azara
USER CONFERENCE
APR 30–MAY 2
BOSTON, MA
2024

Pretty Darn Quick

DRVS Success Stories

What is a PDQ?

A 5-to-7-minute presentation detailing the success an organization has had using Azara products.

Each success story will highlight what strategies were implemented to achieve this success.

Why Are PDQ's Important?

Learn new skills from people who actively use DRVS in their workplace.

Take similar steps after seeing peer's success.

Better understand how your work is positively impacting communities.

Help us determine what other updates Azara can create for DRVS.

Today's PDQ Presenters

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Chandra Beasley

Director of Information Technology

South Carolina Primary Health Care Association

Tina Golding-Jewett

Senior Manager of Integration and Care Management

Honor Community Health

Kaitlin Deel

Health Informatics Manager

Honor Community Health

Neikisha Charles

Director of Quality Improvement and Risk Management

Bedford-Stuyvesant Family Health Center

Sarah Judd

Population Health Analyst

Missouri Primary Care Association

Felicia Scroggs

Population Health Manager

Amite County Medical Services, Inc.

Using Azara to Lead the Way for a Diabetes Free South Carolina

Chandra Beasley

Director of Information Technology

South Carolina Health Center Controlled Network

SCHCCN

SOUTH CAROLINA HEALTH CENTER CONTROLLED NETWORK

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South Carolina Primary Health Care Association (SCPHCA)

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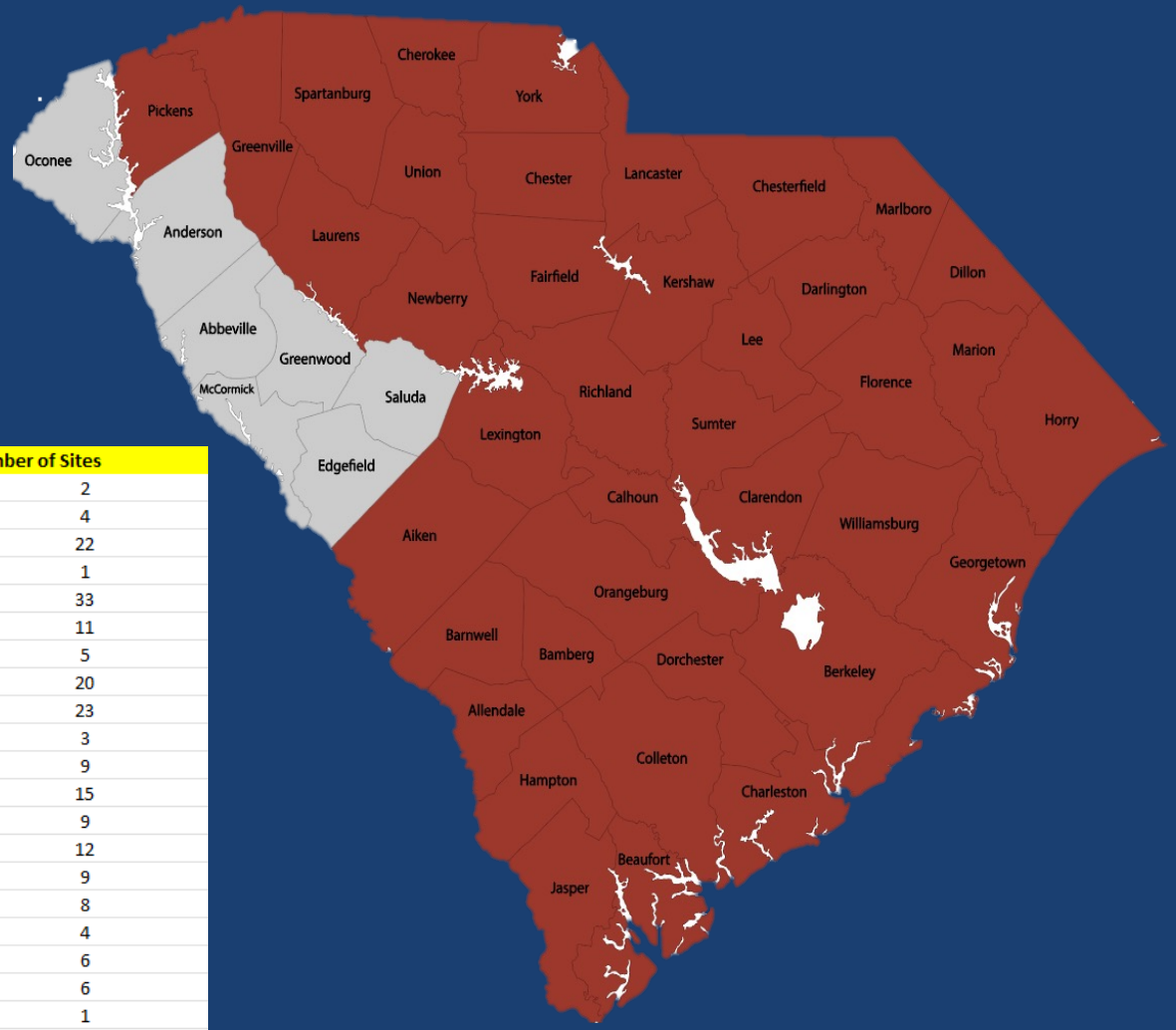
Established in 1979

Serves as the unifying organization for:

- 22 Community Health Centers
- Statewide Agriculture Worker Program (AWP)
- 2 Health Center Program Look-Alikes in South Carolina

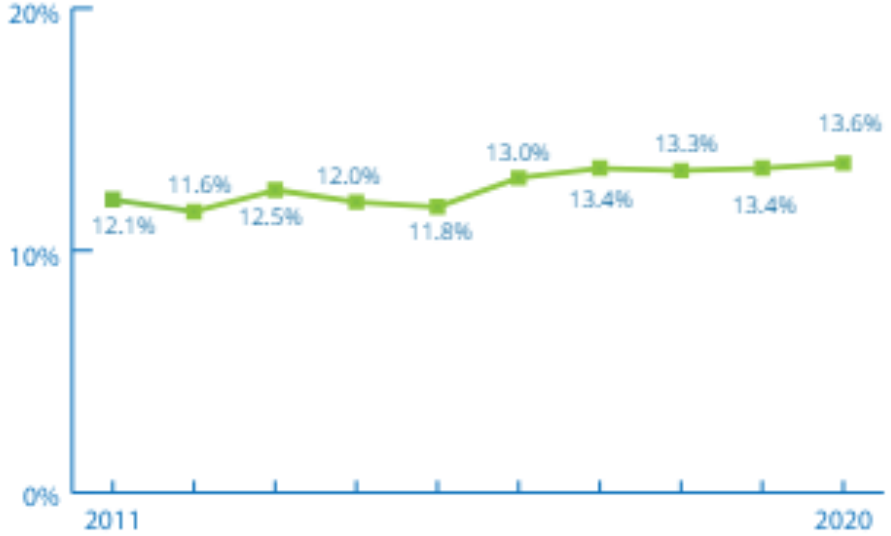
Health Center	Number of Sites
Plexus	2
Affinity	4
Beaufort	22
CareTeam Plus	1
Cooperative Health	33
Family Health	11
Health Care Partners of SC	5
CareSouth	20
Fetter	23
Foothills	3
Genesis	9
HopeHealth	15
Low Country	9
Little River	12
New Horizon	9
ReGenesis	8
Rural Health	4
St James Santee	6
Tandem	6
SCAgWHP	1



USC Center for Community Health Alignment

Approximately **531,143 people (13.2% of adult population)** in South Carolina have been diagnosed diabetes. **An additional 123,000 people in South Carolina have diabetes but don't know it, greatly increasing their health risk.**

Since 2011, diabetes prevalence among adults has **increased from 12.1% to 13.6%** in 2020. Diagnosed prediabetes has increased from 6.7% in 2011 to 10.9% in 2018.



https://scdhec.gov/sites/default/files/Library/CR-013028.pdf

Program Initiatives

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Tracking Outcomes | Dashboard

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Patients with Diabetes

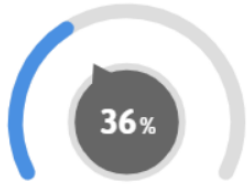
37,483

Pts w/ Diabetes

-4,386 ▼

2019

A1c < 7%



CHW Pre-Diabetes Interactions

91

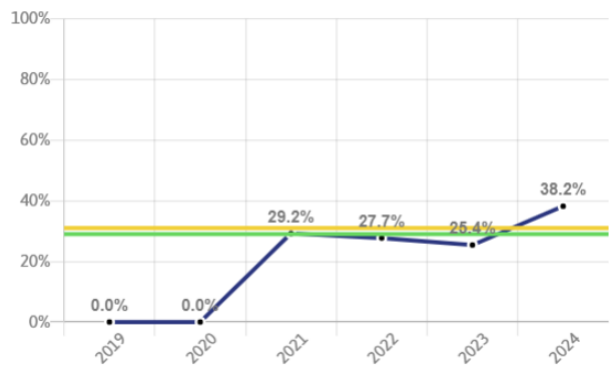
# of Patient Interactions

CHW Diabetes Interactions

443

# of Patient Interactions

A1c > 9% / Untested



Diabetes Scorecard

MEASURE	RESULT	NUM	DENOM	EXCL
Diabetes: Eye Exam (CMS 131v9)	29.2%	10,942	37,489	209
DM Foot Exam	19.1%	6,993	36,703	114
DM BP < 130/80	35.2%	13,202	37,483	209
DM BP < 140/90	72.0%	26,981	37,483	209
DM Depression Screening	66.9%	18,879	28,239	9,453
DM Tobacco Use Assessment & Cessation	83.7%	31,379	37,483	209
DM Nephropathy	83.1%	31,085	37,417	208

