



azara
USER CONFERENCE
APRIL 13-15
BOSTON, MA
2026

Navigating The Shift: A Proven Framework for VBC Success



Today's Presenters

15



**Breann Streck, RN,
BSN, CPC**

Senior Practice
Transformation Coach
Montana PCA
Montana Health Plus



**Megan Duncan, RN
BSN**

Lead Care Manager
PureView Health Center



Today's Agenda

Building a network of FQHCs

Network support for VBC success

FQHC Perspective: Supporting the Shift to VBC

Successes



Megan Duncan, RN, BSN Lead Care Manager

15



FQHC serving 9,400 unique patients (42,700+ visits annually)

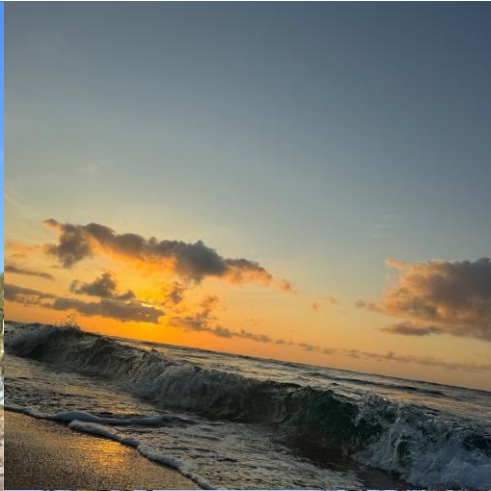
- Primary Care
- Mental Health
- Integrated Behavioral Health
- LAC and Peer Support
- Dentistry
- Pharmacy
- Case Management
- Care Management
- School Based Care
- Mobile Clinic



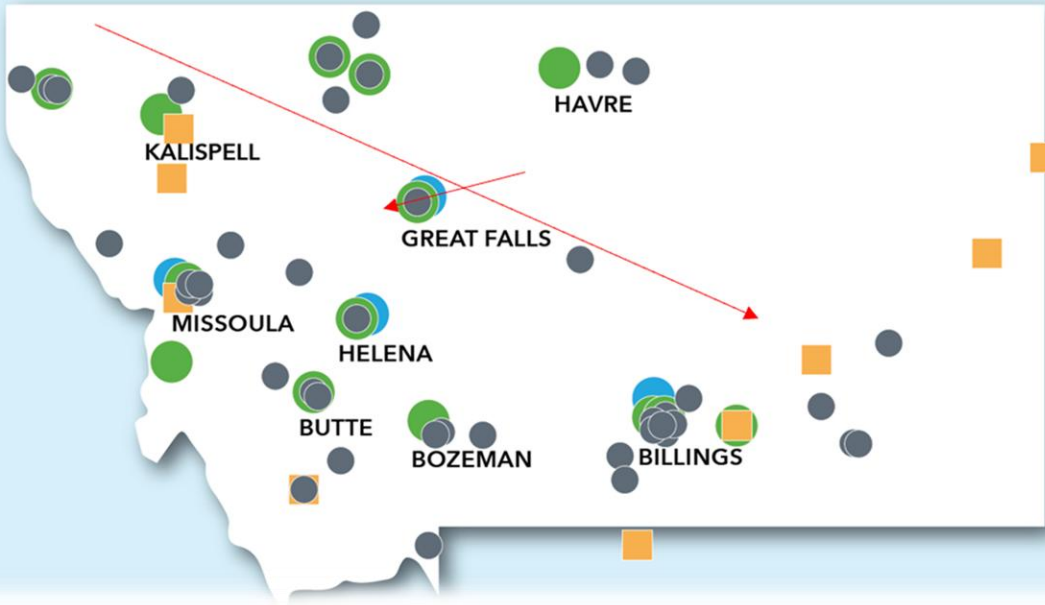




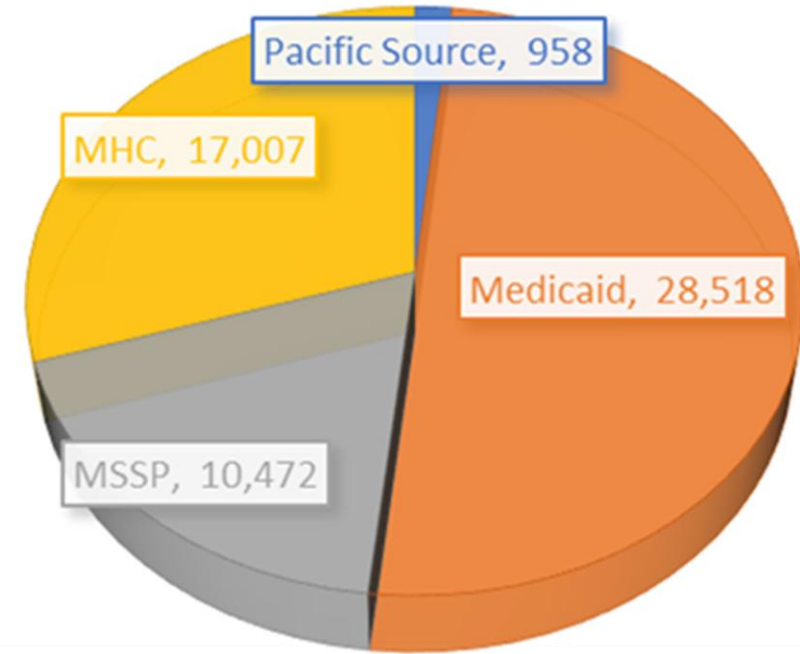
Breann Streck, RN, BSN



MONTANA COMMUNITY HEALTH CENTERS



NETWORK MEMBER ATTRIBUTION



Purpose of MT H+ Network: Improving population health, providing a formal statewide system of care, increasing optimal clinical outcomes and decreasing overall healthcare costs for people in Montana regardless of income or coverage status, by providing integrated, high-quality, patient-centered care in a network of community-based health centers to the citizens of the State of Montana and private and public payers.



The Landscape of VBC

15

CMS 2030 Goal

- **All** traditional Medicare beneficiaries are in an accountable care arrangement
- As of January 2025, **53.4%** of people with Traditional Medicare are in an accountable care relationship.*

FQHCs are critical in VBC:

- Serve populations that VBC is designed to impact most
- Deliver Comprehensive, Team-Based Primary Care
- Prevention and Comprehensive Disease Management
- Reduce Total Cost of Care
- Positioned as a National Leader in VBC Transformation



* <https://www.cms.gov/newsroom/fact-sheets/cms-moves-closer-accountable-care-goals-2025-aco-initiatives>





Montana

Oldest State in the West

Approximately **21%** of Montana residents are **65+**

By 2030 it is anticipated **32%** of Montana residents will be 65+.

[MSU: Project 2030](#)



MH+ and FQHC Partnership for VBC

CIN/ACO Strengths	FQHC Strengths
<p><u>Data and Analytics</u> Population health platforms, risk stratification, quality dashboards</p>	<p><u>Access</u> Trusted access to underserved, high risk populations, transitions of care</p>
<p><u>Contracting Expertise</u> Payor negotiations, shared savings, risk model designs</p>	<p><u>Integrated Primary Care</u> Medical, behavioral health, dental, pharmacy</p>
<p><u>Standardized Protocols</u> Align quality measures, evidence-based guidelines Redefine roles...</p>	<p><u>Social Drivers of Health</u> Screening, navigation and community partnerships</p>
<p><u>Education</u> Care Management, clinic design, quality measures, coding, etc.</p>	<p><u>Culturally Competent Care</u> Patient centered approaches that improve engagement</p>



MH+



FQHC



- Improved quality performance
- Reduced total cost of care
- Stronger attribution and continuity
- Enhanced SDoH impact
- Better patient engagement



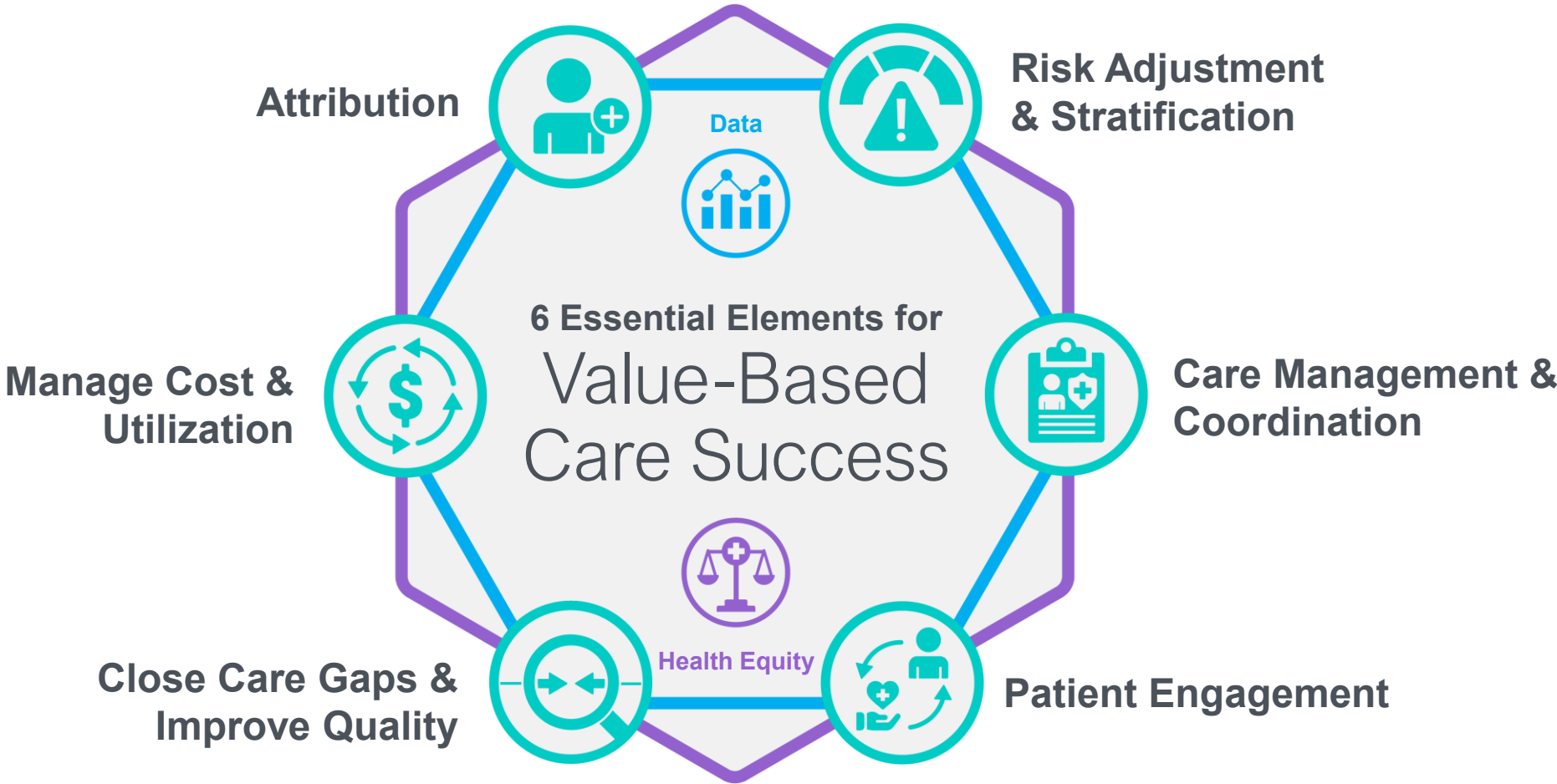
How We Work Together



The Data Strategy



Framework for FQHC Readiness to VBC model **15**



"The Aha Moment" - Networking to Facilitate the Transition to VBC

15



Care Team – The Mindset Shift

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Initial

We started with a dream, but no dedicated staff or workflow

- Invested in one Care Manager for the entire practice
- QI Leader and Medical Director and CEO were huge proponents for Value-Based Care
- Initial focus was on TOC/TCM
- Expanded into Population Health and targeted outreach for gaps/UDS
- Provided Care Coordination for the most complex patients
- Quickly saw the need and opportunity for a Chronic Care Management Program

