

# From Volume to Value

Navigating the Transition to Value-Based Care

azara2026

USER CONFERENCE APRIL 13-15 | BOSTON, MA



# Today's Presenters

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**Emma White BSN, RN**  
Director of Quality and Risk  
Management  
Cabin Creek Health Systems



**Charlene Wright, BSMI,  
RT(R)(ARRT)**  
Director of Quality and Risk  
Management  
Family Health Services of  
Darke County, Inc





## Laying the Foundation

Organization, Data & Infrastructure



## Identifying Opportunities

Annual Wellness Visits (AWVs) & Performance Gaps



## Driving Change

Workflow, Incentives & Team Alignment



## Demonstrating Value

Performance Outcomes & Lessons Learned





# Cabin Creek Health Systems

Emma White BSN, RN, Director of Quality and Risk Management

# Cabin Creek Health Systems

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- **Founded over 50 years ago**, CCHS was established to serve coal mine workers and their families
- **12 care locations** across the region, including 6 primary sites and 6 School-Based Health Centers (SBHCs)
- **Comprehensive service offerings**, including primary care, well child care, integrated behavioral health, addiction recovery, pulmonary rehabilitation, Department of Labor (DOL) services, and Black Lung counseling
- **Serving 20,581 patients annually**, delivering more than 77,000 encounters
- **5,439 patients aged 65+**, reflecting a significant Medicare-eligible population



# Azara Solutions in Our Organization

Improved data visibility drove more targeted and effective patient outreach.





# **Annual Wellness Visit Challenges & Opportunity**

Identifying barriers and unlocking opportunity

# Why Medicare Annual Wellness Visits?

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The **COVID-19** pandemic significantly disrupted preventive care delivery and quality performance.



Medicare Annual **Wellness Visit (AWV)** completion rates declined substantially.



Only **11%** of eligible patients received a **Medicare AWV**, highlighting a significant care gap.



# Advancing Preventive Care with AWVs



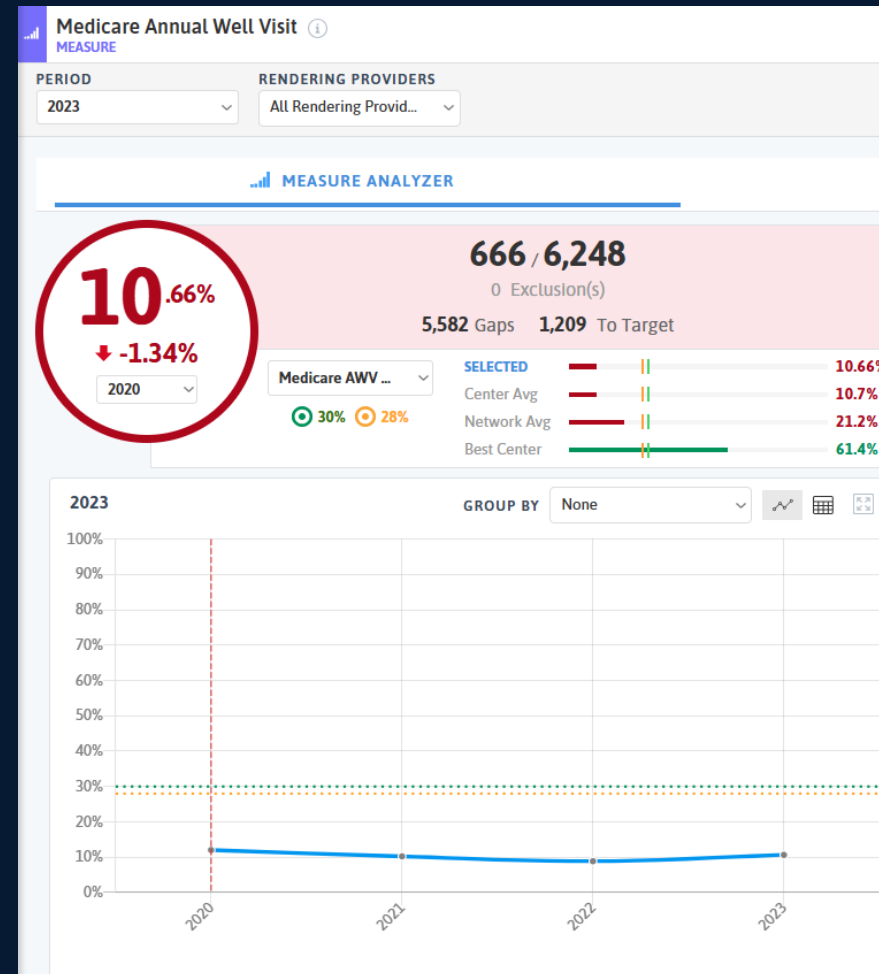
▶ MAWV improvement efforts began in earnest in 2023.

## AWVs: A Critical Opportunity to Improve Care

Increase preventive screening rates

Identify health risks earlier

Enhance care coordination across teams



Attribution inaccuracies  
across all payers

Fragmented data sources

- Worklists
- Gap lists
- Payer portals

Challenges

Variability in coding and  
documentation for AWWs

Significant provider workload  
and time constraints



# Workflow Standardization & Organization Alignment

Aligning teams through consistent, scalable processes

# Custom Next Appointment Registry



Next Appt Registry REGISTRY FILTER + Update

VISIT DATE RANGE: 01/01/2026-03/31/2026  
 RENDERING PROVIDERS: All Rendering Provid...  
 PERIOD TENSE: No Match

REGISTRY VALUE SETS

Search Patients ... Reset Columns SAVED COLUMNS

INSURANCE			NEXT PRIMARY CARE APPOINTMENT			NEXT APPOINTMENT		
DATE	FINANCIAL CLASS	PRIMARY PAYER	DATE	PROVIDER	LOCATION	TYPE	REASON	MOST RECENT INTERACTION DATE
3/31/2026 11:59:59 PM	Medicare	AETNA (MEDICARE REPLACEMENT/ADVANTAGE - PPO)	6/9/2026	SMITH, LILY	CLENDENIN	Medicare AWV	+A1C/DM check o...	3/23/2026
3/31/2026 11:59:59 PM	Dual Eligible Medicare an...	AETNA (MEDICARE REPLACEMENT/ADVANTAGE - PPO)	4/15/2026	GROSE, SHANNON	CLENDENIN	Medicare AWV		1/2/2026
3/31/2026 11:59:59 PM	Medicare	MEDICARE-WV (MEDICARE)	4/15/2026	MUSIL, CHRISTOPH...	CLENDENIN	Medicare AWV	3 month FU A1C 1...	1/15/2026
3/31/2026 11:59:59 PM	Dual Eligible Medicare an...	AETNA (MEDICARE REPLACEMENT/ADVANTAGE - PPO)	4/16/2026	HENSON, CANDICE	CLENDENIN	Medicare AWV		1/8/2026
3/31/2026 11:59:59 PM	Dual Eligible Medicare an...	AETNA (MEDICARE REPLACEMENT/ADVANTAGE - PPO)	9/24/2026	SMITH, LILY	CLENDENIN	Medicare AWV	after 9/23	3/24/2026
3/31/2026 11:59:59 PM	Dual Eligible Medicare an...	HUMANA - GOLD PLUS (MEDICARE REPLACEMENT/ADVANTAGE - HMO)	7/29/2026	HENSON, CANDICE	CLENDENIN	Medicare AWV		1/29/2026
3/31/2026 11:59:59 PM	Medicare	HUMANA (MEDICARE REPLACEMENT/ADVANTAGE - PPO)	6/3/2026	GROSE, SHANNON	CLENDENIN	Medicare AWV		3/24/2026
3/31/2026 11:59:59 PM	Dual Eligible Medicare an...	MEDICARE-WV (MEDICARE)	4/20/2026	SMITH, LILY	CLENDENIN	Medicare AWV		2/17/2026
3/31/2026 11:59:59 PM	Medicare	HUMANA (MEDICARE REPLACEMENT/ADVANTAGE - PPO)	8/13/2026	MUSIL, CHRISTOPH...	CLENDENIN	Medicare AWV	Last visit 8/13/2025	3/12/2026



# Reducing AWW No-Show Rates



AWVs demonstrated higher no-show rates than other primary care visits

Analysis revealed key contributing factors:

- Patients lacked understanding of what an AWW entails
- Limited awareness that AWWs have no copay



Interventions included:

- Staff education and scripting for patient conversations
- Increased communication during scheduling and check-in



# Return to Office & Re-schedule Cancellations

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Providers initiate a one-year return-to-office reminder when completing an AWW

Patient Service Representatives (PSRs) actively reschedule cancelled or missed AWWs

In cases where patients decline an AWW:

- Declination is documented in Athena “sticky notes”
- Outreach is paused for one year to avoid unnecessary follow-up



# Medicare AWW Workgroup

## Findings:

Significant variation in how providers conducted AWWs

Some visits extended beyond AWW scope, increasing workload and provider burden

## Action:

The Chief Medical Officer convened a provider workgroup including high-performing AWW providers, and providers less likely to schedule AWWs

## Outcome:

Peer collaboration identified efficient workflows and established best practices



# Clinician and Medical Assistant QI Bonus

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In 2024, AWW completion was integrated into the Clinician Quality Improvement Bonus program.

Incentives expanded to include Medical Assistants, reinforcing team-based accountability.

Aligned incentives across the care team to drive AWW performance and outcomes.



