Boosting HCCN Grant Impact: How DRVS Tools Drive Better Outcomes

Louisiana Primary Care Association

April 2025

Today’s Presenters

Carrie Taylor

Director, Clinical Transformation

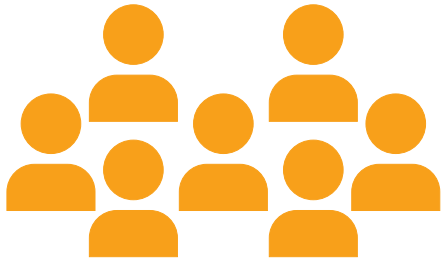
Azara Healthcare

Erin Murphy

Clinical Improvement Specialist

Azara Healthcare

Goals for the Day



TACKLING VALUE BASED CARE

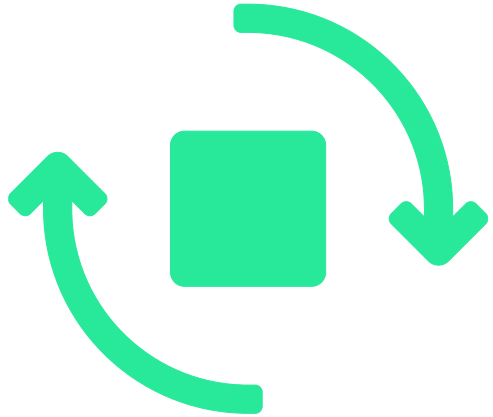
Understand the core principles of value-based care and how DRVS tools support these efforts

EXPLORE DRVS MODULES

Utilizing Azara Patient Outreach (APO) and Transitions of Care (TOC)

TEAM WORK MAKES THE DREAM WORK

Reviewing data hygiene practices & learning validation tools



UDS+ PREPAREDNESS

Understand the steps in submitting for UDS+ through Azara

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Louisiana DRVS Deployment

Health Centers

26

# of lives

371,239

Health Center IPAs and Networks

Louisiana Public Health Institute
LPCACO
LSU

PCA Name

Louisiana Primary Care Association

DRVS Population Health Analytics and Reporting

All data integrated into ONE SINGLE SYSTEM

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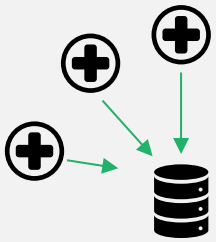
DRVS
Centralized Data Warehouse



EHR Data

eCW
eCW Triggerfish
NextGen
Athena
Intergy
CompuGroup
MyWinMed

HIE/RHIO

Greater New Orleans HIE (GNOHIE)

Enrollment

Wellcare
Aetna
UHC
Anthem
Amerihealth
Humana
(outside of BCBSLA)

Claims/Care Gaps

Wellcare
Aetna
UHC
Anthem
Amerihealth
Humana

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HCCN 2025 - 2028

Upcoming new cycle

Objectives & Activities

Obj. 1: Data Management & Analytics

Increase the percentage of PHCs that advance and optimize clinical, financial, and operations data to improve clinical quality, health outcomes, and operations.

1.1. Establish Data Governance Committee

1.2. Data Validation Workshops for DRVS Users

- **67%** (22/33) of PHCs reported utilizing a data analytics platform
  - 15% (5/33) rating the capacity to use data for quality improvement (QI) as "Excellent",
  - 18% (6/33) as "Good",
  - 64% (21/33) as "Fair",
  - 3% (1/33) at "Poor"

Challenges

- lack of staff expertise at 55% (18/33),
- data integration challenges at 64% (21/33),
- limited financial resources at 36% (12/33),
- inadequate data infrastructure at 27% (9/33),
- other complications (such as staffing needs, staff training, data conflicts between multiple platforms) at 12% (4/33).

Obj. 2: Interoperability and Data Sharing

Increase the percentage of PHCs that improve bidirectional interoperability with health care providers and community-based organizations

2.1. Build on Admit Discharge Transfer (ADT) Integration

2.2. Workplan Development in the PHCs

100% (33/33) sharing data with external healthcare providers & community-based organizations.

- 42% hospitals/ emergency rooms (14/33),
- 36% specialty providers (12/33),
- 94% labs or imaging (31/33),
- 61% HIEs (20/33),
- 70% state health department (23/33),
- 85% pharmacies (28/33).

Challenges

- technical challenges (85%, 28/33),
- lack of standardized data-sharing protocols (42%, 14/33),
- insufficient IT support (42%, 14/33),
- privacy /security concerns (21%, 7/33).

Obj. 3: UDS+ Implementation

Increase the percentage of PHCs that submit some or all disaggregated patient level data in their UDS + reports in each calendar year as required by AHA.

3.1. DRVS UDS+ Support

3.2. EHR UDS+ Support

9% (3/33) reported submitting "all data" for UDS+ data submission,

- 27% (9/33) only submitting "some data",
- 39% (13/33) not submitting any data,
- 24% (8/33) unsure about submitting any UDS data.

27% (9/33) PHCs reported participating in their EHR-specific vendor UDS+ testing

21% (7/33) reported participating in Azara DRVS UDS+ testing.

Needs

- additional training, technical assistance,
- guidance on optimizing current data systems, data validation, and
- health center-specific steps for UDS+ reporting.

Obj. 4: Artificial Intelligence

Increase the percentage of PHCs participating in T/TA designed to support the implementation of AI practices that adhere to industry ethical guidelines and established protocols

4.1. Azara User Groups

4.2. Educational Sessions on AI

- Reported "no" to actively utilizing any AI-related tools or processes at 52% (17/33)
- 21% (7/33) reported "yes" to actively utilizing AI-related tools or processes.
  - 45% (15/33) reported potential usage in clinical decision support,
  - 52% in predictive analytics for population health (17/33),
  - 48% in patient risk stratification (16/33).

Needs

- AI usage in healthcare training (58%) (19/33),
- tools / technology (64%) (21/33),
- policy and procedure templates (64%) (21/33),
- staffing resources (55%) (18/33).

Obj. 5: Additional Value-Based Care (VBC)

Increase the percentage of PHCs that use data to update operational processes in health IT systems to support VBC

5.1. Annual Economic Impact Study

5.2. Azara Patient Outreach Module

5.3. Provider Coding & Billing Trainings

- **78% (26/33)** of PHCs reported participating in an ACO & reported implementing clinical process improvements based on the data,
- 61% (20/33) reported use the data for financial management.

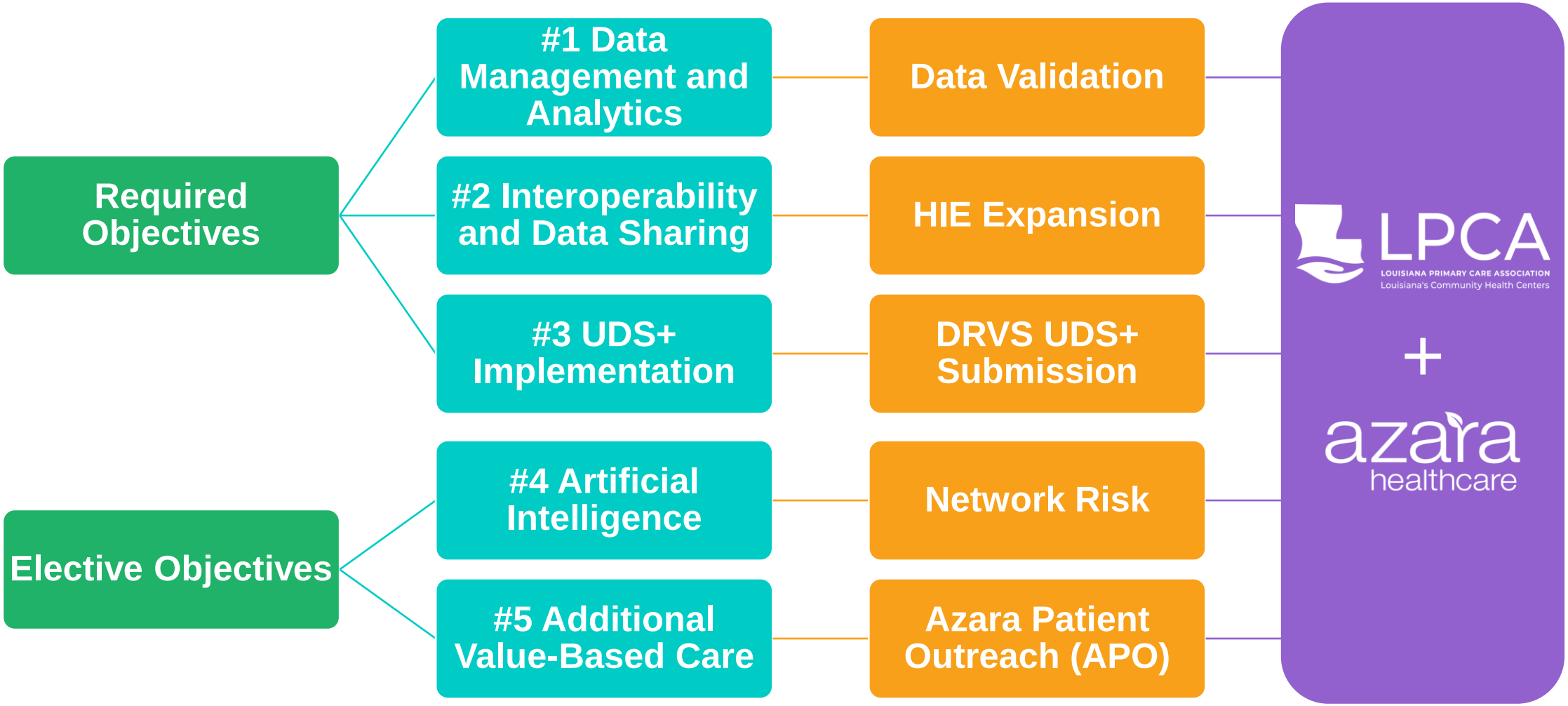
In assessing preparedness and readiness to expand VBC initiatives,

- 12% (4/33) of PHCs reported “very prepared”,
- 55% (18/33) as “somewhat prepared

Barriers

- Lack of staff training at 55% (18/33), EHR / Health IT limitations at 39% (13/33), financial constraints at 24% (8/33), and lack of payer engagement at 24% (8/33).

How Azara Supports Upcoming Objectives



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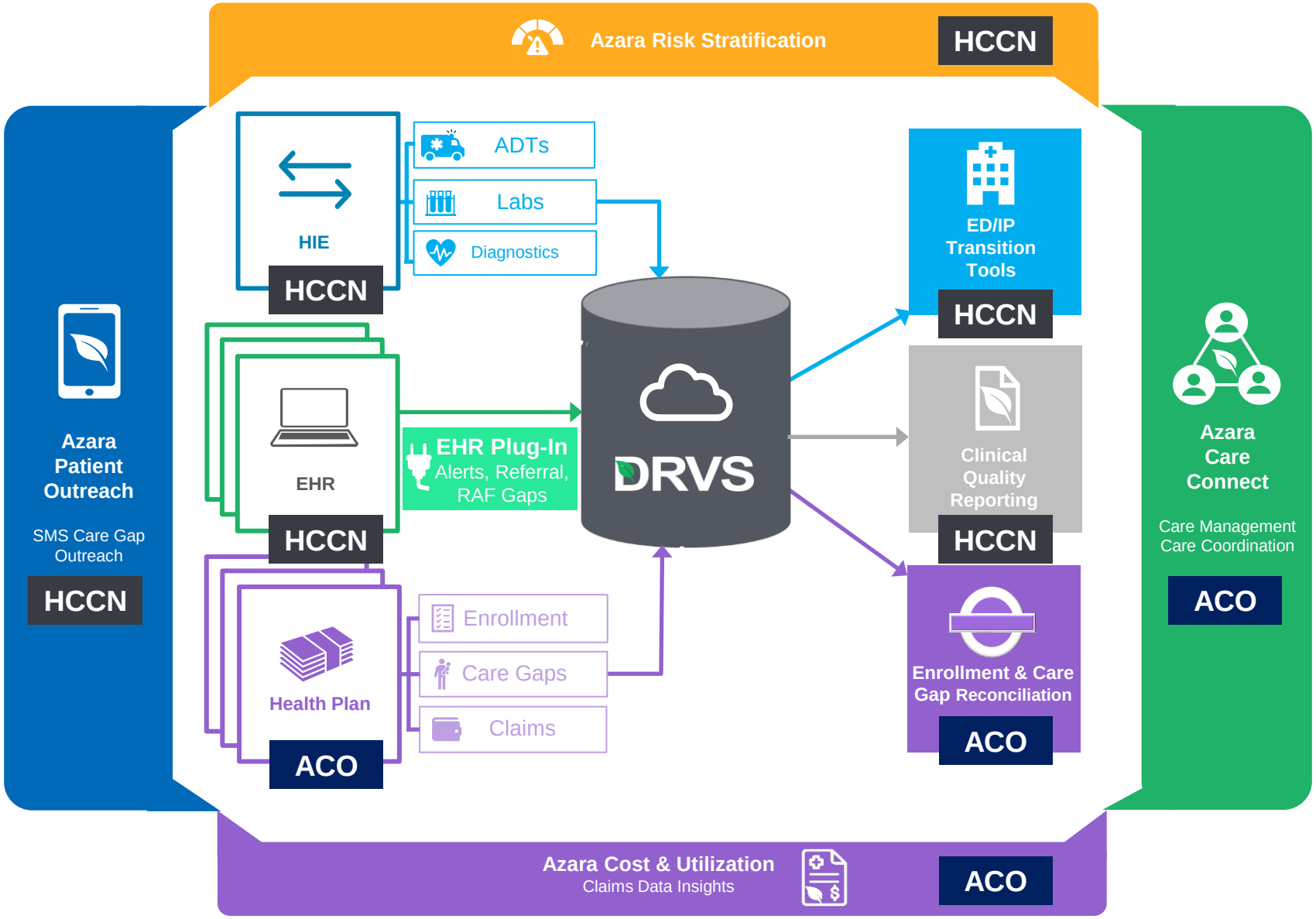
Azara Ecosystem



Value-Based Care

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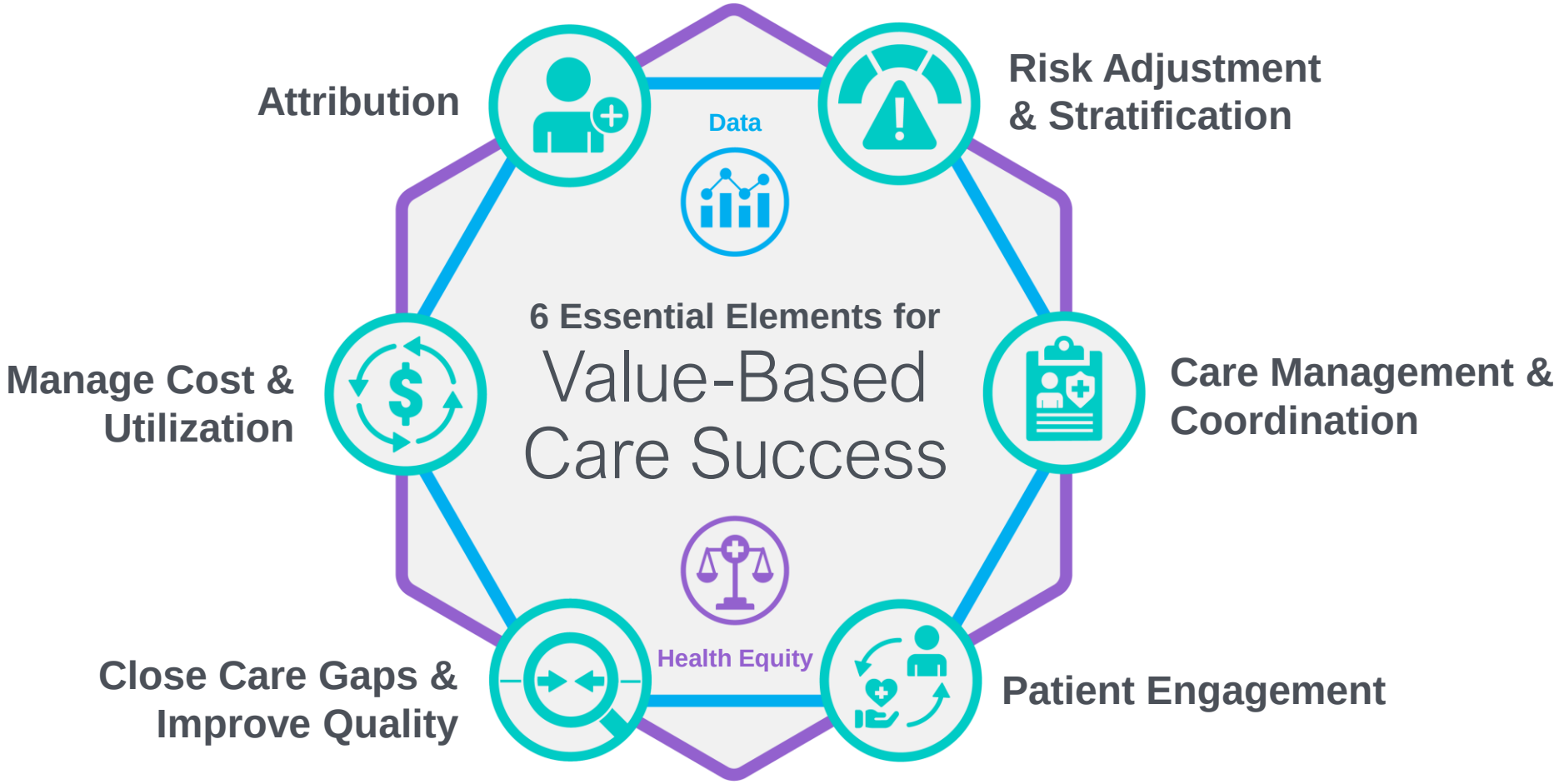
Essential Elements of VBC



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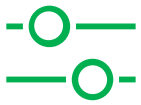
Attribution

Attribution is the process that payers use to assign patients to a provider who is accountable for the quality, patient experience, and total cost of care.

Key Challenges:

Difficulty obtaining attribution rosters



Payer attribution methods are different

Reconciling payer rosters with active patients is time consuming and burdensome

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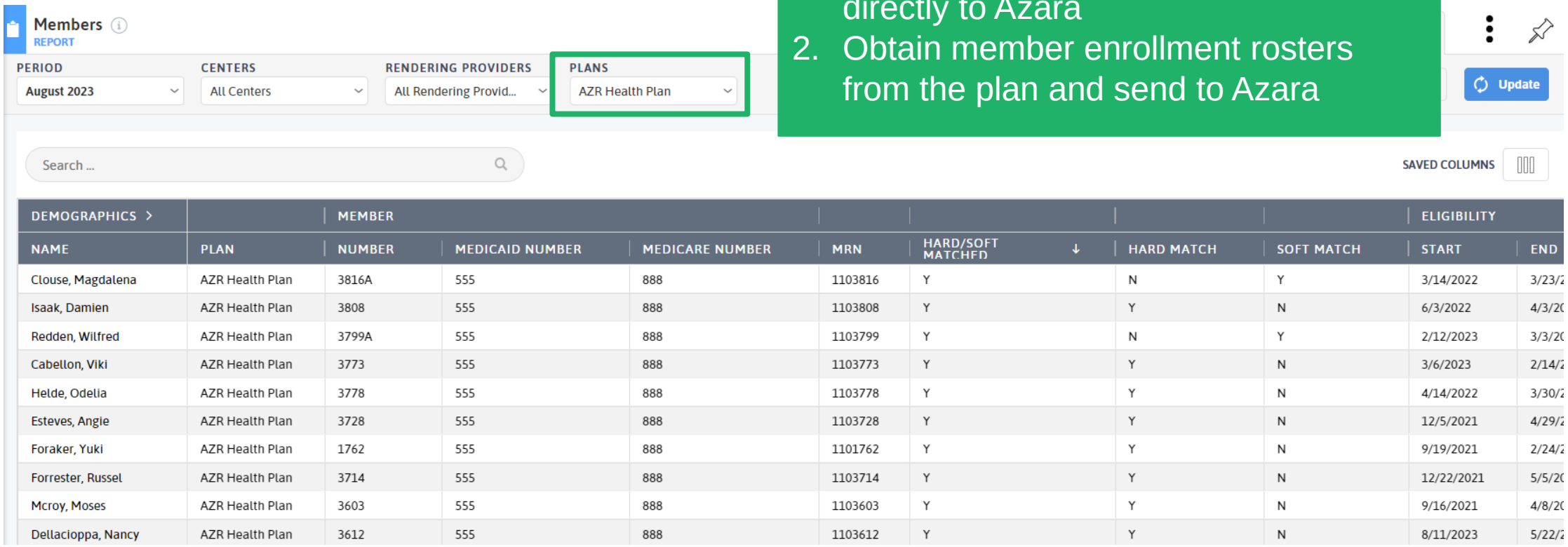
Attribution | Members Report

1. Plan sends member enrollment rosters directly to Azara
2. Obtain member enrollment rosters from the plan and send to Azara



DEMOGRAPHICS		MEMBER							ELIGIBILITY	
NAME	PLAN	NUMBER	MEDICAID NUMBER	MEDICARE NUMBER	MRN	HARD/SOFT MATCHED	HARD MATCH	SOFT MATCH	START	END
Clouse, Magdalena	AZR Health Plan	3816A	555	888	1103816	Y	N	Y	3/14/2022	3/23/2
Isaak, Damien	AZR Health Plan	3808	555	888	1103808	Y	Y	N	6/3/2022	4/3/20
Redden, Wilfred	AZR Health Plan	3799A	555	888	1103799	Y	N	Y	2/12/2023	3/3/20
Cabellon, Viki	AZR Health Plan	3773	555	888	1103773	Y	Y	N	3/6/2023	2/14/2
Helde, Odelia	AZR Health Plan	3778	555	888	1103778	Y	Y	N	4/14/2022	3/30/2
Esteves, Angie	AZR Health Plan	3728	555	888	1103728	Y	Y	N	12/5/2021	4/29/2
Foraker, Yuki	AZR Health Plan	1762	555	888	1101762	Y	Y	N	9/19/2021	2/24/2
Forrester, Russel	AZR Health Plan	3714	555	888	1103714	Y	Y	N	12/22/2021	5/5/20
Mcroy, Moses	AZR Health Plan	3603	555	888	1103603	Y	Y	N	9/16/2021	4/8/20
Dellacioppa, Nancy	AZR Health Plan	3612	555	888	1103612	Y	Y	N	8/11/2023	5/22/2

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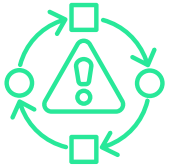
Risk Adjustment

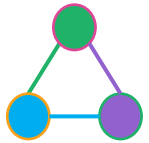
Risk Adjustment is the process by which payers ensure that providers are paid enough to appropriately care for all their patients.

Key Challenges:

Ensuring providers code for the appropriate level of acuity



Payers use a variety of risk adjustment models



Models do not account for non-clinical factors that influence health

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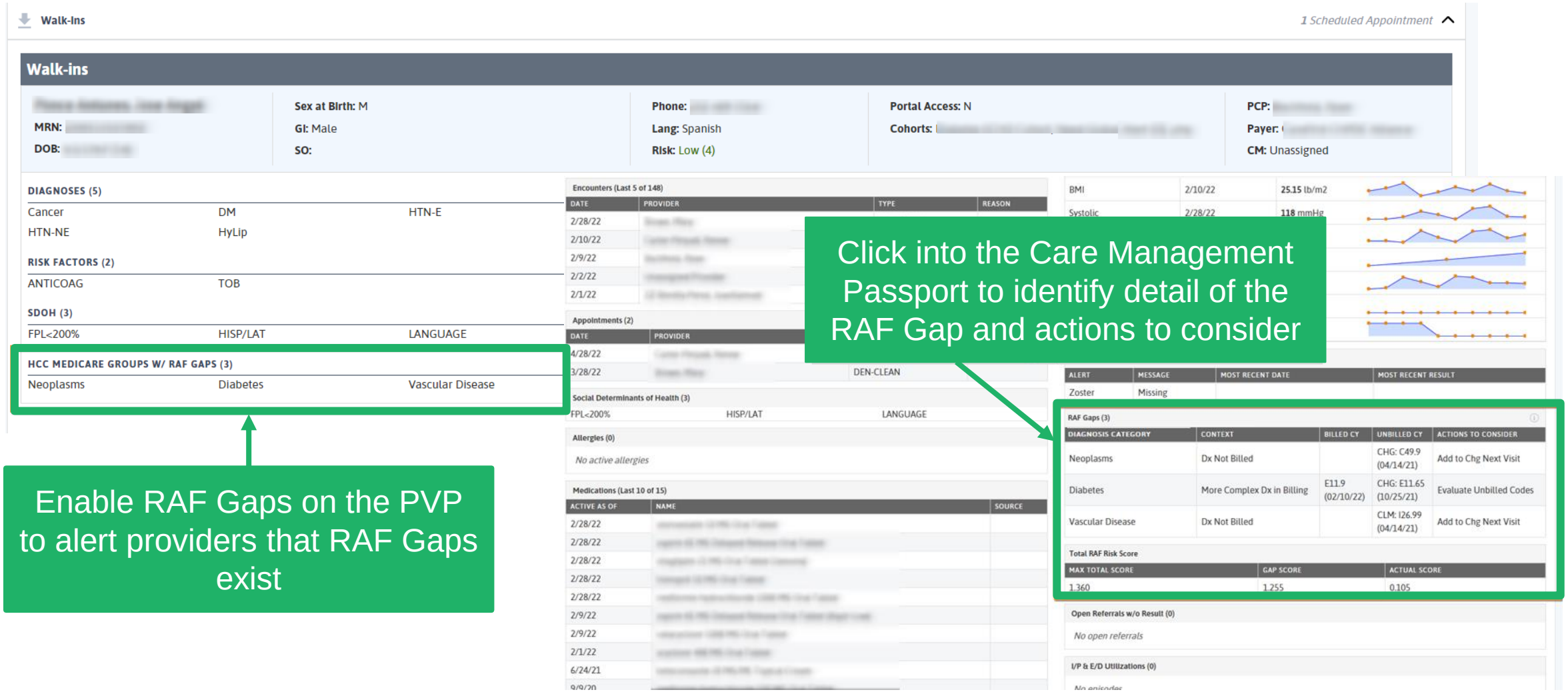
Alert Providers of RAF Gaps



Click into the Care Management Passport to identify detail of the RAF Gap and actions to consider

Enable RAF Gaps on the PVP to alert providers that RAF Gaps exist

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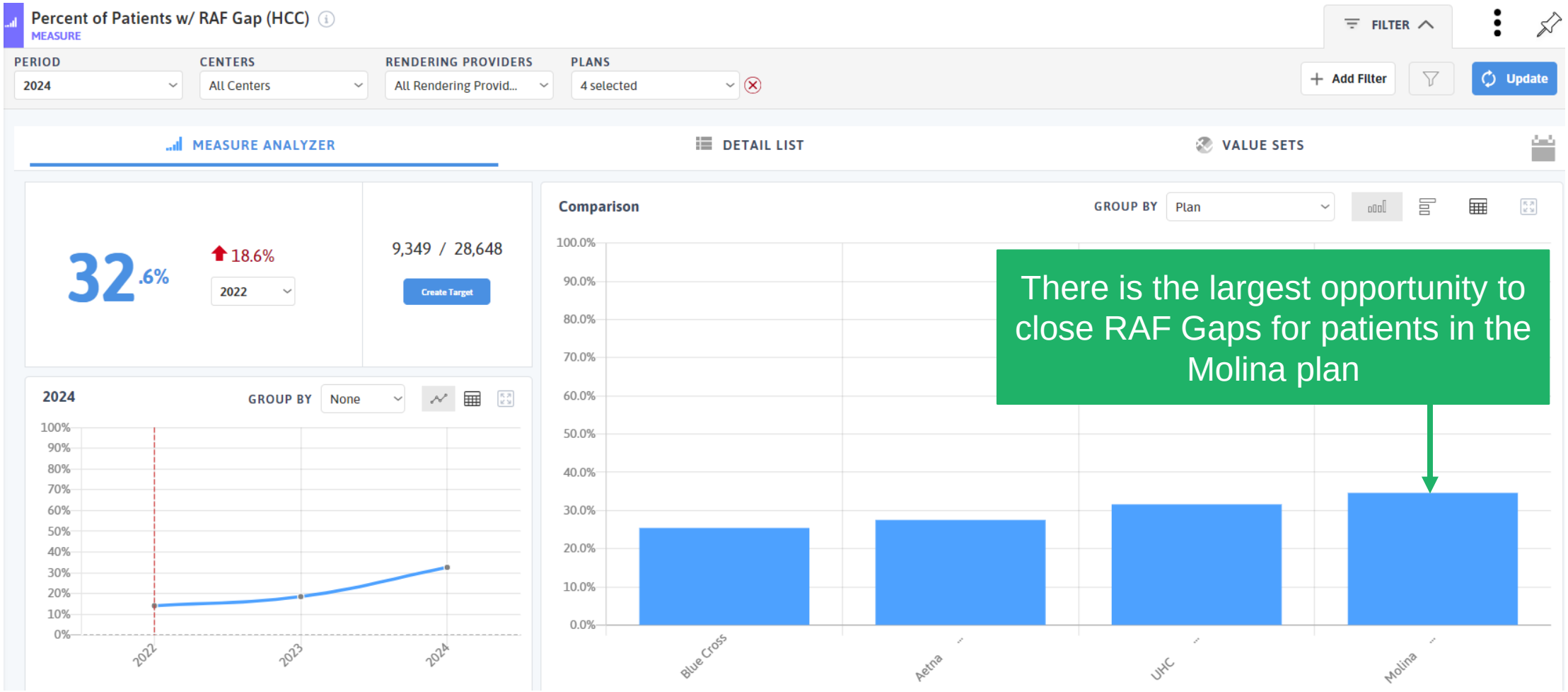
Where is the Opportunity?



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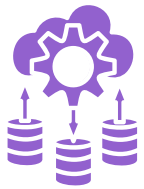
Risk Stratification

Risk Stratification is the process of classifying patients into groups based on their likelihood of developing certain health problems or experiencing negative health outcomes.