DM Patients with Primary Care Encounters

Periods	% PATIENT W/ PRIMARY ENCOUNTER
2015	0.0%
2016	0.0%
2017	0.0%
2018	93.1%
2019	92.0%
2020	90.9%
2021	90.7%
2022	89.5%
2023	90.0%

LDL Cascade

PTS W/ DIABETES	37,417	
DM LDL < 100	9,063	24%
DM LDL >= 100 AND < 130	3,775	10%
DM LDL >= 130	2,986	8%
DM LDL Untested	21,593	58%

A1c Cascade

PTS W/ DIABETES	37,483	
DM A1c < 7	13,534	36%
DM A1c >= 7 and A1c <= 8	6,370	17.0%
DM A1c > 8 and A1c <= 9	3,276	8.7%
DM A1c > 9	5,824	16%
DM A1c does not exist	8,402	22.4%

A1c Uncontrolled by Age

AGE	RESULT	NUMERATOR	DENOMINATOR	EXCL	GAP
18-19	79.3%	46	58	0	46
20-34	53.2%	847	1,593	0	847
35-44	44.1%	1,649	3,740	0	1,649
45-64	39.1%	7,696	19,663	2	7,696
65 +	32.7%	4,064	12,429	207	4,064

Data-Driven Approach

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Accurate and timely monitoring of progress

Make informed decisions

Implement targeted interventions

HONOR Community HEALTH

Live healthy. Be well.

Care Plan Conundrum:

An Azara Success Story

Azara User Conference 2024

Our Team

Tina Golding-Jewett

Integration and Care Management, Senior Manager

Kaitlin Deel

Health Informatics Manager

About Us

2011
Founded

21
Sites

17,493
Patients

Services

HONOR Community HEALTH

Live healthy. Be well.

Behavioral Health Home

The Behavioral Health Home (BHH) provides comprehensive care management and coordination services to Medicaid, Healthy Michigan Plan, and MiChild enrollees.

For enrolled beneficiaries, the BHH functions as the central point of contact for directing patient-centered care across the broader health system.

For each 100 enrollees the BHH team is comprised of:

- **1 RN Case Manager**
- **3-4 Community Health Workers**

As well as a

- **Behavioral Health Specialist consultant**
- **Psychiatrist consultant**
- **Medical Doctor consultant**

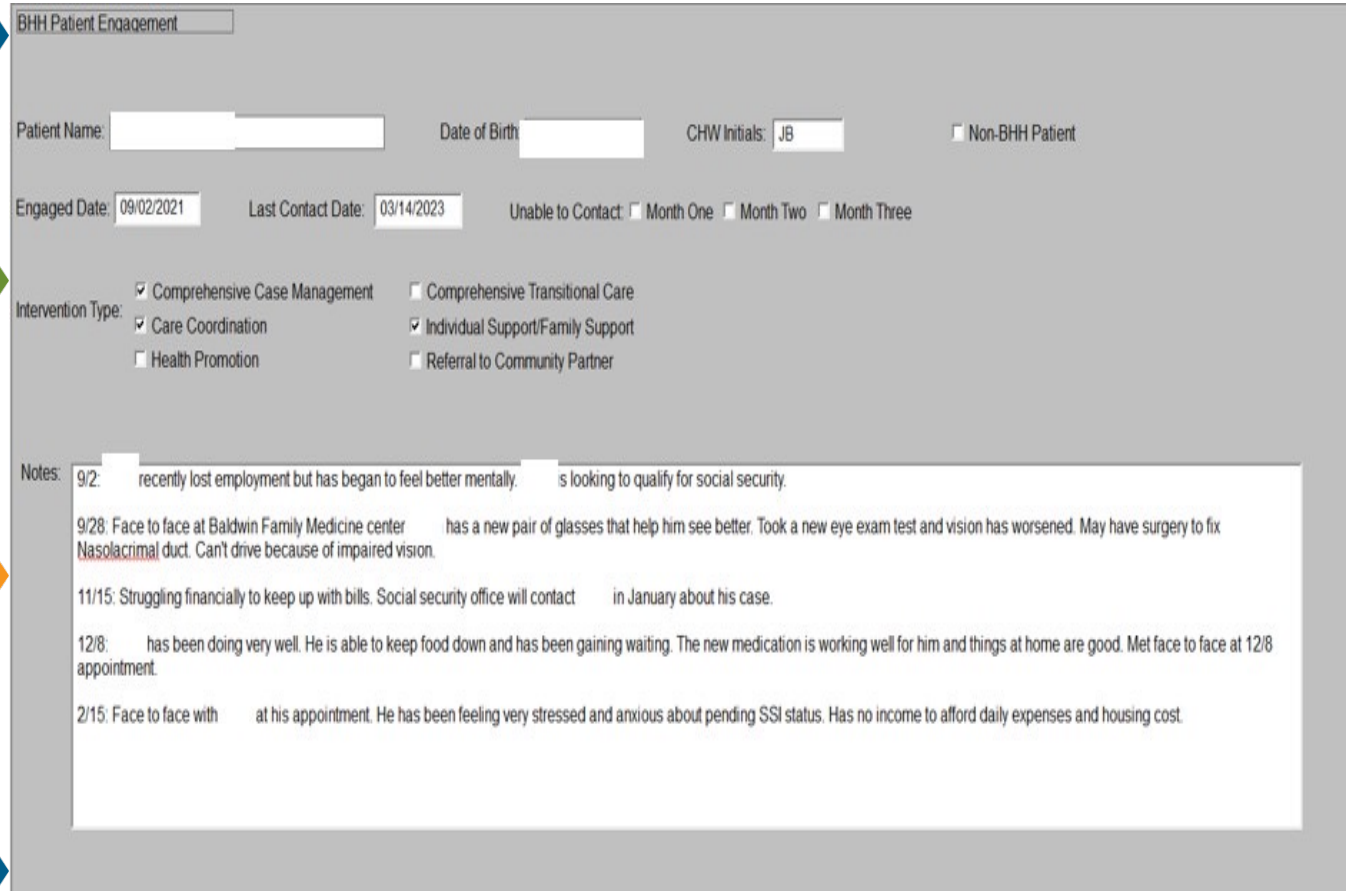
How could we:

Simplify Care Plan creation?

Meet the demands of the program?

Why Not Utilize the EMR?

In order to satisfy documentation requirements, we had to build our own template to track data elements



BHH Patient Engagement

Patient Name: [redacted] Date of Birth: [redacted] CHW Initials: JB ☐ Non-BHH Patient

Engaged Date: 09/02/2021 Last Contact Date: 03/14/2023 Unable to Contact: ☐ Month One ☐ Month Two ☐ Month Three

Intervention Type:
- ☑ Comprehensive Case Management
- ☑ Care Coordination
- ☐ Health Promotion
- ☐ Comprehensive Transitional Care
- ☑ Individual Support/Family Support
- ☐ Referral to Community Partner

Notes:

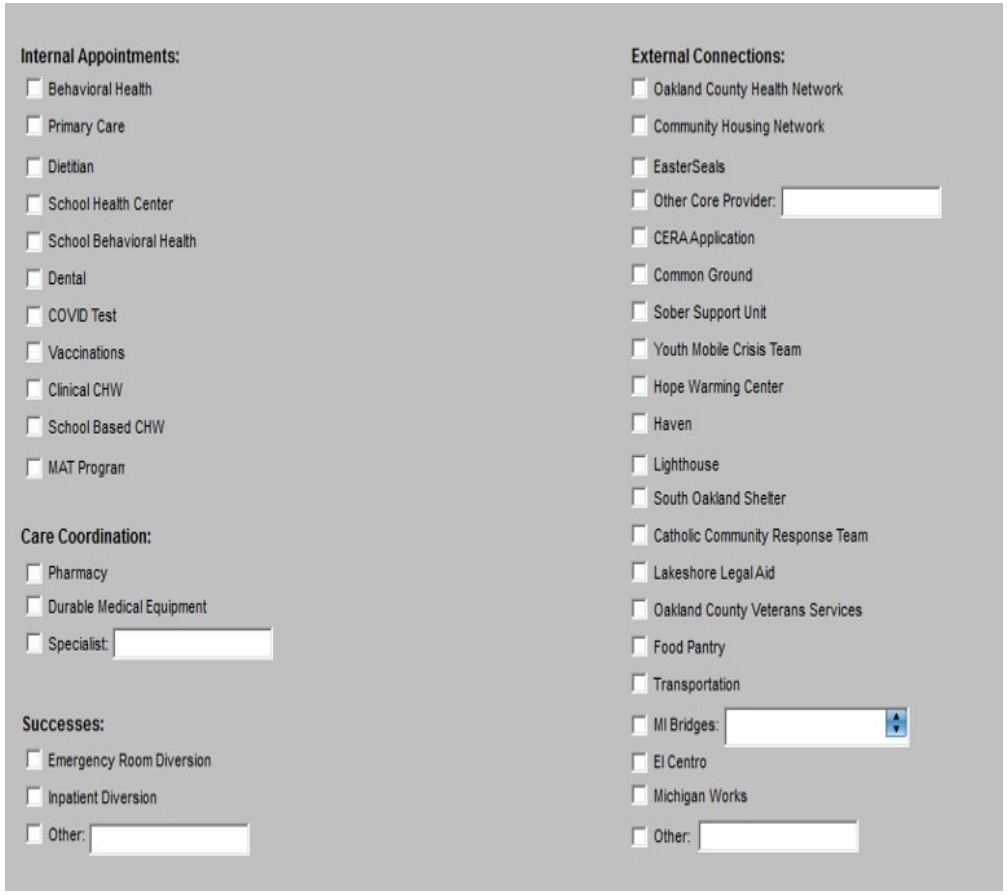
9/2: [redacted] recently lost employment but has began to feel better mentally. [redacted] s looking to qualify for social security.