# Preventive Screening and Care Performance



Provider Quality Incentive Scorecard <sup>?</sup>  
REPORT

PERIOD: 2025 | RENDERING PROVIDERS: All Rendering Provid... | UDS FINANCIAL CLASSES: Medicare <sup>?</sup>

+ Add Filter | Update

REPORT | CARE GAPS

GROUPING: No Grouping | TARGETS: Primary (Green), Secondary (Yellow), Not Met (Red) | REPORT FORMAT: Scorecard

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	
Cervical Cancer Screening (CMS 124v13)	43.4%	60.0%	163	376	210	↓
Colorectal Cancer Screening (CMS 130v13)	59.6%	60.0%	2,122	3,561	271	↓
Hypertension Controlling High Blood Pressure (CMS165v13)	79.1%	76.0%	2,699	3,414	441	↓
Tobacco Use: Screening and Cessation (CMS 138v13)	85.7%	83.0%	4,079	4,757	25	↓
HIV Screening (CMS 349v7)	69.3%	63.0%	1,116	1,611	13	↓
Breast Cancer Screening Ages 50-74 (CMS 125v13)	59.1%	60.0%	1,060	1,795	150	↓
BMI Screening and Follow-Up 18+ Years (CMS 69v13)	70.9%	65.0%	3,772	5,319	179	↓
Diabetes A1c or GMI > 9 or Untested (CMS 122v13)	15.5%	16.0%	225	1,447	113	↓
Screening for Depression and Follow-Up Plan (CMS 2v14)	82.0%	80.5%	4,289	5,231	346	↓
Medicare Annual Well Visit	35.0%	30.0%	2,029	5,801	0	↓
Diabetes Care Comprehensive - Medicare ACO	43.6%	Not Set	680	1,560	0	↓
Hepatitis C Lifetime Screening	70.9%	63.0%	3,640	5,131	675	↓
Diabetes A1c does not exist (CMS122v11 Modified)	2.1%	2.0%	31	1,447	113	↓
Diabetes A1c Tested in the past year (CMS 122v11 Modified)	97.8%	Not Set	1,415	1,447	113	↓



# Building AWP Cohort to Track Performance



Provider Quality Incentive Scorecard REPORT

PERIOD: 2025 | RENDERING PROVIDERS: All Rendering Provid... | COHORTS: 2025 MAWV Comple... ✕

+ Add Filter | Update

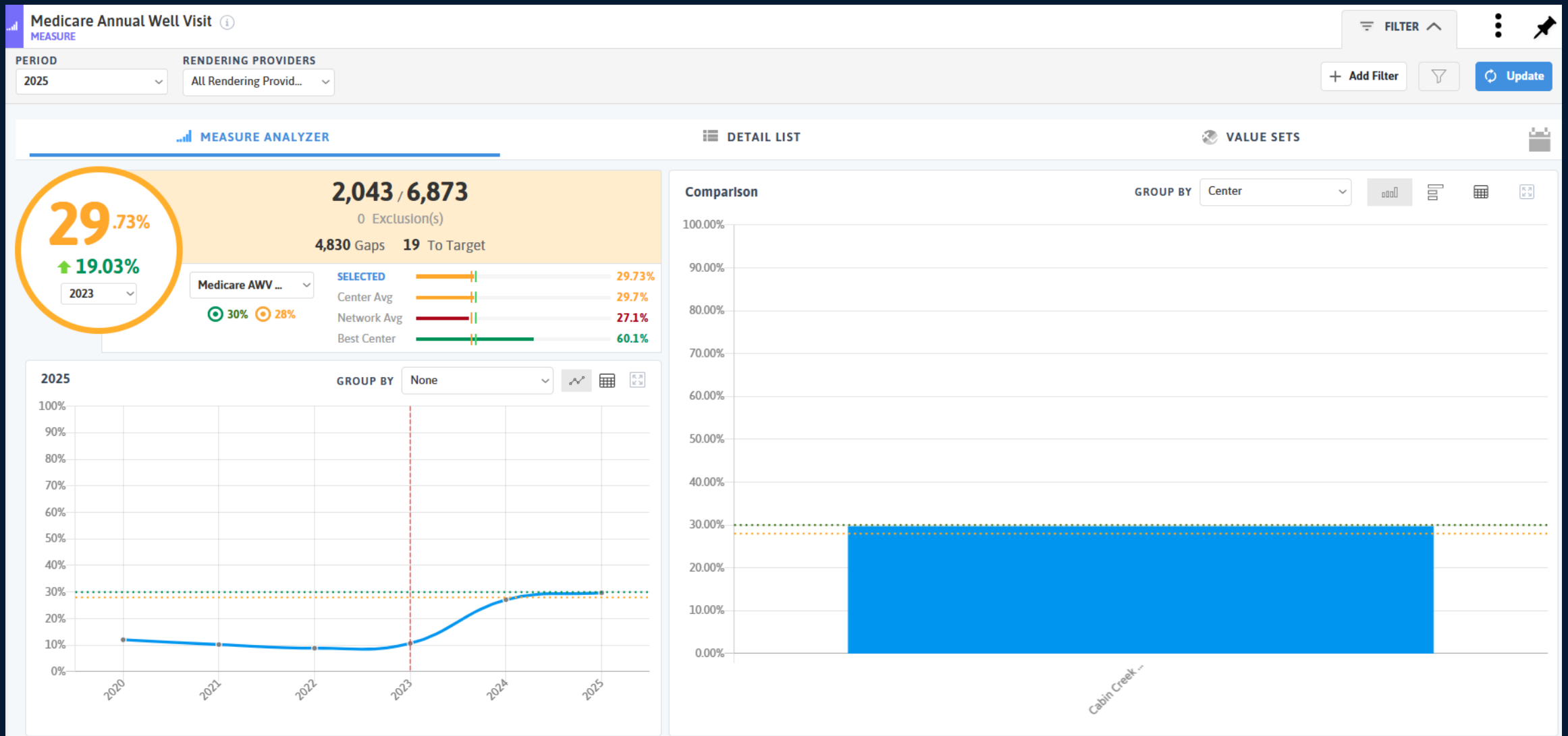
REPORT | CARE GAPS

GROUPING: No Grouping | TARGETS: Primary (Green), Secondary (Yellow), Not Met (Red) | REPORT FORMAT: Scorecard

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	
Cervical Cancer Screening (CMS 124v13)	63.1%	60.0%	53	84	68	↓
Colorectal Cancer Screening (CMS 130v13)	73.3%	60.0%	959	1,309	122	↓
Hypertension Controlling High Blood Pressure (CMS165v13)	80.5%	76.0%	1,104	1,372	196	↓
Tobacco Use: Screening and Cessation (CMS 138v13)	89.9%	83.0%	1,834	2,041	2	↓
HIV Screening (CMS 349v7)	81.3%	63.0%	369	454	1	↓
Breast Cancer Screening Ages 50-74 (CMS 125v13)	73.4%	60.0%	477	650	68	↓
BMI Screening and Follow-Up 18+ Years (CMS 69v13)	95.7%	65.0%	1,927	2,014	26	↓
Diabetes A1c or GMI > 9 or Untested (CMS 122v13)	11.3%	16.0%	63	559	57	↓
Screening for Depression and Follow-Up Plan (CMS 2v14)	94.1%	80.5%	1,818	1,933	110	↓
Medicare Annual Well Visit	100.0%	30.0%	2,043	2,043	0	↓
Diabetes Care Comprehensive - Medicare ACO	81.7%	Not Set	503	616	0	↓
Hepatitis C Lifetime Screening	84.2%	63.0%	1,486	1,764	279	↓
Diabetes A1c does not exist (CMS122v11 Modified)	0.5%	2.0%	3	559	57	↓
Diabetes A1c Tested in the past year (CMS 122v11 Modified)	99.5%	Not Set	556	559	57	↓



# AWV Performance Progression (2023–2025)



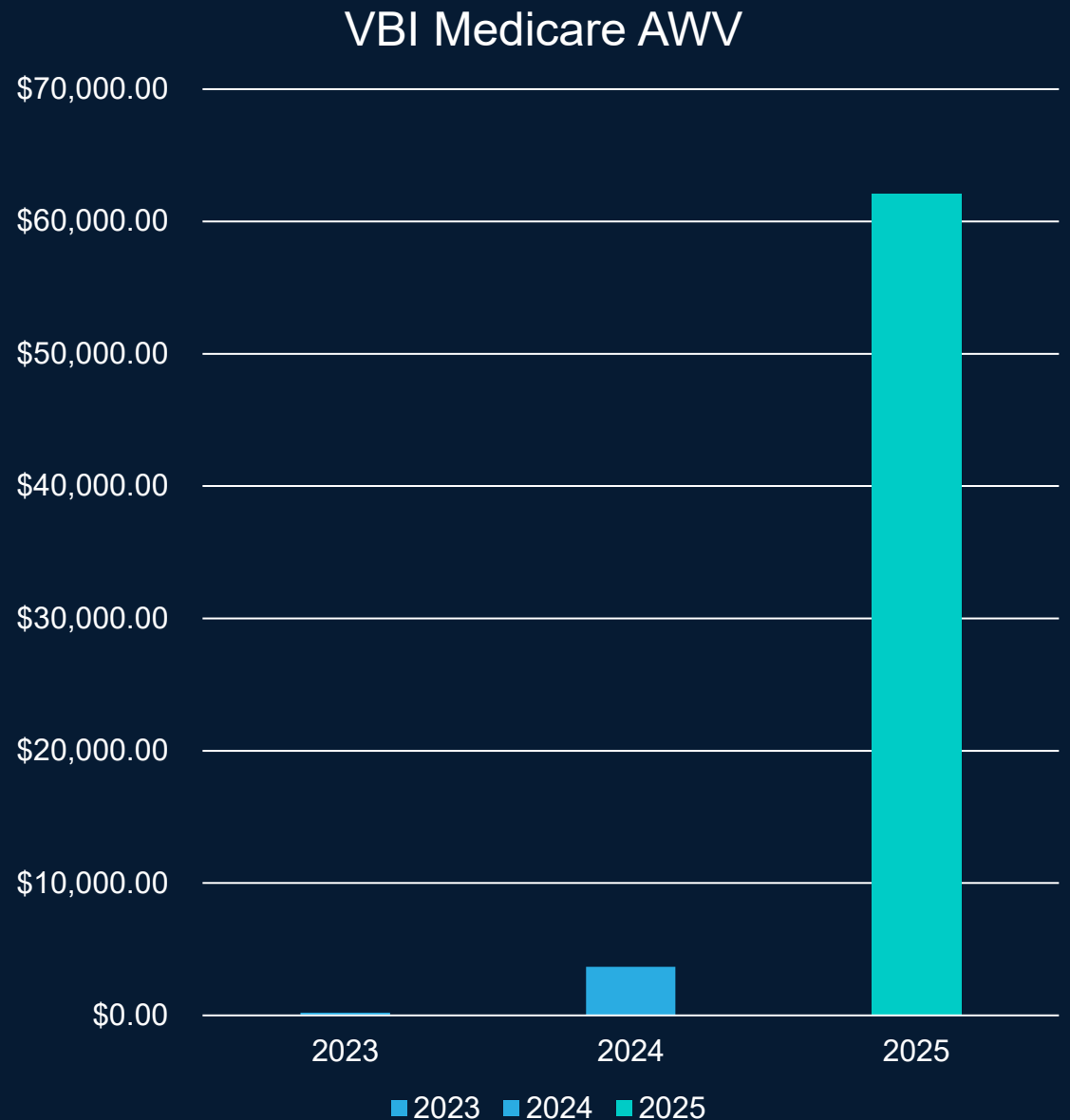
# Value-Based Incentive Revenue?

