

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

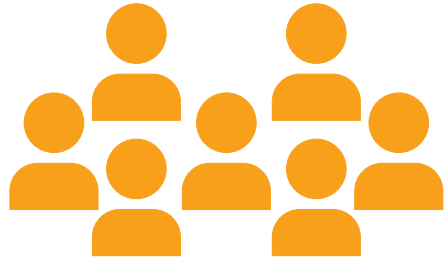


Erin Murphy

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



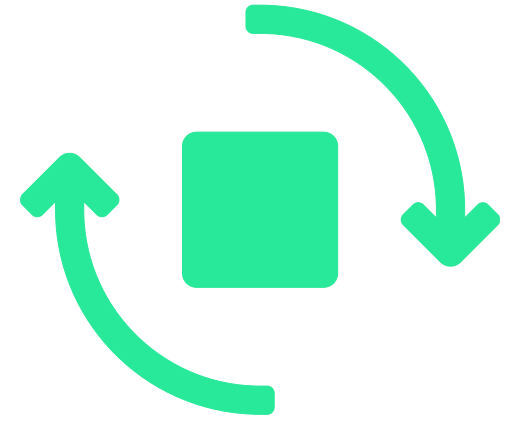
EXPLORE DRVS MODULES

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



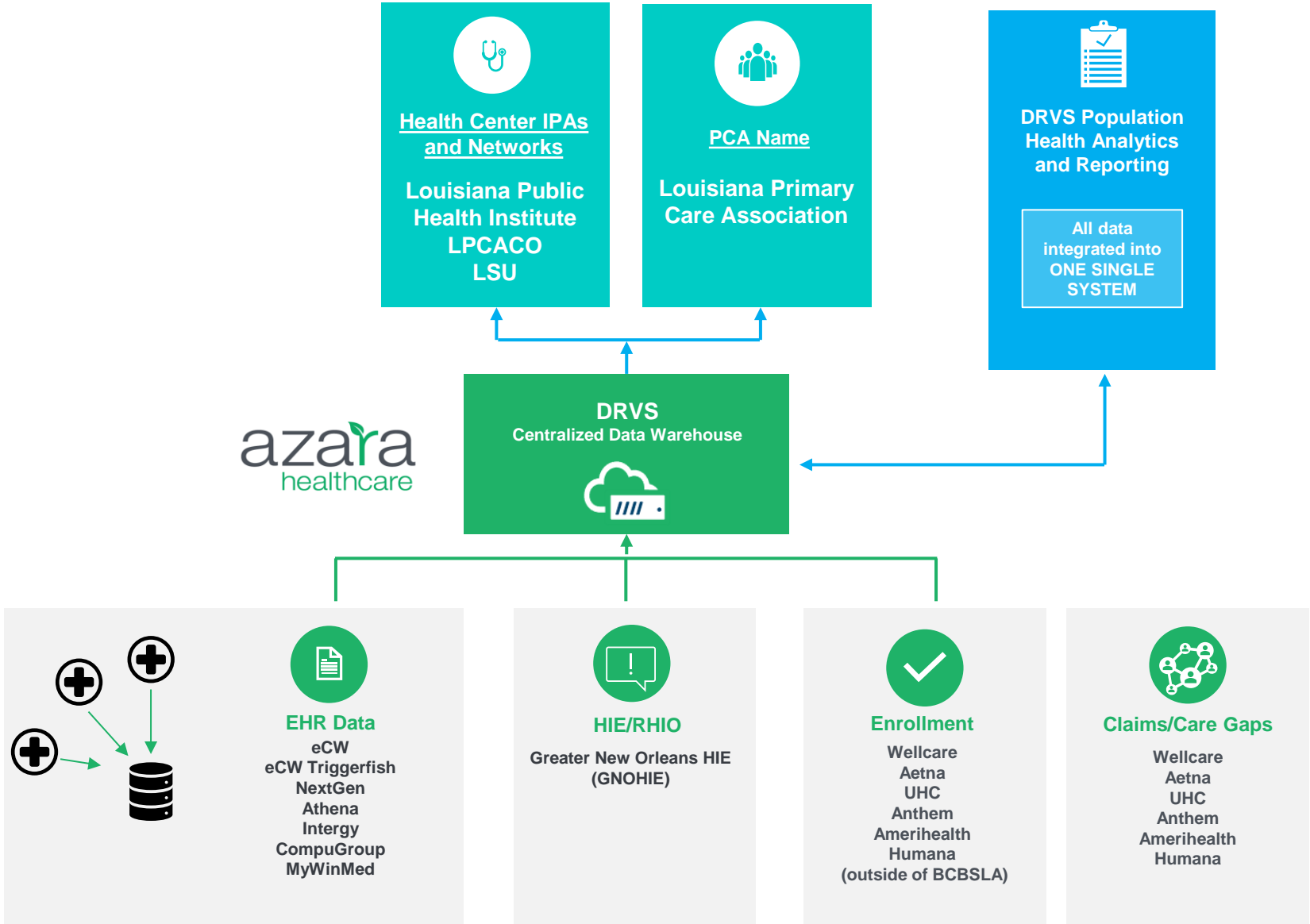
Louisiana DRVS Deployment

Health Centers

26

of lives

371,239



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.

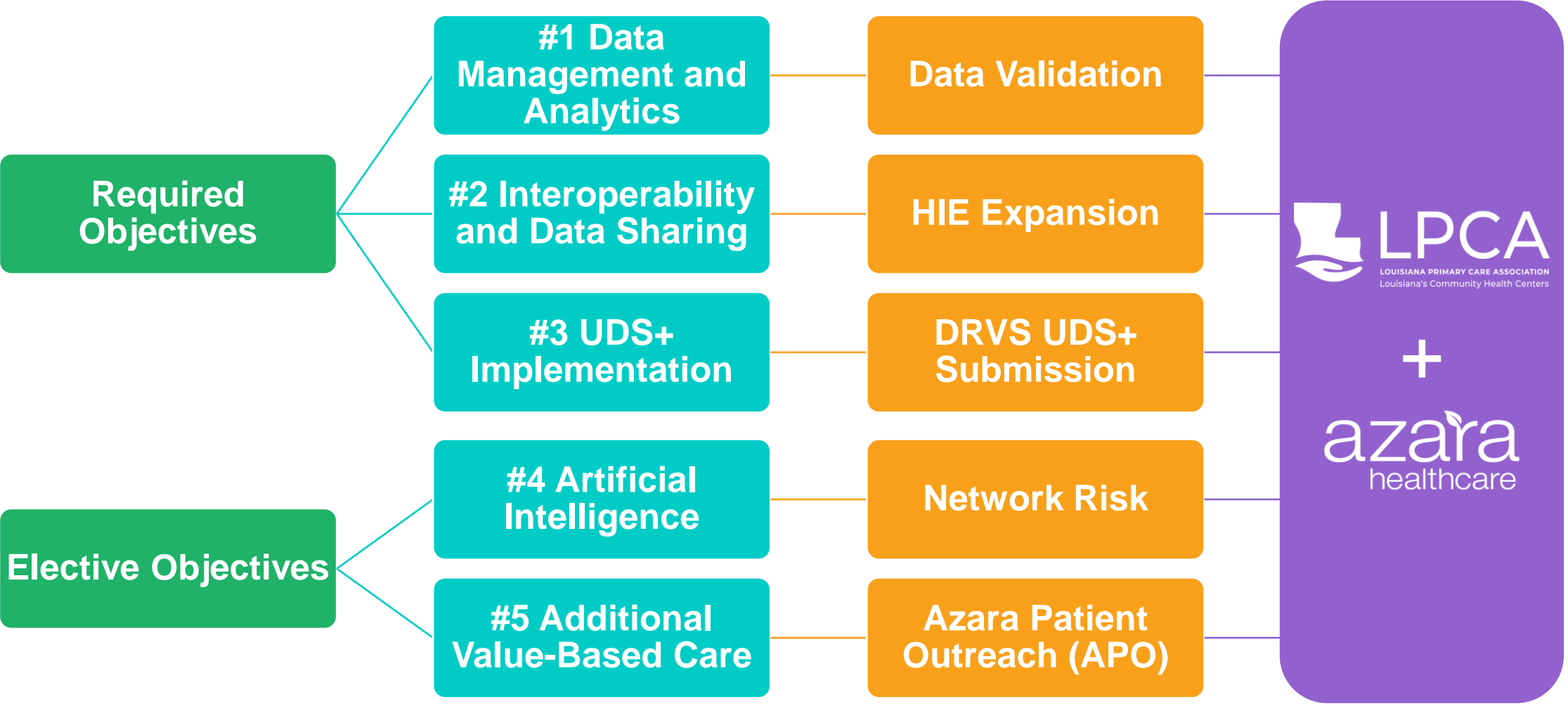
In assessing preparedness and readiness to expand VBC initiatives,

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

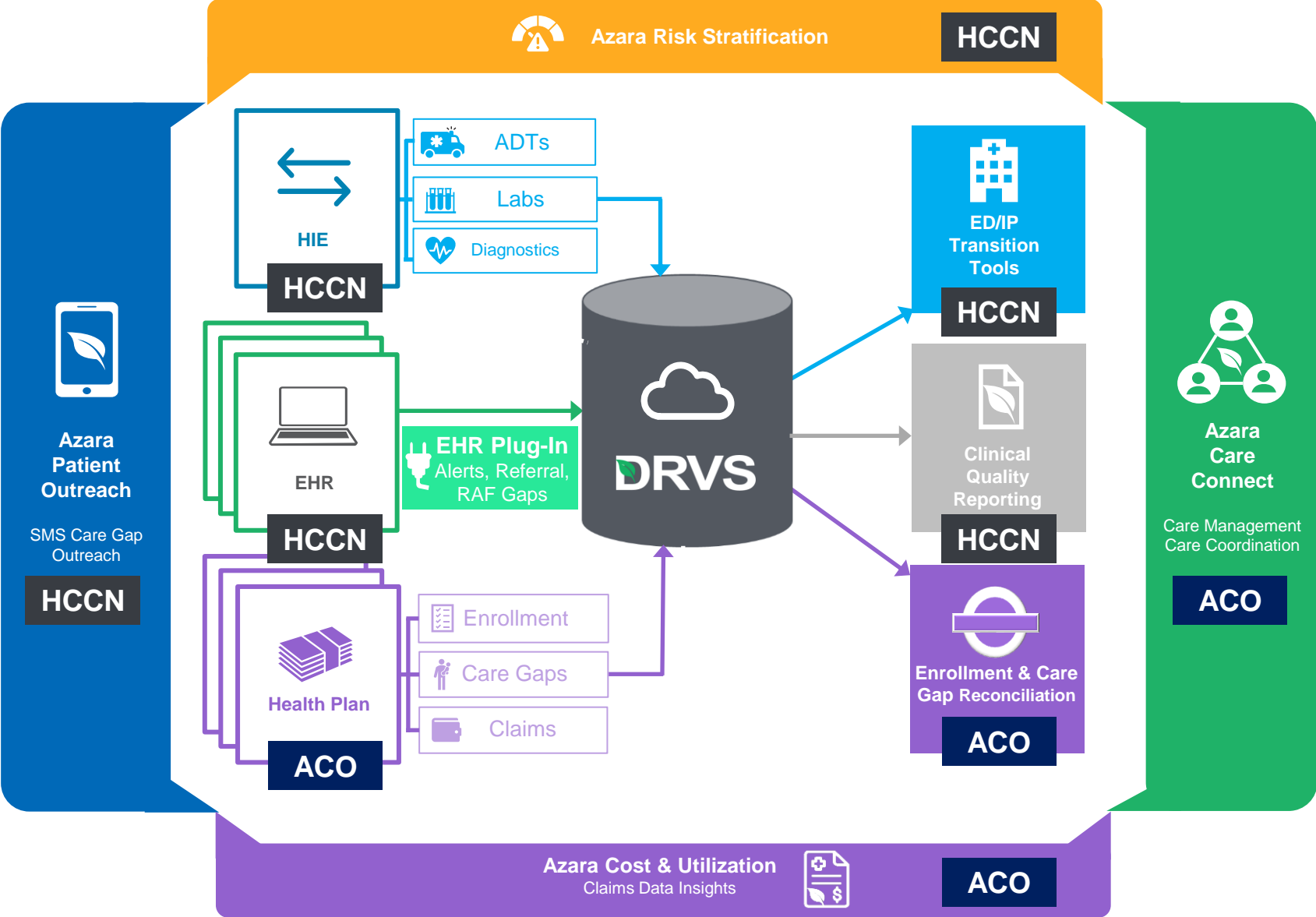
Barriers

- 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



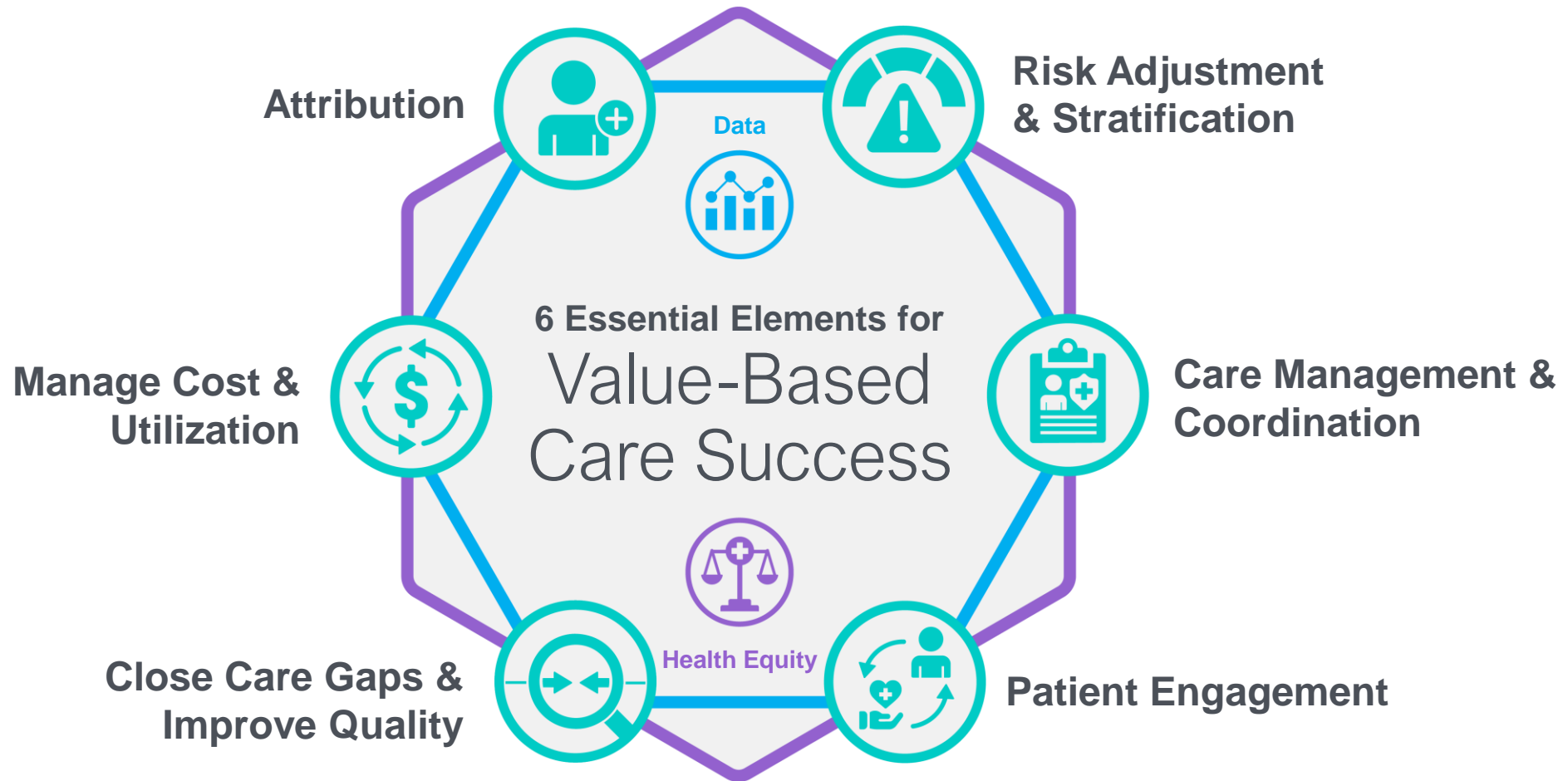
Azara Ecosystem



Value-Based Care



Essential Elements of VBC



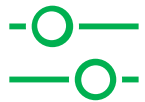
Attribution

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.

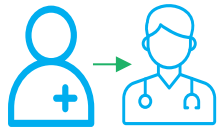
Key Challenges:



Difficulty obtaining attribution rosters



Payer attribution methods are different



Reconciling payer rosters with active patients is time consuming and burdensome



Attribution | Members Report

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

Members

REPORT

PERIOD

August 2023

CENTERS

All Centers

RENDERING PROVIDERS

All Rendering Provid...

PLANS

AZR Health Plan

Update

Search ...