Key Challenges:



Comprehensive risk stratification requires multiple sources of data

Payer risk models use lagged claims data

Identifying the “right” patients to maximize limited resources

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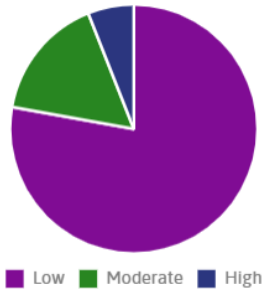
Risk Stratify the Population

Risk Criteria Weighting

DIAGNOSES	PATIENT COUNT	PREVALENCE	% HIGH RISK	POINTS
Diabetes	66,385	13%	20%	2
Hypertension	148,818	29%	13%	2
Hyperlipidemia	138,087	27%	12%	1
ASCVD	26,076	5%	30%	1
CHF	10,443	2%	45%	3
CAD	17,715	3%	35%	2
Ischemic Stroke	4,772	1%	31%	1
Hemorrhagic Stroke	608	0%	25%	2
IVD	23,062	4%	31%	1
Afib	8,612	2%	31%	2
Persistent Asthma	17,654	3%	20%	2
COPD	27,575	5%	25%	2
Chronic NonMalignant Pain	54,224	10%	15%	1
Cirrhosis	2,332	0%	28%	2
CKD Stages 3&4	11,596	2%	23%	1
CKD Stage 5	495	0%	44%	2
ESRD	1,019	0%	40%	1

Risk Category Distribution



High Risk Patients

31,156

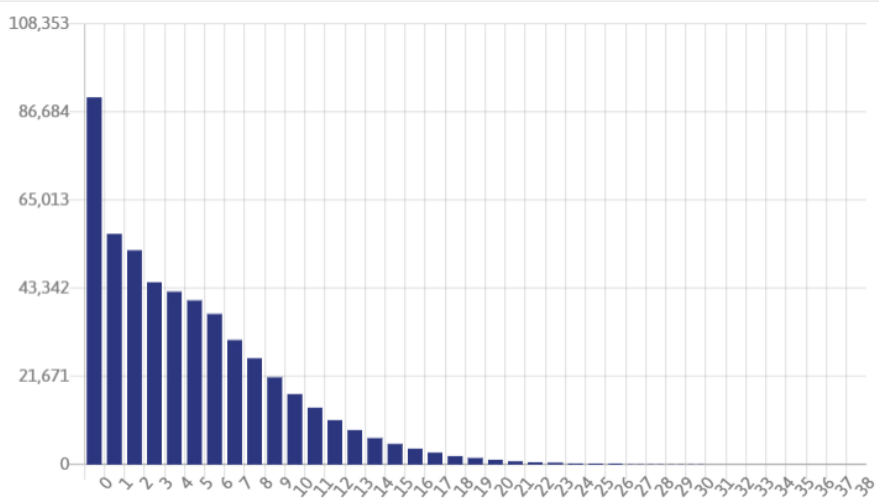
Pts w/ qualifying encounter

Total Patients

518,529

Pts w/ qualifying encounter

Risk Score Distribution



Risk Score Thresholds

Geriatric (65-149)

CATEGORY	# PATIENTS	PREVALENCE	THRESHO
High	4,521	6%	16.00
Moderate	12,880	17%	11.00
Low	56,594	76%	0

Adult (22-64)

CATEGORY	# PATIENTS	PREVALENCE	THRESHO
High	17,196	6%	14.00
Moderate	47,505	16%	9.00
Low	226,152	78%	0

Pediatric (0-21)

CATEGORY	# PATIENTS	PREVALENCE	THRESHO
High	9,439	6%	8.00
Moderate	23,449	15%	5.00
Low	120,792	79%	0

Rising Risk Patients

1,628

Pts w/ New High Risk Level

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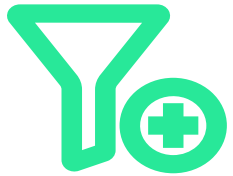
Many Ways to Use Azara Risk

PVP & CMP

Registry

Dynamic Cohorts

Rising Risk Measure



Risk Filter

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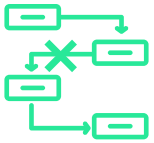
Care Management & Care Coordination

By proactively managing patient populations through care coordination and care management programs, healthcare providers can close care gaps, improve population health outcomes, and achieve success in value-based care models.

Key Challenges:



Ineffective processes for identification and placement of patient into the appropriate care program

Staffing shortages

Tools/technology does not align with workflows

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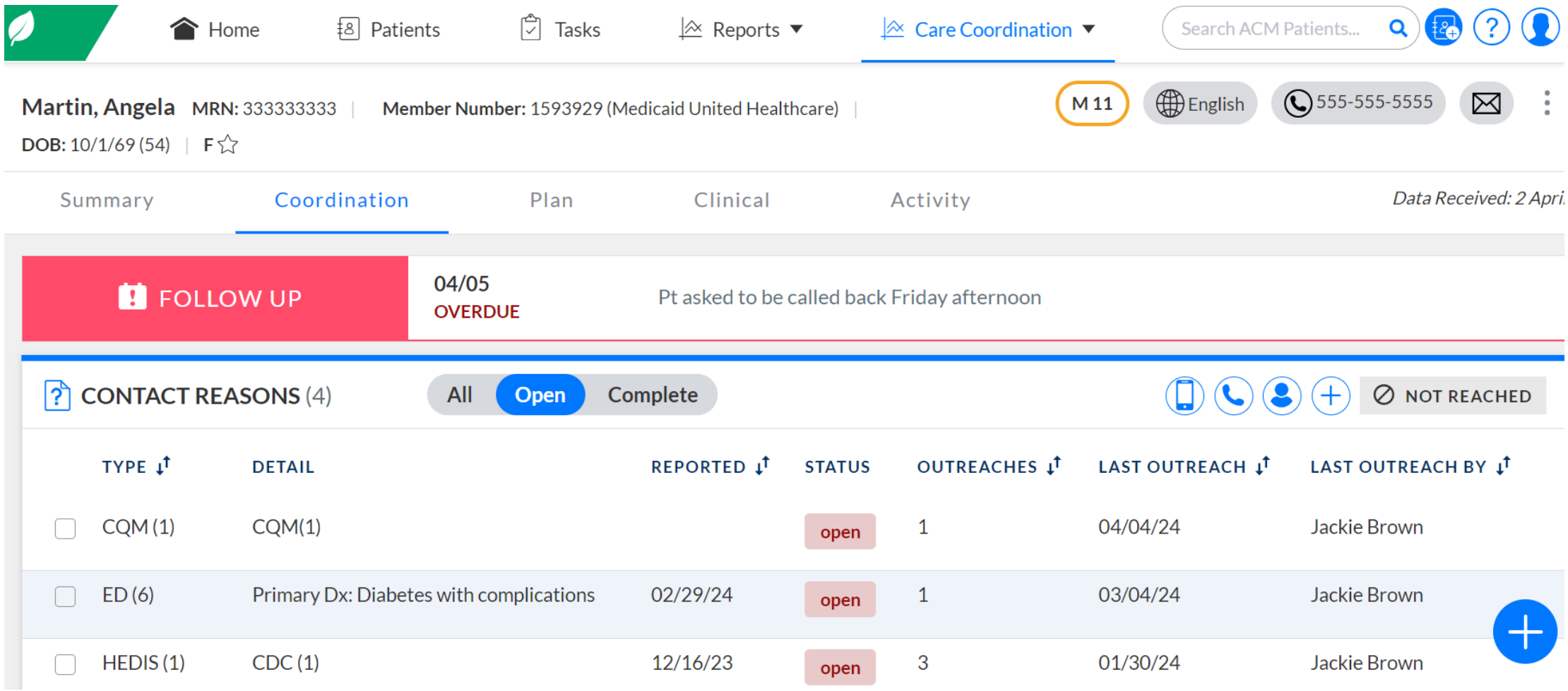
Care Coordination



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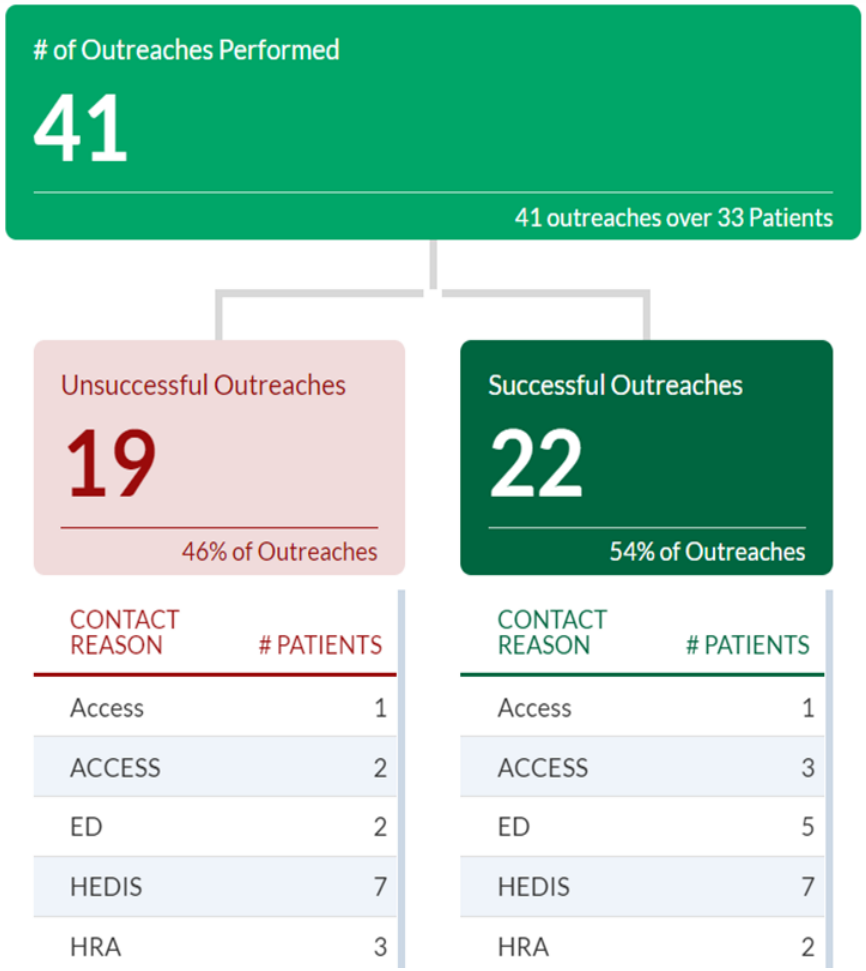
Care Coordination Productivity



CONTACT REASON	# PATIENTS
Access	1
ACCESS	2
ED	2
HEDIS	7
HRA	3

CONTACT REASON	# PATIENTS
Access	1
ACCESS	3
ED	5
HEDIS	7
HRA	2

OUTREACH METHOD

In Person | Mailing | Phone | Research | Text

USER	TOTAL	SUCCESSFUL					UNSUCCESSFUL				
Jackie Brown	6	1	0	1	0	1	1	0	1	1	0
Ipsa Nirupa	7	1	1	1	0	1	1	0	1	1	0
Sianeh Bah	6	0	1	1	0	1	1	0	1	1	0
Ambaya Dinath	6	1	0	1	0	1	1	0	1	0	1
Braeden Orr	5	1	0	1	0	1	0	0	1	1	0
Hudson Lim	4	0	0	1	0	1	1	0	0	1	0
Andala Motala	3	0	0	1	0	0	0	0	1	1	0
Nora Misbahi	3	0	0	2	0	0	0	0	0	1	0
Cohen Braswell	1	0	0	1	0	0	0	0	0	0	0
	41	4	2	10	0	6	5	0	6	7	1

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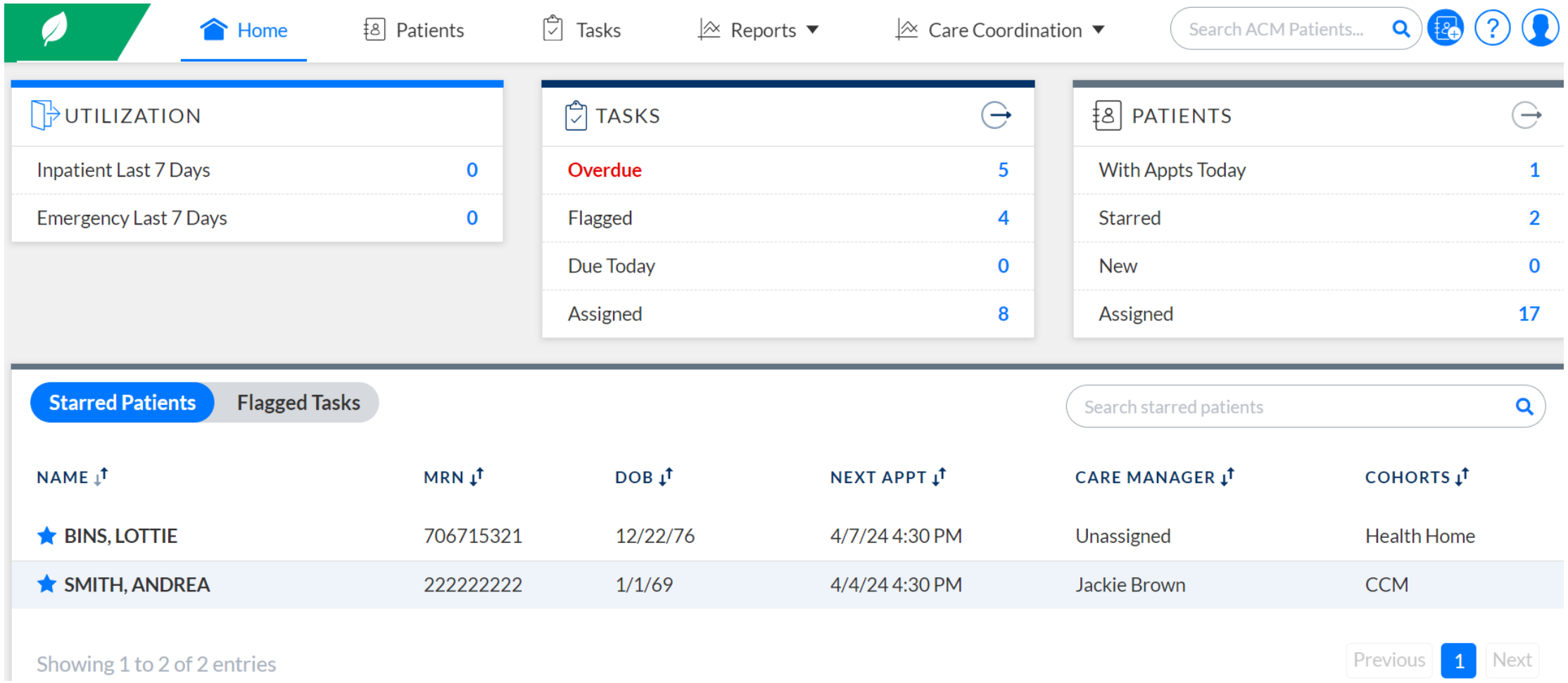
Care Management



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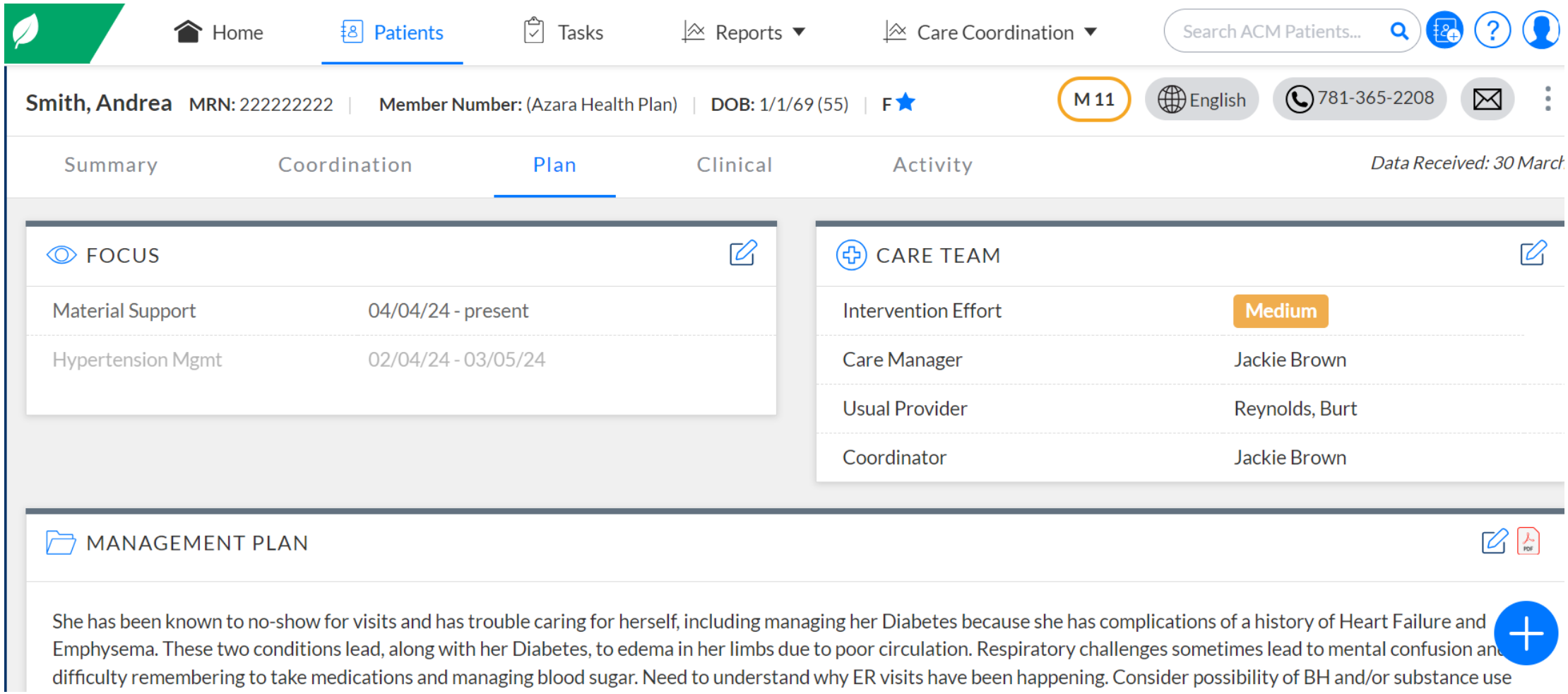
Care Management Plan



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Patient Engagement

Patient Engagement fosters a collaborative partnership between patients and providers, empowering patients to take a proactive role in preventive care and early disease detection, ultimately leading to better health outcomes.

Key Challenges:

Outreach is time consuming and labor intensive

Using the right modality to reach the most patients

Health literacy barriers

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Included in HCCN Workplan | HCCN | ACO

Patient Engagement through APO

Key Outcomes

Reduced Costs	Engaged patients are more likely to adopt healthy behaviors, such as exercising regularly, taking their medications, and improved self management skills, leading to better management of chronic conditions and reduced hospital / ED visits.
Improved Patient Satisfaction	Timely appointment reminders, preventive care reminders, and easy access to information can contribute to a more positive patient experience and higher satisfaction scores.
Increased Efficiency	Using analytics and dynamic cohorts coupled with automated texting, provider organizations can drive care gap closure across their patient population with limited staff involvement.

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Included in HCCN Workplan | HCCN | ACO

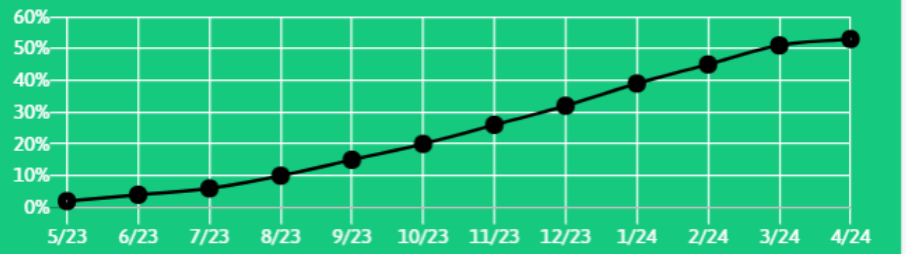
Evaluate Engagement Programs

IMPACT

473
CARE GAPS CLOSED
▲ 18 Last Month

53%
CARE GAP CLOSURE RATE

ENROLLEES W/CARE GAP CLOSURES BY MONTH



EFFECTIVENESS

+46.6%
SINCE BASELINE
▲ 2.0% Last Month

HOW IS THIS CALCULATED?
Increase in % of patients who received a Diabetes A1c compared to the baseline

CAMPAIGN DETAILS

1,003
TOTAL ENROLLEES
TY April 2024

925
ENROLLEES MESSAGED
TY April 2024

Campaign Name	Diabetes A1c reminder without appointment
Start Date	Jan 2023 *15 months*
Duration	1 messages after 27 days
Success Criteria	Diabetes A1c

5,383
MESSAGES SENT
TY April 2024
▲ 225 Last Month

PATIENT ENGAGEMENT

892
PTS SUCCESSFULLY REACHED
TY April 2024
▲ 18 Last Month

59%
MADE APPT

50%
KEPT APPT

53%
CARE GAP CLOSED

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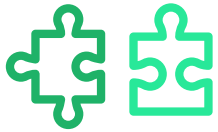
Included in HCCN Workplan | HCCN | ACO

Close Care Gaps & Improve Quality

Closing care gaps and improving clinical quality measure performance is critical to unlock valuable financial incentives, achieve shared savings, and deliver improved health outcomes for patients.

Key Challenges:

Tracking performance across multiple plans and programs



Reconciling claims and clinical data

Lack of information at point of care

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Evaluate Care Gaps Across Programs

Target Achievement - All

TARGET ACHIEVEMENT	
PRIMARY	2
SECONDARY	2
NOT MET	7

Capital Target Achievement

TARGET ACHIEVEMENT	
PRIMARY	2
SECONDARY	2
NOT MET	7

Capital High Deductible Target Achievement

TARGET ACHIEVEMENT	
PRIMARY	4
SECONDARY	0
NOT MET	7

Capital Medicare Advantage Target Achievement

TARGET ACHIEVEMENT	
PRIMARY	1
SECONDARY	3
NOT MET	7

Total - Capital High Deductible

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Breast CA Screening Ages 50-74 (CMS125v11)	66.4%	459	691	31	232	94
Cervical Cancer Screening (CMS124v11)	11.7%	81	695	160	614	510
Colorectal Cancer Screening (CMS130v11)	67.9%	911	1,341	26	430	229
Appropriate Rx for Asthma	34.3%	12	35	0	23	15
HTN Controlling High BP (CMS165v11)	75.0%	628	837	35	209	84
Statin Therapy CVD (CMS347v6)	71.8%	405	564	33	159	75
Depression Screening & Follow-Up (CMS2v12)	22.8%	459	2,017	490	1,558	1,256
BMI Screen & Follow-Up 18+ (CMS69v11)	29.5%	229	776	7	547	
DM A1c > 9 or Untested (CMS122v11)	19.4%	67	346	9	67	0
Diabetes: Eye Exam (CMS 131v9)	43.4%	150	346	9	196	138
Childhood Immunization Status (CMS117v11)	38.5%	45	117	0	72	0

Capital

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Breast CA Screening Ages 50-74 (CMS125v11)	68.5%	185	270	9	85	31
Cervical Cancer Screening (CMS124v11)	13.6%	49	360	96	311	257
Colorectal Cancer Screening (CMS130v11)	65.9%	368	558	8	190	107
Appropriate Rx for Asthma	29.4%	5	17	0	12	8
HTN Controlling High BP (CMS165v11)	77.3%	225	291	4	66	23
Statin Therapy CVD (CMS347v6)	73.9%	147	199	11	52	23
Depression Screening & Follow-Up (CMS2v12)	20.3%	158	777	187	619	503

Capital Medicare Advantage

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Breast CA Screening Ages 50-74 (CMS125v11)	69.4%	77	111	8	34	12
Cervical Cancer Screening (CMS124v11)	0.0%	0	4	2	4	4
Colorectal Cancer Screening (CMS130v11)	73.6%	142	193	10	51	23
Appropriate Rx for Asthma	0.0%	0	0	0	0	0
HTN Controlling High BP (CMS165v11)	75.9%	126	166	13	40	16
Statin Therapy CVD (CMS347v6)	79.0%	79	100	9	21	6
Depression Screening & Follow-Up (CMS2v12)	11.4%	27	237	84	210	175

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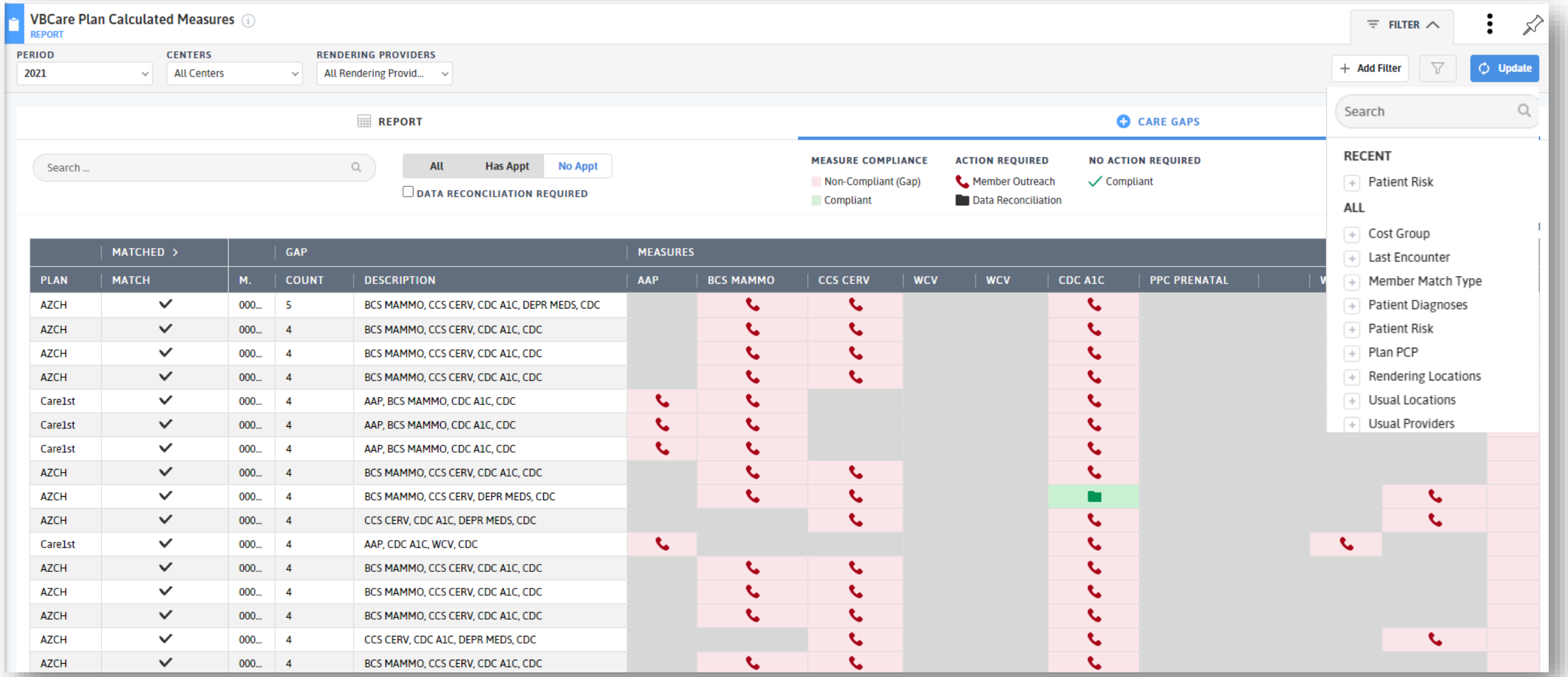
Available in DRVS

ACO

HCCN

Targeted Outreach | Gap Lists



	MATCHED		GAP		MEASURES							
PLAN	MATCH	M.	COUNT	DESCRIPTION	AAP	BCS MAMMO	CCS CERV	WCV	WCV	CDC A1C	PPC PRENATAL	
AZCH	✓	000...	5	BCS MAMMO, CCS CERV, CDC A1C, DEPR MEDS, CDC		✆	✆			✆		
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆		
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆		
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆		
Care1st	✓	000...	4	AAP, BCS MAMMO, CDC A1C, CDC	✆	✆				✆		
Care1st	✓	000...	4	AAP, BCS MAMMO, CDC A1C, CDC	✆	✆				✆		
Care1st	✓	000...	4	AAP, BCS MAMMO, CDC A1C, CDC	✆	✆				✆		
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆		
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, DEPR MEDS, CDC		✆	✆			■		✆
AZCH	✓	000...	4	CCS CERV, CDC A1C, DEPR MEDS, CDC			✆			✆		✆
Care1st	✓	000...	4	AAP, CDC A1C, WCV, CDC	✆					✆	✆	
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆		
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆		
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆		
AZCH	✓	000...	4	CCS CERV, CDC A1C, DEPR MEDS, CDC			✆			✆		✆
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆		

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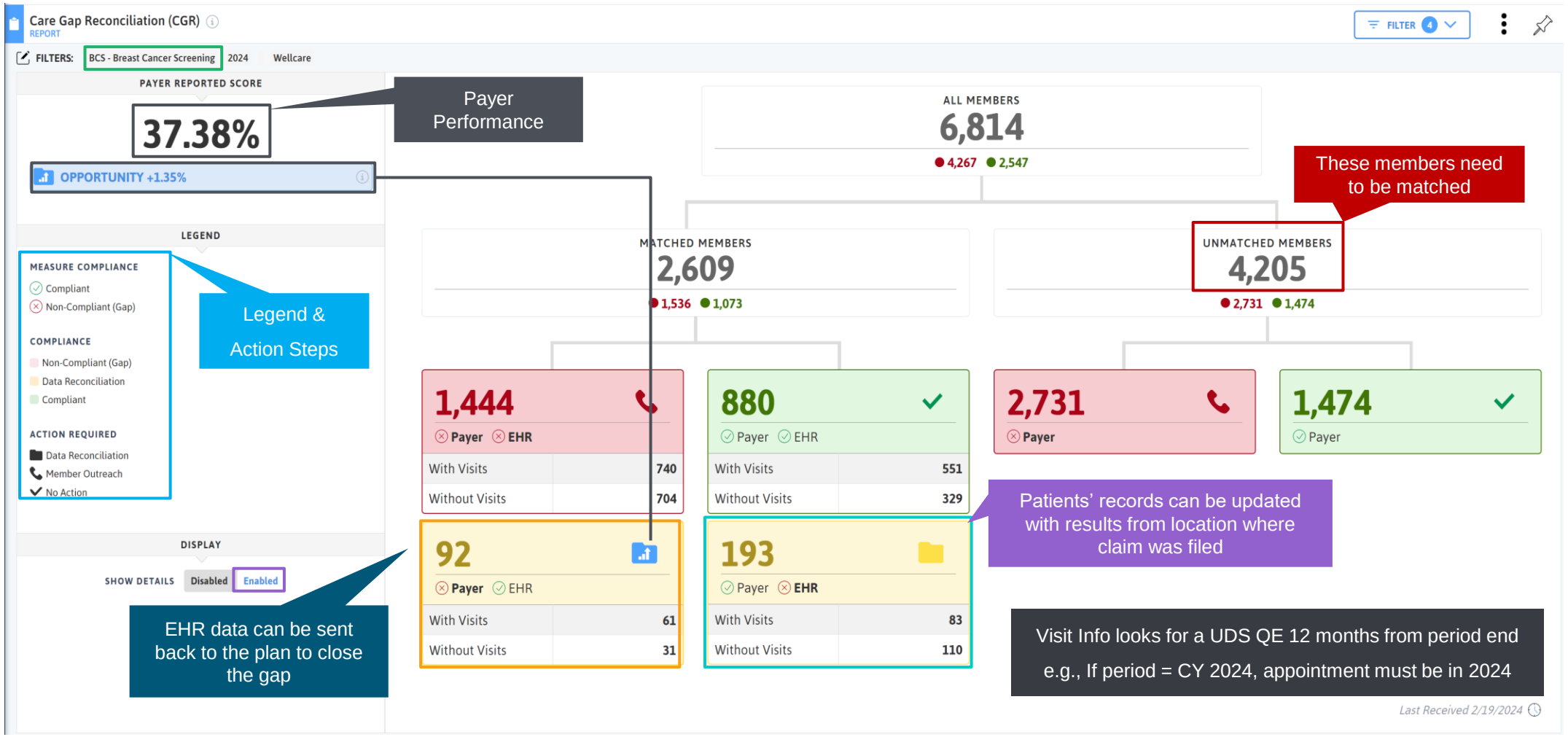
Reconcile Claims and Clinical Data



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Available in DRVS | **ACO** | **HCCN**

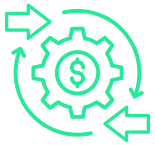
Manage Cost & Utilization

Managing costs and utilization is a critical driver of value-based care success and can be a significant source of new revenue.

