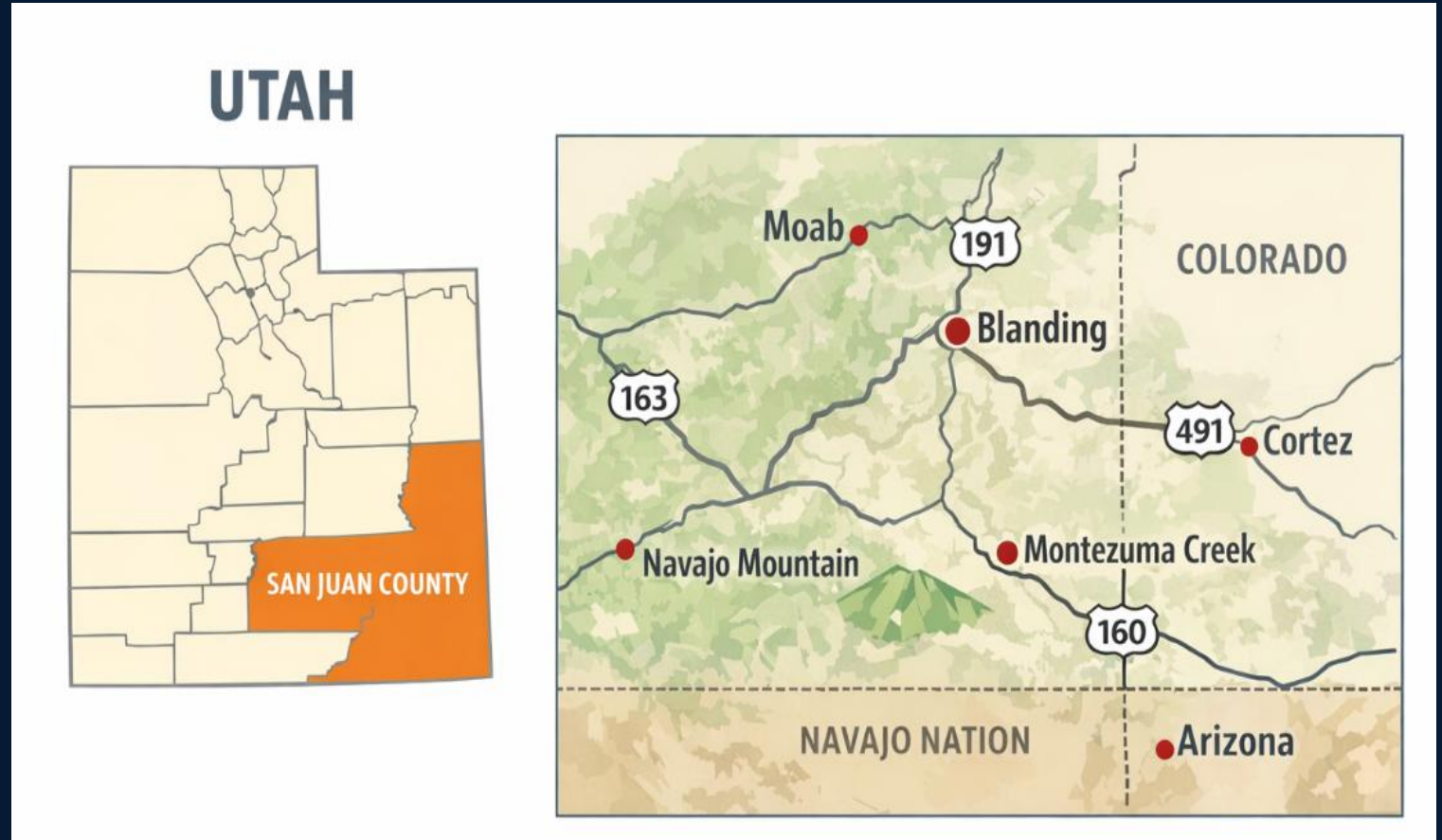
Behavioral Health

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



GENERAL

POPULATION DEFINITION

DEFINITION
Select the population criteria from the dropdown. The description will appear to the right. Note: once the cohort is created, you will not be able to edit the population criteria.

DESCRIPTION
Patients who have a diagnosis of diabetes and whose most recent hemoglobin A1c lab result is > 9.0%. Patients who are deceased or inactive at the center are excluded from the cohort.

SELECT POPULATION CRITERIA *

- DM A1c > 9
- DM A1c Untested
- DSMES
- ER Visit
- Hepatitis C
- High Risk Chronic Kidney Disease
- High Risk Patients
- HIV
- Hypertension
- Hypertension BP > 140/90
- IP Visit

ALLOW DYNAMIC EXIT
If set to 'yes', once a patient no longer meets criteria they will automatically be removed from the cohort

Yes No

Confirm

Patients (632)

NAME	MRN	DOB	NEXT APPT	CARE MANAGER	COHORTS
☆ ABELN, TAMMERA	1104945	5/30/15		Samuel Bar	Diabetes
☆ ACIERNO, ARCHIE	1101193	8/5/97		Mike Bomber	Diabetes
☆ AI, STRIKE	1103997	2/10/85	6/4/26 10:03 AM	Kevin Donohue	Diabetes
☆ AILSHIRE, LASHAY	1102912	4/19/73	3/28/26 8:18 AM	Nicollette Dessy	Diabetes, Health Home
☆ AKAHI, FILIBERTO	1101655	2/4/93		Eric Gunther	Diabetes
☆ ALFIERI, LEANDRO	1100044	2/7/10		Alex Shvarts	Diabetes
☆ ALT, WILBERT	1104055	9/3/77		Eric Gunther	Diabetes, Health Home
☆ AMOS, BISSONNETTE	1103902	2/4/25		Phill Proto	Diabetes
☆ ANDERE, NATHALIE	1101953	11/19/67		Renata Fritz	Diabetes, Health Home
☆ ANDING, LEIDA	1103002	7/10/23		Paula Silvia	Diabetes
☆ ANDRUS, NORMAND	1103359	11/4/91		Nicollette Dessy	Diabetes
☆ ANNETTE, TREUTER	1100548	11/15/08		Siddhi Chouhan	Abnormal Cancer Screen Outreach, Diabetes