SAVED COLUMNS

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, Odella	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

directly to Azara

2. Obtain member enrollment rosters from the plan and send to Azara

azara

healthcare

Available in DRVS

ACO

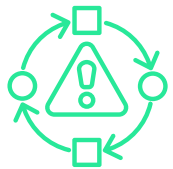
Risk Adjustment

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

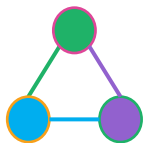
Key Challenges:



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



Alert Providers of RAF Gaps

Walk-Ins

MRN: [REDACTED]

DOB: [REDACTED]

Sex at Birth: M

GI: Male

SO:

Phone: [REDACTED]

Lang: Spanish

Risk: Low (4)

Portal Access: N

Cohorts: [REDACTED]

PCP: [REDACTED]

Payer: [REDACTED]

CM: Unassigned

DIAGNOSES (5)

Cancer

DM

HTN-E

HTN-NE

HyLip

RISK FACTORS (2)

ANTICOAG

TOB

SDOH (3)

FPL<200%

HISP/LAT

LANGUAGE

HCC MEDICARE GROUPS W/ RAF GAPS (3)

Neoplasms

Diabetes

Vascular Disease

Encounters (Last 5 of 148)

DATE	PROVIDER	TYPE	REASON
2/28/22	[REDACTED]		
2/10/22	[REDACTED]		
2/9/22	[REDACTED]		
2/2/22	[REDACTED]		
2/1/22	[REDACTED]		

Appointments (2)

DATE	PROVIDER
4/28/22	[REDACTED]
3/28/22	[REDACTED]

Social Determinants of Health (3)

DATE	PROVIDER
4/28/22	[REDACTED]
3/28/22	[REDACTED]

Allergies (0)

No active allergies

Medications (Last 10 of 15)

ACTIVE AS OF	NAME	SOURCE
2/28/22	[REDACTED]	
2/28/22	[REDACTED]	
2/28/22	[REDACTED]	
2/28/22	[REDACTED]	
2/28/22	[REDACTED]	
2/9/22	[REDACTED]	
2/9/22	[REDACTED]	
2/1/22	[REDACTED]	
6/24/21	[REDACTED]	
9/9/20	[REDACTED]	

BMI

2/10/22

25.15 lb/m2

Systolic

2/28/22

118 mmHg

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

RAF Gaps (3)

DIAGNOSIS CATEGORY	CONTEXT	BILLED CY	UNBILLED CY	ACTIONS TO CONSIDER
Neoplasms	Dx Not Billed		CHG: C49.9 (04/14/21)	Add to Chg Next Visit
Diabetes	More Complex Dx in Billing	E11.9 (02/10/22)	CHG: E11.65 (10/25/21)	Evaluate Unbilled Codes
Vascular Disease	Dx Not Billed		CLM: I26.99 (04/14/21)	Add to Chg Next Visit

Total RAF Risk Score

MAX TOTAL SCORE	GAP SCORE	ACTUAL SCORE
1.360	1.255	0.105

Open Referrals w/o Result (0)

No open referrals

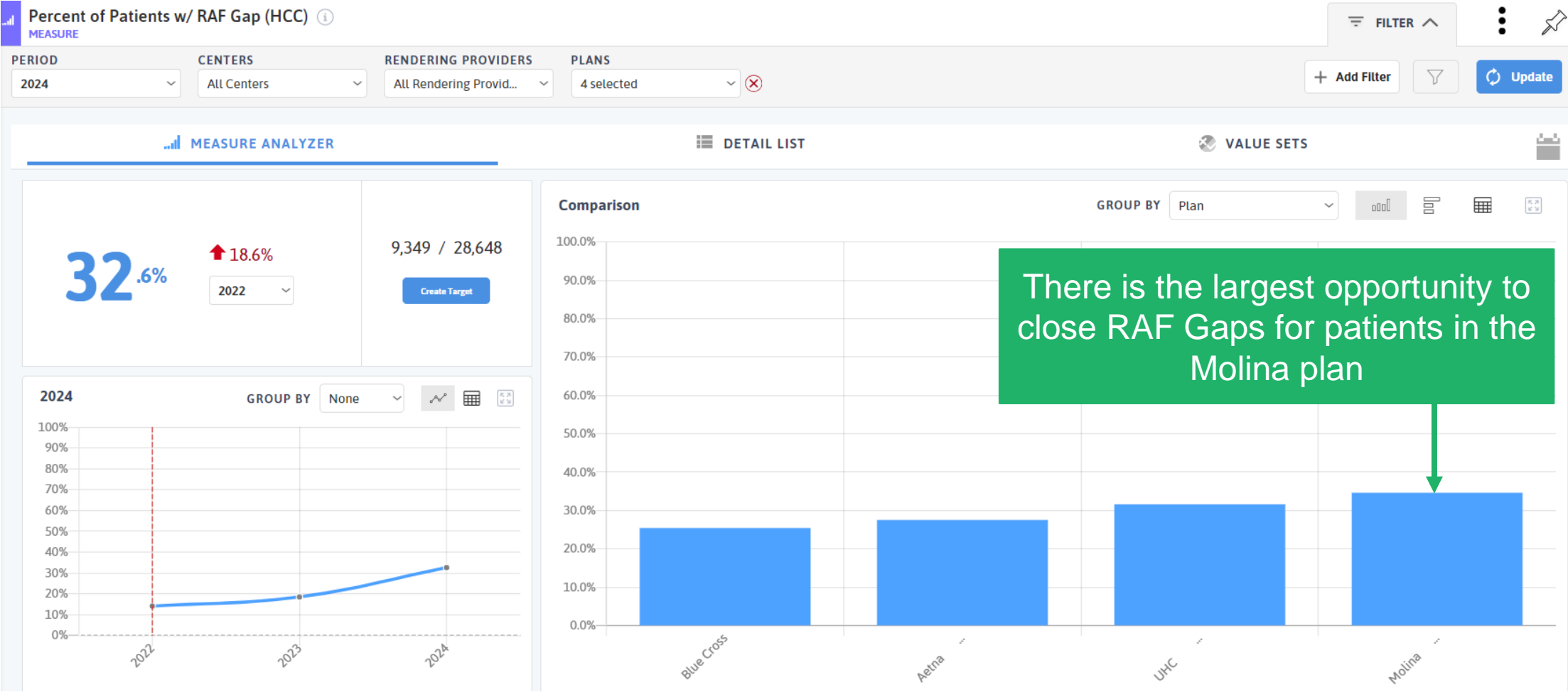
I/P & E/D Utilizations (0)

No anomalies

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



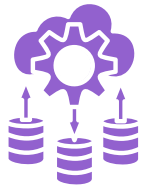
Where is the Opportunity?



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

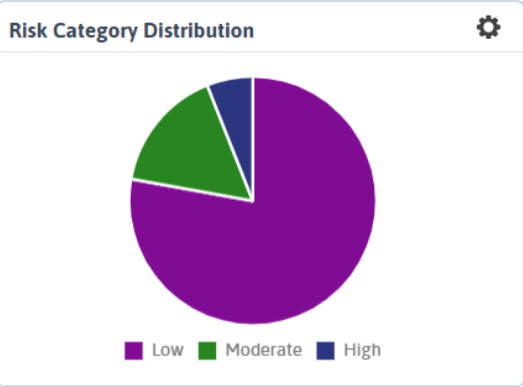


Identifying the “right” patients to maximize limited resources



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
Hypertlipidemia	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

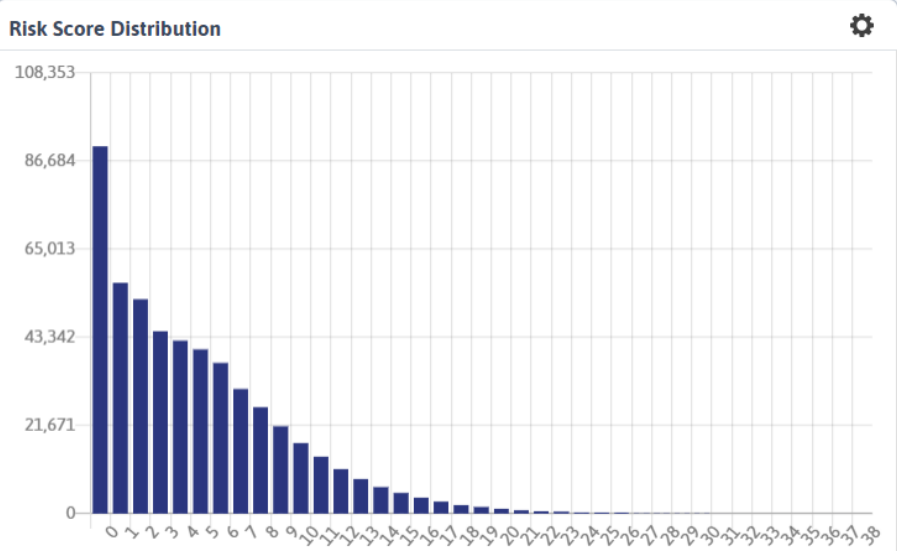


High Risk Patients

31,156
Pts w/ qualifying encounter

Total Patients

518,529
Pts w/ qualifying encounter



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



Many Ways to Use Azara Risk



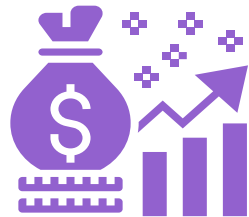
PVP & CMP



Registry



Dynamic
Cohorts



Rising Risk
Measure



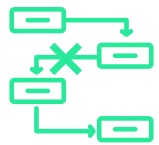
Risk
Filter



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




Care Coordination

DOB: 10/1/69 (54) | F ☆


SummaryCoordinationPlanClinicalActivity

Data Received: 2 April





 FOLLOW UP


04/05
OVERDUE

Pt asked to be called back Friday afternoon


 CONTACT REASONS (4)

AllOpenComplete

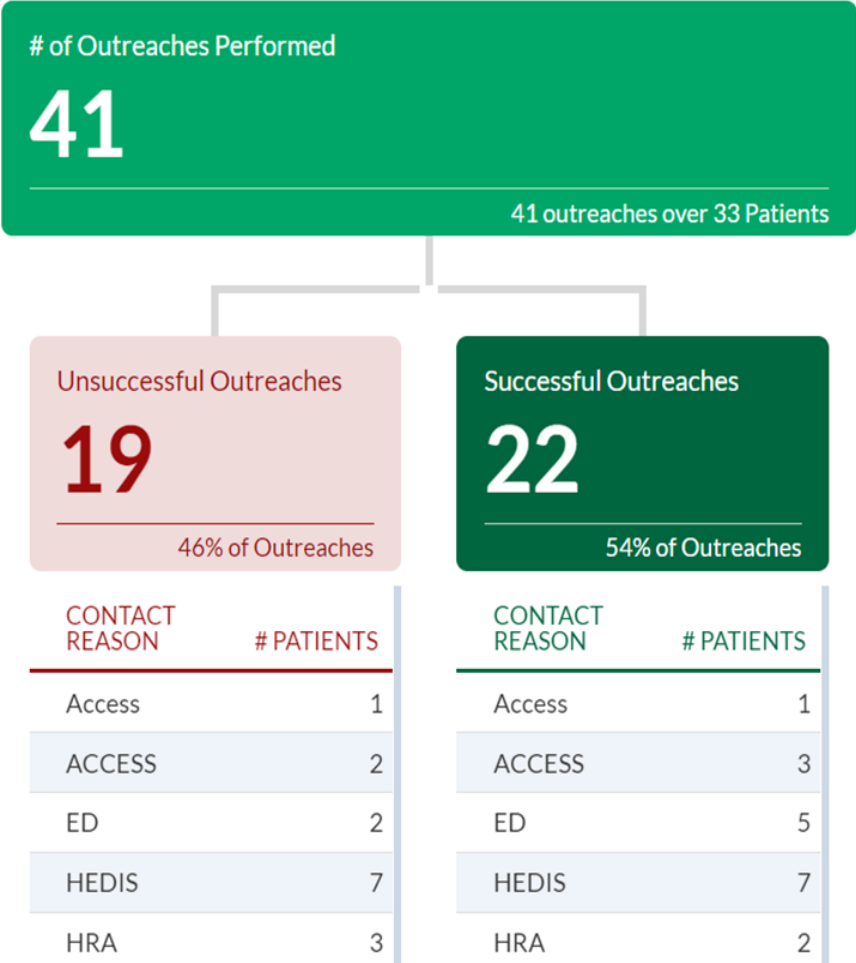


 NOT REACHED

TYPE	DETAIL	REPORTED	STATUS	OUTREACHES	LAST OUTREACH	LAST OUTREACH BY
<input type="checkbox"/> CQM (1)	CQM(1)		open	1	04/04/24	Jackie Brown
<input type="checkbox"/> ED (6)	Primary Dx: Diabetes with complications	02/29/24	open	1	03/04/24	Jackie Brown
<input type="checkbox"/> HEDIS (1)	CDC (1)	12/16/23	open	3	01/30/24	Jackie Brown



Care Coordination Productivity



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



Care Management

[Home](#) [Patients](#) [Tasks](#) [Reports](#) [Care Coordination](#)

UTILIZATION

Inpatient Last 7 Days0

Emergency Last 7 Days0

TASKS

Overdue5

Flagged4

Due Today0

Assigned8

PATIENTS

With Appts Today1

Starred2

New0

Assigned17

Starred Patients

Flagged Tasks

NAME	MRN	DOB	NEXT APPT	CARE MANAGER	COHORTS
★ BINS, LOTTIE	706715321	12/22/76	4/7/24 4:30 PM	Unassigned	Health Home
★ SMITH, ANDREA	222222222	1/1/69	4/4/24 4:30 PM	Jackie Brown	CCM

Showing 1 to 2 of 2 entries

Previous

1

Next



Care Management Plan

Home

Patients

Tasks

Reports

Care Coordination

Search ACM Patients...

Smith, Andrea

MRN: 222222222

Member Number: (Azara Health Plan)

DOB: 1/1/69 (55)

F

M 11

English

781-365-2208

Summary

Coordination

Plan

Clinical

Activity

Data Received: 30 March

FOCUS

Material Support

04/04/24 - present

Hypertension Mgmt

02/04/24 - 03/05/24

CARE TEAM

Intervention Effort

Medium

Care Manager

Jackie Brown

Usual Provider

Reynolds, Burt

Coordinator

Jackie Brown

MANAGEMENT PLAN

She has been known to no-show for visits and has trouble caring for herself, including managing her Diabetes because she has complications of a history of Heart Failure and Emphysema. These two conditions lead, along with her Diabetes, to edema in her limbs due to poor circulation. Respiratory challenges sometimes lead to mental confusion and difficulty remembering to take medications and managing blood sugar. Need to understand why ER visits have been happening. Consider possibility of BH and/or substance use



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



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.



Evaluate Engagement Programs

IMPACT



473

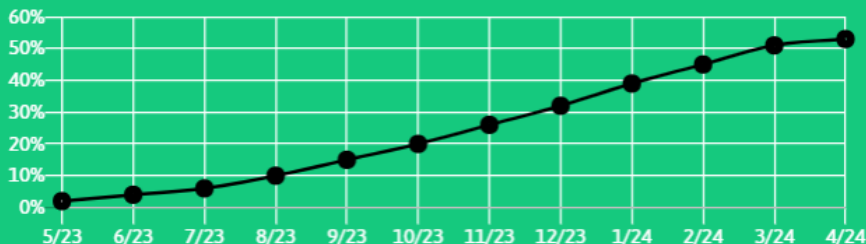
CARE GAPS CLOSED

▲ 18 Last Month

53%

CARE GAP
CLOSURE RATE

ENROLLEES W/CARE GAP CLOSURES BY MONTH



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

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

PATIENT ENGAGEMENT



892

PTS SUCCESSFULLY
REACHED

TY April 2024

▲ 18 Last Month



59%

MADE APPT



50%

KEPT APPT



53%

CARE GAP CLOSED



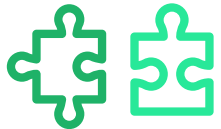
Close Care Gaps & Improve Quality

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



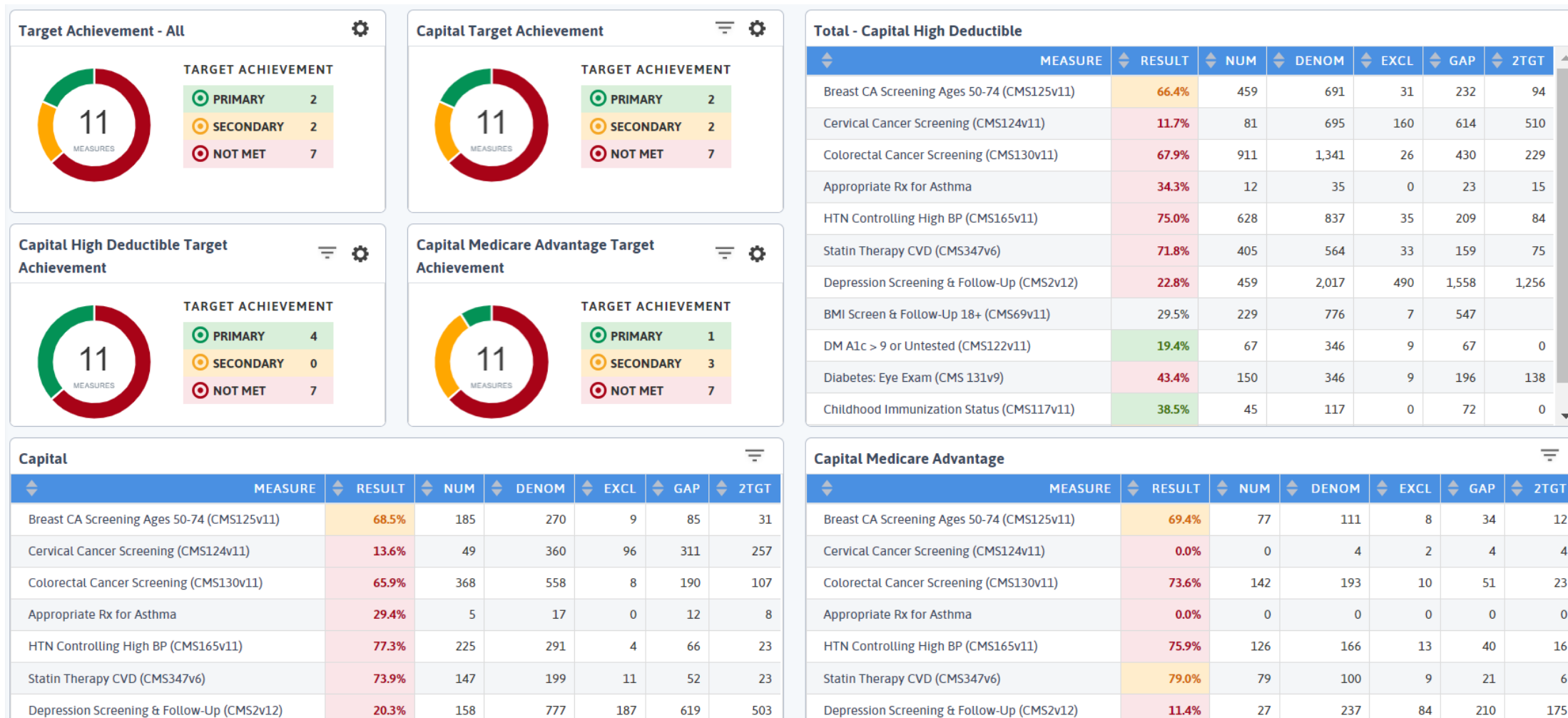
Reconciling claims and clinical data



Lack of information at point of care



Evaluate Care Gaps Across Programs



Targeted Outreach | Gap Lists

VBCare Plan Calculated Measures

REPORT

PERIOD

2021

CENTERS

All Centers

RENDERING PROVIDERS

All Rendering Provid...

