

Azara Care Connect

Complete Care Management + Care Coordination Solution

A fully integrated solution to efficiently manage and coordinate care – leveraging your DRVS data to optimize performance.

Whether you're a Care Manager or Care Coordinator, Azara Care Connect's (ACC) features and functionality help manage the full spectrum of your organization's patient needs. ACC is designed to leverage the full set of clinical, claims, HIE and practice management data in Azara DRVS and makes it available in a simple and intuitive user interface. Care Coordinators are further enabled to improve productivity and efficiency, close care gaps, and track adherence to health plan contract requirements across a large population of patients.

Care Coordination

Simplify care coordination and increase performance by documenting outreach activities, prioritizing patients, and closing care gaps – all in one place.

Care Coordination enables your practice staff to organize patient data from health plans and DRVS to quickly and easily perform and document outreach and outcomes for each patient. These care coordination activities enable organizations to improve productivity and efficiency, close care gaps, and track adherence to health plan contract requirements—leading to increased performance on value-based care metrics and higher reimbursements.

REASON DETAILS	LAST OUTREACH	OUTREACHES	REPORTED	STATUS
<input type="checkbox"/> TOC: 10/27/2024 - St. Josephs Hospital: ER Visit	JB 11/07/24	1	10/28/24	Open
<input type="checkbox"/> CQM				
<input type="checkbox"/> BMI Screen & Follow-Up 18+ (CMS 69v12)	JB 11/07/24	2	08/07/24	Open
<input type="checkbox"/> HIV Screening (CMS 349v6)	JB 11/07/24	2	11/07/24	Open
<input type="checkbox"/> Depression Screening & Follow-Up (CMS 2v13)	JB 11/07/24	2	11/07/24	Open
<input type="checkbox"/> Medicare AWW	JB 11/07/24	2	11/07/24	Open

ACTION	SUMMARY	DUE	ASSIGNEE	COMMENTS
<input type="checkbox"/> Call	Call Pt within 2 days after discharge	03/10/25	Sam Owings	

Features & Benefits:

- Build patient care plans with integrated, evidence-based content from Elsevier.
- ACU integration to triage and prioritize members for outreach, driving better outcomes and performance across your population.
- Track completion of tasks and interventions provided across your population to close care gaps, lower ED and hospital utilization, and support best practices.
- Drive high-priority patient engagement with flexible filtering and built-in prioritization.
- Document, view, and complete outreach efforts.
- Set follow-up events in adherence with value-based agreements.
- Automate ingestion of monthly plan gaps with logic to prevent completed or out of date gaps from resurfacing.
- Quickly view medical and demographic information, active gaps, outreach notes, and history for each patient.

Care Management

Track components of patient care by reviewing and understanding a patient's longitudinal record in a synthesized view of data from multiple sources.

Care Management features enable practices to organize patients into groups of high cost, high risk or other characteristics, such as chronic diseases—allowing care management staff to effectively oversee and monitor a panel of patients by tracking the day-to-day tasks and follow-up activities related to their care to meet chronic care management and patient centered medical home program requirements.

Azara Cost & Utilization integration can also be leveraged to pinpoint high-risk, high-cost patients and seamlessly manage their care journey, ensuring every member receives the attention and support they need.

The screenshot displays the Azara Care Connect application interface. On the left, a 'Patients' list shows names and DOBs, such as BERGE, ZETTA (5/22/76) and BERONJUA, EVE (2/26/57). The main panel shows a patient profile for SMITH, ANDREA (MRN: 22222222, DOB: 1/1/49/55). The interface includes sections for 'NOTIFICATIONS' (Upcoming Appointment, ER Discharge, No Show), 'TASKS' (Call, Schedule), and 'ALERTS' (A1c, Colonoscopy, Eye, Mammogram). A 'CARE TEAM' section lists roles like Intervention Effort, Care Manager, Usual Provider, and Coordinator. A 'NOTES' section contains clinical observations.

Care Management can help solve a variety of patient challenges including:

- Identifying, Tracking and Closing Care Gaps
- Care Plan Creation and Management
- Following up on Transitions of Care
- Chronic Care Management
- Coordination of Hospice or Palliative Care
- Time Tracking & Documentation for Billing
- Prenatal/Postpartum Programs & Retention
- Care Managing High-Risk Populations

“The data coming out of the Care Connect application saves us tremendous time in the way of reporting performance/activity both internally and to our external Health Plan partners. **I would say the time savings is 70%**, as several of us invested a lot of time each month reviewing, cleaning and normalizing outreach activity data submitted independently by each CHW.”

Chris Hicks

Network Analytics Director | Michigan Community Health Network

Interested in learning more about Azara Care Connect?

Azara Care Connect is a separate application that leverages the data within Azara DRVS. It requires setup, configuration and a separate subscription.

Contact your practice, PCA/HCCN, Azara Representative or solutions@azarahealthcare.com for additional details, including pricing.