9/28. Face to face at Baldwin Family Medicine center [redacted] has a new pair of glasses that help him see better. Took a new eye exam test and vision has worsened. May have surgery to fix Nasolacrimal duct. Can't drive because of impaired vision.

11/15: Struggling financially to keep up with bills. Social security office will contact [redacted] in January about his case.

12/8: [redacted] has been doing very well. He is able to keep food down and has been gaining waiting. The new medication is working well for him and things at home are good. Met face to face at 12/8 appointment.

2/15. Face to face with [redacted] at his appointment. He has been feeling very stressed and anxious about pending SSI status. Has no income to afford daily expenses and housing cost.



Internal Appointments:
- ☐ Behavioral Health
- ☐ Primary Care
- ☐ Dietitian
- ☐ School Health Center
- ☐ School Behavioral Health
- ☐ Dental
- ☐ COVID Test
- ☐ Vaccinations
- ☐ Clinical CHW
- ☐ School Based CHW
- ☐ MAT Program

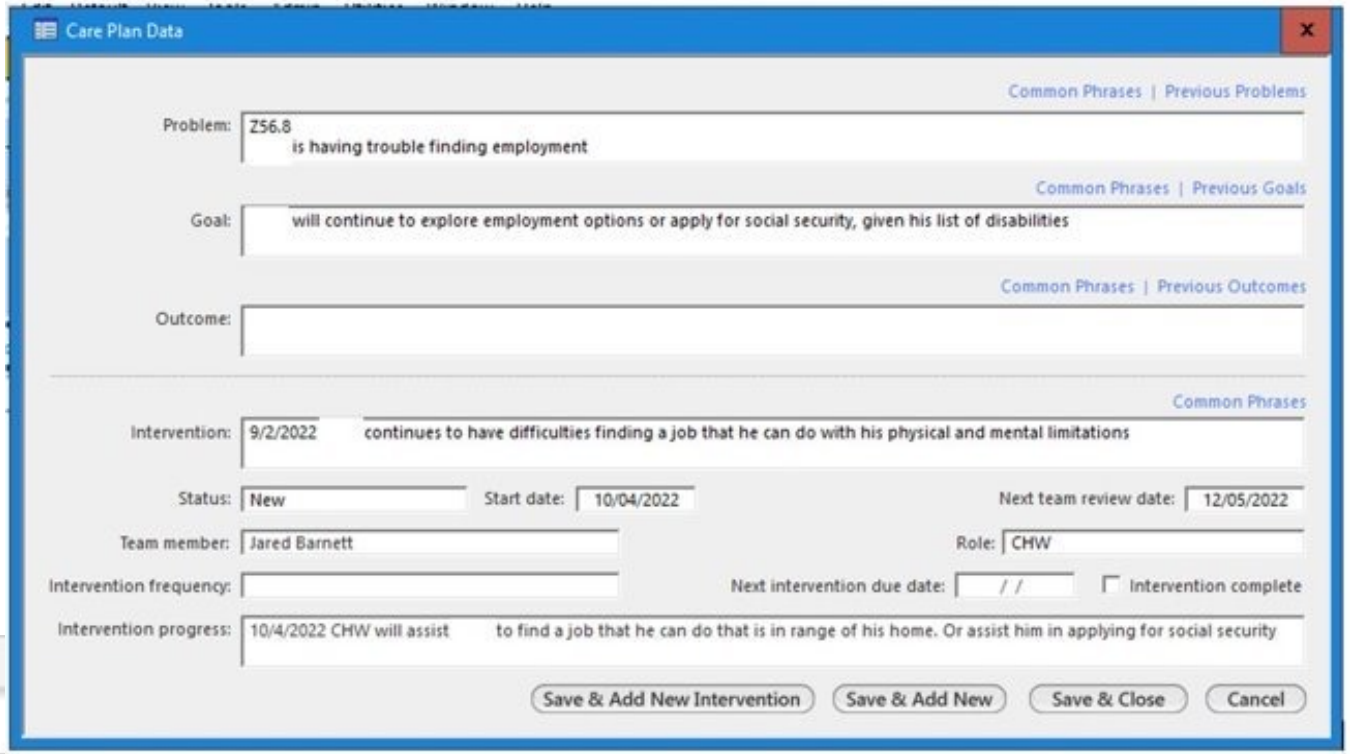
Care Coordination:
- ☐ Pharmacy
- ☐ Durable Medical Equipment
- ☐ Specialist:

Successes:
- ☐ Emergency Room Diversion
- ☐ Inpatient Diversion
- ☐ Other:

External Connections:
- ☐ Oakland County Health Network
- ☐ Community Housing Network
- ☐ EasterSeals
- ☐ Other Core Provider:
- ☐ CERA Application
- ☐ Common Ground
- ☐ Sober Support Unit
- ☐ Youth Mobile Crisis Team
- ☐ Hope Warming Center
- ☐ Haven
- ☐ Lighthouse
- ☐ South Oakland Shelter
- ☐ Catholic Community Response Team
- ☐ Lakeshore Legal Aid
- ☐ Oakland County Veterans Services
- ☐ Food Pantry
- ☐ Transportation
- ☐ MI Bridges:
- ☐ El Centro
- ☐ Michigan Works
- ☐ Other:

Why Not Utilize the EMR?

Designed for Healthcare Professionals not Community Health Workers



History

Problem	Goal	Intervention	Role	Status	Start Date	Next Review
has open referrals to specialists	will have complete all specialists initial appointments within six months	CM to assist in scheduling appointments	CHW	Continued	04/01/2022	10/30/2022
reports a 15 pound weight loss in the past two weeks	will report no further decrease in his weight in the next six months	CM to monitor for weight changes over the next twelve months	CHW	Continued	12/01/2021	11/30/2022
reports a 15 pound weight loss in the past two weeks	will report no further decrease in his weight in the next six months	CM will work with o obtain his needed medications	Nursing	Complete	09/20/2021	/ /
eports increasing feelings of anxiety in the past months	will report a 10% decrease in feelings of anxiety in the next six months	CM to encourag to keep his behavioral healt appointments and identify barriers to that end	Nursing	Continued	09/20/2021	09/30/2022
reports increasing feelings of anxiety in the past months	will report a 10% decrease in feelings of anxiety in the next six months	CM will explore ways that feels has worked in decreasing his anxiety previously	Nursing	Complete	09/20/2021	/ /

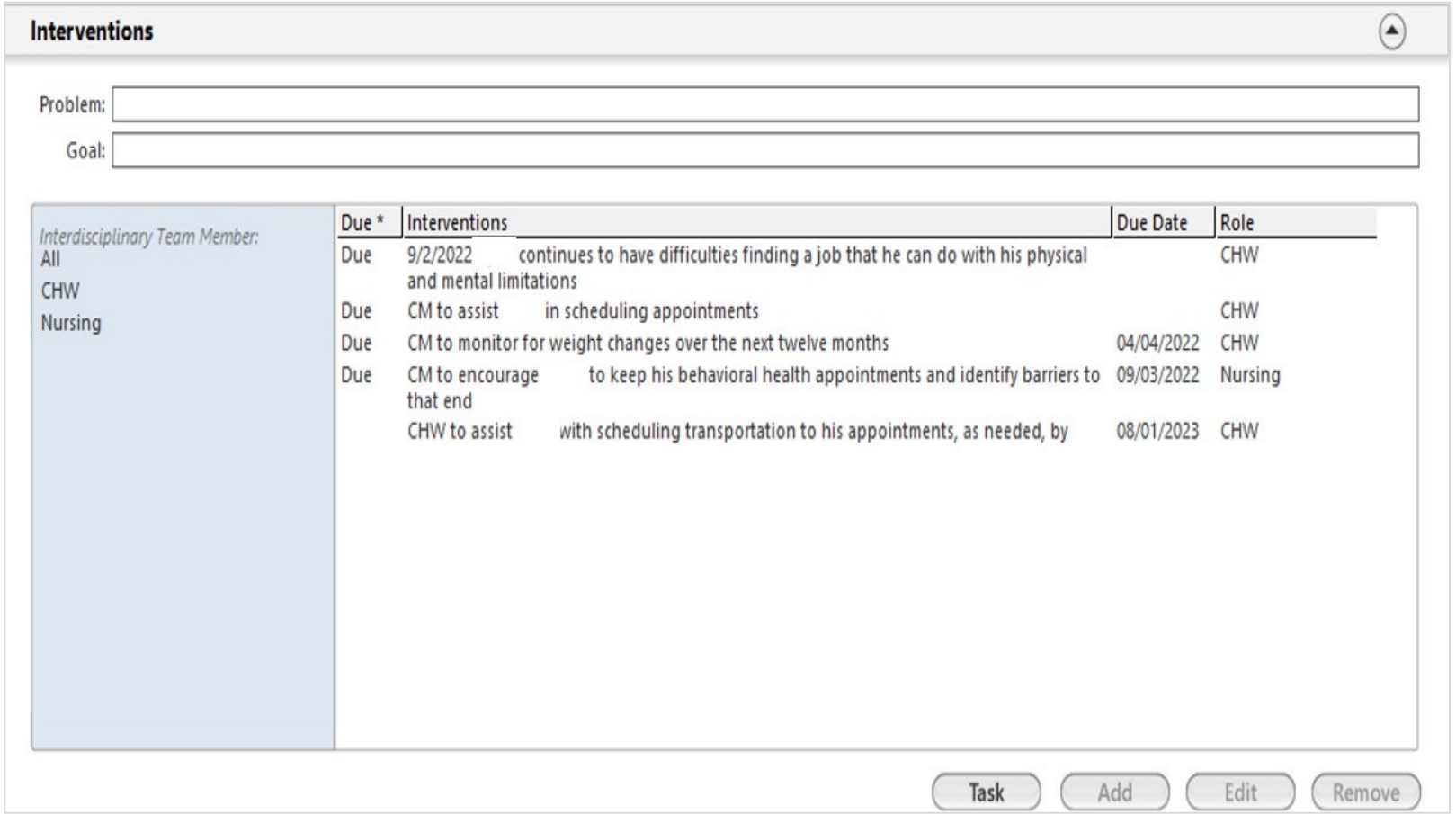
Why Not Utilize the EMR?