Determining value-based revenue opportunities with payers is complex.

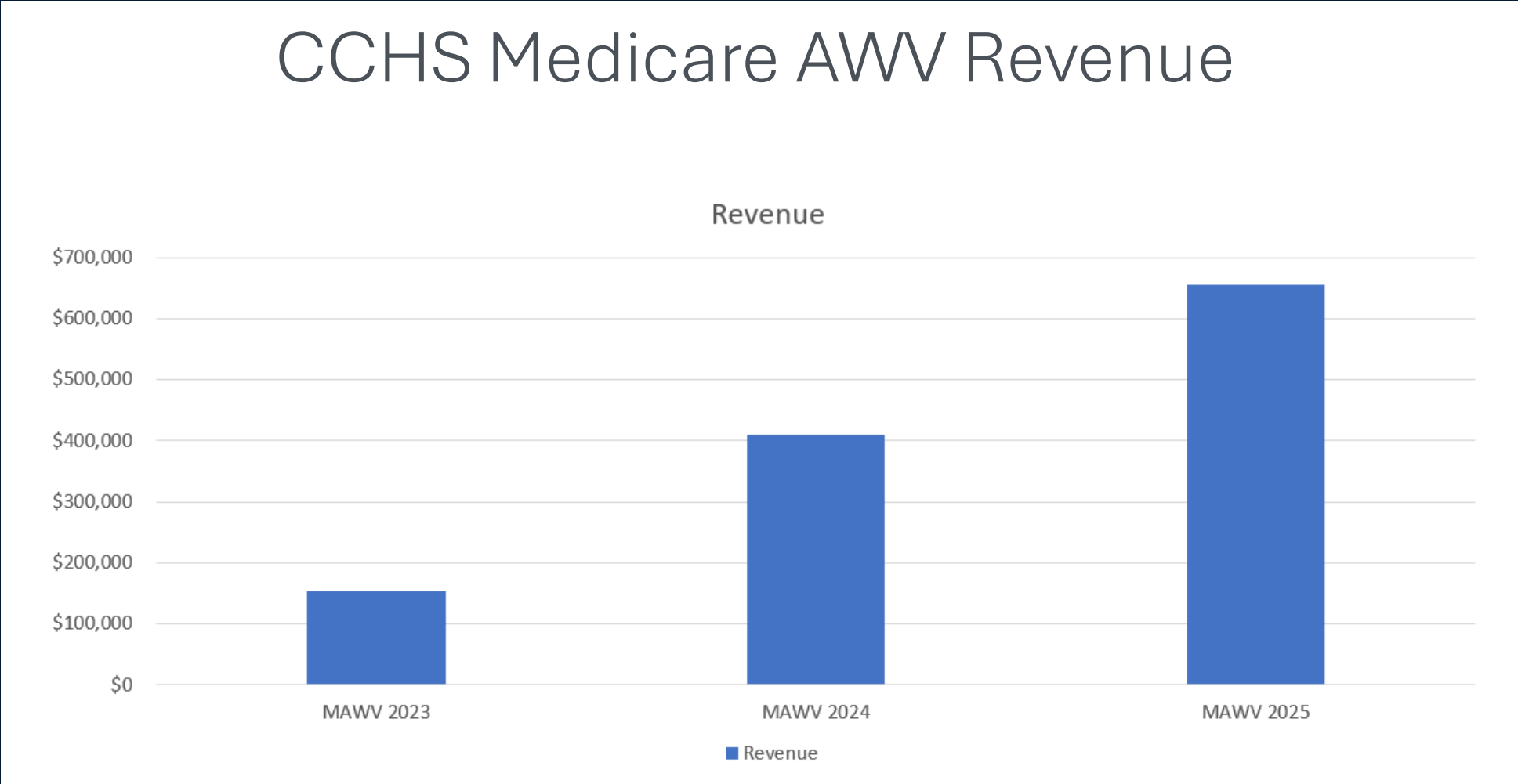
Key questions included:

- What incentives are available?
- What performance metrics drive payment?
- How much potential revenue is being missed?

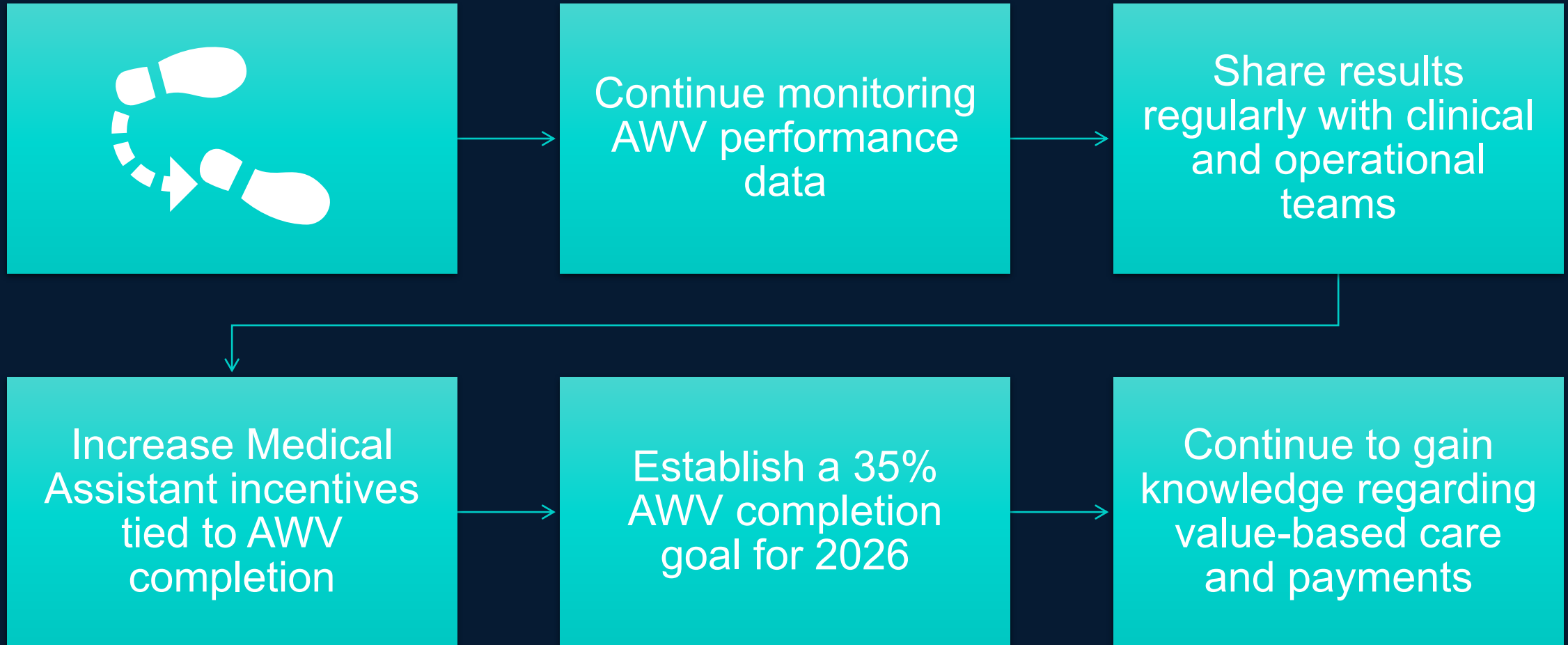
This analysis includes two Medicare Advantage plans as examples.



# Increased Encounter Revenue



# Next Steps Moving Forward





# Family Health Services of Darke County

Charlene Wright, BSMI, RT(R)(ARRT), Director of Quality and Risk Management

# Family Health Services of Darke County (FHSDC)

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Family Health Services of Darke County (FHSDC) is a Federally Qualified Health Center in rural Southwest Ohio with four primary locations and three school-based locations.

In 2025, FHSDC provided care for **27,963 unique patients**.

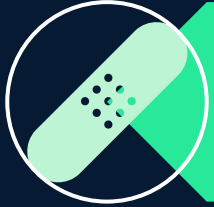
**EMR:** eClinicalworks implemented in 2018.

