

How Utah Navajo Health System Unified Chronic Care Management Across Rural Tribal Communities

With Azara Care Connect, UNHS is improving and supporting sustainable care delivery in one of the nation's most remote care environments



Organization

Utah Navajo Health System (UNHS) is a federally designated 330(e) Community Health Center serving approximately 15,000 patients annually across the remote Four Corners region of southeastern Utah. Geographic isolation, transportation barriers, and limited specialty access create significant challenges for both patients and their care teams.

UNHS supports more than 500 employees and 50 providers delivering integrated medical, dental, behavioral health, pharmacy, EMS, and transportation services to a geographically dispersed population spanning rural and tribal communities. Many patients travel several hours for specialty care, while others face barriers tied to food insecurity, limited broadband access, and inconsistent transportation.

As chronic disease rates and care coordination demands increased, so did the operational complexity of managing patient follow-up across multiple programs and care settings. UNHS teams were coordinating Chronic Care Management (CCM), Transitional Care Management (TCM), behavioral health outreach, diabetes education, and other follow-up initiatives through fragmented workflows that required staff to move between systems, manually track outreach, and document activities in multiple places.

For care teams operating in an already resource-constrained environment, these disconnected processes made it difficult to consistently monitor patient engagement, coordinate follow-up activities, track billable time, and maintain visibility into what work had been completed versus what still required attention.

“We needed a solution where we could track everything we needed to and document that,” said Heidi Riphenburg, MPH, Director of Quality Improvement at Utah Navajo Health System. “We wanted one place to manage workflows instead of jumping between systems and manually tracking everything.”

Challenge

As care coordination programs expanded across the organization, UNHS struggled to manage growing outreach, documentation, follow-up, and reporting demands through workflows that were largely manual and disconnected across systems.

Existing care plan functionality within the organization’s EHR was difficult to navigate, required extensive manual documentation, and lacked the workflow functionality needed to support coordinated, longitudinal care management. Staff frequently moved between multiple systems to document patient interactions, manage tasks, track outreach efforts, and monitor billing requirements.

The operational burden became increasingly difficult as UNHS expanded care coordination efforts across several distinct programs, including:

- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Newly diagnosed depression monitoring and behavioral health follow-up
- Diabetes Control Program (DCP) outreach

Each program carried its own documentation requirements, outreach timelines, reporting expectations, and care coordination workflows.

“We were looking for a platform where we could do all of this in one place and not be jumping around between systems,” said Riphenburg. “Managing multiple programs across different systems made reporting, coordination, and follow-up much harder than it needed to be.”

The organization also faced unique challenges tied to its rural and tribal patient population. Many patients travel two to five hours for specialty care, often requiring hospitalization outside the local area.

Limited transportation access, connectivity barriers, and financial constraints make consistent follow-up particularly difficult, especially for patients managing multiple chronic conditions.

At the same time, UNHS needed better visibility into staff workload, patient engagement, and program productivity. Leadership needed a way to demonstrate the value of both billable and non-billable care coordination activities while ensuring limited staff resources were being deployed effectively.

For a small care coordination team operating across multiple high-need populations, success required more than better reporting. UNHS needed a centralized operational platform capable of standardizing workflows, improving visibility, supporting care team collaboration, and embedding care coordination directly into daily clinical operations.



The Solution

To streamline care coordination and centralize workflows across its chronic care programs, UNHS partnered with Azara Healthcare to implement Azara Care Connect (ACC), a care coordination application designed to unify patient outreach, documentation, task management, care planning, and program oversight within a single environment.

Built on the Azara DRVS population health management and analytics platform, ACC combines real-time data visibility with workflow management tools that help care teams create care plans, coordinate follow-up activities, monitor patient engagement, track billable time, and manage outreach across multiple care programs.

Rather than managing multiple disconnected workflows across separate systems, UNHS used Azara DRVS with ACC to create a centralized operational infrastructure capable of supporting both billable and non-billable care coordination activities within a single environment.

UNHS initially focused implementation efforts on Chronic Care Management (CCM) and Transitional Care Management (TCM), using ACC to standardize patient identification, automate follow-up workflows, support time tracking for billing, and improve communication between care team members.

Key capabilities included:

- Centralized care coordination documentation
- Real-time task assignment and follow-up tracking
- Automated patient cohort identification
- Billing time tracking for CCM reimbursement
- Hospital discharge monitoring through HIE integration
- Standardized transitional care workflows
- Shared visibility across care coordination teams

As adoption expanded, UNHS extended ACC into additional workflows, including behavioral health follow-up, diabetes outreach, and depression monitoring programs.

For behavioral health teams, ACC enabled staff to track patients with a new depression diagnosis, manage follow-up outreach, and document patient engagement activities in a more structured and visible way. Within the Diabetes Control Program, care teams used ACC to identify high-risk patients, coordinate outreach, and document education and follow-up efforts for patients managing diabetes and prediabetes.

Importantly, ACC allowed UNHS to support programs that extended beyond traditional reimbursement models. While CCM billing remained an important use case, the organization also leveraged the platform to coordinate non-billable outreach activities tied to behavioral health, diabetes education, and preventive care initiatives.

This flexibility helped transform ACC from a single-program solution into a broader operational foundation for care coordination across the organization.

1. Scaling Care Coordination Across Programs

With DRVS and Azara Care Connect in place, UNHS was able to standardize and modernize workflows across multiple care coordination initiatives, giving staff a more consistent and scalable way to manage complex patient populations.