Care Plans were clunky and confusing for CHWs as well as difficult to print with the desired information showing

Documented Date Time	Intervention	Intervention Progress
10/04/2022 1:48PM	9/2/2022 continues to have difficulties finding a job that he can do with his physical and mental limitations	10/4/2022 CHW will assist o find a job that he can do that is in range of his home. Or assist him in applying for social security
08/01/2022 3:40PM	CHW to assist with scheduling transportation to his appointments, as needed, by	8/2 called McLaren insurance transportation and the representative was unwilling to work with Case Manager, stated patient needed to call. CHW created 3 way call with and Insurance, representative stopped responding mid-call. Call attempted again, same result stated that his neighbor would take him to his appointment
04/05/2022 2:44PM	CM to assis in scheduling appointments	CM sent referral and facilitated an appointment with Beaumont Eye for 8/9/2022 @10:30 am 5/4: as an appt with an ENT doctor today
12/01/2021 4:06PM	to connect to career center for guidance in job search	1/4/22: Recommended Michigan Works as job search partner for tated he would be interested in a job at a vape shop or custodial work. CM also looked at SnagA Job and found openings at Aramark. Link was sent via CareMessage to phone 6/: reports working 2 jobs, at Family Dollar as a custodian and as a dishwasher. He is pleased with his current employment and has plans to continue working at these 2 jobs. CHW to continue to provide support as needed 3/2: said that he tried these resources and none of them helped provide jobs that are walking distance to him and can accommodate his symptoms
12/01/2021 3:54PM	CM to monitor for weight changes over the next twelve months	1/4: Weight 98lbs. Discussed benefits of weight gain 2/3 has been working out more and trying to do push ups to build up body strength 3/2: did not report weight loss
11/19/2021 2:34PM	CM to conta n with appeal results	was contacted, he stated he had received Tina's voicemail and understood the instructions but that he was not going to take any action because his skin was "good". CHW encourage to call the pharmacy to have the medication refilled, and bring it in to the office and then discuss with a doctor whether or not to take medication. CHW explained that he could call the CHW or the call center and get a appointment for the coming Mon/Tues as soon as he received the medication. 12/1/21 reports that he has an appointment on 12/3/2021 to receive his injection 3/2: reported taking his injection with the help of his nurse neighbor
11/18/2021 2:39PM	CM to contact with appeal results	CM left voicemail for apprising him of successful appeal to McLaren for Dupixent and instructing him to call Walgreen's specialty pharmacy to have medication refilled and bring the med to an Honor clinic for administration.

Why Not Utilize the EMR?

Interventions Completed are not Displayed in Exported Care Plans



Why Not Utilize the EMR?

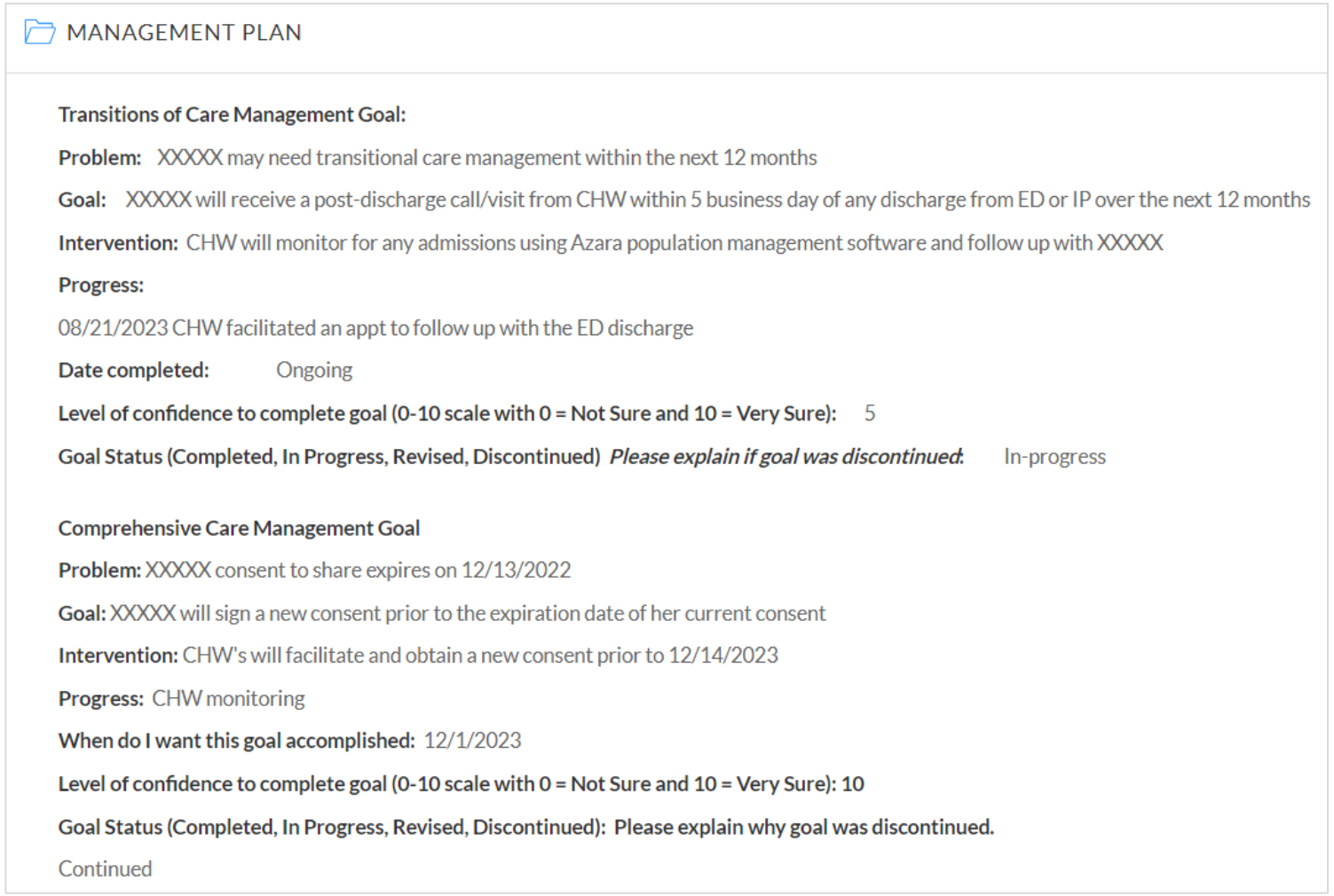
EMR Care Plans did not align to Audit requests

CARE PLAN HISTORY

Start date	Problem	Goal	Intervention
01/12/2022	states that she is ready to quit smoking	will report smoking zero cigarettes per day within twelve months	01/12/202 will continue to use nicotine patches to wean off of cigarettes
01/12/2022	states that she is ready to quit smoking	will report smoking zero cigarettes per day within twelve months	02/01/2023: reported being unable to find a pharmacy that caries the inhaler she was prescribed for smoking, CHW urged her to discuss with Dr to find an alternative medication
01/12/2022	eports that she would like to receive behavioral health counseling	will report completion of an intake appointment with a behavioral health clinician within the next month	01/12/2022 CM facilitated an appointment with Health Center
01/12/2022	reports housing insecurity due to uncoupling with her husband	will report stable housing within the next six months	07/12/2022 CM to provide information on Community Housing Network resources
02/04/2022	consent to share expires on 12/14/2023	will sign a new consent prior to the expiration date of her current consent	12/15/2022 CHW's will facilitate and obtain a new consent prior to 12/14/2023
02/21/2022	has a history of behavioral health issues	report zero emergency room or hospital inpatient admissions related to her behavioral health issues over the next twelve months	09/28/2022 continues her treatment with easter seals, and pt state doing.
03/03/2022	reports not having her Gabapentin refilled	will successfully report receiving and completing a referral for Neurologist	03/03/2022 CHW to provide support and assistance with scheduling appointments
06/08/2022	Z71. has a history of behavioral health issues	will report a 25% perceived decrease in her behavorial health issues over the next 12 months	08/21/2023 eports that her depression and anxiety are well-controlled and does not need assistance at this time to manage
08/16/2022	needs help with healthy choices after	will report starting the nutrition	09/27/2022 Pt continues working on quitting smoking.

Why Azara Documentation?