**Azara DRVS:** Implemented in June of 2022.



# Our Services

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Medical Services



340B Pharmacy



Dental Services



Behavioral Health



Vision Services



Home Health



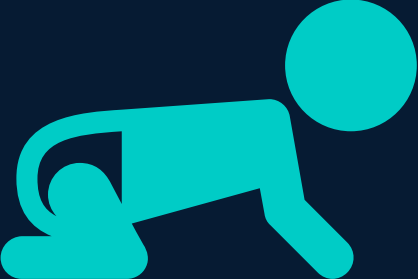
WIC



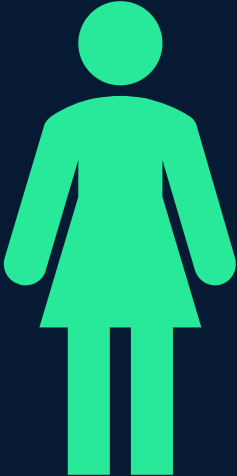
Family Rural Residence



# Patients by Age



0 – 17  
6,647  
24%



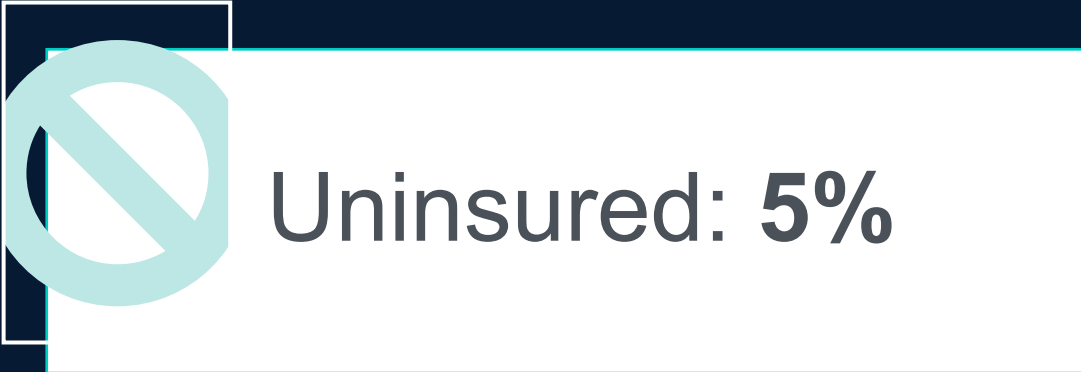
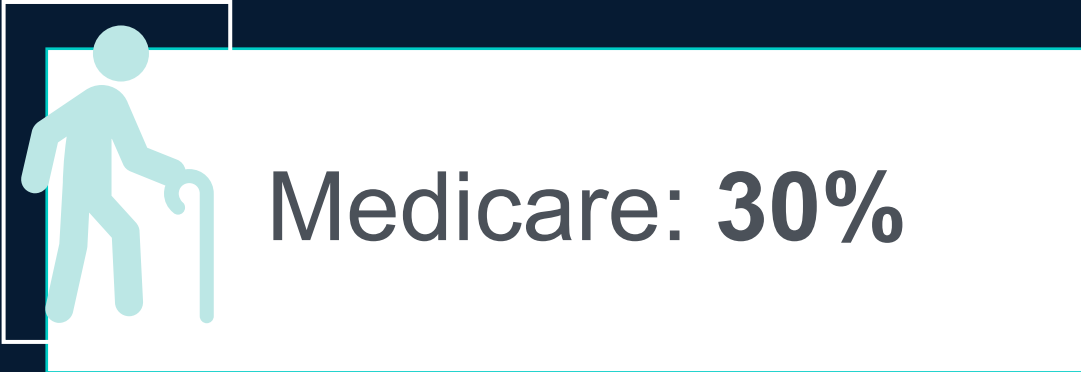
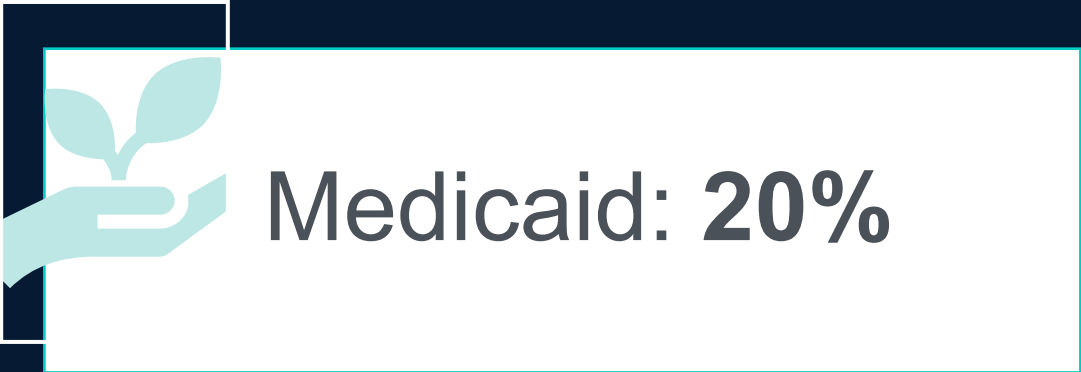
18 – 64  
13,212  
47%



65+  
8,104  
29%



# Payer Mix



# Why Value-Based Care?

## Importance of Value-Based Care Programs

Improved patient outcomes

Cost efficiency

Focus on quality over quantity

Encourages care coordination

Supports preventative care

Enhances patient experience

Sustainability for healthcare systems

Evaluate & partner with reputable ACO & CIN



# Partnerships

## Ohio Association of Community Health Centers Collaborations:

- CIN for Medicaid managed care plans
- ACO for Medicare patients

## Ohio Health Center Networking:

- Azara: Ohio Data Integration Platform (ODIP), DRVS, Transitions of Care, Cost & Utilization
- EMR User Groups

## Payer Relationship:

- Why is working with health centers appealing?
- Quality expectations

## Importance of Value-Based Care Reimbursement:

- Makes healthcare more responsive, cost-effective, and outcome driven

# Multi-Source Population Health

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Data: Accurate, Validated, Live



OACHC collaboration including HCCN provides support through training and financial support for Azara Healthcare (ODIP) for health outcome tracking Network benchmarking.



Payer-Provider Collaboration:  
Accurate Patient Attribution



Multidisciplinary Approach



Develop staff quality incentive program (launched January 2024)



Quality Team Support

# Prioritizing Outcomes Through Innovation



Value Based Care Agreements (Payer and Network)



Azara DRVS reporting & patient outreach utilizing Azara APO/CareMessage automated text campaigns



Appointment Access – Optimize scheduling capacity, reduce no-show rates, and implement targeted appointment blocks (e.g., hospital follow-up/TOC, WCC, AWV, and Group Medicare Annual Wellness visits)



Integrated Team Based Care – utilize Physician/APP that allows for increased panel capacity management, along with clinical pharmacy shared visits for high risk chronic conditions



Implemented staff incentive program (2024)



# Organizational Challenges

Understanding key barriers to performance and opportunity

# Challenges

## Staff Buy-in

- What can we do to motivate the staff to participate at ALL levels of the organization?
- Incentives: How do they work?

## Program Development

- How will we operate a program that engages the staff and that does not burden the patient population with additional time within the office?
- Quality incentive thresholds getting tighter and more stringent, as well as shifting to Shared Savings
- How do we avoid the loss of forward momentum?
- What did not work?

## Leadership Support

- How was the program developed? CEO, CFO, Director of Quality
- Internal meetings, approvals, Board of Directors



# Medicare Annual Well Visits (MAWV) Barriers

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Patient lack of understanding of visit type



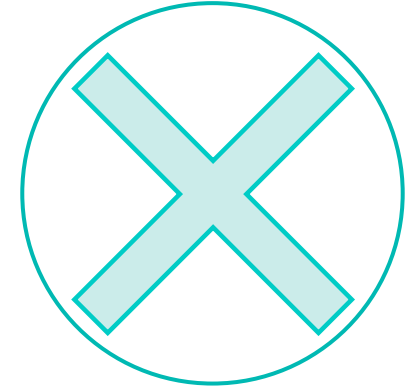
Lack of patient engagement and/or refusal of MAWV



Time consuming visits



High cost ER/IP utilization + avoidable ER/IP visits > hospital coding



Payers' third party vendors - denied claims



# Leadership & Team-Based Collaboration

Driving coordinated efforts to improve performance and patient  
outcomes

# Facility Collaboration

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## Leadership, Financial, & Quality:

All aspects of the organization are on the same page regarding this program.



## Quarterly Meetings – Review Departmental Dashboards:

CEO, CFO, and Director of Quality meet with each Suite/Care Team quarterly to review progress with an estimate of semi-annual payout.



## Lunch Provided!

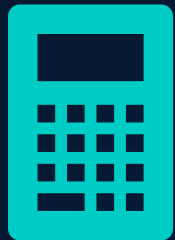
FHSDC provides lunch for the staff as we are requesting them to offer their lunch time for the quarterly meetings.



# Innovation | Staff Quality Incentive Program

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To effectively launch a staff incentive program that aligns with organizational goals and promotes VBC, the following key steps should be addressed:



## Establish Budget

- Determine available funds for incentives.
- Set parameters for individual vs. team-based rewards.
- Align budget with expected return on investment (ROI).
- Use current VBC incentives to fund program.



## Review VBC Agreements

- Analyze current VBC contracts for performance metrics tied to reimbursement.
- Identify payer-specific priorities and incentives.
- Ensure staff incentives align with contract expectations

# Designing & Implementing a Staff Incentive Program

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## Identify Top Measures for ROI

- Use historical data to determine which quality or cost measures have the greatest financial impact.
- Prioritize metrics that show strong correlation with improved reimbursement or shared savings.



## Identify Top Area(s) for Improvement

- Conduct gap analysis using performance reports.
- Focus on areas where performance lags and improvement is feasible in the short to medium term.



## Recommend Team-Based Approaches to Promote Staff Buy-In

- Create multidisciplinary teams to foster collaboration and accountability.
- Offer team-level rewards to reinforce collective effort and morale.
- Involve staff in the planning process to enhance ownership.