Transition

Leadership support – From top down

- In addition, all teams were willing to participate – they saw the big picture
- Responsibilities were shifted – worked to higher licensure
- Shifted work **without** having to create more FTE to support over-all vision
- Eventually did begin expanding the team once billable revenue streams (TCM/CCM) were established to support ability to invest further



It Takes A Team

PureView - Value Based Care Team Design

Front Desk Staff

- Script for AWV
- Outreach as requested by CM team

Nursing Team

- PVP
- Use highest specificity code
- Promote Preventive Care
- Standing orders for screenings

Providers

- Improve coding specificity
- Improve code recapture
- Promote preventive care
- MH+ provided periodic training on coding tips

Care Management

- Provide TCM and CCM care
- Huddle/Warm-Handoffs
- Regular outreach to address gaps
- Promote preventive care
- Education and leadership

QI

- Identifies trends
- Assists in prioritizing outreach
- Assists with outreach strategy
- Reporting

Leadership

- Supports VBC vision
- Invests in staff and data/tech
- Invests in education
- Active involvement with ACO Board
- Participates in 1:1 meetings
- CMO Leadership

Coders/Billing

- Billing for TCM/CCM
- Validate documentation
- Coding tips/expertise



DRVS Tools:

- UDS Quality
- Transition of Care
- CMP/PVP
- Member Report
- Newly Assigned Members
- Medicare RAF Gaps
- Dashboards
- Risk Stratification
- ACC
- ACU



Transitions of Care (TOC)

Connection with BSCC (statewide HIE)

- Identify ED Visits
- Identify Inpatient Admissions/Discharges

Patient Outreach

- Care coordination
- Medication reconciliation
- Patient education

TCM

- Transitional care management (TCM) is a billable revenue stream
- Compliance with documentation requirements
- TOC services within specified time-frame to qualify



RAF (Risk Adjustment Factor) Gaps

15

① Prep for visit utilizing the Medicare Raf Gap Report

② Upgrades in DRVS – PVP/CMP



Medicare RAF Report



RAF Gaps Medicare REPORT FILTER + Update

PERIOD: 2026 CENTERS: All Centers LAST VISIT CY: Current Year

REPORTS VALUE SETS Demo Data

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

PATIENT DEMOGRAPHICS						TOTAL HCC MEDICARE RISK			GAP SUMMARY HCC	
LAST NAME	FIRST NAME	MRN	DOB	USUAL PROVIDER	PRIMARY PAYER	MAX	GAP	ACTUAL	DISEASE GROUP	DESCRIPTION
Gormally	Paulita	1100728	8/12/1982	Bridgewater, Bill	Medicare	1.077	1.077	0	Diabetes	Diabetes with Glycemic, U
Aboud	Peter	1102265	2/22/1949	Houser, Dougie	BCBS	2.05	1.27	0.78	Heart	Heart Failure, Except End
Amistoso	Benjamin	1100133	6/27/1944	Smith, Joe	Medicare	3.094	2.245	0.849	Heart	Heart Failure, Except End
Amons	Delsie	1103228	11/20/1953	Houser, Dougie	Aetna	2.679	2.006	0.673	Heart	Heart Failure, Except End
Barone	Tyson	1100838	4/2/1942	Doe, Jane	Aetna	2.304	1.455	0.849	Heart	Heart Failure, Except End
Boehlke	Hilario	1100912	12/5/1957	Fritz, Renata	Medicare	3.04	2.43	0.61	Heart	Heart Failure, Except End
Brouillette	Elijah	1103452	4/2/2010	Gunther, Eric	Medicare	2.696	2.418	0.278	Heart	Heart Failure, Except End
Chewning	Rudolf	1103218	5/19/1944	Crowley, Patrick	Medicare	3.157	2.308	0.849	Heart	Heart Failure, Except End



RAF Details via PVP Configuration



Create new PVP template and add "RAF GAP Details" to the PVP in the Patient Visit Planning Admin.

PVP Layouts Cancel Save

PVP CONFIGURATION
Access Community Health

LAYOUT NAME:

DESCRIPTION:

SHOW IN PVP: YES NO

SET TO DEFAULT: YES NO

SECTIONS

- ALERTS
- DIAGNOSES
- OPEN REFERRALS
- RAF GAP CATEGORIES
- RAF GAP DETAILS
- RAF SCORE
- RISK FACTORS
- SDOH
- VISITS AT OTHER PLACES

Use the layout builder to customize what displays on the PVP. Elements with a lock (🔒) cannot be updated or removed.

DEMOGRAPHIC INFORMATION

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
<input checked="" type="checkbox"/> Name	Sex at Birth	Phone	Portal Access	PCP
<input checked="" type="checkbox"/> MRN	Gender Identity	Language	Plan	Payer
<input checked="" type="checkbox"/> DOB (With age)	Sexual Orientation	Risk Level	Cohort	Care Manager
Gestational Weeks	<i>Options Available</i>	<i>Options Available</i>	<i>Options Available</i>	<i>Options Available</i>
<i>Options Available</i>	<i>Options Available</i>	<i>Options Available</i>	<i>Options Available</i>	<i>Options Available</i>

RAF Gap Details

RAF DISEASE GROUP	DESC	CONTEXT/ACTIONS	BILLED CY	UNBILLED CY
Diabetes	Diabetes	Dx Not Billed Add to Chg Next Visit		EHR E11.9 (07/24/24)
Kidney	Kidney	Dx Not Billed Add to Chg Next Visit		CHG N18/31 (07/24/24)

RAF Score

RAF RISK TOTAL SCORE (MAX)	GAP SCORE	ACTUAL SCORE
1.360	1.255	0.105

Alerts

ALERT	MESSAGE	DATE	RESULT	OWNER
Pan HPV	Missing	7/16/2026		MA

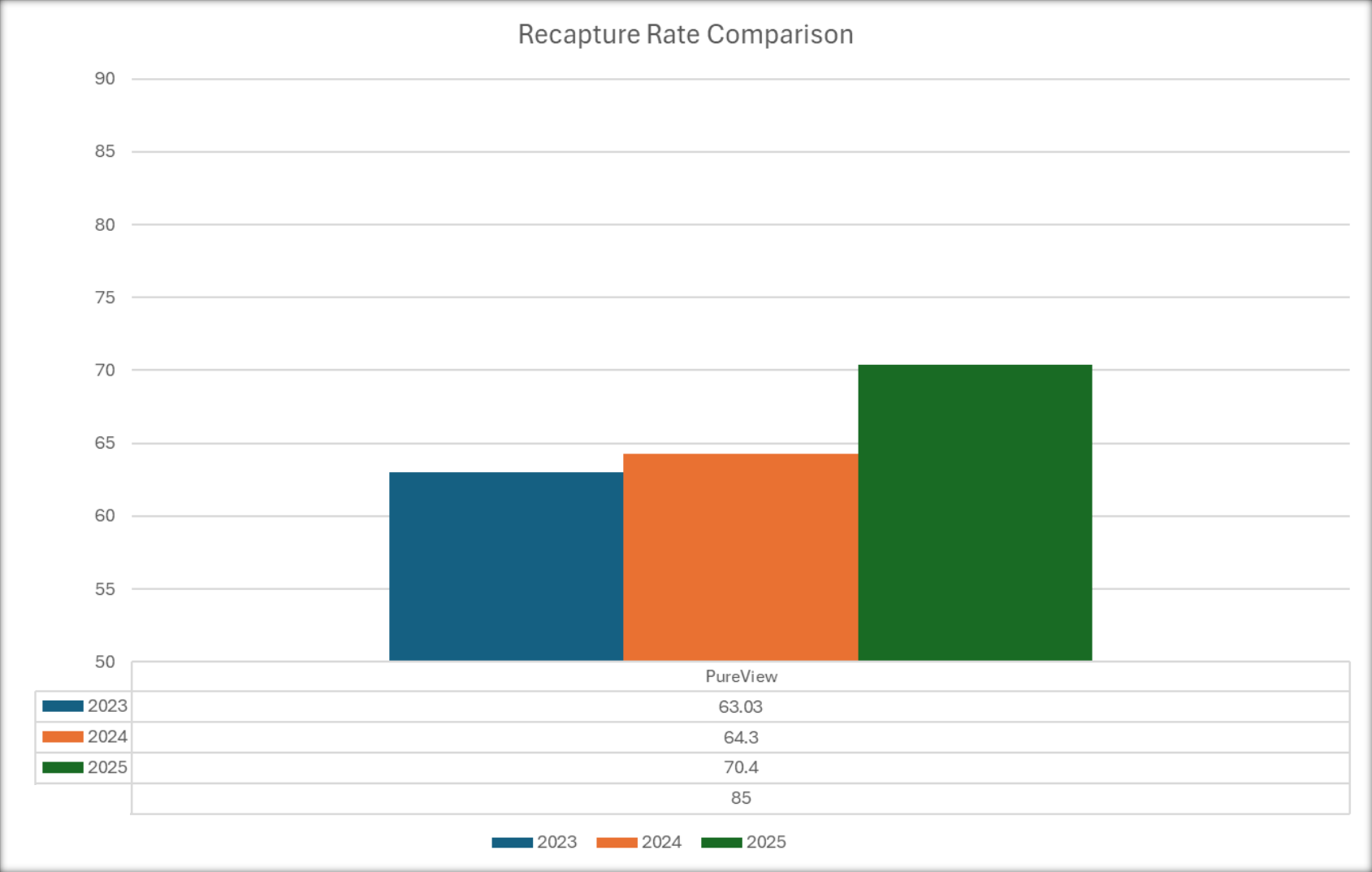
Risk Factors

RISK FACTORS (5)