Azara Benefits



MANAGEMENT PLAN

Transitions of Care Management Goal:

Problem: XXXXX may need transitional care management within the next 12 months

Goal: XXXXX will receive a post-discharge call/visit from CHW within 5 business day of any discharge from ED or IP over the next 12 months

Intervention: CHW will monitor for any admissions using Azara population management software and follow up with XXXXX

Progress:

08/21/2023 CHW facilitated an appt to follow up with the ED discharge

Date completed: Ongoing

Level of confidence to complete goal (0-10 scale with 0 = Not Sure and 10 = Very Sure): 5

Goal Status (Completed, In Progress, Revised, Discontinued) ***Please explain if goal was discontinued:*** In-progress

Comprehensive Care Management Goal

Problem: XXXXX consent to share expires on 12/13/2022

Goal: XXXXX will sign a new consent prior to the expiration date of her current consent

Intervention: CHW's will facilitate and obtain a new consent prior to 12/14/2023

Progress: CHW monitoring

When do I want this goal accomplished: 12/1/2023

Level of confidence to complete goal (0-10 scale with 0 = Not Sure and 10 = Very Sure): 10

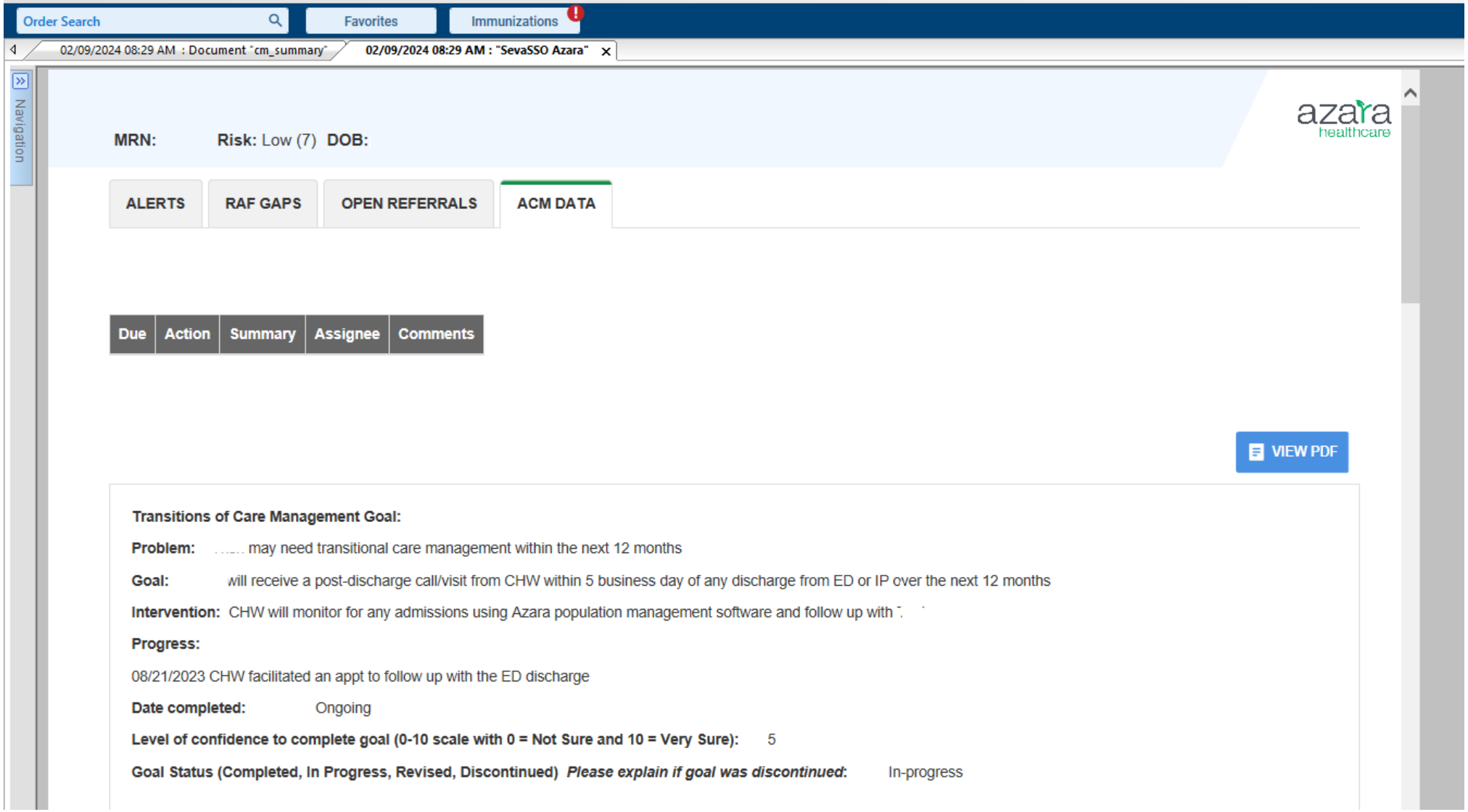
Goal Status (Completed, In Progress, Revised, Discontinued): Please explain why goal was discontinued.

Continued

Using **ACC**, we created custom templates for each goal

Simple to print out Care Plans using the *Create PDF* button for submission to auditors

Azara Benefits



EHR Plug In shares information with clinicians without the need to go into a separate program

So……..how did we do?

Out of all care plans reviewed,

100% had at least one specific goal or objective focused on improving health conditions.

100% had at least one specific goal or objective focused on improving social support.

100% demonstrated activation and action to achieve goals through specific steps that shall be taken reach the goals and objectives.

100% demonstrated a focus on the beneficiary's engagement and empowerment through reference to one or more engagement, activation, or health promotion/literacy areas.

100% aligned with the six required health home services.

100% had SMART goals and objectives.

100% had a mechanism in place to track the beneficiary's goal achievement.

100% clearly indicated the people involved in the development of the care plan.

100% indicated agreement from the beneficiary.

100% indicated agreement from the care team.

IMPACT

- Reduction in Documentation Errors
- Increased Productivity
- Less Time Spending Documentation
- More Time Spent with Patients

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APR 30–MAY 2
BOSTON, MA
2024

APO for Colorectal Cancer Screening

Neikisha Charles
Director of Quality Improvement and Risk Management
Bedford-Stuyvesant Family Health Center

Bedford-Stuyvesant Family Health Center

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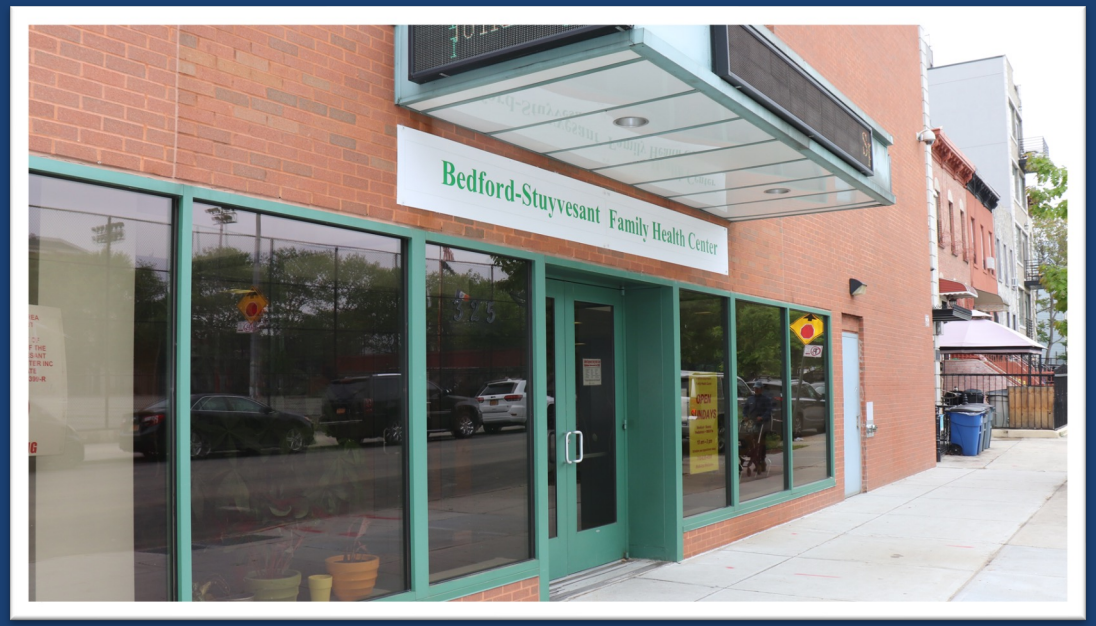
Founded in 1978

- 60,000 patient care visits to over 16,000 unique patients
- 50 different ZIP codes across the five boroughs of New York City
- Provides health services to the neediest residents in North and Central Brooklyn
- Service Area has expanded to seven Brooklyn ZIP codes since our founding



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Challenges

- ✓ Colorectal Cancer Screening performance decline due to low FOBT and Colonoscopy compliance
- ✓ Measure denominator widened in 2023 to include 45-49 year old patients

Solutions

- ✓ Partnered with ExactSciences (Cologuard)
- ✓ Use of DRVS APO to outreach non-compliant patients and offer them at home test kits
- ✓ Patients who opted in, were contacted to arrange the delivery of kits

