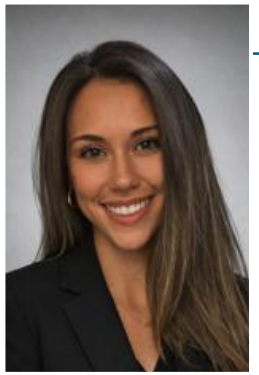
carina
HEALTH NETWORK

CLEAR! RESTARTING CVD IMPROVEMENT AT COLORADO CARINA HEALTH NETWORK WITH DRVS AMA MAP TOOLS

2026 Azara User Conference – Breakout Session
April 15, 2026
11:00 am - 12:00 pm

PRESENTER PANEL



MacKenzie Chackman

Practice Transformation Coach

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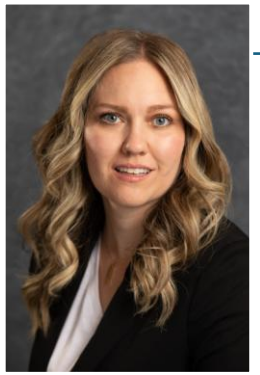


Meredith Munoz

Performance Programs Manager

carina HEALTH NETWORK

Ashley Absmeier-Koppenhafer

Director of Physical Therapy and Quality Improvement

Valley-Wide Health Systems, Inc.

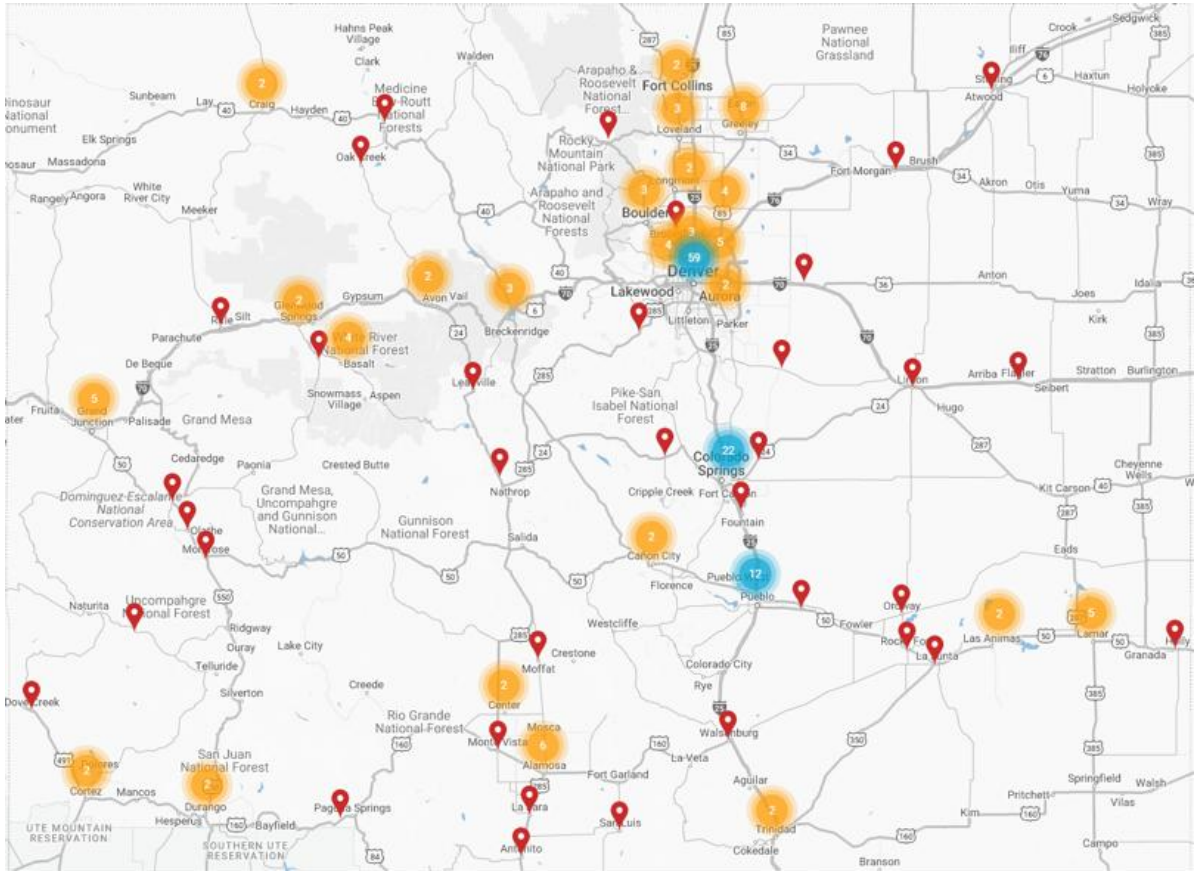
Silvia Santana

Director of Quality & Compliance

Mountain Family HEALTH CENTERS

CARINA HEALTH NETWORK

- 250+ clinic sites in 47 counties and 1,000+ medical and behavioral health providers
- Serving 857,000+ patients with a focus on those who are uninsured, underinsured, and under-resourced
- All members are fully integrated with medical, dental, and behavioral health services
- Over 75% of population with co-morbidities and are struggling with the social determinants of health (SDoH)



OUR MEMBERS

AXIS Health System

Clinica family health & wellness

Colorado Coalition for the Homeless — Creating Lasting Solutions

Denver Health — est. 1860

Denver Indian Health and Family Services

Elevated Community Health

High Plains Community Health Center

ICH Inner City Health

Mountain Family Health Centers

Northwest Colorado Health — Formerly Northwest Colorado Visiting Nurse Association—VNA

Peak Vista Community Health Centers

PrimeHealth

Pueblo Community Health Center — Your Health. Our Mission.

River Valley Family Health Center

Salud Family Health

Sheridan Health Services

STRIDE Community Health Center

sunrise Community Health

Tepeyac Community Health Center

UMC Uncompahgre Medical Center

Uptown Community Health Center

Valley-Wide Health Systems, Inc.

LEARNING OBJECTIVES

- Describe a process to adopt the American Medical Association (AMA) MAP HTN Program in an Accountable Care Organization and the impact on individual team members, health centers, performance, and culture.
- Determine how collaboration with a standardized program can be individualized and accelerate performance.
- Apply key learnings to identify actionable next steps that drive sustainable practice change and measurable performance outcomes.

OUR PARTNERSHIP WITH THE AMERICAN MEDICAL ASSOCIATION (AMA)

1994

Colorado Community Managed Care Network (CCMCN) Established - Health Center Control Network

2014

Community Health Provider Alliance (CHPA) Established – Accountable Care Organization

January 2024

CCMCN Introduced to American Medical Association (AMA) MAP Hypertension Program

March 2024

CHPA and CCMCN Partner and Introduce AMA MAP HTN Measures to QAL Members

End of 2024

Network adoption of AMA HTN Measures Minimal

January 2025

Carina Health Network Established (CHPA and CCMCN merger) and collaborate with AMA MAP HTN Program

MOUNTAIN FAMILY HEALTH CENTER

- Federally Qualified Health Center (FQHC) since 1978
  - Five main locations
  - Three school-based health centers
    - Serving ≈16,828 patients
- Carina member since 2014
  - Started participating in MSSP in 2022

PCMH Patient-centered Medical Home (PCMH) recognized through NCQA

Mountain Family
HEALTH CENTERS

HYPERTENSION CONTROL EFFORTS IN 2024:
A FRAGMENTED APPROACH

Azara Use

- Tracked HTN Controlling High BP(CMS165v13) in **Measure Analyzer Report**
- No use of **Registries** yet
- Used **Scorecards** and **Care Gap Reports** for outreach

Patient Engagement

- HTN Nurse Cohorts for small group engagement
- Discussions around medication adherence
- Scheduled follow-up appointments (no cadence)

Mountain Family
HEALTH CENTERS

HYPERTENSION CONTROL EFFORTS IN 2024:
A FRAGMENTED APPROACH

Care Team Involvement	Improvement Approach	Challenges
• Providers, RNs, & MAs	• Focus based on Value-Based Contracts • QI team set goals based on location	• No formal work structure for controlling BP • Support staff turnover • Lack of follow-up • No tracking of 2nd BP

Mountain Family HEALTH CENTERS

Left to Right - Adreanna Rael, Healthcare Informatics Specialist, Autumn Squires, Clinical Quality Assurance Coordinator, Ashley Absmeier-Koppenhafer, Director of Quality Improvement

VALLEY-WIDE HEALTH SYSTEMS

- FQHC since 1976 with 30 locations across the state of Colorado
  - Serving ≈35,783 patients
  - 16 rural clinics covering
- Carina member since 2015

PCMH

Patient-centered Medical Home (PCMH) recognized through AAAHC/HRSA

AMERICAN MEDICAL ASSOCIATION TARGET BP SILVER+ 2025 AMERICAN HEART ASSOCIATION

Recognized by the American Heart Association: Target BP (2025)

Valley-Wide Health Systems, Inc.

Awarded Accreditation by AAAHC

HYPERTENSION CONTROL EFFORTS IN 2024:
A FRAGMENTED APPROACH

Azara Use

- Tracked HTN Controlling High BP(CMS165v13) in **Measure Analyzer Report**
- No use of **Registries** yet
- Used **Scorecards** and **Care Gap Reports** for outreach
- **Alerts** on **PVP** and **CMP** prompted BP discussion with patients during visit

Patient Engagement

- Follow-up visit scheduled 4-weeks after visit
- Inconsistent due to patient compliance

Valley-Wide Health Systems, Inc.

HYPERTENSION CONTROL EFFORTS IN 2024:
A FRAGMENTED APPROACH

Care Team Involvement	Improvement Approach	Challenges

• QI Team, Providers, RNs, & MAs	• Providers set BP goals with the patient
	• QI team set goals with individual care teams
	  • Developed PDSAs
	  • Targeted care teams with lowest numbers (DRVS data)
		• PDSA approach was not consistent
		  • Some teams had goals, some didn't
		  • Patients fell through the cracks
		  • Reality? Total chaos at times!

Valley-Wide Health Systems, Inc.