+ Add Filter

Update

REPORT

CARE GAPS

Search ...

AllHas ApptNo Appt

DATA RECONCILIATION REQUIRED

MEASURE COMPLIANCE

Non-Compliant (Gap)

Compliant

ACTION REQUIRED

Member Outreach

Data Reconciliation

NO ACTION REQUIRED

Compliant

	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									

RECENT

Patient Risk

ALL

Cost Group

Last Encounter

Member Match Type

Patient Diagnoses

Patient Risk

Plan PCP

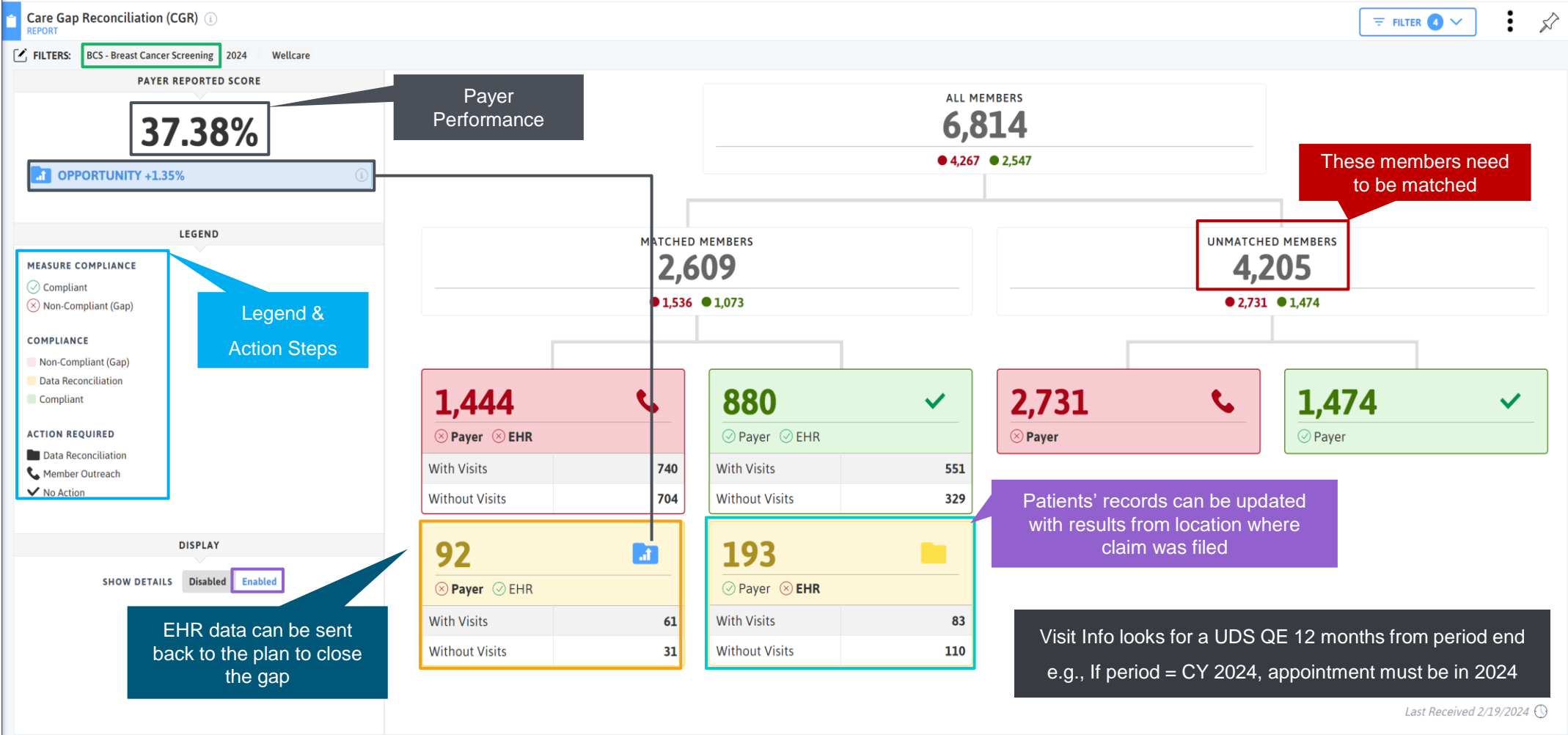
Rendering Locations

Usual Locations

Usual Providers



Reconcile Claims and Clinical Data



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.

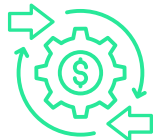
Key Challenges:



Extracting actionable insights from claims data



Track multiple plans and programs in one place



Effectively manage hospital utilization



Manage Multiple VBC Contracts

Summary

Total Claims Paid
\$428.1m ▼\$76.5m

Member Months
901.1k ▼132.6k

PMPM
\$475 ▼\$25

Avg RUB
3 ▲2

Top Cost Members

70.1% of Cost

8.2% of Members

\$300.1m

Total Cost Top Members

70.1% of total cost (\$253.2m) is attributed to 8.2% of top cost members (population of 6,150 members)

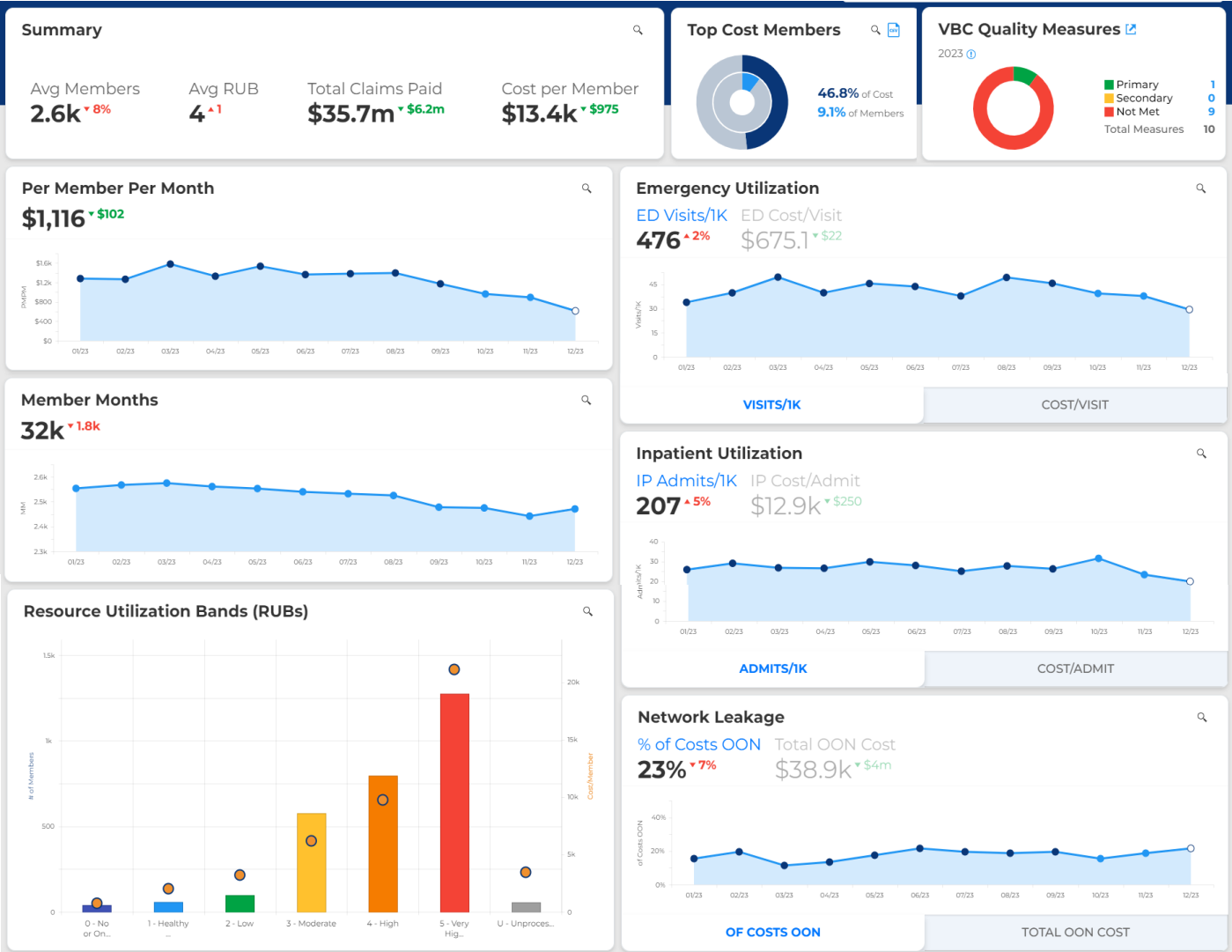
Plan and Line of Business Summary

Plan & LOB	Total Cost ↓	MMs	PMPM	Resource Utilization Band	Quality
				U 0 1 2 3 4 5	Primary Secondary Not Met
Health Plan 2 - Commercial	\$126,128,124	327,569	\$385	<div><div>4,494</div><div>14,332</div><div>6,235</div></div>	<div><div>5</div><div>1</div><div>2</div></div>
Health Plan 1 - Commercial	\$112,688,289	225,123	\$500	<div><div>2,428</div><div>7,294</div><div>3,206</div></div>	<div><div>1</div><div>4</div></div>
Health Plan 2 - Medicare	\$38,407,479	31,739	\$1,210	<div><div>1,480</div><div>3,157</div><div>1,048</div><div>803</div><div>1,065</div></div>	<div><div>1</div><div>5</div></div>
Health Plan 3 - Medicare	\$35,722,124	32,000	\$1,116	<div><div>502</div><div>775</div><div>1,234</div></div>	<div><div>2</div><div>6</div></div>
Health Plan 3 - Medicaid	\$32,116,280	71,848	\$447	<div><div>3,246</div><div>1,344</div><div>2,814</div><div>1,165</div></div>	<div><div>3</div><div>2</div></div>
Health Plan 1 - Medicaid	\$29,142,800	38,095	\$765	<div><div>2,400</div><div>1,002</div><div>2,001</div><div>4,225</div><div>1,900</div></div>	<div><div>1</div><div>1</div><div>3</div></div>

Available in ACU

ACO

Contract Details



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 ...

Q

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



Transitions of Care (TOC)



The Cost of Readmissions

**\$26
Billion**

Medicare spends
annually on hospital
readmissions

**\$17
Billion**

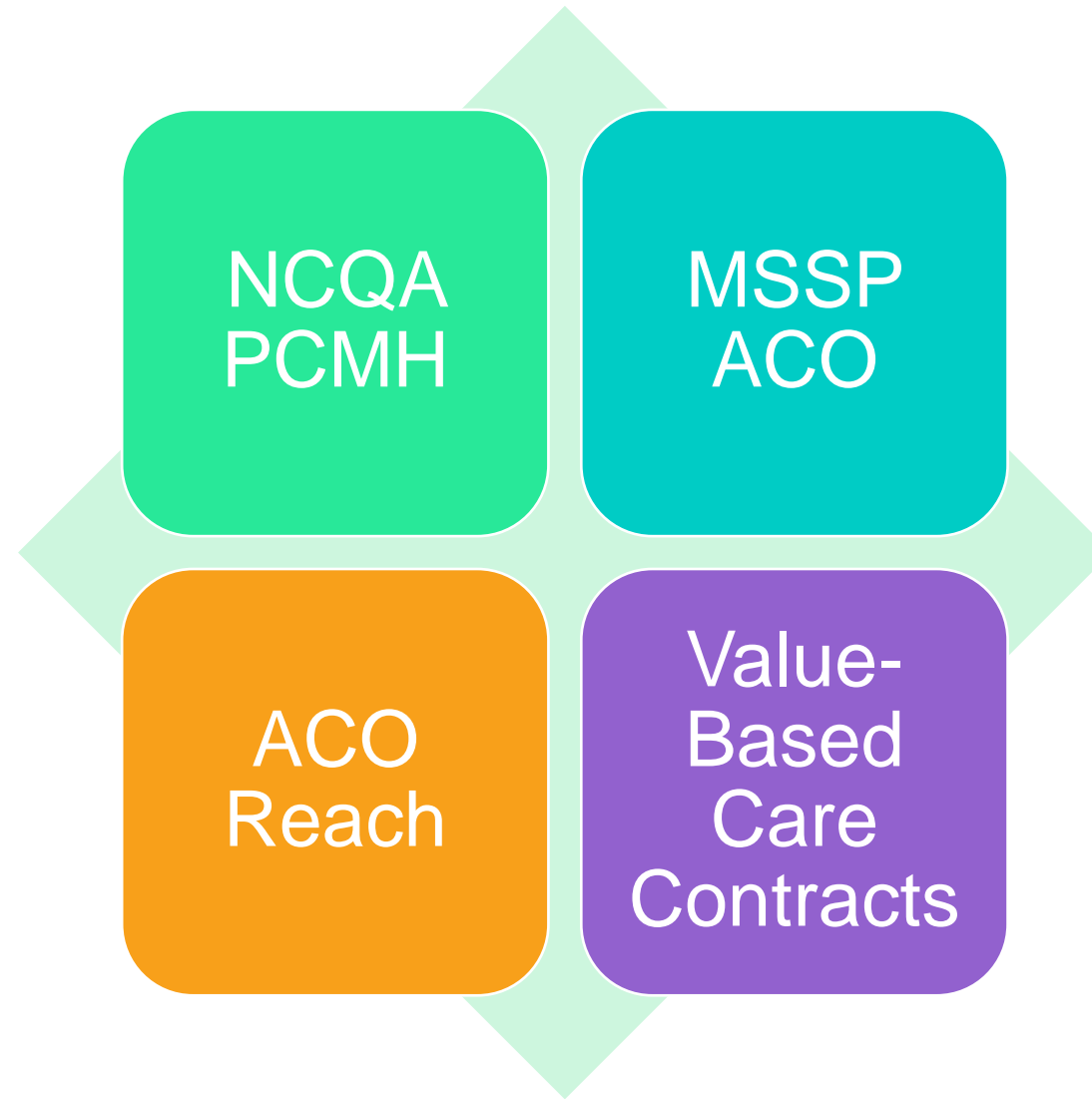
Spent on avoidable
readmissions

**30% of
Patients**

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



TOC Work Supports Many Programs



HIE Data in DRVS

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



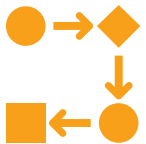
Lists of discharged patients who need follow-up