APO = Azara Patient Outreach

Setting Up the APO Campaign

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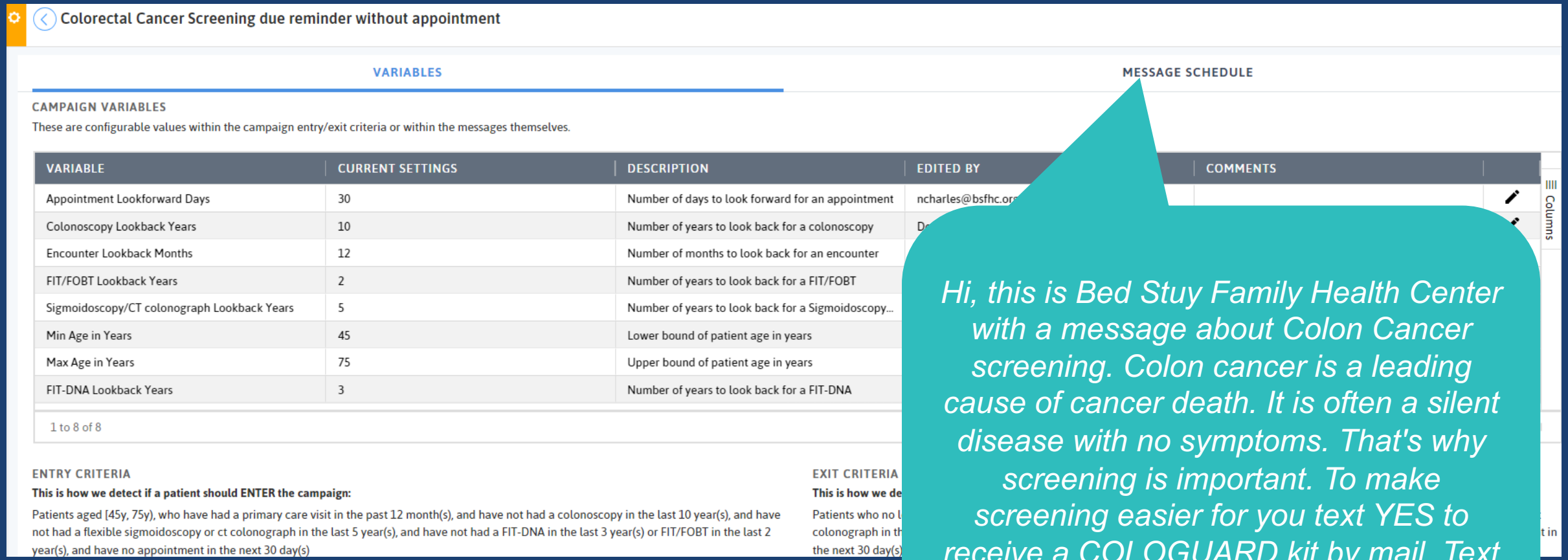

Colorectal Cancer Screening due reminder without appointment

VARIABLES | MESSAGE SCHEDULE

CAMPAIGN VARIABLES

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

VARIABLE	CURRENT SETTINGS	DESCRIPTION	EDITED BY	COMMENTS
Appointment Lookforward Days	30	Number of days to look forward for an appointment	ncharles@bsfhc.org	
Colonoscopy Lookback Years	10	Number of years to look back for a colonoscopy	D...	
Encounter Lookback Months	12	Number of months to look back for an encounter		
FIT/FOBT Lookback Years	2	Number of years to look back for a FIT/FOBT		
Sigmoidoscopy/CT colonograph Lookback Years	5	Number of years to look back for a Sigmoidoscopy...		
Min Age in Years	45	Lower bound of patient age in years		
Max Age in Years	75	Upper bound of patient age in years		
FIT-DNA Lookback Years	3	Number of years to look back for a FIT-DNA		

1 to 8 of 8

Columns

ENTRY CRITERIA

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

Patients aged [45y, 75y), who have had a primary care visit in the past 12 month(s), and have not had a colonoscopy in the last 10 year(s), and have not had a flexible sigmoidoscopy or ct colonograph in the last 5 year(s), and have not had a FIT-DNA in the last 3 year(s) or FIT/FOBT in the last 2 year(s), and have no appointment in the next 30 day(s)

EXIT CRITERIA

This is how we de...

Patients who no l... colonograph in th... the next 30 day(s)

Hi, this is Bed Stuy Family Health Center with a message about Colon Cancer screening. Colon cancer is a leading cause of cancer death. It is often a silent disease with no symptoms. That's why screening is important. To make screening easier for you text YES to receive a COLOGUARD kit by mail. Text NO to opt-out.

Responses from Patients

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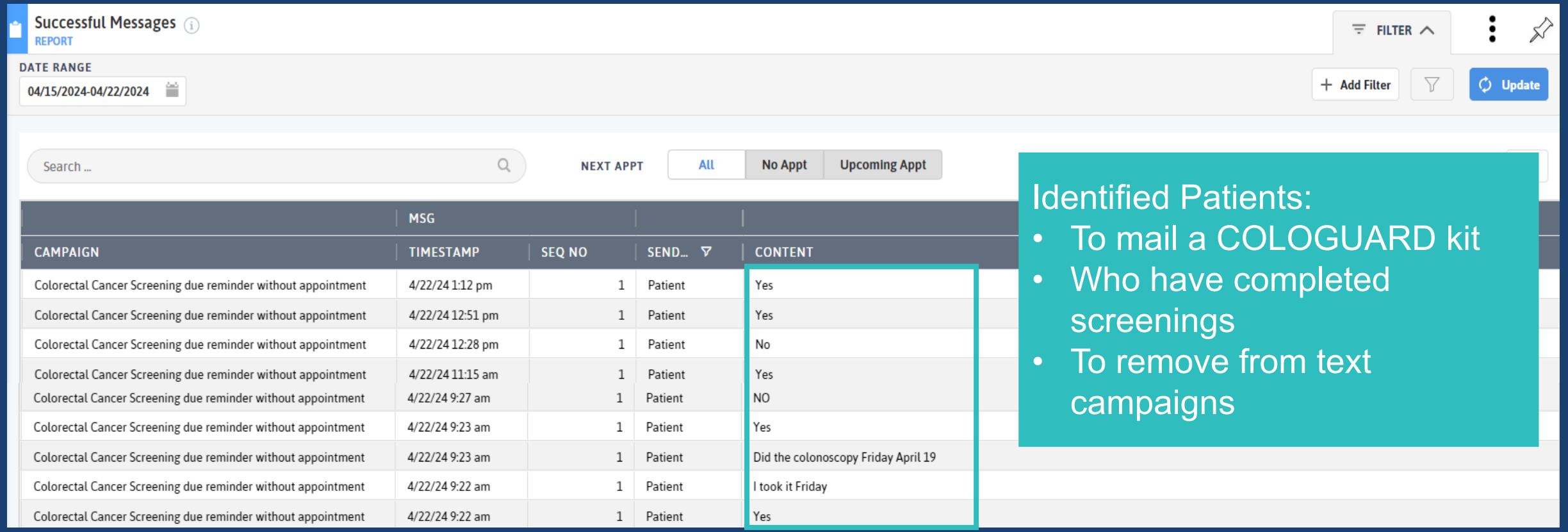

Successful Messages
REPORT

FILTER

DATE RANGE
04/15/2024-04/22/2024

+ Add Filter | Update

Search ...

NEXT APPT | All | No Appt | Upcoming Appt

	MSG			
CAMPAIGN	TIMESTAMP	SEQ NO	SEND...	CONTENT
Colorectal Cancer Screening due reminder without appointment	4/22/24 1:12 pm	1	Patient	Yes
Colorectal Cancer Screening due reminder without appointment	4/22/24 12:51 pm	1	Patient	Yes
Colorectal Cancer Screening due reminder without appointment	4/22/24 12:28 pm	1	Patient	No
Colorectal Cancer Screening due reminder without appointment	4/22/24 11:15 am	1	Patient	Yes
Colorectal Cancer Screening due reminder without appointment	4/22/24 9:27 am	1	Patient	NO
Colorectal Cancer Screening due reminder without appointment	4/22/24 9:23 am	1	Patient	Yes
Colorectal Cancer Screening due reminder without appointment	4/22/24 9:23 am	1	Patient	Did the colonoscopy Friday April 19
Colorectal Cancer Screening due reminder without appointment	4/22/24 9:22 am	1	Patient	I took it Friday
Colorectal Cancer Screening due reminder without appointment	4/22/24 9:22 am	1	Patient	Yes

Identified Patients:

- To mail a COLOGUARD kit
- Who have completed screenings
- To remove from text campaigns