2025 QUALITY ACTION LAB (QAL) IMPLEMENTATION

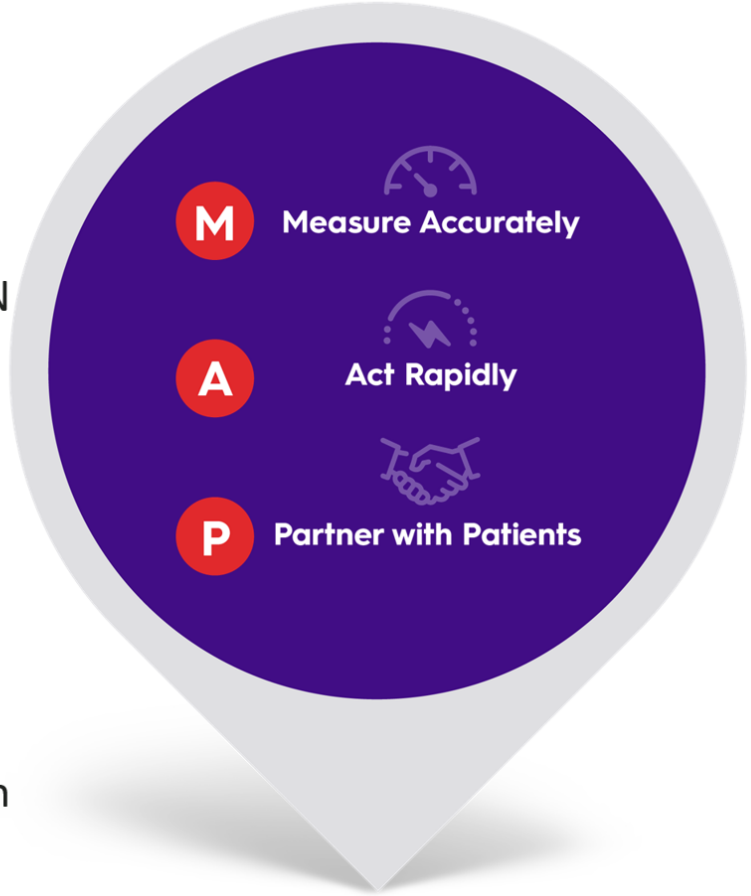
CARINA ADOPTS AMA MAP FRAMEWORK

AMA MAP™ Framework

Measure Accurately
Obtain accurate, representative BPs to diagnose HTN and assess control

Act Rapidly
Initiate and intensify treatment for patients with uncontrolled BP

Partner with Patients
Engage patients in self-management of hypertension



AMA MAP™

AMA MAP™ Htn. Solution Adopters & Disseminators

Network Champions

Executive Sponsor
Brandi Apadoca
Physician Leader
*Dr. Autumn Orser

Project Managers
* BJ Dempsey & * Jenn Ammerman

Clinical Education Lead
* Heather Martinez

Clinical Operations & Quality Improvement Lead
*BJ Dempsey

EHR / Data Technical Lead
* Meredith Munoz
*Jenn Ammerman

Pharmacist Lead
Leah Fitzgerald, PharmD

Who supports Azara User Group?

HC Members

2025 HTN Quality Action Lab –
(Deep Strategy)

Track 1 CHCs
8 - 9 CHCs Engaged

Track 2 CHCs
2 CHCs Engaged (River Valley)

Non-2025 HTN Quality Action Lab CHCs
(Broad Strategy)

~11 CHCs Engaged

*** = indicates access to Azara***

TEAMS

Leadership Council

- Executive Sponsors
- Project Managers
- Clinical Education Lead
- AMA Leadership

Data Tech Team

- EHR / Data Technical Leads
- AMA Representatives

Clinical Education Team

- Clinical Education Lead
- Clinical Ops and QI Lead
- Clinical Pharmacist (as needed)
- AMA Facilitators

AMA MAP™

LEADERSHIP COUNCIL

Goal Setting

Outcome & Process Measures	Target 2	Target 1
Hypertension Controlling High Blood Pressure	75%	85%
AMA MAP™ Confirmatory BP Measurement In-Clinic	65%	75%
AMA MAP™ Follow-up for SBP ≥140 or DBP ≥90	50%	60%

Standard Work

HYPERTENSION TREATMENT PROTOCOL POCKET GUIDE

2017 AHA/ACC Hypertension Guideline as the standard clinical protocol.

Network Core Guideline

Blood Pressure (BP) Target: <130/80 mmHg for most adults w/ confirmed hypertension.
Note: Clinicians may deviate from the core guidelines under evidence-based scenarios outlined in section 7.

1 Blood Pressure Classification

Categories	Systolic BP, mm Hg	and/or	Diastolic BP, mm Hg
Normal	<120	and	<80
Elevated	120–129	and	<80
Hypertension, stage 1	130–139	or	80–89
Hypertension, stage 2	≥140	or	≥90
Hypertensive Crisis	≥180	and/or	≥120

2 Initial Treatment Approach

LIFESTYLE MODIFICATIONS FOR ALL PATIENTS

Diet: DASH diet (rich in fruits, vegetables, whole grains, low-fat dairy, reduced sodium)
Exercise: At least 150 minutes per week of moderate-intensity activity
Weight Management: Aim for BMI <25 kg/m²
Sodium Reduction: Target <1,500 mg/day (at least reduce by 1,000 mg/day)
Limit Alcohol: ≤2 drinks/day for men, ≤1 drink/day for women
Smoking: Cessation

3 Pharmacologic Treatment Recommendations

HYPERTENSION STAGE 1 (130-139/80-89 MMHG)

ASCVD risk ≥10%: Start medication + lifestyle modifications
ASCVD risk <10%: Lifestyle modifications only
First-line medications:

- Thiazide diuretics (chlorthalidone, hydrochlorothiazide)
- ACE inhibitors (ACEi) (lisinopril, enalapril)
  - OR Angiotensin II receptor blockers (ARBs) (losartan, valsartan)
  - OR Calcium channel blockers (CCBs) (amlodipine, diltiazem)

HYPERTENSION STAGE 2 (≥140/90 MMHG)

Initiate two first-line antihypertensive agents from different classes

- Example: Thiazide diuretic + ACEi/ARB OR CCB + ACEi/ARB OR Single Pill Combinations
- Refer to Colorado Preferred Drug List for covered Single Pill Combinations

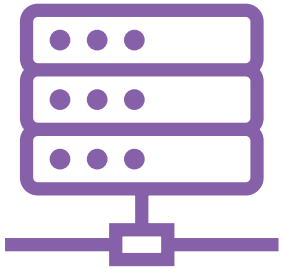
DATA TECH TEAM

Centralized Infrastructure

Performance reporting & QI support

Network-wide **Azara DRVS** adoption

Standardized dashboards



Performance Alignment

Translate data → actionable insights

Align with **UDS, HRSA, Value-Based Care**

Accurate data (validation, hygiene, entry)

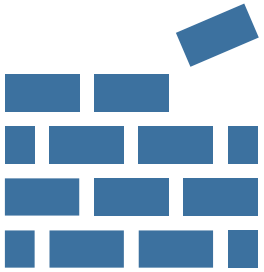
Data Support & Engagement

Technical assistance on MAP BP workflows

Monthly **DRVS User Groups**

Build data literacy across teams

CLINICAL EDUCATION TEAM



Foundation Building

Driven by Data

Focused on Culture

CLINICAL EDUCATION DELIVERY MODEL

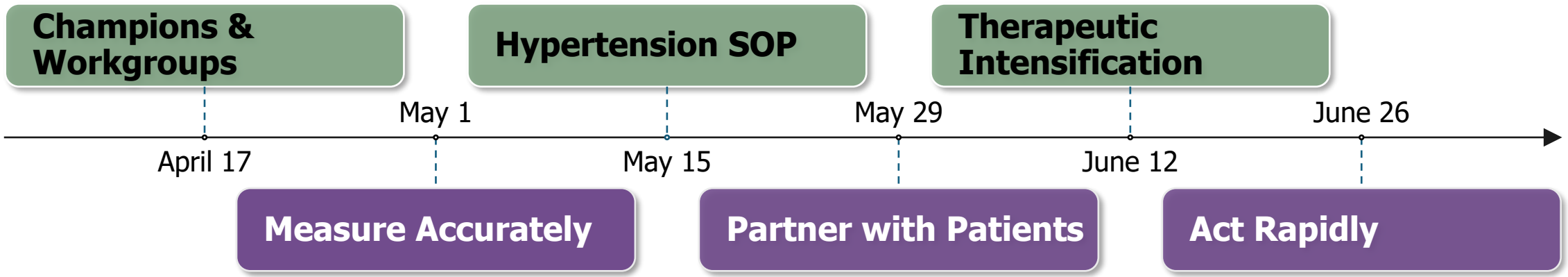
NETWORK-WIDE STRATEGY

Minimal-coaching model embedded into existing network structures

AMA MAP™

CLINICAL EDUCATION DELIEVERY MODEL

TARGETED STRATEGY – QAL COHORT



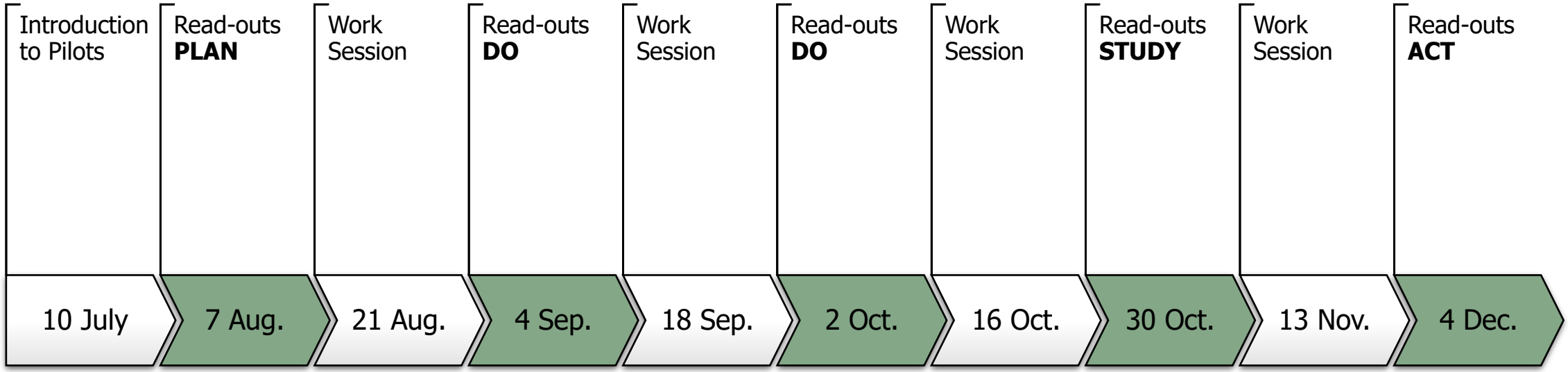
Quality Action Lab (QAL) Cohort Participants:

Axis Health Systems
Colorado Coalition for the Homeless
High Plains Community Health Center
Inner City Health
Mountain Family Health Center
Pueblo Community Health Center
River Valley Family Health Center
STRIDE Community Health Center
Uncompahgre Medical Center
Valley-Wide Health

AMA MAP™

2025 QAL PILOT TIMELINE

PDSA structure used to guide testing, accountability, and peer learning



PILOT OPTIONS TIED TO AMA MAP HTN FRAMEWORK

M — Self-Measured Blood Pressure (SMBP)

- Strengthen SMBP by standardizing how your clinic trains patients, captures readings, and uses data in decision-making.
- Support patient engagement while improving accuracy and continuity of BP management.