# Identify Measures & Populations



## UDS

- Health Center Clinical Quality Measures
- Identified measures lower than network performance and/or lower than facility expectations

## CIN/ACO

- Decrease overall cost of care
- Reduce ER/IP utilization
- Network benchmarking
- Shared Best Practices
- Aggregate & Health Center performance
- Data support

## VBC Payer Agreements

- Large measure set. Varies by payer priority.
- Quality incentive thresholds getting tighter & more stringent, as well as shifting to Shared Savings

## Annual Wellness

- Well child visit
- Adult wellness
- Medicare wellness
- Preventative cancer screenings

## Chronic Disease Control

- Comprehensive Diabetic measures (A1c, Kidney Health, Diabetic eye exam)
- BP Control
- BMI trends
- Medication Adherence (Statin due to ease of reporting)

## Appropriate Coding

- Ongoing staff education
- HCC
- RAF gap closure rates



# Tracking Performance

Monitoring progress to drive continuous improvement

# Quality Team Support

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## Patient Outreach:

Automated text campaigns through Azara Healthcare APO & CareMessage



## Monthly Reports:

Monitor progress, validate data, timely



## Care Gap Reports:

Review HIE for external records, such as specialists, endocrinologists, OB/GYN



## Validate Payer Gap Reports:

Compare to internal reports



## Data Transparency:

Staff meetings, bi-monthly newsletters, leadership/board meetings

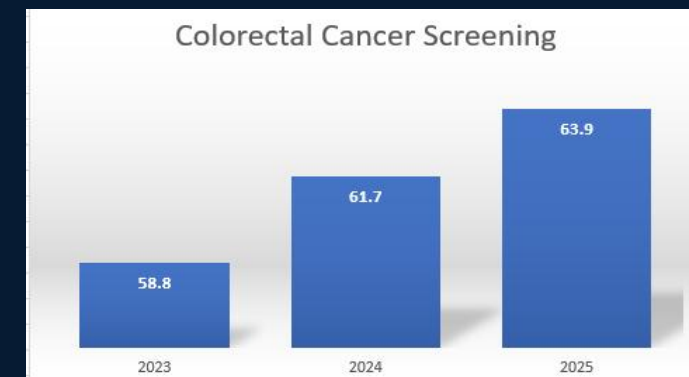
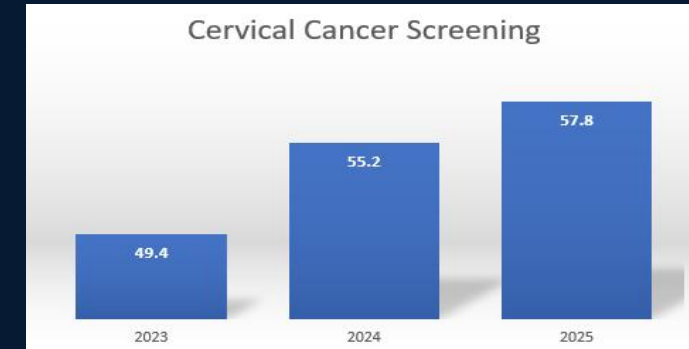
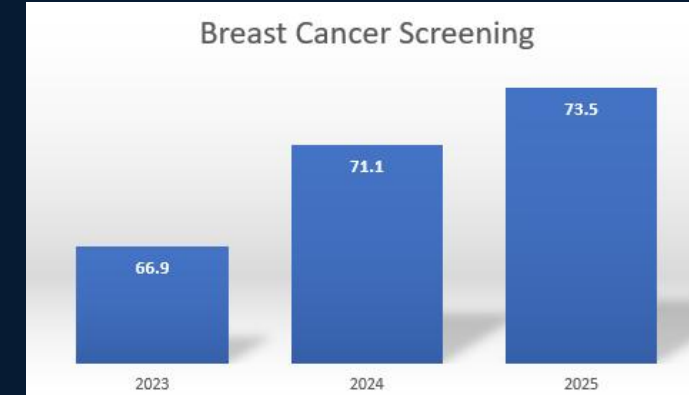
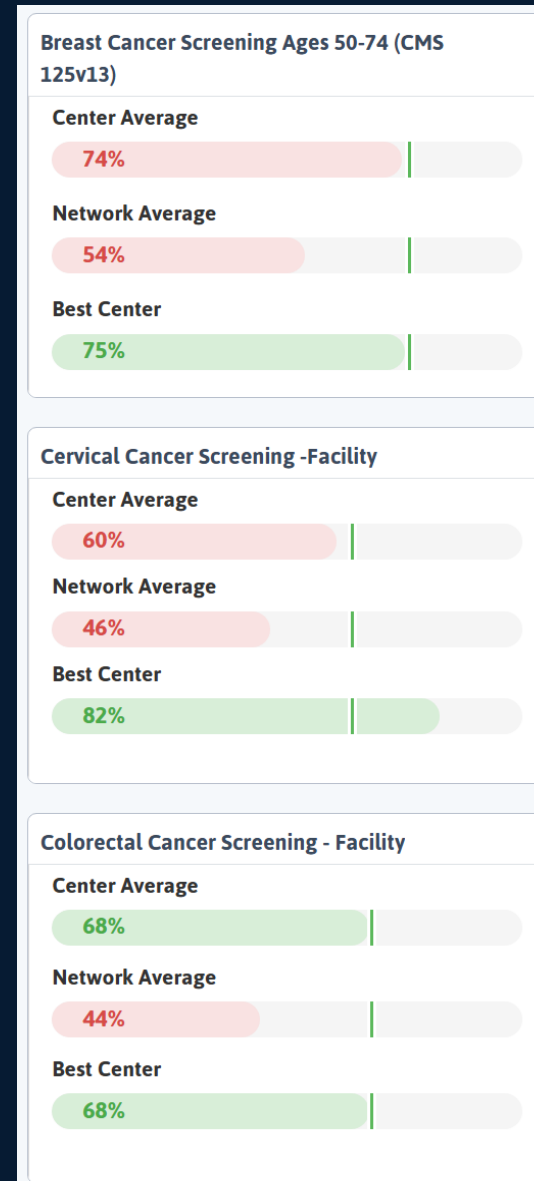
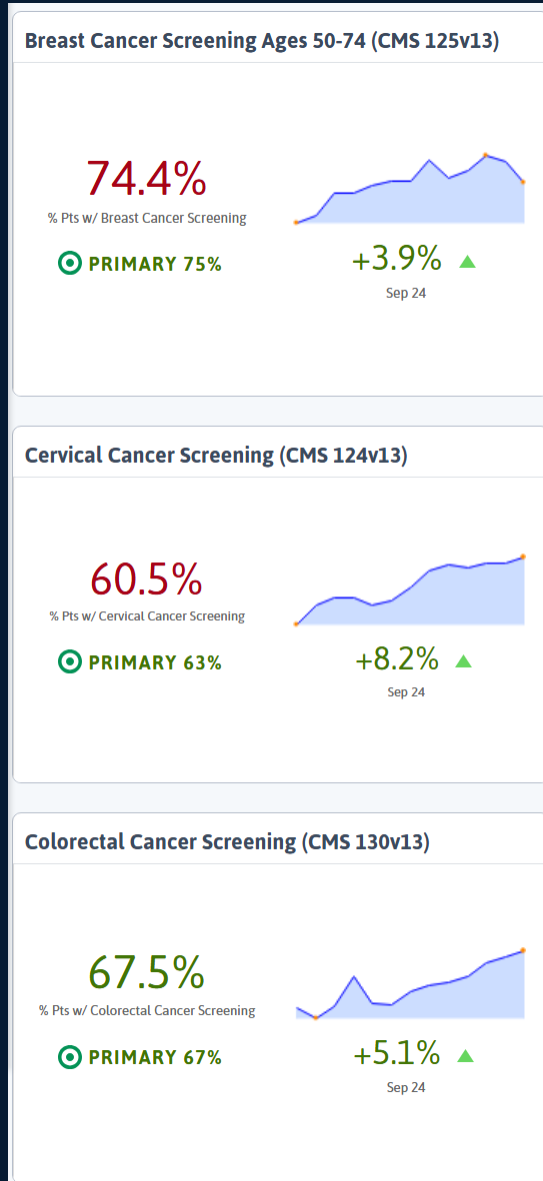