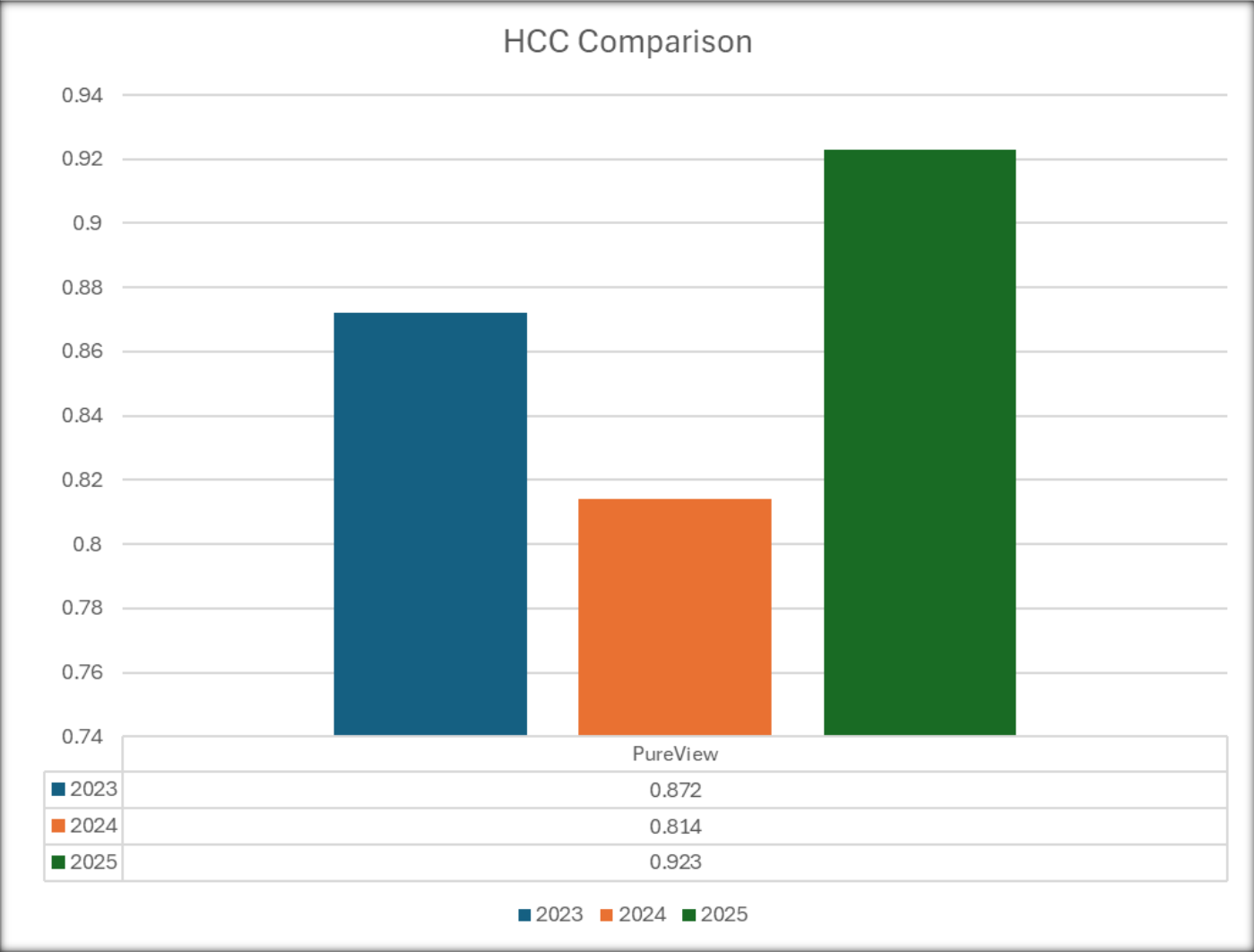
Anticoag	MSM	SED
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Recapture Rate Improvement



HCC Improvement



Patient Spend Data Comparison - Pureview

	2025	2024
Estimated CMS Financial Benchmark	\$12,144.22	\$10,815.69
YTD Average Per Patient Spend	\$11,461.65	\$10,253.55



Medicare Wellness Visit (MWV)



Medicare Annual Well Visit Member Based MEASURE

PERIOD: 2025 | RENDERING PROVIDERS: All Rendering Provid... | PLANS: Medicare MSSP ACO | PRODUCTS: All Products

+ Add Filter | Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

700 / 1,014
0 Exclusion(s)