Track Tasks: Automate Care Manager To-Do List



Home Patients **Tasks** Reports Care Coordination Search ACM Patients... LD

Tasks (21) **Open** Completed Flagged All DOWNLOAD AS: Excel

PATIENT	ACTION	SUMMARY	DUE	ASSIGNEE	COMMENTS
<input type="checkbox"/> ☆Happer, Ronny	Call	Call Pt within 2 days after discharge	02/19/26	Samuel Bar	🚩 ⋮
<input type="checkbox"/> ☆Happer, Ronny	Call	Medication Reconciliation	02/19/26	Samuel Bar	🚩 ⋮
<input type="checkbox"/> ☆Blalock, Dewayne	Call	Confirm upcoming appointment	02/24/26	Samuel Bar	🚩 ⋮
<input type="checkbox"/> ☆Blalock, Dewayne	Schedule	Setup BH visit	02/25/26	Samuel Bar	🚩 ⋮
<input type="checkbox"/> ☆Mcginnes, Karl	Schedule	Follow-up appointment with Psych	03/02/26	Samuel Bar	🚩 ⋮
<input type="checkbox"/> ☆Chernich, Eddy	Schedule	Follow-up appointment with Psych	03/10/26	Samuel Bar	🚩 ⋮
<input type="checkbox"/> ☆Zenon, Janay	Call	Review "red flag" indicators of worsening condition with Pt	03/11/26	Samuel Bar	🚩 ⋮
<input type="checkbox"/> ☆Zenon, Janay	Schedule	Schedule follow-up visit with provider	03/11/26	Samuel Bar	🚩 ⋮

Search Tasks... 🔍

DUE DATE

Overdue

Today

Next 3 Days

Next 7 Days

ASSIGNEE

None selected ▾

ACTION

None selected ▾

CARE MANAGER

None selected ▾ **Demo Data**

PATIENTS



Track Patients



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

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

Summary Plan Screenings Clinical

Demo Data

NOTIFICATIONS

ED Visit	St. Marys Hospital	10/7/25
Hospital Admission		9/22/25
Hospital Discharge		9/22/25

CARE TEAM

Intervention Effort	Not Set
Care Manager	Minori Rios Access
Usual Provider	Crowley, Patrick

TASKS (2)

Open Completed Flagged All

ACTION	SUMMARY	DUE	ASSIGNEE	COMMENTS
<input type="checkbox"/> Call	SDOH Screening	10/15/25 ⚠	amelia fox	
<input type="checkbox"/> Call	Make sure he has a ride to health center for upcoming appt	10/22/25	amelia fox	

Showing 1 to 2 of 2 entries

View tasks that need to be completed.

NOTES

Just now Noah is very close with his two grandkids - Jeffrey and Alicia. Really into ice fishing in the winters. Has a small house at Higgins Lake. fa

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.

ALERTS

NAME	MESSAGE		MOST RECENT RESULT
BMI % >85%	At Risk	9/22/25	144
A1c	Out of Range	9/22/25	9.8

Tasks & Time Tracking



Aasby, Emmitt MRN: 1101759 | DOB: 7/2/74 (51) | M☆

L 14 English (508)542-2896 No email

Summary Plan Screenings Clinical Activity Demo Data

NOTIFICATIONS

- Upcoming Appointment Fritz, Renata / ACH - N
- Upcoming Appointment Fritz, Renata / ACH - N
- Upcoming Appointment Bridgewater, Bill / ACH - N
- Upcoming Appointment Bridgewater, Bill / ACH - N
- Upcoming Appointment Decelles, Larry / ACH - N
- Upcoming Appointment Bridgewater, Bill / ACH - N
- Inpatient Stay Sacred Heart Hospital

CARE TEAM

- Manager Ian Farquhar
- Provider Ronda Black

TASKS (0) Open Completed

ACTION SUMMARY DUE ASSIGNEE COMMENTS

TASKS

Aasby, Emmitt

Patient Visit: Follow-Up on DM goals

Due: 04/15/2026 Assignee

Add Comment

- Call
- Schedule
- Other
- Coordinate
- Follow-up
- Order
- Patient Visit**

ADD TASK

ADD A TIME ENTRY

Aasby, Emmitt

Responsible Leah Dafoulas Date 04/15/2026

Add Time Time Total

+1 +5 +10 15m Billable

Patient Visit - DM goals

ADD TIME ENTRY



Review Time Spent with Patient



Summary Plan Clinical **Activity**

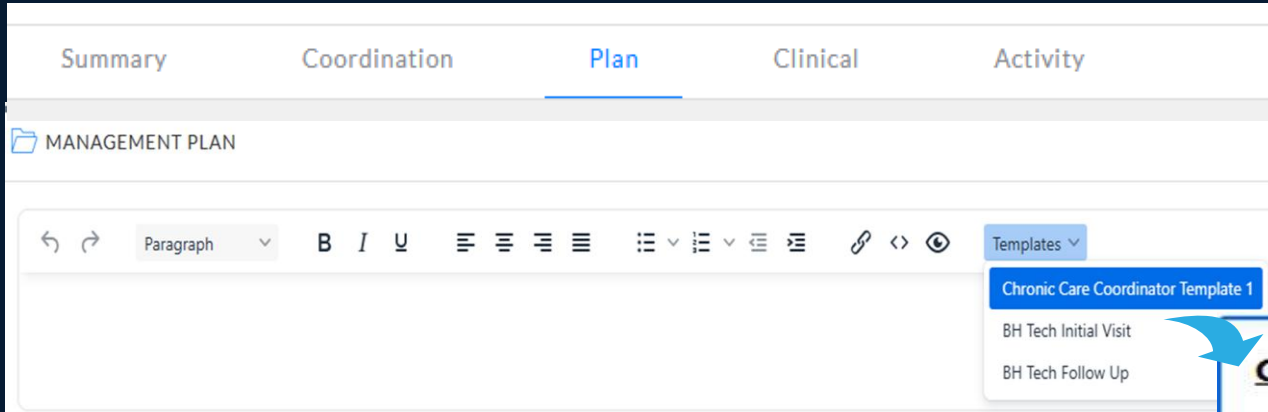
TIME LOG (2) 📅 October 1, 2025 - October 31, 2025 Only Billable Time **UPDATE** Time History

October 2025 11m

BR	10/14/25 @ 0937-4m: f/u message to PCP nurse, f/u call to PCP nurse, Pt insurance approved. Will follow up with referrals and Pt. @ 0932 -1m: Called Pt, Pt is planning on attending PCP appt today, CC nurse will f/u Pt f/u call - 10/2025	5m 10/14
BR	10/10/25 @ 1318-5m - reviewed referrals. HH/Cardio/Hemtologist/Nephrology, Infectious disease Specialist, Clinical Cardiac Electrophysiologist- new referrals needed at next appt on 10/10/25 @ 1324-2m: message to PCP nurse HH referral review - 10/2025	6m 10/10



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.