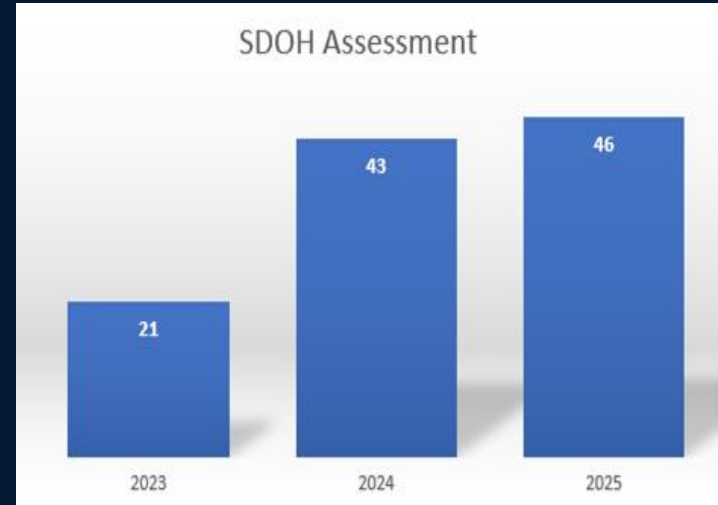
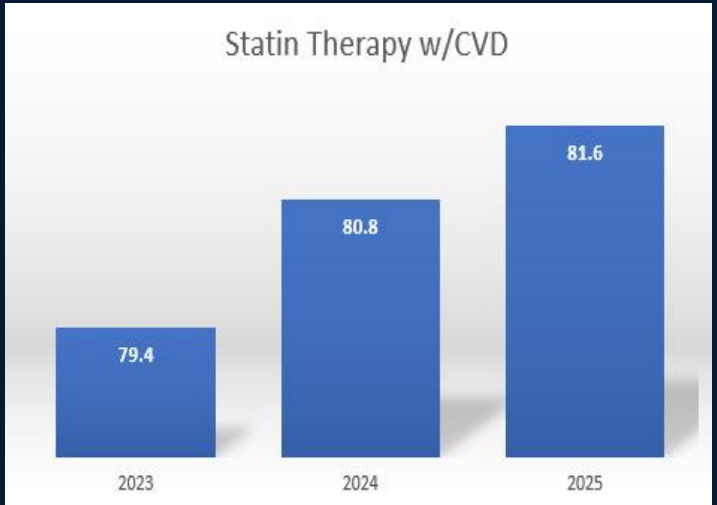
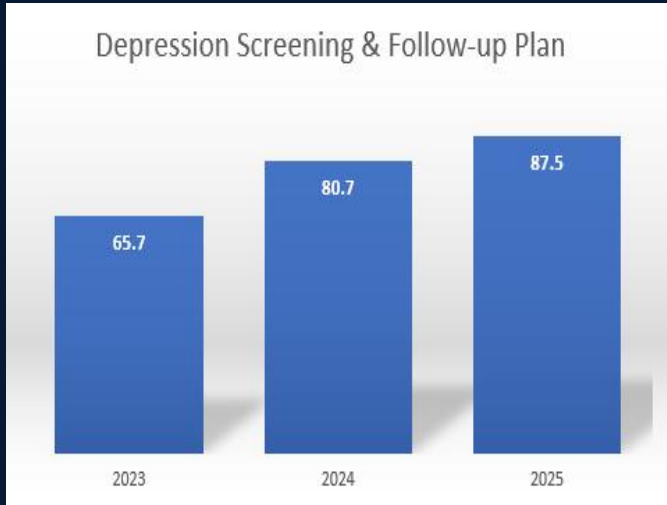
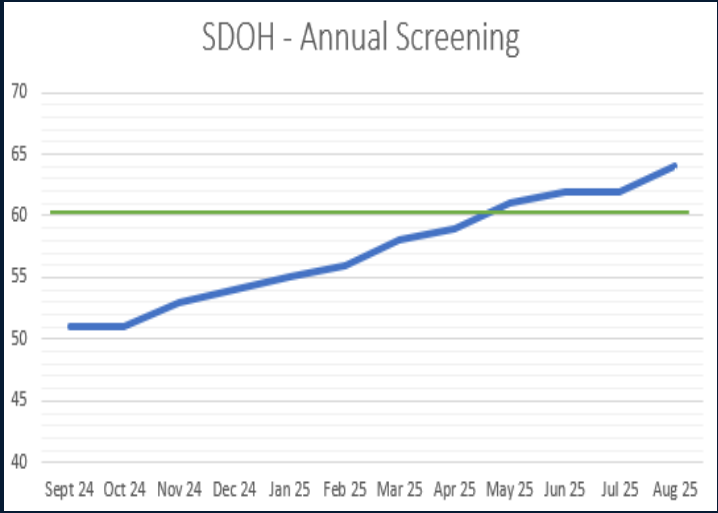
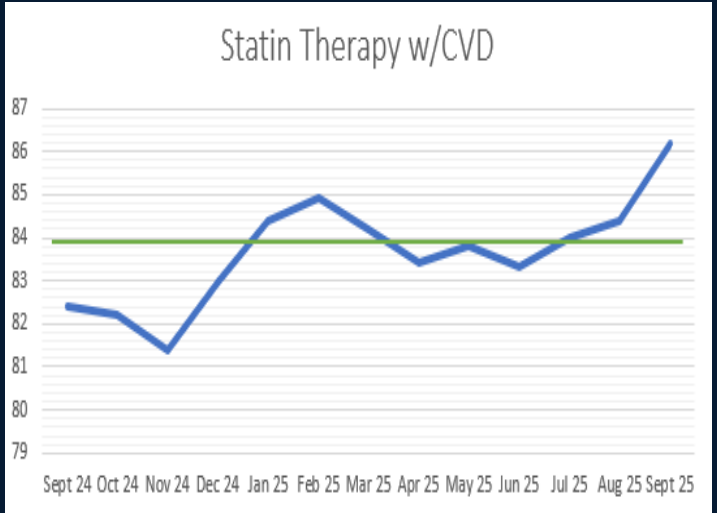
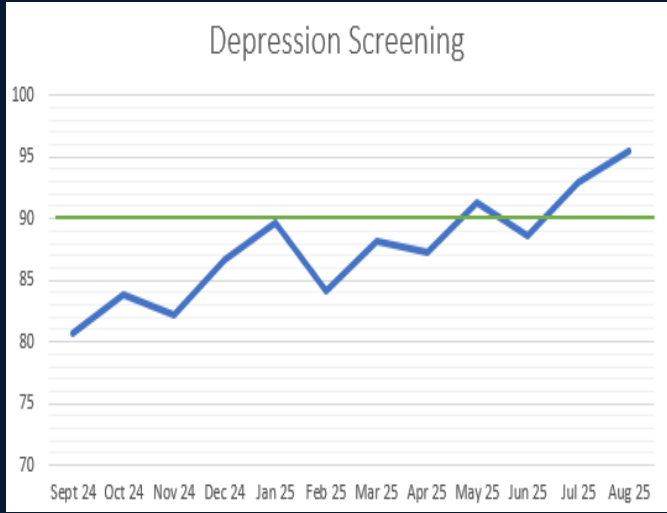
## Quarterly meetings with payers

# Quality Metric VBC Focus



- High ROI measures
- Identified areas for improvement
- Align across several VBC agreements
- Staff Incentive Program: Drives performance improvement by aligning with VBC initiatives



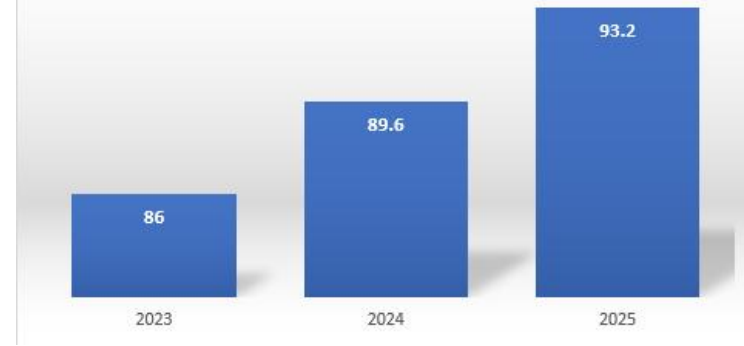


### Tobacco Use: Screening and Cessation (CMS 138v13)

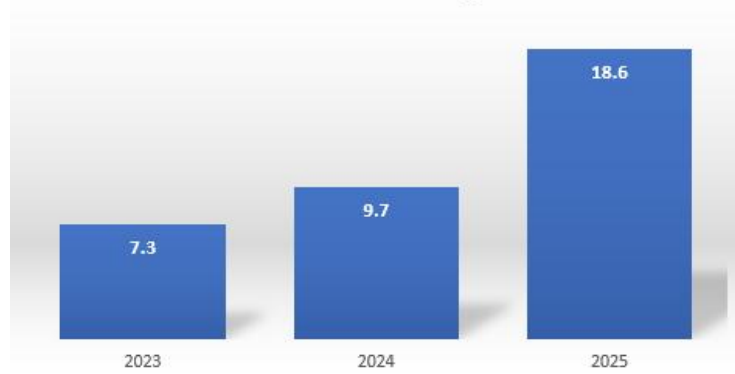
**95.1%**  
% Pts w/ Tobacco Screening & Cessation