Key Challenges:

Extracting actionable insights from claims data

Track multiple plans and programs in one place



Effectively manage hospital utilization

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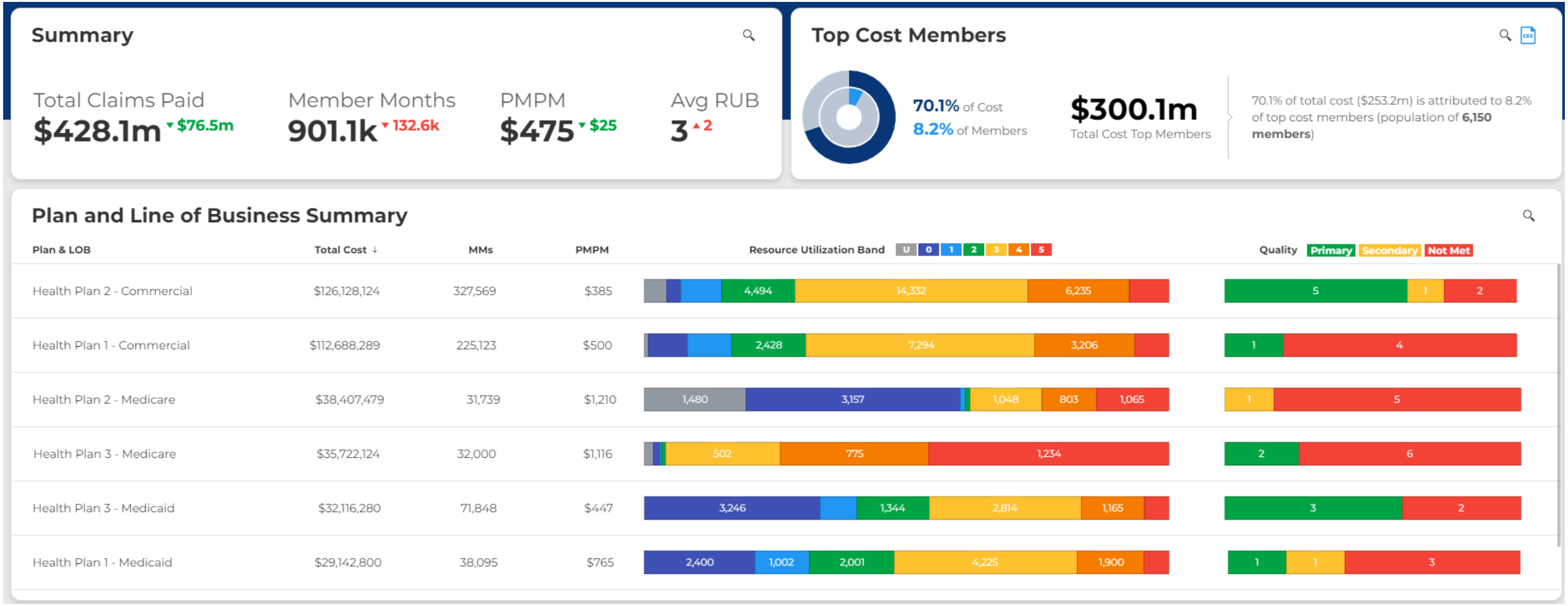
Manage Multiple VBC Contracts



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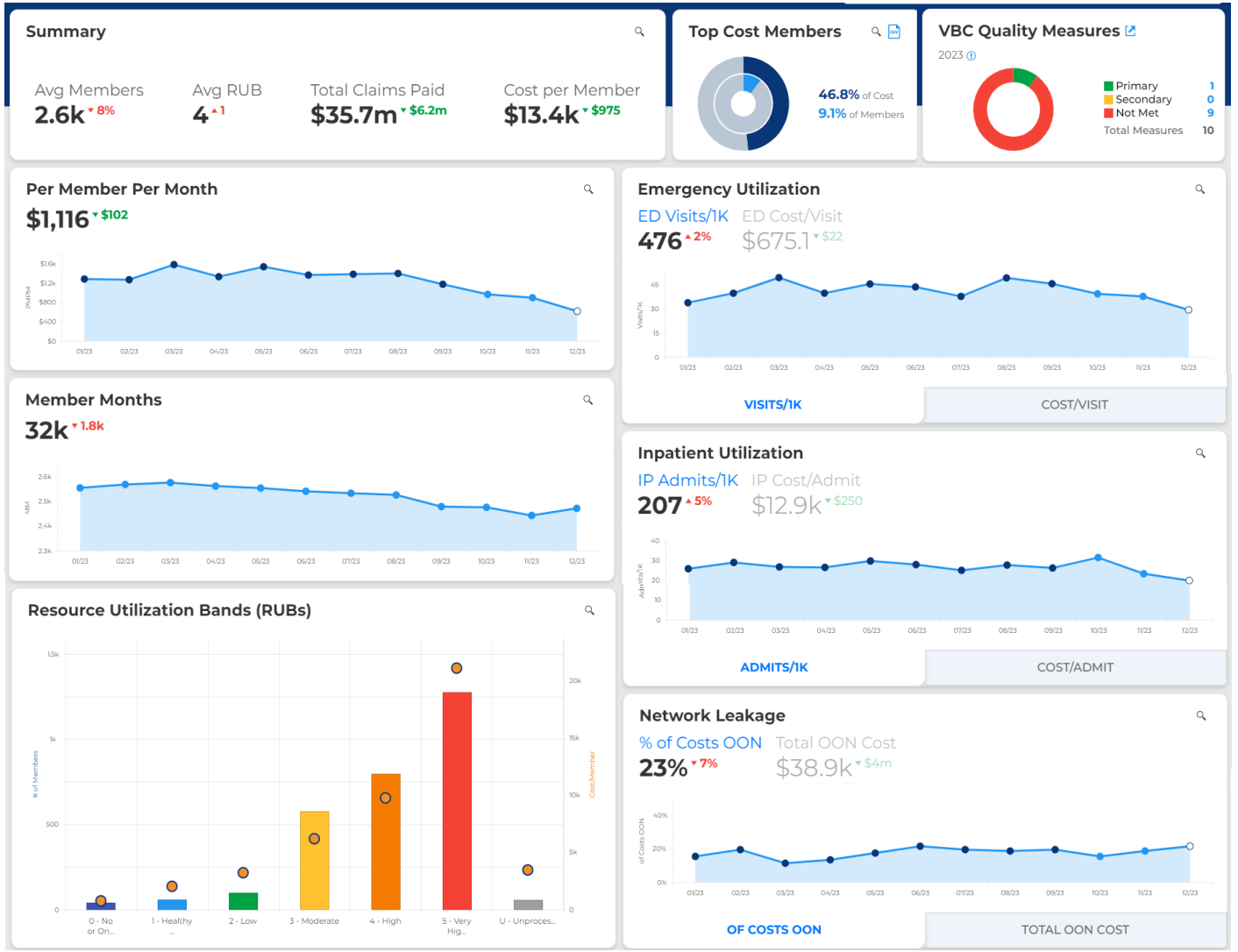
ACO

Contract Details



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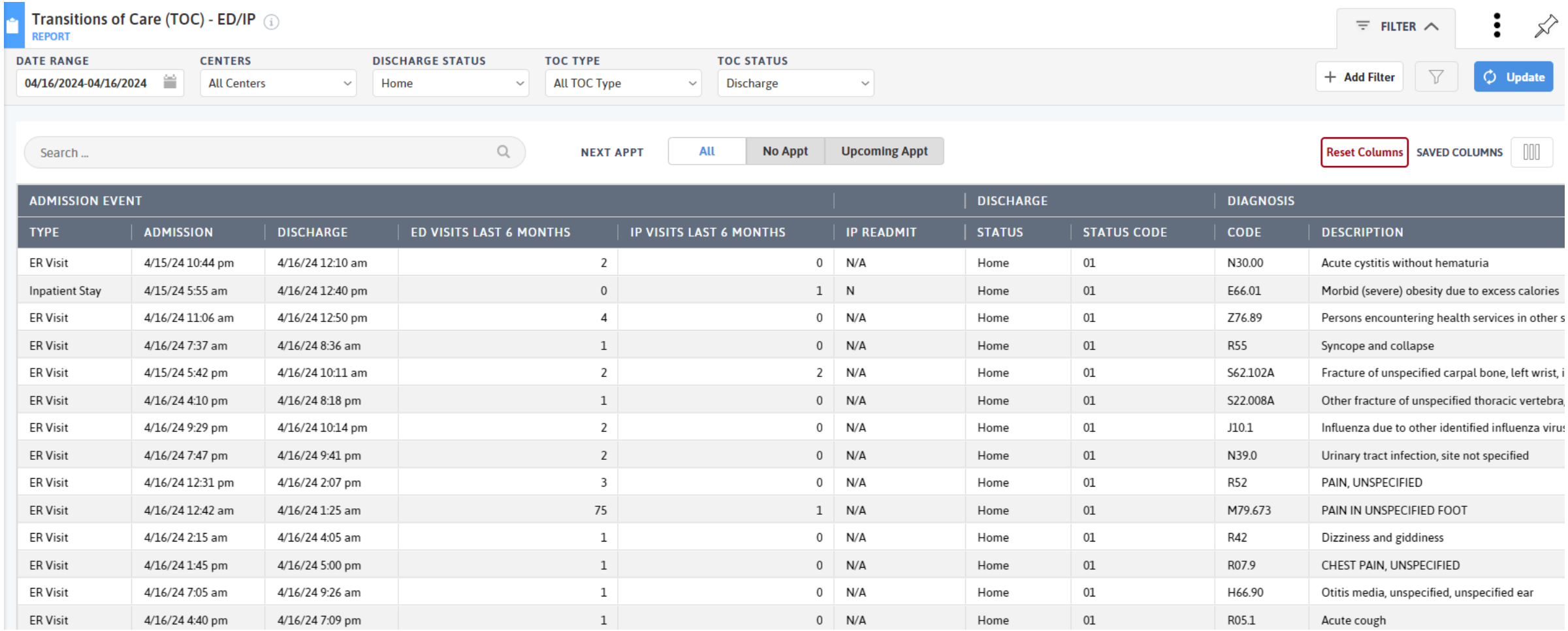
Available in ACU

ACO

Reduce Hospital Utilization | TOC



Transitions of Care (TOC) - ED/IP
REPORT

FILTER

DATE RANGE: 04/16/2024-04/16/2024 | CENTERS: All Centers | DISCHARGE STATUS: Home | TOC TYPE: All TOC Type | TOC STATUS: Discharge

Add Filter | Update

Search ... | NEXT APPT: All | No Appt | Upcoming Appt | Reset Columns | SAVED COLUMNS

ADMISSION EVENT						DISCHARGE		DIAGNOSIS	
TYPE	ADMISSION	DISCHARGE	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS	IP READMIT	STATUS	STATUS CODE	CODE	DESCRIPTION
ER Visit	4/15/24 10:44 pm	4/16/24 12:10 am	2	0	N/A	Home	01	N30.00	Acute cystitis without hematuria
Inpatient Stay	4/15/24 5:55 am	4/16/24 12:40 pm	0	1	N	Home	01	E66.01	Morbid (severe) obesity due to excess calories
ER Visit	4/16/24 11:06 am	4/16/24 12:50 pm	4	0	N/A	Home	01	Z76.89	Persons encountering health services in other s
ER Visit	4/16/24 7:37 am	4/16/24 8:36 am	1	0	N/A	Home	01	R55	Syncope and collapse
ER Visit	4/15/24 5:42 pm	4/16/24 10:11 am	2	2	N/A	Home	01	S62.102A	Fracture of unspecified carpal bone, left wrist, i
ER Visit	4/16/24 4:10 pm	4/16/24 8:18 pm	1	0	N/A	Home	01	S22.008A	Other fracture of unspecified thoracic vertebra
ER Visit	4/16/24 9:29 pm	4/16/24 10:14 pm	2	0	N/A	Home	01	J10.1	Influenza due to other identified influenza virus
ER Visit	4/16/24 7:47 pm	4/16/24 9:41 pm	2	0	N/A	Home	01	N39.0	Urinary tract infection, site not specified
ER Visit	4/16/24 12:31 pm	4/16/24 2:07 pm	3	0	N/A	Home	01	R52	PAIN, UNSPECIFIED
ER Visit	4/16/24 12:42 am	4/16/24 1:25 am	75	1	N/A	Home	01	M79.673	PAIN IN UNSPECIFIED FOOT
ER Visit	4/16/24 2:15 am	4/16/24 4:05 am	1	0	N/A	Home	01	R42	Dizziness and giddiness
ER Visit	4/16/24 1:45 pm	4/16/24 5:00 pm	1	0	N/A	Home	01	R07.9	CHEST PAIN, UNSPECIFIED
ER Visit	4/16/24 7:05 am	4/16/24 9:26 am	1	0	N/A	Home	01	H66.90	Otitis media, unspecified, unspecified ear
ER Visit	4/16/24 4:40 pm	4/16/24 7:09 pm	1	0	N/A	Home	01	R05.1	Acute cough

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Included in HCCN Workplan | HCCN | ACO

Transitions of Care (TOC)

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The Cost of Readmissions

$26 Billion

Medicare spends annually on hospital readmissions

$17 Billion

Spent on avoidable readmissions

30% of Patients

Experience at least 1 discrepancy between discharge list of meds and meds they actually take home

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https://journals.lww.com/lww-medicalcare/Fulltext/2021/08001/Patient_Centered_Approaches_to_Transitional_Care.4.aspx

TOC Work Supports Many Programs

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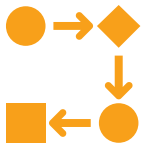
HIE Data in DRVS

Azara uses admit/discharge/transfer (ADT) alerts to populate reports, alerts, and measures

Lists of discharged patients who need follow-up

Identify high utilizers for care management

Track readmission rates for cost management



Understand the impact of interventions and process changes

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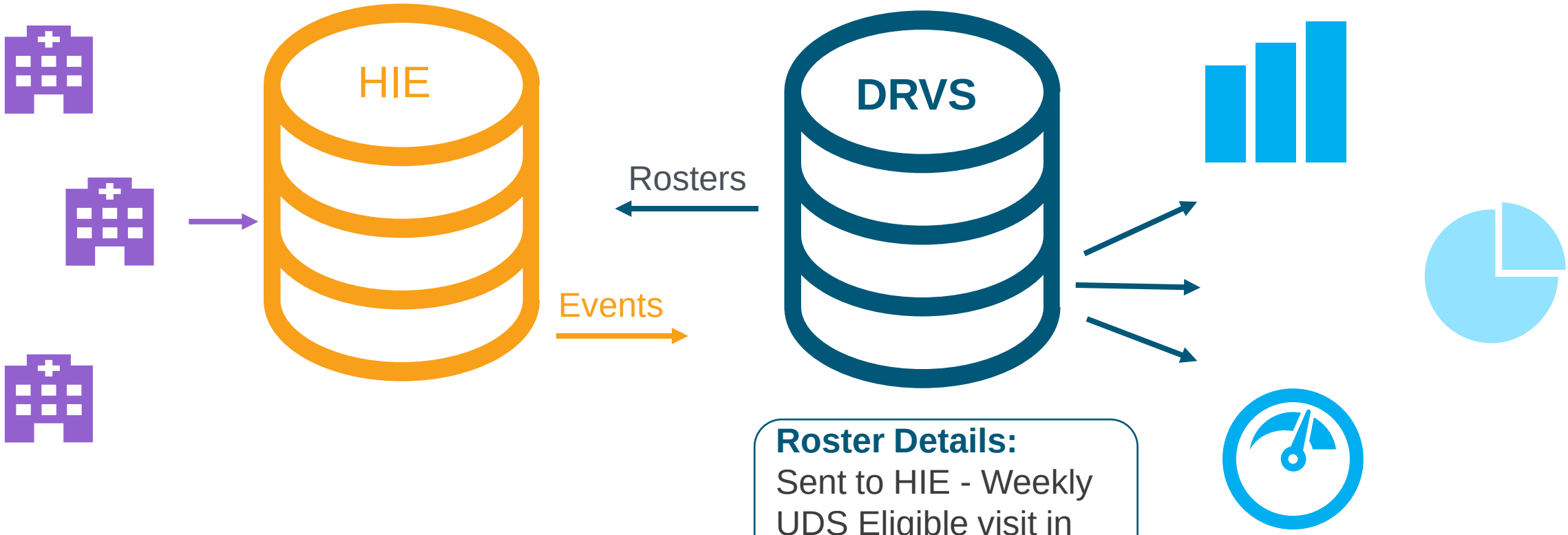
How ADT Data Gets into DRVS

Azara integrates Admit, Discharge, Transfer (ADT) Messages from Hospitals and HIEs and combines it with EHR data.



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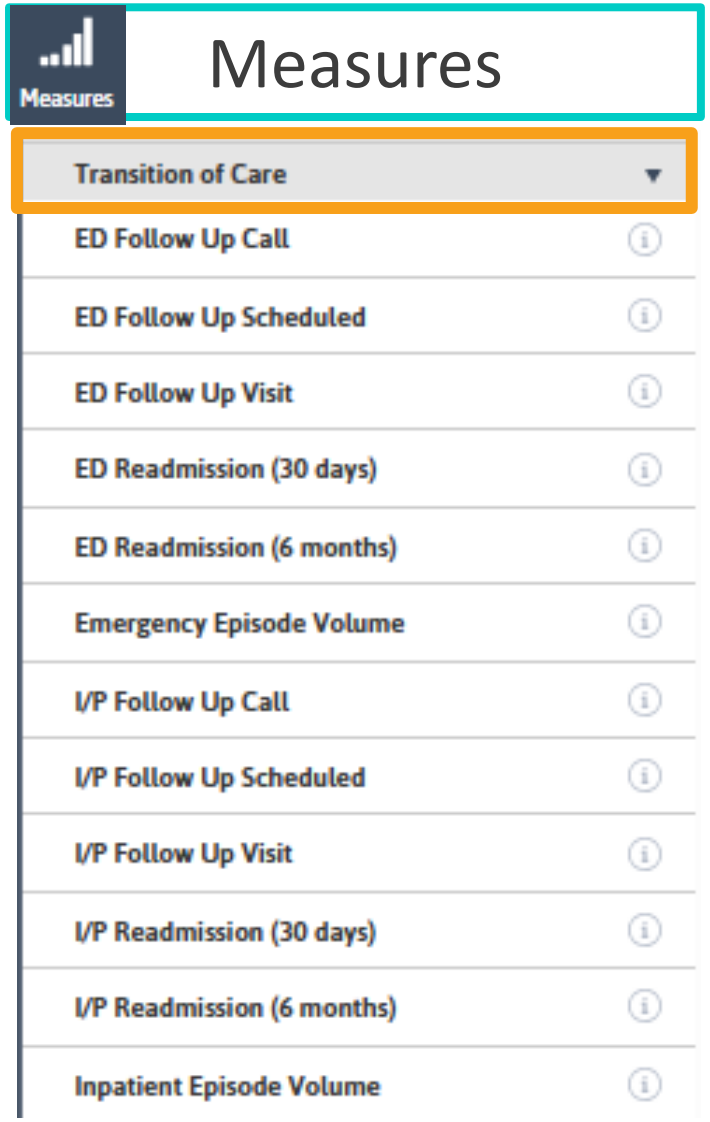
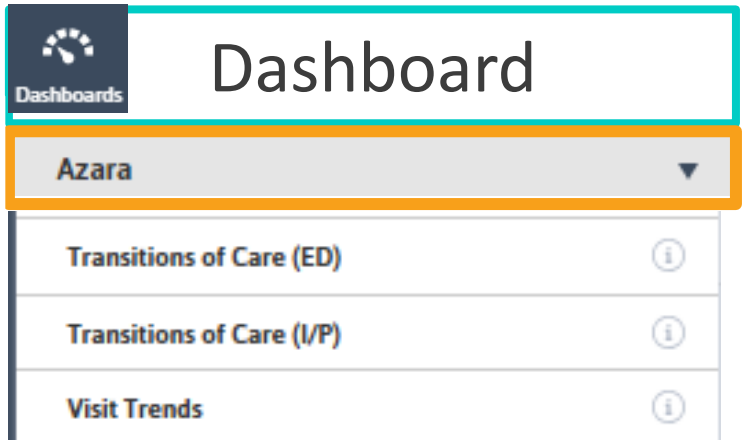
The TOC DRVS Tools

Reports

Measures



Dashboard



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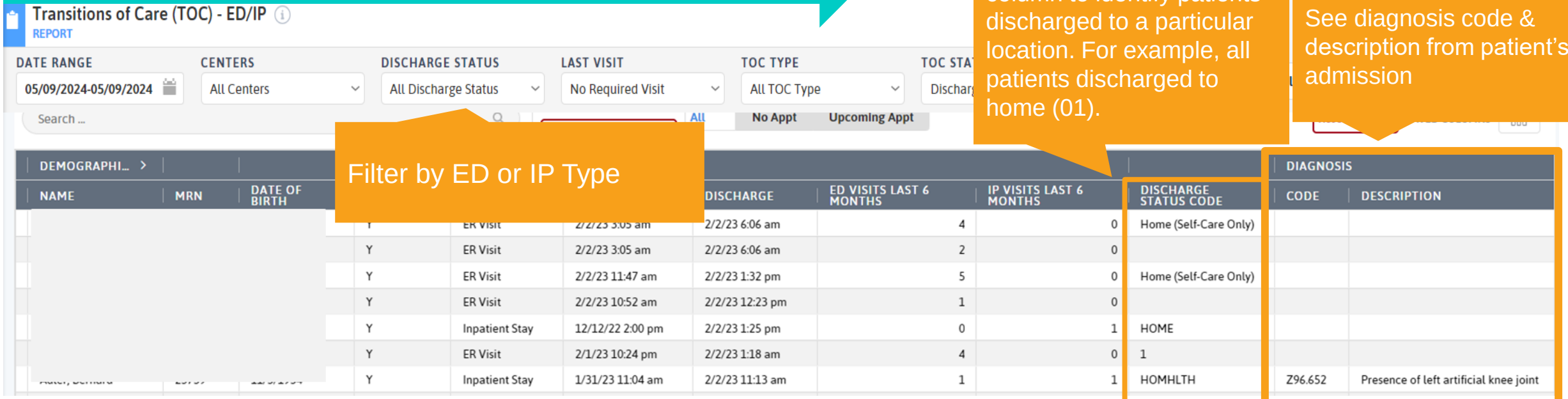
Transitions of Care (TOC) – ED/IP

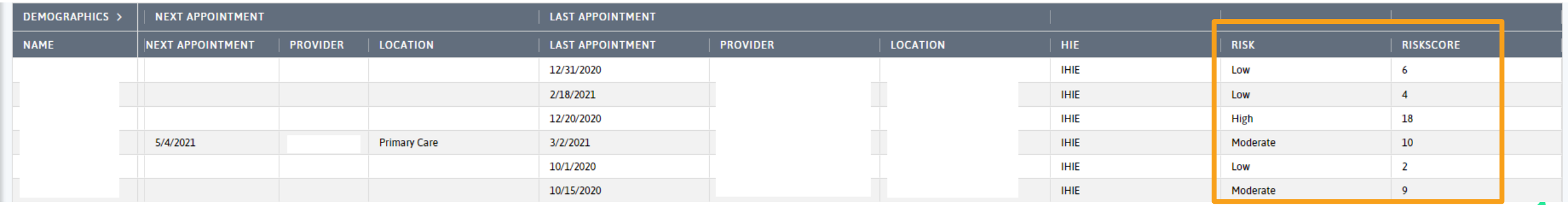
Run the ED/IP Report by Discharge Date

Filter the discharge status column to identify patients discharged to a particular location. For example, all patients discharged to home (01).

See diagnosis code & description from patient's admission

Filter by ED or IP Type





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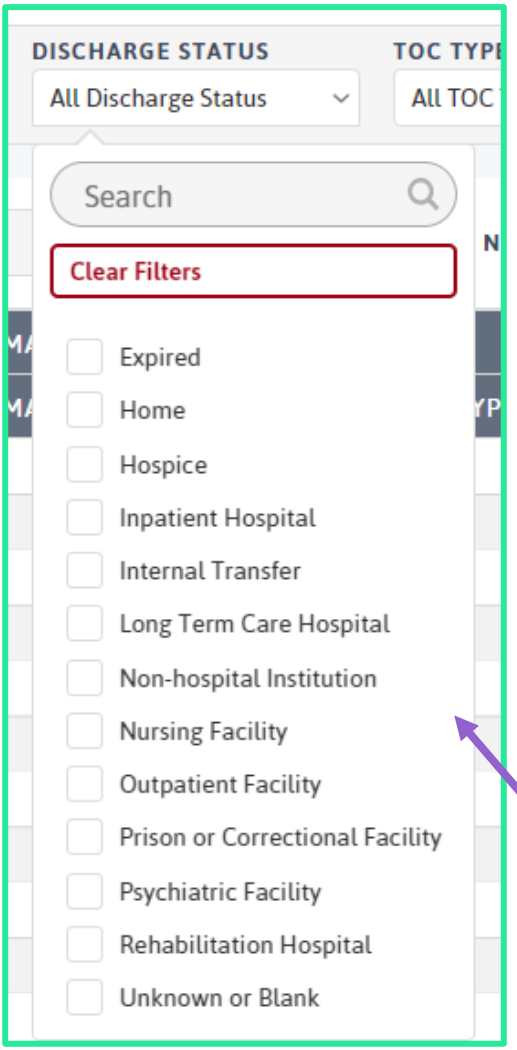
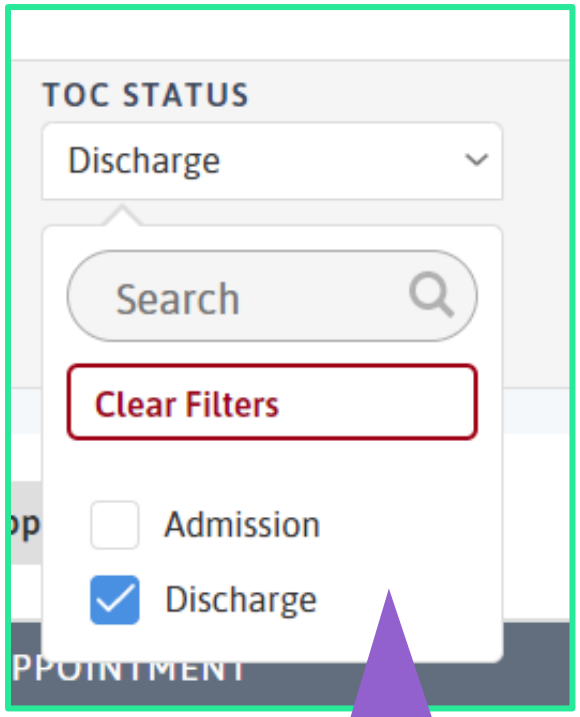
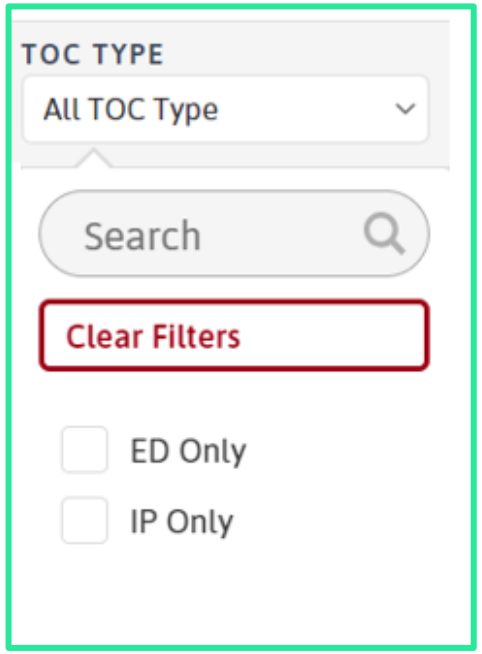
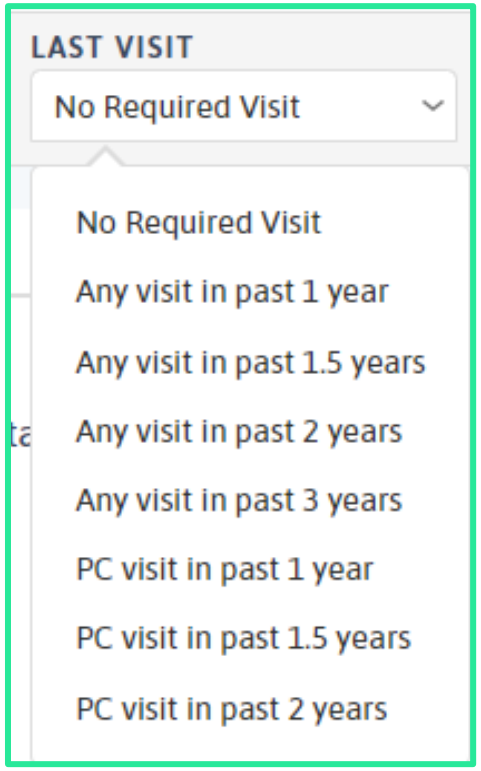
Additional Filters on TOC - ED/IP Report



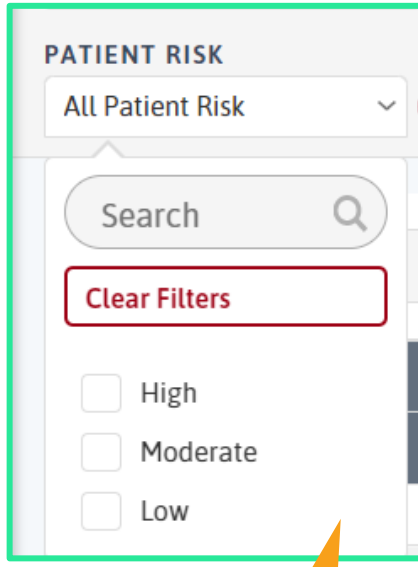


Filter by discharge status and TOC status to help subgroup patients





Filter by last visit for active patients in PC or any visit type



Use the Patient Risk filter to help prioritize follow up and outreach.