AWV Tar...
60% 50%

69.0% ↑ 30.5%
2023

2025 | GROUP BY: None

Year	Performance (%)
2023	38%
2024	61%
2025	69%

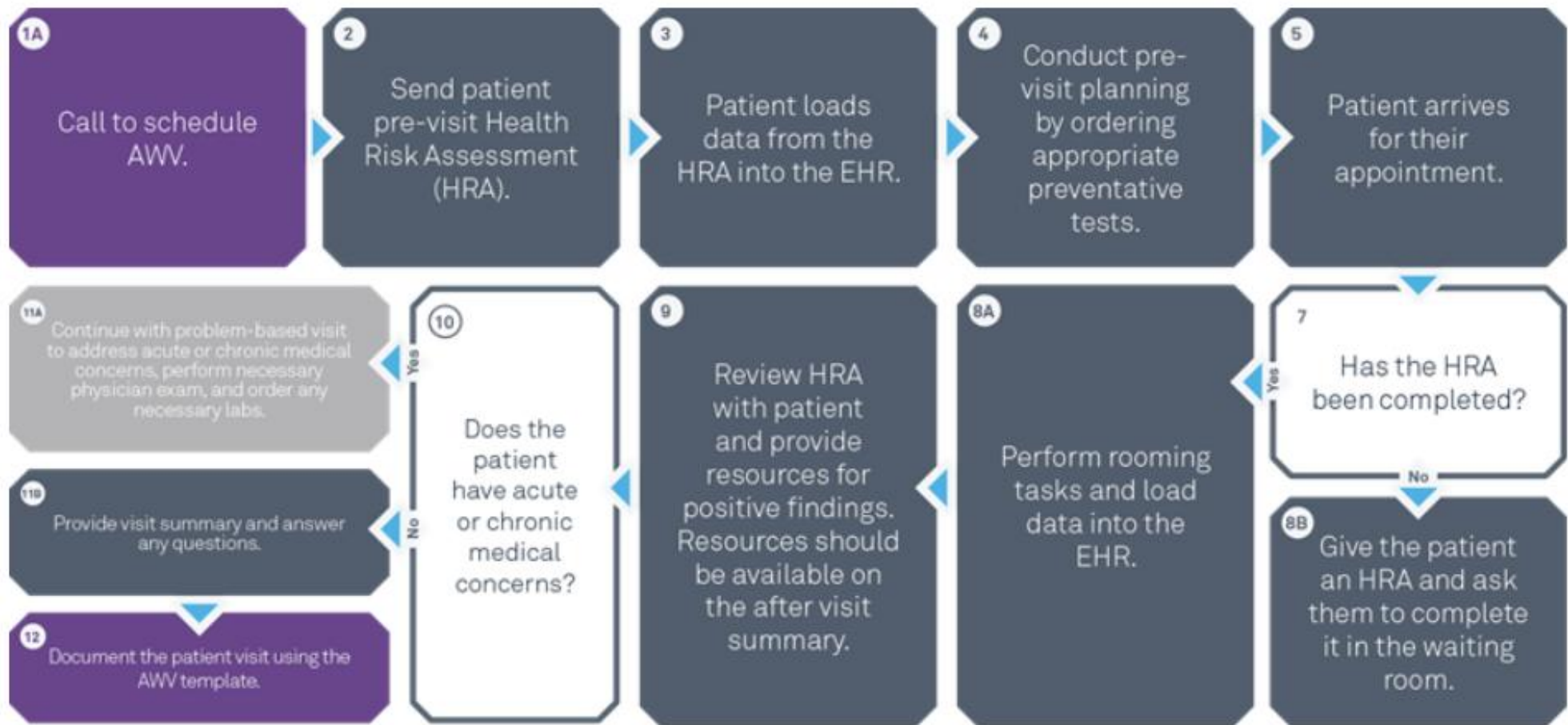
Comparison | GROUP BY: Center

Category	Performance (%)
PureView Hea...	69%

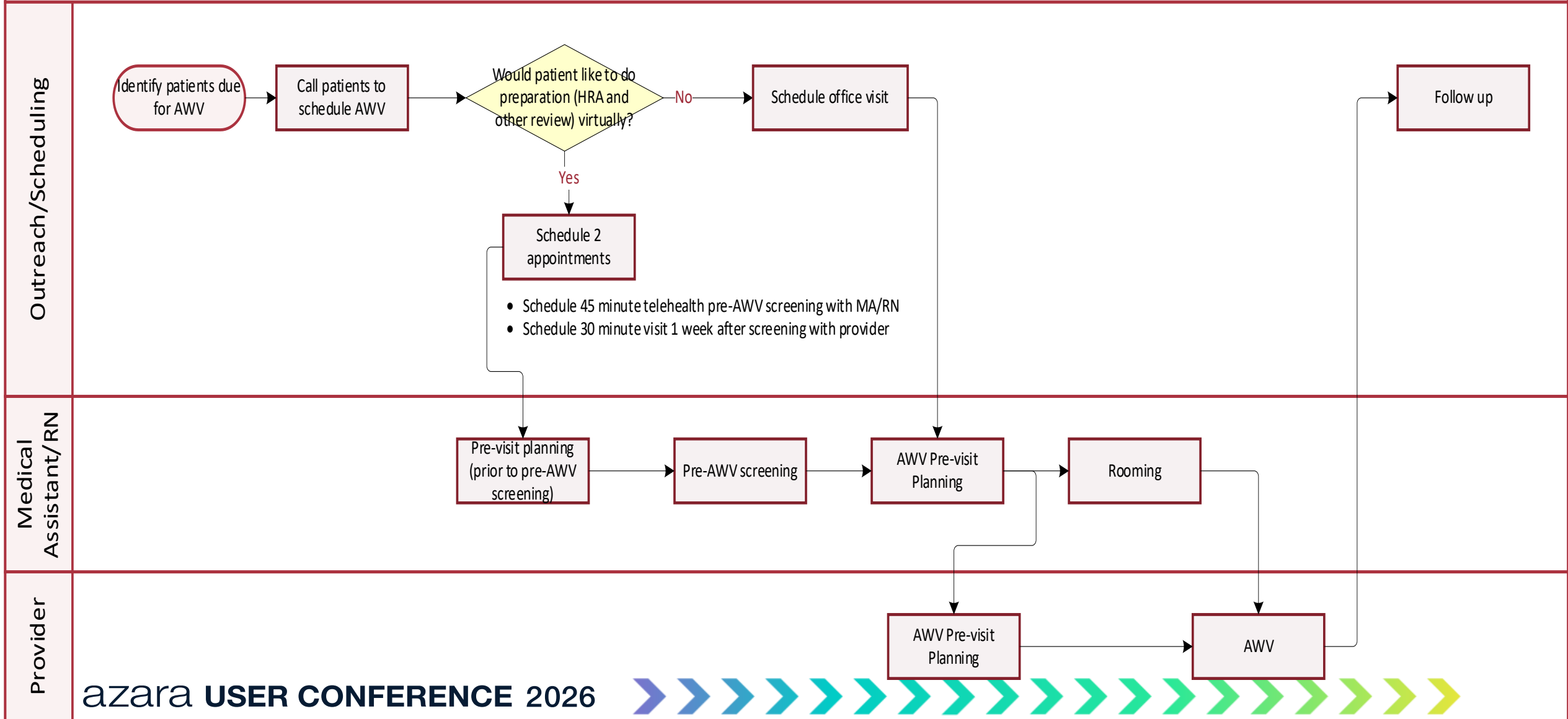


Examples of MWV Workflows



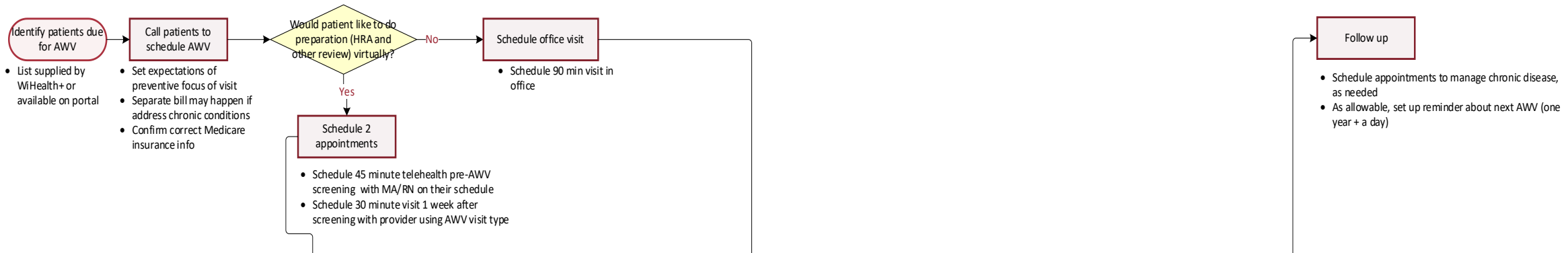


Annual Wellness Visit Workflow – Proposed 5.25.22

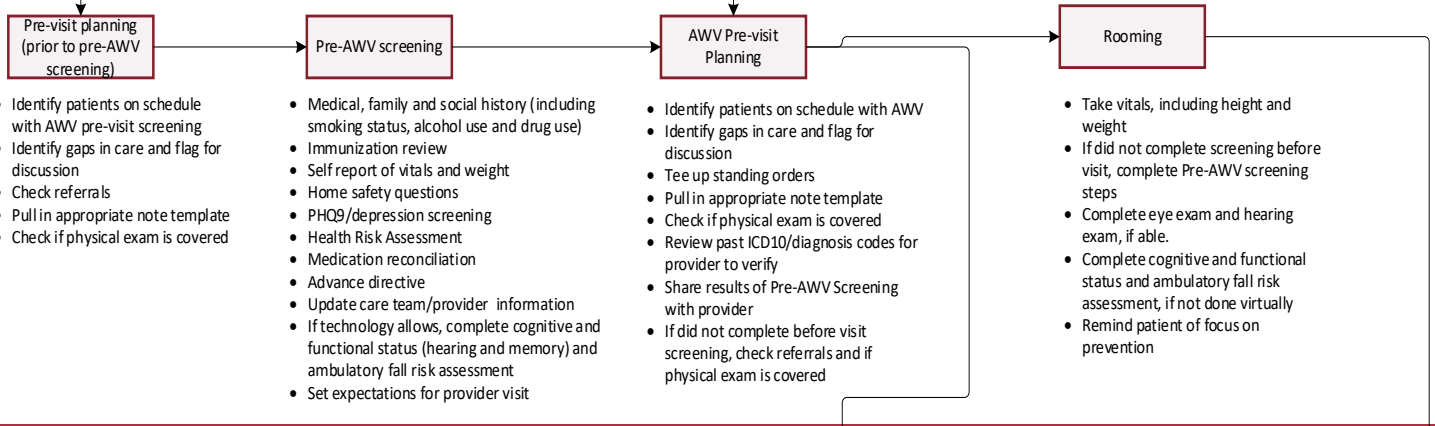


Annual Wellness Visit Workflow – Proposed 5.25.22

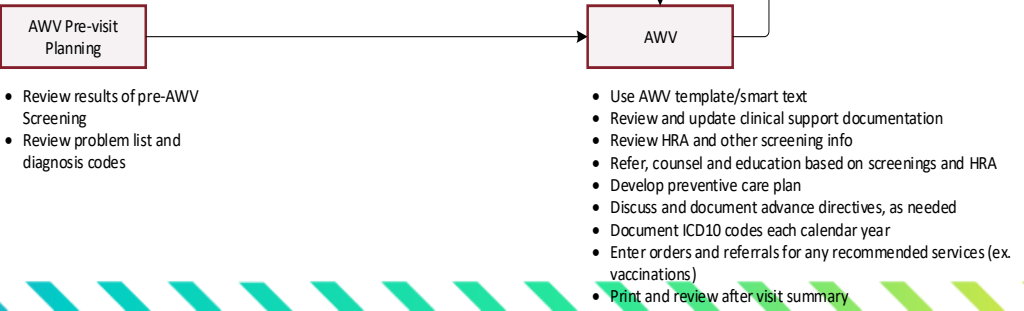
Outreach/Scheduling



Medical Assistant/RN



Provider



Follow up

- Schedule appointments to manage chronic disease, as needed
- As allowable, set up reminder about next AWW (one year + a day)



Member Report

- Identify patients who haven't been seen
- Stratify by cost
- Ensure that patient is seen for annual preventative care appointment



Members REPORT FILTER 1

FILTERS: March 2026

REPORTS VALUE SETS

Search ... Reset Columns SAVED COLUMNS

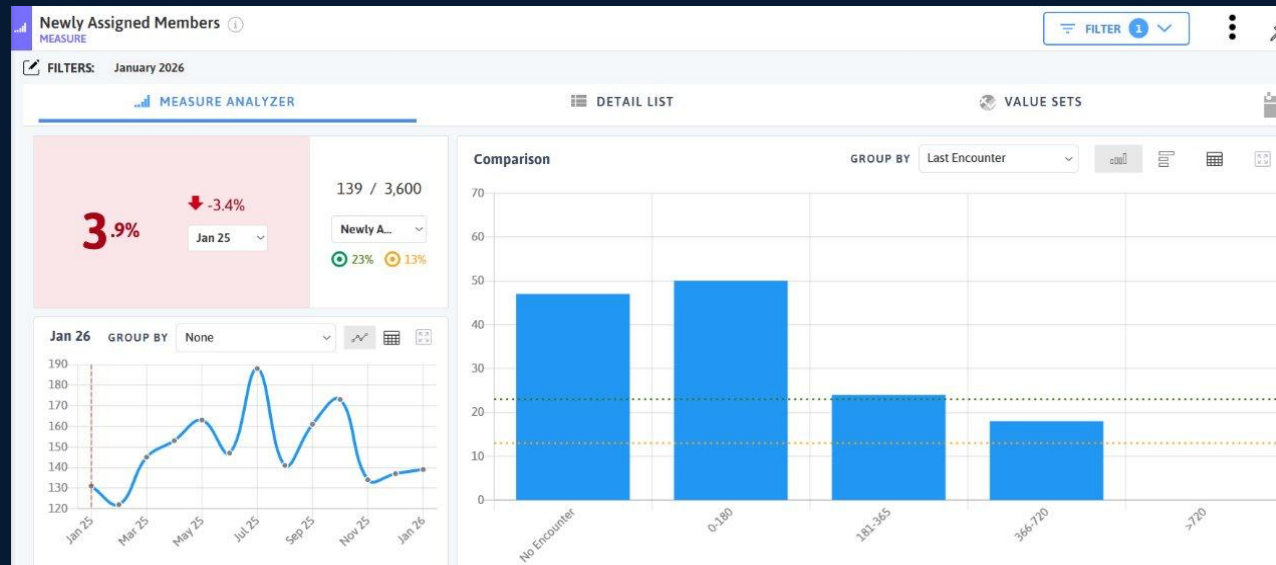
DEMOGRAPHICS >	MEMBER			ELIGIBILITY		MOST RECENT ENC			
NAME	NUMBER	MEDICAID NUMBER	MEDICARE NUMBER	START	END	LAST ENCOUNTER GROUP	MOST RECENT ENC	PROVIDER	LOC
Hober, Tristan	1814	555	888	3/3/2026	9/26/2026	No Encounter			
Vincent, Niesman	1204	555	888	3/1/2026	9/9/2026	No Encounter			
Humphry, Eusebio	266	555	888	11/15/2024	4/16/2027	366-720	11/1/2024	Fritz, Renata	1400
Kenneth, Amrich	3450	555	888	9/14/2024	8/19/2026	181-365	10/1/2025	Black, Ronda	70 BI
Barranca, Emily	3467	555	888	11/29/2024	1/27/2027	No Encounter			
Burlett, Bud	948	555	888	3/28/2025	3/29/2027	0-180	12/31/2025	Augustine, Greg	1400



Newly Assigned Member Measure



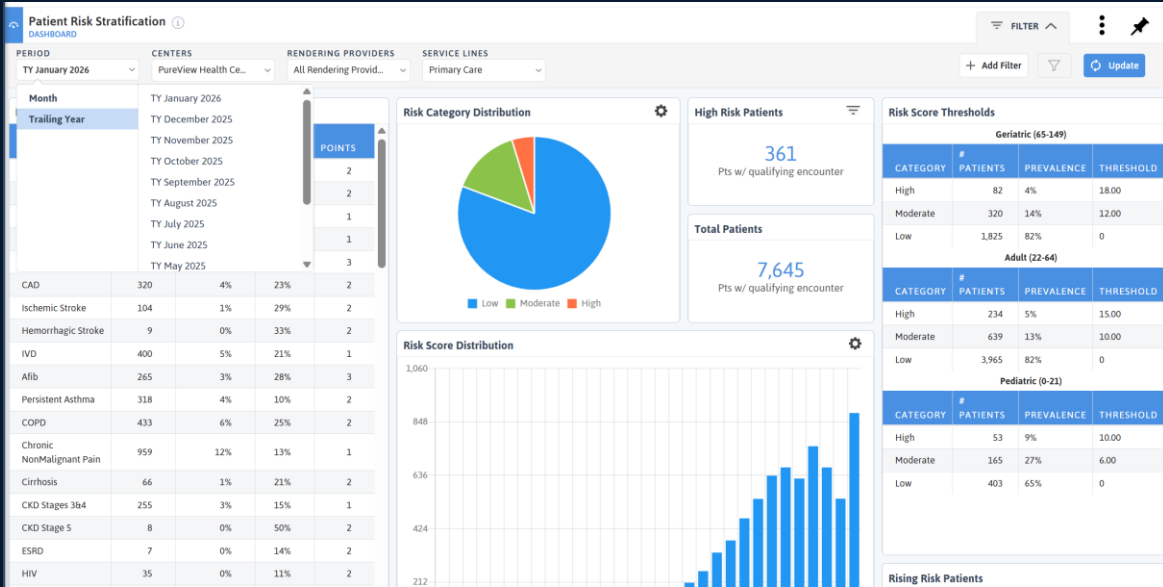
- Outreach to newly assigned members
- Offer to establish with a primary care provider
- Coordinate integrated care services
- PureView is the preferred provider
- Focus on prevention to decrease downstream healthcare costs