Identify high utilizers for care management



Track readmission rates for cost management

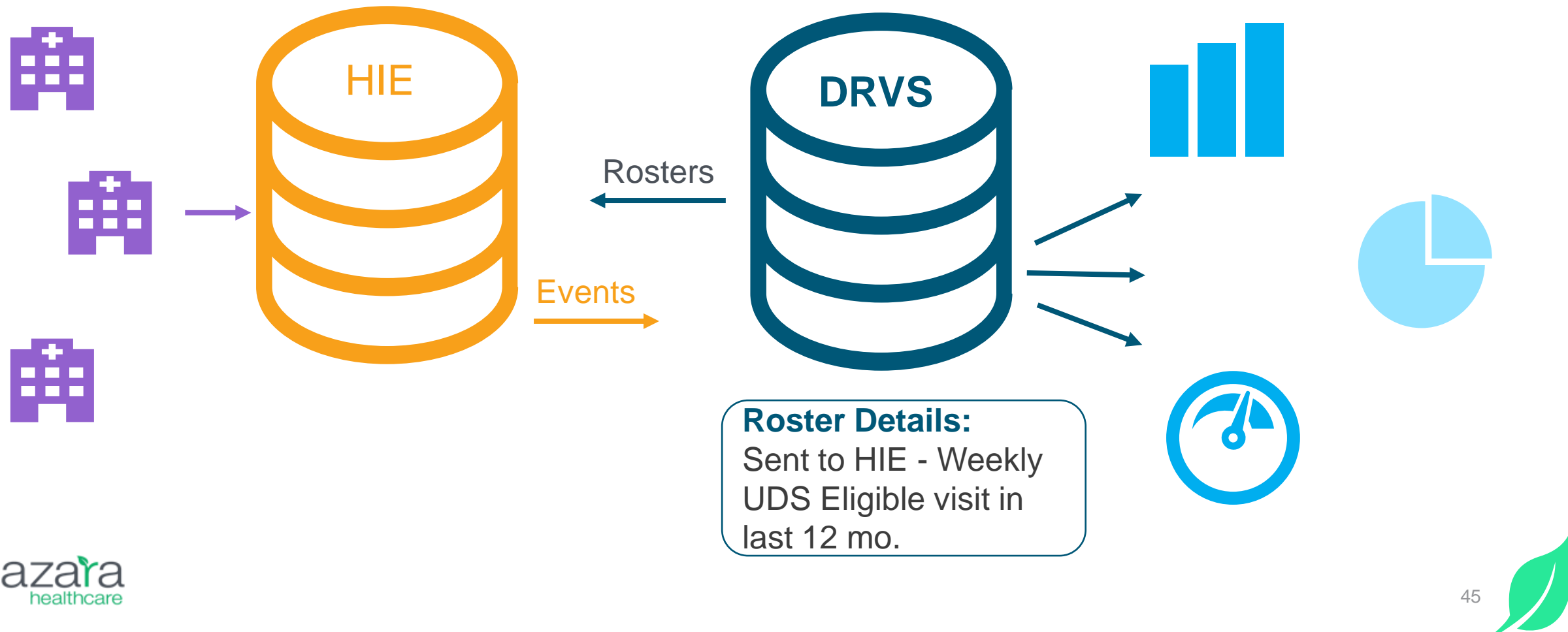


Understand the impact of interventions and process changes



How ADT Data Gets into DRVS

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



The TOC DRVS Tools

Reports

Reports

Transition of Care

Transitions of Care (TOC) - ED/IP

Measures

Measures

Transition of Care

ED Follow Up Call

ED Follow Up Scheduled

ED Follow Up Visit

ED Readmission (30 days)

ED Readmission (6 months)

Emergency Episode Volume

I/P Follow Up Call

I/P Follow Up Scheduled

I/P Follow Up Visit

I/P Readmission (30 days)

I/P Readmission (6 months)

Inpatient Episode Volume

Dashboards

Dashboard

Azara

Transitions of Care (ED)

Transitions of Care (I/P)

Visit Trends



Transitions of Care (TOC) – ED/IP

Run the ED/IP Report by Discharge Date

Transitions of Care (TOC) - ED/IP

REPORT

DATE RANGE

05/09/2024-05/09/2024

CENTERS

All Centers

DISCHARGE STATUS

All Discharge Status

LAST VISIT

No Required Visit

TOC TYPE

All TOC Type

TOC STA

Discharge

Search ...

Filter by ED or IP Type

DISCHARGE

ED VISITS LAST 6 MONTHS

IP VISITS LAST 6 MONTHS

DISCHARGE STATUS CODE

DIAGNOSIS

NAME	MRN	DATE OF BIRTH	DISCHARGE	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS	DISCHARGE STATUS CODE	CODE	DESCRIPTION		
			ER Visit	2/2/23 3:05 am	2/2/23 6:06 am	4	0	Home (Self-Care Only)		
			ER Visit	2/2/23 3:05 am	2/2/23 6:06 am	2	0			
			ER Visit	2/2/23 11:47 am	2/2/23 1:32 pm	5	0	Home (Self-Care Only)		
			ER Visit	2/2/23 10:52 am	2/2/23 12:23 pm	1	0			
			Inpatient Stay	12/12/22 2:00 pm	2/2/23 1:25 pm	0	1	HOME		
			ER Visit	2/1/23 10:24 pm	2/2/23 1:18 am	4	0	1		
			Inpatient Stay	1/31/23 11:04 am	2/2/23 11:13 am	1	1	HOMHLTH	Z96.652	Presence of left artificial knee joint

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

DEMOGRAPHICS >	NEXT APPOINTMENT			LAST APPOINTMENT					
NAME	NEXT APPOINTMENT	PROVIDER	LOCATION	LAST APPOINTMENT	PROVIDER	LOCATION	HIE	RISK	RISKSCORE
				12/31/2020			IHIE	Low	6
				2/18/2021			IHIE	Low	4
				12/20/2020			IHIE	High	18
	5/4/2021		Primary Care	3/2/2021			IHIE	Moderate	10
				10/1/2020			IHIE	Low	2
				10/15/2020			IHIE	Moderate	9



Additional Filters on TOC - ED/IP Report

DISCHARGE STATUS

All Discharge Status ▾

Search 🔍

Clear Filters

- ☐ Expired
- ☐ Home
- ☐ Hospice
- ☐ Inpatient Hospital
- ☐ Internal Transfer
- ☐ Long Term Care Hospital
- ☐ Non-hospital Institution
- ☐ Nursing Facility
- ☐ Outpatient Facility
- ☐ Prison or Correctional Facility
- ☐ Psychiatric Facility
- ☐ Rehabilitation Hospital
- ☐ Unknown or Blank

TOC STATUS

Discharge ▾

Search 🔍

Clear Filters

- ☐ Admission
- ☒ Discharge

TOC TYPE

All TOC Type ▾

Search 🔍

Clear Filters

- ☐ ED Only
- ☐ IP Only

LAST VISIT

No Required Visit ▾

- No Required Visit
- Any visit in past 1 year
- Any visit in past 1.5 years
- Any visit in past 2 years
- Any visit in past 3 years
- PC visit in past 1 year
- PC visit in past 1.5 years
- PC visit in past 2 years

PATIENT RISK

All Patient Risk ▾

Search 🔍

Clear Filters

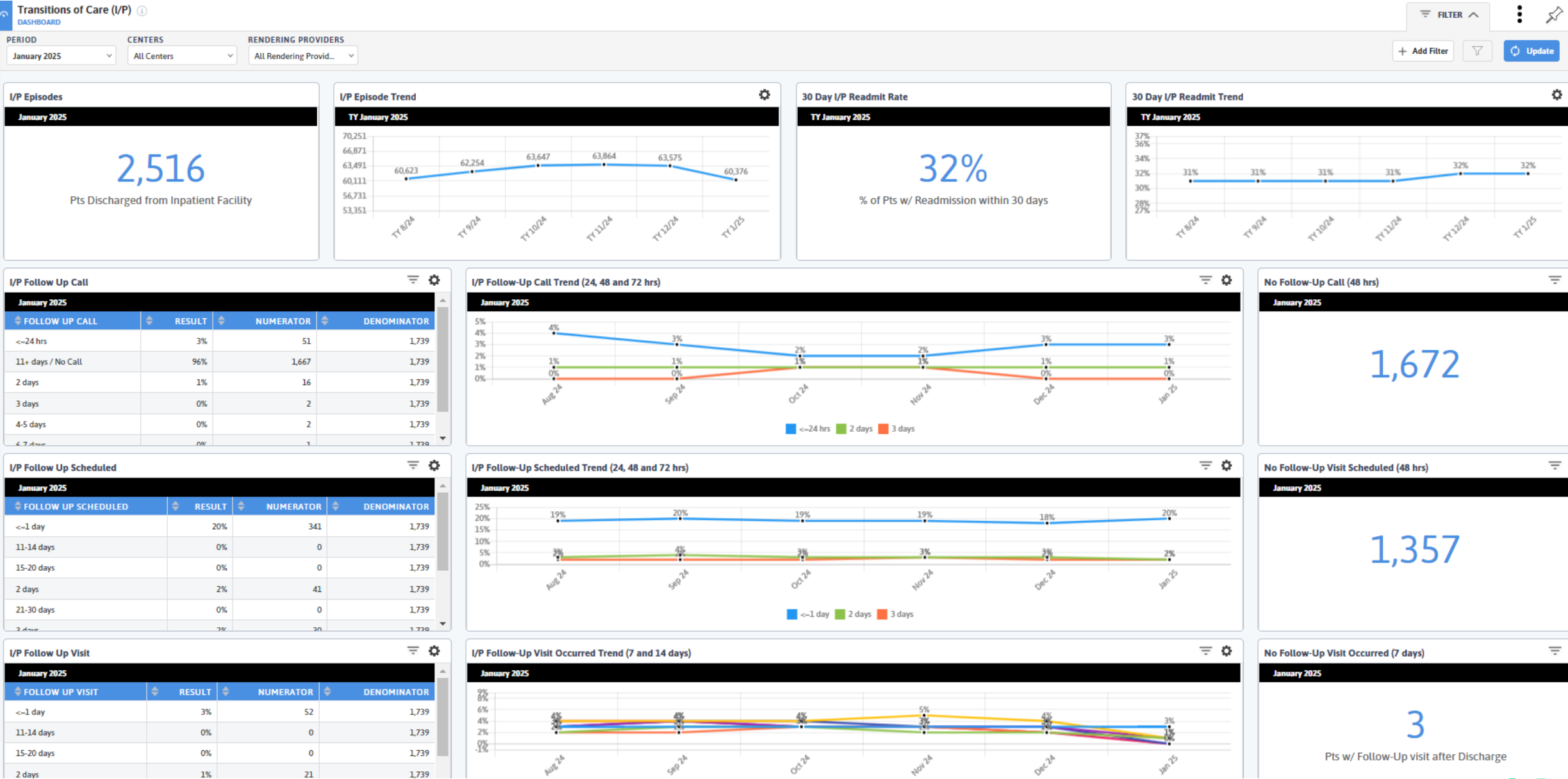
- ☐ High
- ☐ Moderate
- ☐ Low

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.

New TOC Dashboard - IP





PVP Alerts

Point of Care: Run the Patient Visit Planning Report

CATEGORY ▾	NAME	PVP NAME	DESCRIPTION		thyroid-aware of loc, mask and no visitor-agt ER Or Hospital Follow-Up
Other	E/D Encounter	E/D Encounter	Alert will trigger if E/D Episode has occurred in the last 60 days.	⚙	PCP: Payer: Care Manager: Unassigned
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	⚙	

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	

Turn on the alerts.



The Care Management Passport (CMP)



Patient History: Run the CMP

Care Management Passport (CMP) 1 Patient Lookup

MRN:
 DOB:
 Sex at Birth: M
 Gt: 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



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	Dictofenac Sodium 75 MG Delayed Release Oral Tablet
1/4/21	Chantix Starting Month PAK

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.

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		

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

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



Azara Patient Outreach (APO)



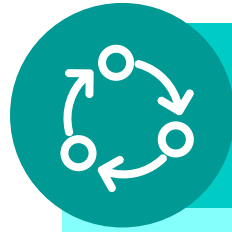
Member Outreach Challenges



Members

Who needs outreach?

Who will Respond?



Method

What communication method works best?

Call, letter, text, or combination?



Staff

Existing staff?

New staff?

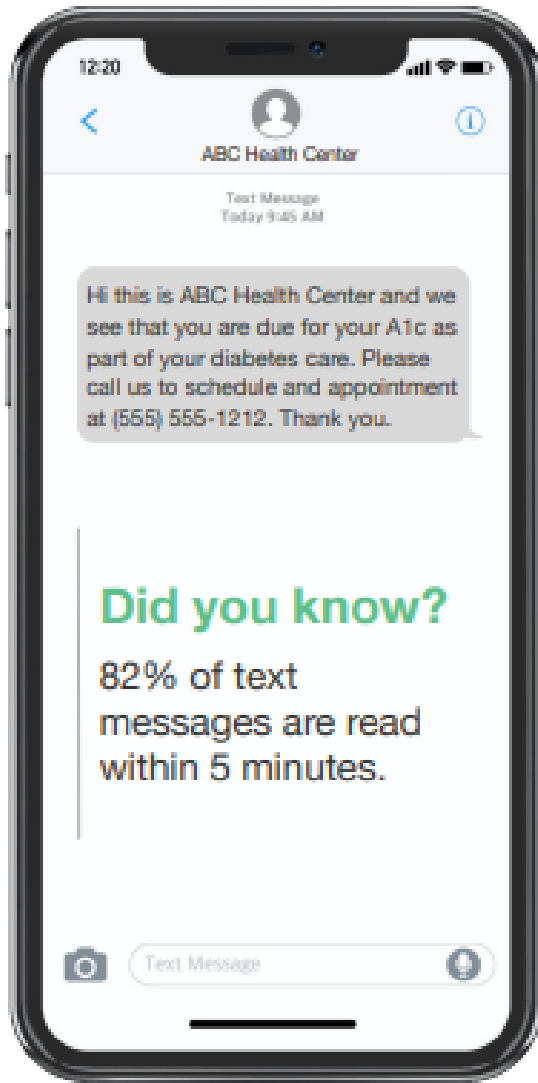


ROI

How to measure value?

What is the ROI?





Patient Engagement



Automated and targeted campaigns

Text messaging is most effective

Use analytics to reach the right people at the right time with the right message

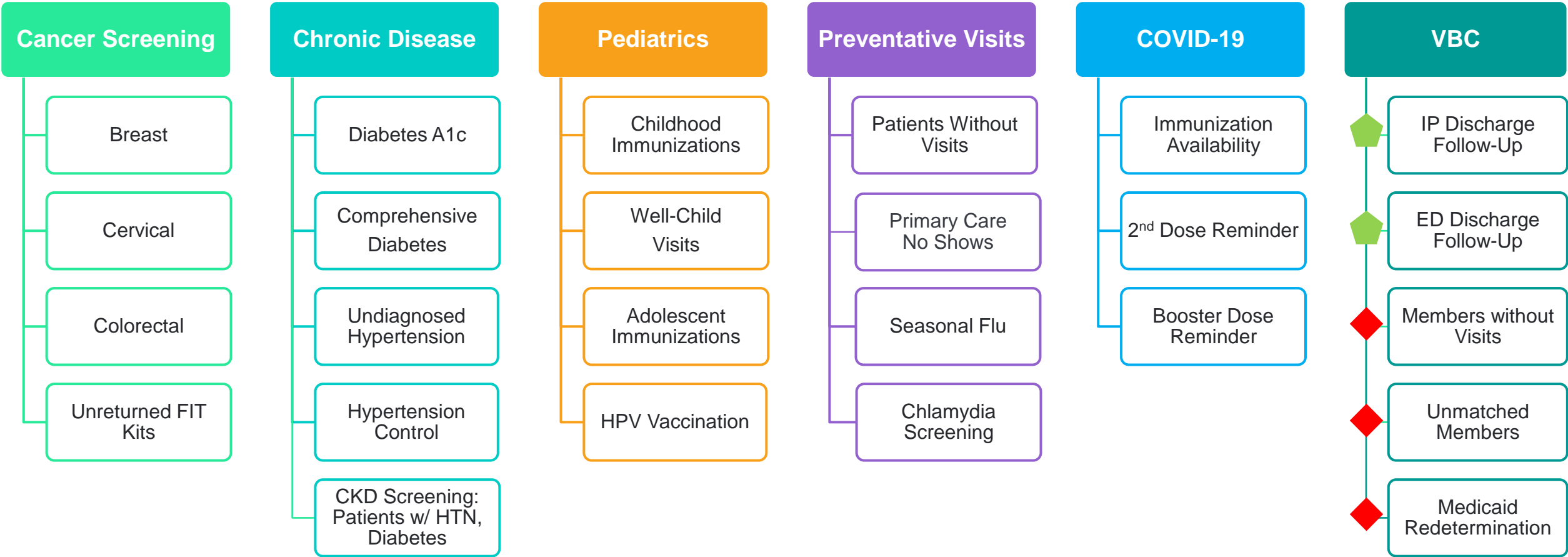
Data humanizes and drives meaningful experiences