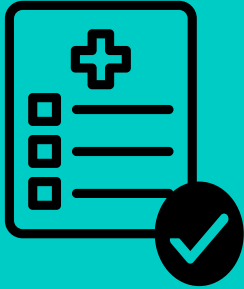
Medications: Reviewed with patient.

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.

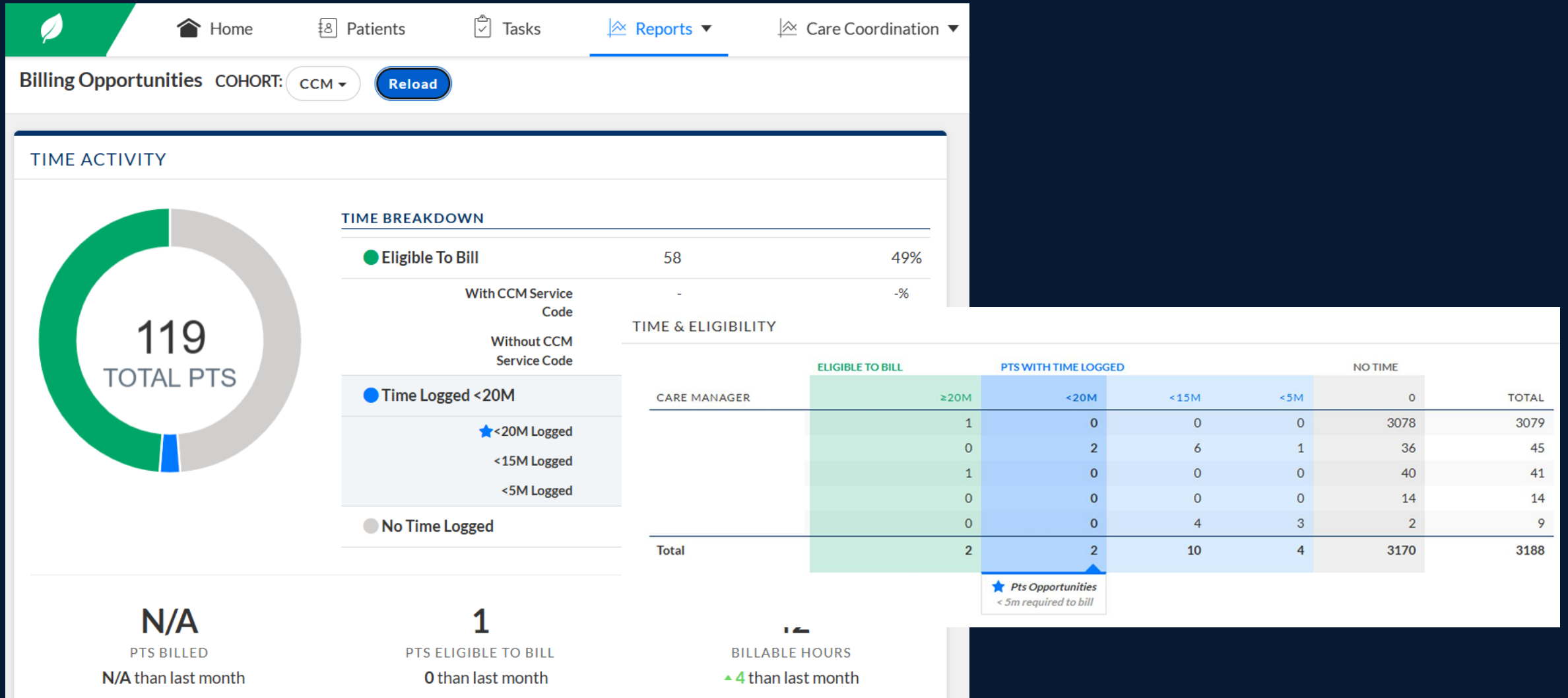


Documentation & Reporting

Detailed timely records.



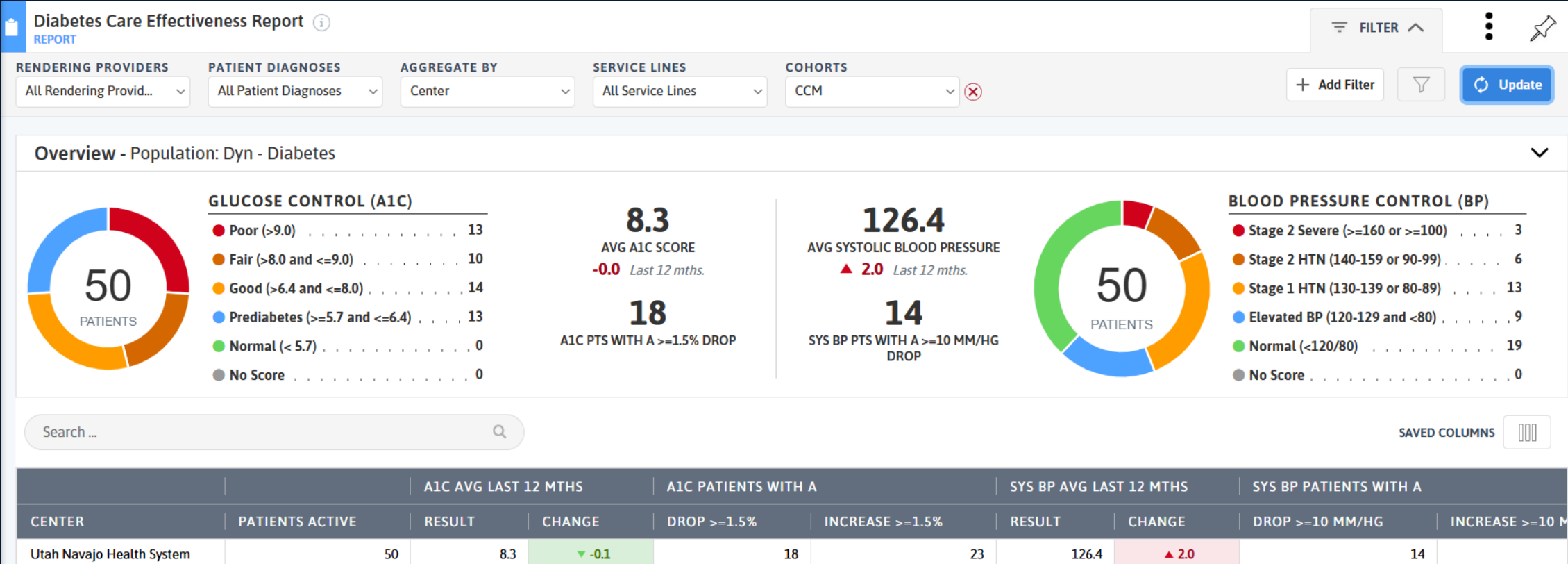
Billing for CCM Monthly: Generate Revenue