A — Therapeutic Intensification

- Create protocols to guide timely med adjustments when BP is consistently above goal.
- Define when and how care teams escalate treatment, with workflows that support consistent follow-through.

P — Remote Patient Monitoring (RPM)

- Implement RPM by enrolling eligible patients and building workflows for device setup, data tracking, and care team response.
- Use real-time home BP data to support early intervention and improve control.

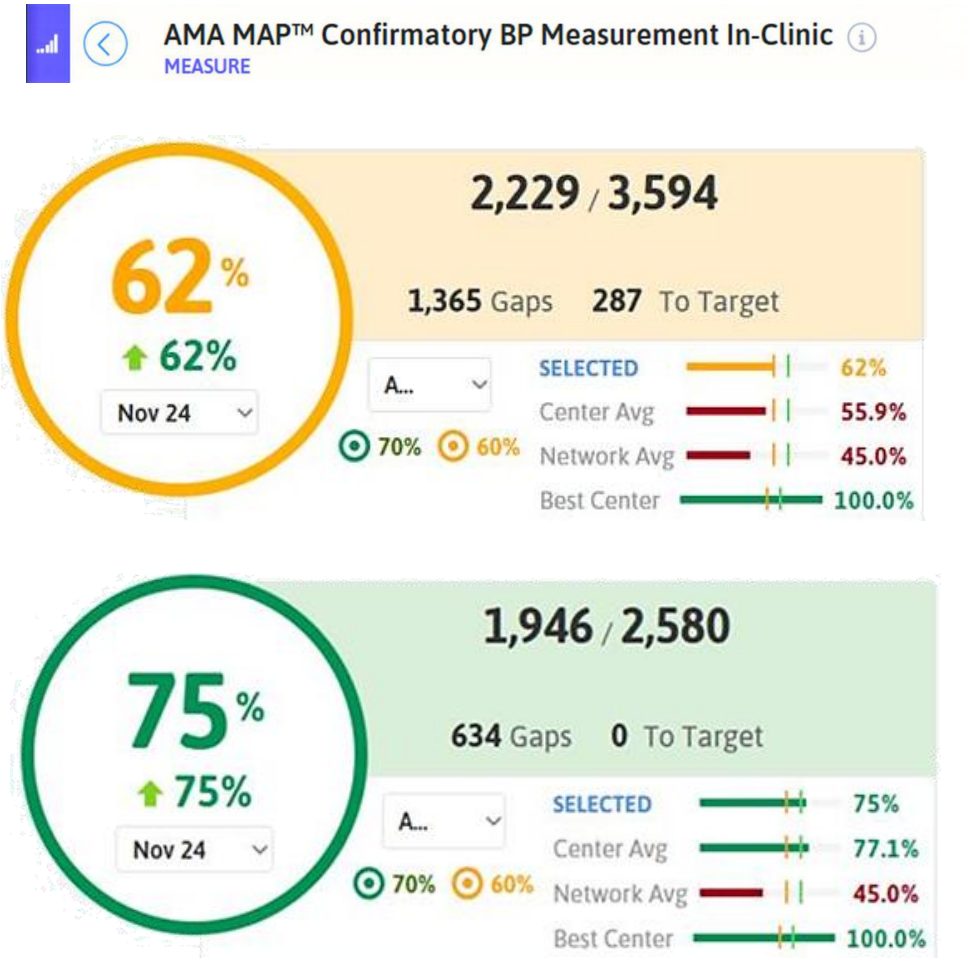
AMA MAP HYPERTENSION METRICS AND REPORTS SUITE

The AMA MAP Hypertension metrics support each component of the MAP framework and program. Additional details are included in the Foundational Activities to Operationalize AMA MAP section of this playbook.

Here is an overview of the metrics, descriptions and proposed goals:

Metric name	Brief description	Proposed goal
AMA MAP™ Confirmatory Blood Pressure Measurement	The percentage of office encounters with patients aged 18 to 85 years old with a high initial blood pressure followed by a confirmatory blood pressure measurement.	70%
AMA MAP™ Antihypertensive Medication Intensification	The percentage of encounters with patients aged 18 to 85 years old with a diagnosis of hypertension and an uncontrolled blood pressure that have an antihypertensive medication intensification.	30%
AMA MAP™ SBP Reduction After Medication Intensification	The percentage of encounters with patients aged 18 to 85 years old with a diagnosis of hypertension who have a reduction in systolic blood pressure following an antihypertensive medication intensification.	70%
AMA MAP™ Blood Pressure Follow-Up	The percentage of encounters with patients aged 18 to 85 years old with a high blood pressure who then have a follow-up encounter with a blood pressure within 30 days.	50%

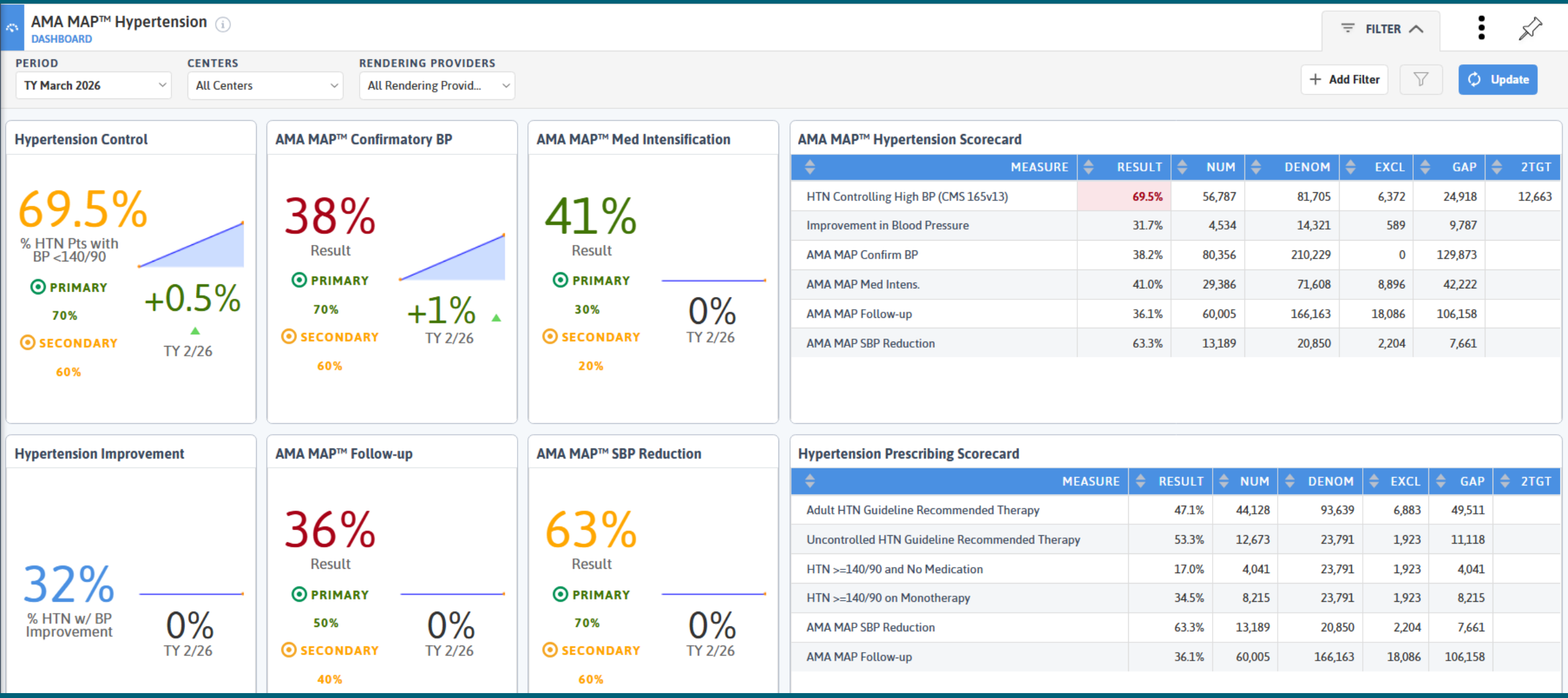
DRIVEN BY DATA



- Integrated internal **dashboards** to strengthen data-driven culture in both Quality Assurance Lab and Practice Transformation Meetings
- Used PT meetings to reinforce accountability and support workflow adoption
- Promoted use of **DRVS AMA MAP HTN Dashboard** for real-time tracking
- Drove project metrics and consistently informed CHCs of their progress

