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MPCA
Montana Primary Care Association

DRVS to Support Care Management & Access

MTPCA User Group

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Agenda

CREATING ACCESS FOR PATIENTS

Review operational measures & data in DRVS to understand patient visit trends and access to care.

CARE MANAGEMENT BACKGROUND

Understand benefits of Care Management & importance.

IDENTIFY & OUTREACH PATIENTS

Highlight strategies to identify, outreach, and track care managed patients.

CARE MANAGEMENT EVALUATION

Utilize DRVS functionality to evaluate the effectiveness of care management efforts.

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Understanding & Creating Access for Patients

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How can operational measures help?

Explore what patients are coming in and from where.

Dive into what appointments are being kept, lost or recouped.

Understand workload and activity of providers.

Recognize activity of non-provider care team members.

Operational Data Use Cases & Users

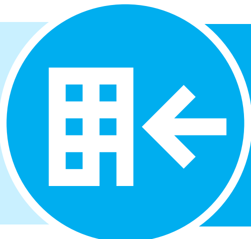
Data Clean Up

- Operations
- DRVS Admin
- IT

Appointment Tracking

- Operations
- Medical director
- Quality

Visit Volume



- Operations
- Medical director
- Quality

Demographics & New Patient

- Operations
- Marketing
- Quality

Using Appointment Data

Goal	Role	Details
Track who is or is not coming in	• Operations team • Medical director • Care Management	Review measures like **Walk In/Same Day** or **No Show/Cancelled** stratified by factors like key patient demographics, service line, appointment type, provider.
Assess equity of access	• PCMH manager	Review measures like **Walk In/Same Day** or **No Show/Cancelled** stratified by factors like key race, ethnicity, language, etc.
Follow up with patients the no-showed or rescheduled	• Front Desk	Review **No Show** and **Cancelled** measures to identify patients that need a new appointment.
Understand scheduling capacity	• Front Desk • Operations Team	Review **Appts/Day** measure, stratified by factors like Appointment Status, EHR Appointment Type, Provider, and Service Line.

How Do Our Populations Access Care? MT

Same Day Appointments
MEASURE

FILTER

PERIOD: November 2024
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

Add Filter
Update

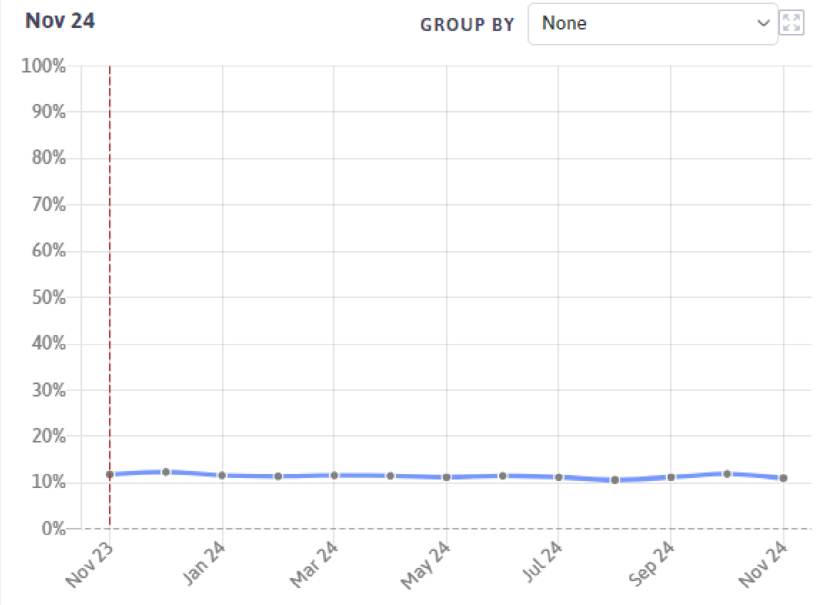
MEASURE ANALYZER | DETAIL LIST | VALUE SETS

11.0%
-0.8%
Nov 23

5,362 / 48,603
20,462 Exclusion(s)

Create Target

Nov 24
GROUP BY: None



Comparison
GROUP BY: Center

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

Who’s *cancelling* appointments? MT

Canceled Appointments <24 hrs
MEASURE

FILTER

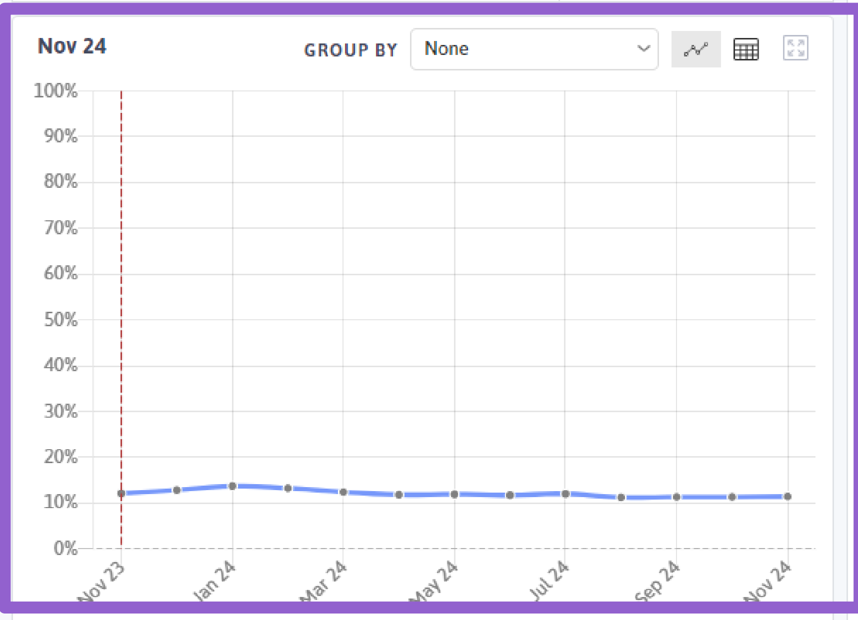
PERIOD: November 2024
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

Add Filter
Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

11.4%
-0.7%
Nov 23

5,547 / 48,603
20,462 Exclusion(s)
Create Target



Comparison
GROUP BY: Service Line

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

Optometry
Ignore
Specialty
Primary Care
Dental
Unmapped
Rehab
Behavioral H...

10.6%
2,583 / 24,471
11,706 Exclusions
Primary Care

14.5%
1,587 / 10,966
3,195 Exclusions
Behavioral Health

Behavioral Health has highest cancelled appts rate

Who's *not* coming in? MT

No Show Appointments
MEASURE

FILTER 1

FILTERS: November 2024

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

10.6%

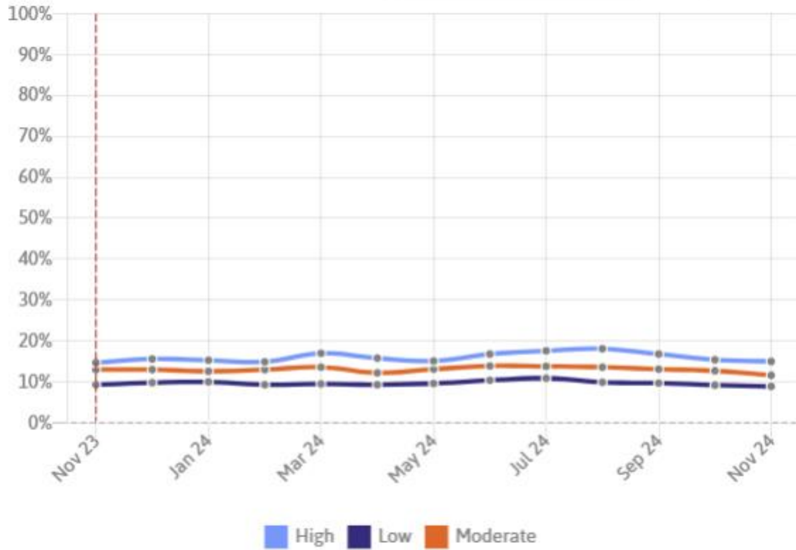
-0.5%

Nov 23

5,117 / 48,173

20,892 Exclusion(s)

Create Target



Comparison

GROUP BY Age

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

<=1 | 2-4 | 5-12 | 13-14 | 15-19 | 20-34 | 35-44 | 45-64 | 65 +

Would telehealth visits help reduce no-shows?

Patient Recall | Rescheduling No Shows

No Show Appointments
MEASURE

FILTERS: PERIOD: WE 10/20/24 - 10/26/24 | RENDERING PROVIDERS: All Rendering Provid...

Year / Quarter / Month / Trailing Year / Week / Day

WE 10/20/24 - 10/26/24
WE 10/13/24 - 10/19/24
WE 10/06/24 - 10/12/24
WE 09/29/24 - 10/05/24
WE 09/22/24 - 09/28/24
WE 09/15/24 - 09/21/24
WE 09/08/24 - 09/14/24
WE 09/01/24 - 09/07/24
WE 08/25/24 - 08/31/24

1. Choose a previous day or week to review.

3. Export list to use for outreach.

FILTER 1

Export Excel
Export CSV
Create Cohort

APPOINTM							NEXT APPOINTMENT		
DATE	TIME	STATUS	MAPPED STATUS	TYPE	SCHEDULED DATE	SERVICE LINE	DATE	PROVIDER	LOCATION
10/11/2024	11:30	N/S	No Show	NP	8/21/2024	Primary Care			
10/11/2024	09:30	N/S	No Show	NP	6/17/2024	Primary Care			
10/11/2024	09:30	N/S	No Show	NP	8/23/2024	Primary Care			
10/21/2024	11:30	N/S	No Show	NP	8/21/2024	Primary Care			
10/11/2024	14:30	N/S	No Show	NP	10/3/2024	Primary Care			
10/18/2024	14:30	N/S	No Show	NP	8/19/2024	Primary Care			
10/9/2024	14:30	N/S	No Show	NP	8/20/2024	Primary Care			
10/17/2024	09:30	N/S	No Show	NP	8/29/2024	Primary Care			
10/22/2024	14:30	N/S	No Show	NP	8/29/2024	Primary Care			

2. Identify patients that no-showed and don't have a follow up appointment scheduled.

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Do you have a workflow to reschedule No-Show or last-minute Cancellations?

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Appointment Measures

Measure Name	Description
Appointments per Day	The average number of appointments scheduled per day (on days where appointments were scheduled).
Canceled Appointments <24 hrs	Appointments that were canceled up to 24 hours prior to the visit or the same day as the visit was scheduled to occur.
Same Day Appointments	All appointments scheduled on the same day as the appointment occurred.
Walk In Appointments	All appointments not scheduled in advance.
No Show Appointments	All appointments patient did not keep, without advance notice.
Alert Closure – Point of Care	POC Alerts closed within the same week as the kept appointment.

Active Pts With No Visit in the Past Year | MT

Active Patients With No Visit in Past Year
MEASURE

FILTER

PERIOD: TY November 2024
CENTERS: All Centers
USUAL PROVIDERS: All Usual Providers
USUAL LOCATIONS: All Usual Locations

Add Filter
Update

MEASURE ANALYZER
DETAIL LIST
VALUE SETS

40.4%
-2.6%
TY 11/23

85,799 / 212,235
Create Target

Access patient details

TY 11/24
GROUP BY: None

93,000
92,000
91,000
90,000
89,000
88,000
87,000
86,000
85,000

TY 11/23, TY 1/24, TY 3/24, TY 5/24, TY 7/24, TY 9/24, TY 11/24

Comparison
GROUP BY: Age

40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0

44.2%
29,138 / 65,856
26-45

<= 2, 3-6, 7-17, 18-25, 26-45, 46-64, 65 +

Active Patients With No Visit in the Past Year

Active Patients With No Visit in Past Year
MEASURE

FILTER

FILTERS: TY October 2024

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ...