APO for Colorectal Cancer Screening

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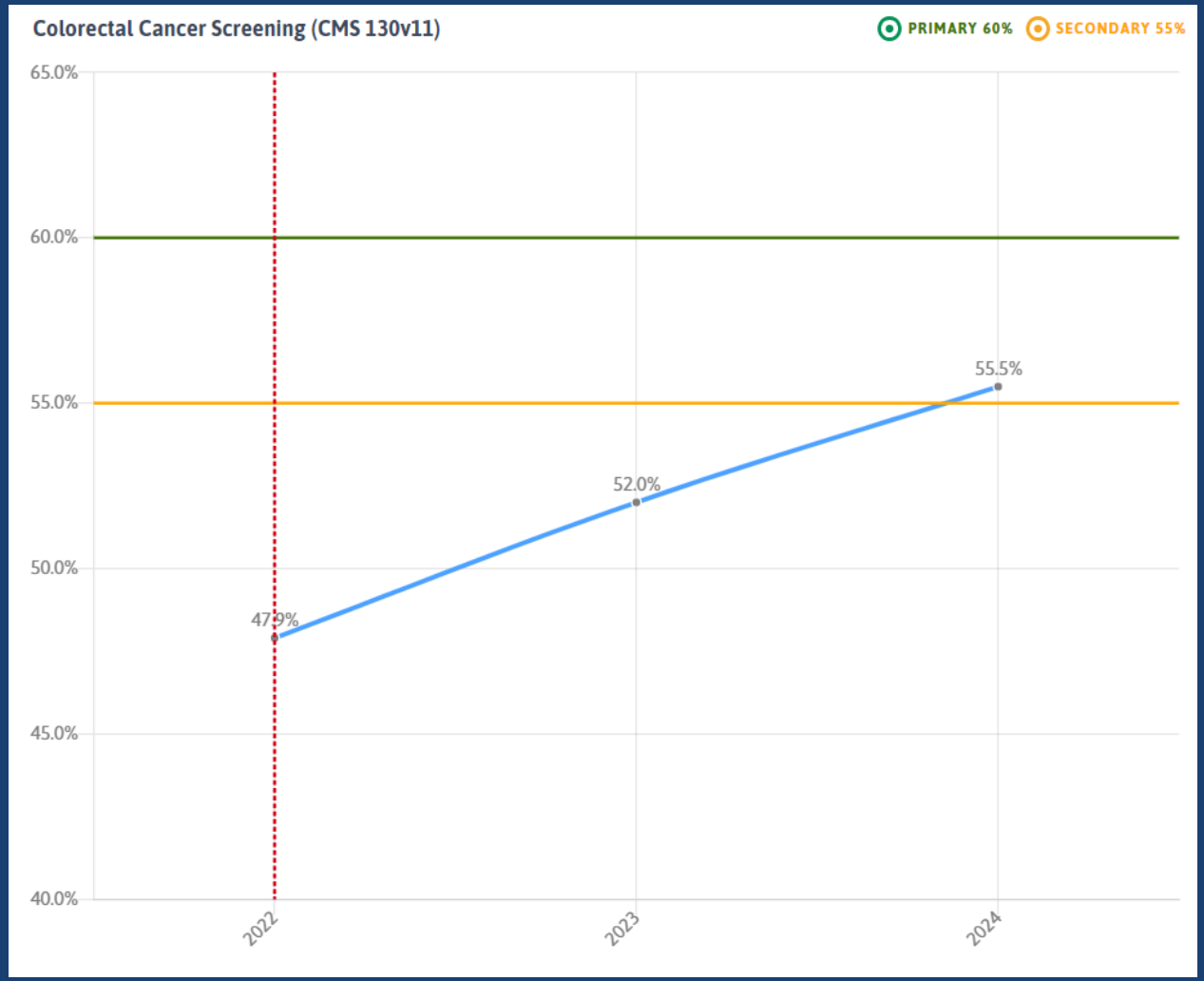
Program Success

419 patients completed CRC screening (12%) since campaign initiation in May 2023

Patients had previously requested kits, but did not have 2023 qualifying encounters scheduled, thus this was an opportunity to re-engaging them in care



MISSOURI PRIMARY CARE ASSOCIATION

DRIVING DRVS

Sarah Judd, CPHQ
Population Health Analyst

Missouri Primary Care Association

Founded in 1984

A network of 28 Community Health Centers with 2 Look-a-Likes across more than 150 sites in Missouri.

Collaborates with state agencies to enhance the ability of its membership to provide and expand comprehensive primary care services.

Works closely with educational institutions to develop the health care workforce needed to care for Health Center patients.

Began connecting to EMRs and connecting to DRVS in 2007.

Driving DRVS

What we hope for….

Driving DRVS

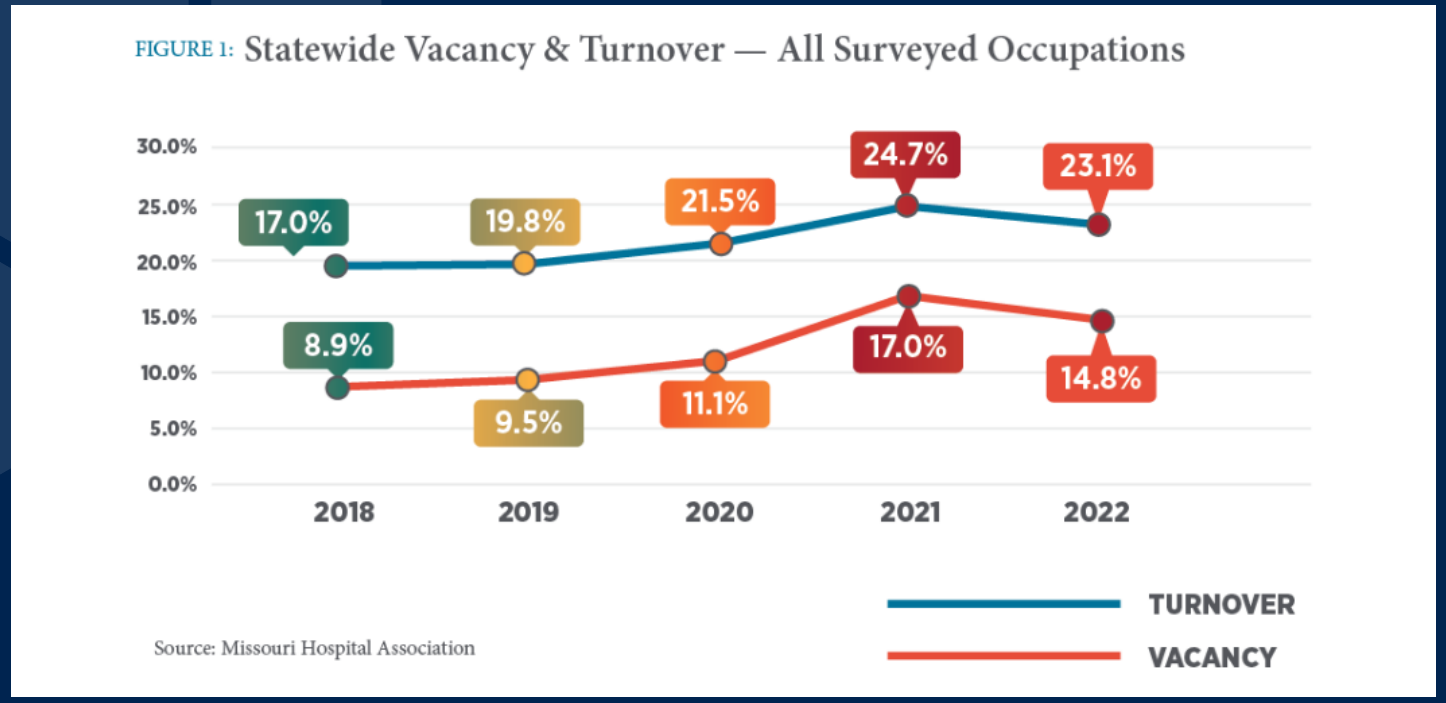
What we sometimes get in rural Missouri with limited internet….

Driving DRVS

During reporting season….


Driving DRVS
A bigger problem….

Orienting an ever-changing class of Student DRV-ers



Initial goal:

Develop a workbook/outline in hopes of providing a valuable tool for onboarding new employees as well as current staff moving into roles that utilize DRVS data.

Driving DRVS

DRVS Administrator(s)	Name	Title/Role	Contact Information

Support Ticket Oversight	Name	Title/Role	Contact Information

Designated for:	Name	Title/Role	Contact Information
Mapping			
Data Validation			
Report monitoring			
Report dissemination			

HC Administrators & Users | Diabetes HbA1c Poor Control | Screening for Depression & FU | Controlling High Blood ...

Driving DRVS

Falls: Screening for Future Fall Risk (CMS 139 v 12)

Percentage of patients aged 65+ years of age who were screened for future fall risk during the measurement period.

Numerator

Patients who were screened for future fall risk at least once during the measurement period, as mapped to either of the following structured clinical data elements
-Falls Screen
-TUG Assessment
-Stay Independent
-Fallen Past Year
-Falls Screen Full Assessment

Denominator

Patients aged 65 years and older with a visit during the measurement period.
-Age >=65 at the start of the measurement period
-Qualifying visit (see Technical Specifications) in the last 12 months

Exclusions

Patients with hospice care for any part of the measurement period

Workflow
Do you have an alert for this measure enabled on your PVP?
How often is Fall risk assessed?
Who is completing the assessment?
Where is the result located in the EMR?
How is the result mapped in DRVS?
Reporting
Who is running measure numbers?
Who is contacted if an issue is noted?
Who is auditing this measure and at what frequency?
Who should receive reports?

Driving DRVS

Hemoglobin A1c Control for Patients with Diabetes- Poor Control
Members 18-75 years of age with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) were at poor control levels (>9.0%) during the measurement year.

Numerator
Members whose most recent HbA1c result is >9, or the result is missing, or there was no HbA1c test during the measurement year

Denominator
Members 18-75 years of age.
-Age >=18 and <=76 years by the end of the measurement period.

-Members with diabetes, as identified by claim/encounter data or pharmacy data during the measurement year or the year prior to the measurement year.

-Members have at least one active enrollment during the measurement period

Exclusions
-Members who died any time during the measurement year
-Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
-Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
-Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File.
-Members 66 years of age and older as of December 31st of the measurement year with frailty and advanced illness.
-Members who did not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.
-Members in hospice or using hospice services anytime during the measurement year
-Members receiving palliative care during the measurement year.

Workflow

Do you have an alert for this measure enabled on your PVP?
Which staff member is responsible for completing the lab draw?
Is this a POC test or is it sent to an outside lab?
If sent to an outside lab, which lab?
If resulted by an outside lab, how are these results integrated into your EMR?
Where is the result located in the EMR?
How is the result mapped in DRVS?

Reporting

Who is running measure numbers?
Who is contacted if an issue is noted?
Who is auditing this measure and at what frequency?
Who should receive reports?

Just a workbook?