Track results and adjust campaigns

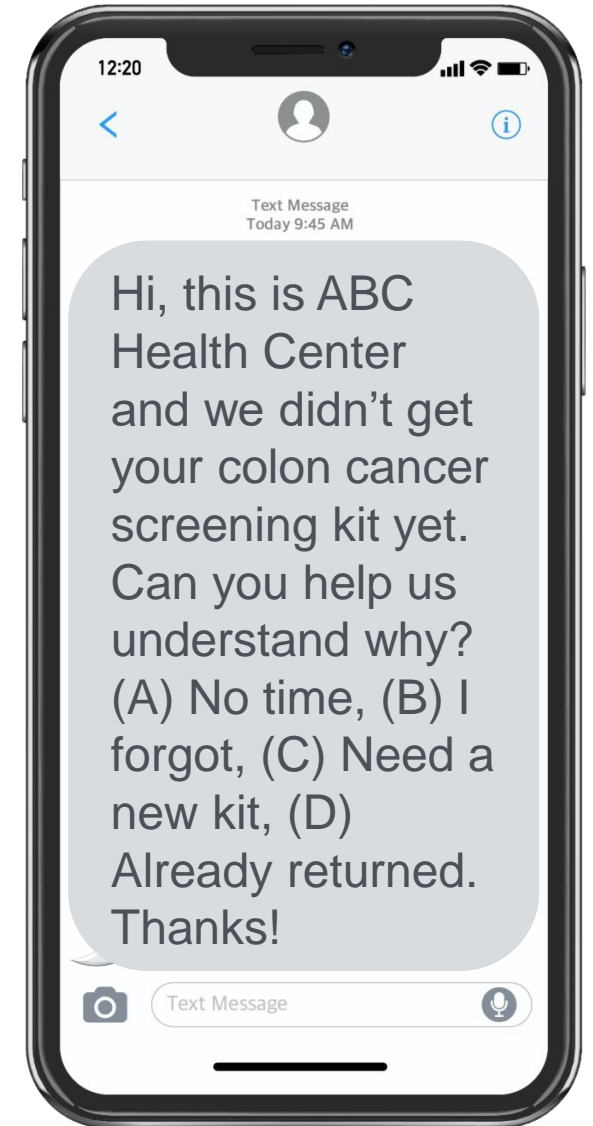
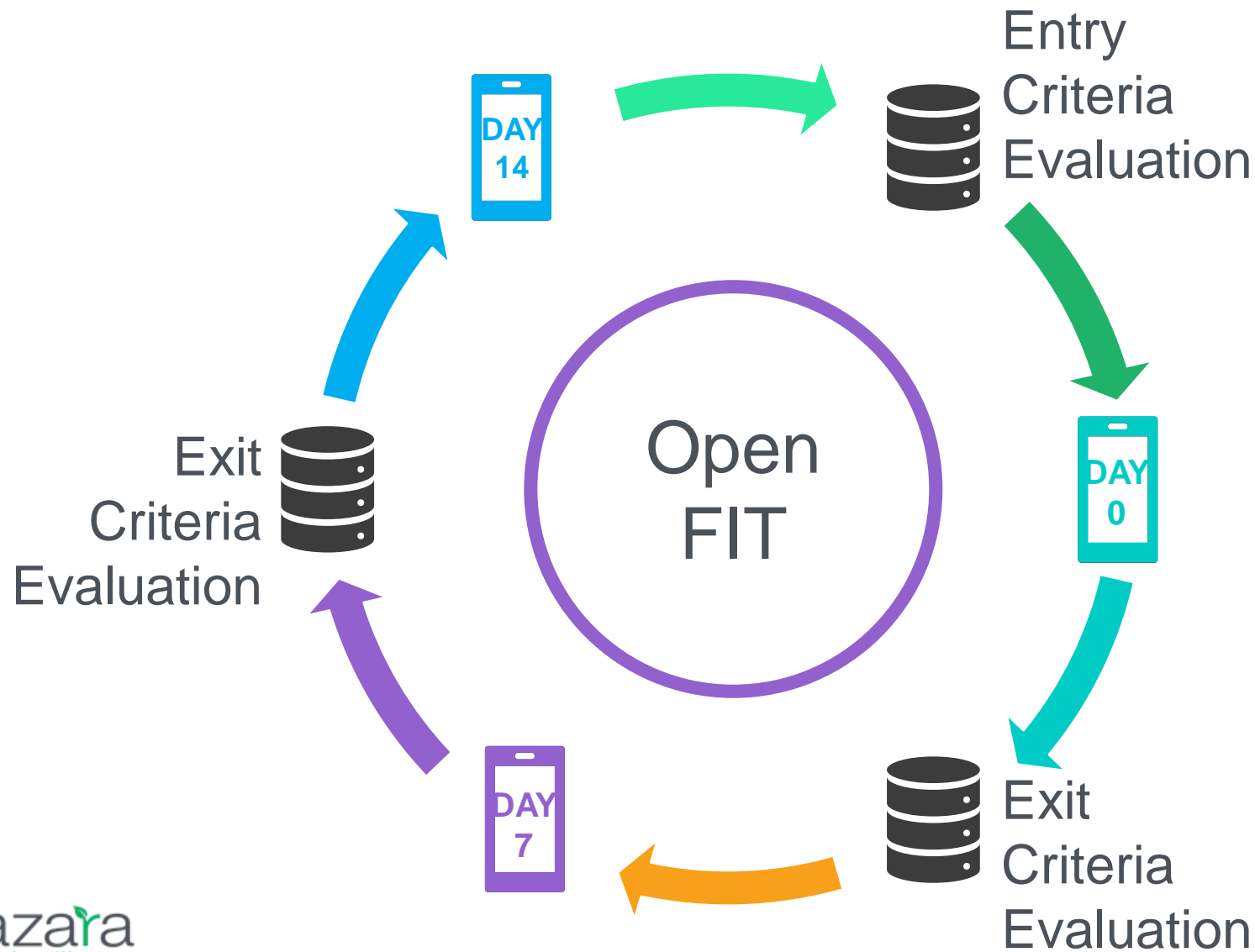
Utilize flexible solutions to reach diverse populations



Available SiFi Campaigns

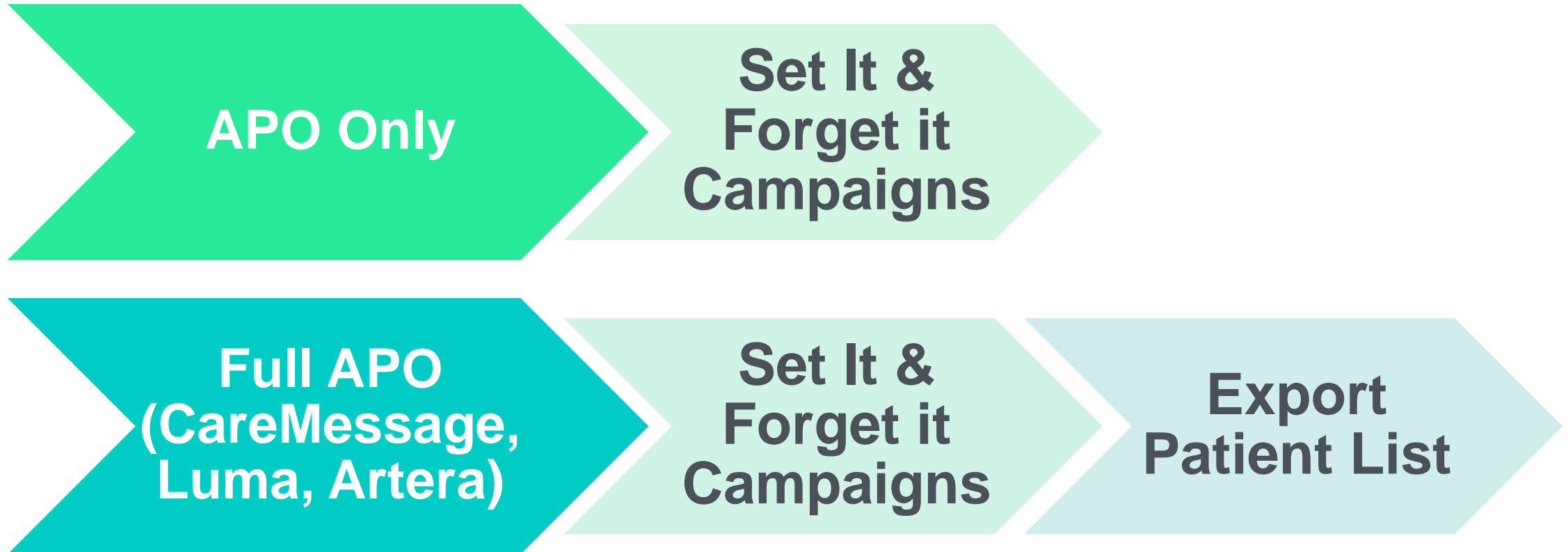


Patient Text Journey



Manual Campaign Availability

Manual campaigns available on measure detail list and registries



Manual Campaign | Registries

Asthma

REGISTRY

VISIT DATE RANGE

09/01/2024-09/30/2024

RENDERING PROVIDERS

All Rendering Provid...

FILTER

+

Ac

Export Excel

Export CSV

Export Patient List

Copy Registry

Create Cohort

REGISTRY

VALUE SETS

Search Patients ...

DEMOGRAPHICS >		INSURANCE		MOST RECENT ENCOUNTER			NEXT APPOINTMENT			
NAME	MRN	FINANCIAL CLASS	PRIMARY PAYER	DATE	PROVIDER	LOCATION	DATE	PROVIDER	LOCATION	TYPE
Raymond, Bethanie	1101015	Private Insurance	BCBS	9/14/2023	Augustine, Greg	1400 Cambridge St.	5/2/2024	Black, Ronda	ACH - Needs Update	Injury
Hauth, Jermaine	1101024	Private Insurance	Coventry	1/4/2024	Bridgewater, Bill	Main St. Office	5/11/2024	Crowley, Patrick	ACH - Needs Update	Office visit
Crippin, Emmett	1101030	Private Insurance	Coventry	10/20/2023	Decelles, Larry	1400 Cambridge St.	5/15/2024	Decelles, Larry	ACH - Needs Update	Office visit
Lopilato, Fallon	1101040	Private Insurance	Aetna	3/17/2024	Crowley, Patrick	1400 Cambridge St.	5/11/2024	Decelles, Larry	ACH - Needs Update	Annual Visit
Tarras, Nicolas	1101041	Medicaid	Medicaid	11/24/2023	Fritz, Renata	1400 Cambridge St.	5/1/2024	Fritz, Renata	ACH - Needs Update	Mental Heal
Gadbaw, Lakesha	1101043	Private Insurance	Aetna	9/24/2022	Augustine, Greg	1400 Cambridge St.	4/29/2024	Crowley, Patrick	ACH - Needs Update	Mental Heal
Angviano, Edmond	1101064	Medicaid	Medicaid	1/15/2024	Doe, Jane	70 Blanchard Rd.	4/24/2024	Augustine, Greg	ACH - Needs Update	Annual Visit
Stample, Mauro	1101065	Private Insurance	BCBS	3/10/2024	Black, Ronda	Main St. Office	4/30/2024	Decelles, Larry	ACH - Needs Update	Sick Visit
Seeberger, Jackelyn	1101080	Private Insurance	BCBS	5/22/2023	Decelles, Larry	70 Blanchard Rd.	4/22/2024	Augustine, Greg	ACH - Needs Update	Physical
Falcioni, Jesus	1101081	Private Insurance	Coventry	1/15/2024	Winslow, Francine	1400 Cambridge St.	4/20/2024	Bridgewater, Bill	ACH - Needs Update	Mental Heal
Estela, Mindi	1101091	Medicaid	Medicaid	10/28/2023	Smith, Joe	Main St. Office	5/4/2024	Smith, Joe	ACH - Needs Update	Office Visit

1 to 11 of 816

Demo Data

<

<


Page 1 of 75

>

>

APO in DRVS | Campaign Control

 Patient Outreach Administration 

Global Campaign Status  [Send Messages](#) [Stop Messages](#) 

 CAMPAIGNS

 SCHEDULE SETTINGS

Search Campaigns...



All

Enabled

Disabled

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
	Members with no visit	Payer Integration	0	0	0	Disabled

Columns

APO Measures & Reports

Pins

PVP

CMP

Reports

Dashboards

Measures

Registries

Admin

Measures

Search

MU Asthma CQMs

MU Core CQMs

MU Dental CQMs

MU General Practice CQMs

MU Heart CQMs

MU HIV CQMs

MU Immunization CQMs

MU Legacy (2011-2013) Core CQMs

MU Objectives

Operational

Order Management

Panel Management

Patient Outreach

APO Attempted Msgs

APO Care Gap Closure

APO Enrollees Who Had an Encounter

APO Enrollees Who Made an Appointment

APO Failed Msgs

APO Pending Msgs

APO Responses

APO Successful Msgs

APO Successfully Reached Enrollees



Pins

PVP

CMP

Reports

Dashboards

Measures

Registries

Admin

Reports

Search

Care Management Passport

Clinical Operations

Controlled Substance

Data Health

Dental

Diabetes

HTN

Infectious Disease

Meaningful Use

OB

Patient Outreach

APO Campaign Performance

Failed Messages

Pending Messages

Successful Messages

Upcoming Messages

Payer Integration

PCMH

Pediatrics

Referrals

Title X

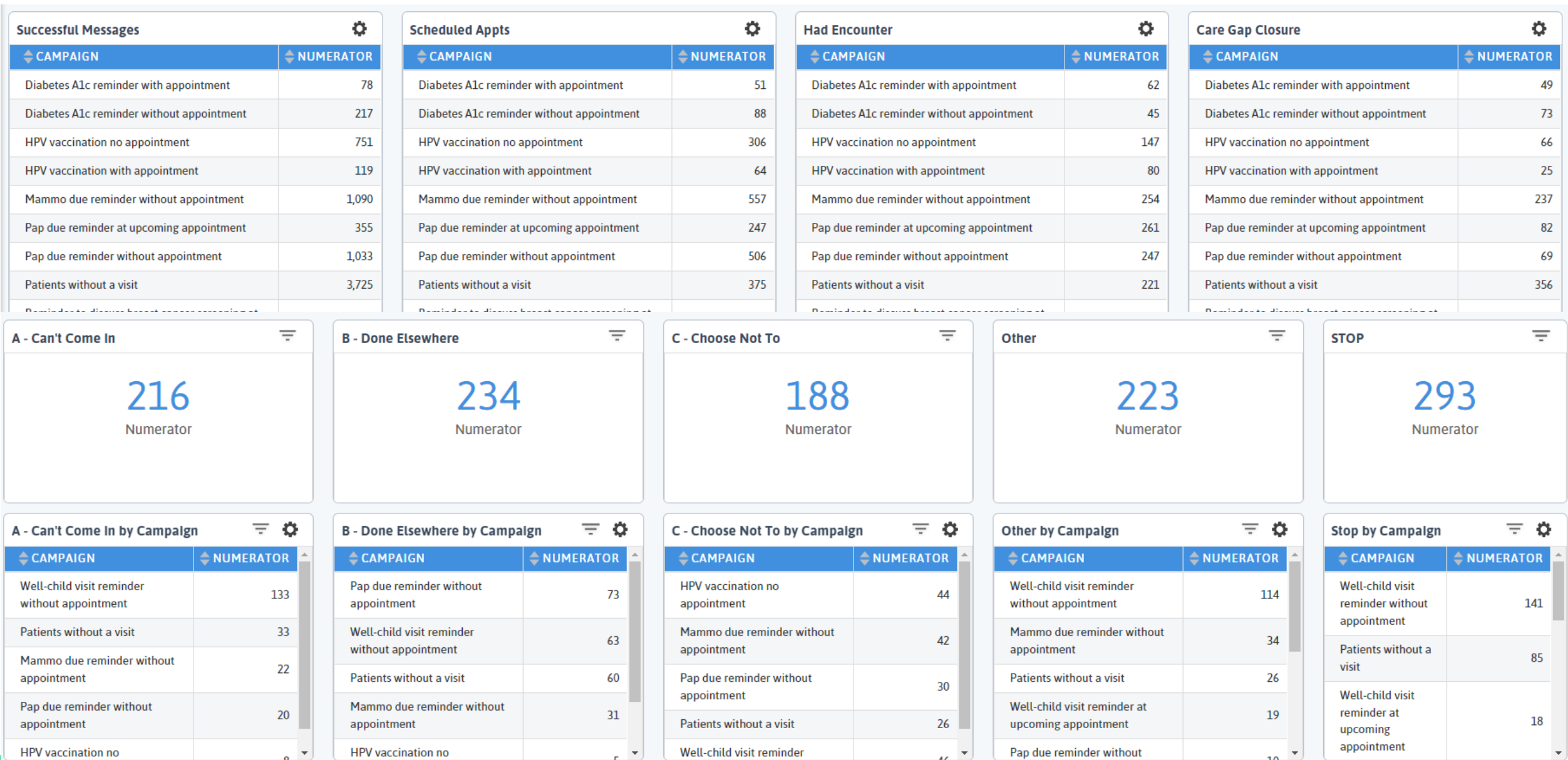
Transition of Care

Upstream Family Planning

Custom Scorecards



Custom APO Dashboards



Key Take-Aways



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



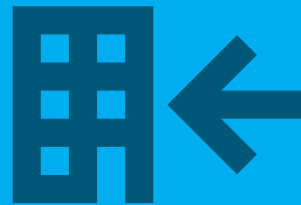
Determine which campaigns to focus on and *prioritize*



Consider *when is best* to send messages



Set up the campaigns



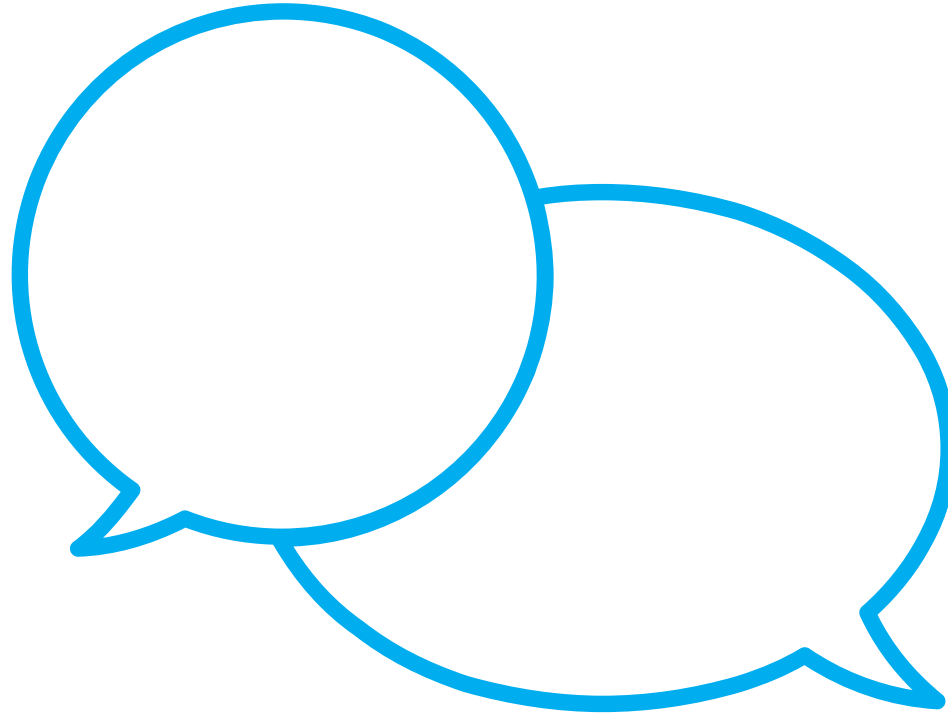
Track operational measures



Evaluate success of the campaigns



Questions?