All | Num

SAVED COLUMNS

MOST RECENT ENCOUNTER			NEXT APPOINTMENT	NUM
DATE	PROVIDER	LOCATION	DATE	
5/12/2023				Y
5/30/2023				Y
4/18/2023				Y
4/18/2023				Y
3/24/2023				
4/13/2023				
4/18/2023				
7/28/2023				
7/18/2023				
4/21/2023				
6/21/2023				
3/27/2023				
3/23/2023				

No Date

- After
- Before
- On
- No Date
- In range

1 to 13 of 13,041

Toggle to **Num** and filter to those with No Next Appointment

Key Filtering Considerations

- Filters based on visits/services provided (Rendering Provider/Location, Service Line) will **NOT WORK** on this measure because those filters only look at qualifying visits in the last 12 months.
- Patient-level filters (like age, SDOH, or Usual Provider) will **WORK.**

UDS Qualifying Encounters

UDS Qualifying Encounters
MEASURE

FILTER

PERIOD: TY October 2024
RENDERING PROVIDERS: All Rendering Provid...
RENDERING LOCATIONS: All Rendering Locati...

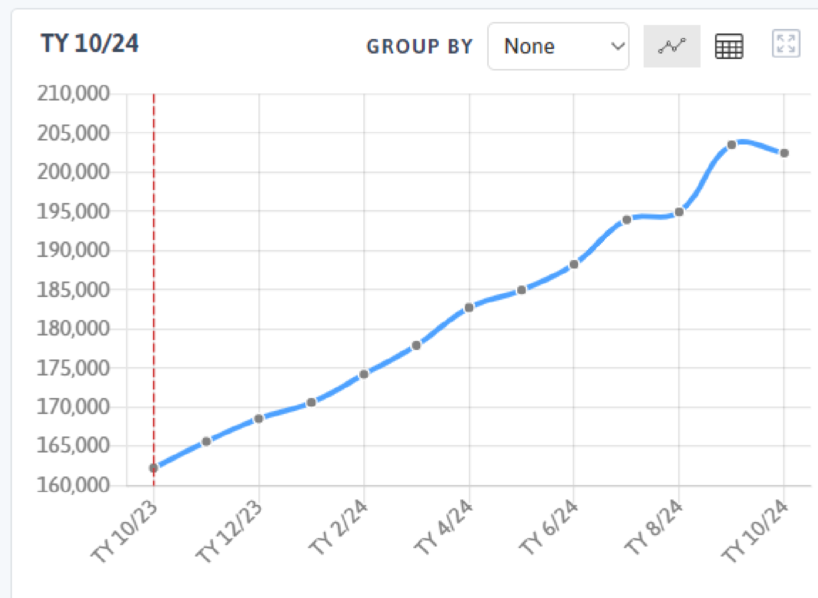
Add Filter
Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

202,474
Count of Encounters

40,237
TY 10/23

Create Target



Comparison

GROUP BY: Provider Group - Rendering

30,000
25,000
20,000
15,000
10,000
5,000
0

Understand volume by providers and locations.

Visit Trends by Rendering Provider

Use Quarter/Month periods to explore seasonality in trends

Grouped by Rendering Locations

UDS Qualifying Encounters

Lower in June and July, but uptick in August – do we see a lot of children for back-to-school/sports physicals?

2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0

Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24

Most Recent Visit | MT

Most Recent Visit (All)
MEASURE

FILTER 1

FILTERS: TY November 2024

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

212,853 -1,996
Patients
TY 11/23

Create Target

TY 11/24
GROUP BY None

Comparison
GROUP BY Last Encounter Time Frame

100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0

18 to < 24 m...
12 to < 18 m...
6 to <12 mon...
24 to 36 mon...
< 6 months

Who are we losing to follow up?

Most Recent Visit | Identify Patients

Most Recent Visit (All)
MEASURE

FILTER

PERIOD: TY November 2024
RENDERING PROVIDERS: All Rendering Provid...
LAST ENCOUNTER TIME FRAME: 3 selected

Add Filter | Update

Search
Clear Filters
- [x] 12 to < 18 months
- [x] 18 to < 24 months
- [x] 24 to 36 months
- [ ] < 6 months
- [ ] 6 to <12 months

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ...

All | Num

Reset Columns | SAVED COLUMNS

RISK			MO...	...SIT	MOST RECENT BEHAVIORAL HEALTH V...		MOST RECENT DENTAL VISIT			MOST RECENT S...	
SCORE	LEV...	TOTAL QUAL ENC 3 YRS	DA...		DATE	COUNT	DATE	LOCATION	COUNT	DATE	L...
14	Moderate	12	10/...	12							
14	Moderate	4	1/13/2023	4							
13	Moderate	3	10/3/2023	3							
14	Moderate	17	1/12/2022	1	6/16/2022	16					
13	Moderate	3	8/24								
10	Moderate	11									
10	Moderate	15	10/4								
10	Moderate	1	6/16								

Where were the patients lost?

Use the detail list to identify number of visits at each service line.

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New Patient Measures

New (Service Line) Patients

- Understand individual service line growth.
- Answers the question:
  - *Of my (service line) patients, who is new to the (service line) this year?*
- Use Case:
  - Individual service line director reviews growth and plans for new staffing or resources within department.

New Patient Entry Through (Service Line)

- Understand where net new patients are first accessing care.
- Answers the question:
  - *Of my new (service line) patients, who are also new to the practice?*
- Use Case:
  - Operations Director, Marketing Director, and CEO review for overall population growth and impact of marketing campaigns.

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New Primary Care Patients | MT

New Primary Care Patients
MEASURE

FILTER 1

FILTERS: TY November 2024

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

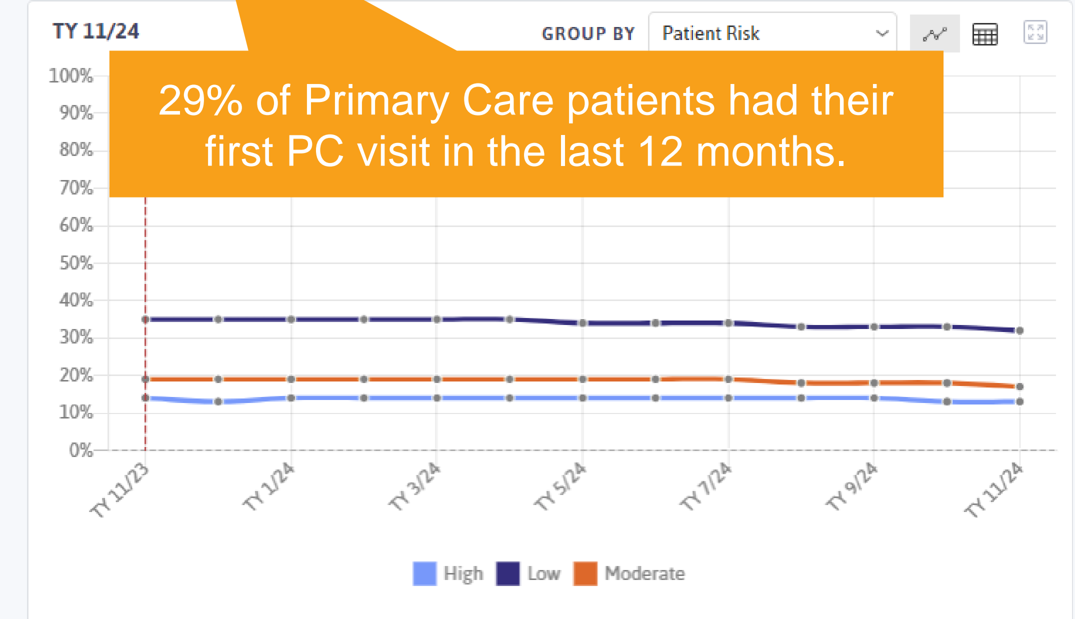
29%
-3%
TY 11/23

28,792 / 99,303

70,511 Gaps

Create Target

SELECTED	29%
Center Avg	28.5%
Network Avg	29.0%
Best Center	48.0%



Comparison

GROUP BY Age

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

<= 1, 2-4, 5-12, 13-14, 15-19, 20-34, 35-44, 45-64, 65 +

No surprise that patients <= 1 have higher new patient rates.

Young adults transitioning from pediatrician or off parents' insurance plan.

Service Line Measures

Measure Name	Description
New Primary Care Patients	Patients new to the Primary Care service line in the measurement period.
New Behavioral Health Patients	Patients new to the Behavioral Health service line in the measurement period.
New Dental Patients	Patients new to the Dental service line in the measurement period.
New Optometry Patients	Patients new to the Optometry service line in the measurement period.
New Specialty Patients	Patients new to the Specialty service line in the measurement period.
New Patient Entry Through Primary Care	Patients new to the Primary Care service line AND new to the practice in the measurement period.
New Patient Entry Through Dental	Patients new to the Dental service line AND new to the practice in the measurement period.
New Patient Entry Through Behavioral Health	Patients new to the Behavioral Health service line AND new to the practice in the measurement period.
New Patient Entry Through Optometry	Patients new to the Optometry service line AND new to the practice in the measurement period.
New Patient Entry Through Specialty	Patients new to the Specialty service line AND new to the practice in the measurement period.

Care Management Background

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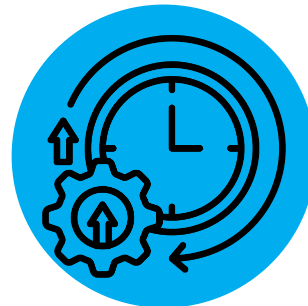
Key Elements of Care Management

Identify & engage
with patients at high risk

Coordinate care
with patients, caregivers, and external resources

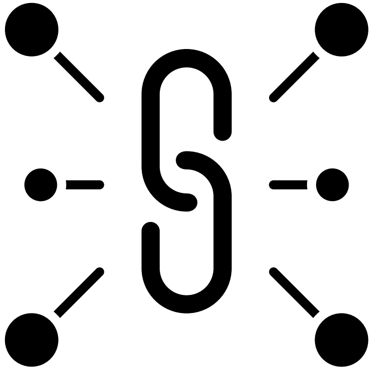
Health assessments
to identify problems that can be addressed



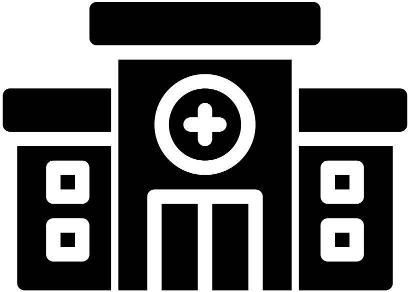
Respond & react
to changes in patients' conditions

http://www.statecoverage.org/files/CMWF_Caring_for_high_need_high_cost_patients.pdf

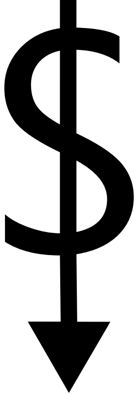
Goals of Care Management



Improve Care Coordination

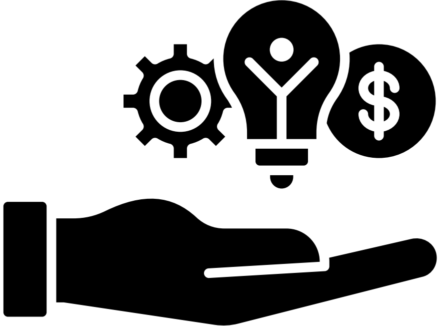


Reduce Hospitalizations



Reduce Costs

Increase Patient Satisfaction



Optimize Resource Utilization

Essential Elements

Attribution

Risk Adjustment & Stratification

Data

6 Essential Elements for

Value-Based Care Success

Manage Cost & Utilization

Care Management & Coordination

Health Equity

Close Care Gaps & Improve Quality

Patient Engagement

VBC & Care Management Highlight

Medicare Chronic Care Management is designed to drive improved health outcomes among patients with multiple chronic conditions. CCM offers **monthly reimbursement per each enrolled CCM patient**.