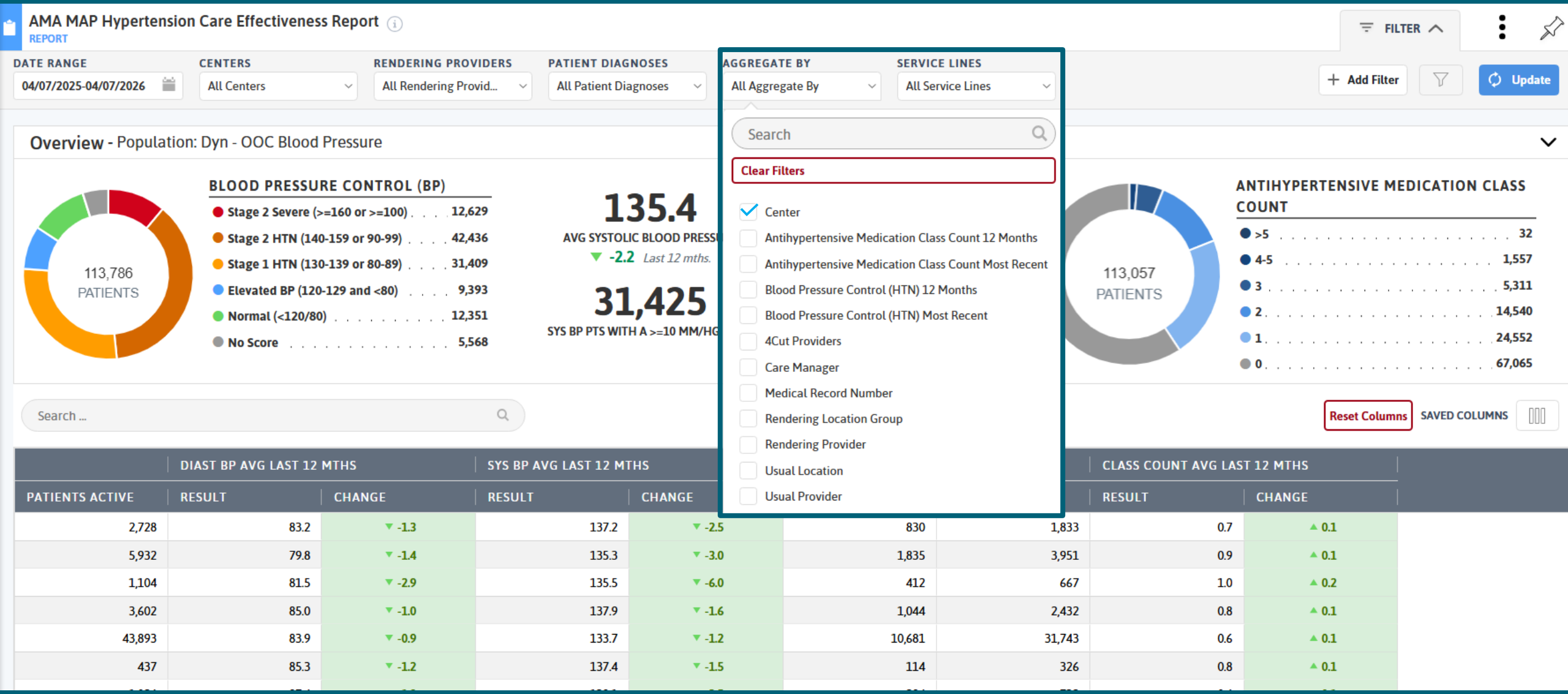
AMA MAP™

AMA MAP™ HYPERTENSION DASHBOARD
CARINA HEALTH NETWORK



AMA MAP HYPERTENSION CER (BY CENTER)

CARINA HEALTH NETWORK



	DIAST BP AVG LAST 12 MTHS		SYS BP AVG LAST 12 MTHS				CLASS COUNT AVG LAST 12 MTHS	
PATIENTS ACTIVE	RESULT	CHANGE	RESULT	CHANGE			RESULT	CHANGE
2,728	83.2	▼ -1.3	137.2	▼ -2.5	830	1,833	0.7	▲ 0.1
5,932	79.8	▼ -1.4	135.3	▼ -3.0	1,835	3,951	0.9	▲ 0.1
1,104	81.5	▼ -2.9	135.5	▼ -6.0	412	667	1.0	▲ 0.2
3,602	85.0	▼ -1.0	137.9	▼ -1.6	1,044	2,432	0.8	▲ 0.1
43,893	83.9	▼ -0.9	133.7	▼ -1.2	10,681	31,743	0.6	▲ 0.1
437	85.3	▼ -1.2	137.4	▼ -1.5	114	326	0.8	▲ 0.1

SUCCESSES

22%

QAL Cohort Improvement

7%

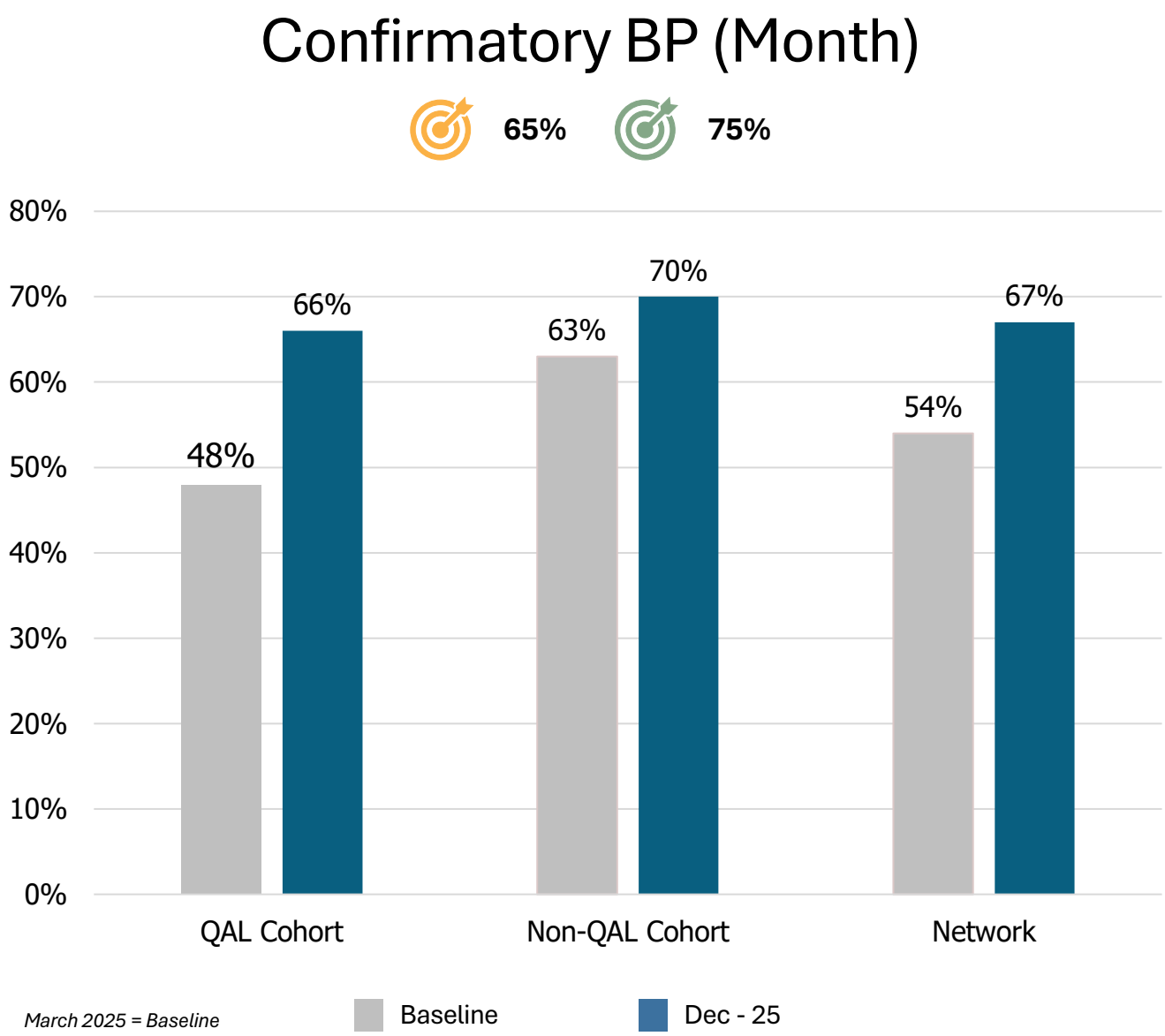
Non-QAL Cohort Improvement

13%

Network Improvement

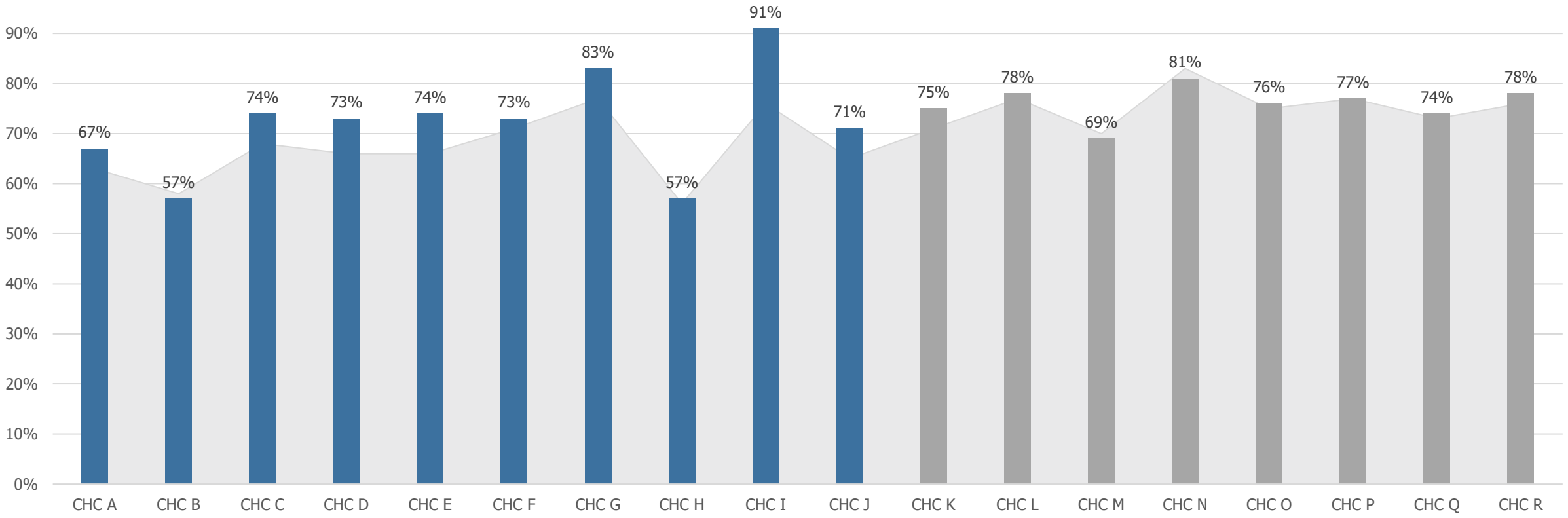
Discovery

33% of confirmatory BP results showed patients were in control.