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



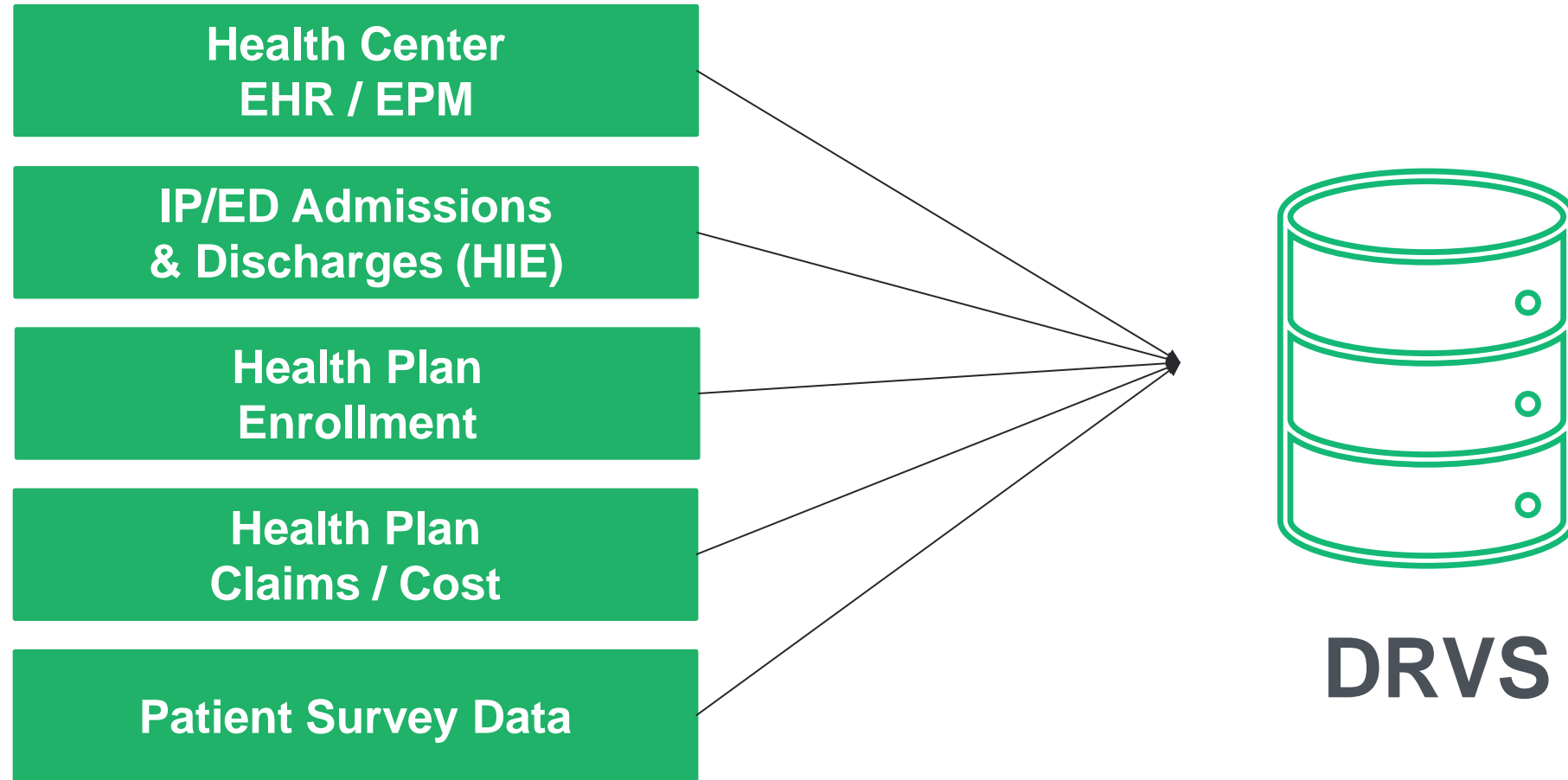
Understand Your Measure Landscape

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	

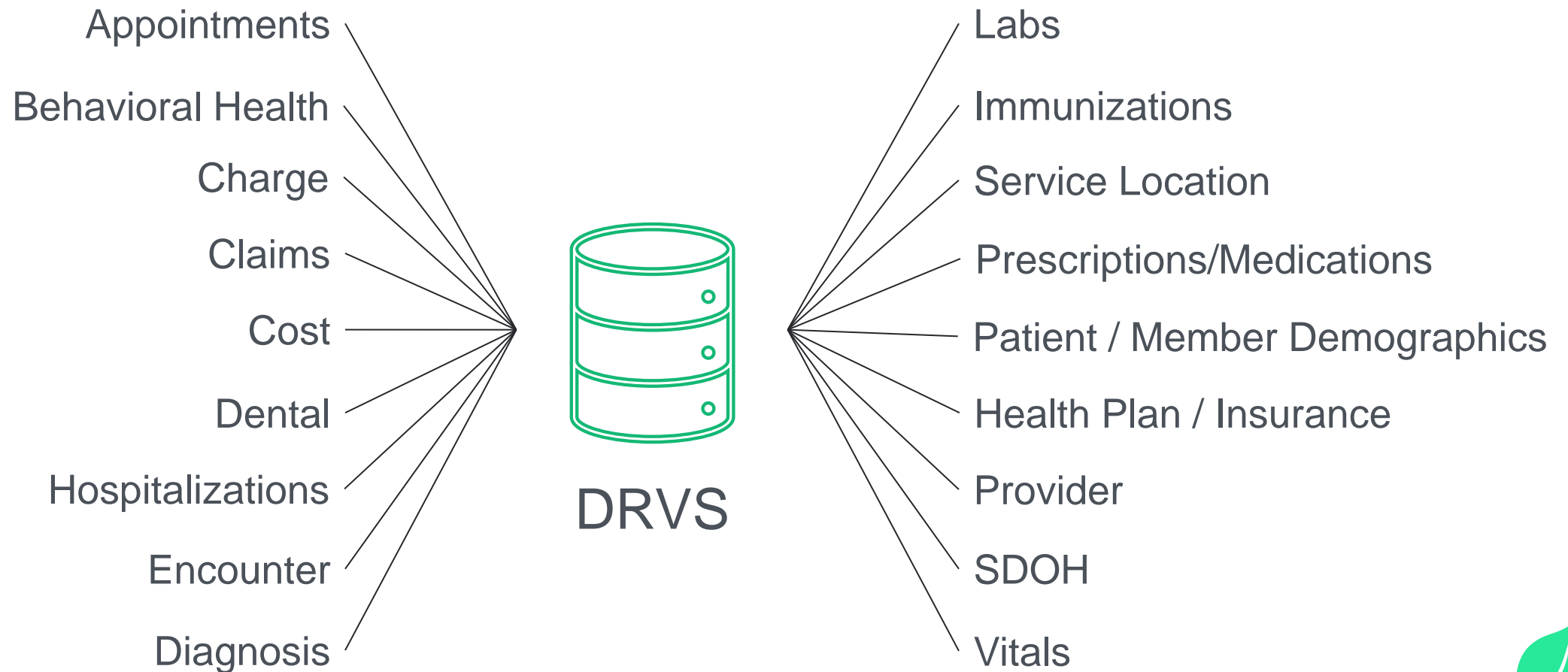


Azara DRVS Data Sources



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



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.

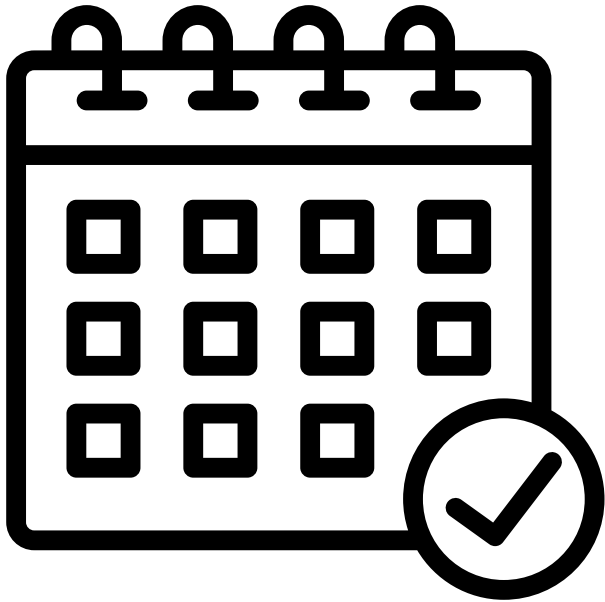
Prevent data discrepancies from occurring.



Ensuring Data Accuracy

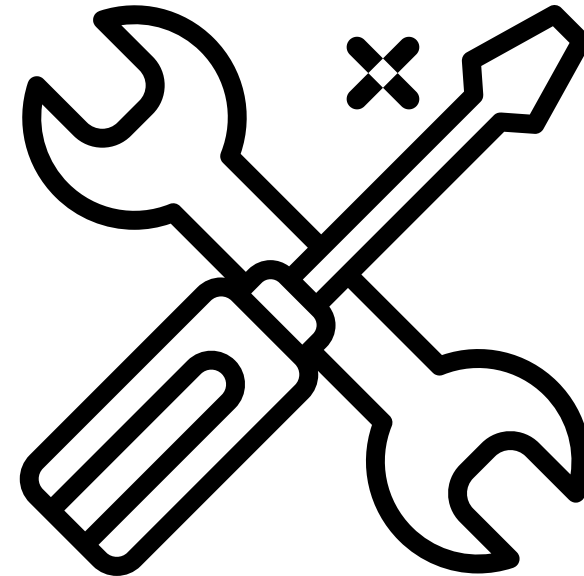
Data Hygiene

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

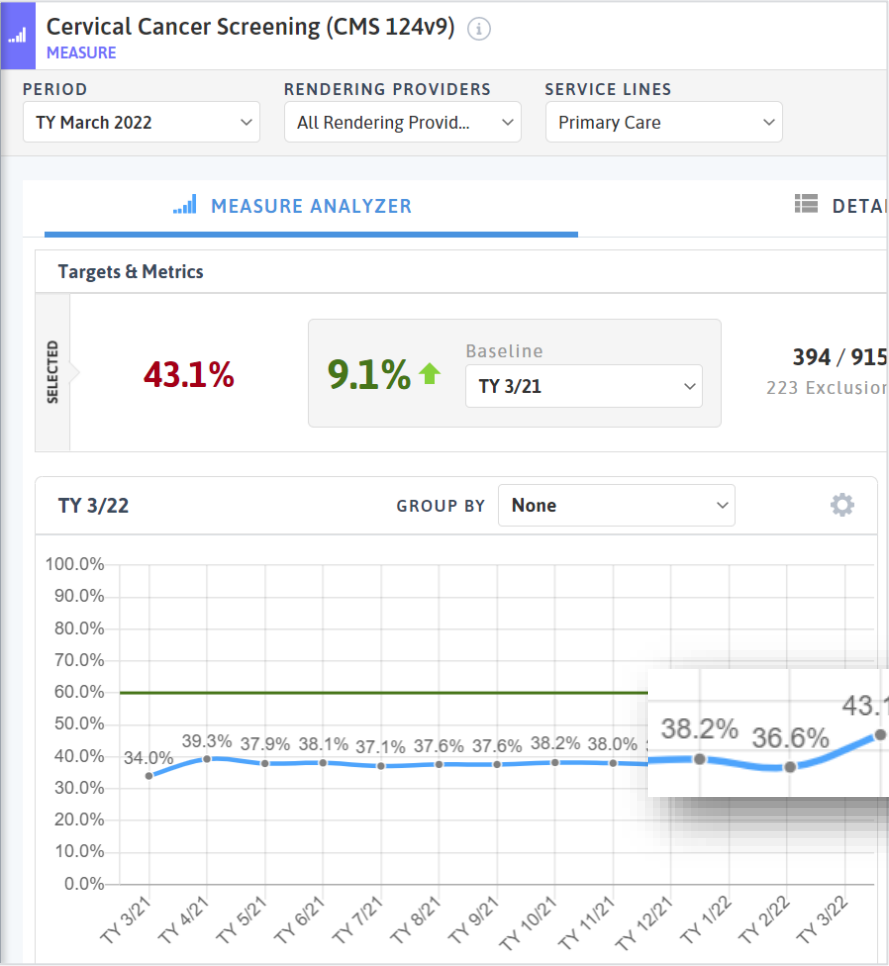


Data Validation

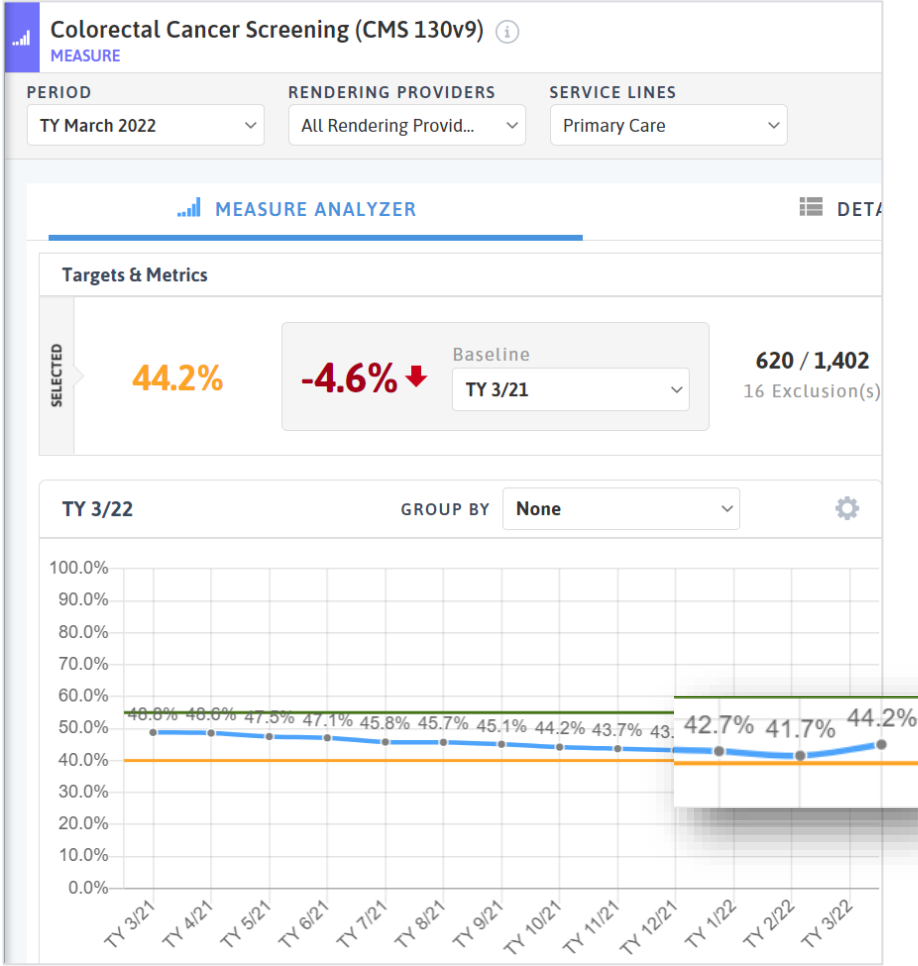
- Activities and tools for investigating data in DRVS and comparing to data in the EHR



Data Hygiene Success | Cancer Screening

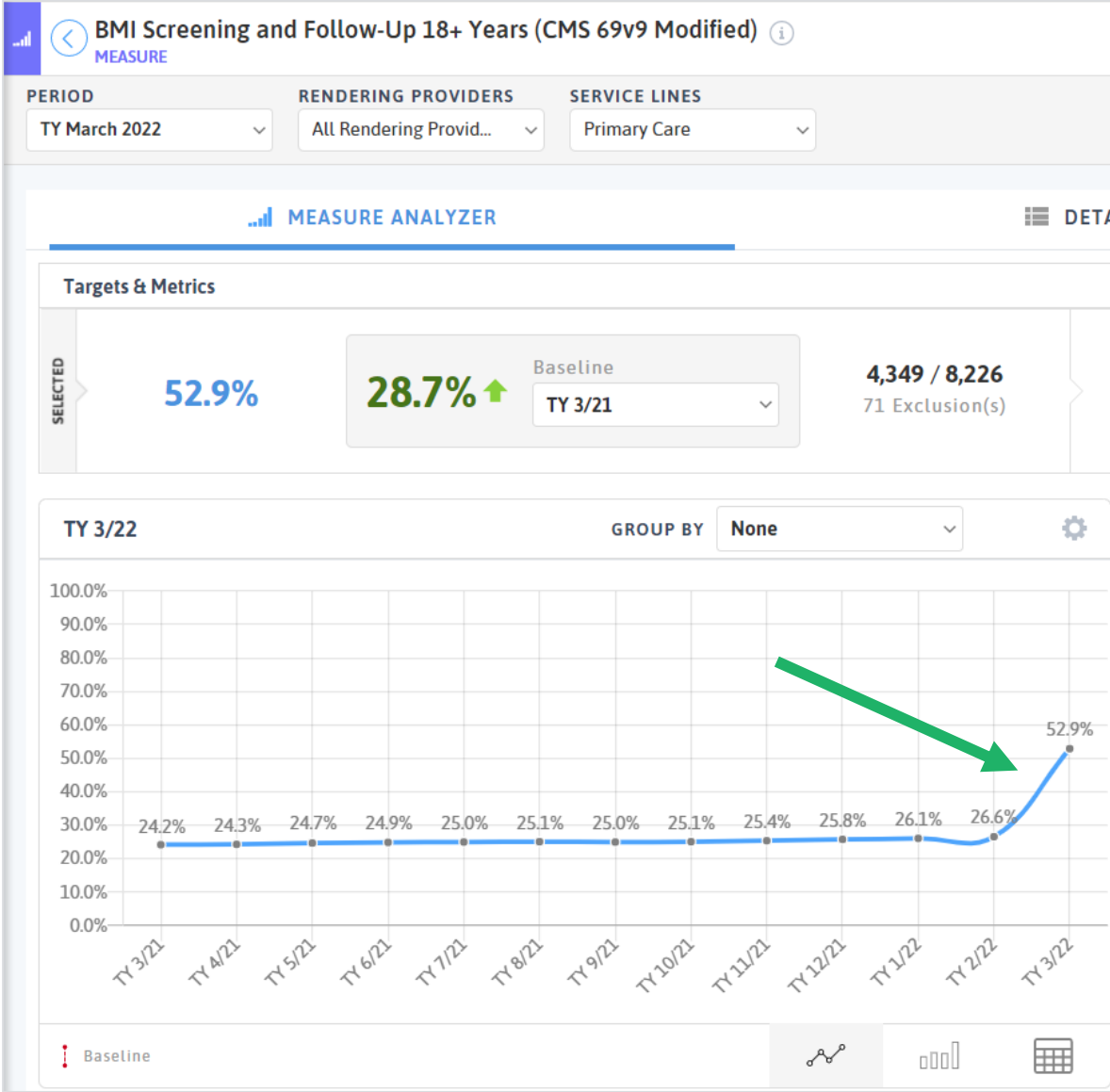


Identified unmapped workflows through CQM gap analysis and saw 6.5% increase in Cervical Cancer screening and 2.5% increase in Colorectal Cancer screening



Data Hygiene Success | BMI Screening & FU

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



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						



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.