Studies have shown that CCM both improves patient outcomes and reduces costs:

Patient Outcomes

- Hospitalizations reduced by nearly 5%
- ED visits reduced by 2.3%
- Preventative care E&M Encounters increased by 8%

Reduced Costs

- Taxpayers save: $74 (gross) and $30 (net), per patient, per month when patients are enrolled for at least a year
- Revenue for providers: Fee-For-Service + Shared Savings earn $348 per year, per beneficiary

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Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report

What aspects of your care management program are working well?

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What are the greatest barriers or challenges your practice faces in your care management program?

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Identifying Patients for Care Management / Appointments

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What criteria are you using to identify patients for care management or to prioritize for appointments?

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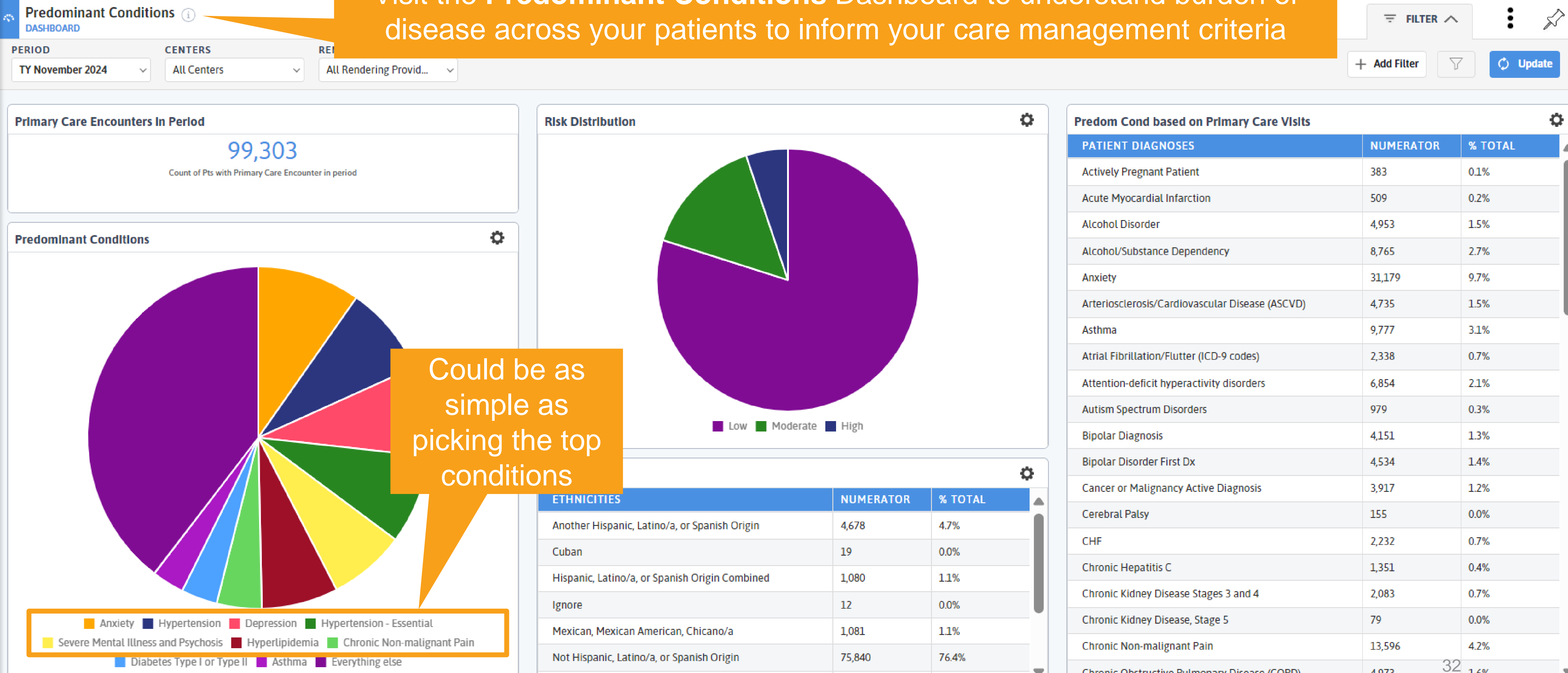
Determine Care Management Criteria | MT



Patient Volume & Comparison | MT

Example: Select Diabetes and Hypertension diagnoses in the filter for an **AND**; use the comparison chart to filter for an **OR**

Patients with Qualifying Encounters
MEASURE

FILTER

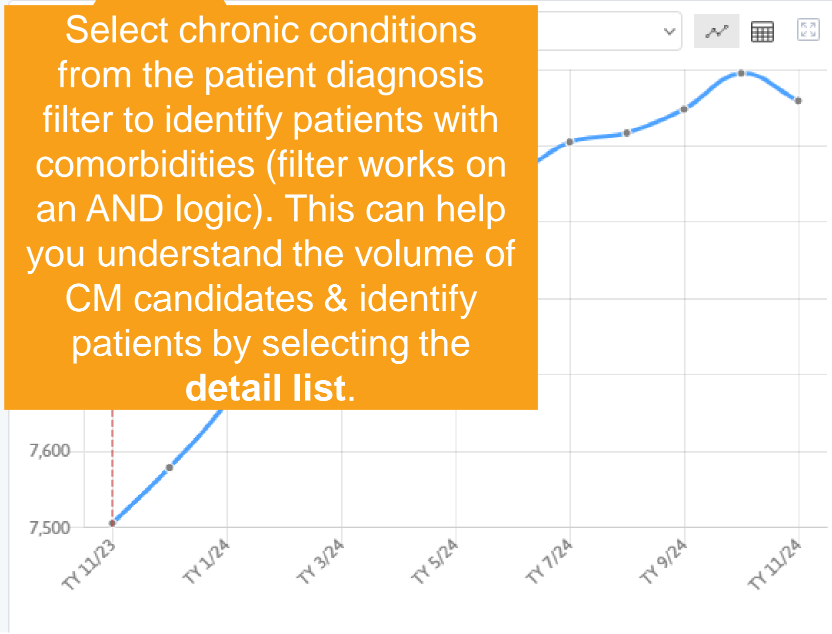
PERIOD	CENTERS	RENDERING PROVIDERS	PATIENT DIAGNOSES
TY November 2024	All Centers	All Rendering Provid...	2 selected

Add Filter
Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

8,059
Numerator
553
TY 11/23

8,394
Create Target



Comparison
GROUP BY Patient Diagnosis

40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
3,000

Hypertension
Diabetes Typ...

Group the comparison chart by patient diagnosis to understand the volume of patients for each chronic condition (comparison table works on an OR logic).

Identify Patients | Risk Registry

Risk Registry
REGISTRY

FILTER

VISIT DATE RANGE: 08/01/2022-08/01/2023

RENDERING PROVIDERS: All Rendering Provid...

Add Filter

Update

REGISTRY

VALUE SETS

Search Patients ...

SAVED COLUMNS

Filter to High-Risk to identify patients for care management

- Search...
- (Select All)
- (Blanks)
- [x] High
- Low
- Moderate

DEMOGRAPHICS >			RISK		PREVIOUS RISK		DIABETES DX		HTN DX		HYPERLIPIDEMIA DX		CHF DX		CAD DX	
NAME	MRN	AGE	LEV...				DATE	CODE	DATE	CODE	DATE	CODE	DATE	CODE	DATE	CO
Edell, Yajaira	1100181	25	High			48.00	11/5/2021	E10.21	7/12/2022	I12.9					7/12/2022	I24
Buescher, Chelsea	1100247	16	High			36.00	9/15/2021	E10.21	9/26/2021	I12.9					4/20/2021	I24
Scozzafava, Jamaal	1100286	1	High			39.00	4/21/2022	E10.21								
Shinney, Dino	1101394	59	High			40.00	6/20/2022	E10.321	6/20/2022	I11.0					9/26/2021	I24
Shellman, Adelia	1101434	10	High			47.00	2/22/2023	E10.21	3/20/2022	I12.9						
Puig, Len	1101438	12	High			39.00	2/12/2023	E10.21	2/12/2023	I11.0					12/10/2022	I24
Fruin, Ezequiel	1101442	47	High			40.00	11/29/2022	E10.21	11/7/2022	I11.0					11/7/2022	I24
Corti, Gary	1101483	34	High			42.00	7/9/2022	E10.21	7/19/2022	I11.0						
Vongkhamchanh, Marilu	1101486	11	High	41.00	High	41.00	11/24/2022	E10.21	12/24/2021	I11.0					12/24/2021	I24
Lengerich, Maximo	1101492	3	High	35.00	High	35.00	6/23/2022	E10.22	6/23/2022	I11.0						
Candee, Jacque	1101502	6	High	43.00	High	43.00	2/11/2021	E10.21	7/28/2022	I11.0					7/28/2022	I24
Benites, Dorsey	1101509	20	High	40.00	High	40.00			12/1/2022	I10					12/1/2022	I24
Huschle, Francisca	1102605	2	High	37.00	High	37.00	9/7/2022	E10.21	9/16/2022	I10					9/7/2022	I24
Gembler, Mandy	1102656	9	High	45.00	High	45.00	9/25/2021	E10.21	9/25/2021	I11.0					9/25/2021	I24
Cirelli, Mindy	1102675	0	High	35.00	High	35.00	3/18/2022	E10.21	9/23/2022	I10					10/25/2021	I24
Melland, Bula	1102676	36	High	42.00	High	42.00	1/7/2023	E10.321	1/7/2023	I12.9						