HYPERTENSION CONTROL

March 2025 vs December 2025



Quality Action Lab Cohort

5% Average improvement from baseline

15% Greatest improvement from baseline

Non-Quality Action Lab Cohort

1% Average improvement from baseline

5% Greatest improvement from baseline

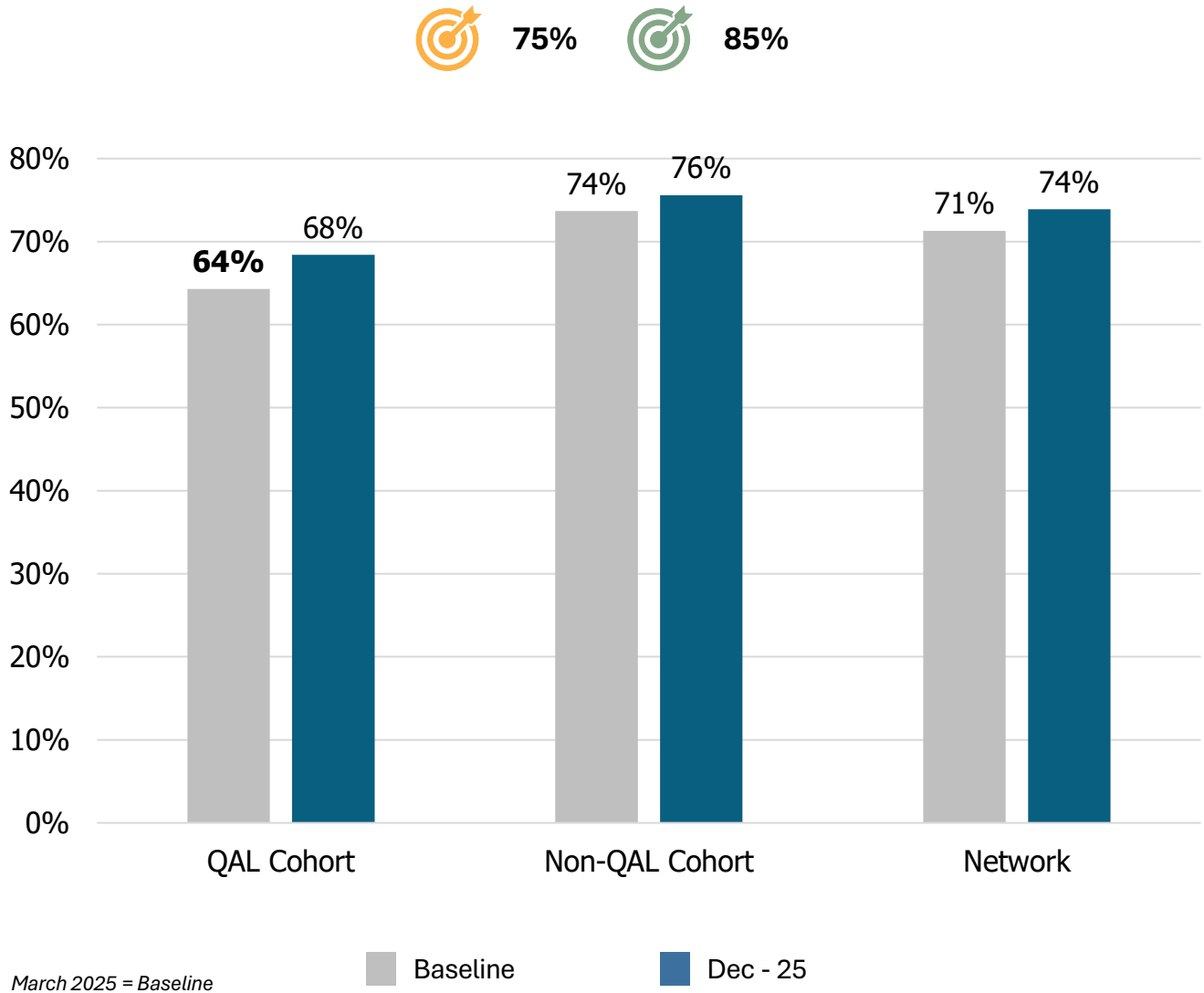
Number of patients positively impacted since baseline:

Network
2,646 Patients

QAL Cohort
1,511 Patients

Non QAL Cohort
1,135 Patients

Hypertension Control (TY)



March 2025 = Baseline

POPULATION HEALTH MANAGEMENT TRANSFORMATION

Shift from reporting to **real-time performance management** using Azara DRVS.

Greater use of data for **proactive patient outreach and follow-up** with help of Azara Patient Outreach (APO).

Stronger **data trust**, **validation practices**, and **cross-team collaboration**

EMBRACING THE AMA FRAMEWORK IN 2025

WHAT CHANGED FOR MOUNTAIN FAMILY

Embracing Azara

Continued tracking HTN Controlling High BP(CMS165v13)

Started tracking AMA Metrics:

- Confirmatory BP
- Follow-up Visits within 4 Weeks

Started using the **AMA MAP™ Hypertension Scorecard** and **Care Effectiveness Reports (CERs)**

Patient Engagement

Targeted patients for outreach with CER

Started using the **Azara Patient Outreach** Tool

Intentional patient education related to chronic condition

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EMBRACING THE AMA FRAMEWORK IN 2025

WHAT CHANGED FOR MOUNTAIN FAMILY (CONTINUED)

Team-based Care

Providers, RNs, & MAs

QI Team

Population Health Team

Site Leadership

Front Desk

Call Center

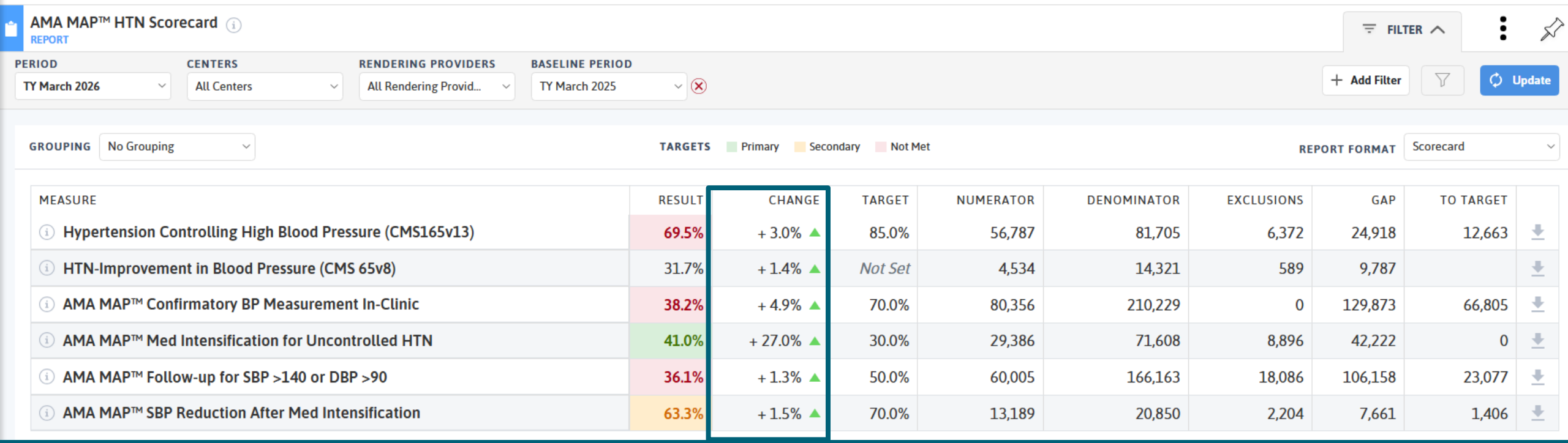
Improvement Approach

- QI team set goals (org/location)
  - Outcome & Process Measures
- Staff education regarding role within hypertension management
- Provider training on exclusion codes
- Weekly review of process measures
- Weekly outreach to patients
- Timers for confirmatory BP reminders
- Patient passports to support follow-up

Mountain Family HEALTH CENTERS

AMA MAP™ Hypertension Scorecard

CARINA TY MAR 25-TY MAR 26



AMA MAP™ HTN Scorecard
REPORT

FILTER

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

Add Filter | Update

GROUPING: No Grouping | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: Scorecard

MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	GAP	TO TARGET
Hypertension Controlling High Blood Pressure (CMS165v13)	69.5%	+ 3.0% ▲	85.0%	56,787	81,705	6,372	24,918	12,663
HTN-Improvement in Blood Pressure (CMS 65v8)	31.7%	+ 1.4% ▲	*Not Set*	4,534	14,321	589	9,787	
AMA MAP™ Confirmatory BP Measurement In-Clinic	38.2%	+ 4.9% ▲	70.0%	80,356	210,229	0	129,873	66,805
AMA MAP™ Med Intensification for Uncontrolled HTN	41.0%	+ 27.0% ▲	30.0%	29,386	71,608	8,896	42,222	0
AMA MAP™ Follow-up for SBP >140 or DBP >90	36.1%	+ 1.3% ▲	50.0%	60,005	166,163	18,086	106,158	23,077
AMA MAP™ SBP Reduction After Med Intensification	63.3%	+ 1.5% ▲	70.0%	13,189	20,850	2,204	7,661	1,406

MOUNTAIN FAMILY HEALTH CENTERS

MEDICATION INTENSIFICATION PDSA

WHO

Project Sponsor

Project Lead

Supporting Champions

WHAT

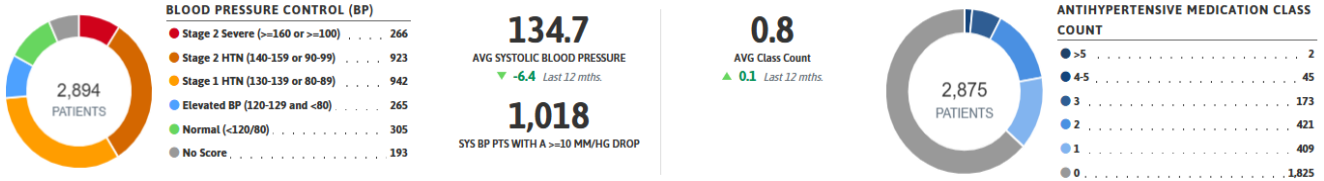
Increase HTN controlling blood pressure performance from

68% to **75%**

by the end of 2025

HOW

- Created Medication Intensification tool for clinicians
- Provided training for established and newly licensed clinicians
- Identified patients at Stage 2 Hypertension through the AMA Hypertension CER
- RNs provided patient education