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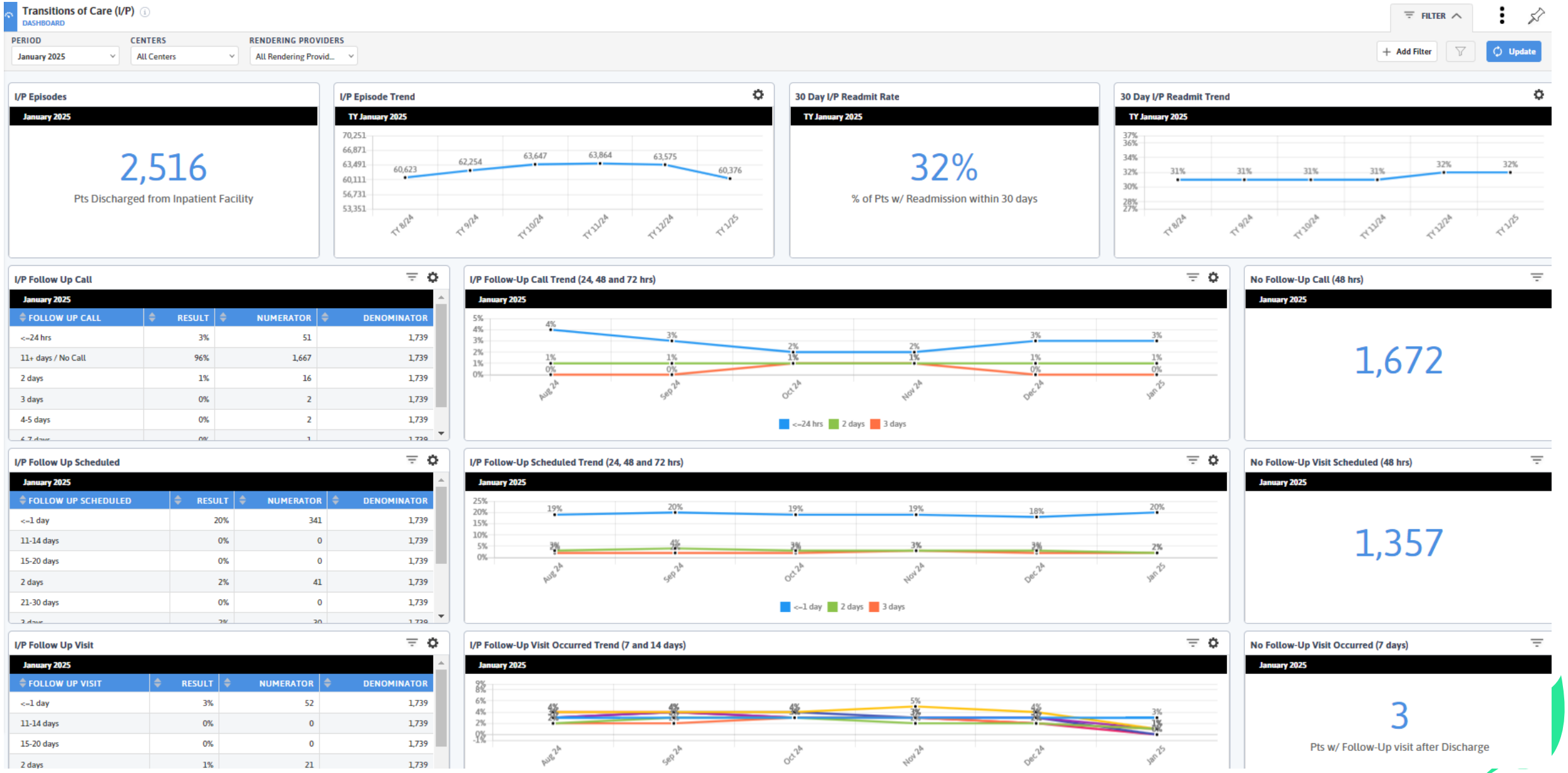
New TOC Dashboard - IP



PVP Alerts

Point of Care: Run the Patient Visit Planning Report

CATEGORY	NAME	PVP NAME	DESCRIPTION	
Other	E/D Encounter	E/D Encounter	Alert will trigger if E/D Episode has occurred in the last 60 days.	
Other	I/P Encounter	I/P Encounter	Alert will trigger if I/P Episode has occurred in the last 60 days. This alert is not configurable	

thyroid--aware of loc, mask and no visitor--agt ER Or Hospital Follow-Up

PCP:
Payer:
Care Manager: Unassigned

Turn on the alerts.

DIAGNOSES (3)

ASM	CNMP	HTN-E

RISK FACTORS (1)

BMI

SDOH (2)

INSURANCE	HISP/LAT

ALERT	MESSAGE	MOST RECENT DATE	MOST RECENT RESULT
Pap	Missing		
Pap HPV	Missing		
Gonorrhea	Overdue	9/13/2016	Negative
LDL	Overdue	12/19/2019	137
Depr Screen	Overdue	12/5/2019	0
Sub Use Scr	Missing		
BP	Out of Range	2/5/2021	140/90
Flu - Seasonal	Overdue	10/25/2019	
Asthma Rx	Overdue		
Medicare AWV	Overdue	10/7/2019	G0439
E/D Encounter	Occurred	3/4/2021	Franciscan Health Lafayette

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Screening mammography of both breasts		11/16/2020	
Dermatology		8/11/2020	
Rheumatology		8/11/2020	

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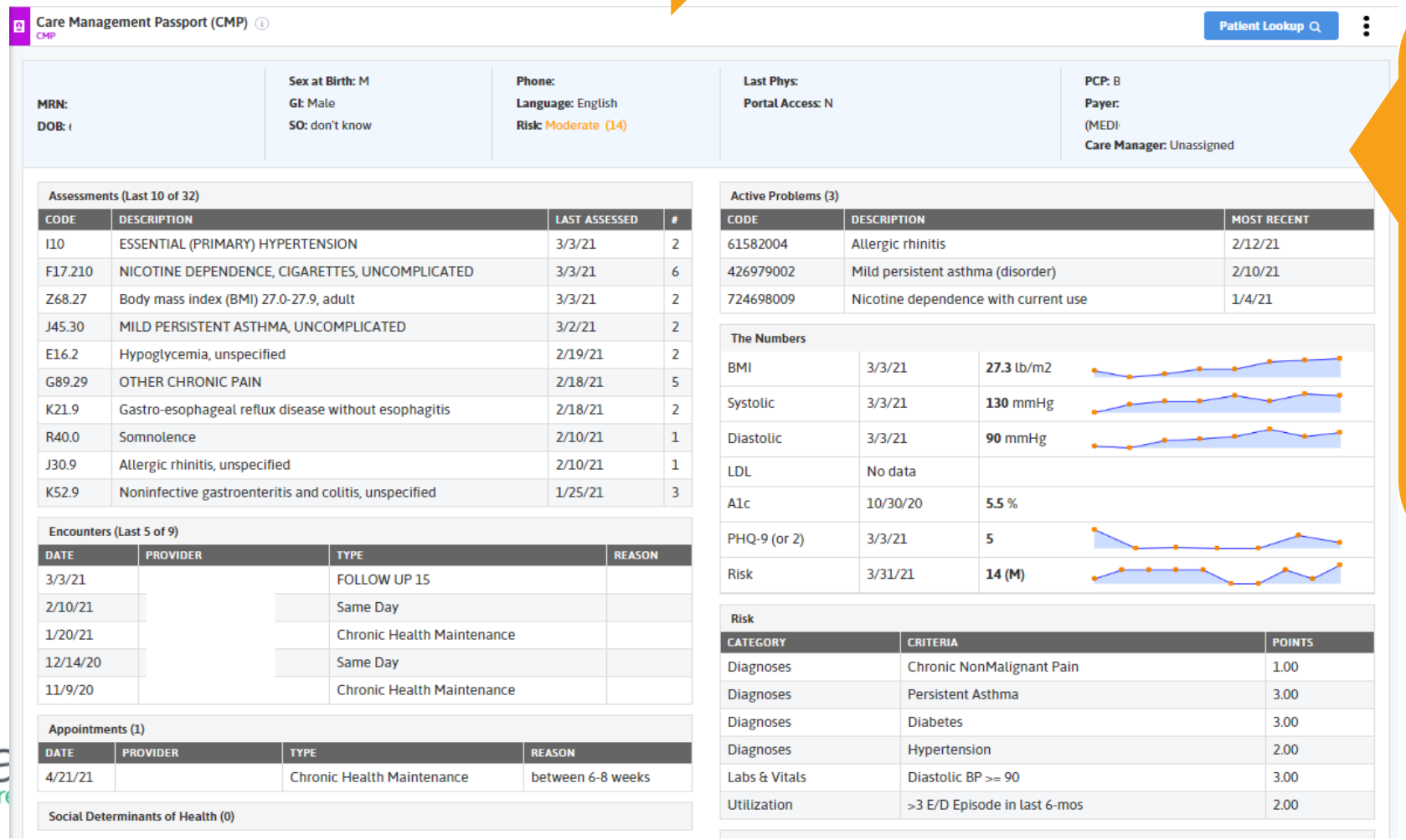
The Care Management Passport (CMP)

Patient History: Run the CMP



Care Management Passport (CMP)
CMP

Patient Lookup

MRN:
DOB:

Sex at Birth: M
GI: Male
SO: don't know

Phone:
Language: English
Risk: Moderate (14)

Last Phys:
Portal Access: N

PCP: B
Payer:
(MEDI
Care Manager: Unassigned

Assessments (Last 10 of 32)

CODE	DESCRIPTION	LAST ASSESSED	#
I10	ESSENTIAL (PRIMARY) HYPERTENSION	3/3/21	2
F17.210	NICOTINE DEPENDENCE, CIGARETTES, UNCOMPLICATED	3/3/21	6
Z68.27	Body mass index (BMI) 27.0-27.9, adult	3/3/21	2
J45.30	MILD PERSISTENT ASTHMA, UNCOMPLICATED	3/2/21	2
E16.2	Hypoglycemia, unspecified	2/19/21	2
G89.29	OTHER CHRONIC PAIN	2/18/21	5
K21.9	Gastro-esophageal reflux disease without esophagitis	2/18/21	2
R40.0	Somnolence	2/10/21	1
J30.9	Allergic rhinitis, unspecified	2/10/21	1
K52.9	Noninfective gastroenteritis and colitis, unspecified	1/25/21	3

Encounters (Last 5 of 9)

DATE	PROVIDER	TYPE	REASON
3/3/21		FOLLOW UP 15	
2/10/21		Same Day	
1/20/21		Chronic Health Maintenance	
12/14/20		Same Day	
11/9/20		Chronic Health Maintenance	

Appointments (1)

DATE	PROVIDER	TYPE	REASON
4/21/21		Chronic Health Maintenance	between 6-8 weeks

Social Determinants of Health (0)

Active Problems (3)

CODE	DESCRIPTION	MOST RECENT
61582004	Allergic rhinitis	2/12/21
426979002	Mild persistent asthma (disorder)	2/10/21
724698009	Nicotine dependence with current use	1/4/21

The Numbers

BMI	3/3/21	**27.3** lb/m2
Systolic	3/3/21	**130** mmHg
Diastolic	3/3/21	**90** mmHg
LDL	No data	
A1c	10/30/20	**5.5** %
PHQ-9 (or 2)	3/3/21	**5**
Risk	3/31/21	**14 (M)**

Risk

CATEGORY	CRITERIA	POINTS
Diagnoses	Chronic NonMalignant Pain	1.00
Diagnoses	Persistent Asthma	3.00
Diagnoses	Diabetes	3.00
Diagnoses	Hypertension	2.00
Labs & Vitals	Diastolic BP >= 90	3.00
Utilization	>3 E/D Episode in last 6-mos	2.00

Use the CMP to understand the patient story.

- Identify problems, assessments
- View most recent encounters, upcoming appointments
- Understand key vitals and lab trends
- View the components contributing to the risk score

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CMP Continued

Allergies (0)

No active allergies

Medications (Last 10 of 28)

ACTIVE AS OF	NAME
3/3/21	amlodipine 5 MG Oral Tablet
2/19/21	isopropyl alcohol 70 % Topical Swab
2/19/21	ACCU-CHEK GUIDE (GLUCOSE) TEST STRIP
2/18/21	Naproxen 500 MG Oral Tablet
2/18/21	Omeprazole 40 MG Delayed Release Oral Capsule
2/10/21	Zyrtec 10 MG Oral Tablet
2/10/21	Advair Diskus 250/50 Dry Powder Inhaler, 60 ACTUAT
2/10/21	gabapentin 600 MG Oral Tablet
1/8/21	Diclofenac Sodium 75 MG Delayed Release Oral Tablet
1/4/21	Chantix Starting Month PAK

Alerts (5)

ALERT	MESSAGE	MOST RECENT DATE	MOST RECENT RESULT
LDL	Missing		
Depr Follow-Up	Missing Follow-up		
BP	Out of Range	3/3/21	130/90
Foot	Missing		
E/D Encounter	Occurred	3/2/21	IU Health

Open Referrals w/o Result (4)

TYPE	SPECIALIST/LOCATION	ORDER DATE	APPT DATE
Z12.11 - GASTROENTEROLOGY REFERRAL	IU HEALTH PHYSICIANS GASTROENTEROLOGY / IU HEALTH PHYSICIANS GASTROENTEROLOGY	1/25/21	
M79.605 - PODIATRY REFERRAL	TOD S REED DPM / TOD S REED DPM	8/11/20	
M79.605 - PHYSICAL THERAPY REFERRAL	IU HEALTH BALL MEMORIAL REHABILITATION CENTER / IU HEALTH BALL MEMORIAL REHABILITATION CENTER	8/11/20	
R55 - NEUROLOGY REFERRAL	IU HEALTH BALL MEMORIAL PHYSICIANS NEUROLOGY-ALAN SCHMITT / IU HEALTH BALL MEMORIAL PHYSICIANS NEUROLOGY- ALAN SCHMITT	6/9/20	

I/P & E/D Utilizations (Last 10 of 35)

SOURCE	TYPE	ADMIT DATE	DISCHARGE DATE	LOCATION	DIAGNOSIS	DESCRIPTION
IHIE	ER Visit	3/2/21	3/2/21	IU Health		
IHIE	ER Visit	3/1/21	3/1/21	IU Health		
IHIE	ER Visit	2/25/21	2/26/21	IU Health		
EHR	Hospital Discharge	2/11/21	2/11/21			
IHIE	ER Visit	2/9/21	2/9/21	IU Health		
IHIE	ER Visit	1/17/21	1/17/21	IU Health		
EHR	Hospital Discharge	1/12/21	1/12/21			
IHIE	ER Visit	1/10/21	1/10/21	IU Health		
IHIE	ER Visit	1/8/21	1/8/21	IU Health		
IHIE	ER Visit	1/7/21		Reid Hospital		

The **Care Management Passport** will help the Care Coordinators, RN Care Managers, and other care team members prepare prior to their communication with the patient.

Follow up on open referrals to improve coordination of care efforts.

Identify each ER Visit and Hospital Discharge based on the HIE data.

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Azara Patient Outreach (APO)

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Member Outreach Challenges

Members

Who needs outreach?

Who will Respond?

Method

What communication method works best?

Call, letter, text, or combination?

Staff

Existing staff?

New staff?

ROI

How to measure value?

What is the ROI?

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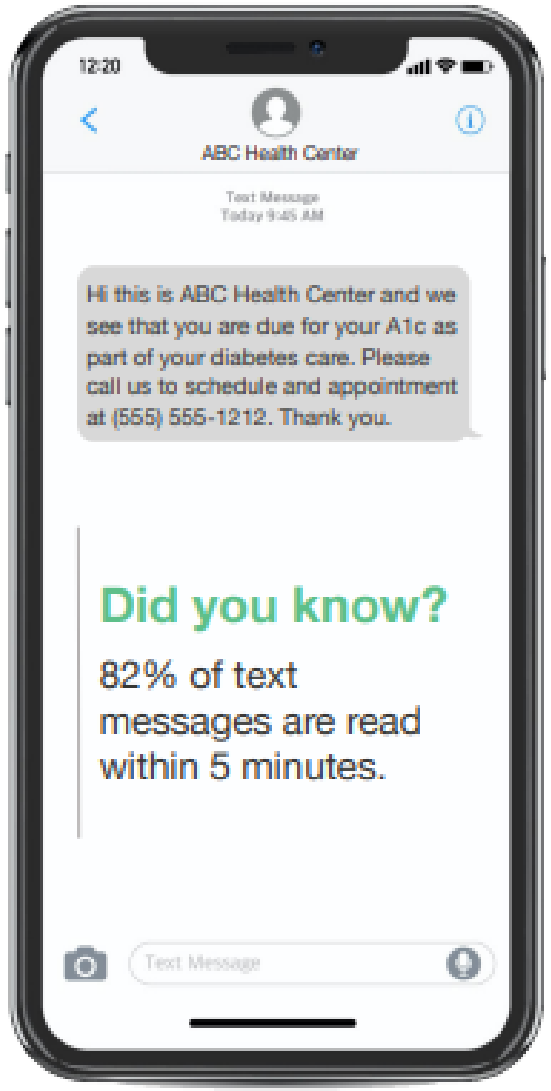

Patient Engagement

O

!

- Automated and targeted campaigns
- Text messaging is most effective
- Use analytics to reach the right people at the right time with the right message
- Data humanizes and drives meaningful experiences
- Track results and adjust campaigns
- Utilize flexible solutions to reach diverse populations

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Available SiFi Campaigns

- **Cancer Screening**
  - Breast
  - Cervical
  - Colorectal
  - Unreturned FIT Kits
- **Chronic Disease**
  - Diabetes A1c
  - Comprehensive Diabetes
  - Undiagnosed Hypertension
  - Hypertension Control
  - CKD Screening: Patients w/ HTN, Diabetes
- **Pediatrics**
  - Childhood Immunizations
  - Well-Child Visits
  - Adolescent Immunizations
  - HPV Vaccination
- **Preventative Visits**
  - Patients Without Visits
  - Primary Care No Shows
  - Seasonal Flu
  - Chlamydia Screening
- **COVID-19**
  - Immunization Availability
  - 2nd Dose Reminder
  - Booster Dose Reminder
- **VBC**
  - IP Discharge Follow-Up
  - ED Discharge Follow-Up
  - Members without Visits
  - Unmatched Members
  - Medicaid Redetermination

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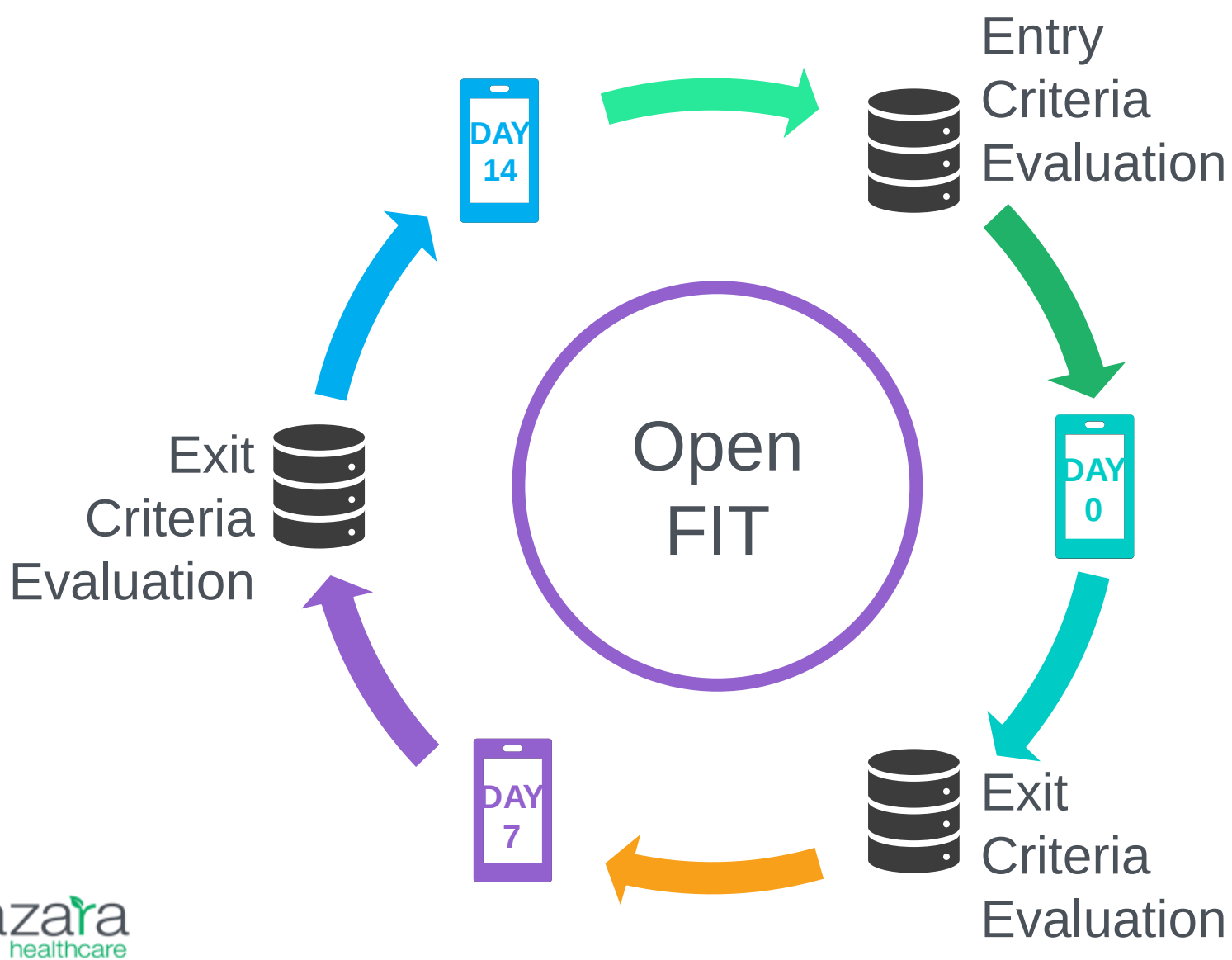
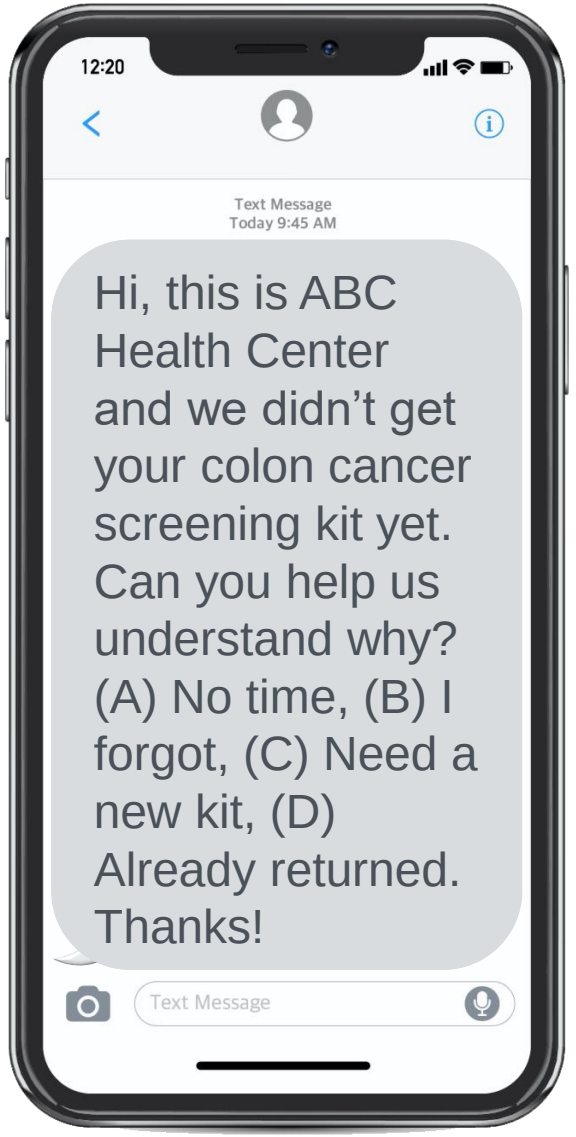
◆ Requires Payer Integration

⬟ Requires HIE

Patient Text Journey





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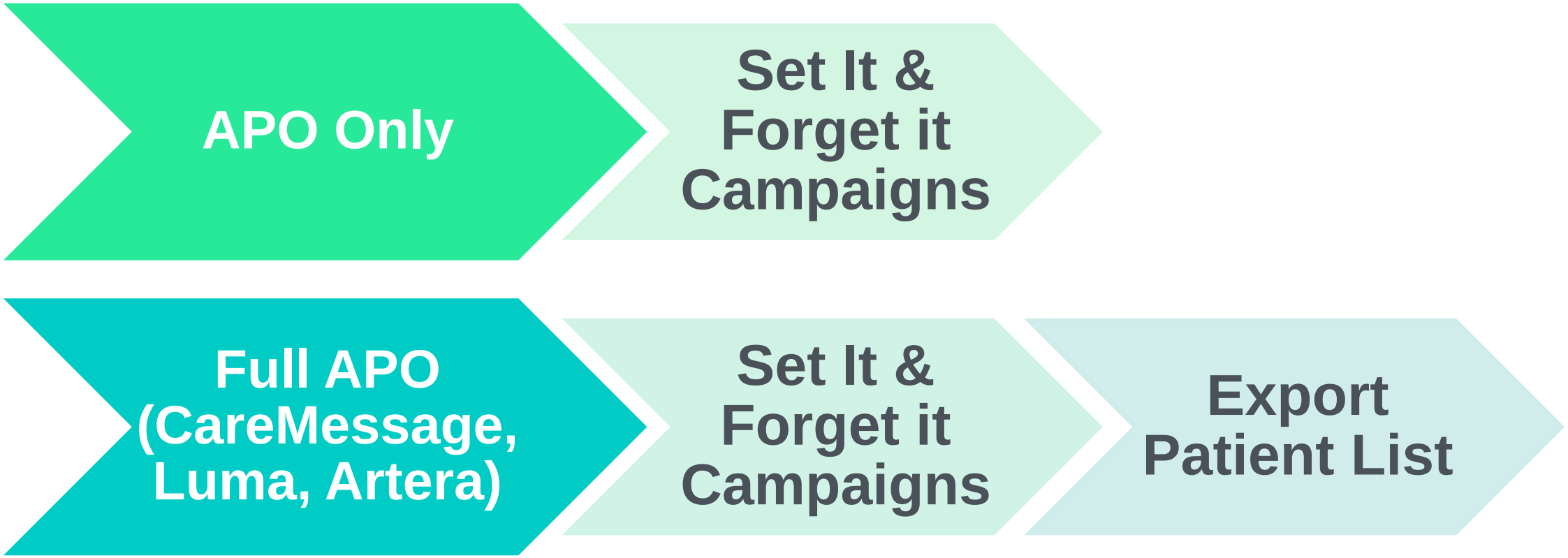
Manual Campaign Availability