Tracking Outcomes



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





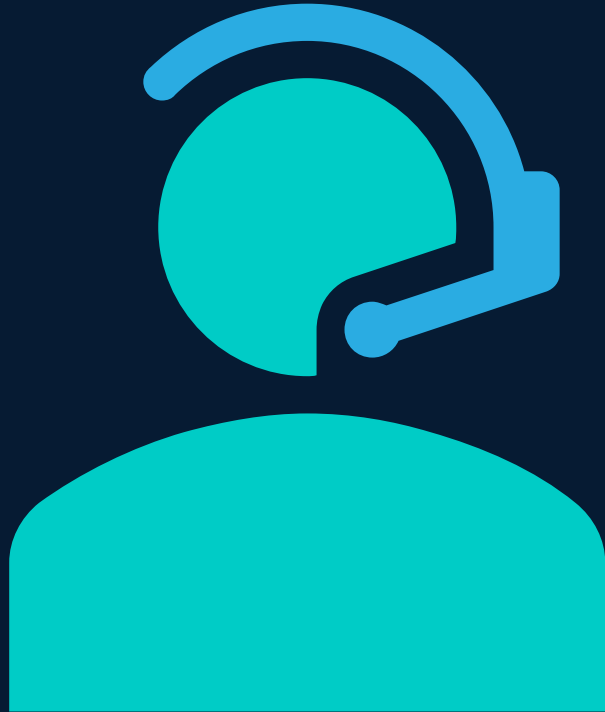
Transitional Care Management



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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

15



Timely identification of discharged patients



Standardized post-discharge follow-up



Documentation of activities



Track Outcomes (Clinical & Operational)



Identifying Patients In Need of Follow-Up



Transitions of Care (TOC) - ED/IP

REPORT

FILTERS: 02/01/2026-02/28/2026 Discharge

REPORTS VALUE SETS Demo Data

Search ... NEXT APPT All No Appt Upcoming Appt Reset Columns SAVED COLUMNS

DEMOGRAPHICS		ADMISSION EVENT				DISCHARGE			DIAGNOSIS		
NAME	TYPE	ADMISS...	DISCHAR...	FACILITY	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS	IP READMIT	STATUS	STAT_CODE	CODE	DESCRIPTION
Aasby, Emmitt	Inpatient S...	2/24/26 9:18 am	2/27/26 7:03 pm	Sacred Heart Hospit...	0	2	N	Unknown or...	0	J96.01	
Aarvang, Odell	ER Visit	2/19/26 8:18 am	2/19/26 12:03 p...	Burlington General ...	1	1	N/A	Unknown or...	0	R55	
Abela, Windy	Inpatient S...	2/17/26 3:03 am	2/22/26 6:03 pm	Trinity Hospital	0	2	N	Unknown or...	0	R07.89	
Adey, Dessie	Inpatient S...	2/21/26 6:33 am	2/25/26 9:18 pm	Burlington General ...	0	1	N	Unknown or...	0	B34.9	
Aiello, Damien	ER Visit	2/2/26 6:33 am	2/2/26 5:18 pm	Trinity Hospital	2	0	N/A	Unknown or...	0	J96.01	
Ailsworth, Eric	ER Visit	2/22/26 4:33 am	2/22/26 11:48 a...	Sacred Heart Hospit...	1	0	N/A	Unknown or...	0	W19.XXXA	
Aker, Ivey	ER Visit	2/1/26 9:18 am	2/1/26 3:48 pm	Sacred Heart Hospit...	2	0	N/A	Unknown or...	0	R11.2	
Alcaraz, Billie	Inpatient S...	2/11/26 6:33 am	2/14/26 11:03 p...	St. Marys Hospital	0	1	N	Unknown or...	0	J96.01	
Alferi, Leandro	Inpatient S...	1/31/26 10:18 ...	2/5/26 11:48 pm	St. Marys Hospital	0	3	N	Unknown or...	0	R56.9	
Alibozek, Nada	Inpatient S...	1/30/26 7:18 am	2/2/26 6:33 pm	Trinity Hospital	1	2	N	Unknown or...	0	J18.9	
Alibozek, Nada	Inpatient S...	1/31/26 5:48 am	2/6/26 8:18 pm	St. Marys Hospital	1	2	Y	Unknown or...	0	F10.10	
Alibozek, Nada	ER Visit	2/21/26 5:48 am	2/21/26 9:18 am	St. Josephs Hospital	1	2	N/A	Unknown or...	0	R56.9	
Alto, Will	Inpatient S...	2/12/26 10:03 ...	2/18/26 9:48 pm	Burlington General ...	1	1	N	Unknown or...	0	I10	

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.