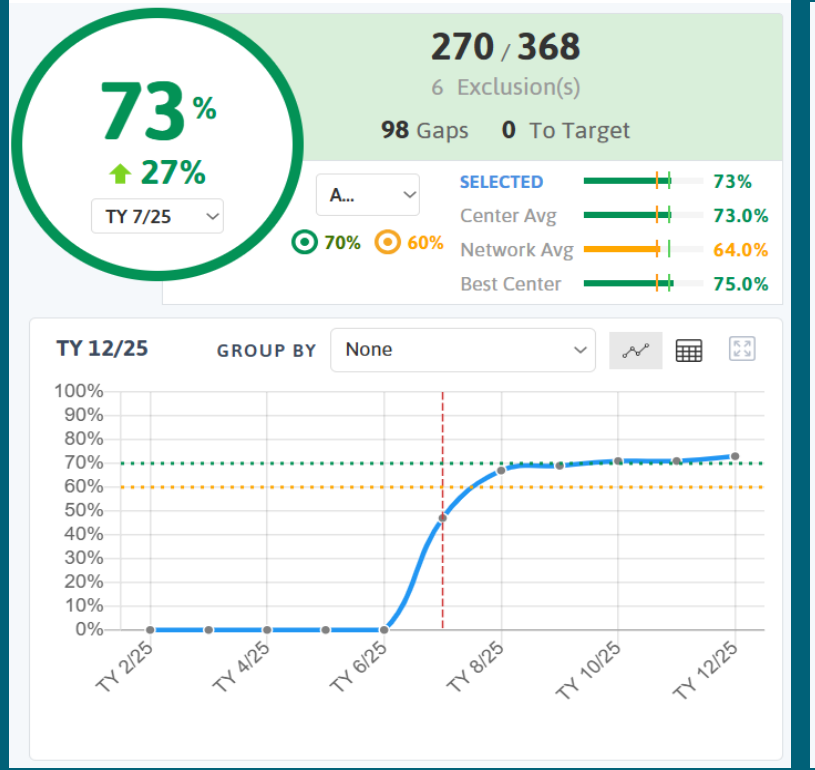
Plan, Do, Study, Act

MOUNTAIN FAMILY HEALTH CENTERS

WHAT WENT WELL

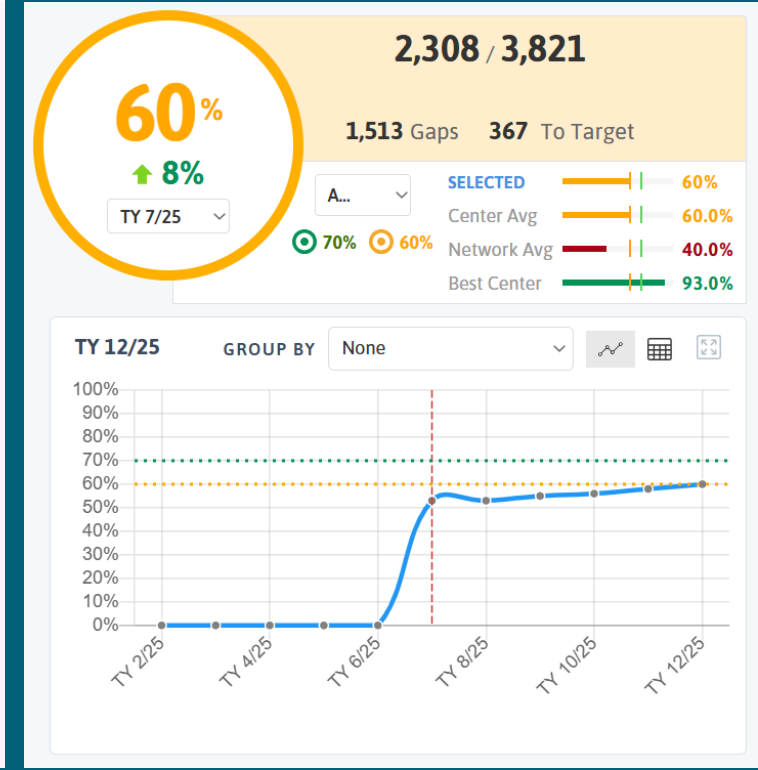
AMA MAP™ SBP Reduction After Med Intensification

MEASURE



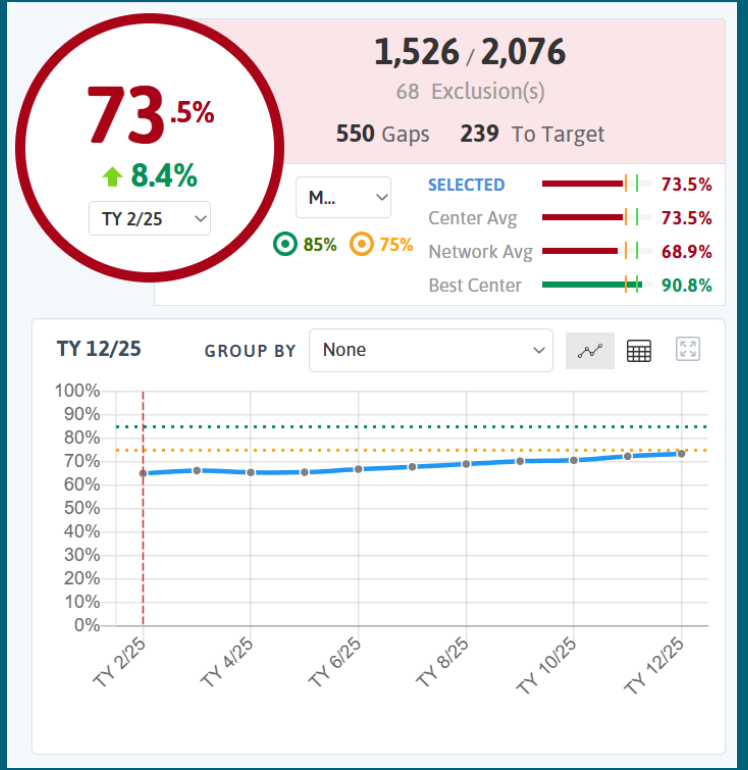
AMA MAP™ Confirmatory BP Measurement In-Clinic

MEASURE



Hypertension Controlling High Blood Pressure (CMS165v13)

MEASURE



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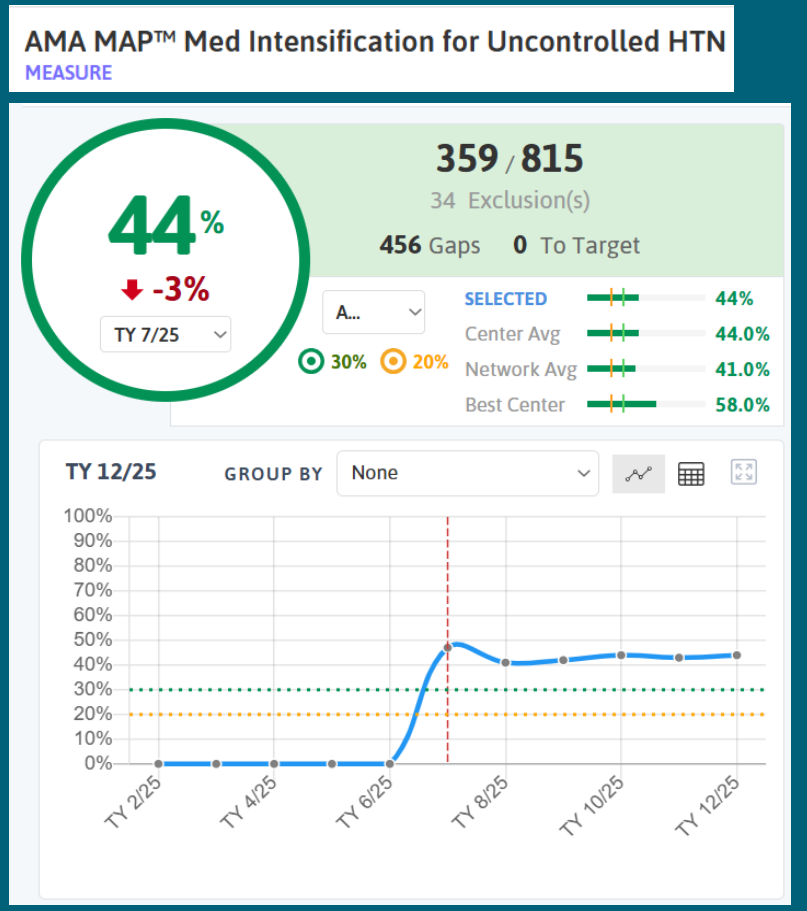
HEALTH CENTERS

MOUNTAIN FAMILY HEALTH CENTERS

CHALLENGES

- Gaps in provider knowledge (pregnancy pathways, labetalol, CCB use)
- Inconsistent workup for secondary causes (renin/angiotensin, OSA, renal disease)
- Patient education not reliably delivered (NSAIDs, alcohol, tobacco)
- Variation in nurse education materials across sites



Mountain Family
HEALTH CENTERS

EMBRACING THE AMA FRAMEWORK IN 2025

WHAT CHANGED FOR VALLEY-WIDE

Embracing Azara

- Continued tracking HTN Controlling High BP(CMS165v13)
- Started tracking Confirmatory BP **Measures Grouped by location**
- Started using **Azara Registries**

Patient Engagement

- Intentional patient education related to chronic condition
- Patient works with Pod Support to schedule 3-4 wk. follow-up with provider or RN
- Patients reported positive experiences

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EMBRACING THE AMA FRAMEWORK IN 2025

WHAT CHANGED FOR VALLEY-WIDE (CONTINUED)

Team-Based Care

- Providers, RNs, & MAs
- Pod Support
- QI Team
  - Healthcare Informatics Specialist

Improvement Approach

- Providers set BP goals with the patient
- QI team set goals (org/location)
  - Outcome & Process Measures
- Targeted PDSA cycles org-wide

Valley-Wide Health Systems, Inc.