Measure Name	Targets	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
DM A1c Control	25%													Deep Dive
														Regular Review
HTN BP Control	70%													
Breast Cancer Screening	65%													
Childhood Immunizations	55%													



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 appropriately 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 appropriately 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 appropriately or should you update the name, if you have specific instructions for running something did you include those in the description (info snippet).			



DRVS Tools for Data Validation



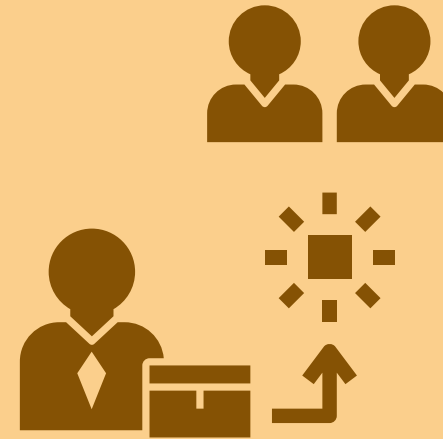
To Build Trust, Deconstruct the Problem



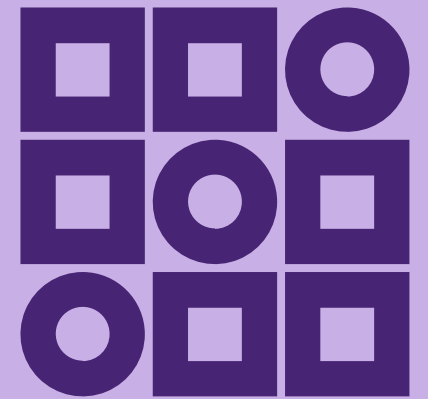
Be aware of any assumptions you may have.



Look at all aspects of the issue.



Get specific with examples.



Look for patterns.



Data Timing



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).



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

EHR Data Latency
REPORT DATA LATENCY REPORT

CENTERS

All Centers

Search ...

SAVED COLUMNS

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	6/3/2022	6/6/2022	5/30/2022	5/31/2022	5/31/2022	5/31/2022



Investigating Your Data | The Tools



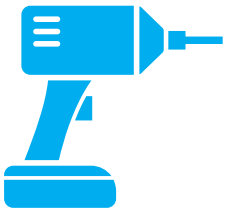
Measure Investigation Tool



Value Sets



Data Health Dashboards



Mapping Administration



Measure Investigation Tool



Patient Detail Lists

Use the detail list to investigate individual patients

Screening for Depression and Follow-Up Plan (CMS 2v12)

MEASURE

PERIOD

TY August 2023

RENDERING PROVIDERS

All Rendering Provid...

FILTER

+ Add Filter

Update

MEASURE ANALYZER

DETAIL LIST

VALUE SETS

Search Patients ...

AllGapsNumExcl

Measure Investigation Tool

SAVED COLUMNS

	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						

Investigate Measure

Care Management Passport

SDOH Resources

Copy

Ctrl+C

Right click on a cell in the table to open the Measure Investigation tool



Measure Investigation Tool

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

Screening for Depression and Follow-Up Plan (CMS 2v12)

Search

Center: Access Community Health

Period: TY August 2023

Name: Sibyl Kuss

Sex at Birth: F

DOB: 3/23/1981 (42 years as of 8/31/2023)

Patient Only In Denominator

Age/Sex at Birth Criteria

AGE: 42 years at end of period

SEX: F

Numerator

[STRUCTURED CLINICAL DATA](#) [ENCOUNTERS](#)

DEPRESSION SCREEN FOLLOW-UP INTERVENTIONS: N/A

DEPRESSION SCREEN FOLLOW-UP MEDICATION NAME: N/A

DEPRESSION SCREEN RESULT: 8/9/23 - Positive (PHQ-9 Depression Screen - Screening)

QUALIFYING ENCOUNTER FOR DEPRESSION SCREENING: 8/9/23 (G0438 - Encounter)

Denominator

[CHARGES](#) [ENCOUNTERS](#)

DEPRESSION QUALIFYING ENCOUNTER: 8/9/23 (G0438 - Encounter)

DEPRESSION SCREENING ENCOUNTER FIRST: 8/9/23 (G0438 - Encounter)

Exclusion

Endorser: CMS eCQM 2v12

Steward: CMS

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Numerator:
Patients screened for depression on the date of a qualifying encounter or 14 days prior to the date a qualifying encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of or up to two days after the date of the qualifying encounter.

- Standardized depression screening in the last 12 months from 14 days prior to a qualifying encounter up to the date of a qualifying encounter*
 - Negative Depression Screening Result (PHQ-2 < 3 or PHQ-9 < 10 or negative result from a standardized screening tool) in the last 12 months
 - Negative
 - PHQ2 < 3
 - PHQ9 < 10
 - EPDS < 10
 - CAT-MH Depression Severity < 66
 - Geriatric Depression Scale Short Form (GDS) < 5
 - Geriatric Depression Scale Long Form (GDS) < 10
 - PSC-17 Internalizing < 5
 - Standardized Depression Screen maint item = 'negative'
 - Center for Epidemiological Studies Depression Scale for Children (CES-DC) <15

OR

- Positive Depression Screening Result (PHQ-2 >= 3 or PHQ-9 >= 10 or positive result from a standardized screening tool) in the last 12 months
 - Positive
 - PHQ2 >= 3

Demo data

Value Sets



Value Sets Tab

Screening for Depression and Follow-Up Plan (NQF 0418) ⓘ

PERIOD

TY November 2019

CENTERS

All Centers

RENDERING PROVIDER

All Rendering Provid...

Advanced Filters +

Update

MEASURE ANALYZER

DETAIL LIST

VALUE SETS

Search Value Sets ...

AllNumDenomExcl

NUM	DEN	EXCL	CATEGORY	VALUE SET	CODE SYSTEM	CODE	DESCRIPTION
Y	N	N	Procedure	Additional evaluation for depression - adolescent	SNOMED-CT	10197000	10197000
Y	N	N	Procedure	Additional evaluation for depression - adolescent	SNOMED-CT	10997001	
Y	N	N	Procedure	Additional evaluation for depression - adolescent	SNOMED-CT	165171009	165171009
Y	N	N	Procedure	Additional evaluation for depression - adolescent	SNOMED-CT	165190001	
Y	N	N	Procedure	Additional evaluation for depression - adolescent	SNOMED-CT	370803007	370803007
Y	N	N	Procedure	Additional evaluation for depression - adolescent	SNOMED-CT	88756009	
Y	N	N	Procedure	Additional evaluation for depression - adolescent	SNOMED-CT	441000124107	
Y	N	N	Procedure	Additional evaluation for depression - adolescent	SNOMED-CT	9008	
Y	N	N	Procedure	Additional evaluation for depression - adolescent	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		
Y	N	N	Procedure	Additional evaluation for depression - adult	SNOMED-CT		

1 to 19 of 2,097

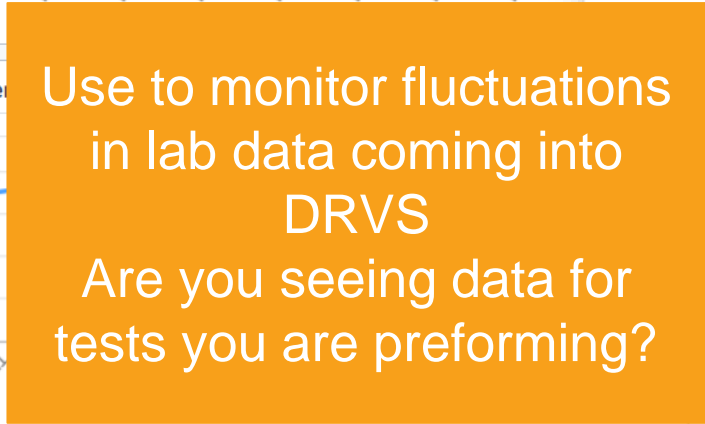
<< Page 1 of 111 >>

View and filter for the different Code Systems and Codes related to a measure



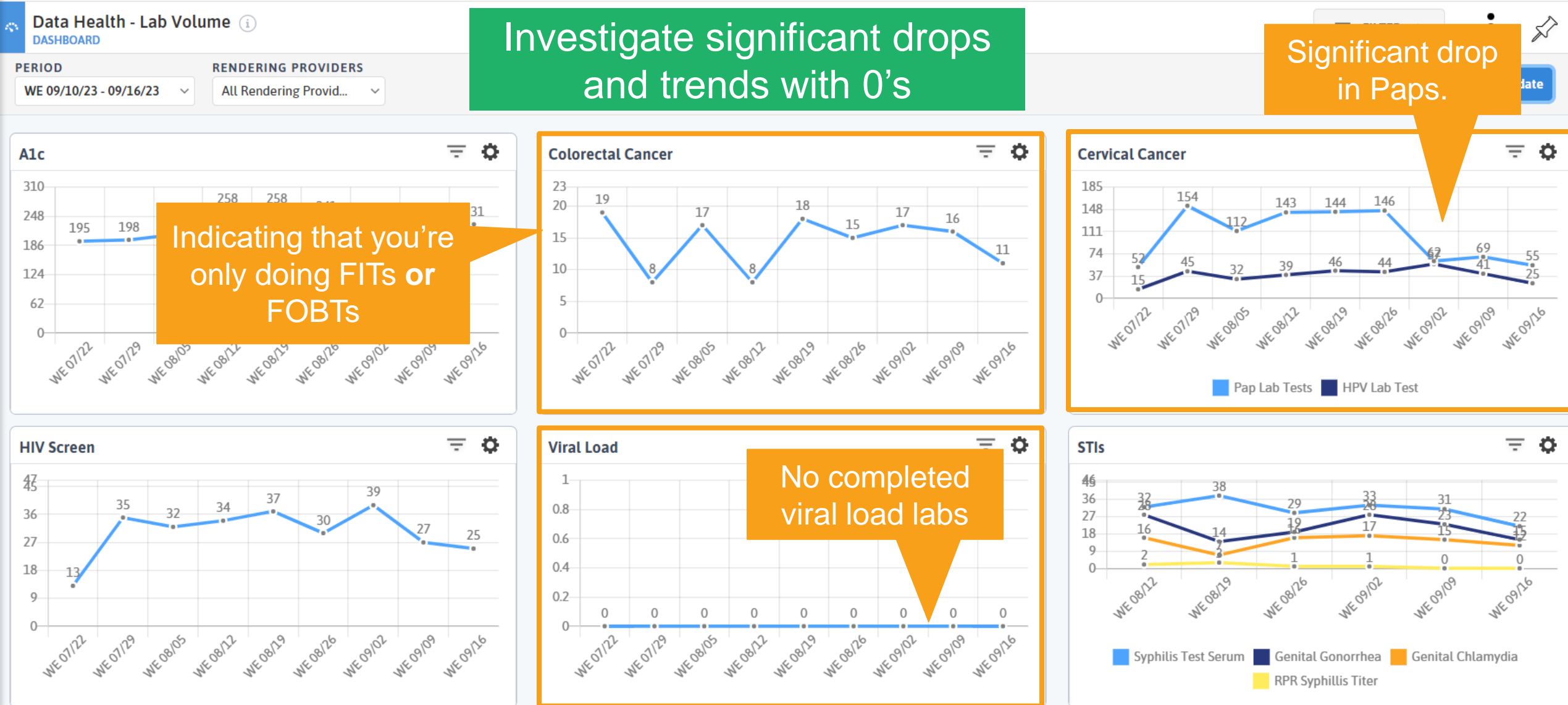
Data Health Dashboards







Data Health | Lab Volume





Data Health | Questionable Values

Data Health - Questionable Values

DASHBOARD

PERIOD

WE 05/05/24 - 05/11/24

RENDERING PROVIDERS

All Rendering Provid...

FILTER

+ Add Filter

Update

Investigate where numbers indicate questionable values

Patient > 120 Years Old

Patient with

3

Questionable A1C lab results

Birth Weight < 1500g or > 6000g

1

Questionable Birth Weights

BP-S < 40 or > 300, BP-D < 20 or > 200

0

Questionable BP entries

A1c < 4 or > 16

3

Questionable A1C lab results

LDL Result < 20 or > 300

2

Questionable LDL lab results

Tobacco Status Not 'Y', 'N' or 'R'

0

Questionable Tobacco Status results

BMI < 9 or > 99

0

Questionable BMI entries

BMI Percentile < 0 or > 100

2

Questionable BMI Percentile entries

PHQ2 < 0 or > 6

5

Questionable PHQ-2 results

PHQ9 < 0 or > 27

0

Questionable PHQ-9 results

Click into these numbers to see further details



Data Health | Questionable Values

Data Health - Questionable Values

DASHBOARD

PERIOD

WE 01

Patient

Birth

BP-S < 40 or

Questionable BP entries

RENDERING PROVIDERS

Questionable Tobacco Status results

FILTER

Details

NAME	MRN	AGE	INACTIVE	NUMERATOR	EXCLUSION	BMI%	HEIGHT	WEIGHT
Connick, Molly	1102296	3	N	Y	N	120	99.00	150.00
Gurkin, Ryan	1101348	70	N	Y	N	110	93.00	89.00

1 to 2 of 2

<

>

Page 1 of 1

<

>

DOWNLOAD

For instance, here we have a 3 year old patient who is over 8 feet tall

Note if this height seems like it was entered properly

This should indicate if you need to make changes in your EHR for this patient as a data point was potentially entered incorrectly

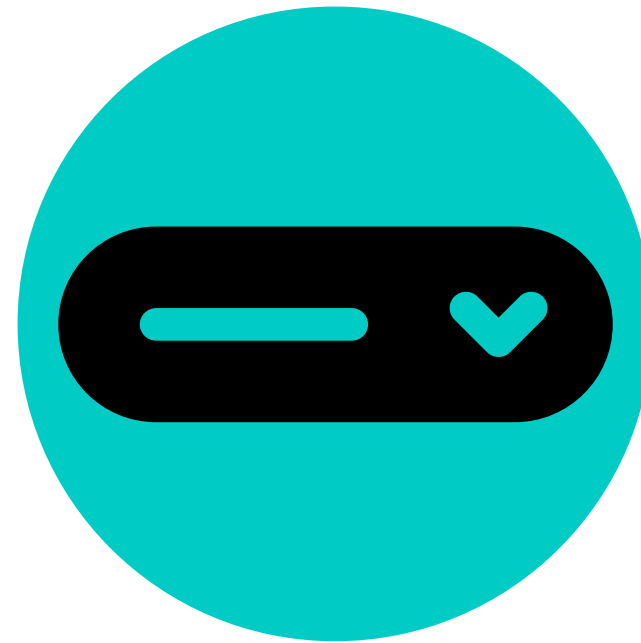
Mapping Administration



Codified vs. Structured Data



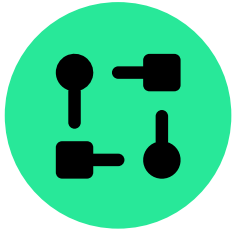
**Codified
Data**



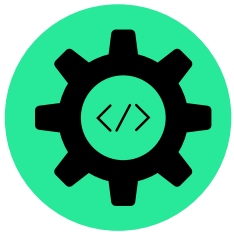
**Structured
Clinical Data**



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

⚙️

← Mapping Administration ⓘ

MAPPING CATEGORY

All ▾

CENTER

▾

TIME PERIOD

Last Year ▾

Frequently Used

Requires Action

All

MAPPING CATEGORY	
ⓘ	Appointment Status
ⓘ	Billable Encounter
ⓘ	Ethnicity
ⓘ	Gender Identity
ⓘ	Homelessness Status
ⓘ	Immunizations
ⓘ	Lab Results
ⓘ	Language
ⓘ	Migrant Status
ⓘ	Patient Interaction
ⓘ	Provider Order Priority
ⓘ	Provider Order Type
ⓘ	Provider Specialty
ⓘ	Provider Type
ⓘ	Race
ⓘ	Refugee Status
ⓘ	Service Line
ⓘ	Sexual Orientation
ⓘ	Structured Clinical Data
ⓘ	Telehealth Encounter
ⓘ	UDS F2F Qualifying Encounter
ⓘ	UDS Financial Class
ⓘ	UDS Service Category
ⓘ	Veteran Status

Common culprits
for over-due
mapping review



Review Structured Clinical Data

Mapping Administration

MAPPING CATEGORY

Structured Clinical Data

CENTER

Adult and Child Health

TIME PERIOD

Last Year

Mapping Summary

Mapped DRVS Values 64

DRVS Values with 0 Count 434

	MAPPED DRVS VALUE	DISTINCT COUNT
	Hysterectomy	1
	Inbound Transition of Care	1
	Incarceration PRAPARE	1
	Mammogram	6
	Material Security - Child Care PRAPARE	1
	Material Security - Clothing PRAPARE	1
	Material Security - Food PRAPARE	1
	Material Security - Medicine/Medical ...	1
	Material Security - Phone PRAPARE	1
	Material Security - Utilities PRAPARE	1
	Med Reconciliation	1
	Nutritional Counseling	7
	Nutritional/Physical Activity Counseli...	2
	Patient Education	2
	PHQ-2 Depression Screen	3

31 to 45 of 64

EHR Mapping Details

Nutritional Counseling 7

All 241

MAPPED DRVS VALUE	COUNT	SOURCE EHR TEXT
Nutritional Counseling	35	Placed Order Dietician
Nutritional Counseling	19	Order Referrals: Dietician. Evaluate and t...
Nutritional Counseling	2	Order Diet education
Nutritional Counseling	2	Placed Order Diet education
Nutritional Counseling	2	HPP BMI Plan Diet education
Nutritional Counseling	1	Placed Order Dietary management educ...
Nutritional Counseling	1	HPP BMI Plan Dietary management edu...