Outreach Directory

All Recently Viewed

PATIENT	GAP COUNT	CONTACT REASONS	LAST OUTREACH	OUTREACH COUNT	USER
ERICH, GROVIER	2	TOC	03/25/26	2	Samuel Bar
FULOP, EVITA	2	CQM, TOC	Never ▲	0	Samuel Bar
BUGGS, VON	3	CQM, MCRD	Never ▲	0	Samuel Bar
CACERES, BRAD	2	CQM, MCRD	Never ▲	0	Samuel Bar
BLUMKIN, LAUREL	2	CQM, MCRD	Never ▲	0	Samuel Bar
EATMON, CURTIS	2	CQM, MCRD	Never ▲	0	Samuel Bar
FRIEDLI, PERRY	3	CQM, MCRD	Never ▲	0	Samuel Bar
BLASETTI, DENIS	2	CQM, MCRD	Never ▲	0	Samuel Bar
CAPUA, PRESTON	3	CQM, HEDIS, MCRD	03/27/26	1	Samuel Bar
ESTRADE, DEMETRA	3	CQM, HEDIS	Never ▲	0	Samuel Bar

FILTERS MANAGE

Search Patient...

NARROW RESULTS BY

- No Contact in Last 30 Days
- Discharged in Last 7 Days

USERS

None selected

CONTACT REASONS

6 selected

- Include No Active Gaps

MEDICAID REDETERMINATION



Standardized Post-Discharge Follow Up



Task groups standardize evidence-based workflows.

TASK GROUPS

Aasby, Emmitt Transition of Care Abbrev

Description: The abbreviated TOC is a shortened series of tasks that are curated and recommended to assign to a patient following an ED or IP related event based on The Care Transitions Program by Dr. Eric Coleman.

Discharge Date: 08/16/2026 Assignee: Leah Dafoulas

ACTION	SUMMARY	DUE
<input checked="" type="checkbox"/> Call	Call Pt within 2 days after discharge	08/18/2026
<input checked="" type="checkbox"/> Call	Review "red flag" indicators of worsening condition with Pt	08/18/2026
<input checked="" type="checkbox"/> Call	Medication Reconciliation	08/18/2026
<input checked="" type="checkbox"/> Schedule	Schedule follow-up visit with provider	08/18/2026

4 Tasks will be added. | Save and add another Task Group Demo Data

Add Tasks



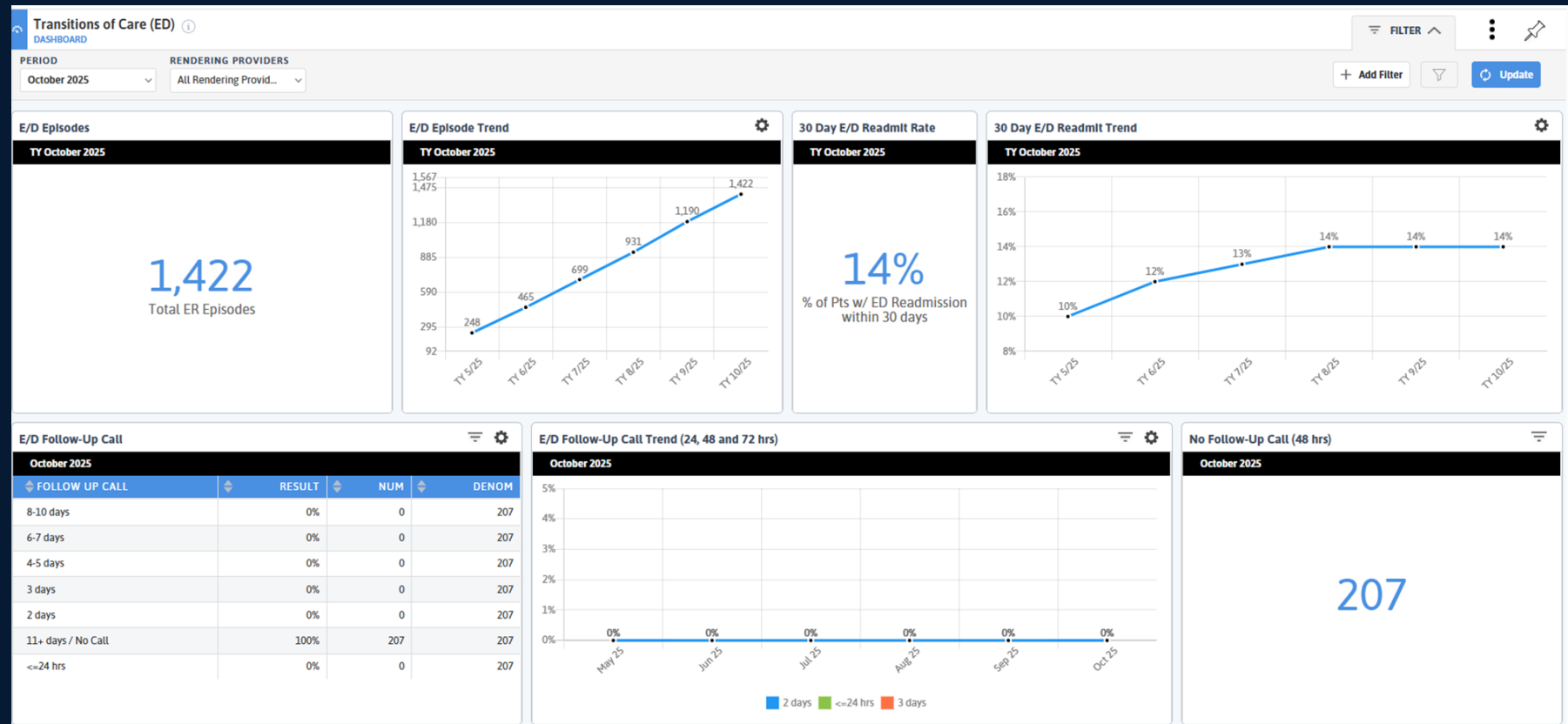
Tracking Outcomes



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

- CMP
- Reports
- Dashboards
- Measures
- Registries
- Admin

- Transition of Care
- ED Follow Up Call
- ED Follow Up Scheduled
- ED Follow Up Visit
- ED Readmission (30 days)
- ED Readmission (6 months)
- Emergency Episode Volume
- I/P Follow Up Call
- I/P Follow Up Scheduled
- I/P Follow Up Visit
- I/P Readmission (30 days)
- I/P Readmission (6 months)
- Inpatient Episode Volume