Manual campaigns available on measure detail list and registries



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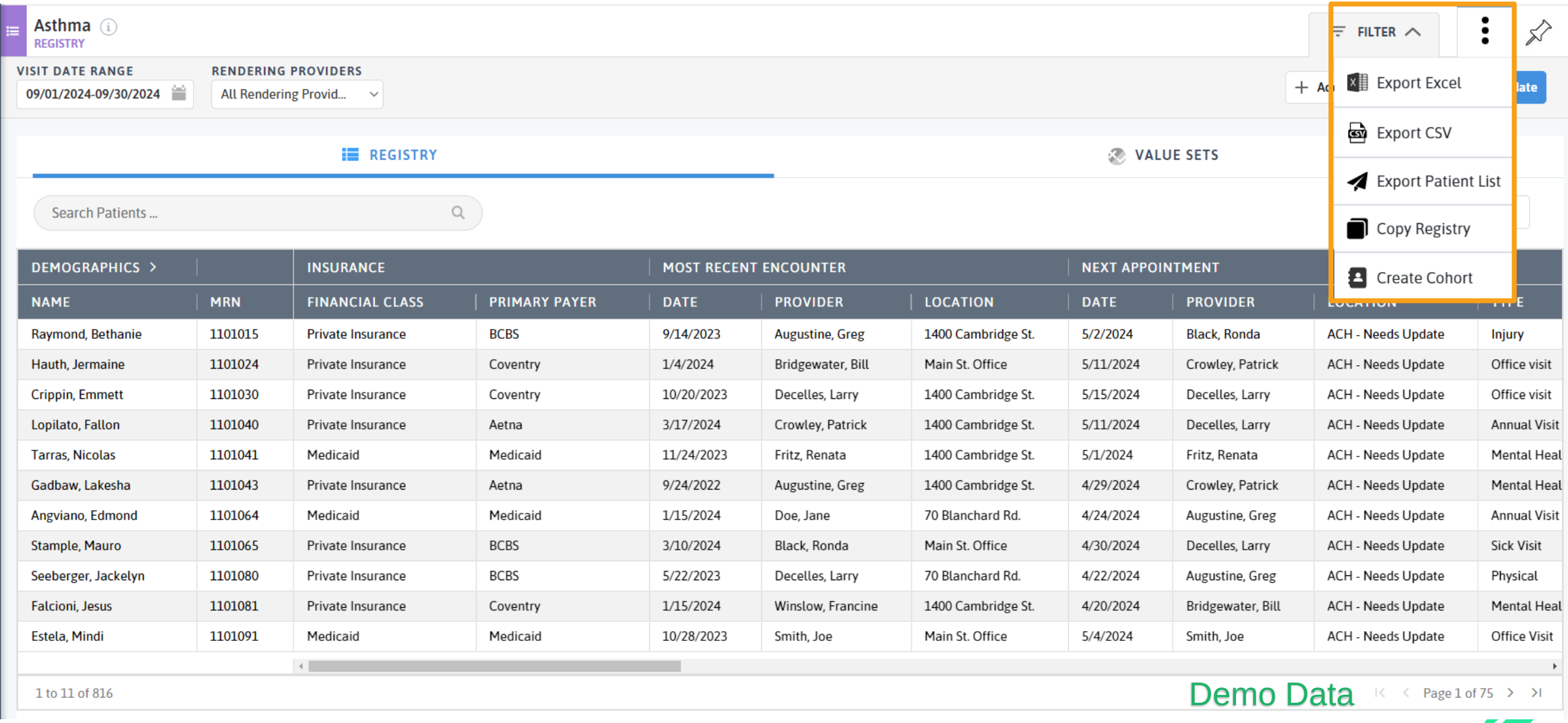
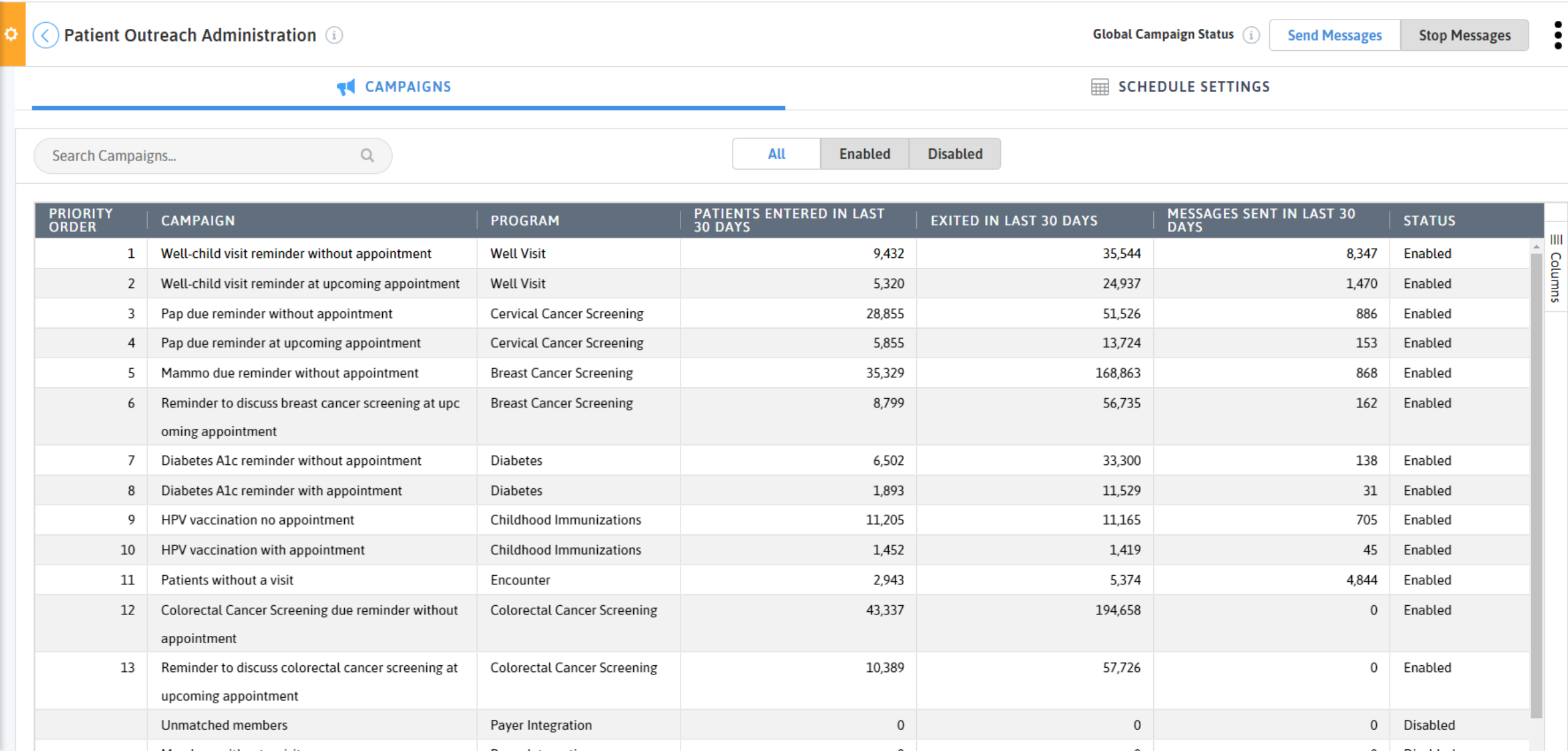
Manual Campaign | Registries



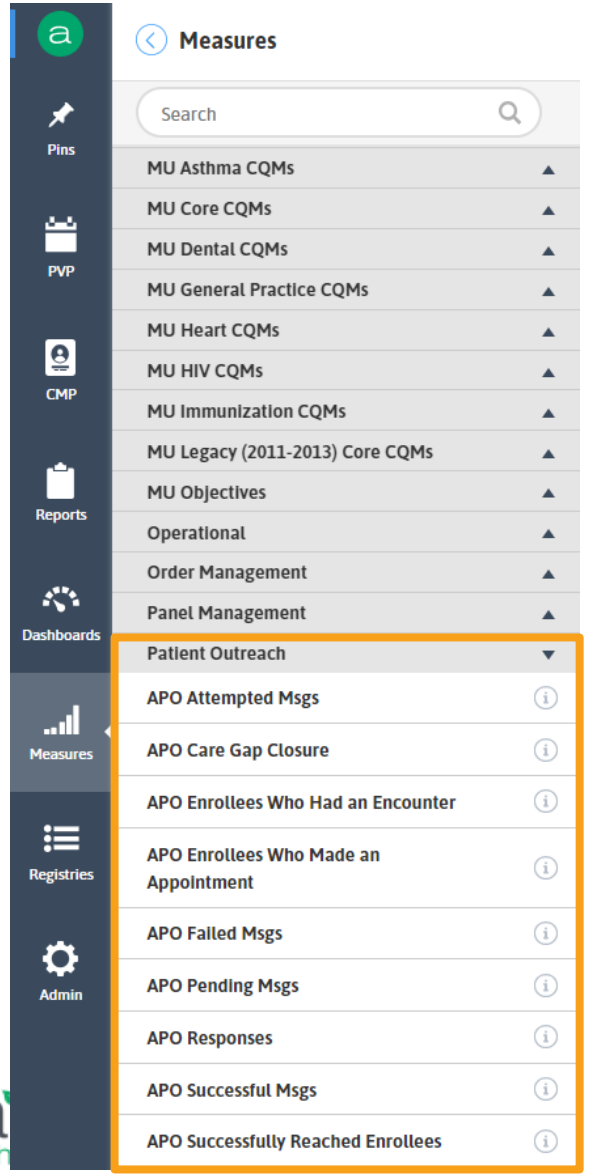
Demo Data

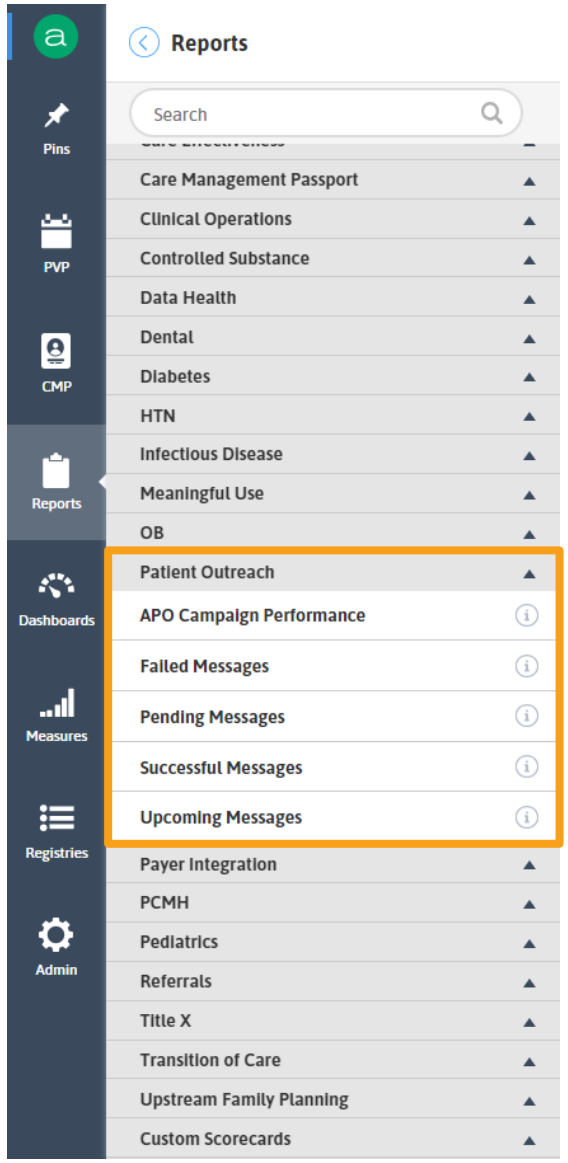
APO in DRVS | Campaign Control



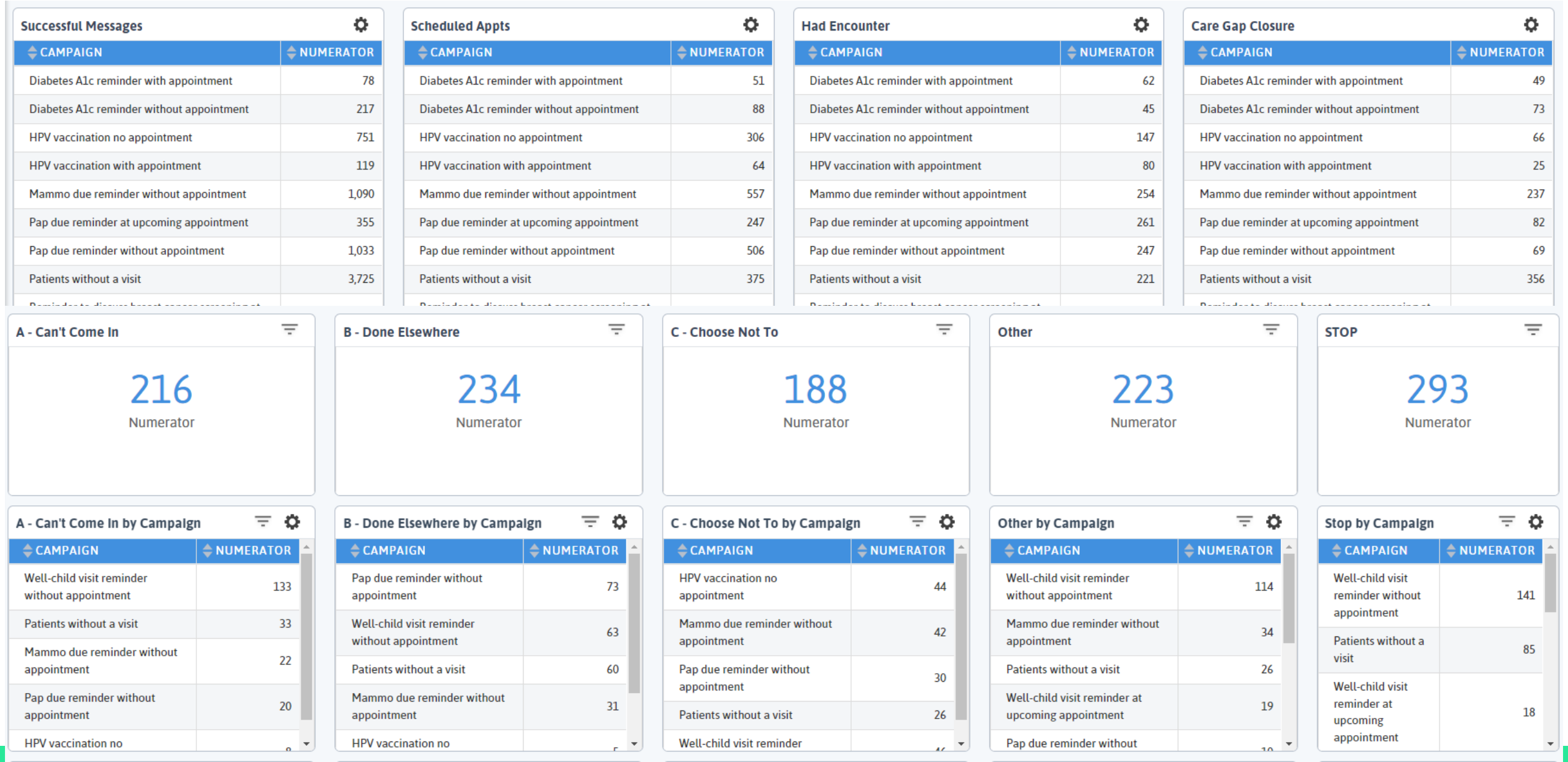
PRIORITY ORDER	CAMPAIGN	PROGRAM	PATIENTS ENTERED IN LAST 30 DAYS	EXITED IN LAST 30 DAYS	MESSAGES SENT IN LAST 30 DAYS	STATUS
1	Well-child visit reminder without appointment	Well Visit	9,432	35,544	8,347	Enabled
2	Well-child visit reminder at upcoming appointment	Well Visit	5,320	24,937	1,470	Enabled
3	Pap due reminder without appointment	Cervical Cancer Screening	28,855	51,526	886	Enabled
4	Pap due reminder at upcoming appointment	Cervical Cancer Screening	5,855	13,724	153	Enabled
5	Mammo due reminder without appointment	Breast Cancer Screening	35,329	168,863	868	Enabled
6	Reminder to discuss breast cancer screening at upcoming appointment	Breast Cancer Screening	8,799	56,735	162	Enabled
7	Diabetes A1c reminder without appointment	Diabetes	6,502	33,300	138	Enabled
8	Diabetes A1c reminder with appointment	Diabetes	1,893	11,529	31	Enabled
9	HPV vaccination no appointment	Childhood Immunizations	11,205	11,165	705	Enabled
10	HPV vaccination with appointment	Childhood Immunizations	1,452	1,419	45	Enabled
11	Patients without a visit	Encounter	2,943	5,374	4,844	Enabled
12	Colorectal Cancer Screening due reminder without appointment	Colorectal Cancer Screening	43,337	194,658	0	Enabled
13	Reminder to discuss colorectal cancer screening at upcoming appointment	Colorectal Cancer Screening	10,389	57,726	0	Enabled
	Unmatched members	Payer Integration	0	0	0	Disabled

APO Measures & Reports





Custom APO Dashboards



Successful Messages

CAMPAIGN	NUMERATOR
Diabetes A1c reminder with appointment	78
Diabetes A1c reminder without appointment	217
HPV vaccination no appointment	751
HPV vaccination with appointment	119
Mammo due reminder without appointment	1,090
Pap due reminder at upcoming appointment	355
Pap due reminder without appointment	1,033
Patients without a visit	3,725

Scheduled Appts

CAMPAIGN	NUMERATOR
Diabetes A1c reminder with appointment	51
Diabetes A1c reminder without appointment	88
HPV vaccination no appointment	306
HPV vaccination with appointment	64
Mammo due reminder without appointment	557
Pap due reminder at upcoming appointment	247
Pap due reminder without appointment	506
Patients without a visit	375

Had Encounter

CAMPAIGN	NUMERATOR
Diabetes A1c reminder with appointment	62
Diabetes A1c reminder without appointment	45
HPV vaccination no appointment	147
HPV vaccination with appointment	80
Mammo due reminder without appointment	254
Pap due reminder at upcoming appointment	261
Pap due reminder without appointment	247
Patients without a visit	221

Care Gap Closure

CAMPAIGN	NUMERATOR
Diabetes A1c reminder with appointment	49
Diabetes A1c reminder without appointment	73
HPV vaccination no appointment	66
HPV vaccination with appointment	25
Mammo due reminder without appointment	237
Pap due reminder at upcoming appointment	82
Pap due reminder without appointment	69
Patients without a visit	356

A - Can't Come In

216
Numerator

B - Done Elsewhere

234
Numerator

C - Choose Not To

188
Numerator

Other

223
Numerator

STOP

293
Numerator

A - Can't Come In by Campaign

CAMPAIGN	NUMERATOR
Well-child visit reminder without appointment	133
Patients without a visit	33
Mammo due reminder without appointment	22
Pap due reminder without appointment	20
HPV vaccination no	

B - Done Elsewhere by Campaign

CAMPAIGN	NUMERATOR
Pap due reminder without appointment	73
Well-child visit reminder without appointment	63
Patients without a visit	60
Mammo due reminder without appointment	31
HPV vaccination no	

C - Choose Not To by Campaign

CAMPAIGN	NUMERATOR
HPV vaccination no appointment	44
Mammo due reminder without appointment	42
Pap due reminder without appointment	30
Patients without a visit	26
Well-child visit reminder	

Other by Campaign

CAMPAIGN	NUMERATOR
Well-child visit reminder without appointment	114
Mammo due reminder without appointment	34
Patients without a visit	26
Well-child visit reminder at upcoming appointment	19
Pap due reminder without	

Stop by Campaign

CAMPAIGN	NUMERATOR
Well-child visit reminder without appointment	141
Patients without a visit	85
Well-child visit reminder at upcoming appointment	18

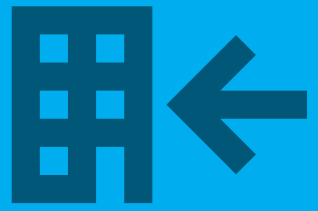
Key Take-Aways

Use APO to ***increase patient engagement & close care gaps***

Determine which campaigns to focus on and ***prioritize***

Consider ***when is best*** to send messages

Set up the campaigns



Track operational measures

Evaluate success of the campaigns

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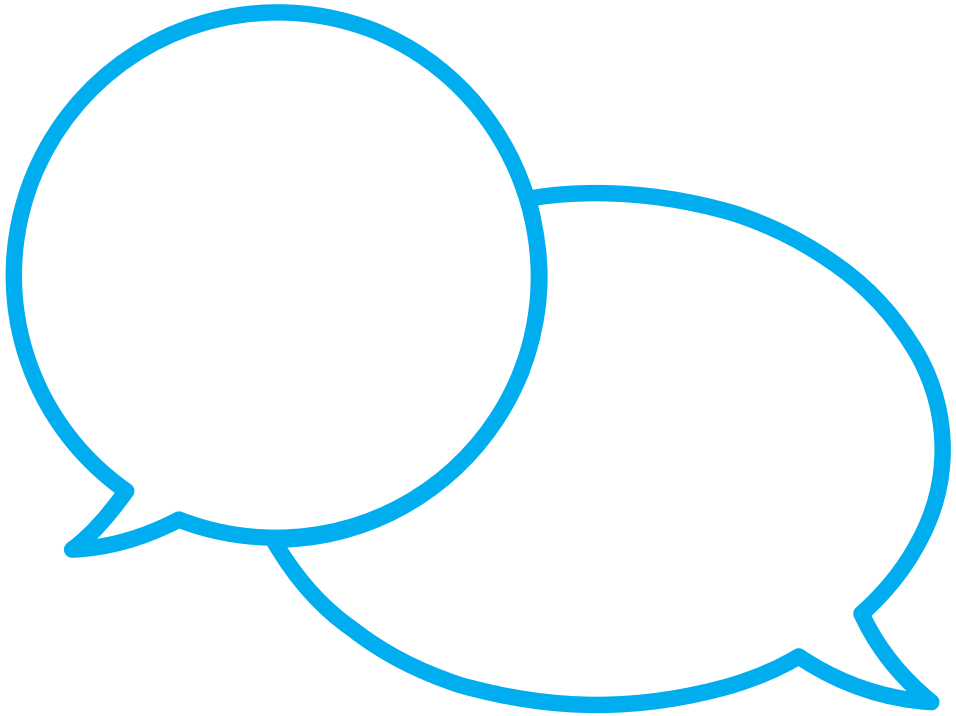
Questions?



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@AzaraDRVS

Make Your Data Work for You

Data on a Mission

Make your data **work for you**

Create **efficiencies**

Implement **data-driven decisions** at all levels of organization

Provide **high-quality, evidence-based** patient care

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Understand Your Measure Landscape

More than just understanding measures

Measure Name		UDS	HCCN	PCA Clinical Quality Award	HEDIS Contracts /P4P	MU CQM	State DOH CRC Grant	Payer A	Payer B	Payer C
	Patient Volume (by Total Pop)*							#members	#members	#members
DM A1c Testing and Control	#	X		X	X	X		X	X	
Cervical Cancer Screening		X	X	X	X	X				X
Childhood Immunizations		X	X	X	X	X				
HTN BP Control		X		X	X	X			X	
Child Weight Screening and Counseling		X		X	X	X				
Colorectal Cancer Screening		X	X	X	X	X	X	X		
Depression Screening and Follow-up		X		X		X				
Adult Weight Screening and Follow-up		X			X	X				
Asthma Pharmacological Therapy (5-11)		X			X	X			X	X
Asthma Pharmacological Therapy (12-18)									X	X
Infant Well Child Visit 0-15 mos					X			X	X	X
Well Child Visits 3-6 yrs	1058				X			X	X	

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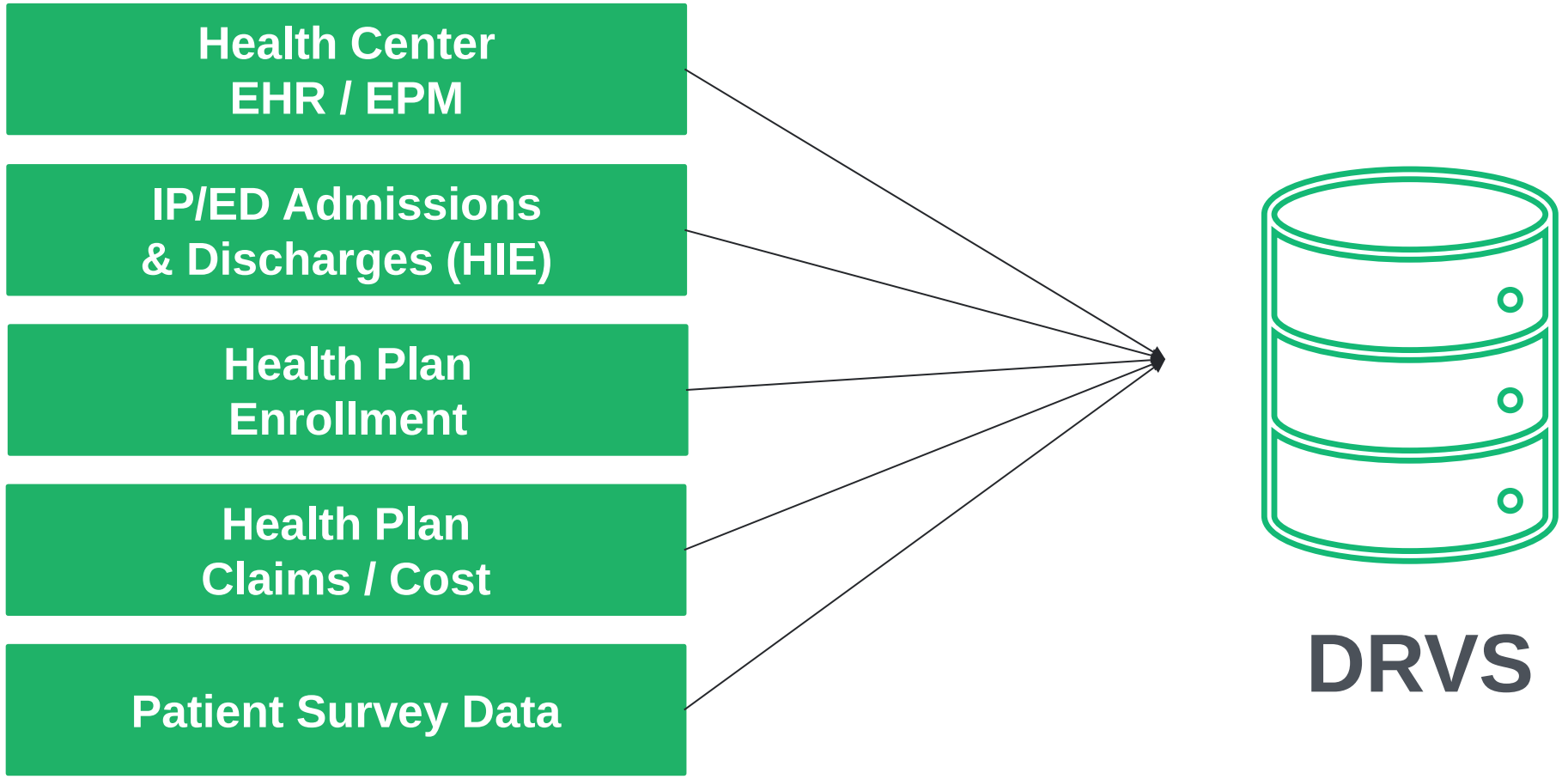
Azara DRVS Data Sources



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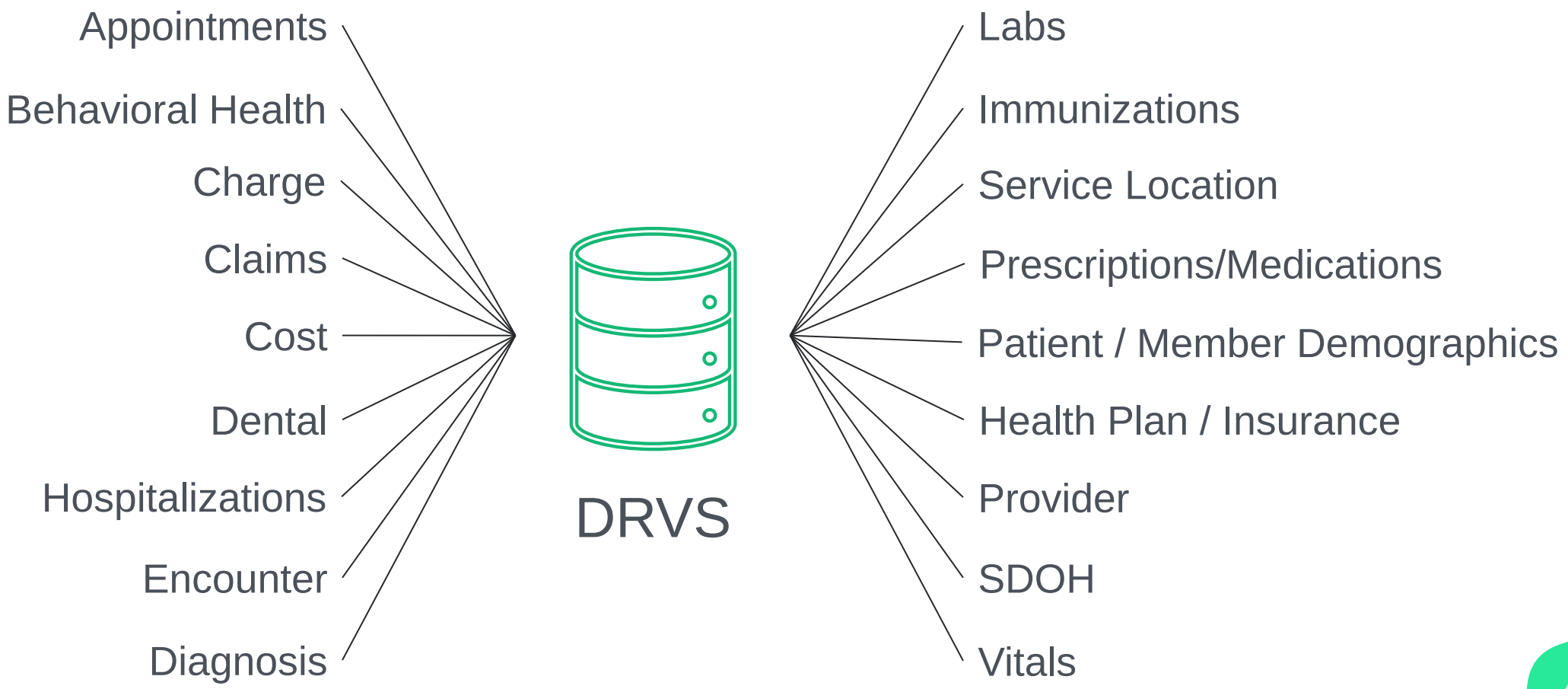
Data Available in Azara DRVS

Azara DRVS collects a wide range of patient data from multiple sources including Electronic Health Records, Payer Claims, and Health Information Exchange



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Why Data Hygiene Matters

Creating a Foundation of Trust

Data Hygiene & Quality Improvement

Data hygiene is about understanding data; understanding data provides the foundation for quality improvement.