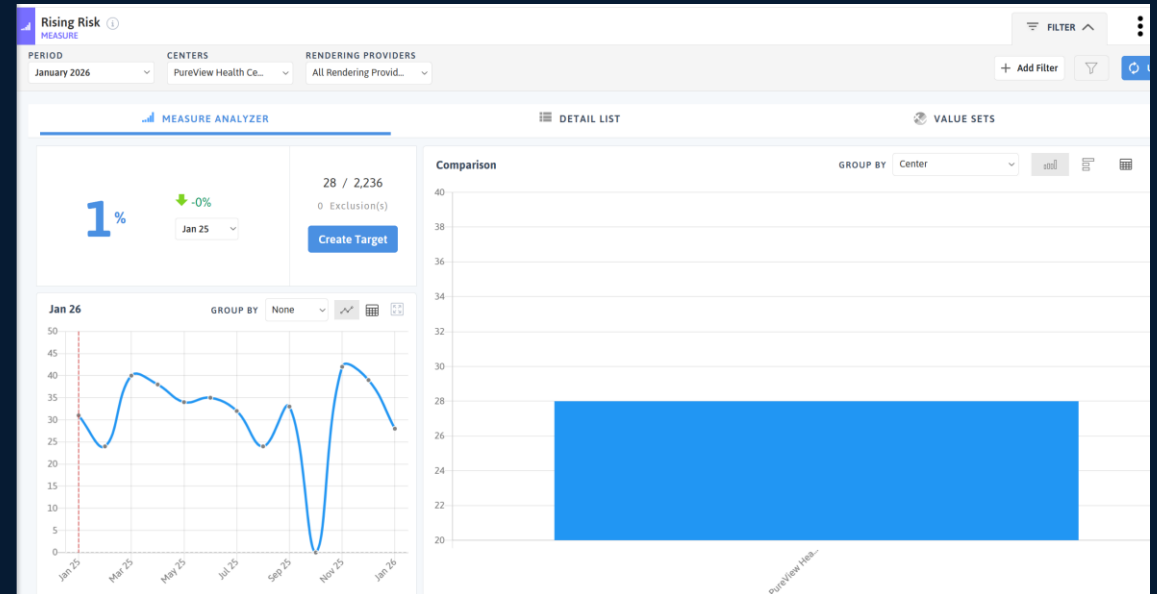
Risk Stratification



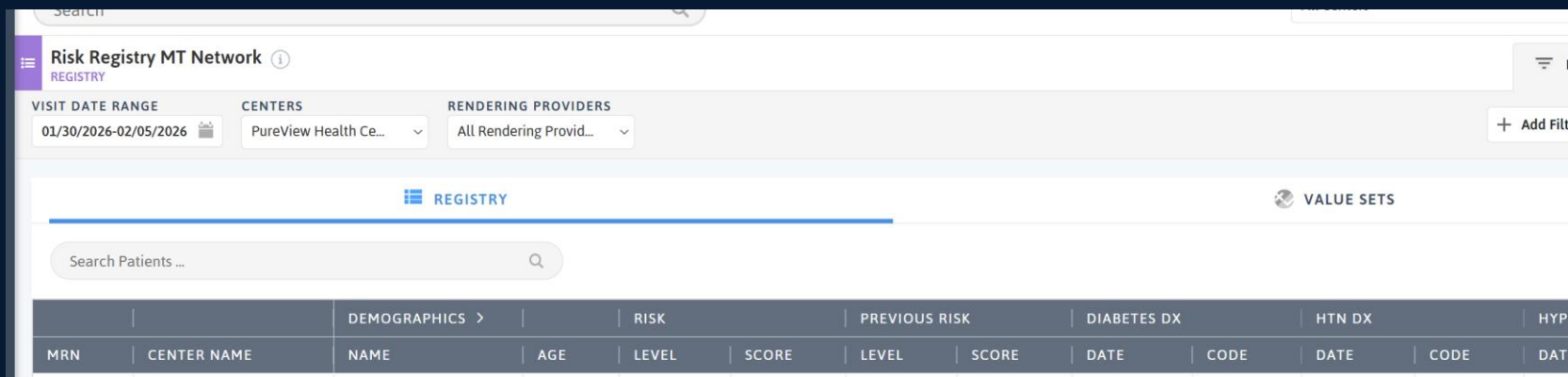
Patient Risk Dashboard



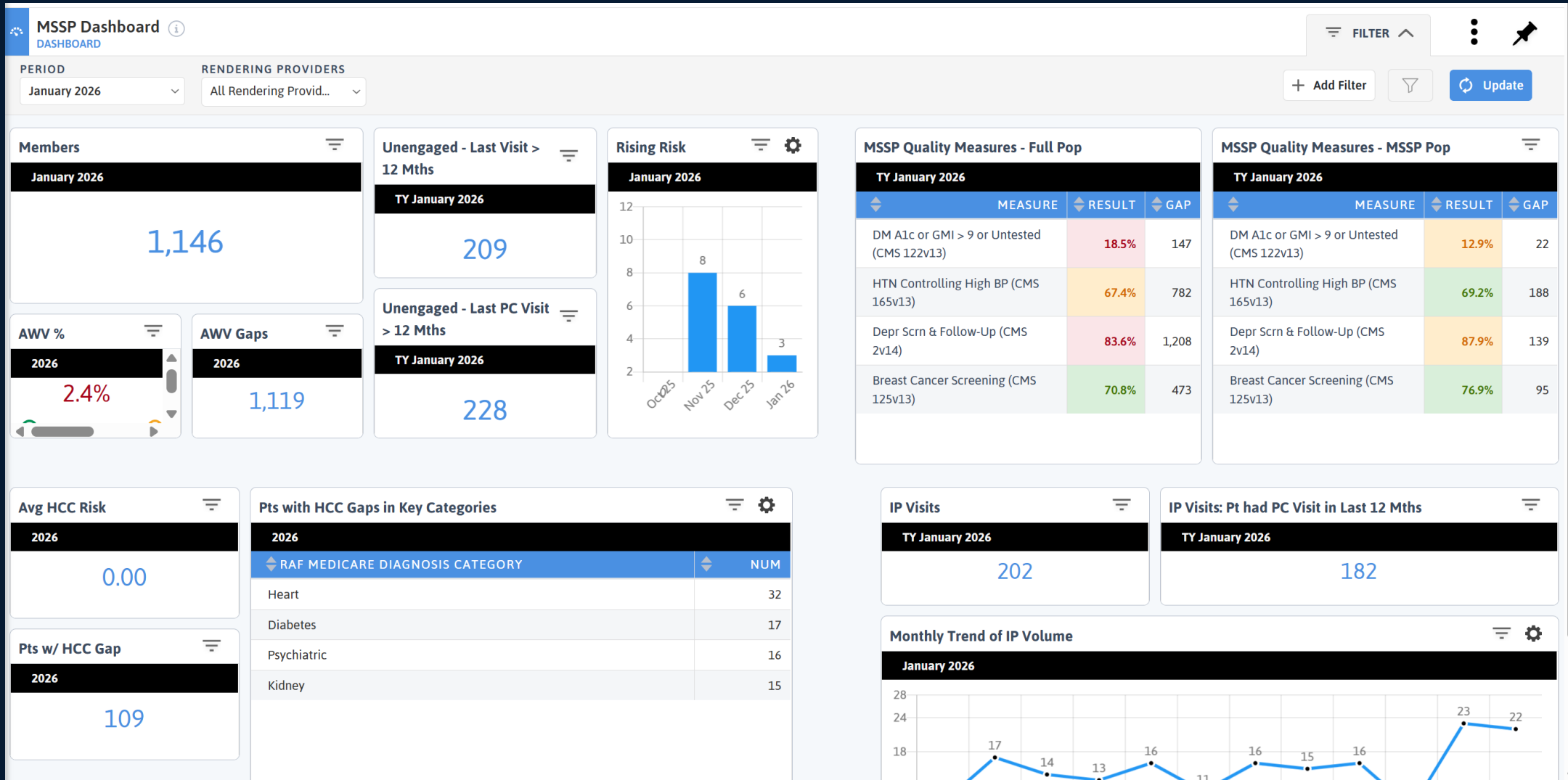
Rising Risk



Custom Registry: Identify Patients for Care Management



MSSP Dashboard



Making the Data Meaningful

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Numbers represent real people



Filter reports to make outreach individualized, not just cold calls



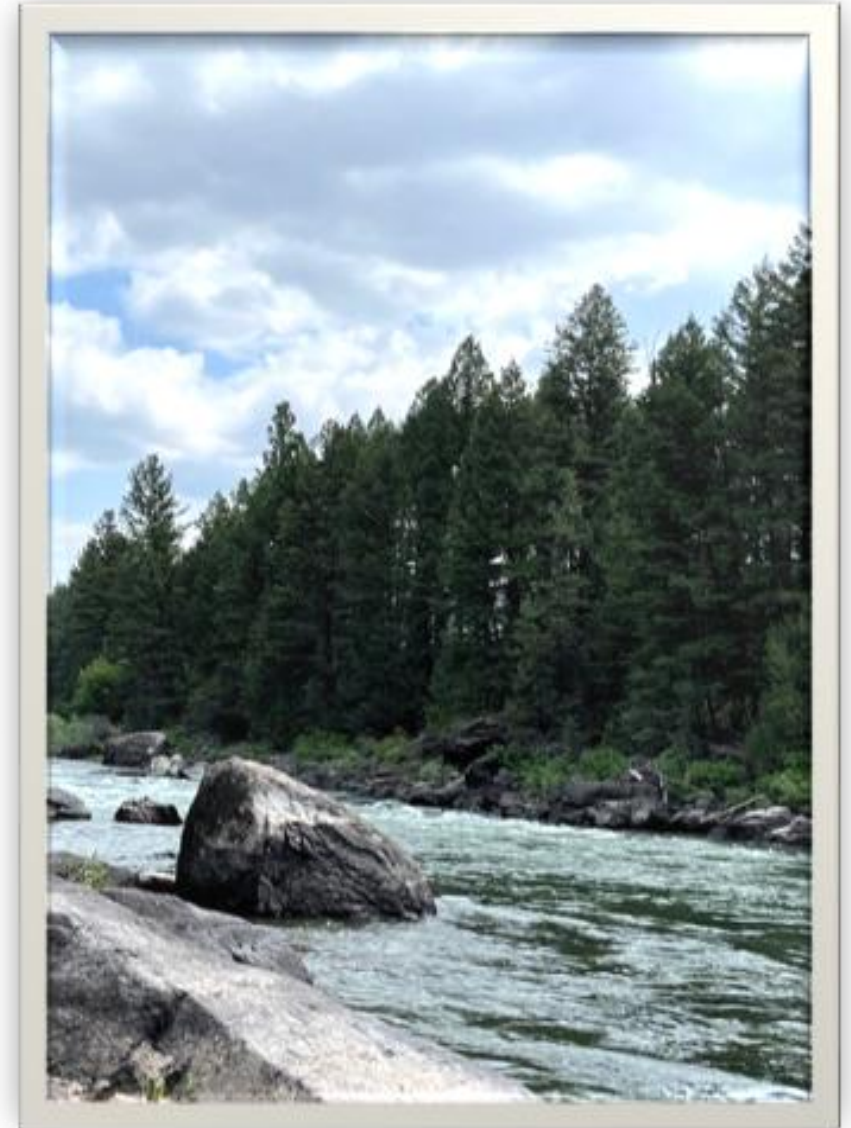
Celebrate those small wins!