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Demo data

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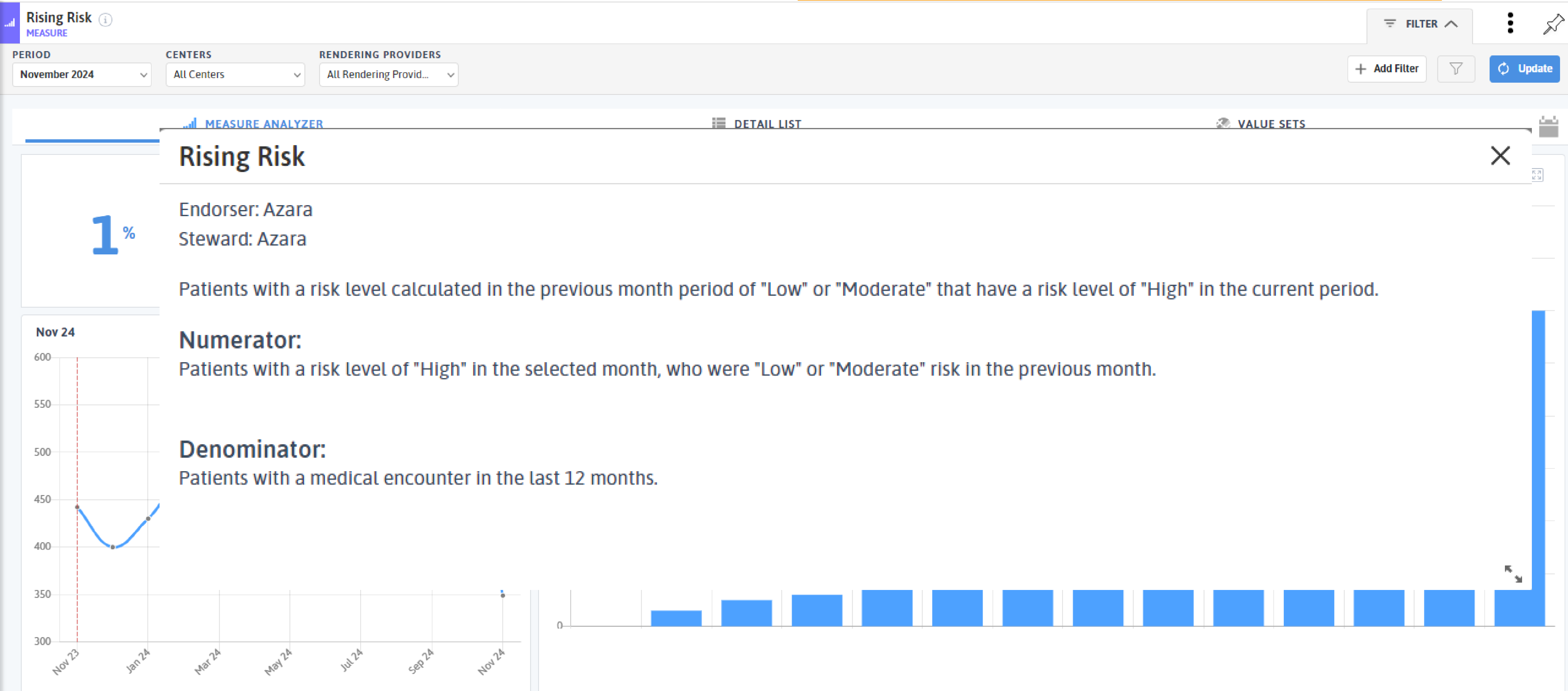
Rising Risk Measure

Use the Rising Risk measure to identify patients experiencing acuity in their care needs. Engage patients before conditions/ circumstances worsen.



Detail List | Identify Patients

Rising Risk
MEASURE

FILTER

PERIOD: June 2023
RENDERING PROVIDERS: All Rendering Provid...

+ Add Filter
Update

MEASURE ANALY... | DETAIL LIST | VALUE SETS

Search Patients ...

All | Num

Measure Investi...

Select Detail List to identify specific patients

Consider enrolling these 39 patients in care management

Export patient list and provide to scheduling team

Prioritize patients without upcoming appointments by filtering the *Next Appointment* column in the **Detail List**

	NEXT APPOINTMENT					PREVIOUS RISK		PATIENT RISK			
LOCATION	DATE	PROVIDER	LOCATION	APPOINTMENT TYPE	NUMERAT...	SCORE	LEVEL	SCORE	LEVEL	AGE	ASSIGNED CARE MANA...
	7/31/23 4:45 pm				Y	6.00	Moderate	8	High	17	Unassigned
	7/28/23 9:00 am				Y	11.00	Moderate	13	High	61	Unassigned
					Y	8.00	Moderate	13	High	36	Unassigned
	7/31/23 10:15 am				Y	10.00	Moderate	12	High	60	Unassigned
	7/31/23 9:00 am				Y	9.00	Moderate	12	High	63	Unassigned
	7/28/23 9:0				Y	11.00	Moderate	13	High	54	Unassigned
	9/20/23 8:4				Y	9.00	Moderate	16	High	28	Unassigned
					Y	4.00	Moderate	7	High	11	Unassigned
					Y	13.00	Moderate	14	High	66	Unassigned
					Y	6.00	Moderate	7	High	17	Unassigned
					Y	11.00	Moderate	12	High	34	Unassigned
	8/25/23 3:45 pm				Y	11.00	Moderate	13	High	30	Unassigned
	8/29/23 6:30 pm				Y	8.00	Moderate	12	High	37	Unassigned
	9/27/23 10:00 am				Y	12.00	Moderate	17	High	71	Unassigned
					Y	9.00	Moderate	12	High	59	Unassigned
					Y	4.00	Low	13	High	25	Unassigned
					Y	6.00	Moderate	8	High	19	Unassigned

1 to 17 of 39

Page 1 of 3

Registry | Outreach & Engagement

Diabetes
REGISTRY

VISIT DATE RANGE: 10/29/2024-11/27/2024
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid

Export Excel
Export CSV
Copy Registry

Update

Search Patients ...

Reset Columns
SAVED COLUMNS

Filter columns to identify patients to engage in care management or outreach for appointments

Export list to provide to outreach department to initiate engagement

Filter columns to identify patients with A1C >9

MOST RECENT ENCOUNT...	NEXT APPOINTMENT			DIABETES DX		DM MED	A1C			LDL		EGFR	
DATE	DATE ↑	PROVIDER	AGE	DATE	CODE	START DATE	DATE	RESULT	NUMERIC RESULT	MOST RECENT DATE	RESULT	DATE	CODE
11/4/2024			22	6/20/2022	E10.42	10/28/2024	11/4/2024	11.5	11.50	11/4/2024	106	7/24/2023	98979-8
11/14/2024			35	10/9/2020	E11.65	11/14/2024	11/14/2024	9.8	9.80	5/23/2022	145		
10/30/2024			65	6/20/2024	E11.9	11/20/2024	7/30/2024	9.7	[illegible]	8/12/2024	164	5/15/2024	98979-8
11/8/2024			59	4/27/2024	E11.9	11/8/2024	9/16/2024	13.8	[illegible]	[illegible]	86	5/6/2024	98979-8
11/12/2024			41	11/15/2023	E11.3393	1/30/2023	10/23/2024	11.8	[illegible]	[illegible]	140		
11/1/2024			72	6/7/2017	E11.22	10/2/2024	8/7/2024	9.1	[illegible]	[illegible]	[illegible]	[illegible]	98979-8
11/20/2024			55	8/5/2024	E11.65	8/5/2024	7/31/2024	9.0	[illegible]	[illegible]	[illegible]	[illegible]	98979-8
11/19/2024			59	5/29/2020	E11.3293	11/25/2024	11/15/2024	9.5	[illegible]	[illegible]	[illegible]	[illegible]	98979-8
11/19/2024			49	11/15/2021	E10.9	11/19/2024	11/19/2024	9.4	[illegible]	[illegible]	[illegible]	[illegible]	50210-4
11/25/2024			81	10/24/2024	E11.9	11/4/2024	10/24/2024	13.4	13.40				
11/13/2024			68	1/16/2020	E11.9	5/6/2022	4/12/2022	10.8	10.80	5/6/2022	120	5/6/2022	33914-3
11/13/2024			62	9/25/2024	E11.65	10/10/2024	10/10/2024	12.1	12.10	8/16/2023	83	8/16/2023	50210-4
11/21/2024			44	7/27/2024	E11.65	11/21/2024	7/27/2024	10.7	10.70	10/8/2024	61	10/8/2024	98979-8
10/29/2024			65	10/3/2024	E11.65	10/29/2024	4/18/2023	12	12.00	4/18/2023	56	4/18/2023	88294-4
11/1/2024			42	8/7/2024	E11.65	11/1/2024	10/9/2024	10.9	10.90	2/13/2024	74	7/31/2024	88294-4
11/5/2024			47	9/30/2024	E11.42	11/5/2024	7/25/2024	12.4	12.40	7/25/2024	17	7/25/2024	88294-4

Outreach Made Easy! APO

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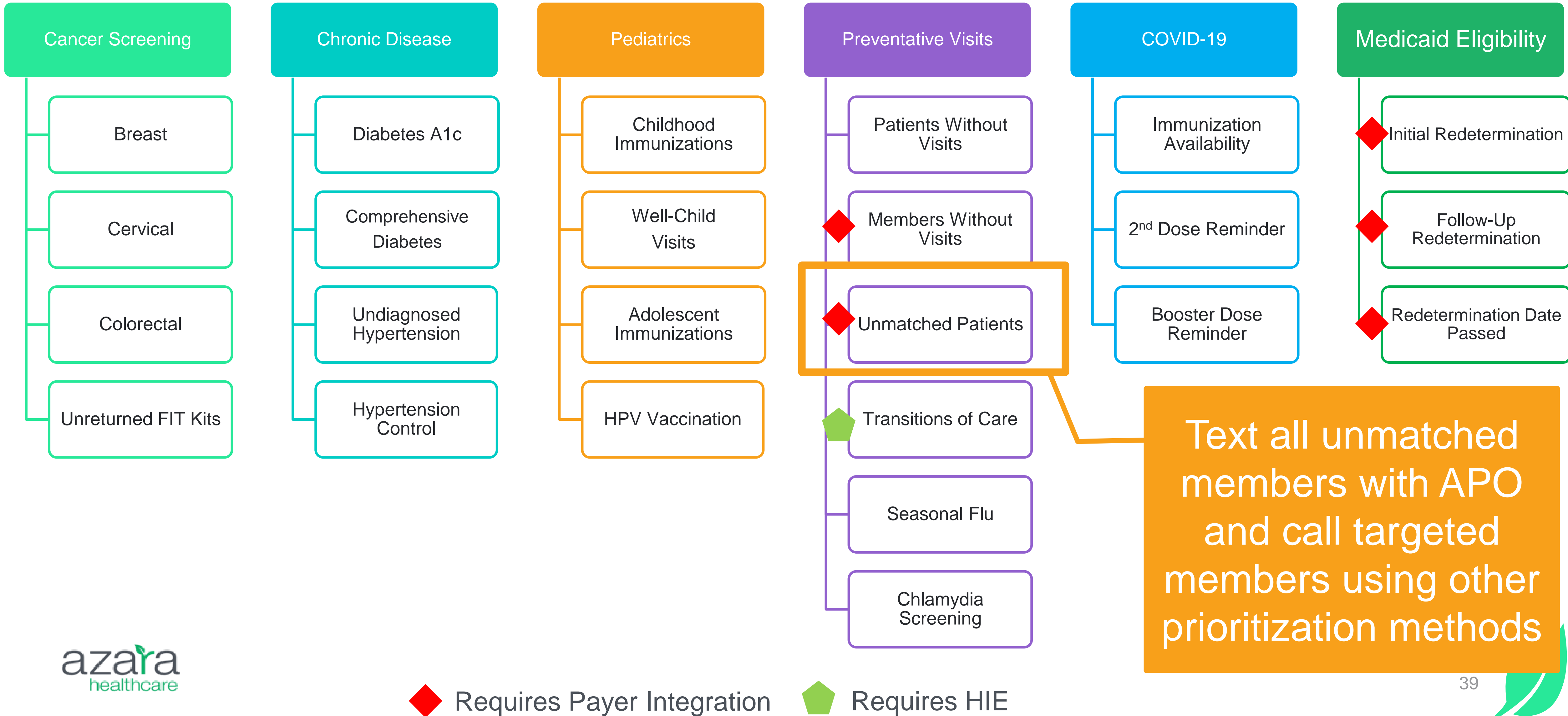
Azara Patient Outreach | Available Campaigns



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Prioritize Outreach Methods

PAYER ENROLLMENT & CARE GAPS

All Unmatched Members	Newly Assigned Members	Members by Care Gap
• Member Report, Member Match Type Filter	• Newly Assigned Members measure, Member Match Type filter	• Custom scorecard with plan-calc measures, Member match type filter

Outreach to All Unmatched Members

Pros	Identifies all unmatched members, no one falls through the cracks
Cons	Could be hundreds/thousands of members
Use Case	If smaller number of members, contact everyone

Members
REPORT

FILTER

PERIOD: February 2023
RENDERING PROVIDERS: All Rendering Provid...
PLANS: All Plans
MEMBER MATCH TYPE: Unmatched

Add Filter
Update

Search ...