Azara's Approach to Data Hygiene

Leverage DRVS tools to investigate data discrepancies.

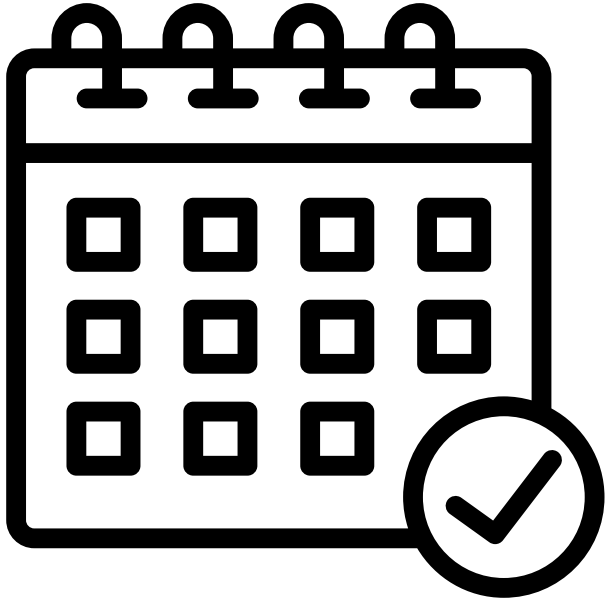
Identify patterns in data issues.

Prevent data discrepancies from occurring.

Ensuring Data Accuracy

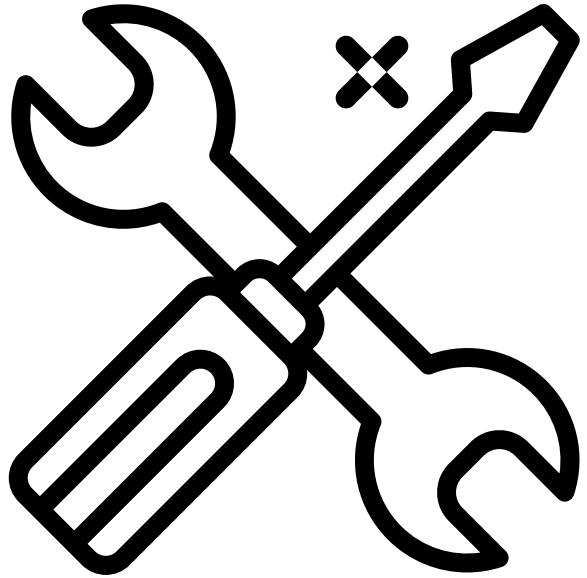
Data Hygiene

- Creating a system and developing processes to ensure data success
- Establishing routines to continuously check on data



Data Validation

- Activities and tools for investigating data in DRVS and comparing to data in the EHR



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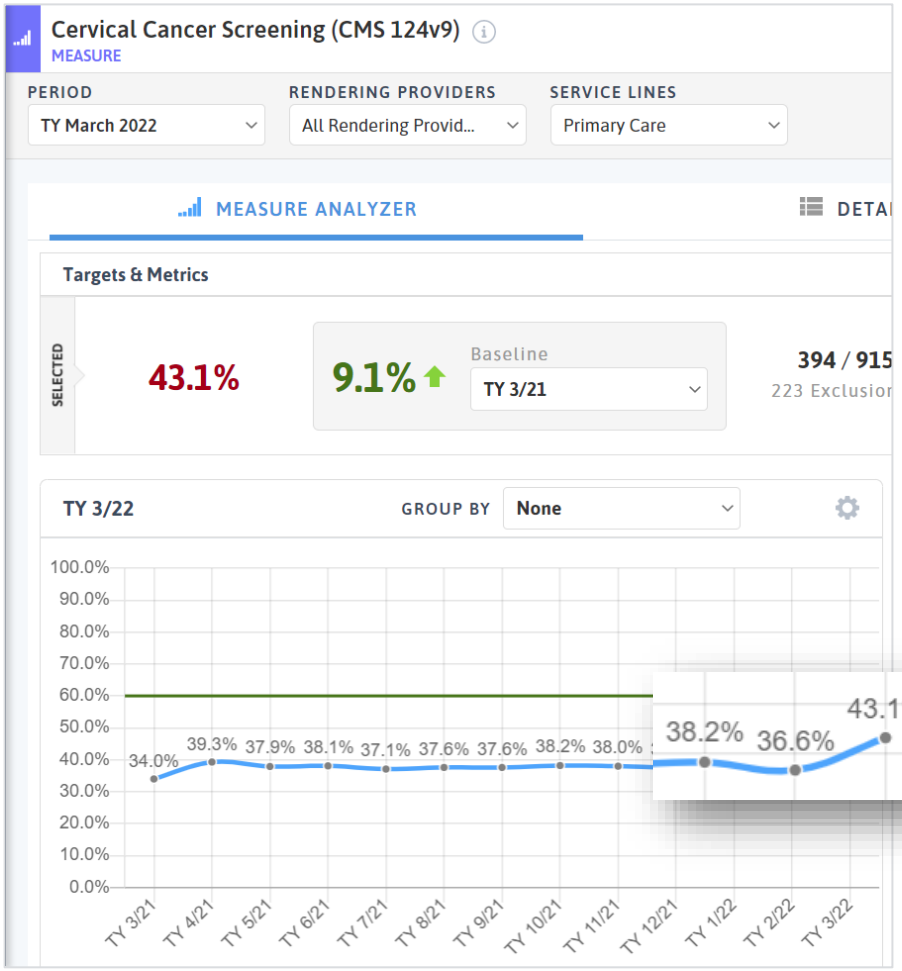
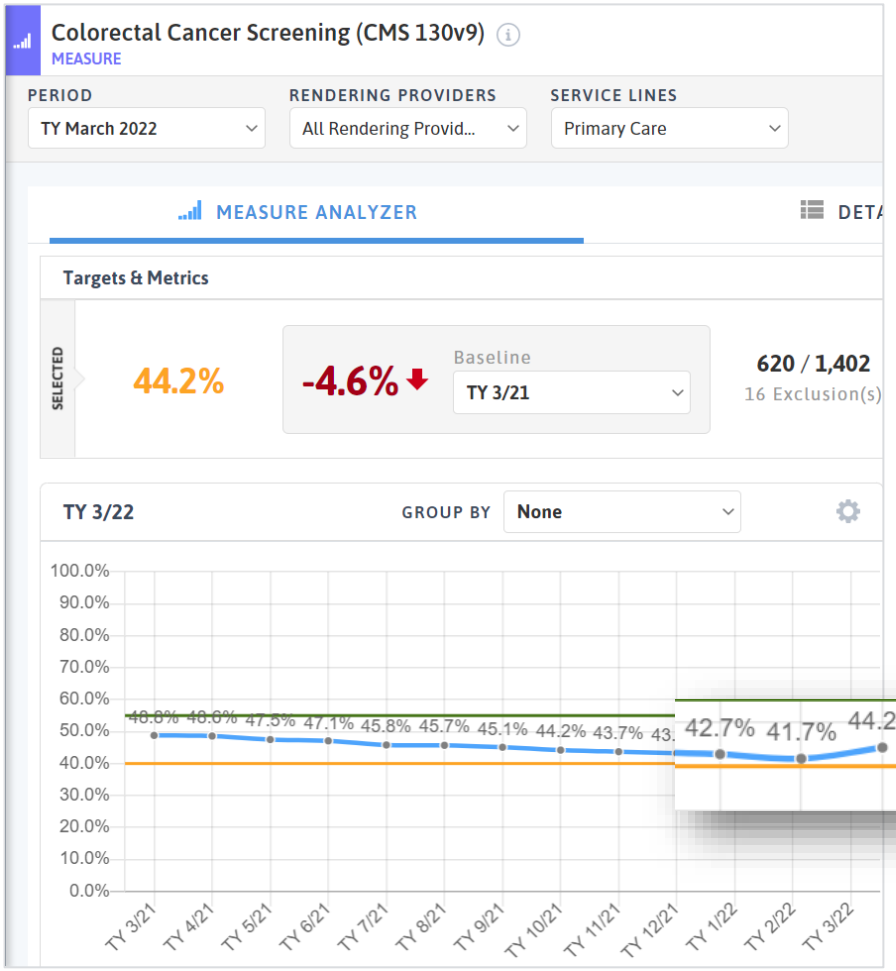
Data Hygiene Success | Cancer Screening



Identified unmapped workflows through CQM gap analysis and saw **6.5% increase** in Cervical Cancer screening and **2.5% increase** in Colorectal Cancer screening



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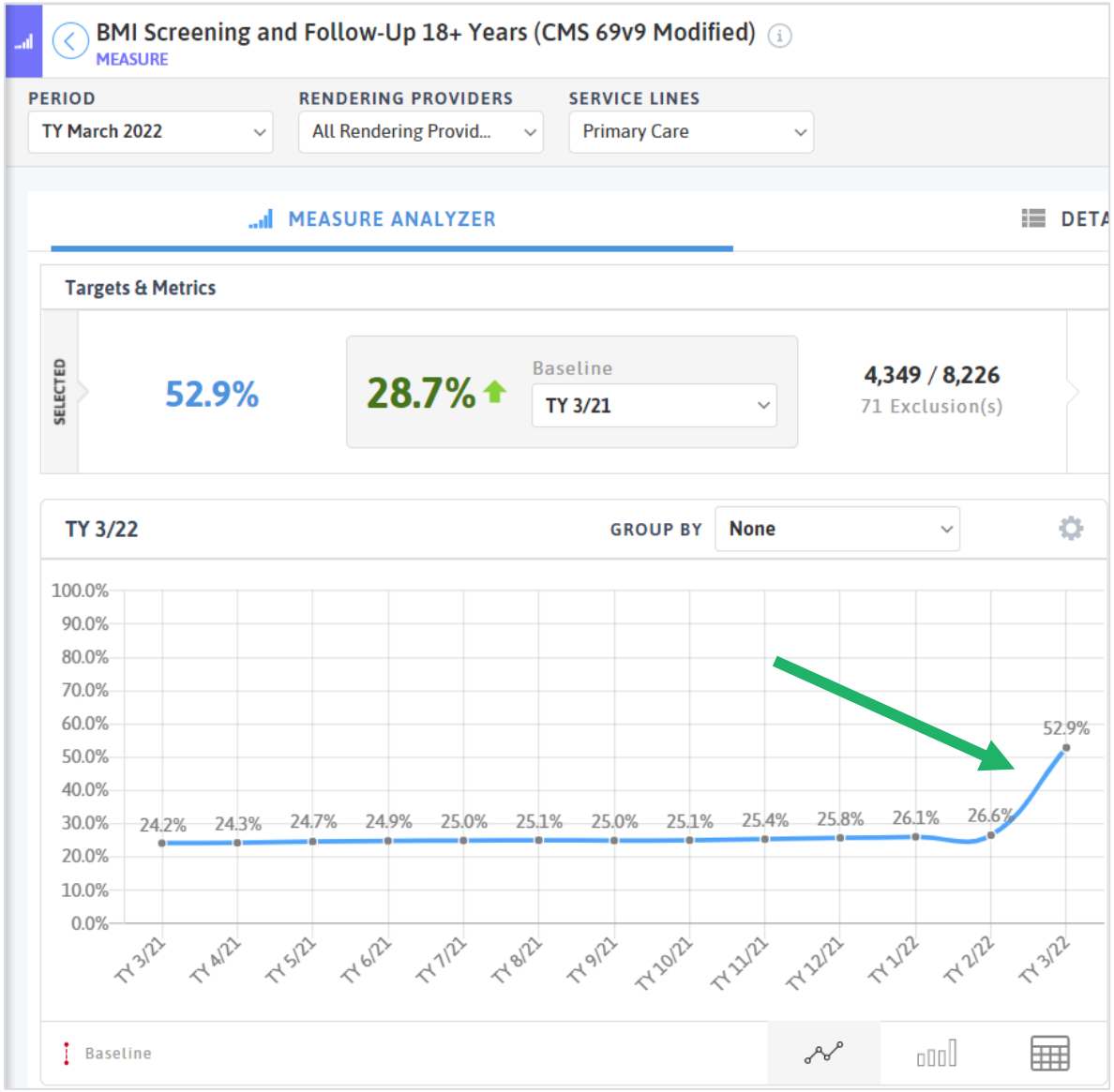
Data Hygiene Success | BMI Screening & FU

Using the scorecard gap analysis, one practice saw a **26.7% increase** in performance.



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Organize Your System

Build a **measure matrix** to identify key measures for your organization

Measure Name	UDS 2024	HCCN	PCA Clinical Quality Award	HEDIS /P4P	Other Grant	ACO	Other
DM A1c Testing and Control	X		X	X			
Cervical Cancer Screening	X	X	X	X			
Childhood Immunizations	X	X	X	X			
HTN BP Control	X		X	X		X	X
Child Weight Screening and Counseling	X		X	X			X
Colorectal Cancer Screening	X	X	X	X	X	X	X
Breast Cancer Screening	X						
Depression Screening and Follow-up	X		X			X	
Depression Remission at 12 Months	X						
Adult Weight Screening and Follow-up	X			X			X
Statin Therapy - Prev&Tx CAD	X			X			
IVD Use of Aspirin	X			X			X
HIV Screening	X						
HIV Linkage to Care	X						
Prenatal Trimester of Entry to Care	X	X		X			
Postnatal Birthweight	X						
Child Dental Sealants	X						

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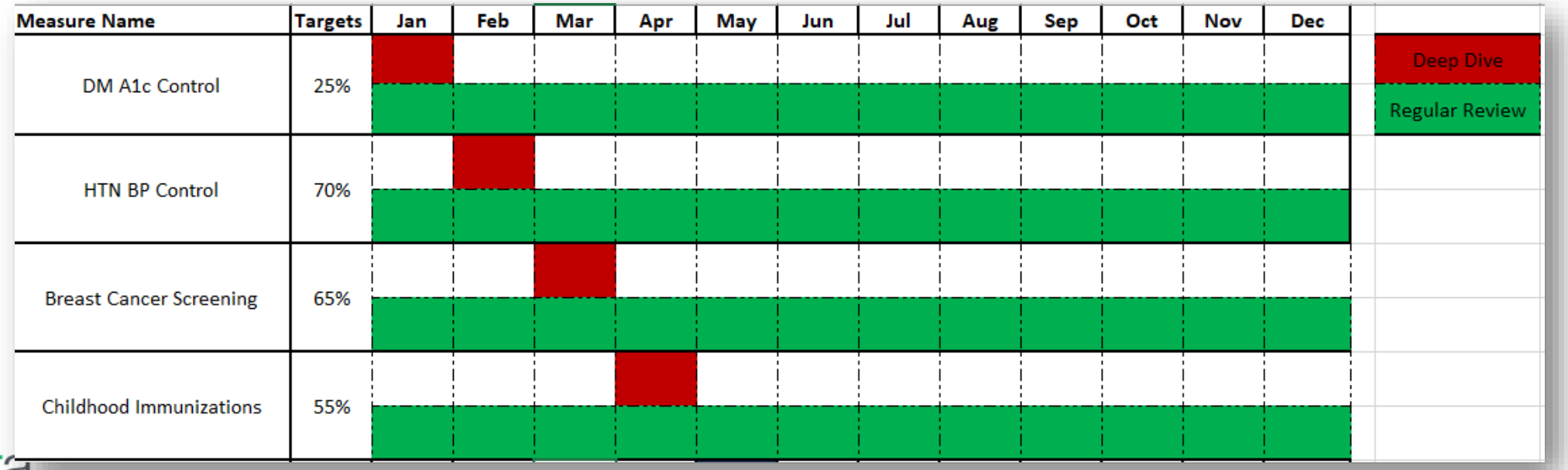
Building a Data Validation Calendar

Data Validation Calendar: measure-based calendar to track validation and review efforts. Consider the following when building your calendar:

- Measure Matrix | identifies measures of interest for **first column**
- Quality Meeting Schedule | determines **regular review** cycle
- Focus Measures | require **deep dive** validation. These measures can be identified through PDSA cycles, reporting deadlines, etc.



Organize Your System

Create a **data hygiene calendar** to plan activities throughout the year

General System Admin						
Item	**Action**	**Suggested frequency**	**Rationale**	**Owner**	**Updates**	**Notes**
Alerts	Review - update/disable	Quarterly/6 months	New alerts are not automatically enabled. Sort for creation date to review new measures. Are they configured correctly to meet your goals? If it's in your quality plan and an alert exists, it should be enabled. Review if you want the alert included in the POC Alert measure. Review PVP Display names to determine if the name is clear. Owners may also be updated to indicate who should take action on the alert (i.e. BMI - MA, Mammogram - Prov).			
Care Effectiveness (custom)	Review - is the report still used	6 months	Requires Support ticket			
Care Managers	Review - Disable/Delete		If you create Care Managers in DRVS to use in ACC, make sure they are up to date.			
Cohorts	Review - update/disable/delete	6 months	Are there any cohorts that are not actively in use that should be deleted or disabled? Check to see if they should be included on the PVP or in ACC. New dynamic cohorts may also be available.			
Dashboards	Review - Disable/Delete	Quarterly/6 months	Do you have old items to clean up? Test items that only you or another admin are using? Are their quick access items that should be pinned and shared in your center folder. Are things named appropriatly or should you update the name, if you have specific instructions for running something did you include those in the description (info snippet).			
Email Subscriptions	Review - update/disable/delete	Quarterly	Are you aware of everything going out? Are all your subscriptions up to date? Still relevant? If not create new and disable or delete old ones.			
Force Match	Review potential matches	Monthly	Keep payer rosters up to date; enhance outreach. *Available for practices with the Payer Integration module.*			
Groups	Review - update/delete	Quarterly/6 months	Assure all appropriate criteria is included. Requires Support ticket.			
Locations/Location Groups	Review - update	Annual	Ensure newly opened/closed are added/deleted from groups, identify school based & public housing sites			
Measure Validation Workbooks	Review/delete	Annual	If you created a MV workbook using a TY period, it is only good for 13 months. Measures do not get generated on a TY basis beyond 13 months so your old workbooks will not generate patients and can't be updated.			
Patient Outreach	Review - update	Quarterly/Monthly	*Available for practices with the Azara Patient Outreach module.* Manage set-it-and-forget-it campaigns. Review the **APO Campaign Performance report** for impact of the texting campaigns. Enable/disable and/or reprioritize as needed. Solicit feedback from staff fielding the calls generated by the texting campaigns. Are they overwhelmed? Do they more time available? Update the **Schedule Settings** as needed.			
Providers	Review - Update	Quarterly	Keep provider groups updated. Look at column - UDS Service category for unmapped, this comes from EHR user accounts. If you start entering providers differently than when you originally mapped they will come over as unmapped. Identify who should be included in filters and the 4-cut Provider groupings improve ease of filtering. Are they new providers? Inactive providers with patients still assigned? Status is updated in the EHR.			
Registries	Review - Disable/Delete	Quarterly/6 months	Do you have old items to clean up? Test items that only you or another admin are using? Are their quick access items that should be pinned and shared in your center folder. Are things named appropriatly or should you update the name, if you have specific instructions for running something did you include those in the description (info snippet).			
Scorecards	Review - Disable/Delete	Quarterly/6 months	Do you have old items to clean up? Test items that only you or another admin are using? Are their quick access items that should be pinned and shared in your center folder. Are things named appropriatly or should you update the name, if you have specific instructions for running something did you include those in the description (info snippet).			

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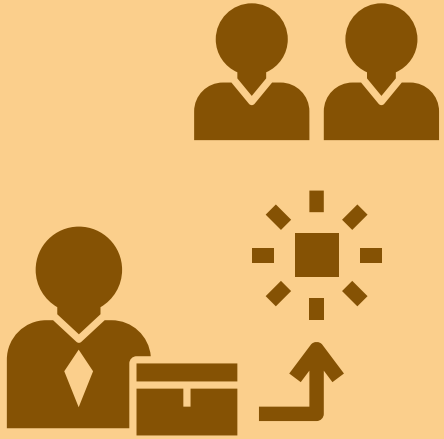
DRVS Tools for Data Validation

To Build Trust, Deconstruct the Problem

Be aware of any assumptions you may have.

Look at all aspects of the issue.



Get specific with examples.

Look for patterns.

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Data Timing

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Data Processing Frequency

WHEN IS MY DATA REPROCESSED IN DRVS?

Daily / Overnight

- Patient Visit Planning (PVP)
- Care Management Passport (CMP)
- Appointments
- Cohort Changes
- Registries
- Referrals reports
- Transitions of Care ADTs
- Patient Level Data including: DRVS/ACC
  - POC Testing Alert Closure / Weekly Option
  - Labs/Vitals (PVP not the measure)
  - Medications
  - Conditions

Weekly / Over the Weekend

- Clinical Quality Measures
- Scorecards
- UDS Tables
- Dashboards
- 4 Cut Provider Changes

FAQs

- Refer to your Data Latency Report to determine your most recent data pull.
- Data Connectors update nightly but could be 24-48 delayed depending on the EHR – reach out to support for your practice's specifics.
- Data processing only goes back a few weeks, if your data needs to be reprocessed further back, please place a support ticket (IE: Lag in billing or chart closures).

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EHR Data Latency Report

- **Create date** = the most recent create date reflected in the data DRVS has from the EHR
- **Data latency** for each category is the difference between the **Date entered** into DRVS and the **create date**

ENCOUNTER		LAB	
CREATED IN EHR	ENTRY IN DRVS	CREATED IN EHR	ENTRY IN DRVS
5/30/2022	5/31/2022	5/31/2022	5/31/2022

	APPOINTMENT		CHARGE		ENCOUNTER		LAB		STRUCTURED CLINICAL DATA (MAINTENANCE)		PATIENT		PRESCRIPTION		PROVIDER ORDER LAB	
	CREATED IN EHR	ENTRY IN DRVS	CREATED IN EHR	ENTRY IN DRVS	CREATED IN EHR	ENTRY IN DRVS	CREATED IN EHR	ENTRY IN DRVS	CREATED IN EHR	ENTRY IN DRVS	CREATED IN EHR	ENTRY IN DRVS	CREATED IN EHR	ENTRY IN DRVS	CREATED IN EHR	ENTRY IN DRVS
F...	6/4/2022	6/6/2022	5/30/2022	5/31/2022	5/30/2022	5/31/2022	5/31/2022	5/31/2022	5/31/2022	5/31/2022	6/3/2022	6/6/2022	5/30/2022	5/31/2022	5/31/2022	5/31/2022

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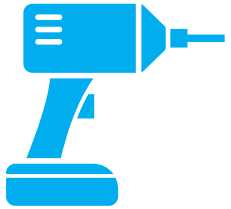
Investigating Your Data | The Tools

Measure Investigation Tool

Value Sets

Data Health Dashboards



Mapping Administration

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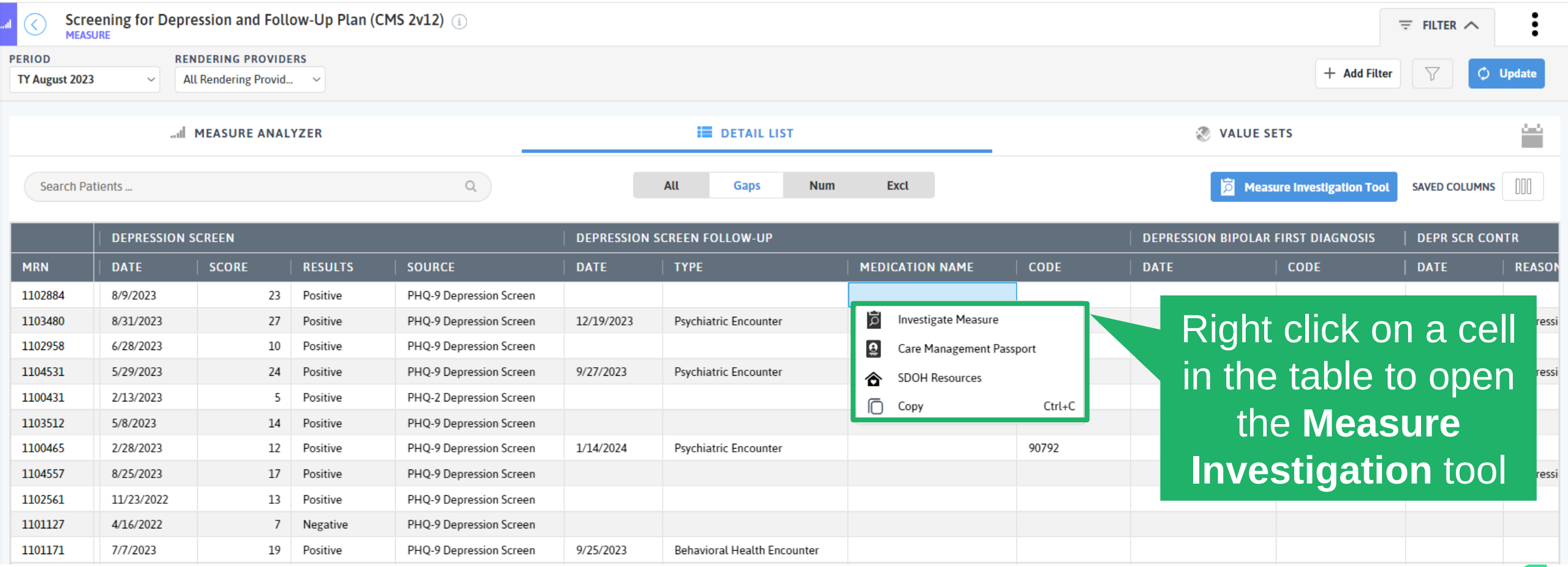
Measure Investigation Tool

Patient Detail Lists

Use the detail list to investigate individual patients



	DEPRESSION SCREEN				DEPRESSION SCREEN FOLLOW-UP				DEPRESSION BIPOLAR FIRST DIAGNOSIS		DEPR SCR CONTR	
MRN	DATE	SCORE	RESULTS	SOURCE	DATE	TYPE	MEDICATION NAME	CODE	DATE	CODE	DATE	REASON
1102884	8/9/2023	23	Positive	PHQ-9 Depression Screen								
1103480	8/31/2023	27	Positive	PHQ-9 Depression Screen	12/19/2023	Psychiatric Encounter						
1102958	6/28/2023	10	Positive	PHQ-9 Depression Screen								
1104531	5/29/2023	24	Positive	PHQ-9 Depression Screen	9/27/2023	Psychiatric Encounter						
1100431	2/13/2023	5	Positive	PHQ-2 Depression Screen								
1103512	5/8/2023	14	Positive	PHQ-9 Depression Screen								
1100465	2/28/2023	12	Positive	PHQ-9 Depression Screen	1/14/2024	Psychiatric Encounter		90792				
1104557	8/25/2023	17	Positive	PHQ-9 Depression Screen								
1102561	11/23/2022	13	Positive	PHQ-9 Depression Screen								
1101127	4/16/2022	7	Negative	PHQ-9 Depression Screen								
1101171	7/7/2023	19	Positive	PHQ-9 Depression Screen	9/25/2023	Behavioral Health Encounter						

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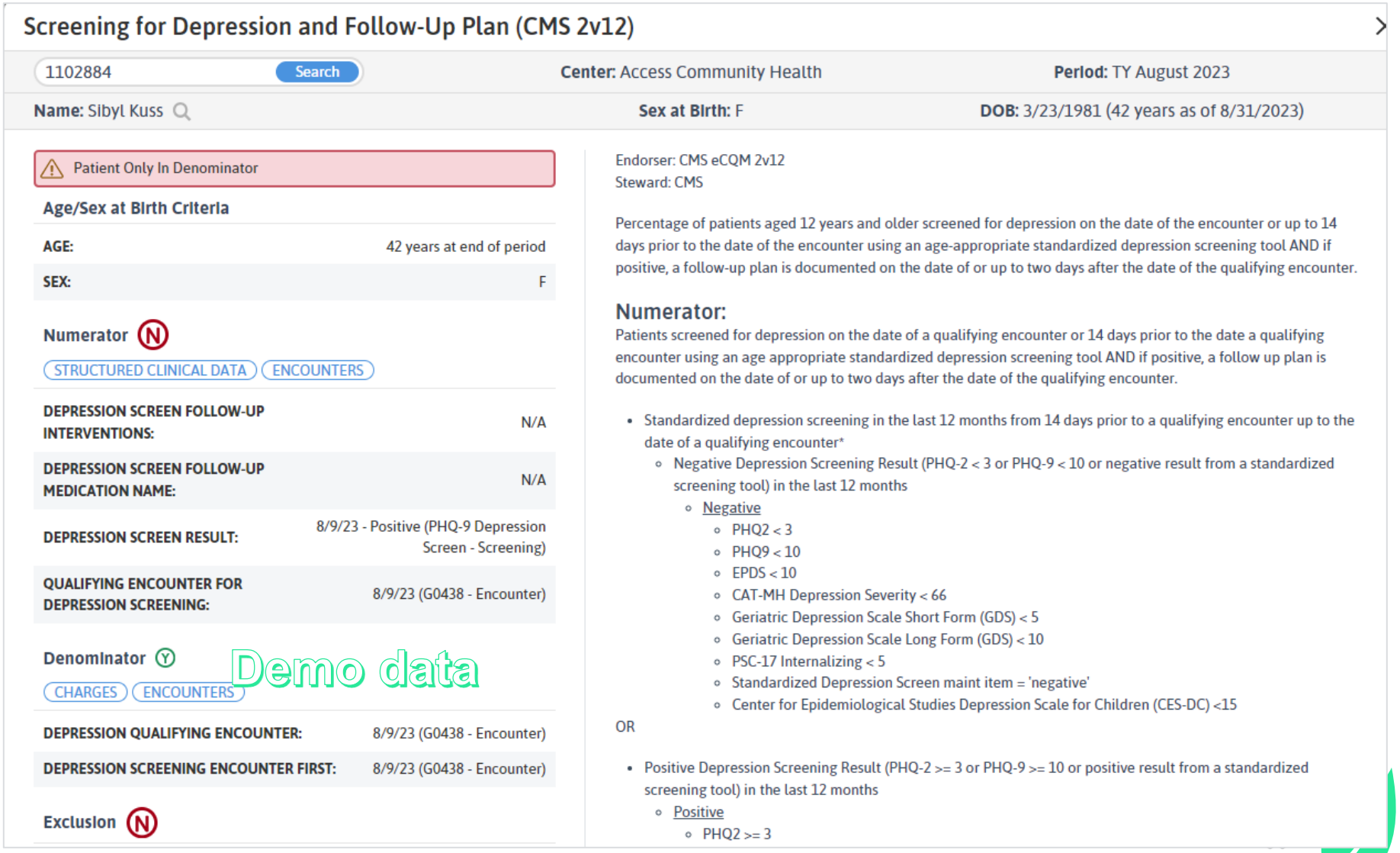
Demo data