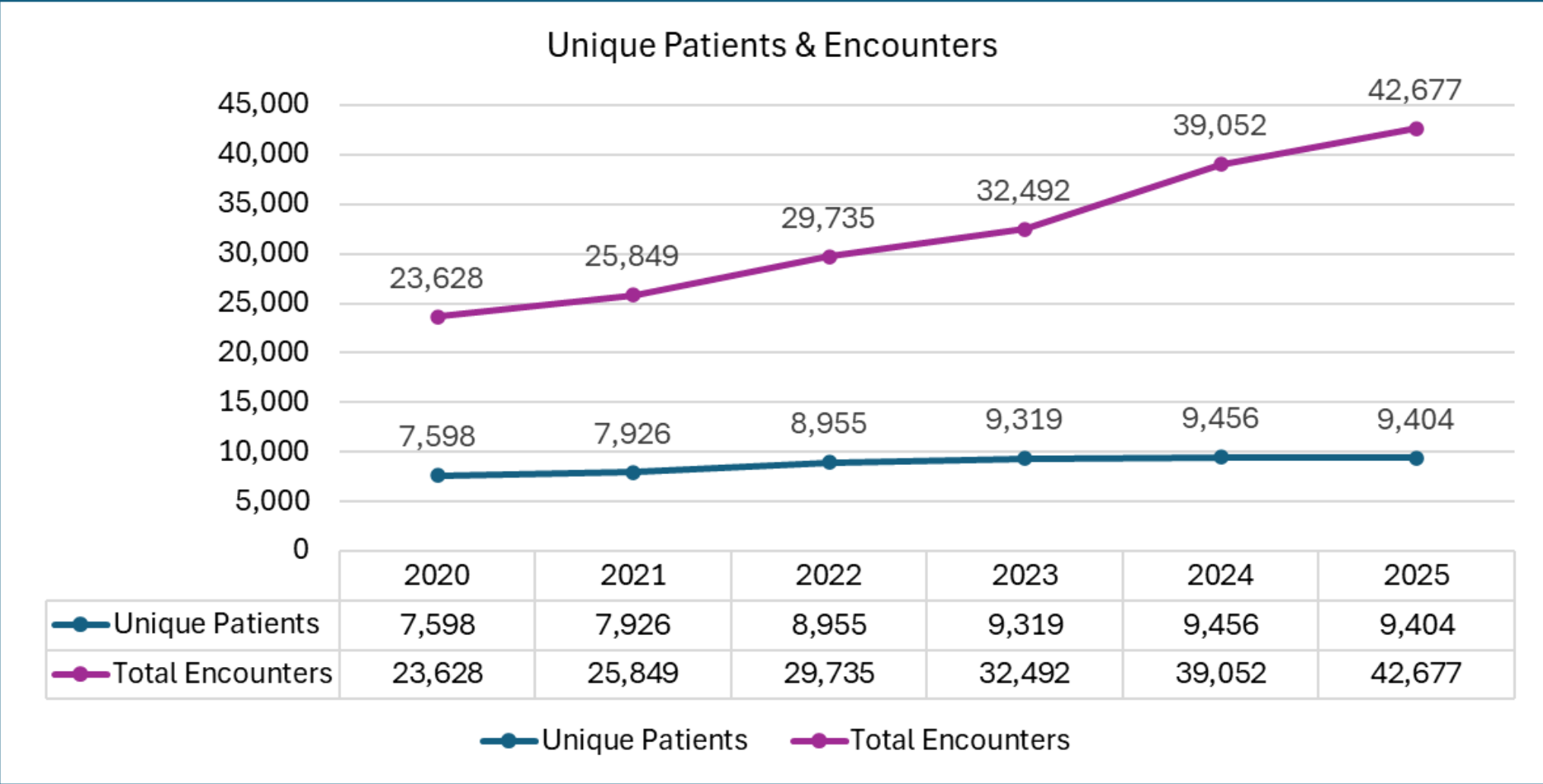
Share the success with whole team



Re-center, re-prioritize, re-educate



Improved Patient Engagement



Quality Data Initiative

- Network Level Support
- Monthly Reporting and Data Stratification of Key Quality Metrics
- Monthly Learning Calls



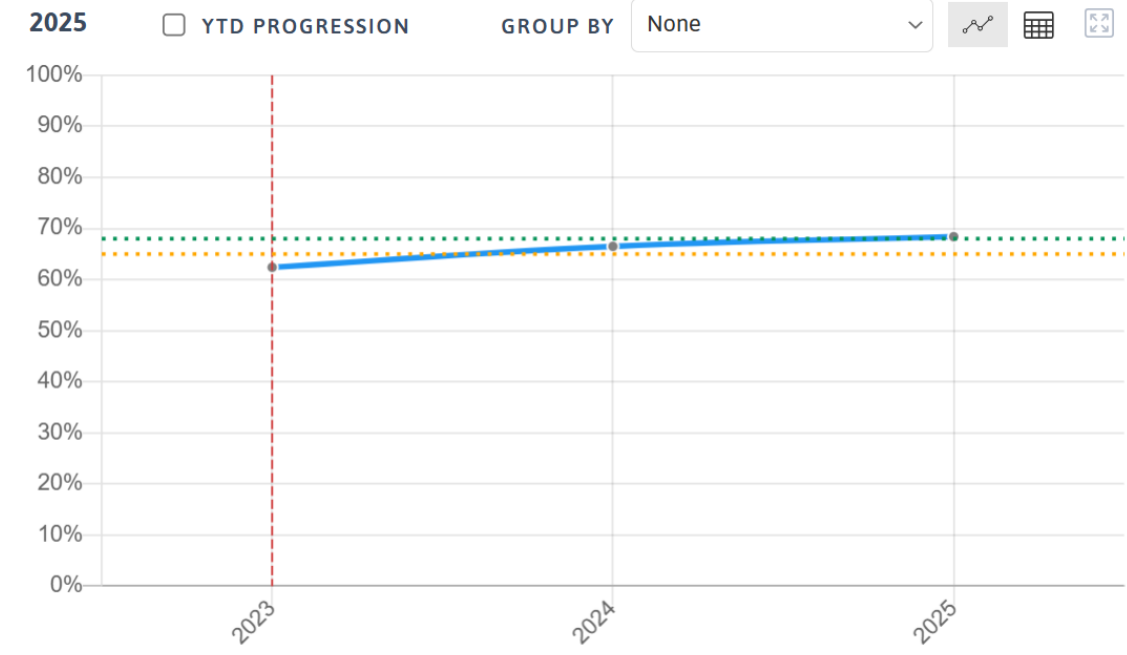
MEASURE ANALYZER

68.4%
↑ 6.0%
2023

1,640 / 2,398
95 Exclusion(s)
758 Gaps 0 To Target

Controlling ...

SELECTED	68.4%
Center Avg	68.4%
Network Avg	62.2%
Best Center	75.2%



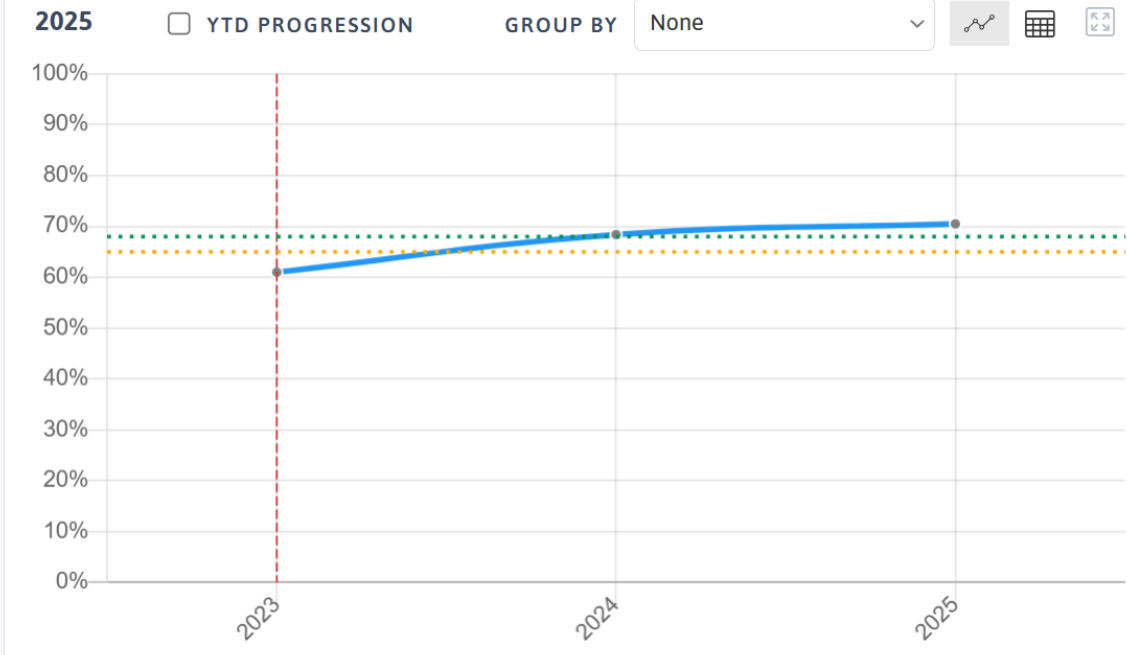
MEASURE ANALYZER

70.5%
↑ 9.5%
2023

328 / 465
35 Exclusion(s)
137 Gaps 0 To Target

Controlling ...

SELECTED	70.5%
Center Avg	68.4%
Network Avg	62.2%
Best Center	75.2%

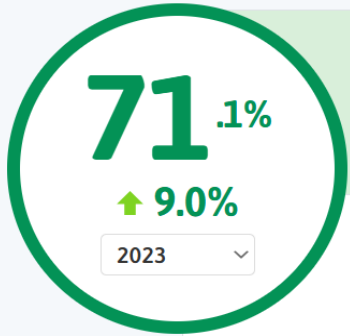


Breast Cancer Screening Ages 50-74 (CMS 125v13)

MEASURE

PERIOD: 2025
RENDERING PROVIDERS: All Rendering Provid...