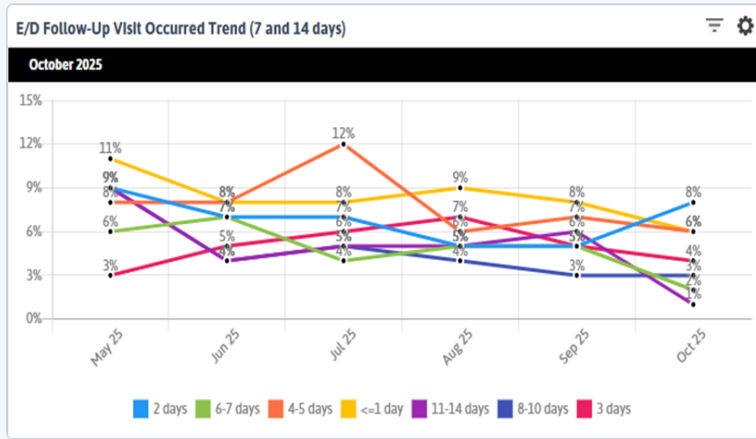
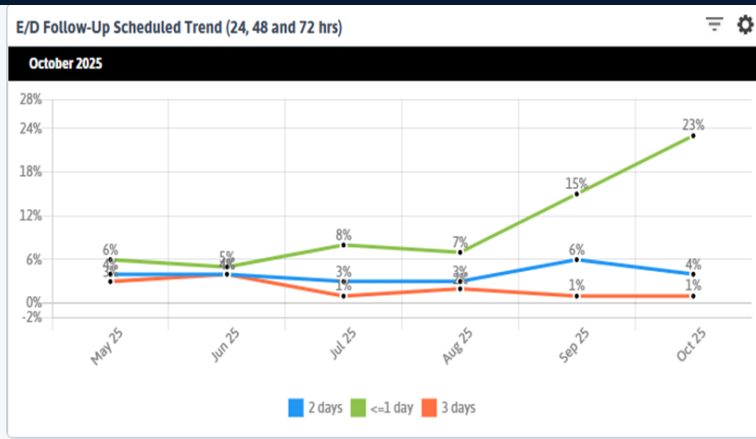
More Efficient Post Discharge Scheduling



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

E/D Follow-Up Scheduled			
October 2025			
FOLLOW UP SCHEDULED	RESULT	NUM	DENOM
8-10 days	4%	9	207
	5%	11	207
	5%	10	207
	49%	102	207
	1%	3	207
	1%	2	207
	4%	9	207
	3%	6	207
	3%	7	207

E/D Follow-Up Scheduled			
October 2025			
FOLLOW UP SCHEDULED	RESULT	NUM	DENOM
	3%	7	207
	2%	5	207
	6%	13	207
No Follow Up Visit	66%	137	207
3 days	4%	9	207
21-30 days	0%	0	207
2 days	8%	16	207
15-20 days	2%	5	207
11-14 days	1%	3	207



*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





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.


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:



Multiple care plan templates in ACC provide flexibility for different programs



Value of Standardized Workflows

15

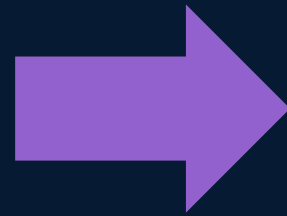
Supports

Workflow documentation and supervision

Improves

Visibility, accountability and reporting





Document

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



Why Document Non-Billable Programs?