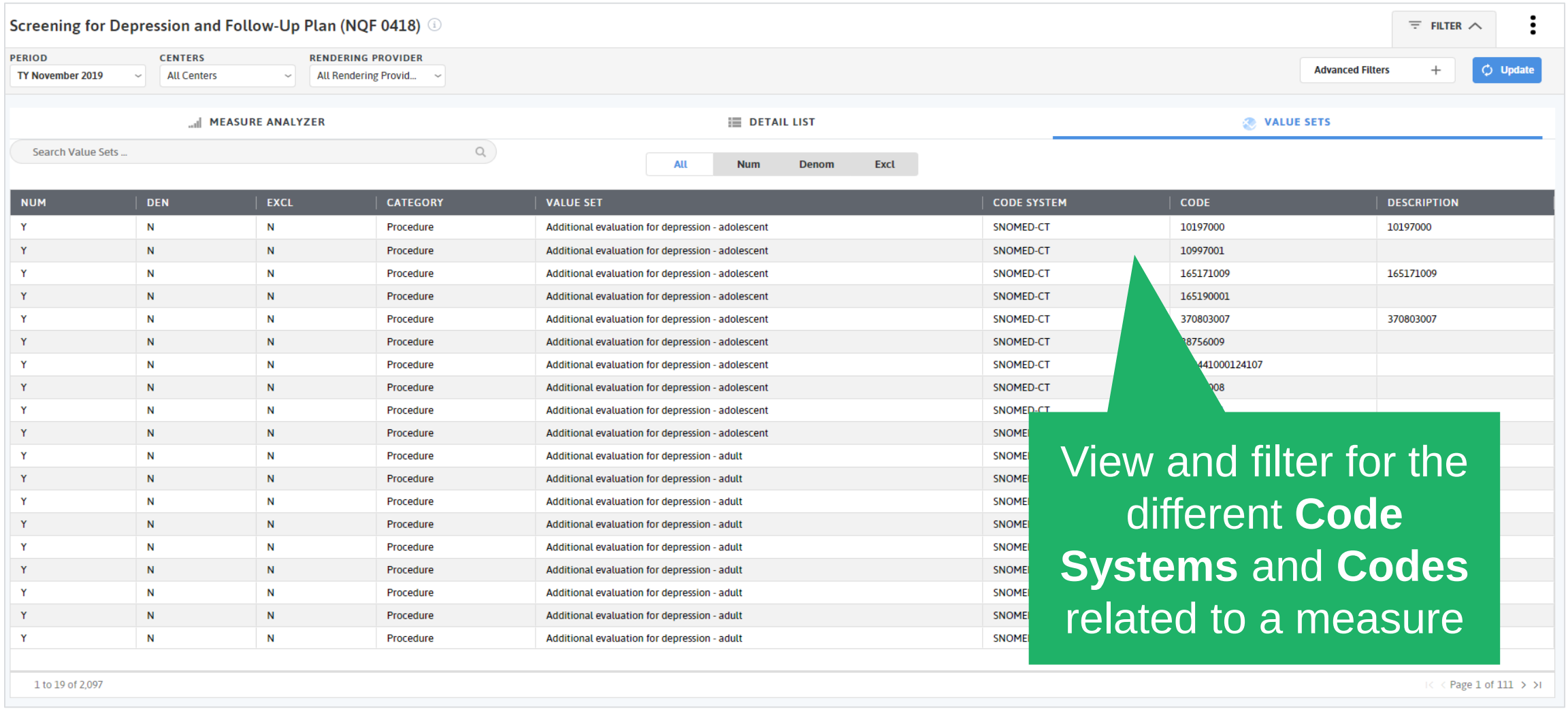
Measure Investigation Tool

- Investigate a specific patient
  - Use the blue pills to pull up data for that patient
  - Compare DRVS data to EHR data



Value Sets

Value Sets Tab



Data Health Dashboards

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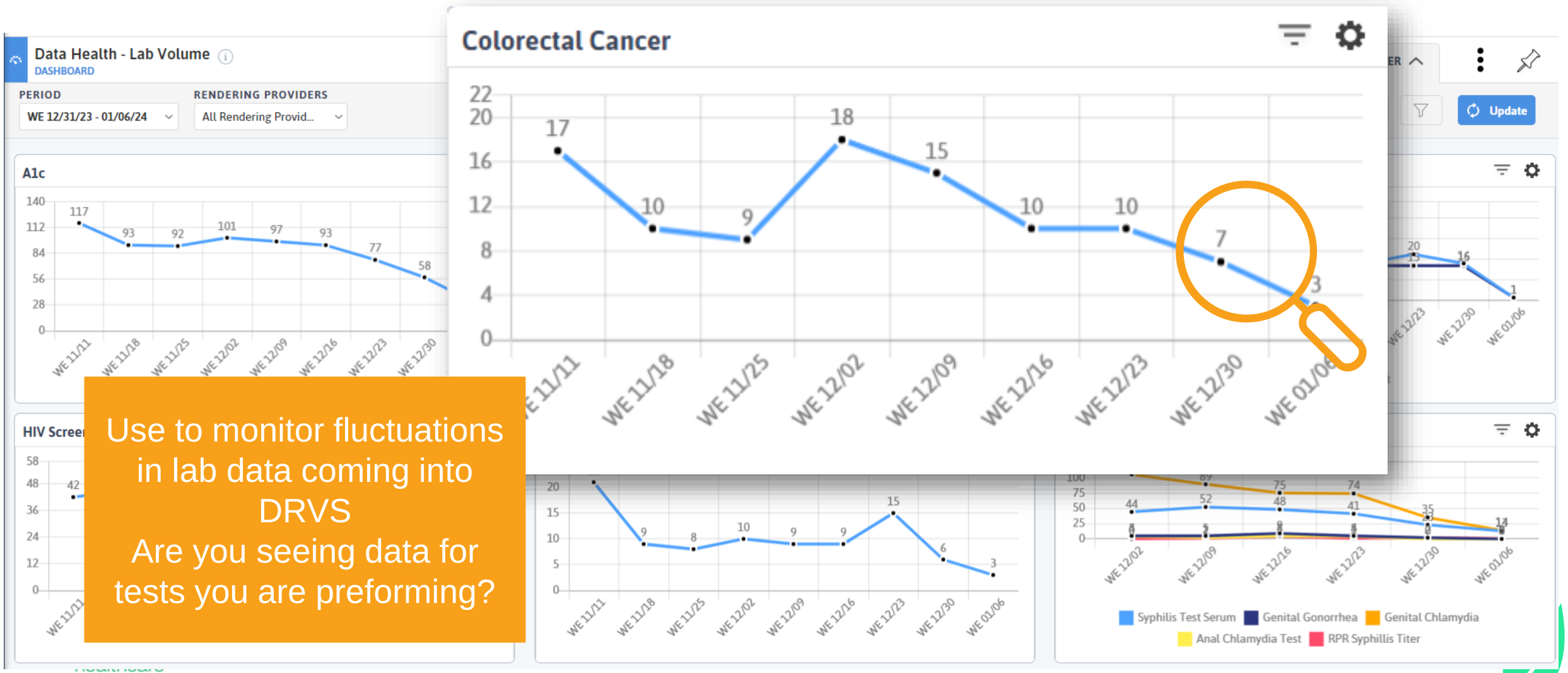
Data Health | Lab Volume



Use to monitor fluctuations in lab data coming into DRVS

Are you seeing data for tests you are preforming?

Data Health | Lab Volume

Data Health - Lab Volume
DASHBOARD

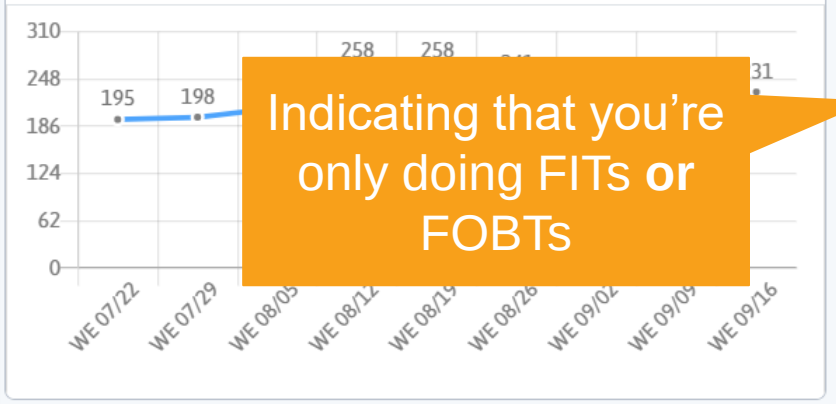
PERIOD: WE 09/10/23 - 09/16/23
RENDERING PROVIDERS: All Rendering Provid...

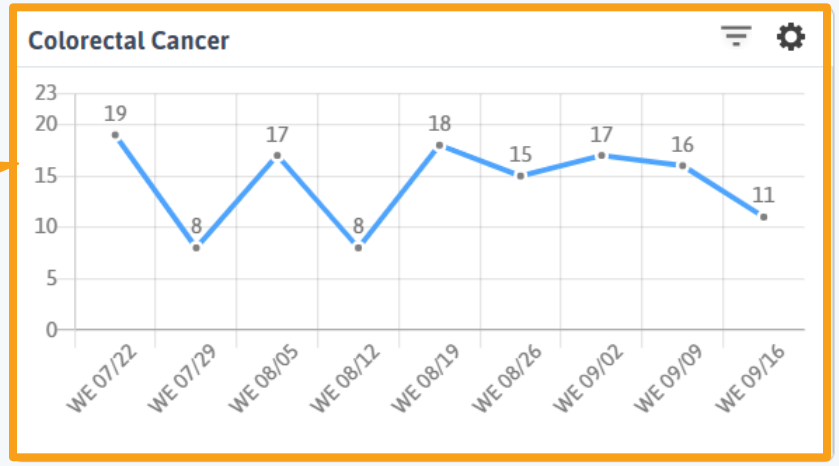
Investigate significant drops and trends with 0's

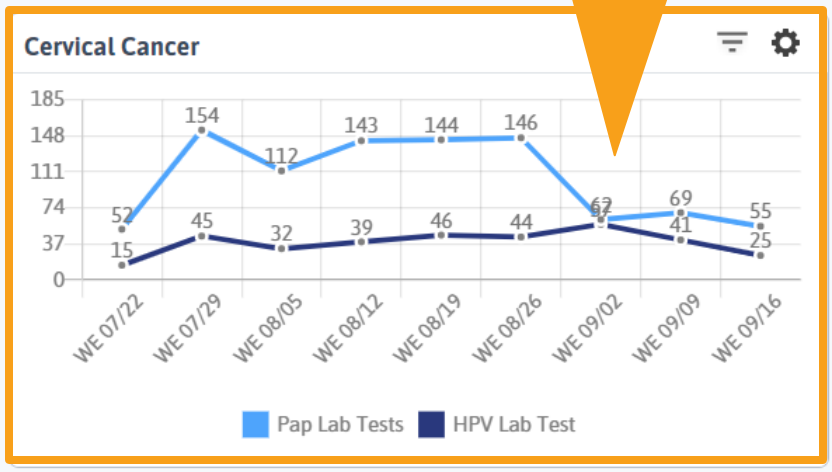
Significant drop in Paps.

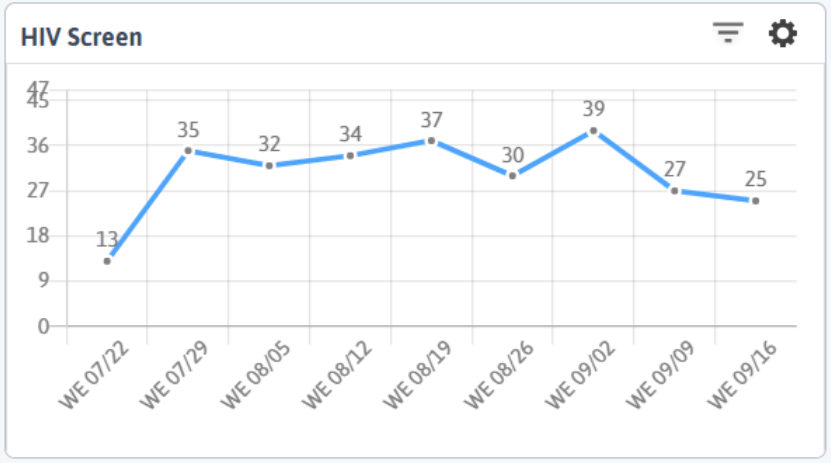
Indicating that you're only doing FITs **or** FOBTs

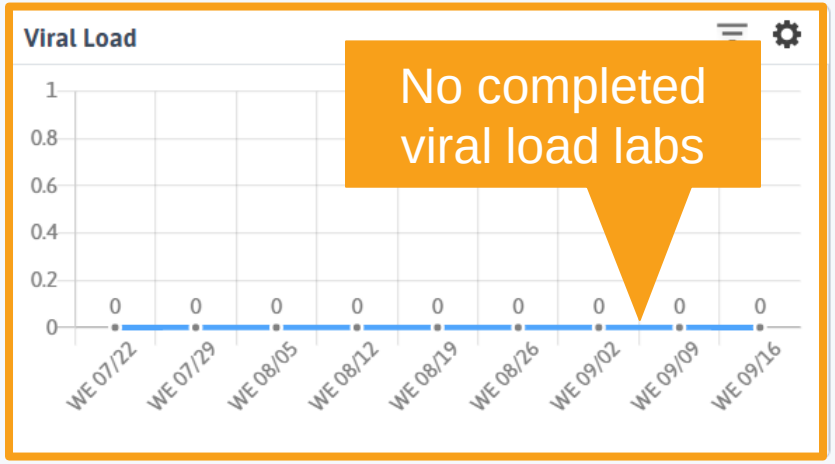
No completed viral load labs

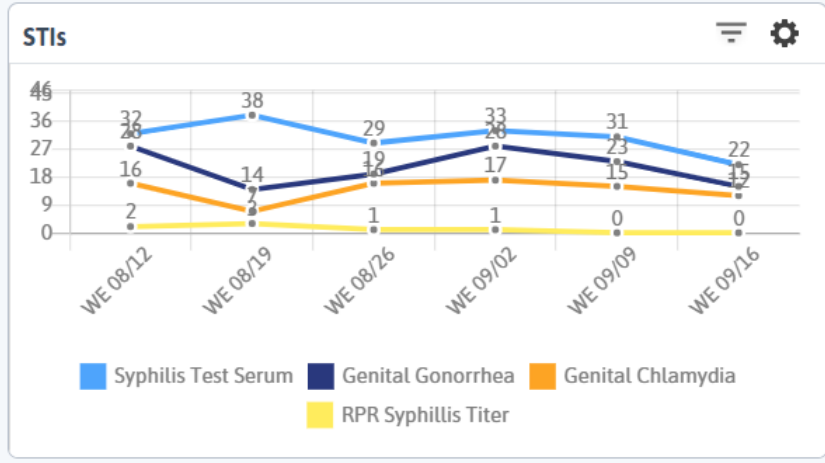




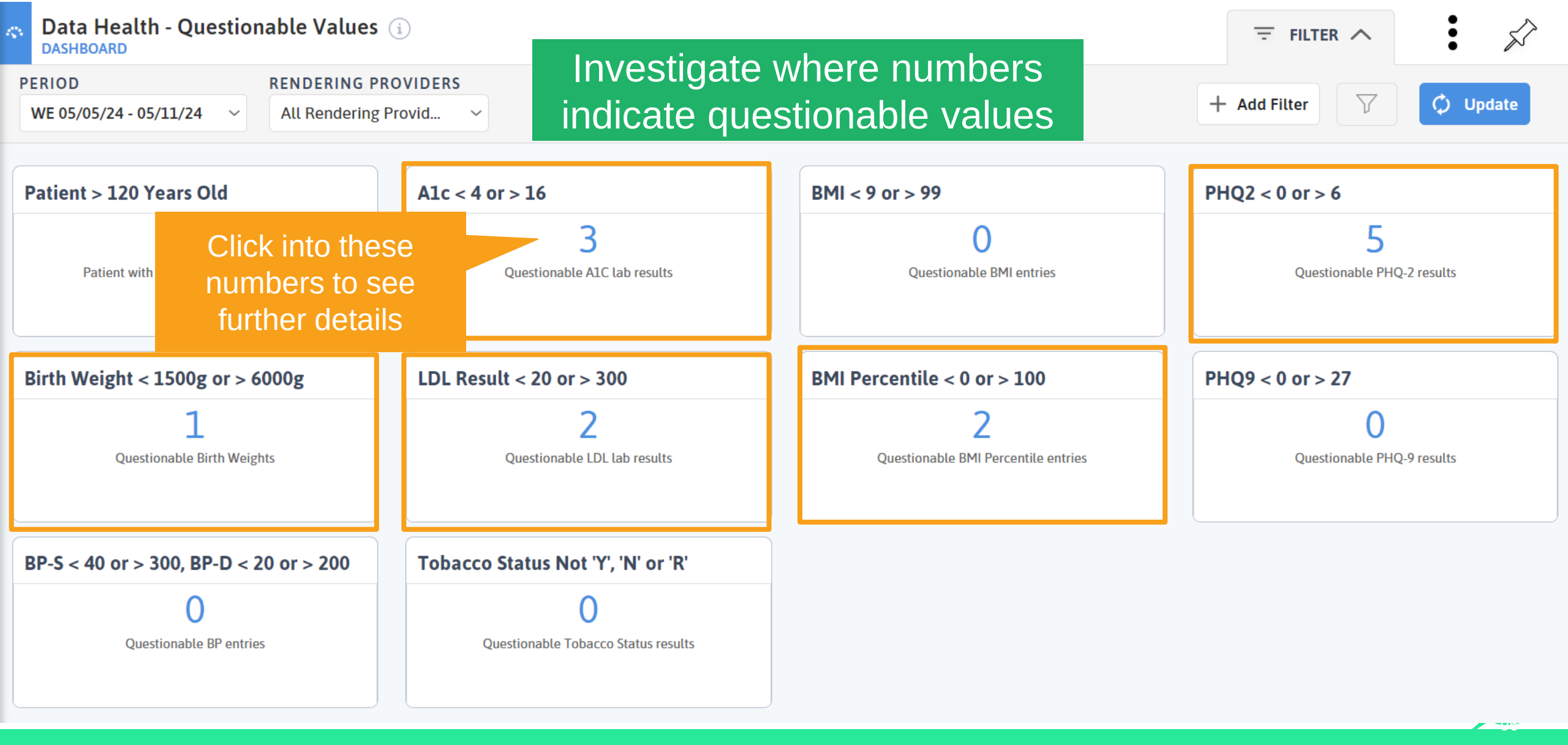




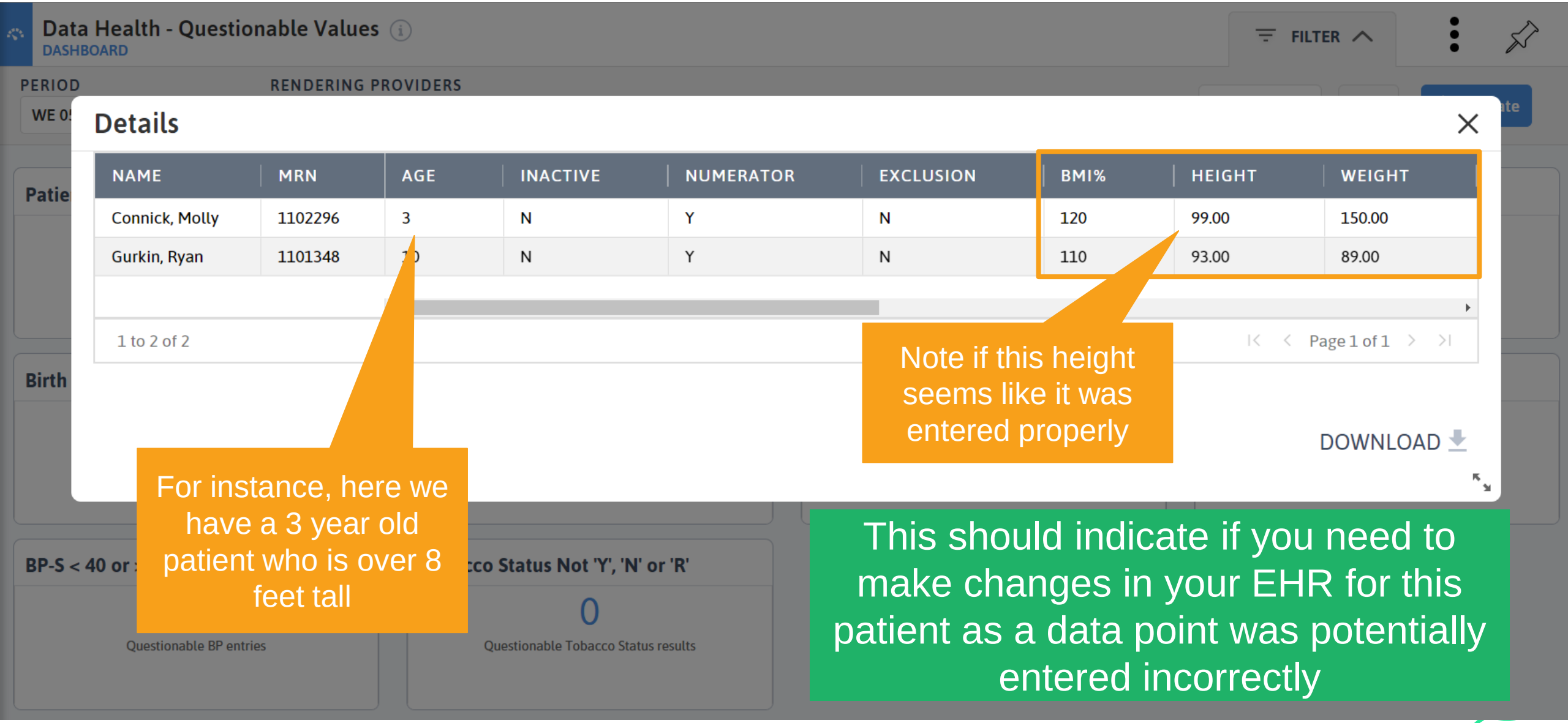




Data Health | Questionable Values



Data Health | Questionable Values



Mapping Administration

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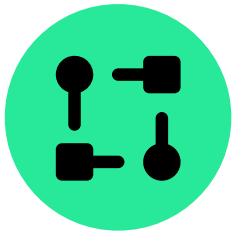
Codified vs. Structured Data

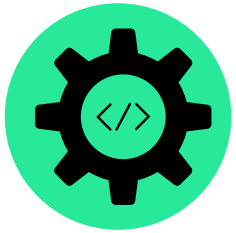
Codified Data

Structured Clinical Data

What is Mapping Admin



Offers insight into the “back-end” part of DRVS and improves transparency.



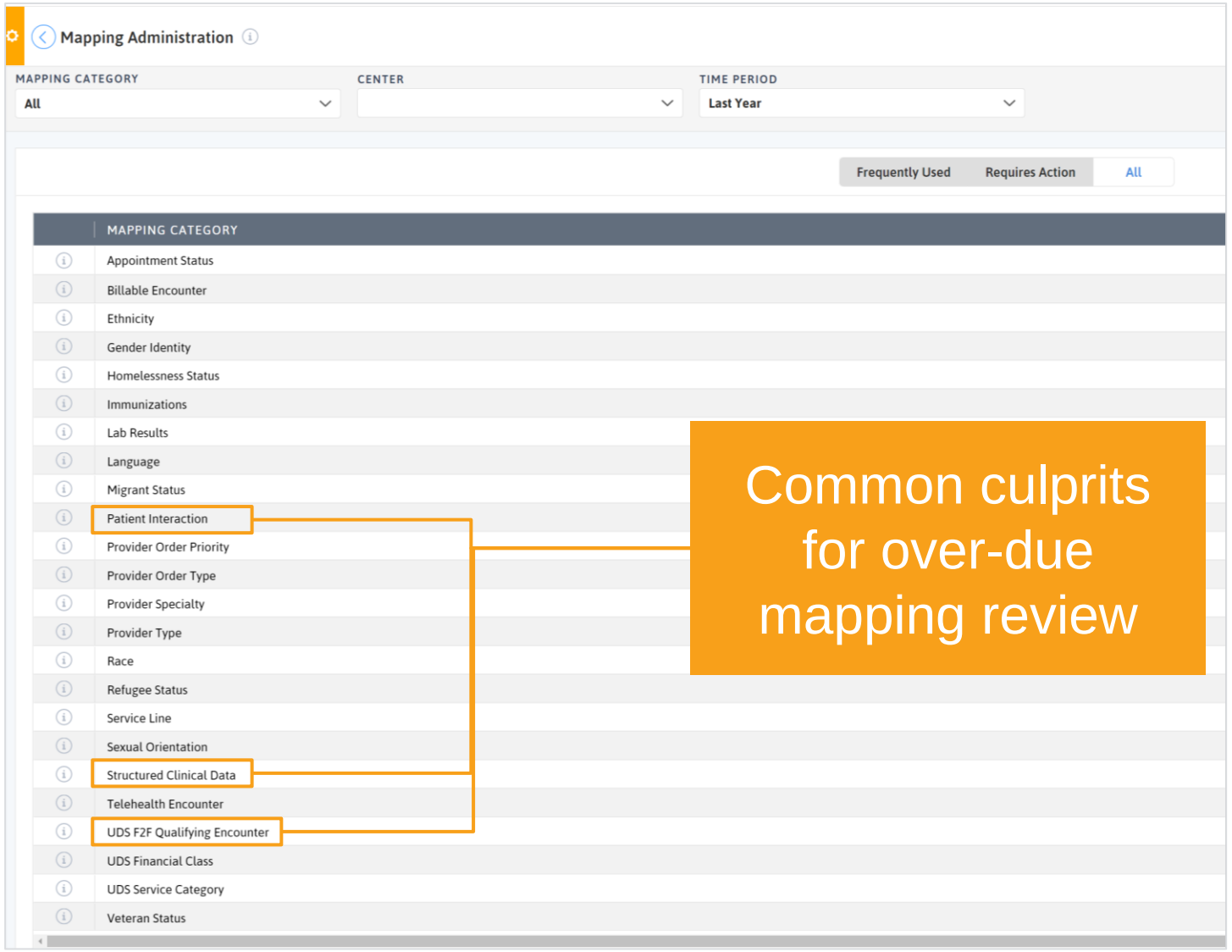
Empowers clients to review their mapping and make adjustments based on workflow changes.

Available to view by all user, updates are made DRVS Admin only.