MEASURE ANALYZER



1,157 / 1,628

38 Exclusion(s)

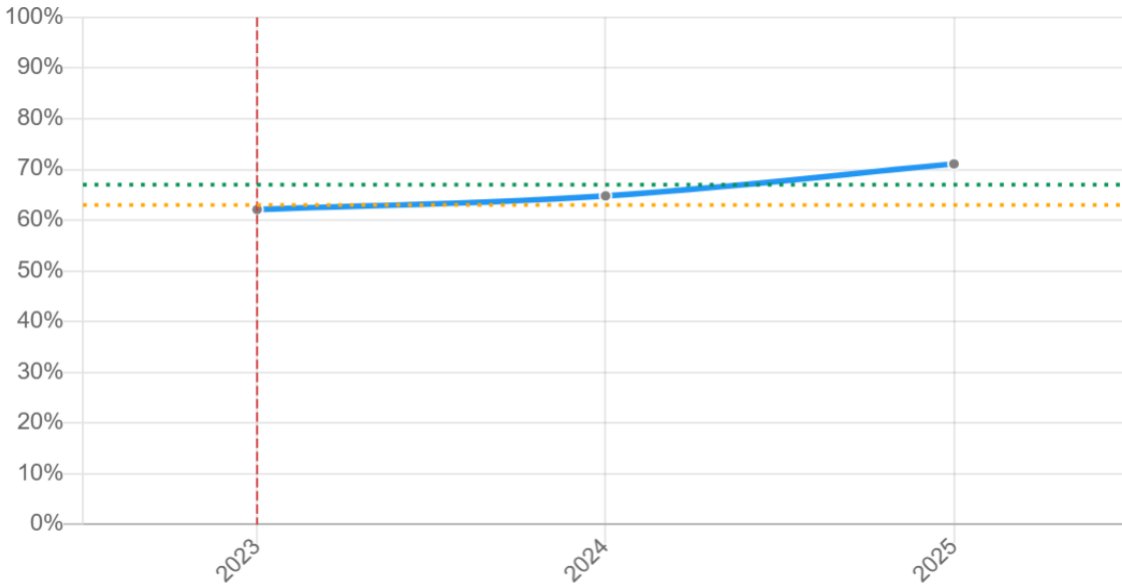
471 Gaps 0 To Target

Category	Value
SELECTED	71.1%
Center Avg	71.1%
Network Avg	52.4%
Best Center	72.8%

2025

YTD PROGRESSION

GROUP BY: None

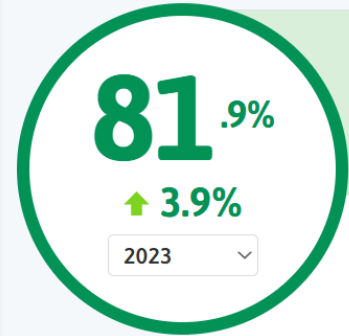


Breast Cancer Screening Ages 50-74 (CMS 125v13)

MEASURE

PERIOD: 2025
RENDERING PROVIDERS: All Rendering Provid...
PLANS: Medicare MSSP ACO

MEASURE ANALYZER



245 / 299

11 Exclusion(s)

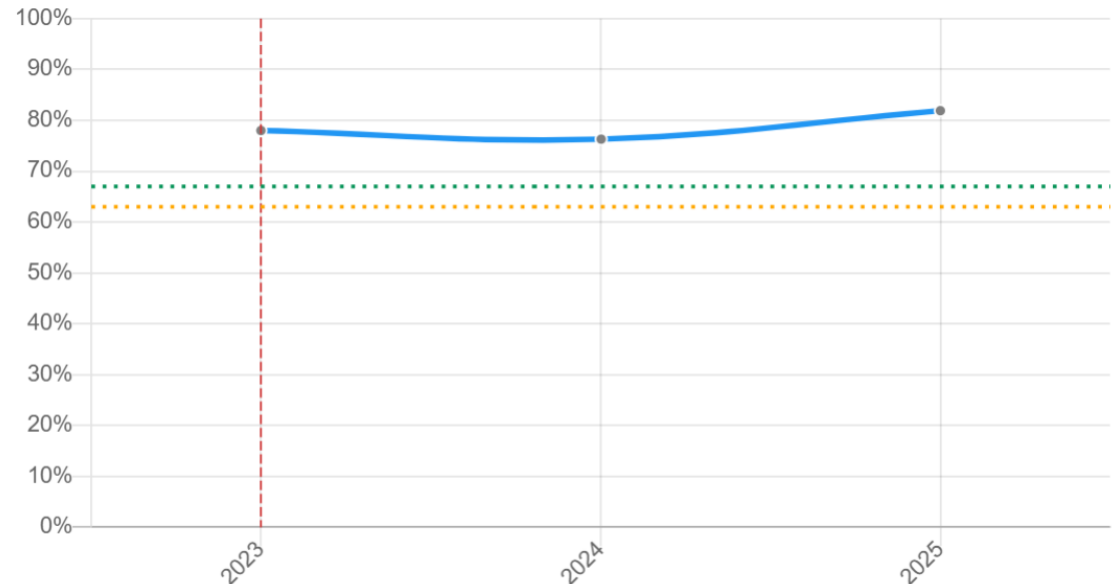
54 Gaps 0 To Target

Category	Value
SELECTED	81.9%
Center Avg	71.1%
Network Avg	52.4%
Best Center	72.8%

2025

YTD PROGRESSION

GROUP BY: None



Colorectal Cancer Screening (CMS 130v13)

MEASURE

PERIOD

2025

RENDERING PROVIDERS

All Rendering Provid...

MEASURE ANALYZER

58.7%

↑ 9.5%

2023

2,237 / 3,810

77 Exclusion(s)

1,573 Gaps 126 To Target

Colorectal ...

SELECTED

58.7%

Center Avg

58.7%

Network Avg

44.9%

Best Center

62.8%

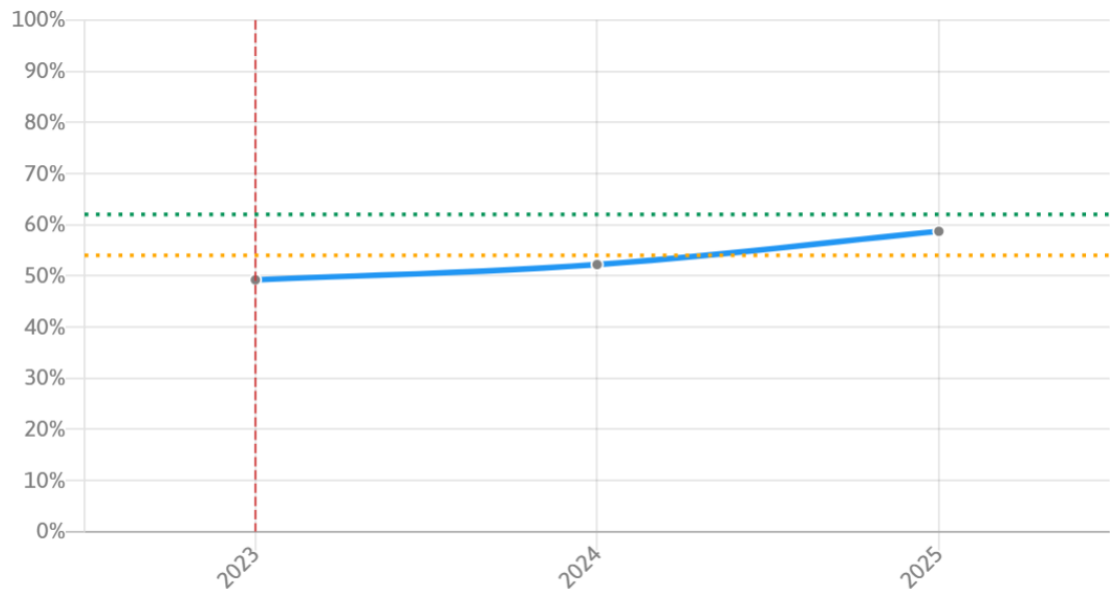
62% 54%

2025

YTD PROGRESSION

GROUP BY

None



Colorectal Cancer Screening (CMS 130v13)

MEASURE

PERIOD

2025

RENDERING PROVIDERS

All Rendering Provid...

PLANS

Medicare MSSP ACO

MEASURE ANALYZER

75.4%

↑ 8.8%

2023

457 / 606

17 Exclusion(s)

149 Gaps 0 To Target

Colorectal ...

SELECTED

75.4%

Center Avg

58.7%

Network Avg

44.9%

Best Center

62.8%

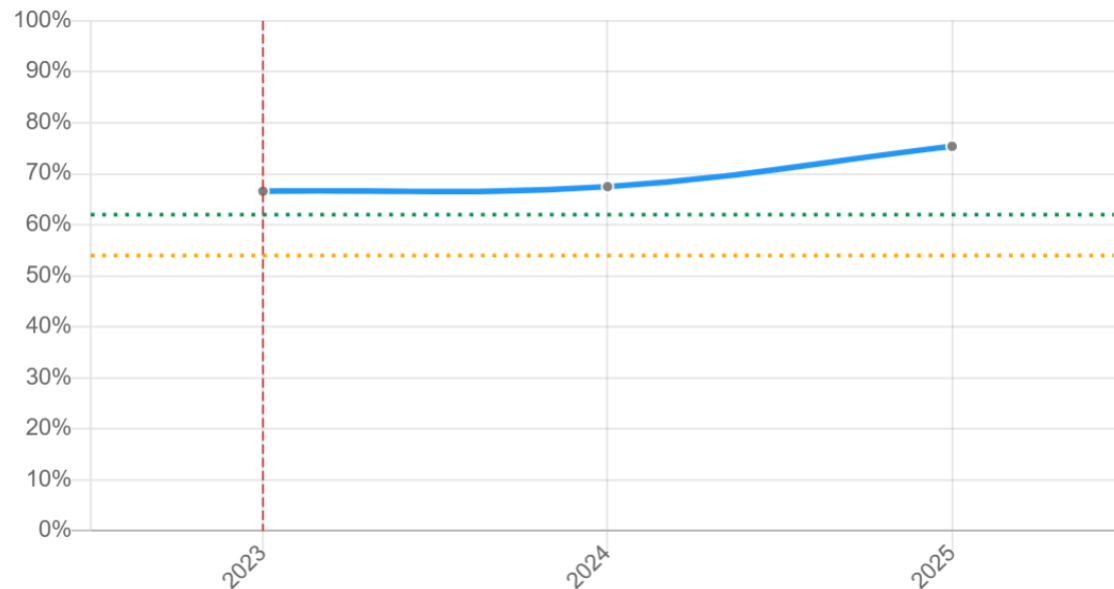
62% 54%

2025

YTD PROGRESSION

GROUP BY

None



The Next Frontier

15



ACC: Our Journey Getting Started

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As our Care Management and Population Health processes evolved, we saw the need for an **interactive dashboard for more comprehensive panel management.**

We wanted to ensure that our outreach processes were **streamlined for efficiency.**


And that our outreach was **tailored, custom, and meaningful** to individual patients.