1 to 7 of 7

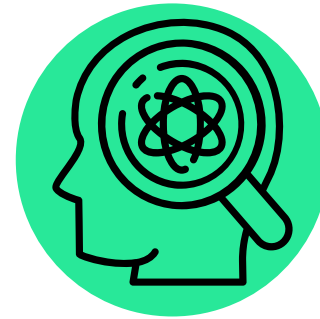
Are there other places care teams document nutritional counseling?

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



Mapping Category

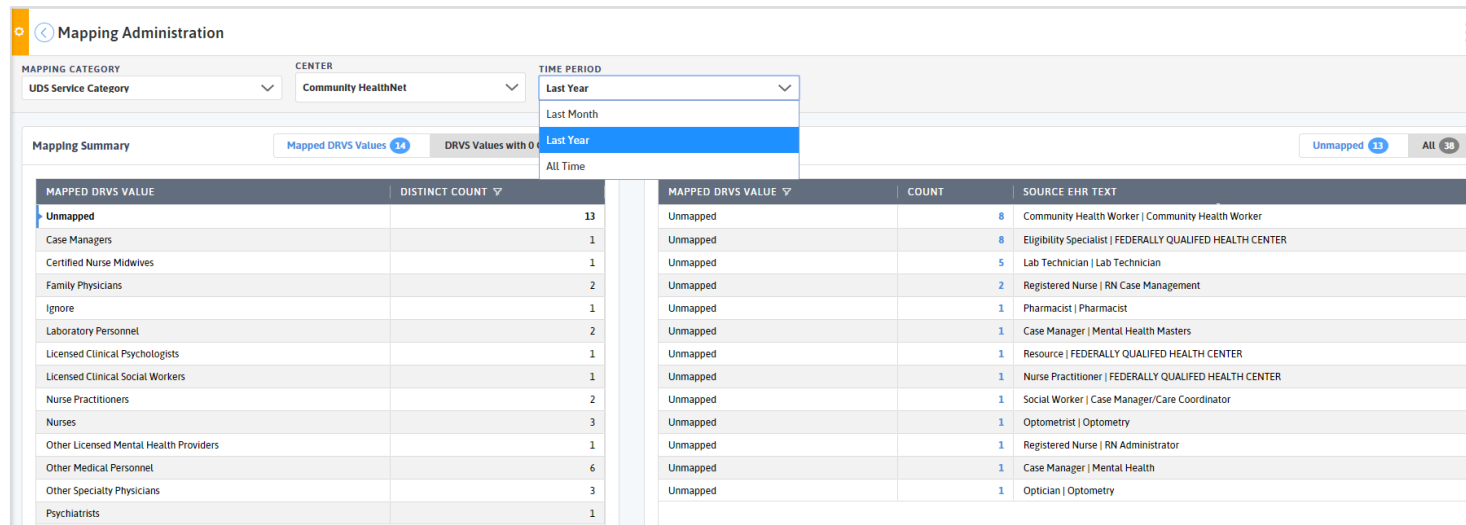
- Mapping categories are the different types of data within DRVS that can be manually mapped.
- Each category needs to be maintained individually, and all can be edited by admins
 - Except for UDS F2F qualifying encounter, immunizations, and lab results which are only maintained by Azara
- Structured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

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



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




The screenshot displays the 'Mapping Administration' interface. At the top, there are filters for 'MAPPING CATEGORY' (UDS Service Category), 'CENTER' (Community HealthNet), and 'TIME PERIOD' (Last Year, Last Month, Last Year, All Time). Below these filters is a 'Mapping Summary' section with two tabs: 'Mapped DRVS Values' (14) and 'DRVS Values with 0' (11). The 'Mapped DRVS Values' tab is active, showing a table with columns: 'MAPPED DRVS VALUE', 'DISTINCT COUNT', and 'SOURCE EHR TEXT'. The table lists various roles and their corresponding counts, such as 'Unmapped' (13), 'Case Managers' (1), 'Certified Nurse Midwives' (1), 'Family Physicians' (2), 'Ignore' (1), 'Laboratory Personnel' (2), 'Licensed Clinical Psychologists' (1), 'Licensed Clinical Social Workers' (1), 'Nurse Practitioners' (2), 'Nurses' (3), 'Other Licensed Mental Health Providers' (1), 'Other Medical Personnel' (6), 'Other Specialty Physicians' (3), and 'Psychiatrists' (1).

MAPPED DRVS VALUE	DISTINCT COUNT	SOURCE EHR TEXT
Unmapped	13	
Case Managers	1	
Certified Nurse Midwives	1	
Family Physicians	2	
Ignore	1	
Laboratory Personnel	2	
Licensed Clinical Psychologists	1	
Licensed Clinical Social Workers	1	
Nurse Practitioners	2	
Nurses	3	
Other Licensed Mental Health Providers	1	
Other Medical Personnel	6	
Other Specialty Physicians	3	
Psychiatrists	1	



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

Mapping Summary		EHR Mapping Details	
Mapped DRVS Values 39		DRVS Values with 0 Count 419	
MAPPED DRVS VALUE	DISTINCT COUNT ▾	MAPPED DRVS VALUE ▾ ↑	COUNT
Unmapped	413	Archive ✎	875
Alcohol Screening	1	archive 🔍	662
Archive	43	Archive	417
Asthma Follow-Up	4	Archive	359
Asthma Symptoms	1	Archive	355
AUDIT	1	Archive	353



Measure Validation Tools



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](#)

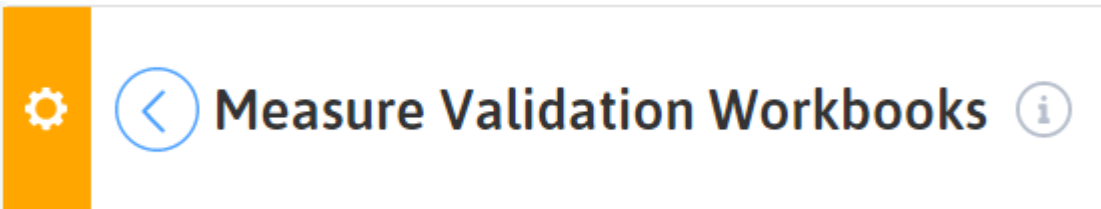
Last Updated: 02/15/2023

Was this information helpful?

☒ Yes

☐ No

Administration | Measure Validation Tools



 **Create Workbook**

Create Workbook

NAME

CENTER

Access Community Health

DEFAULT PERIOD TYPE

Trailing Year

PERIOD

TY February 2023

SERVICE LINE

All Service Lines

OF PATIENTS

5

STATUS

Stock

Custom

SELECTED MEASURES (NOT CONFIGURABLE)

NAME

BMI Screening and Follow-Up 18+ Years (CMS 69v10)

Breast Cancer Screening Ages 50-74 (CMS 125v10)

Cervical Cancer Screening (CMS 124v10)

Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v10)

Childhood Immunization Status (CMS 117v10)

Colorectal Cancer Screening (CMS 130v10)

Diabetes A1c >9 (CMS 122v10 Modified)

Screening for Depression and Follow-Up Plan (CMS 2v11)

Tobacco Use: Screening and Cessation (CMS 138v10)

Cancel

Confirm

- 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)

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?

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	<i>2025 Azara User Conference</i>
	30th	UDS+ CY24 Submissions Due



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?

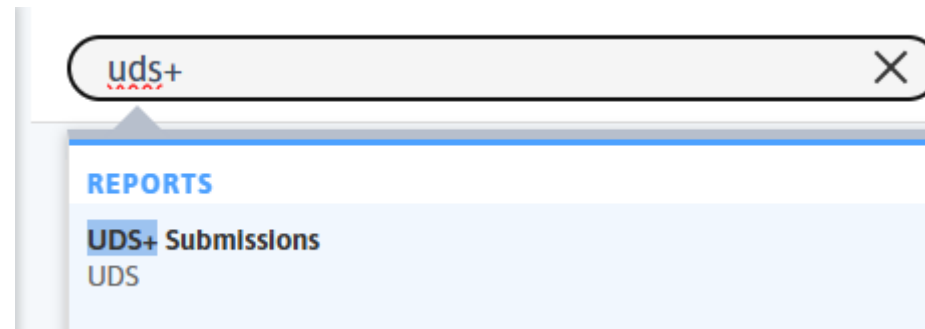
- An automated email is sent when the submission reaches its end state
- Email is sent to the UDS+ Submitter *and* Azara Support
- *This automatically creates a support ticket for you.
If you have questions after submission, please communicate them via the support ticket.



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



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



UDS – DRVS Help!

Welcome to DRVS Help!

To find a resource, use the search bar or browse our quick start menu options below.

Search the Help Section...



Get Started Using DRVS

Ready to dive in? This guide helps new users get up to speed!



User Guides

Detailed documentation on all DRVS features.



Azara Events and Webinars

Register for events and view past recordings.



UDS - Uniform Data System

Access resources for UDS+ and UDS submissions.

Quick Tip Clips

Get the key DRVS insights you need—fast! These quick, targeted clips walk you through essential features and functionality.

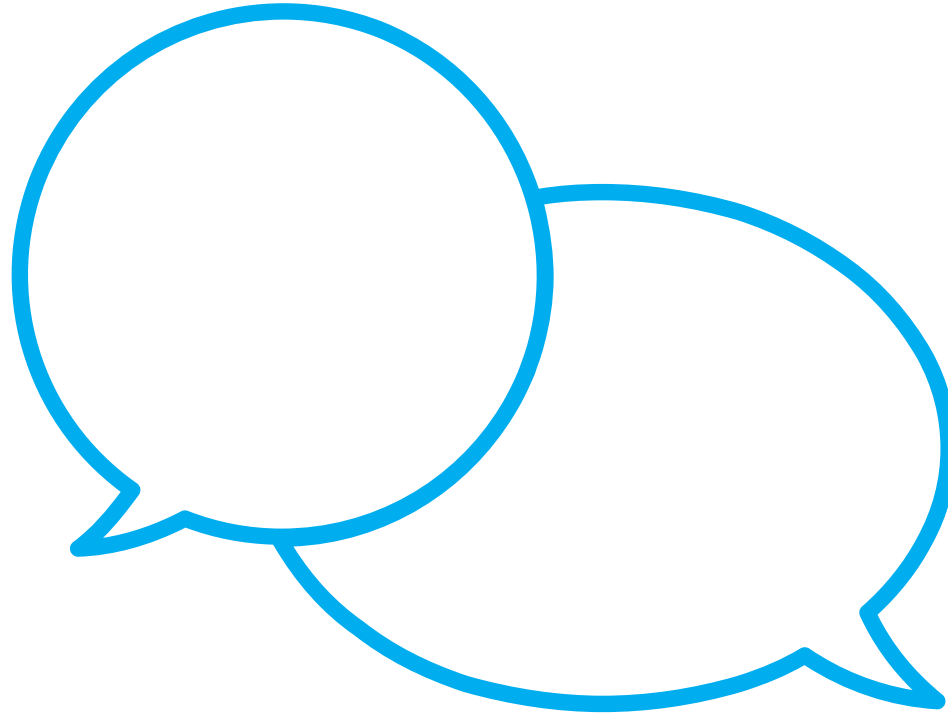
Configuring DRVS

Create custom content and tailor DRVS to your needs.

Return to Top

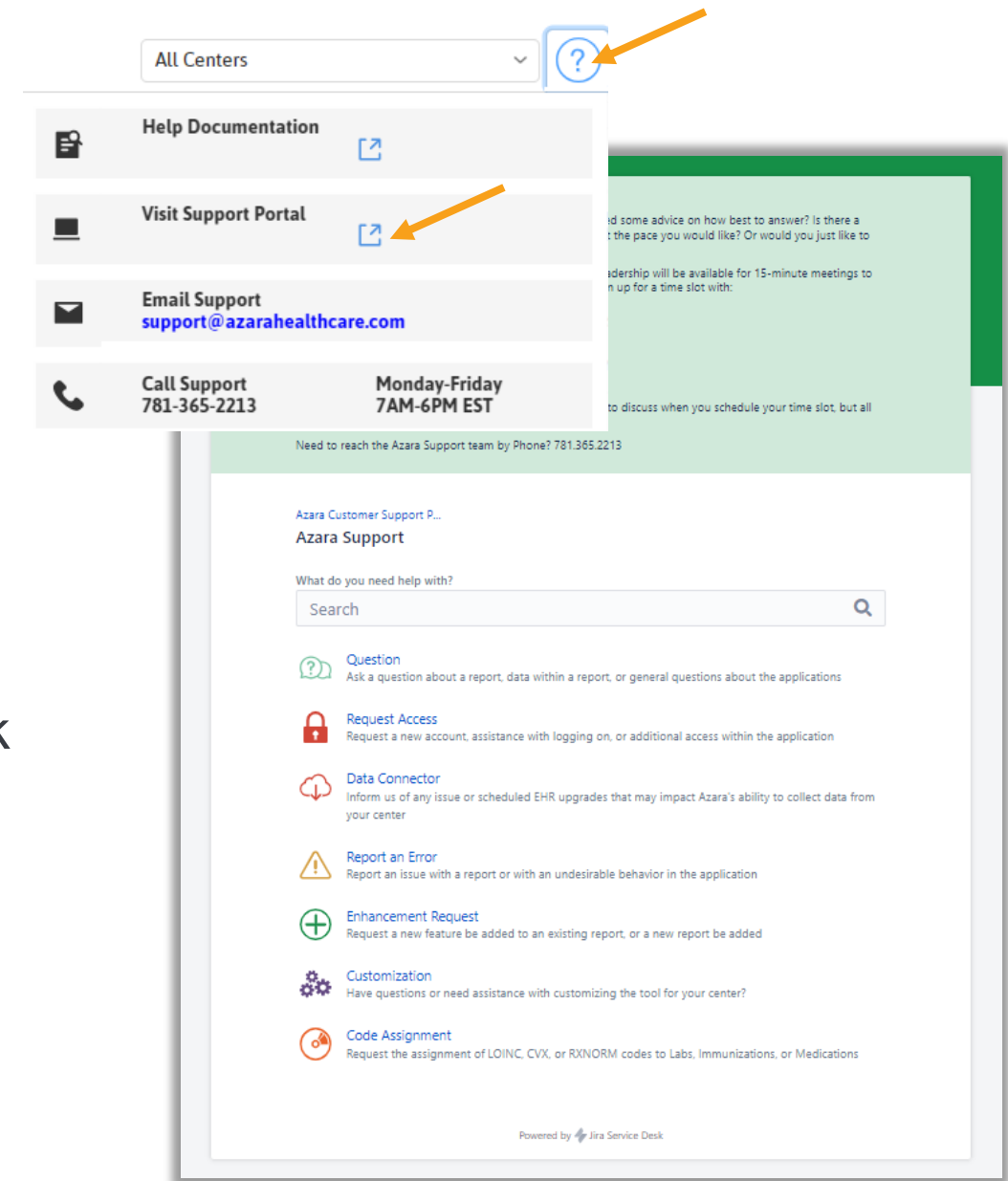


Questions?



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).