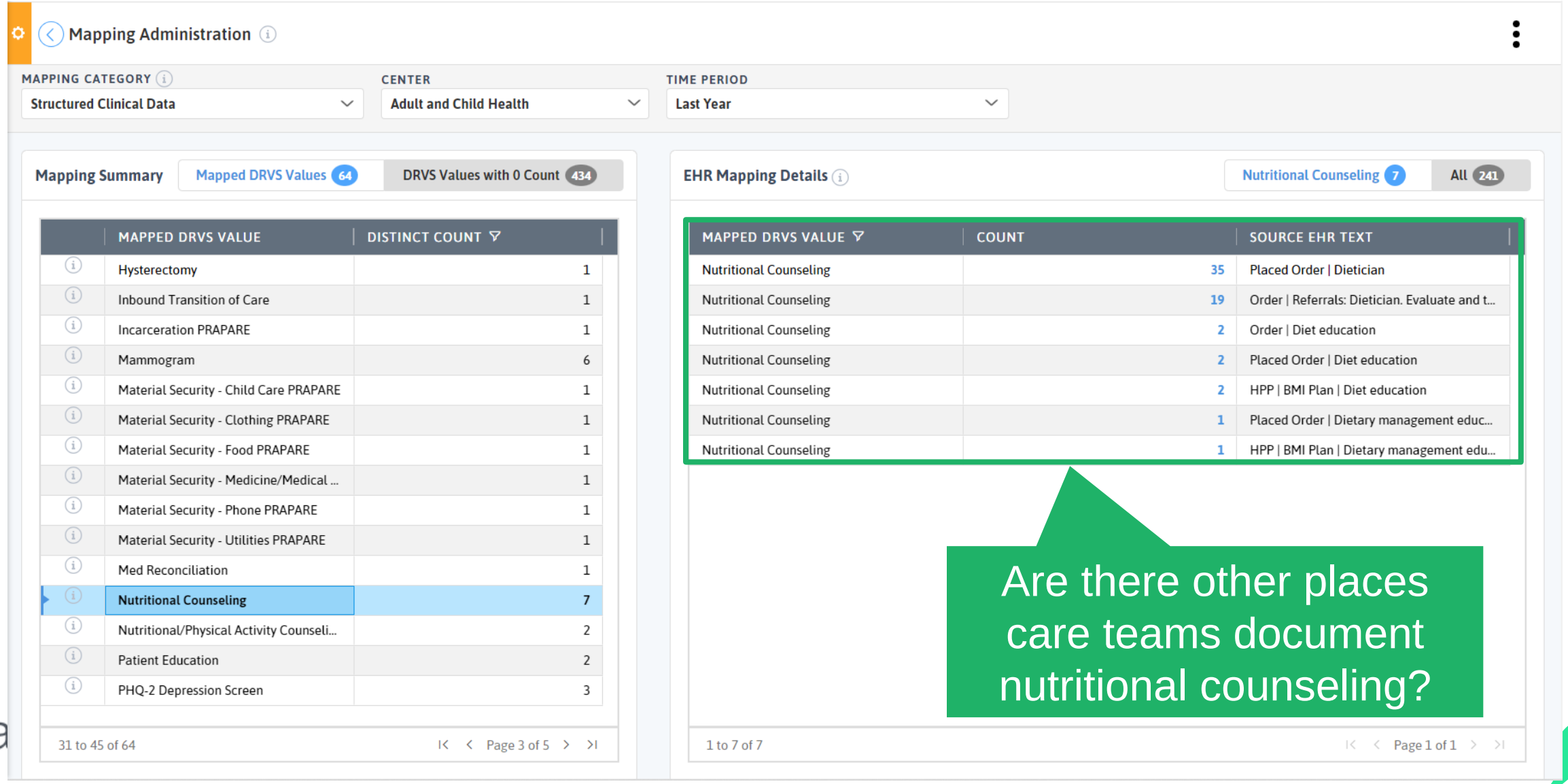
Mapping Admin | High-Level Process

1. Visit Structured Clinical Data
2. Review Unmapped data
3. Map values that have an associated DRVS bucket
4. Archive values that aren’t valuable to practice
5. Visit DRVS Values with 0 Count

Mapping Administration



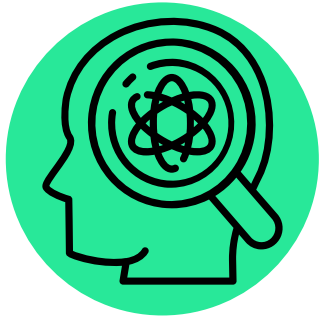
Review Structured Clinical Data



Ongoing Maintenance

Be mindful of changes to practice operations and how this might **impact mapping**

New providers & locations



New lines of service

Changes in the lab

New codes

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Mapping Category

- Mapping categories are the different types of data within DRVS that can be manually mapped.
- Each category needs to be maintained individually, and all can be edited by admins
  - Except for UDS F2F qualifying encounter, immunizations, and lab results which are only maintained by Azara
- Structured clinical data includes data from structured fields in the EHR that do not fall into one of the other categories.

	MAPPING CATEGORY
ⓘ	Ethnicity
ⓘ	Financial Class
ⓘ	Gender Identity
ⓘ	Homelessness Status
ⓘ	Immunizations
ⓘ	Lab Results
ⓘ	Language
ⓘ	Migrant Status
ⓘ	Race
ⓘ	Service Line
ⓘ	Sexual Orientation
ⓘ	Structured Clinical Data
ⓘ	Telehealth Encounter
ⓘ	UDS F2F Qualifying Encounter
ⓘ	UDS Service Category
ⓘ	Veteran Status

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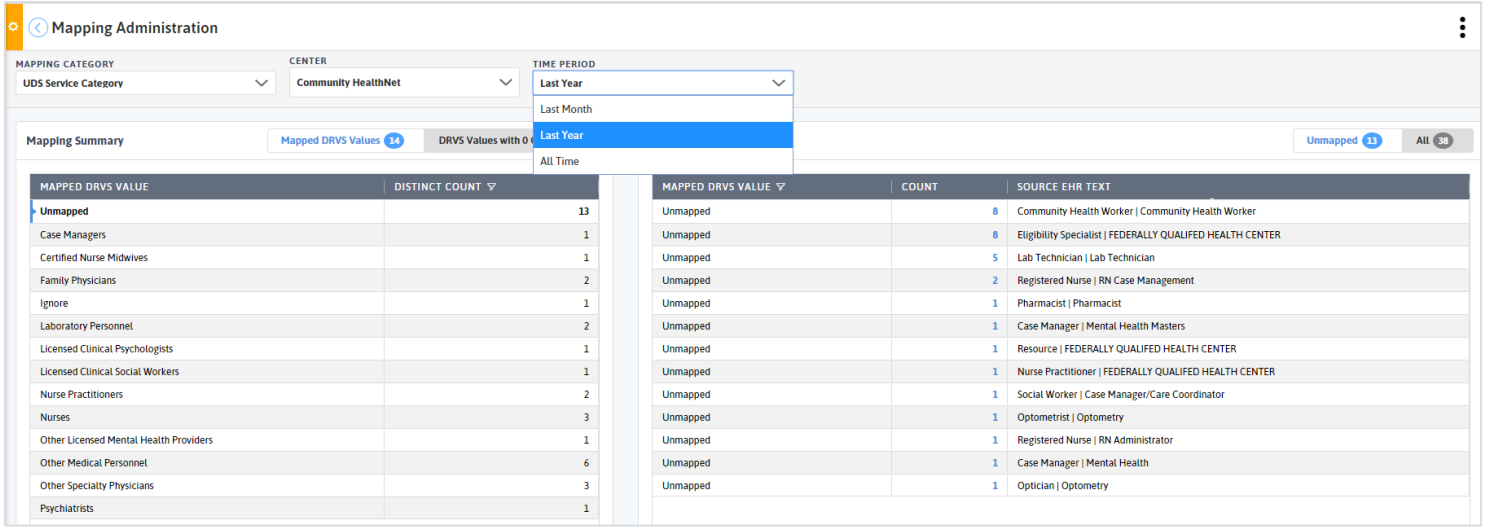
View DRVS Mappings

- Determine what is mapped for a specific data element, and the count of records with the EHR source value during the “time period”
  - Adjusting the “time period” will help users understand how often a value from the EHR is used
- Review unmapped items for each mapping category, and determine what they should be mapped to
  - Should be done *at least* quarterly by admin



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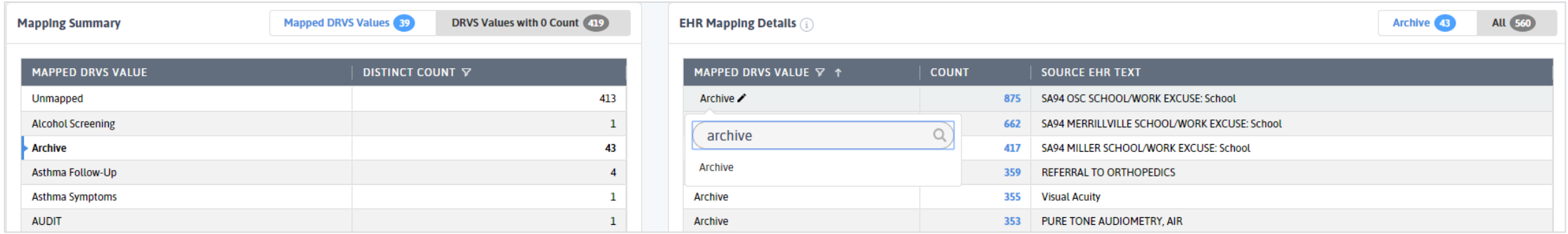
Mapping Admin – Archive, Ignore, Do Not Load

- Archive - records are deemed not currently necessary, but should held into incase they are needed
  - Items can be marked as archive via the pencil icon ( )to the right of the value



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Measure Validation Tools

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Help Section | Measure Validation Guides

Home ›› Population Health Resources ›› Data Hygiene Resources ›› Measure Validation Guides

Measure Validation Guides

Data validation is essential to successfully adopting DRVS into your practice's workflows. Measures can be used to provide population health level insights and are required components of many alternative payment models and national programs like UDS. They are often used for benchmarking and developing improvement plans, but users must first understand and validate the numbers they see before making decisions based on measure performance, as well as before major submissions like UDS.

Below you will find measure-specific guides to assist in validating core CQMs. Each guide includes checks for data elements and workflows specific to one measure. These guides were created to supplement Azara's other data validation and quality improvement materials and offerings; we recommend reviewing the following resources, especially if you are newer to DRVS and/or quality improvement:

- DRVS for Quality Improvement Playbook
- Mapping Administration User Guide

The validation methods presented in these guides should be part of a comprehensive quality improvement and data validation strategy at your practice; anytime a DRVS measure is used to promote practice change, you should be confident in the data behind the numbers. For guidance on how to develop a data hygiene plan, please see the above linked resources.

As always, please reach out to support at Support@azarahealthcare.com with any questions or concerns.

** If you are getting an error message trying to open the Validation Guides, access them by holding down the "Ctrl" key and selecting the link. Alternatively, copy the URL of the validation guide, open a new tab or browser, and then paste and go.**

A1c >9 or Untested
Adult BMI Screening and Follow Up
Breast Cancer Screening
Cervical Cancer Screening
Childhood Immunization Status
Child Weight Screening / Counseling for Nutrition / Physical Activity
Colorectal Cancer Screening
Dental Sealants
Depression Screening and Follow Up
HIV Screening
Hypertension Controlling High Blood Pressure
IVD Aspirin Use
Statin Therapy for Prevention and Treatment of Cardiovascular Disease
Tobacco Screening and Cessation

Last Updated: 02/15/2023

Was this information helpful?

✓ Yes ✗ No

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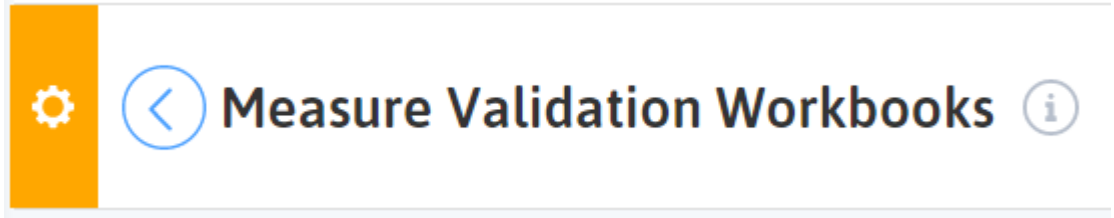
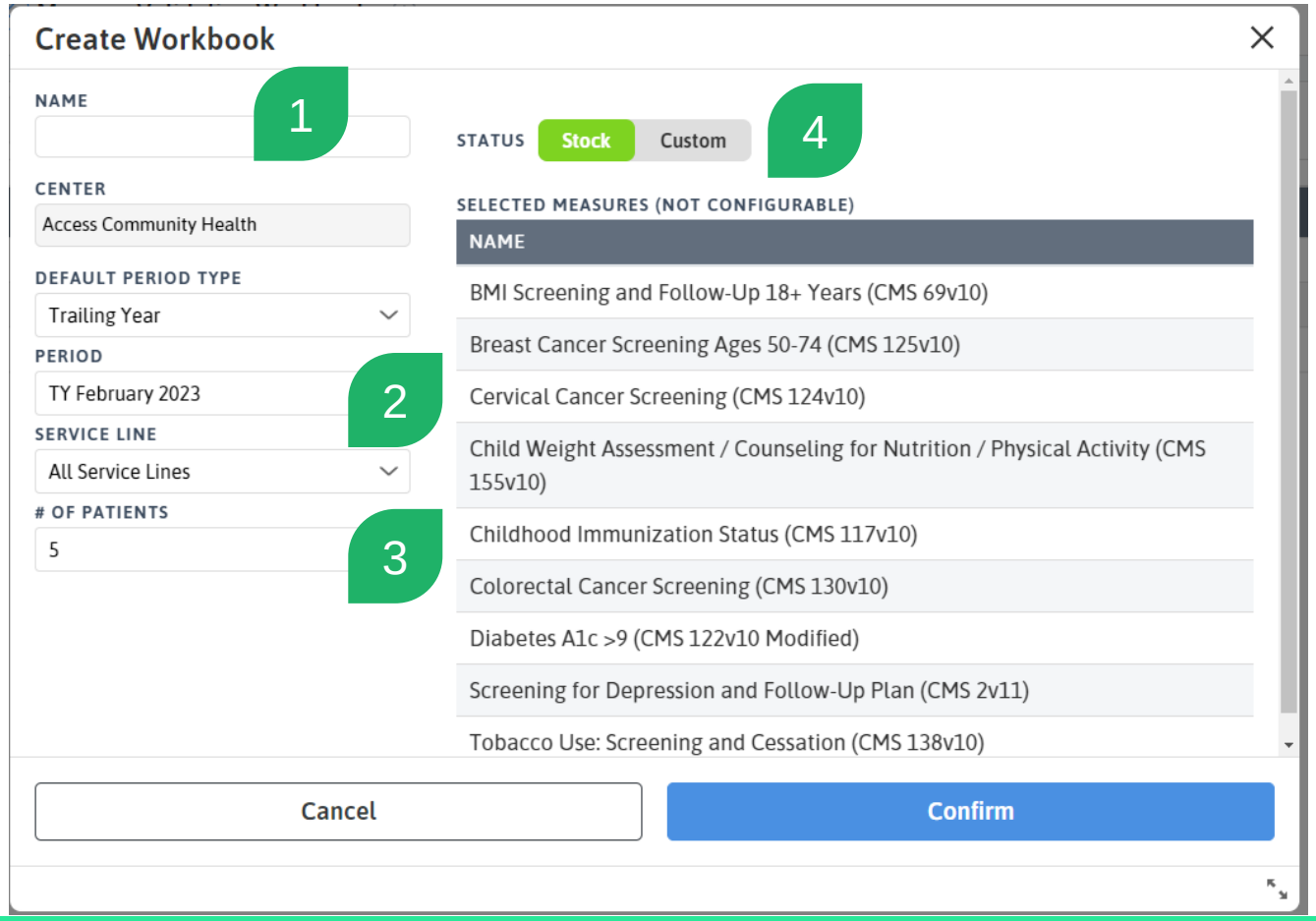
Administration | Measure Validation Tools





1. **Name:** Name of Measure Validation Workbook
2. **Default Period Type, Period, & Service Line:** Period types & service line for which you would like to pull patients from
3. **# of Patients:** How many patients to display from selected measure/s
4. **Status:** Stock or Custom (If Custom, identify which measures using search bar)

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Review

Data Hygiene

Let’s Practice!

1. **Pull a Data Latency Report**
   - Do you see this report? Does everything look ok?

2. **Choose a measure**
   - View the Measure Investigation Tool (MIT) to investigate a patient
   - View the Value Sets and filter by code systems to see what Structured Clinical Data

3. **Open the Data Health: Questionable Values Dashboard**
   - Look at the past week then look at the past month
   - Any changes? Things you want to take back to your team?

4. **Create a Measure Validation Workbook**
   - What would you use this for?

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Functional Re-cap | Questions?

Data Hygiene

Measure Matrix

Data Latency

Mapping Admin

UDS+ CY2024 Submissions with Azara

UDS+ Timeline

Today	HRSA HCPC registration CLOSED
11th	Azara Registration CLOSED
28th	*2025 Azara User Conference*

30th	UDS+ CY24 Submissions Due

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Submission Support

How do I know when my submission starts?

- An automated email is sent to the UDS+ Submitter when the submission has started

What happens when my submission is complete?

- An automated email is sent when the submission reaches its end state
- Email is sent to the UDS+ Submitter *and* Azara Support
- *This automatically creates a support ticket for you.
  If you have questions after submission, please communicate them via the support ticket.

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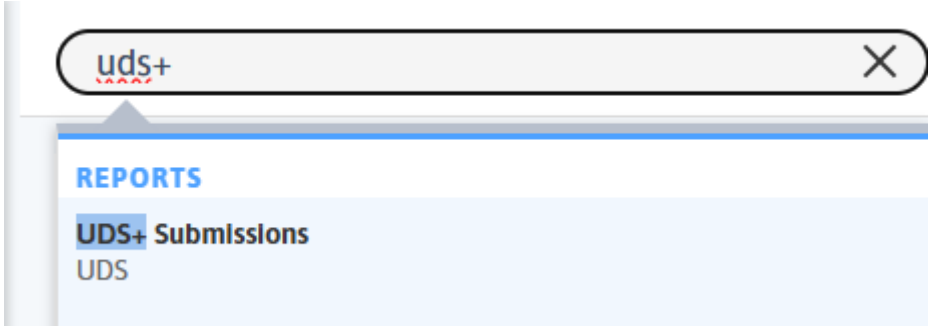
How can I view who is submitting in my org?

UDS+ Network-Level Report

Available for “All Center” users – view the centers who have set up their submission configuration in DRVS, and where they are in the submission process



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Resources

Access to a recording of our 3/12 webinar
https://drvshelp.azarahealthcare.com/uds-current-state-with-azara-3/12/2025

FAQ document from 3/12 webinar
https://drvshelp.azarahealthcare.com/uds-faq

Registration Form
https://drvshelp.azarahealthcare.com/udsplus_cy24_registration_form

Questions for HRSA/BPHC – Email
BPHC Answers bphcanswers@hrsa.gov

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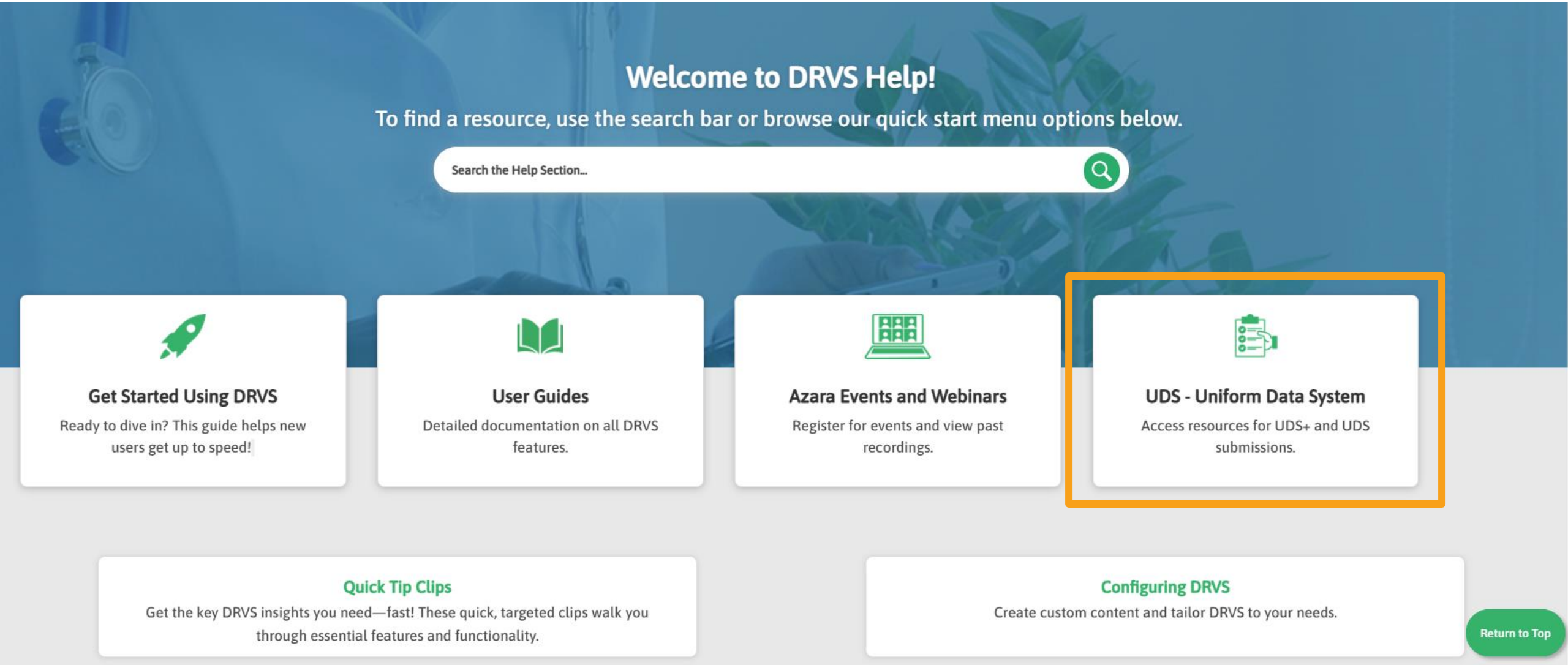
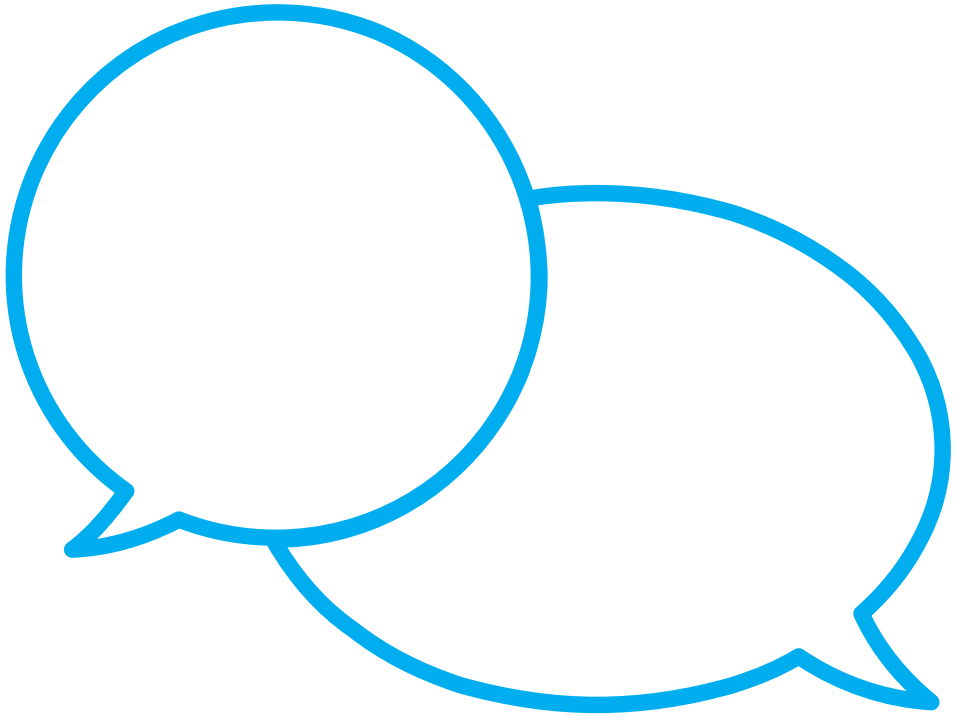
UDS – DRVS Help!



Questions?



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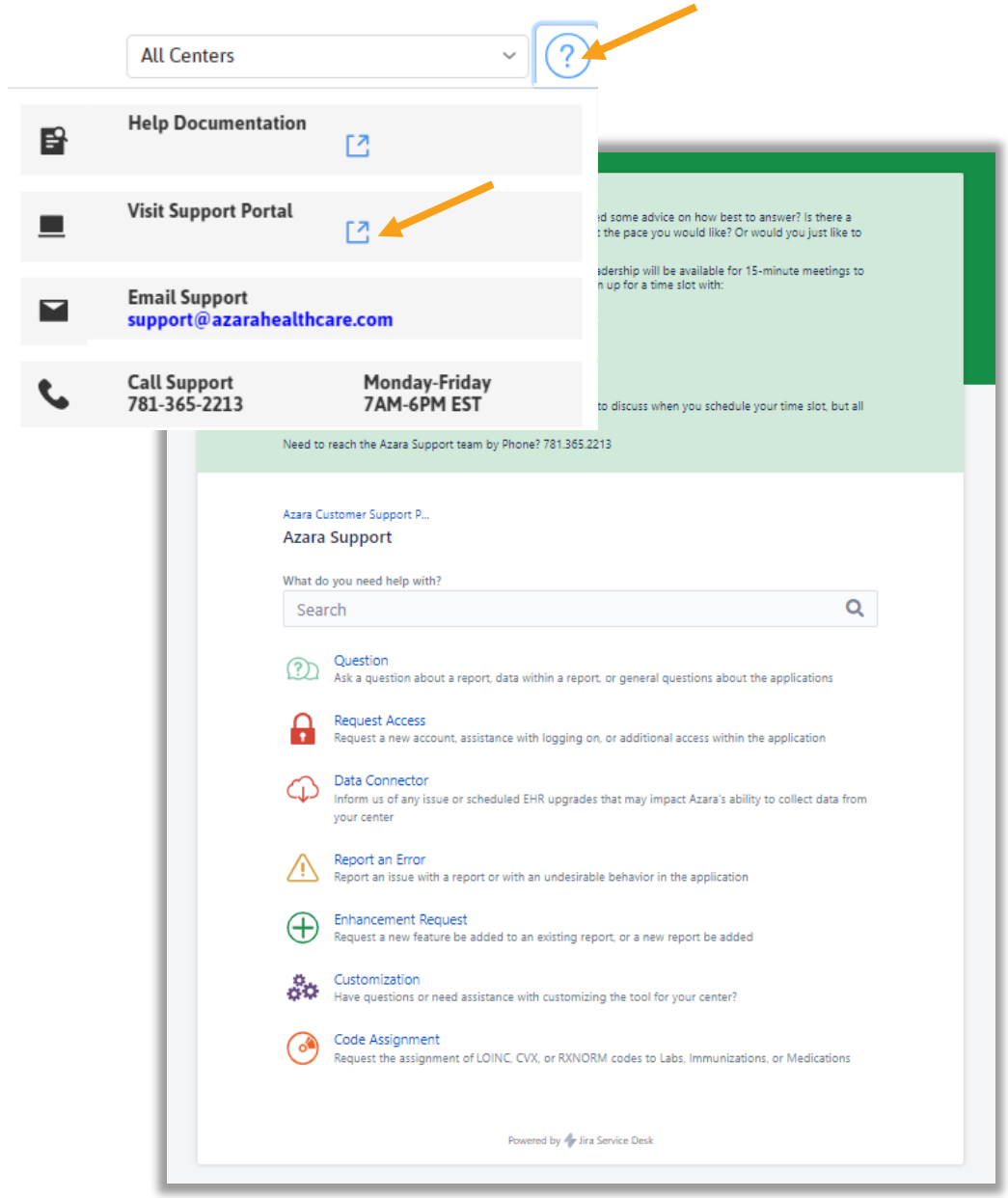
@AzaraDRVS

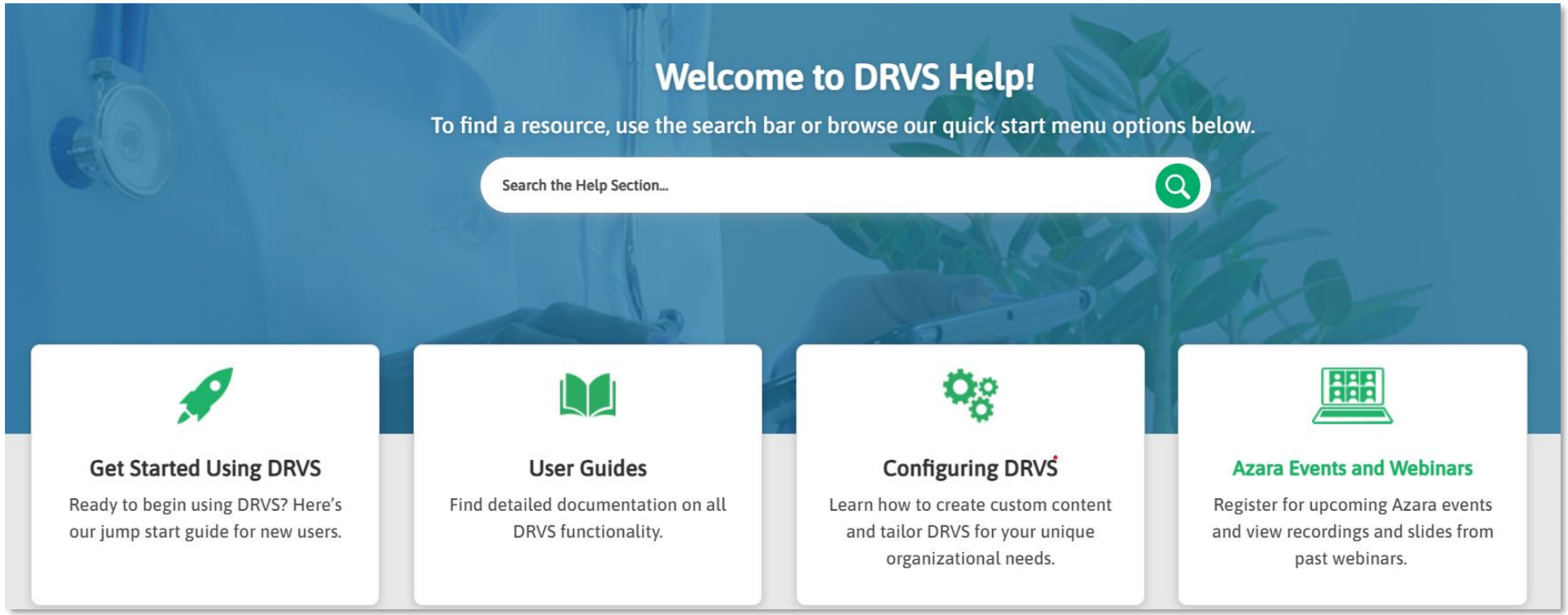
Entering Jira Tickets

- Understanding how to engage with the Azara Support Team is essential to resolving issues with DRVS. Characteristics of a good ticket include:
  - Clear description of the issue
  - Patient examples
  - Screenshots
- Users have access to a support portal to track tickets and can always email Support@azarahealthcare.com for updates and to respond to tickets.



Resources | Azara: DRVS Help

- Utilize the Help section in DRVS for the most current information
- Click the question mark icon and select Help Documentation. Enter your search criteria (i.e. scorecards).



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