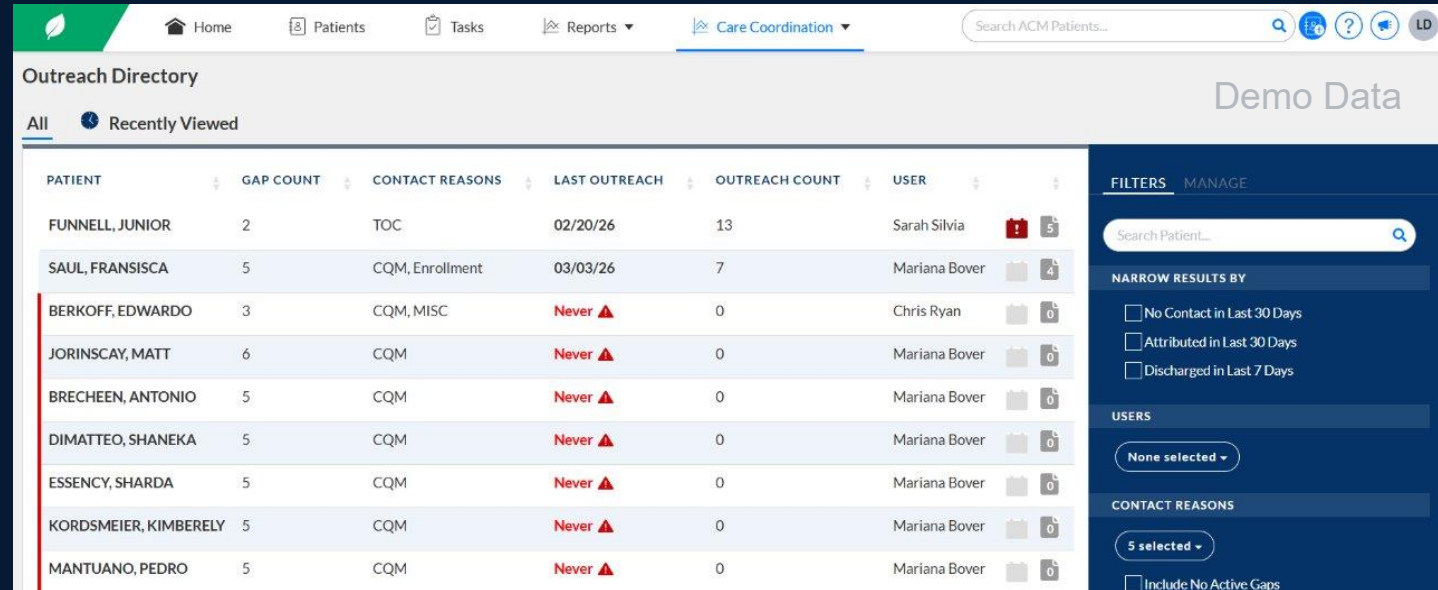
ACC Tool



 Population Health

 Chronic Care Management

 Transition of Care



Outreach Directory

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

Dem Data

All Recently Viewed

PATIENT	GAP COUNT	CONTACT REASONS	LAST OUTREACH	OUTREACH COUNT	USER
FUNNELL, JUNIOR	2	TOC	02/20/26	13	Sarah Silvia
SAUL, FRANCISCA	5	CQM, Enrollment	03/03/26	7	Mariana Bover
BERKOFF, EDUARDO	3	CQM, MISC	Never ▲	0	Chris Ryan
JORINSKAY, MATT	6	CQM	Never ▲	0	Mariana Bover
BRECHHEEN, ANTONIO	5	CQM	Never ▲	0	Mariana Bover
DIMATTEO, SHANEKA	5	CQM	Never ▲	0	Mariana Bover
ESSENCY, SHARDA	5	CQM	Never ▲	0	Mariana Bover
KORDSMEIER, KIMBERELY	5	CQM	Never ▲	0	Mariana Bover
MANTUANO, PEDRO	5	CQM	Never ▲	0	Mariana Bover

FILTERS MANAGE

Search Patient...

NARROW RESULTS BY

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

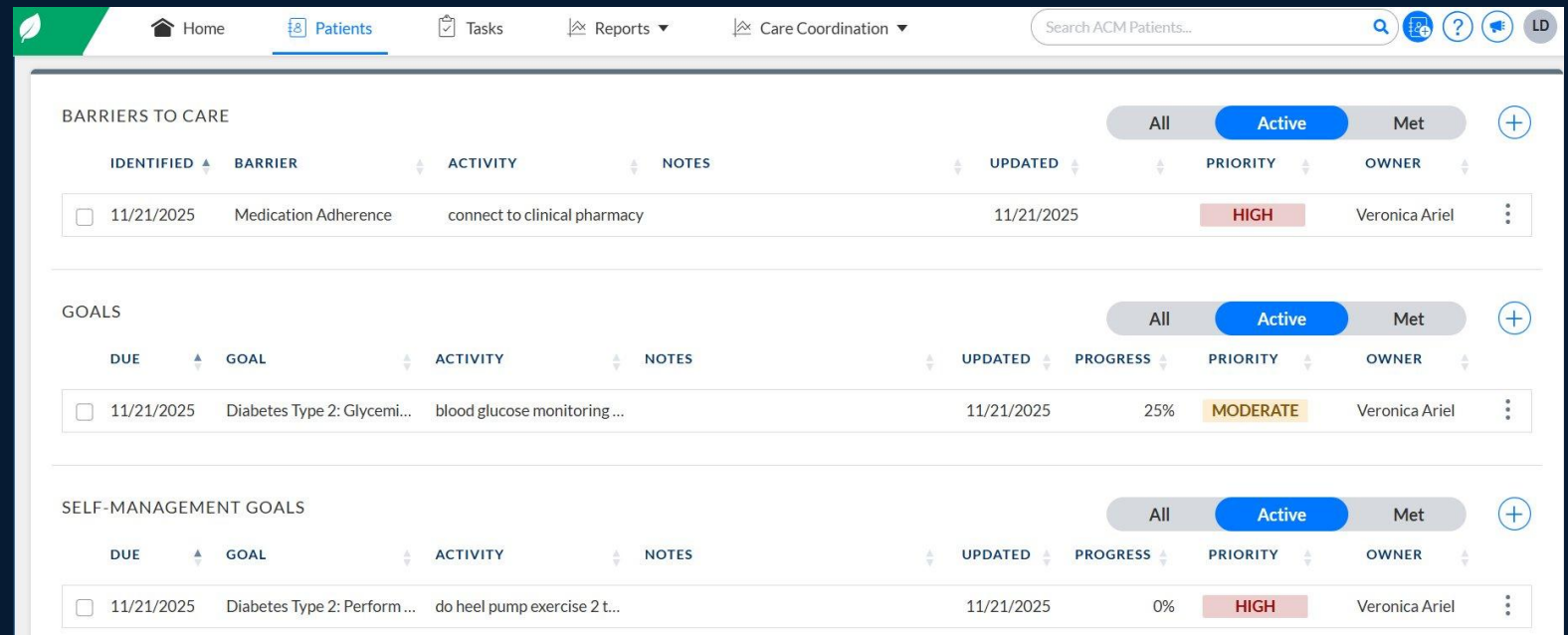
USERS

None selected

CONTACT REASONS

5 selected

Include No Active Gaps



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

BARRIERS TO CARE

All Active Met

IDENTIFIED	BARRIER	ACTIVITY	NOTES	UPDATED	PRIORITY	OWNER
<input type="checkbox"/> 11/21/2025	Medication Adherence	connect to clinical pharmacy		11/21/2025	HIGH	Veronica Ariel

GOALS

All Active Met

DUE	GOAL	ACTIVITY	NOTES	UPDATED	PROGRESS	PRIORITY	OWNER
<input type="checkbox"/> 11/21/2025	Diabetes Type 2: Glycemi...	blood glucose monitoring...		11/21/2025	25%	MODERATE	Veronica Ariel

SELF-MANAGEMENT GOALS

All Active Met

DUE	GOAL	ACTIVITY	NOTES	UPDATED	PROGRESS	PRIORITY	OWNER
<input type="checkbox"/> 11/21/2025	Diabetes Type 2: Perform ...	do heel pump exercise 2 t...		11/21/2025	0%	HIGH	Veronica Ariel



Azara Cost & Utilization (ACU)

15



Partnership between Network and Practice



Starting w/ Member Review

ACU Plans Executive Leakage v Utilization v Claim Completeness Member v

Member Review ⓘ 📄 📄 Dec 2024 - Nov 2025 Filters 0 ?

153 Members

Needs Review 150

Pending Engagement 2

Engaged 0

Not Engaged 1

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

Status	Status Date	Population	Member Name	Alerts	Plan	LOB	Age	RUB	Chronic Cond.	Eps.
--------	-------------	------------	-------------	--------	------	-----	-----	-----	---------------	------



The Partnership Intersect – MH+ and our FQHCs¹⁵

- Continuing to work together between network and FQHC
- Spreading best practices throughout the Network
- Repeat, Repeat, Repeat Education
- Keeping teams engaged
- Keeping patients engaged

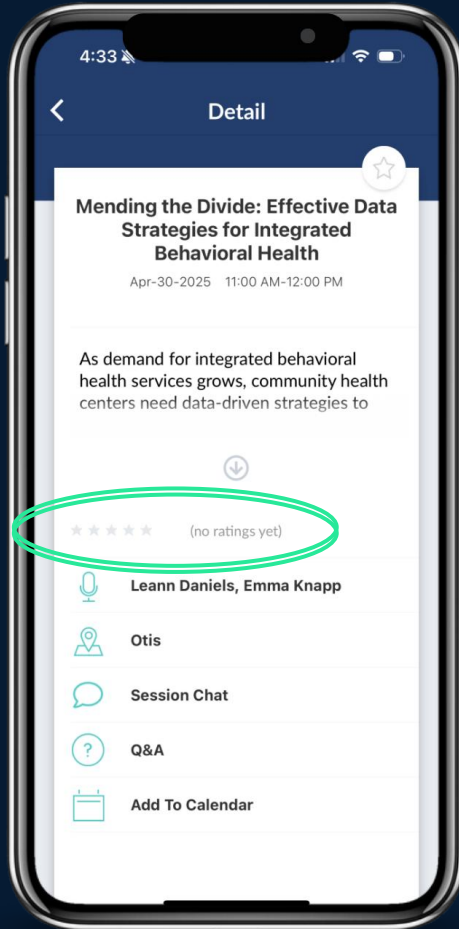


Questions?



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



azara2026

USER CONFERENCE APRIL 13-15 | BOSTON, MA

Thanks for attending!