SAVED COLUMNS

DEMOGRAPHICS >		MEMBER							ELIGIBIL
NAME	PLAN	NUMBER	MEDICAID NUMBER	MEDICARE NUMBER	MRN	HARD/SOFT MATCHED	HARD MATCH	SOFT MATCH	START
Kost, Piper	Plan_08	1218	555	888		N	N	N	2/25/202
Brabson, Dovie	AZR Health Plan	1359	555	888		N	N	N	2/17/202
Bleecker, Velia	CostPerMember	3477	555	888		N	N	N	2/28/202
Pano, Margurite	CostPerMember	70	555	888		N	N	N	2/20/202
Knedler, Leisa	AZR Health Plan	761	555	888		N	N	N	2/13/202
Maigret, Jose	CostPerMember	1858	555	888		N	N	N	2/26/202
Babcock, Mardell	CostPerMember	2638	555	888		N	N	N	2/21/202
Vellone, Dale	CostPerMember	4564A	555	888		N	N	N	2/25/202
Buanno, Marc	Plan_08	4792	555	888		N	N	N	2/14/202
Grubman, Ernie	Plan_08	4983	555	888		N	N	N	2/15/202

Demo data

Campaign Performance | Unmatched Members

MESSAGE

This is Access Family. We are listed as your primary care provider by your insurance. Would you like to receive care from us? Text Yes, No, or STOP to stop messages.

This is Access Family. Your insurance assigned us as your primary care provider. Please call 123-456-7890 x00 to schedule an appointment.

This is Access Family. We'd like you to schedule a visit but haven't heard from you. Do you (A) get care elsewhere (B) don't want an apt (C) feel fine (D) other

APO Campaign Performance
REPORT

PERIOD: TY August 2023
CENTERS: All Centers
CAMPAIGN: Unmatched members

IMPACT

929 CARE GAPS CLOSED
▲ 113 Last Month

3% CARE GAP CLOSURE RATE

ENROLLEES W/CARE GAP CLOSURES BY MONTH

CAMPAIGN DETAILS

44,253 TOTAL ENROLLEES
TY August 2023

37,371 ENROLLEES MESSAGED
TY August 2023

Campaign Name	Unmatched members
Start Date	May 2020 *40 months*
Duration	1 messages after 1 days
Success Criteria	match to a patient

195,084 MESSAGES SENT
TY August 2023
▲ 32,128 Last Month

EFFECTIVENESS

+.8% SINCE BASELINE
▲ .3% Last Month

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

PATIENT ENGAGEMENT

33,188 PTS SUCCESSFULLY REACHED
TY August 2023
▲ 113 Last Month

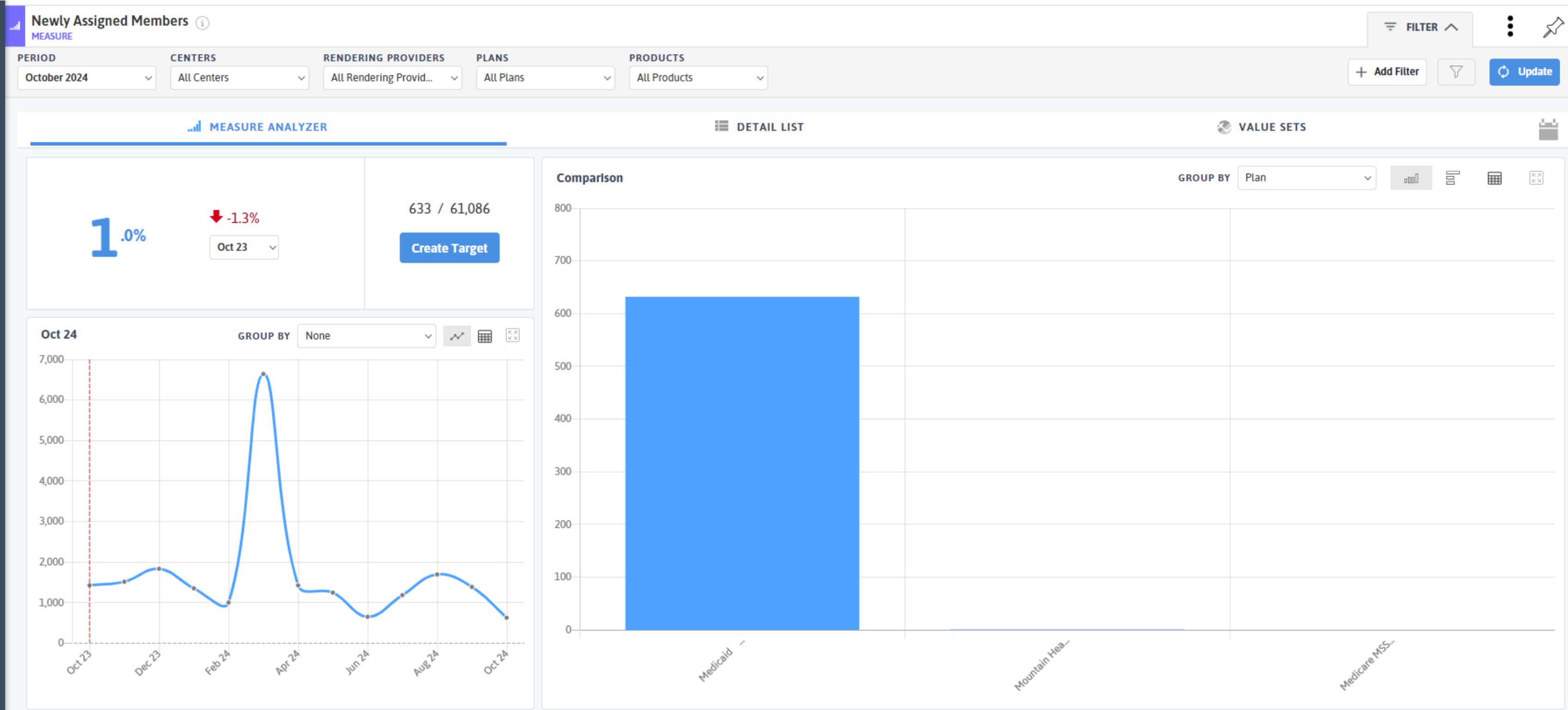
0% MADE APPT

0% KEPT APPT

3% CARE GAP CLOSED

Newly Assigned Members

Pros	Patients may be more likely to engage, have correct contact info
Cons	Still responsible for members assigned previously
Use Case	Targeted outreach for new members, send out “Welcome” letters to those who are unmatched



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Unmatched Members by Care Gap

Pros	Can target care gap closure for quality bonuses
Cons	No previous clinical knowledge, only outreaching based on a specific kind of gap
Use Case	Focus on quality measure performance to increase plan-calculated measure performance

MSSP ACO Quality Measures
REPORT

PERIOD: 2024 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid... | PLANS: Medicare MSSP ACO

FILT | Add Filter

REPORT | CARE GAPS

GROUPING: No Grouping | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	GAP
Breast Cancer Screening Ages 50-74 (CMS 125v12)	60.8%	27.6%	1,512	2,486	106	974
Colorectal Cancer Screening (CMS 130v12)	57.0%	22.6%	2,971	5,212	220	2,241
Depression Remission at Twelve Months (CMS 159v12)	6.6%	3.1%	33	498	145	465
Diabetes A1c >9 (CMS 122v11 Modified)	9.8%	32.3%	136	1,392	56	136
Falls Screening for Future Fall Risk (CMS 139v12)	24.4%	16.8%	1,581	6,470	4	4,889
Hypertension Controlling High Blood Pressure (CMS165v12)	65.4%	55.4%	2,795	4,272	290	1,477
Influenza Immunization - Calendar Yr Only (CMS 147v11)	43.3%	17.7%	2,650	6,117	174	3,467
Screening for Depression and Follow-Up Plan (CMS 2v13)	78.4%	7.1%	5,879	7,500	526	1,621
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS 347v7)	77.8%	66.7%	2,773	3,564	176	791
Tobacco Use: Screening and Cessation (CMS 138v12)	88.6%	25.0%	5,968	6,739	4	771

APO | Colorectal Cancer Screening

Challenges

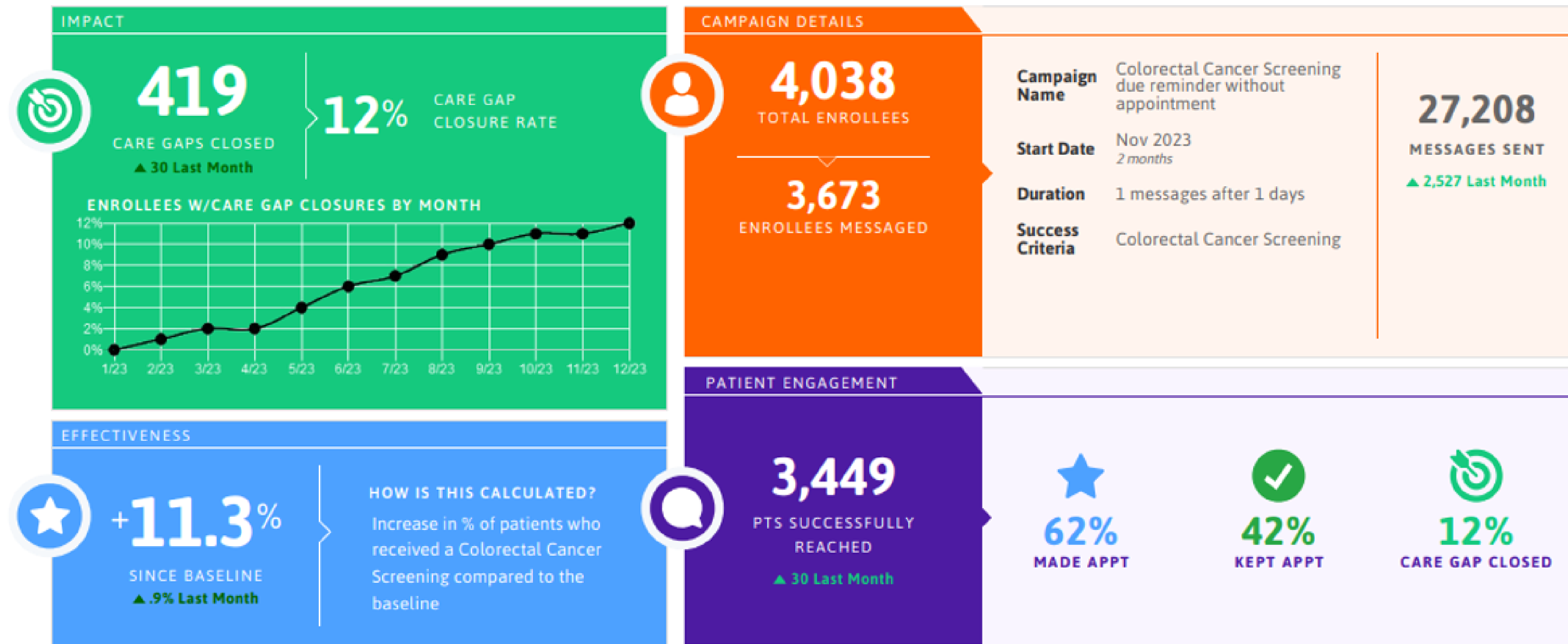
- Colorectal Cancer Screening performance decline due to low FOBT and colonoscopy compliance.
- Measure denominator expanded in 2023 to include patients age 45-49.