VALLEY-WIDE HEALTH CENTERS
SELF-MONITORING BLOOD PRESSURE (SMBP) PDSA

WHO

Project Sponsor

Project Lead

Supporting Champions

WHAT

Increase HTN controlling blood pressure performance from

69.3% to **75%**

by the end of 2025

HOW

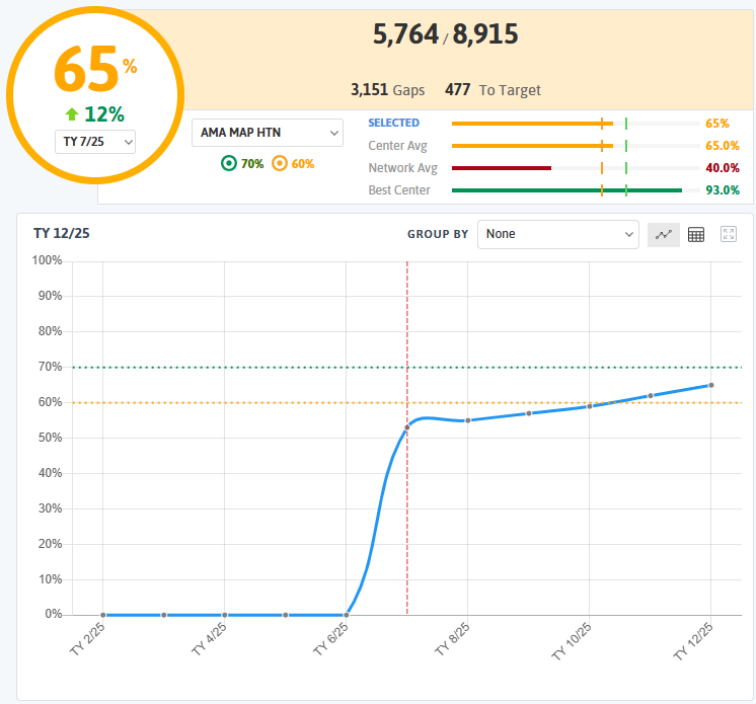
- Provided no-cost Home BP monitors
- Education during clinical visits
  - Teach-back method
  - Provider goal for SMBP readings
- Lead RN tracked individual provider metrics monthly
  - Whiteboard in pod(s)
- Tracked BP cuff distribution with SMBP registry

- My BP Log
- BP Measurement Instructions
- Consequences of High BP
- What Can I Do To Improve My High BP?

Plan, Do, Study, Act

VALLEY-WIDE HEALTH SYSTEMS
WHAT WENT WELL

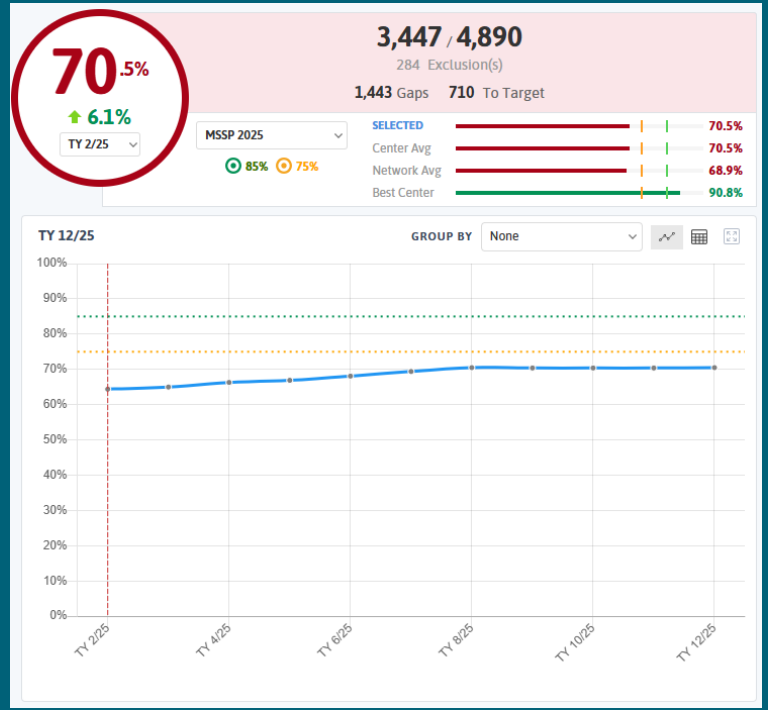
AMA MAP™ Confirmatory BP Measurement In-Clinic
MEASURE



AMA MAP™ Confirmatory BP Measurement In-Clinic
MEASURE

LOCATION - RENDERING	RESULT	CHANGE
Moffat Family Health Center	100%	+ 14% ▲
The Pulse	100%	+ 33% ▲
San Luis Health Center	95%	+ 8% ▲
Sierra Blanca Medical Center	95%	+ 11% ▲
Convenient Care Community Cl...	91%	+ 5% ▲
Edward M Kennedy Health Clinic	90%	- 1% ▼
Rocky Ford Clinic	84%	0%
Valley Wide Buena Vista	75%	+ 7% ▲
Cesar Chavez Family Medical C...	74%	+ 11% ▲
Valley Wide Canon City	74%	+ 3% ▲
Valley Wide Ordway	74%	+ 15% ▲
Alamosa Family Medical Center	73%	+ 17% ▲
Guadalupe Health Center	73%	+ 40% ▲
La Junta Clinic	68%	+ 4% ▲
Rock Creek Family Medicine	31%	- 21% ▼
Las Animas Clinic	20%	- 36% ▼

Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE



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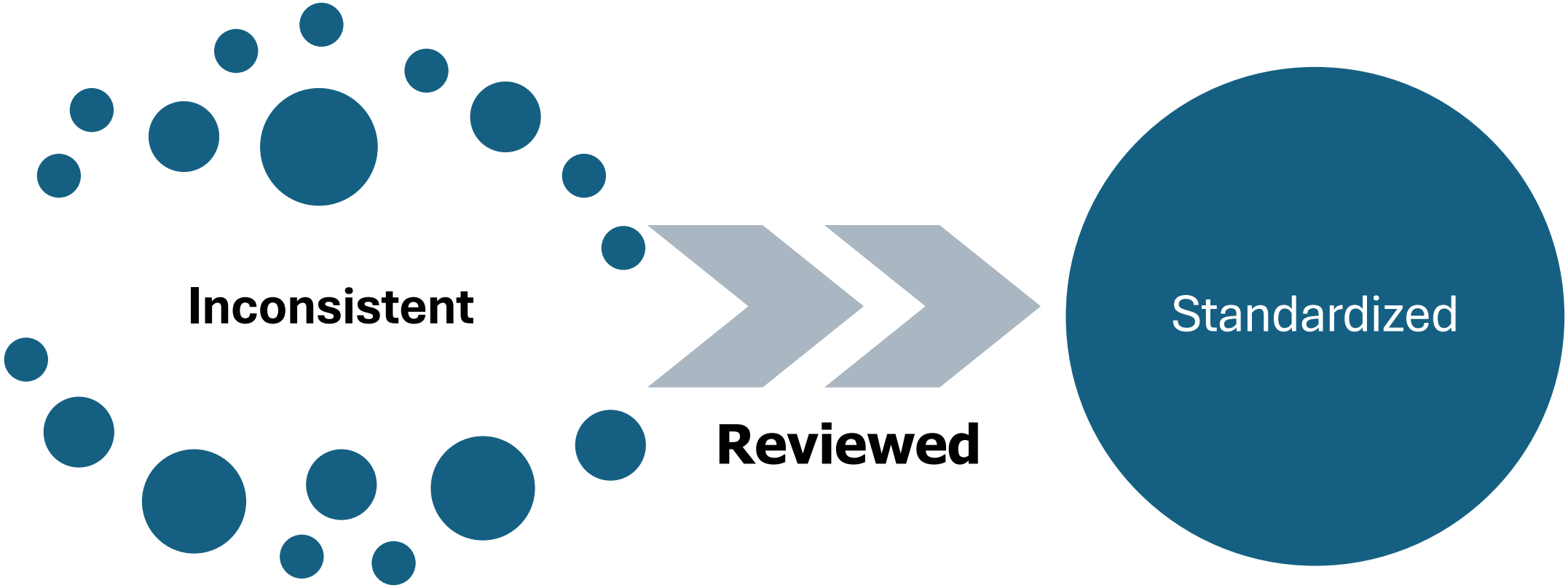
VALLEY-WIDE HEALTH SYSTEMS

IMPLEMENTATION CHALLENGES



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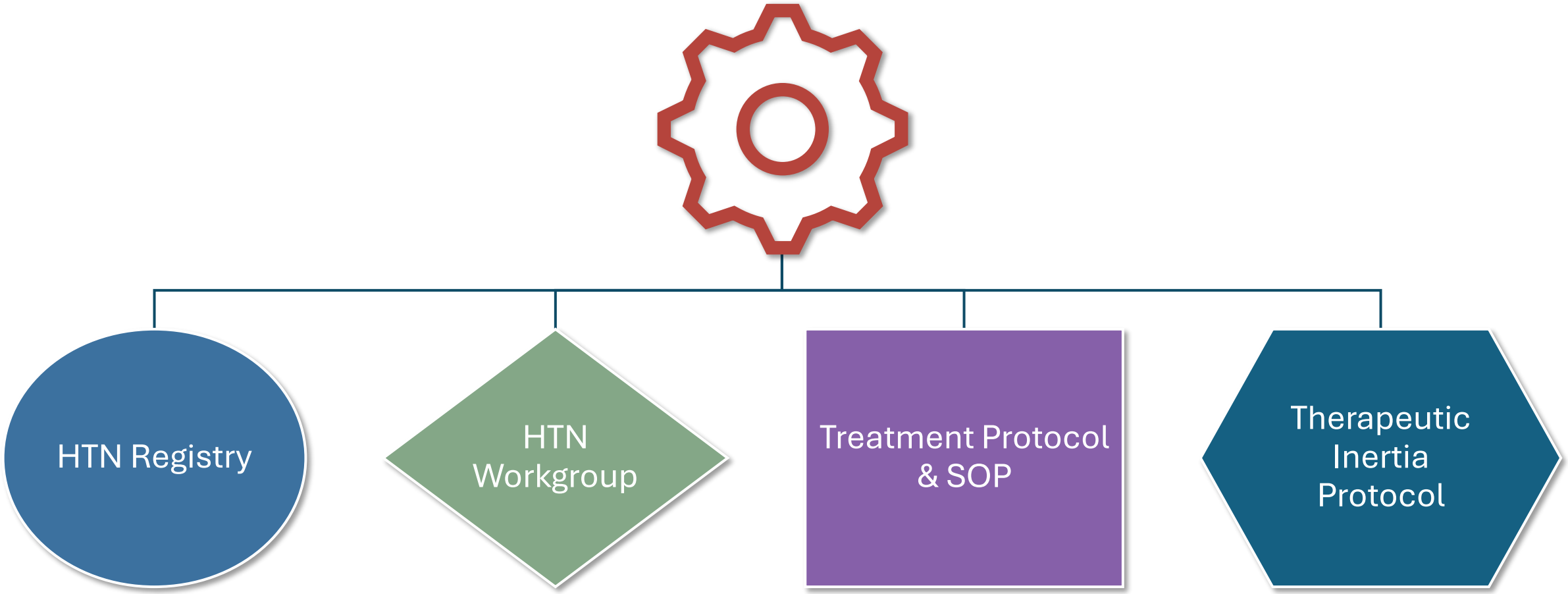
PARTICIPANT DRIVEN-PRIORITIES FOR 2026