2. Chronic Care Management (CCM)

ACC became the operational hub for UNHS's CCM program, allowing the care coordinator to document patient interactions, track monthly outreach requirements, monitor billable time, and maintain longitudinal care plans within a centralized workflow.

Rather than relying on manual tracking in spreadsheets or fragmented EHR documentation, staff could now manage patient engagement activities in real time while maintaining visibility into productivity and reimbursement requirements. For a care coordination program supported by limited staffing resources, this visibility was especially important.

3. Transitional Care Management (TCM)

UNHS also leveraged ACC to strengthen post-discharge follow-up and improve transitions of care for patients returning from emergency department visits or hospitalizations, many of which occurred hours away from the organization's primary service area.

Using Azara DRVS HIE integrations and automated workflows within ACC, care teams could identify discharged patients more quickly, assign follow-up tasks, schedule outreach, and document care coordination activities in a standardized manner. This helped reduce delays in patient outreach while improving consistency across transitional care workflows.

4. Behavioral Health and Diabetes Outreach

Beyond reimbursable care management programs, ACC also became a critical coordination tool for behavioral health and diabetes outreach initiatives. Behavioral health staff used ACC to track patients with new depression diagnoses and manage structured follow-up activities, while diabetes teams leveraged the platform to identify patients needing additional education, outreach, or preventive interventions.

Because all programs operated within the same centralized platform, teams were able to coordinate more effectively across disciplines while reducing duplicate documentation and fragmented communication. For UNHS, this represented a major operational shift, from isolated program management to a more connected, organization-wide approach to care coordination.

"One person can manage the CCM program because everything is centralized. You can see where patients are in the process, what outreach has happened, and what still needs to be done."

Heidi Riphenburg, MPH
*Director of Quality Improvement at
Utah Navajo Health System*

Results

By centralizing care coordination workflows within Azara Care Connect, UNHS transformed how its teams manage chronic disease outreach, transitional care follow-up, behavioral health coordination, and patient engagement across one of the country's most geographically challenging care environments.

Rather than relying on fragmented workflows and manual tracking processes, care teams now operate within a shared system that provides real-time visibility into patient status, outreach activities, assigned tasks, and follow-up requirements across programs.

One of the organization's most significant improvements came within Transitional Care Management workflows. Using ACC to standardize discharge monitoring and automate follow-up coordination, UNHS achieved a 73% increase in emergency department follow-up visits scheduled within one day of discharge.

This improvement helped strengthen continuity of care for patients returning from emergency departments and hospitals, many of which are located several hours away from the communities UNHS serves.

"We're always looking at ways to improve how we connect with patients and support our staff. Having a platform that allows us to coordinate care across programs gives us the flexibility to keep building and improving as our needs change."

Heidi Riphenburg, MPH
*Director of Quality Improvement at
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Additional organizational benefits included:

- Standardized workflows across multiple care coordination programs
- Improved visibility into patient outreach and staff productivity
- Better coordination between medical, behavioral health, and care management teams
- More efficient tracking of billable CCM activities
- Reduced reliance on manual spreadsheets and disconnected systems
- Greater consistency in patient follow-up and outreach activities

Importantly, ACC also gave leadership better insight into how limited staffing resources were being utilized across programs, allowing teams to more effectively prioritize outreach and coordinate care for high-risk patients.

"For us, this was really about creating structure," said Riphenburg. "Now we can see the work that's happening, track follow-up more consistently, and coordinate across programs in a way we couldn't before."

By creating a centralized operational foundation for care coordination, UNHS moved beyond isolated chronic care programs toward a more connected, scalable approach to managing complex patient populations across rural and tribal communities.

Impact Highlights



73% increase in ED follow-up visits scheduled within one day



Reduced reliance on manual tracking and disconnected systems



Improved coordination across medical and behavioral health teams



Greater visibility into care management workflows and staff productivity

Looking Ahead

Utah Navajo Health System continues to expand its use of Azara Care Connect as care coordination needs evolve across the organization.

Building on the success of its CCM, TCM, behavioral health, and diabetes outreach workflows, UNHS plans to further strengthen proactive patient engagement efforts, improve coordination across interdisciplinary teams, and expand standardized workflows for additional chronic disease and preventive care initiatives.

As value-based care expectations continue to grow, leadership sees centralized care coordination infrastructure as increasingly critical to sustaining high-quality care delivery in rural and underserved communities.

For organizations serving geographically dispersed and medically complex populations, UNHS's experience demonstrates that effective care coordination requires more than documentation alone. It requires operational infrastructure capable of connecting workflows, improving visibility, and supporting care teams in real time.

Through Azara DRVS and Azara Care Connect, UNHS has built that foundation, creating a more coordinated, scalable model for chronic care management across rural tribal communities.

Delivering Coordinated Care Across the Four Corners Region

For patients served by Utah Navajo Health System, accessing care can require traveling several hours across remote rural and tribal communities.

To support these populations, UNHS needed a better way to coordinate:

- Chronic disease management
- Hospital follow-up
- Behavioral health outreach
- Diabetes education
- Patient engagement activities

Using Azara Care Connect, UNHS centralized care coordination workflows into a single operational platform, helping teams manage outreach, track follow-up, and support high-risk patients more consistently across programs.



Learn more about how Azara Healthcare can support your organization by exploring the resources available in the DRVS Help section, contacting the Azara support team, or reaching out to your client success manager.

We at Azara can't wait to see what you will do!