### Tobacco Use: Screening & Cessation



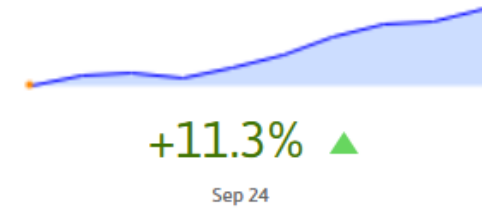
### HIV Screening



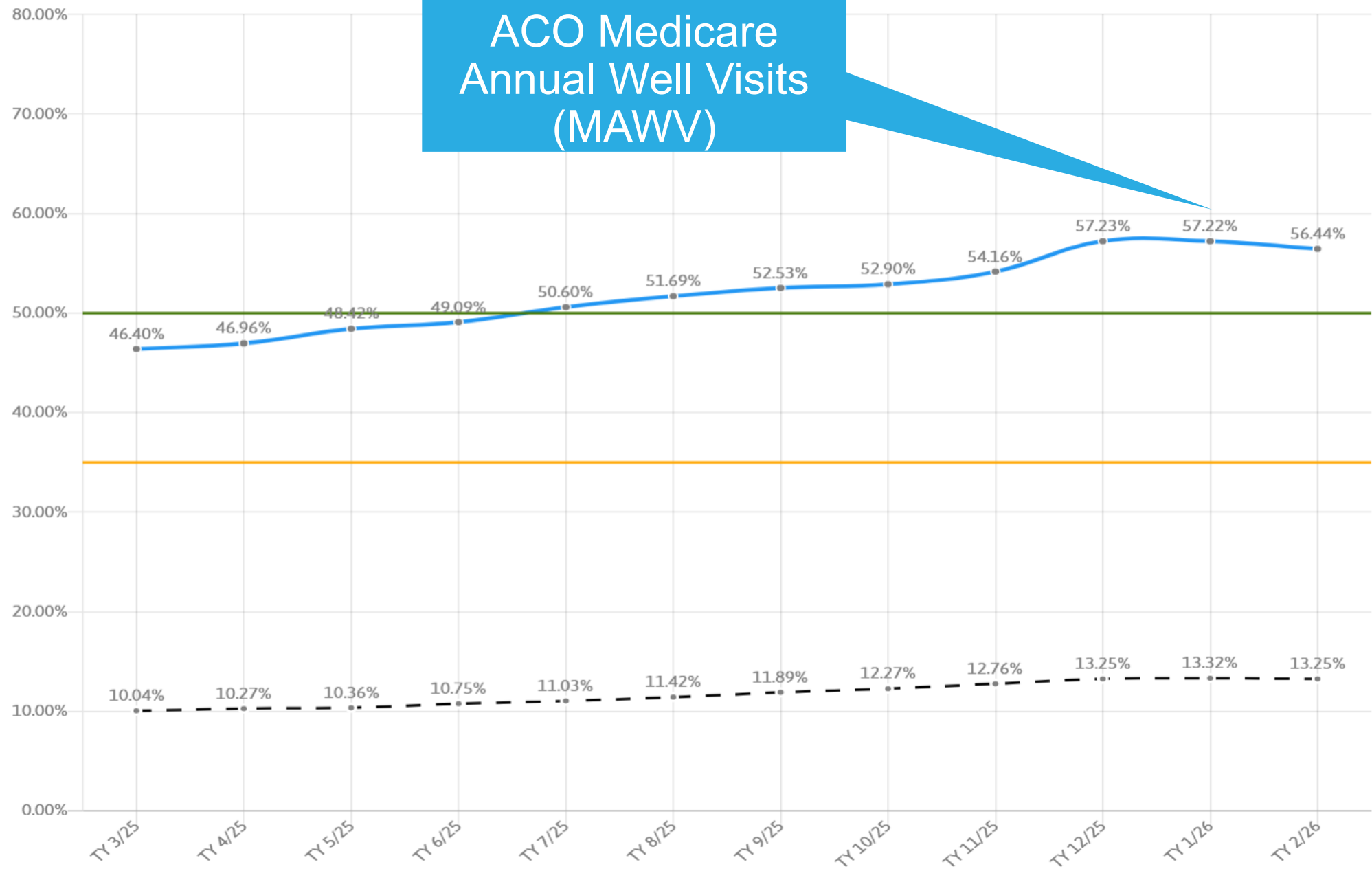
### HIV Screening

**22.7%**  
% Pts screened for HIV

🎯 PRIMARY 50%  
🎯 SECONDARY 20%



OACHC – MSSP  
ACO Medicare  
Annual Well Visits  
(MAWV)



# OACHC MSSP ACO MAWV Success

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## Data Utilization

- Azara DRVS: Network Payer Integration
- Azara Cost & Utilization (ACU): Payer Integration

## Targeted Outreach

- APO (Automated Patient Outreach) Campaigns

## Scheduling

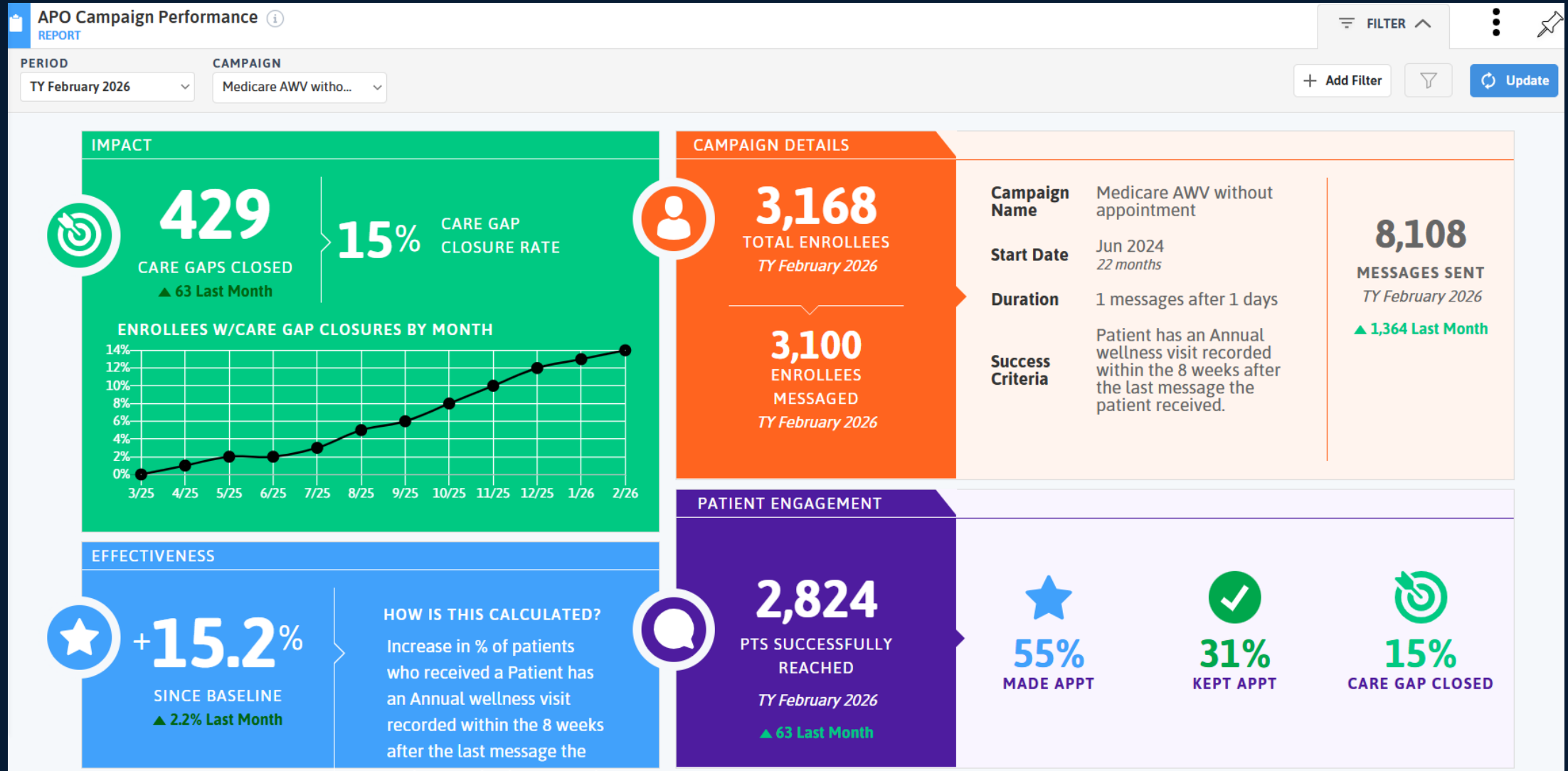
- Schedule at check-out
- Scheduling holds
- Clinical Pharmacy shared visits

## Staff Incentive Program

### Next Phase:

Medicare Annual Wellness Group Visits!

# APO AWW Campaign Performance Report





# Improving Completion Rates of Medicare Annual Wellness Visits in Primary Care

Family Health Services of Darke County, Inc. Presenters: Charlene Wright, BSMI, RT(R), Director of Quality & Risk Management, Jessica Rayburn, BSN, Quality Assurance Nurse

## Background

FHSDC joined OACHC MSSP ACO for program year 2024. Due to rural location and aging community FHSDC has a large Medicare population equally 30% (8,293) of its 27,963 patients in 2025. FHSDC determined Medicare Annual Wellness Visits (MAWV) were lower than facility

## AIM Statement

To improve % of completion rates of MAWV in primary care to 55% by end of CY 2025.