15



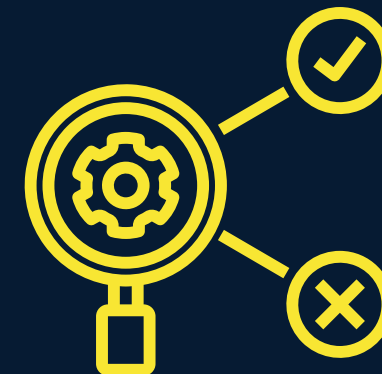
Track staff workload



Population health reporting



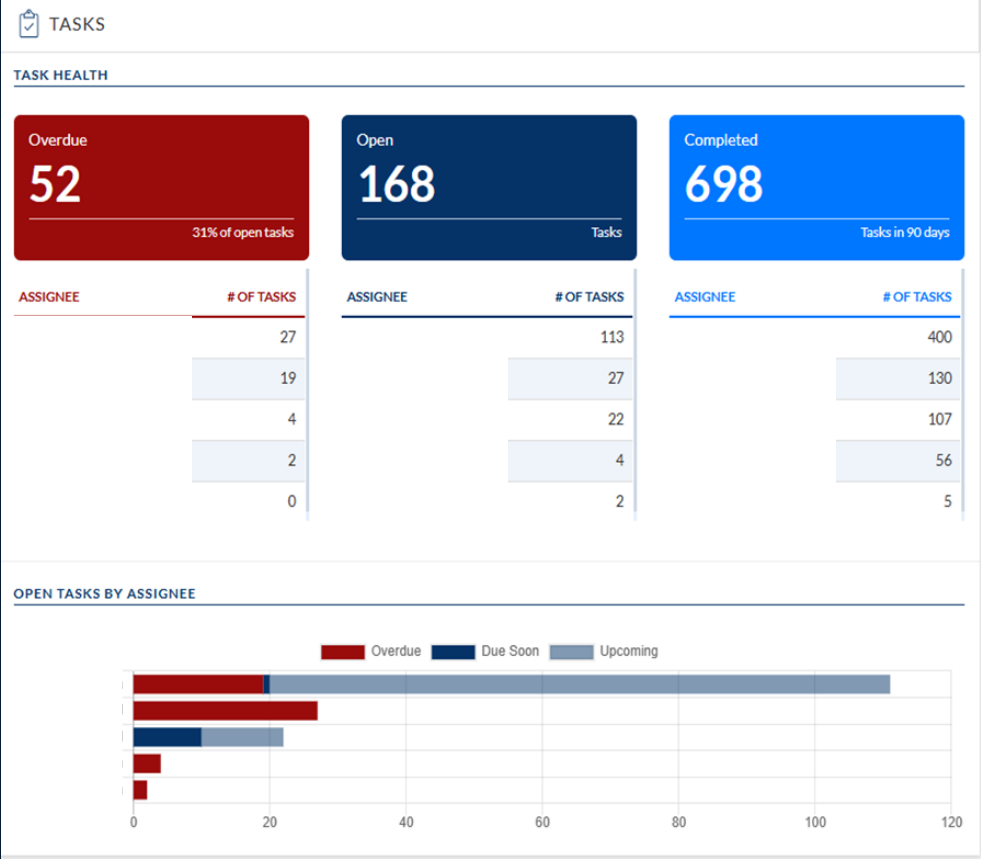
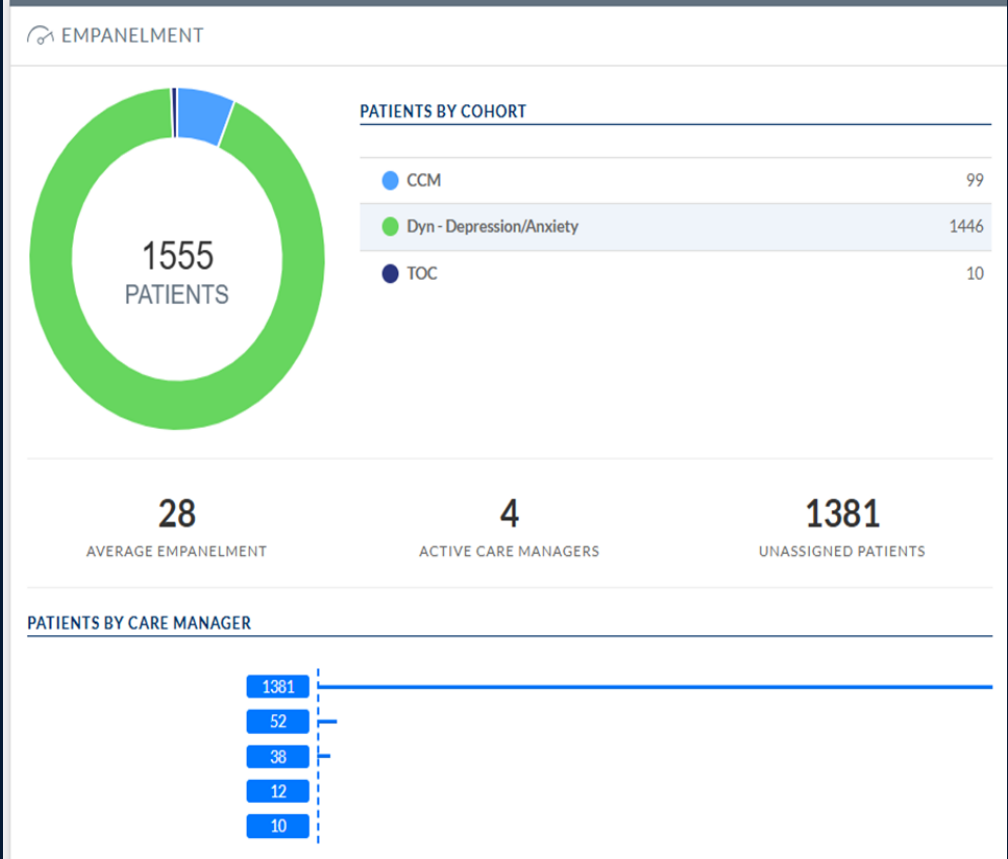
Demonstrate value of outreach



