

# **Azara Patient Outreach**

POWERFUL PATIENT ENGAGEMENT WITHIN DRVS

Azara Patient Outreach supports the efforts of Azara DRVS users to improve patient care and close care gaps by allowing them to conduct targeted outreach programs utilizing patient information already contained and curated within DRVS.

DRVS users can now engage patients through pre-configured "Set it and Forget it" programs that automatically initiate patient contact (text or automated call), track response and follow-up actions, adjust outreach efforts and quantify results. For any program conducted, users can view the efficacy and performance of the effort using DRVS Measures and the APO Campaign Performance Report to gain insights on patient response and impact on quality results. Staff can now prioritize their outreach workload to a much smaller set of unengaged patients—those who do not respond to the automated campaigns.

#### **Azara Patient Outreach allows users to:**

- Greatly expand the number of patients that can be reached
- Identify care gaps or soon to be due items (immunizations, well child visits, etc.)
- Initiate automated patient outreach via text
- Automatically move patients in and out of the program based on their actions/responses
- Report on measure improvement and response rates
- · Improve patient care and patient engagement
- Support and educate patients for wellness and chronic care management outside of office visits\*

#### **Patient Outreach Connector:**

Azara Patient Outreach programs and features seamlessly connect with industry leading outreach platforms through the Patient Outreach Connector. These interfaces quickly and easily integrate DRVS with our text messaging partners to effectively utilize your patient data and track and measure outreach efforts.







Azara Patient Outreach is an additional component of DRVS and not included within the basic DRVS Subscription. \*Education programs are currently only available through CareMessage



### WHY IS PATIENT OUTREACH SO IMPORTANT?



Texting is proven to be highly effective method to engage safety net patients



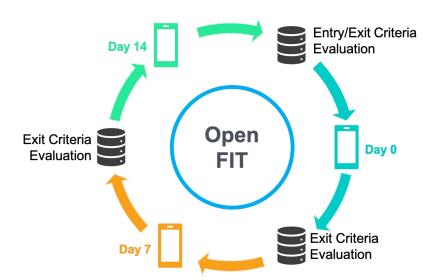
Improves patient engagement, interaction, and communication



Helps ensure patients get the care recommended for them



Provides quantifiable insight into program effectiveness and patient behavior





## **Programs Currently Available**

- Cancer Screenings (Breast, Cervical, Colorectal)
- Chlamydia Screening
- Chronic Kidney Disease
- Comprehensive Diabetes (Nephropathy, Eye and Foot Exam)
- COVID-19 Immunization
- Flu Vaccine
- Hypertension Medication Renewal and Adherence
- Hypertension (Undiagnosed, Control)
- Immunizations (Childhood, Adolescent)
- Medicaid Eligibility<sup>1,2</sup>
- <sup>1</sup>Requires Payer Integration
- <sup>2</sup>Requires redetermination date data
- <sup>3</sup>Requires Medicare rosters
- <sup>4</sup>Requires ADT data

- Medicare Annual Wellness Visits<sup>1,3</sup>
- Members without Visits<sup>1</sup>
- · Patients without Visits
- Open FIT
- Transitions of Care<sup>4</sup>
- Untested A1c / Uncontrolled A1c
- Well Child

"To have messages flow automatically to patients who need them and not those who don't enables us to focus on higher priority outreach."

HARPREET GREWAL
Population Health Specialist, Honor Community Health