Based on consistent 2025 feedback, these high-impact workflows were identified as key areas for focused implementation



QUALITY AS A STRATEGY, NOT A DEPARTMENT

Accountability

Report-out sessions

Shared visibility & ownership

Collaboration

Work Sessions

Team-based care, cross-functional collaboration, group problem-solving

Mindset

Process Over Outcomes

“I can’t impact that”
to
“I can change this”

Data Visualization

Expanded Azara Use

Registries, workflows, performance tracking

NETWORK LEVEL IMPACT ACROSS HEALTH CENTERS

HCCN PERSPECTIVE

Data Successes

- Standardized AMA MAP HTN metrics and reporting across all CHCs
- Network-wide DRVS adoption enabling timely, transparent data access
- Improved data completeness, validation, and trust

Culture Observations

- Growth in peer learning and shared improvement strategies
- Shift to proactive, data-driven performance management

ENABLERS OF SUSTAINABLE CHANGE

HCCN LESSONS LEARNED & KEYS TO SUCCESS

Lessons Learned	Data quality is foundational to driving improvement	Standardization + local flexibility is critical	Technical assistance and coaching are essential for adoption	Sustained change requires ongoing engagement and reinforcement
Keys to Success	Centralized infrastructure through Azara DRVS	Regular performance review cadence with actionable insights	Embedded QALs, user groups, and peer learning environments	

WHAT'S IN STORE FOR 2026

NEXT STEPS FOR MOUNTAIN FAMILY

Continue to:

- Use patient passports and RPM workflows to support engagement
- Maintain Confirmatory BP workflows (second readings, timers, reminders)
- Track and schedule follow-ups for elevated BP
- Leverage CER for HTN management and outreach
- Sustain goal review, medication intensification, and patient education

Building on 2025 Success

Implementing/Strengthening:

- Standardize Confirmatory BP workflows and home BP averaging across sites
- Improve follow-up completion and reduce no-show impact
- Expand provider education on HTN algorithm, pregnancy track, and medication pathways
- Strengthen screening for secondary causes and medication decision-making
- Standardize education and problem list management

Mountain Family HEALTH CENTERS

NEXT STEPS FOR VALLEY-WIDE

Continue to:

- Leverage Azara + HTN registry for outreach & med intensification
- Maintain core measures: CMS165v13, Confirmatory BP (target >70% control)
- Sustain team-based care + established 2025 workflows
- Distribute BP monitors with standardized patient education
- Schedule follow-ups before patient leaves clinic

Building on 2025 Success

Implementing/Strengthening:

- Expand AMA MAP measures (Follow-up After Uncontrolled BP, Med intensification)
- Increase BP cuff distribution (+10%)
- Enhance DRVS use for proactive outreach
- Expand RN/MA-led follow-up visits (per provider care plans)
- Standardize patient engagement strategies

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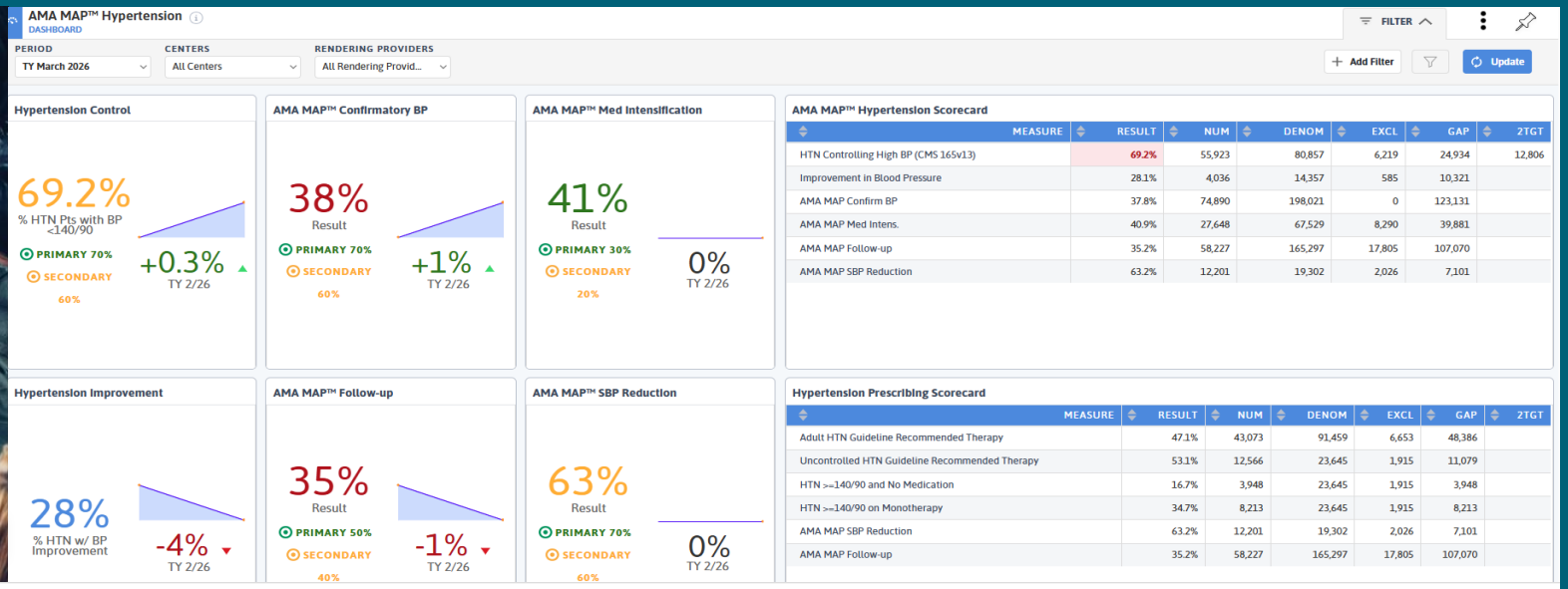
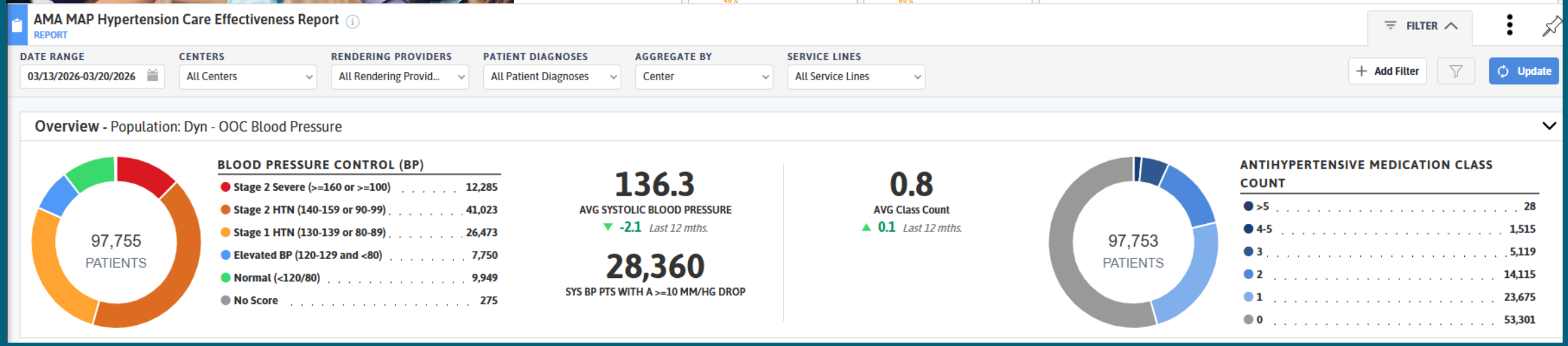
NETWORK FOCUS FOR 2026

HCCN POINT OF VIEW





NEXT STEPS FOR PRACTICE TRANSFORMATION

- ✓Continue Quality Action Labs
  - ❑Focus on key lead measures:
    - ❑ Confirmatory BP
    - ❑ Follow-up within 4 weeks
    - ❑ Medication intensification
- ✓Support targeted work through:
  - ❑ 1:1 coaching for all health centers
  - ❑ Up-to-date resources for HTN
  - ❑ Grant/project opportunities

Support Modalities

- Small group coaching to activate workgroups and strengthen roles
- 1:1 coaching to apply DRVS registries and reports
- Support protocol adoption using Carina pocket guides and resources
- Strengthen workflows for efficient, point-of-care decision-making

THANK YOU.

For questions, please contact the following:

Carina Practice Transformation – MacKenzie Chackman (macKenzie.chackman@carinahealth.org)
Carina Performance Programs – Meredith Munoz (meredith.munoz@carinahealth.org)
Valley-Wide Health Systems – Ashley Absmeier-Koppenhafer (AbsmeierA@valley-widehealth.org)
Mountain Family Health Centers – Silvia Santana (ssantana@mountainfamily.org)

Questions?

azara
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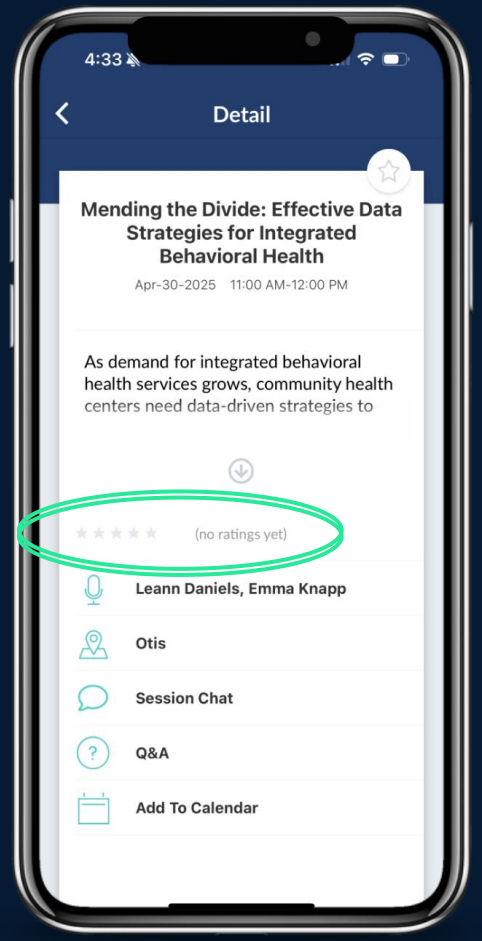

Quick and Easy

Provide brief feedback or ideas

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Thanks for attending!