Solutions

- Partnered with ExactSciences (Cologuard).
- Used Azara Patient Outreach (APO) to contact and offer patients an at home test kits.
- Patients who opted in, were contacted to arrange the delivery of kits.

Success

- **419 care gaps (12%) closed** since campaign initiation in May 2023.
- Patients requested kits, but did not have 2023 qualifying encounters were scheduled, thus **re-engaging them in care**.
- Out of the patients successfully reached, **62% scheduled an appointment**.



Evaluate Impact of Care Management

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Leveraging Cohorts for CM | Use Cases

Identify Patients for Care Management

Facilitate Care Management

Evaluate the Impact of Care Management Efforts

Cohorts

Easy **identification, comparison, or tracking performance**

Helps **measure outcomes** for a specific group of patients defined at one point in time.

Important to track cohorts when measuring success.

- Are the people you're outreaching to coming in?
- Are they receiving annual SDOH screenings?
- Are those enrolled in SMBP seeing improvements in key health outcomes or risk levels?

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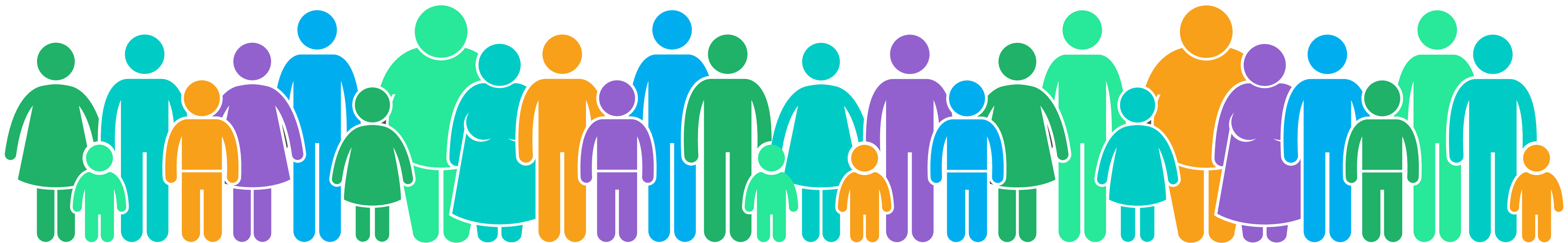


Patient Cohorts

Four ways to create a cohort.

1. Import list of MRNs from a text file.
2. Create from a clinical registry or the detail list in a measure.
3. Request dynamic cohorts be enabled
4. Create a dynamic cohort based on data criteria in EHR. (One-time additional mapping fee).

Cohorts created in DRVS are static; the patient list **will not change** unless manually manipulated

Create Cohort

NAME

Name of my Cohort

DESCRIPTION

This is the description of my cohort

ENABLED Active Disabled DISPLAY ON PVP Yes No INCLUDE IN ACM Yes No

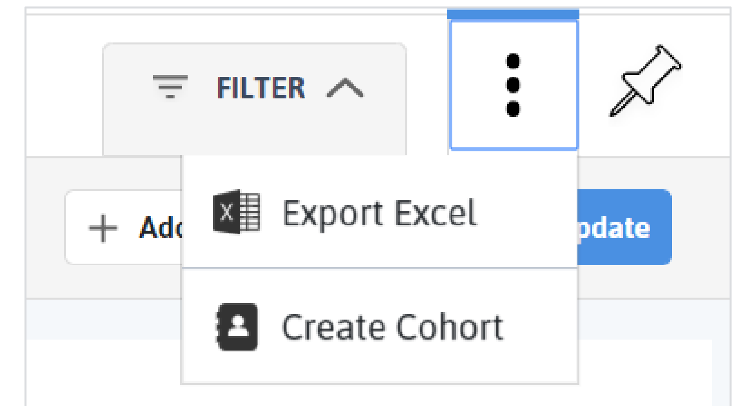
ADD PATIENTS TO COHORT

Upload a text file of MRNs into this box. Each MRN should have its own line.

Download Sample File

Choose File

Cancel Confirm



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Identify Patients Using Dynamic Cohorts

Enable dynamic cohorts that align with your care management criteria to easily **identify** and **track** patients.

Create Dynamic Cohort

GENERAL | POPULATION DEFINITION

DEFINITION
Select the population criteria from the dropdown. The description will appear to the right. Note: once the cohort is created, you will not be able to edit the population criteria.

SELECT POPULATION CRITERIA *

DM A1c > 9

- Anxiety
- Care Management
- CCM
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Depression
- Depression/Anxiety
- Developmental Disorders
- Diabetes
- DM A1c > 8
- DM A1c > 9
- DM A1c Untested
- DSMES
- ER Visit
- Hepatitis C
- High Risk Patients
- HIV
- Hypertension
- Hypertension BP > 140/90
- IP Visit

DESCRIPTION
Patients who have a diagnosis of diabetes and whose most recent hemoglobin A1c lab result is > 9.0%. Patients who are deceased are excluded from the cohort.

CRITERIA
VISIT
n Past Year

ALLOW DYNAMIC EXIT
If set to 'yes', once a patient no longer meets criteria they will automatically be removed from the cohort

Yes | No

Confirm

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Monitor & Track Needs for Care Managed Patients

Care Plan Monitoring
REGISTRY

FILTER

VISIT DATE RANGE: 08/01/2023-08/31/2023
RENDERING PROVIDERS: All Rendering Provid...
COHORTS: Care Mgmt

Apply cohort (static or dynamic) of patients in care management to populate the registry with *only* patients enrolled in CM services

Add Filter | Update

Make a custom registry inclusive of RDEs that you are tracking and monitoring for your care managed patients

REGISTRY

Search Patients ...

SAVED COLUMNS

	ON DX			PHQ-9 RESULT		PHQ-2 RESULT		GAD-7		HIV FIRST DX		OBESITY			
MRN		CODE	DETAIL	DATE	VALUE	DATE	VALUE	DATE	SCORE	DATE	CODE	OBESITY	ONSET DATE	CODE	CARE PLAN DATE
1100170		F32.2		1/27/2023	19	1/27/2023	5			1/27/2023	Z21	1/27/2023			
1102724		F32.2		8/25/2021	16	5/30/2021	1			8/25/2021	B2				
1101523		F32.2		12/26/2022	17	12/26/2022	4			12/26/2022	B2				
1101794		F32.2		12/3/2021	18	12/3/2021	2			12/3/2021	Z21				
1102995		F32.2		9/2/2022	26	9/2/2022	1			8/28/2021	Z21				
1104195		F32.2		1/9/2022	17	4/27/2022	3			4/27/2022	Z21				
1104480		F32.2		10/27/2022	19	10/27/2022	6			10/27/2022	Z21				
1103460		F32.2		11/5/2022	12	11/5/2022	3			11/5/2022	O98.713				
1101065		F32.2		3/20/2022	27	3/20/2022	7			3/20/2022	Z21				
1103786		F32.2		10/16/2022	26	10/16/2022	2			6/3/2021	Z21				
1104937		F32.2		8/15/2022	24	8/15/2022	3			8/15/2022	Z21				

Include a Care Plan RDE to identify patients who do or do not have a care plan on file

Demo data

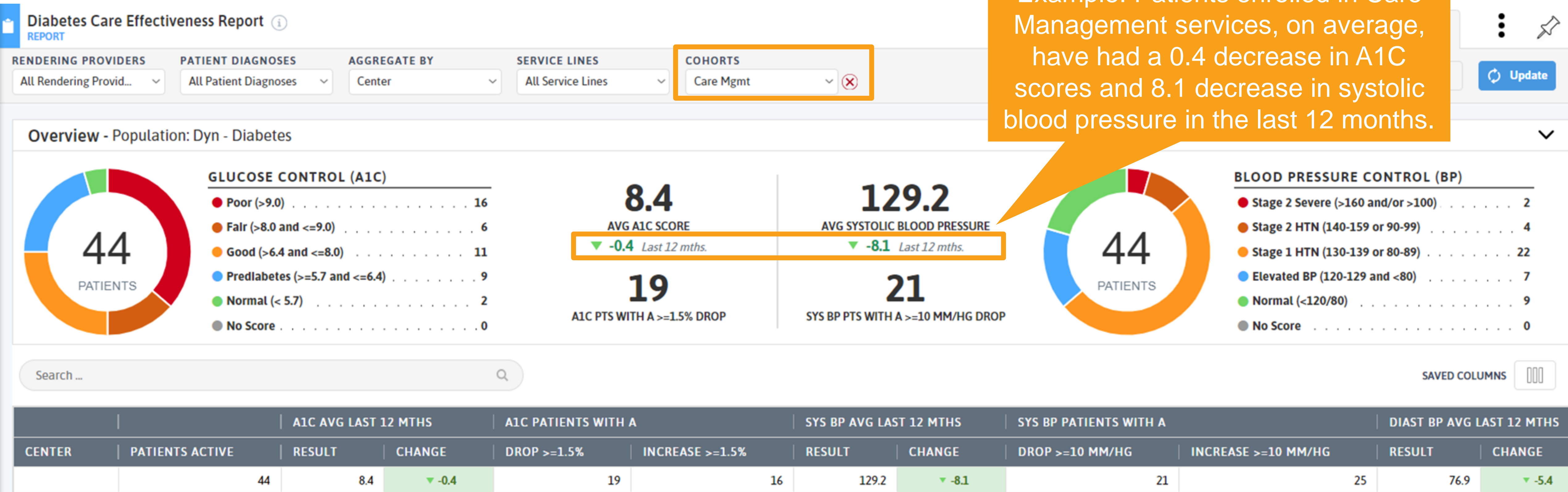
1 to 11 of 11

Care Plan Date RDE requires mapping. Reach out to the Support team via **Jira** or **support@azarahealthcare.com**.

Page 1 of 1

Impact of Care Management on Health Outcomes

Apply your Care Management Cohort to Care Effectiveness reports to evaluate the impact of your care management services on patient health outcomes.



		A1C AVG LAST 12 MTHS		A1C PATIENTS WITH A		SYS BP AVG LAST 12 MTHS		SYS BP PATIENTS WITH A		DIAST BP AVG LAST 12 MTHS	
CENTER	PATIENTS ACTIVE	RESULT	CHANGE	DROP >=1.5%	INCREASE >=1.5%	RESULT	CHANGE	DROP >=10 MM/HG	INCREASE >=10 MM/HG	RESULT	CHANGE
	44	8.4	▼ -0.4	19	16	129.2	▼ -8.1	21	25	76.9	▼ -5.4

Break it Down to Patient-Level

Diabetes Care Effectiveness Patients
REPORT

RENDERING PROVIDERS	PATIENT DIAGNOSES	SERVICE LINES	COHORTS
All Rendering Provid...	All Patient Diagnoses	All Service Lines	Care Mgmt

Apply your care management cohort (static or dynamic) to the patient-level Care Effectiveness Report to evaluate the health trajectory for patients enrolled in care management.