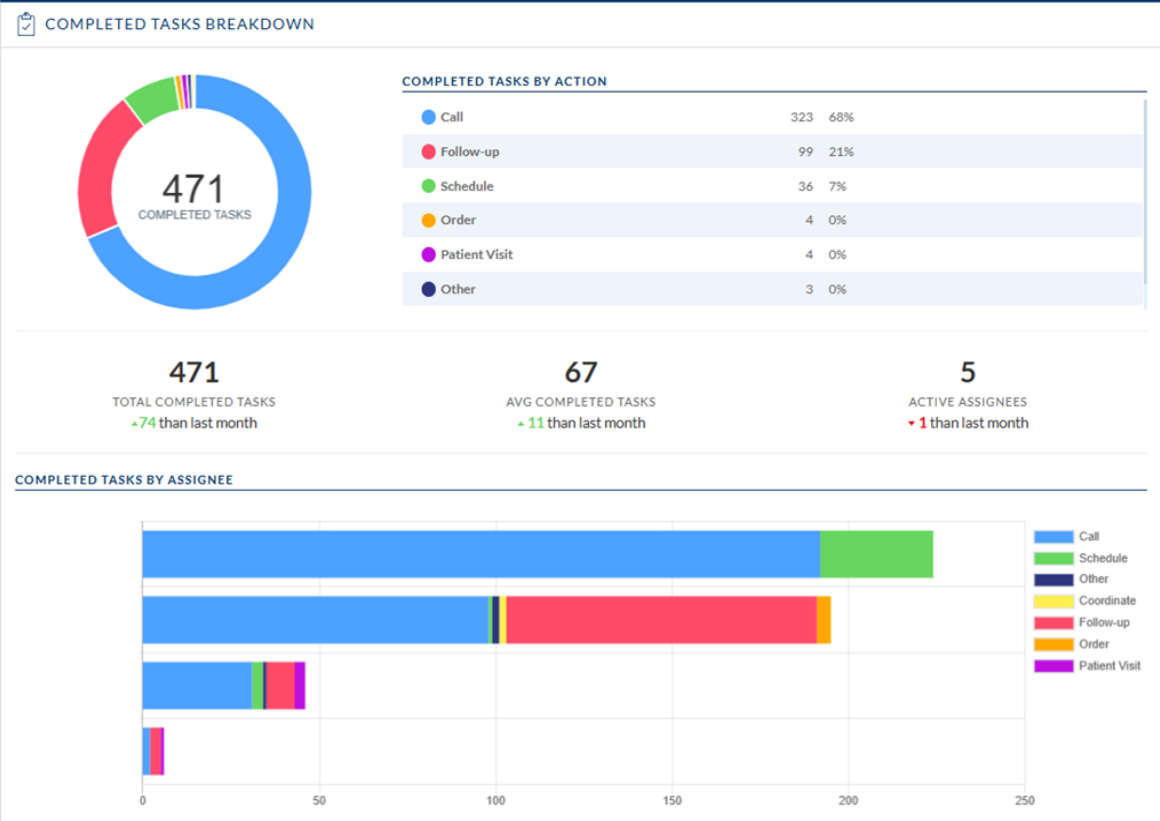
Program evaluation



Data Across All Programs: Workload



Data Across All Program: Productivity





Wrap-Up & Questions

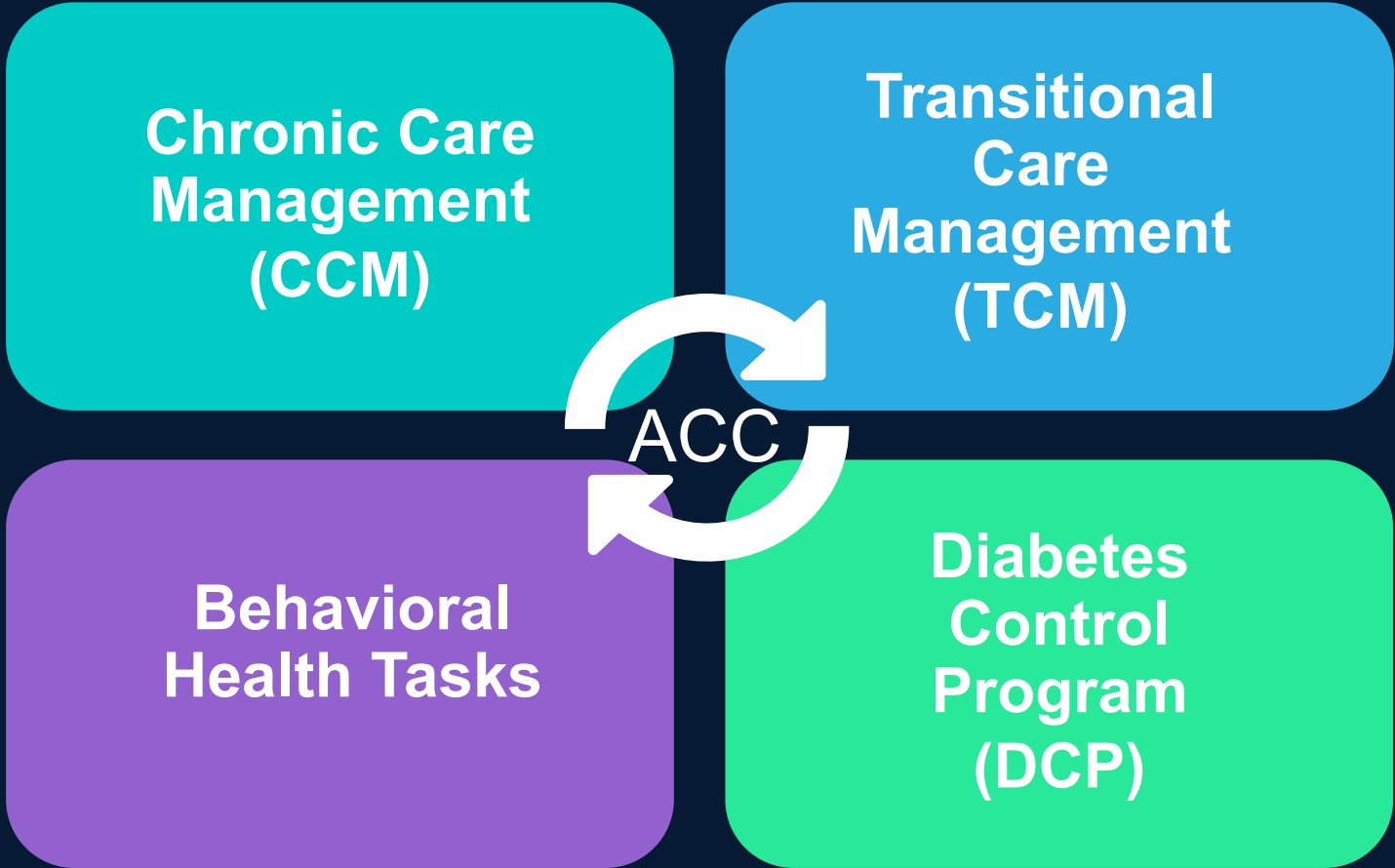


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ACC Facilitates Multiple Chronic Care Programs **15**



The Value of ACC at UNHS

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- ✓ 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.



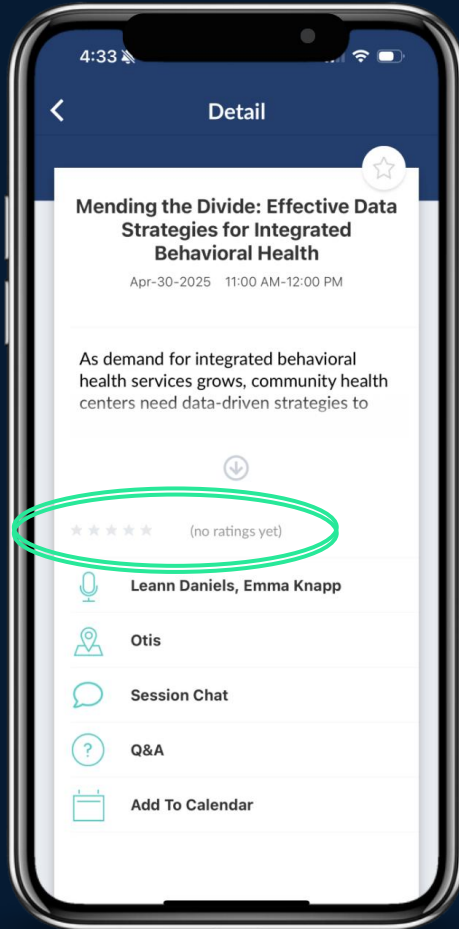


Questions?



We want to hear from you!

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



Quick and Easy



Provide brief feedback or ideas



Rate the session and the speaker(s)



Help us continue to improve



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Thanks for attending!