## Barriers

**i** Patient lack of understanding of visit type

**No** Lack of patient engagement and/or refusal of MAWV

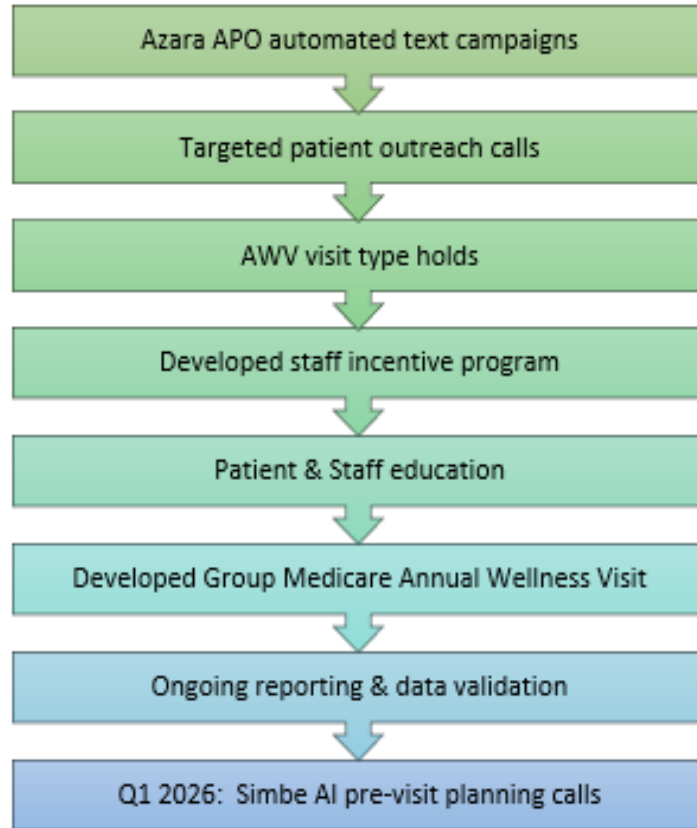
**🕒** Time consuming visits

**📈** High cost ER/IP utilization  
Avoidable ER/IP visits > hospital coding

**⚠️** Payers  
Third party vendors - denied claims

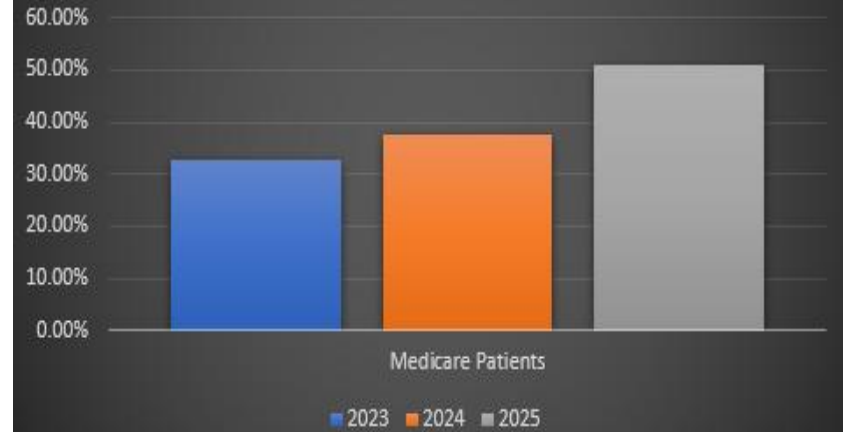


## Methods



## Results

% of Medicare Patients with AWV Completed



## Key Takeaways

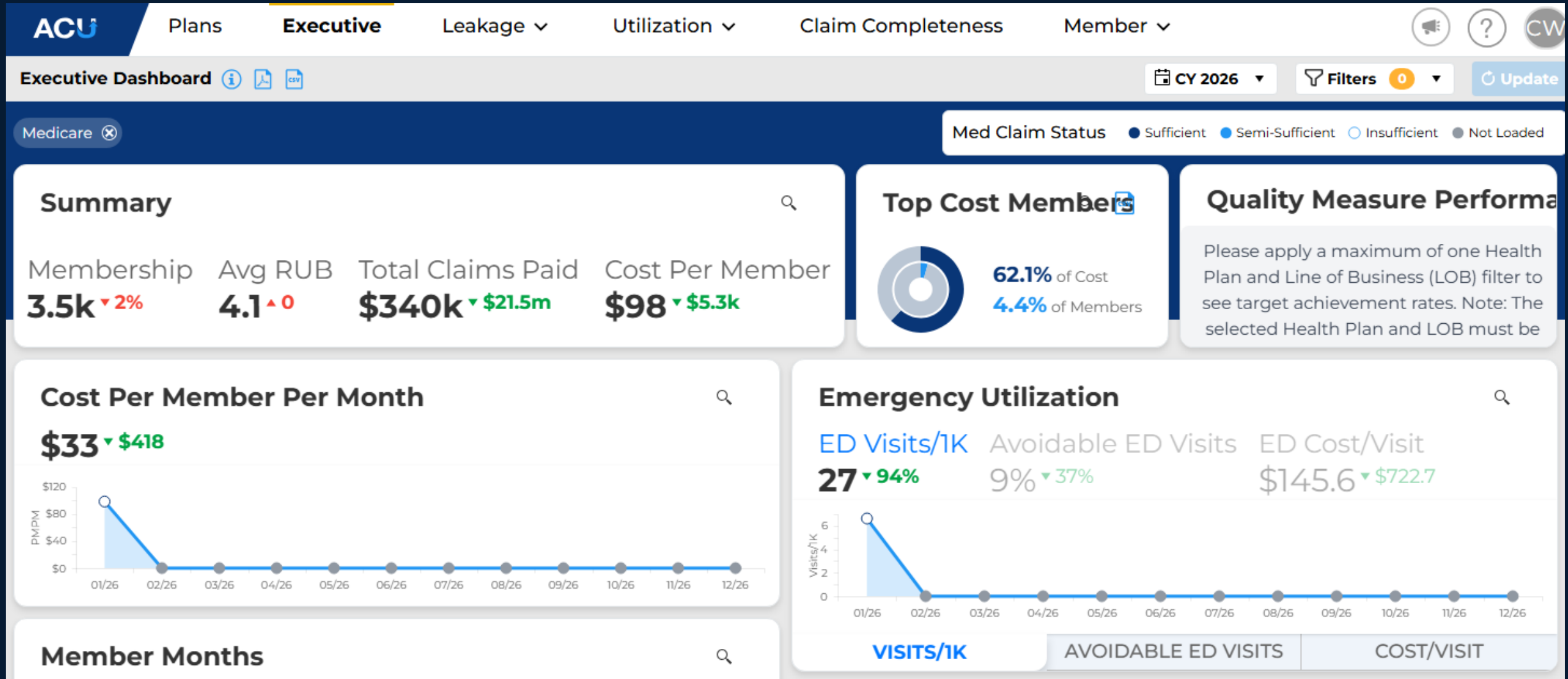
- Staff incentive program and department competition drove quality improvement initiatives
- Ongoing review of gap reports & data validation essential
- Medicare population open to electronic patient outreach
- Patient education is necessary to improve patient understanding of various visit types



# Next Steps for FHSDC



# ACU | Cost & Utilization Management

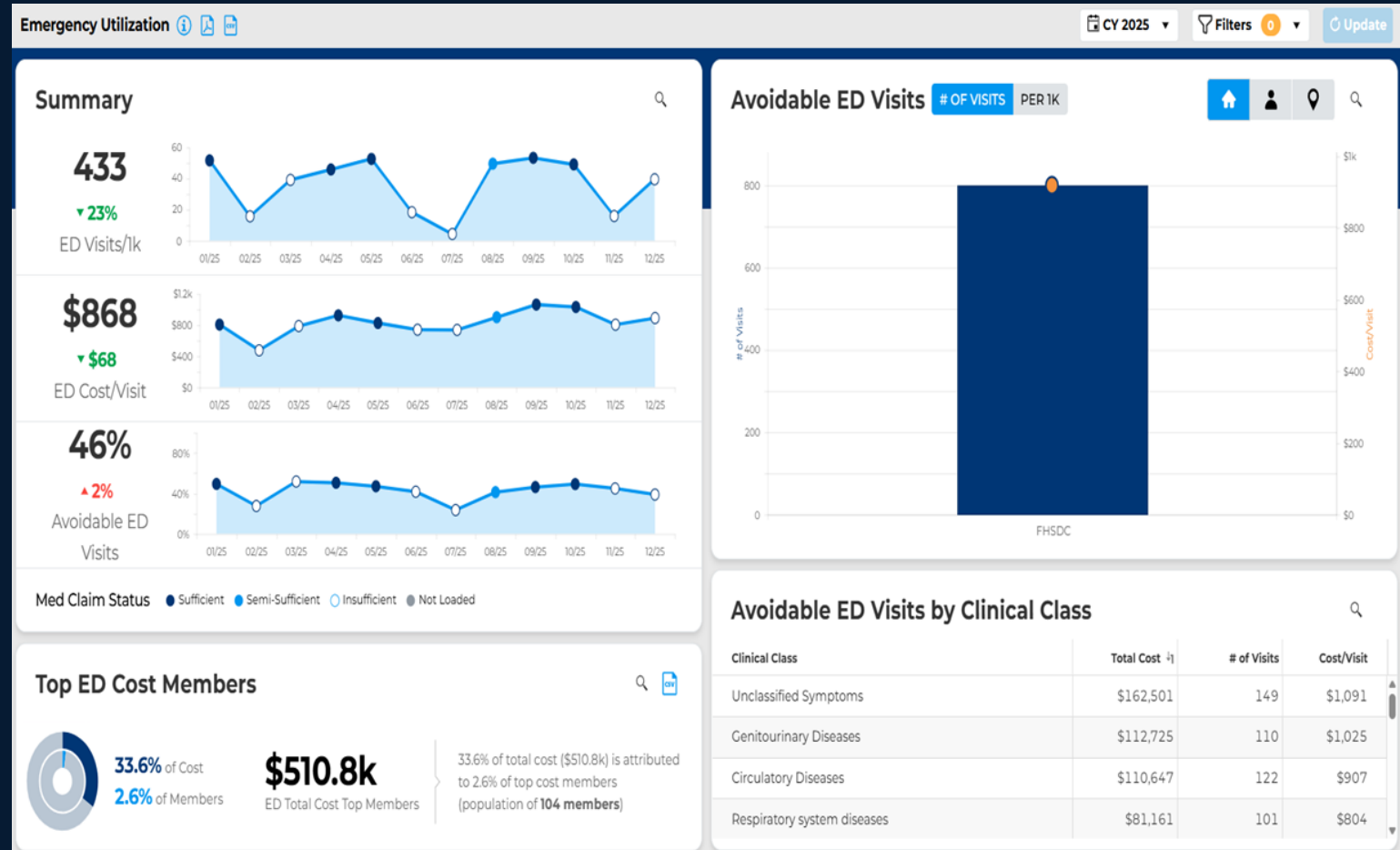


# Community & Hospital Collaboration



**Goal:** Reduce overall cost of care, reduce ER/IP utilization, improve coding

- Review High Cost Members
- Connect Social Services
- Patient education
- Identify top Dx conditions & raise awareness to coding concerns (use of unspecified/unclassified systems)





# Closing & Discussion



# Drivers for AWWV Success

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Standardization + alignment drive performance

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Data enables action and accountability

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Team-based incentives accelerate results

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Targeted tracking improves outcomes

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Sustained focus delivers measurable impact



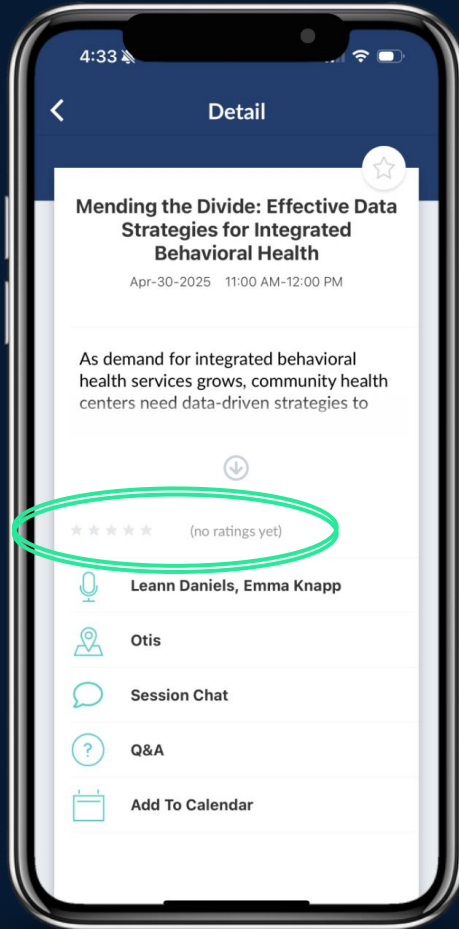


# Questions?



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# Thanks for attending!