Overview - Population: Dyn - Diabetes

44 PATIENTS

GLUCOSE CONTROL (A1C)

- Poor (>9.0) . . . 16
- Fair (>8.0 and <=9.0) . . . 6
- Good (>6.4 and <=8.0) . . . 11
- Prediabetes (>=5.7 and <=6.4) . . . 9
- Normal (< 5.7) . . . 2
- No Score . . . 0

8.4
AVG A1C SCORE
▼ -0.4 *Last 12 mths.*

19
A1C PTS WITH A >=1.5% DROP

129.2
AVG SYSTOLIC BLOOD PRESSURE
▼ -8.1 *Last 12 mths.*

21
SYS BP PTS WITH A >=10 MM/HG DROP

44 PATIENTS

BLOOD PRESSURE CONTROL (BP)

- Stage 2 Severe (>160 and/or >100) . . . 2
- Stage 2 HTN (140-159 or 90-99) . . . 4
- Stage 1 HTN (130-139 or 80-89) . . . 22
- Elevated BP (120-129 and <80) . . . 7
- Normal (<120/80) . . . 9
- No Score . . . 0

Search Patients ...

NEXT APPT: All | No Appt | Upcoming Appt

SAVED COLUMNS

DEMOGRAPHICS >		FIRST A1C IN LAST 12 MTHS		MOST RECENT A1C LAST 12 MTHS				FIRST SYSTOLIC BP IN LAST 12 MTHS		MOST RECENT SYSTOLIC BP LAST 12 MTHS			FIRST DIAST
NAME	MRN	RESULT	DATE	STATUS	RESULT	DATE	CHANGE	RESULT	DATE	RESULT	DATE	CHANGE	RESULT
		5.8	10/10/2022	●	5.8	10/10/2022	0.0	122	8/3/2022	120	7/24/2023	▼ -2	
		7.1	10/11/2022	●	6.4	5/1/2023	▼ -0.7	182	9/13/2022	124	5/31/2023	▼ -58	
		8.7	12/15/2022	●	10.6	5/17/2023	▲ 1.9	112	8/16/2022	104	6/15/2023	▼ -8	
		13.9	10/13/2022	●	7.8	6/8/2023	▼ -6.1	136	10/13/2022	98	6/8/2023	▼ -38	
		8.5	11/1/2022	●	9.1	4/18/2023	▲ 0.6	130	8/15/2022	128	6/7/2023	▼ -2	
		5.7	10/11/2022	●	5.7	6/28/2023	0.0	108	10/11/2022	126	7/13/2023	▲ 18	
		7.6	10/4/2022	●	7.2	6/22/2023	▼ -0.4	138	8/5/2022	118	7/11/2023	▼ -20	
		6.6	11/4/2022	●	5.9	5/12/2023	▼ -0.7	132	8/17/2022	123	7/3/2023	▼ -9	
		8.3	8/4/2022	●	5.4	3/2/2023	▼ -2.9	190	8/4/2022	160	12/5/2022	▼ -30	
		8.3	9/28/2022	●	8.2	6/23/2023	▼ -0.1	142	9/28/2022	142	6/20/2023	0	
		8.2	9/6/2022	●	8.7	1/30/2023	▲ 0.5	144	8/15/2022	130	7/3/2023	▼ -14	
		10.9	9/24/2022	●	9.1	11/18/2022	▼ -1.8	100	10/25/2022	134	4/3/2023	▲ 34	
		6.1	2/28/2023	●	6.1	2/28/2023	0.0	162	2/28/2023	158	3/27/2023	▼ -4	

Impact of Care Management on CQMs

UDS 2023 CQMs
REPORT

FILTER

PERIOD	RENDERING PROVIDERS	BASELINE PERIOD	COHORTS
TY July 2023	All Rendering Provid...	TY December 2022	Care Mgmt

Add Filter | Update

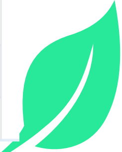
REPORT | CARE GAPS

GROUPING: No Grouping

TARGETS: Primary | Secondary | Not Met

Set baseline to when your practice launched your care management services to evaluate the impact of your services on measure performance

MEASURE	RESULT	CHANGE	TARGE			
Childhood Immunization Status (CMS 117v11)	0.0%	0.0%	50.0			
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v11)	80.0%	+ 5.0% ▲	80.0%		5	0
BMI Screening and Follow-Up 18+ Years (CMS 69v11)	58.3%	- 8.0% ▼	65.0%	49	84	2
Depression Remission at Twelve Months (CMS 159v11)	0.0%	0.0%	5.0%	0	10	6
Screening for Depression and Follow-Up Plan (CMS 2v12)	67.3%	+ 29.0% ▲	80.0%	33	49	40
Tobacco Use: Screening and Cessation (CMS 138v11)	91.7%	+ 1.2% ▲	88.0%	77	84	1
Colorectal Cancer Screening (CMS 130v11)	26.1%	+ 0.7% ▲	45.0%	18	69	3
Cervical Cancer Screening (CMS 124v11)	24.0%	+ 3.2% ▲	55.0%	6	25	15
Breast Cancer Screening Ages 50-74 (CMS 125v11)	34.4%	+ 2.3% ▲	29.0%	11	32	3
Hypertension Controlling High Blood Pressure (CMS165v11)	76.0%	+ 5.5% ▲	59.0%	38	50	5
Diabetes A1c > 9 or Untested (CMS 122v11)	37.5%	- 6.7% ▼	32.0%	18	48	1
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v6)	96.0%	+ 2.8% ▲	78.0%	48	50	1
IVD Aspirin Use (CMS 164v7)	73.3%	- 6.7% ▼	83.0%	11	15	5
HIV Screening (CMS 349v5)	51.4%	+ 4.9% ▲	50.0%	38	74	0
HIV and Pregnant	0.0%	0.0%	*Not Set*	0	0	0
HIV Linkage to Care	0.0%	0.0%	75.0%	0	0	0
Dental Sealants for Children between 6-9 Years (CMS 277v0)	0.0%	0.0%	60.0%	0	0	0



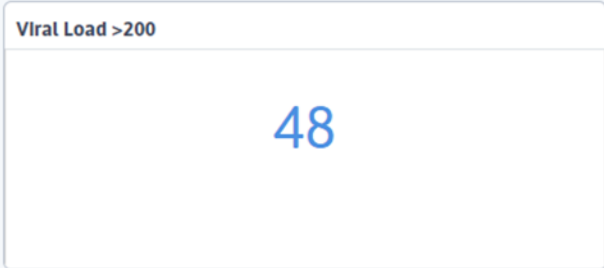
Track Care Management Efforts

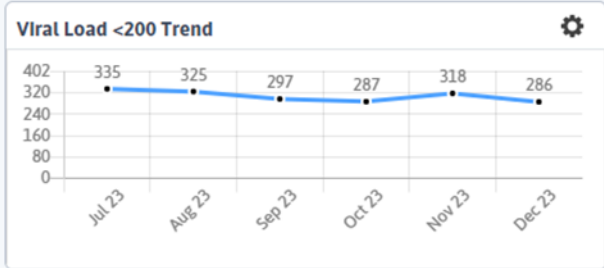
P4C Dashboard
DASHBOARD

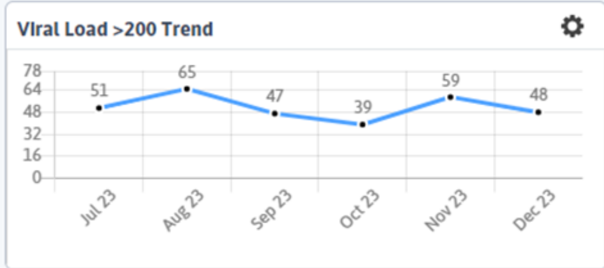
PERIOD: December 2023
RENDERING PROVIDERS: All Rendering Provid...

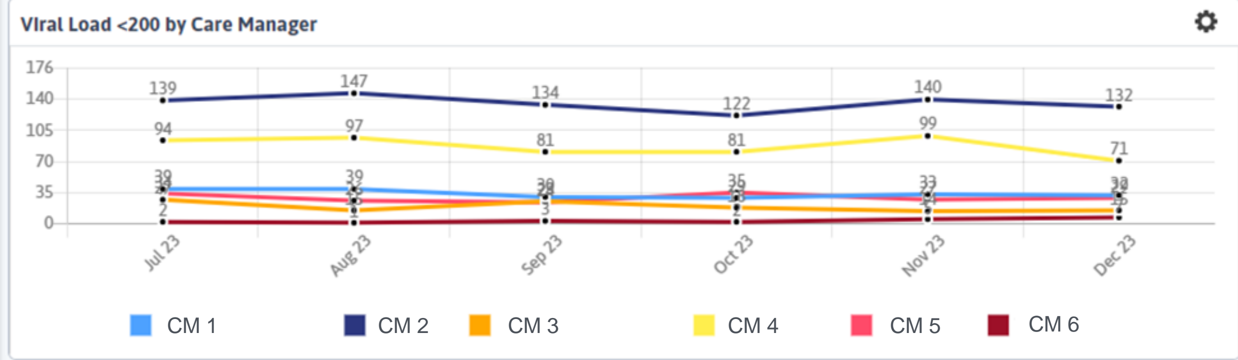
Create a custom dashboard to track care management efforts

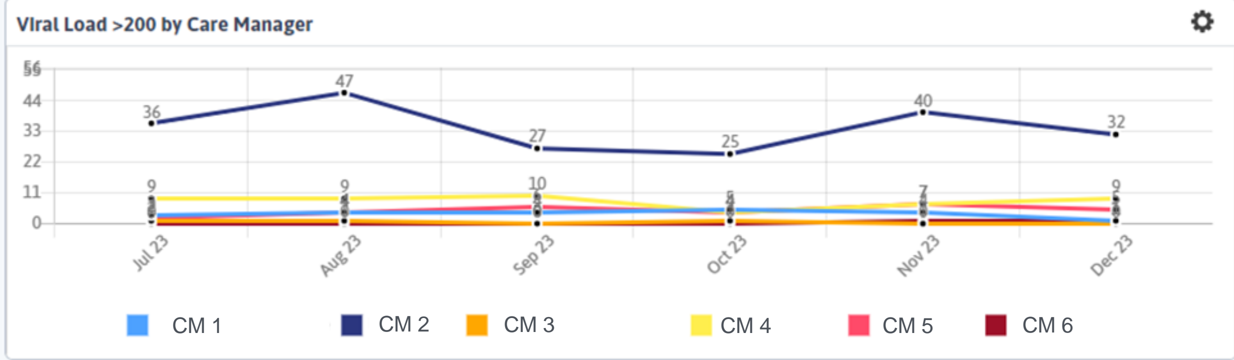
FILTER | Add Filter | Update











Viral Load <200 by Care Manager

CARE MANAGERS	RESULT	NUMERATOR	GAP
CM 1	100.0%	15	0
CM 2	85.3%	29	5
CM 3	88.8%	71	9
CM 4	97.0%	32	1
CM 5	80.5%	132	32

HIV Scorecard

MEASURE	RESULT	NUM	DENOM	EXCL
HIV PCP Prophylaxis	80.0%	16	20	0
HIV CD4 Monitoring	91.4%	254	278	0
HIV Visit Frequency (12-month)	100.0%	246	246	0
HIV Visit Frequency (24-month)	89.0%	138	155	0
HIV New Patient Visit Frequency	100.0%	36	36	0

Demonstrating ROI

Care Management Impact
DASHBOARD

PERIOD: TY December 2021
RENDERING PROVIDERS: All Rendering Provid...

Create a custom dashboard to capture ROI of care management services

FILTER
Add Filter
Update

Interactions per Patient
No Shows
Same Day Appts
Canceled Appts <24 hrs
Breast CA Screening Done
Cervical CA Screening
CRC Screening Done
Portal Login
A1c > 9
DM Eye Exam
DM Foot Exam
BMI Screening and Follow-Up

TY 7/21, TY 8/21, TY 9/21, TY 10/21, TY 11/21, TY 12/21

High Risk Patients
High Risk Pts Getting Care Mgt

New Data Health Measures!

New Data Health Measures

Household Size and Household Income Questionable Values

Household Size Structured Data – Questionable

Description: Records of household size that are 'questionable' or potentially invalid, based on structured data.

Numerator: Records with a questionable or potentially invalid result for household size

- Greater than 12
- Less than or equal to zero
- Blank or null value

Denominator: Structured clinical data records with a completed date within the measurement period for the following item:
Household Size PRAPARE

Exclusions: Records with a result value set by override
If you have any additional questions, please contact support with the link below.

Household Income Structured Data – Questionable

Description: Records of household Income that are 'questionable' or potentially invalid, based on structured data.

Numerator: Records with a questionable or potentially invalid result for household income

- Greater than $300,000
- Less than zero
- Blank or null value

Denominator:
Structured clinical data records with a completed date within the measurement period
for the following item:
Household Income PRAPARE

Exclusions:
Records with a result value set by override

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APO Measures Update:
Additional SDOH Data Added to Detail List

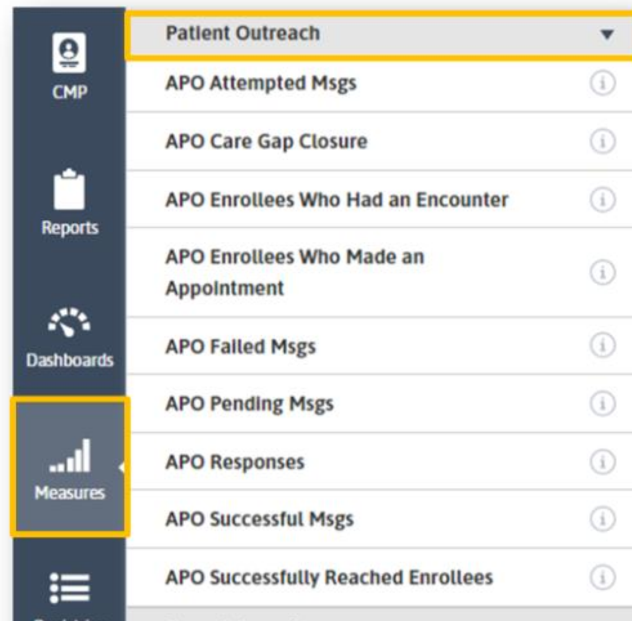
ADDITIONAL DATA ADDED TO APO MEASURES
Social Drivers of Health x APO

View a patient's **Social Drivers of Health Triggers and Assessment information,**

now available in all **APO Measures**.

Target outreach and review effectiveness in outreach efforts by viewing & filtering on patients with certain factors

like Homelessness, Transportation, Isolation, and more



SDOH ASSESSMENT			SDOH	
STATUS	COMPLETED	COUNT	TRIGGERS	TALLY
Core In Progress	MS - Food, Housing status or Housing situation,...	4	HOMELESS INSURANCE TRANSPORT-NONMED	3
Core In Progress	MS - Food, Housing status or Housing situation,...	4	HOMELESS FPL<200% UTILITY PHONE INSURAN...	9
Core Completed	MS - Food, Housing status or Housing situation,...	5	FOOD UTILITY PHONE INSURANCE CLOTHING T...	8
Core In Progress	Housing status or Housing situation, Transport...	2	INSURANCE TRANSPORT-NONMED ISOLATION	3

Available for practices with the Azara Patient Outreach Module.

New APO Campaign:
Primary Care No Show Appointments

NEW CAMPAIGN
Primary Care No Show Appointments

Focus in on patients whose **most recent appointment was a No Show that has not been rescheduled**

This campaign only considers appointments that were in the Primary Care service line, and only considers patients who had a qualifying Primary Care encounter in recent months (*configurable*)

Primary Care No Show Appointments

VARIABLES | MESSAGE SCHEDULE

CAMPAIGN VARIABLES

These are configurable values within the campaign entry/exit criteria or within the messages themselves.

VARIABLE	CURRENT SETTINGS	DESCRIPTION
Appointment Lookforward Days	30	Number of days to look forward for a Primary Care appointment
Encounter Lookback Months	12	Number of months to look back for a qualifying Primary Care encounter
Max Age	85	Maximum Age of a patient to be considered in the campaign
Min Age	85	Minimum Age of a patient to be considered in the campaign

ENTRY CRITERIA

This is how we detect if a patient should ENTER the campaign:

Patients aged 18 to 85 who have had a qualifying encounter in the last 12 months, whose most recent Primary Care appointment was a No Show, and have not rescheduled their Primary Care appointment within the next 30 days. *Does not include Cancelled appointments, or appointments with a flag of 'Walk In'.

EXIT CRITERIA

This is how we detect if a patient should EXIT the campaign:

Patients in the campaign who no longer meet the entry criteria

Available for practices with the Azara Patient Outreach Module.

Value Sets Tab Added to Reports!

Value Sets Tabs have been added to reports in DRVS that contain Detail Lists.

This is not applicable to scorecards or UDS tables.

F2F Qualifying Encounter CPT Mapping Details
REPORT

FILTER

PERIOD
2024

Add Filter

REPORTS | VALUE SETS

Search Value Sets ...

CATEGORY	VALUE SET	CODE SYSTEM	CODE	DESCRIPTION
Encounter	Additional Office Visit Codes	CPT	59400	Routine obstetric care including antepartum
Encounter	Additional Office Visit Codes	CPT	59425	Antepartum care only; 4-6 visits
Encounter	Additional Office Visit Codes	CPT	59426	Antepartum care only; 7 or more visits
Encounter	Additional Office Visit Codes	CPT	59430	Postpartum care only (separate procedure)
Encounter	Additional Office Visit Codes	CPT	59510	Routine obstetric care including antepartum
Encounter	Additional Office Visit Codes	CPT	59610	Routine obstetric care including antepartum
Encounter	Additional Office Visit Codes	HCPCS	G0438	Annual wellness visit; includes a personalized
Encounter	Additional Office Visit Codes	HCPCS	G0439	Annual wellness visit, includes a personalized

Achieve, Celebrate, Engage!

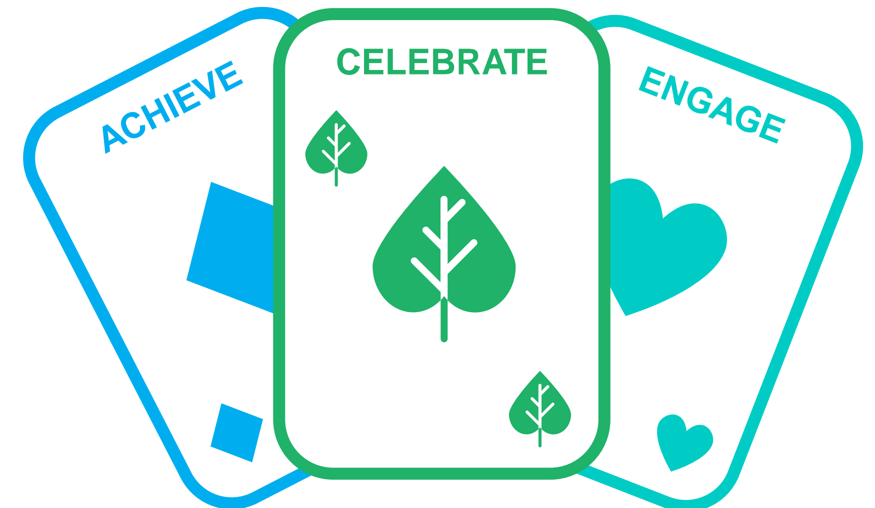
ACE'd it? Share your DRVS success story and become an Azara ACE!

Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

Benefits:

- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Win Azara swag!

Submit your success story by completing the form at this link.



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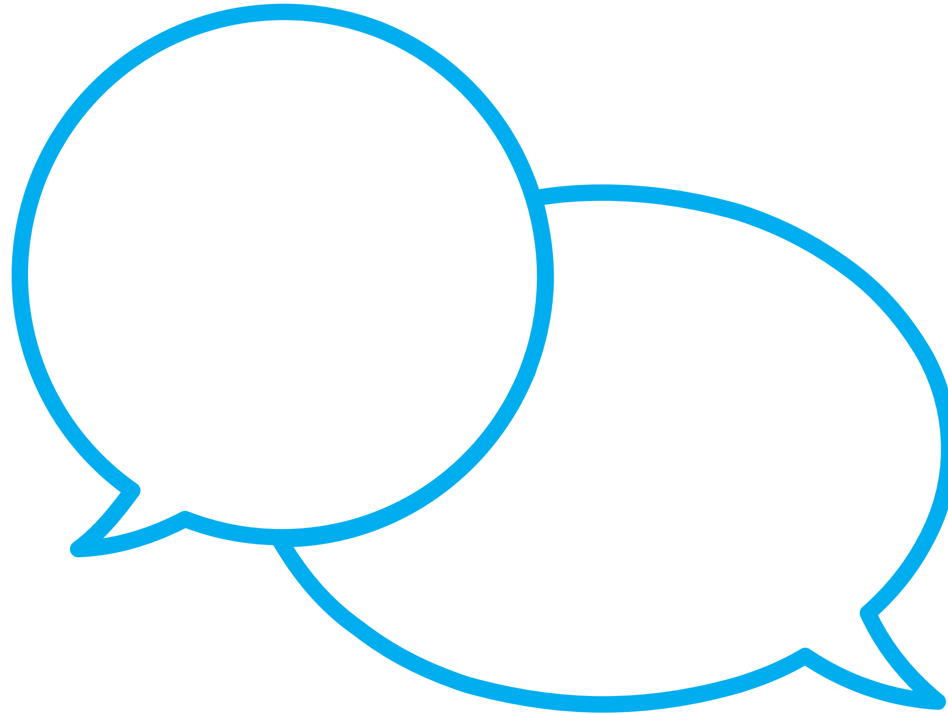
Questions?



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UDS 2024 - Support Open Question Hours

Topic	Date(s)	Notes	Information
Table 6a	11/13 @ 3pm EST		Register
Tables 3, 4, 5	11/20 @ 3pm EST		Register
Table 6b/7 - Tobacco, Depression, IVD, HIV, Statin	12/4 @ 3pm EST	Tobacco, Depression Screening and Remission, IVD Aspirin, Statin Therapy, HIV Screen and Linkage to Care	Register
Table 6b/7 - Adult BMI, Pediatric, Cancer, HTN, Diabetes	12/11 @ 3pm EST	Adult BMI, Child Weight, Childhood Imms, Breast Cancer, Cervical Cancer, Colorectal Cancer, HTN BP, Diabetes a1c, Dental Sealants	Register
Table 6b/7 - Prenatal & Delivery	12/18 @ 3pm EST	Deliveries, Early Entry into Prenatal Care, HIV & Pregnant, Birthweight	Register

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UDS Open Q&A Sessions 2024 (azarahealthcare.com)

Upcoming Webinars | December

Practical Applications: DRVS Data for Functional UDS Reporting

Register – Thursday, December 5th 2pm ET

Submitting UDS+ with Azara: A Review of our Registration and Submission Process in DRVS

Register – Thursday, December 14th 2pm ET

Resources

- Role-Based Series: DRVS for Care Management (webinar)
- Cohorts User Guide
- Cohorts Quick Tip Clips