A very basic idea put into practice led to unintended benefits:

Enhanced communication

Optimized existing workflows

Developed new process and workflows

Adjusting Our Sails, Enhancing Hypertension Management

Felicia Scroggs, RN, Population Health Manager

Amite County Medical Services, Inc.

azara 2024

Amite County Medical Services, Inc.

azara 2024

- Opened in July 1980.
- Second community health center in Mississippi to be accredited by the Joint Commission in 2001.
- Primary Care Medical Home accredited in 2013.
- 2 Medical Clinics, 1 Dental Clinic, 2 mobile units.

Liberty, Mississippi

2021 Controlled Hypertension Compliance

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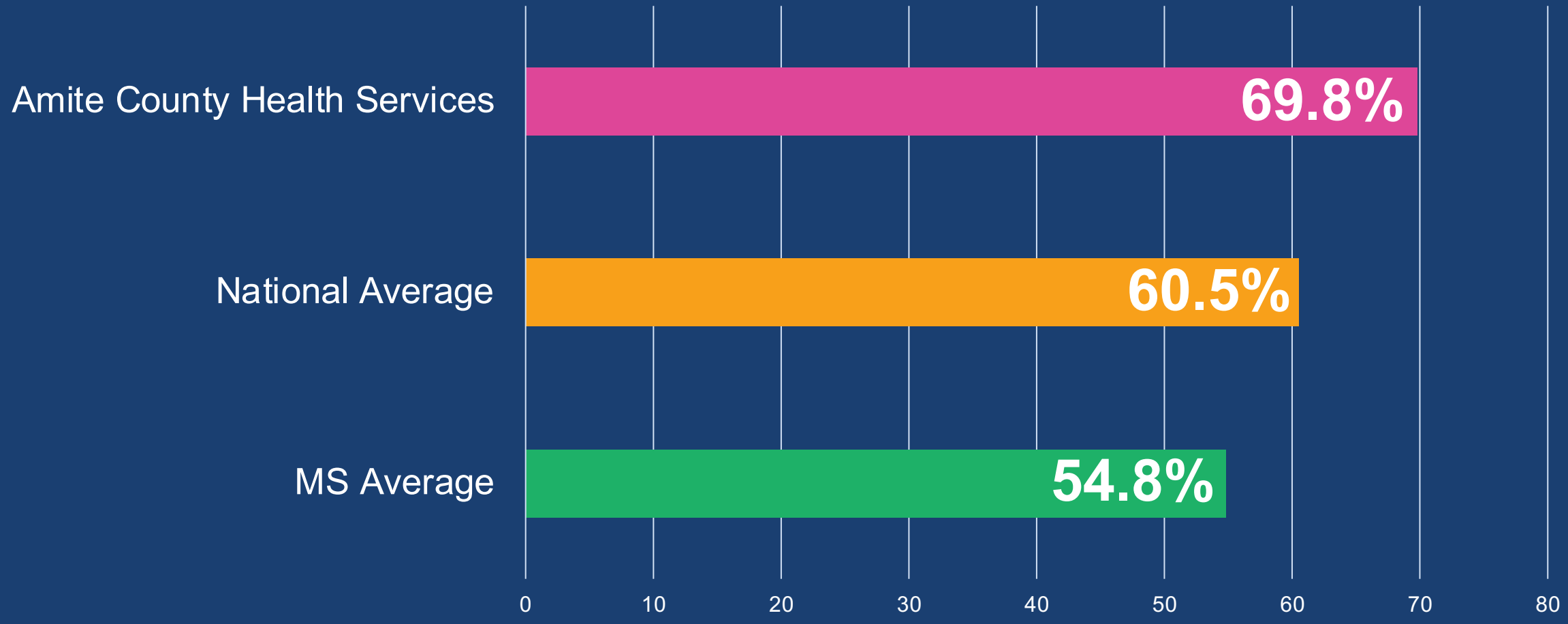
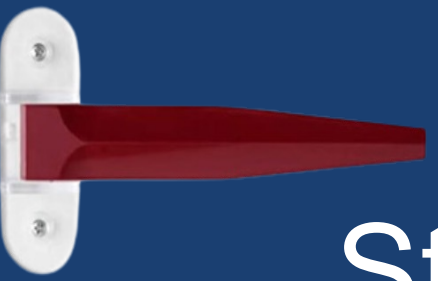




Streamlining Our Workflows

RED DOOR HANGER WORKFLOW

WHO

- Every member of the TEAM!

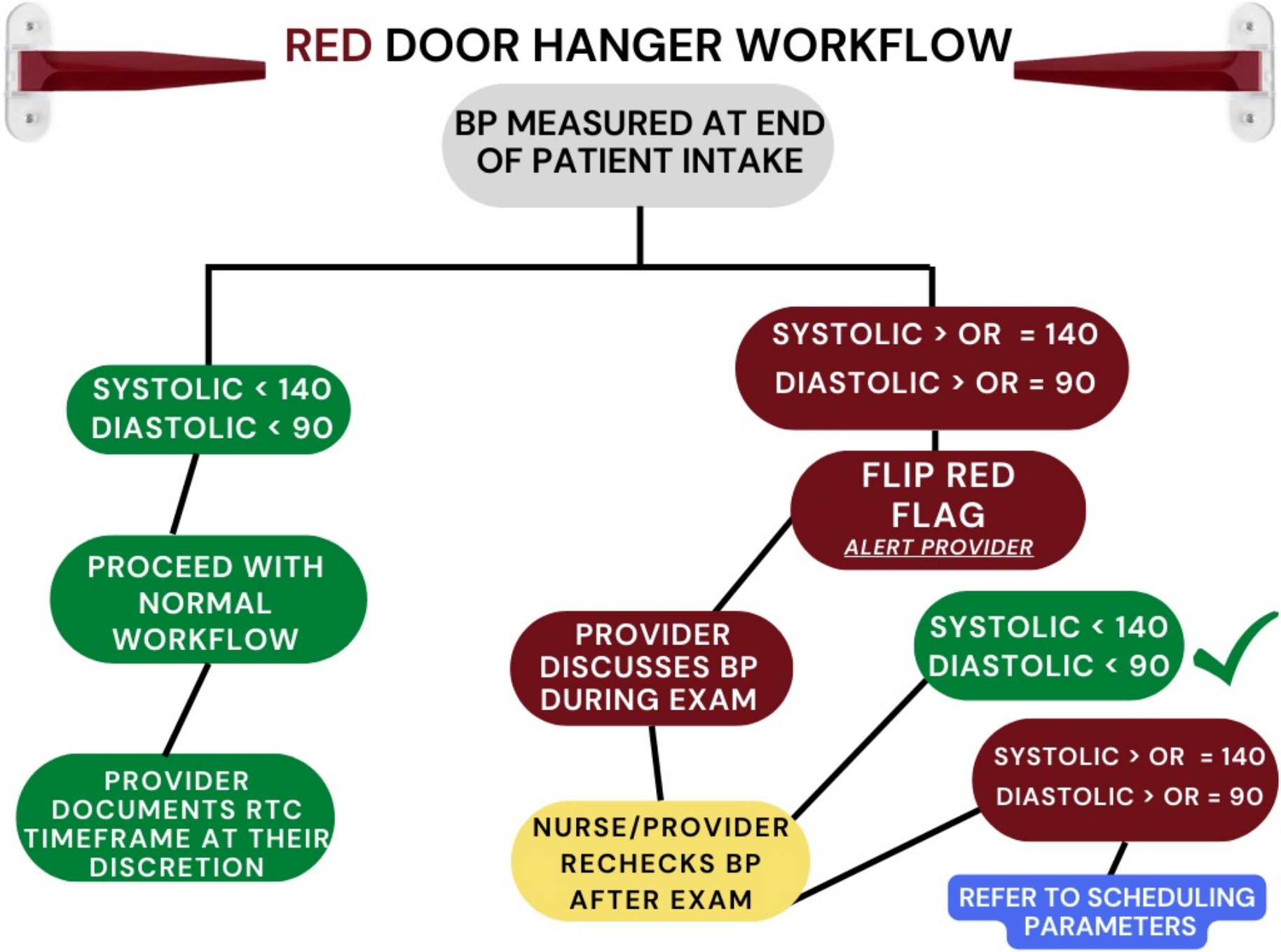
WHAT

- The Red Door Hanger Workflow is a simple yet effective way to ensure patients with elevated blood pressure have accurate measurements and timely follow-up.

WHY

- Everyone involved in the patient's care is made aware of the elevated BP.
- The Provider is reminded to discuss the elevated BP with the patient during the visit and provide education as well as modification of the care plan.
- Every patient with an elevated BP greater than or equal to 140/90 will be scheduled for a follow-up appointment ***prior*** to leaving the office. Follow-up is recommended to be within two (2) weeks if the patient's BP is greater than or equal to 160/100 or within 30 days if greater than or equal to140/90.

Red Door Hanger Workflow



Putting the Pieces Together

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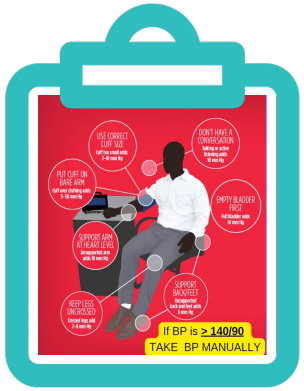
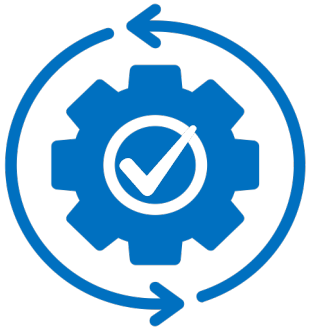


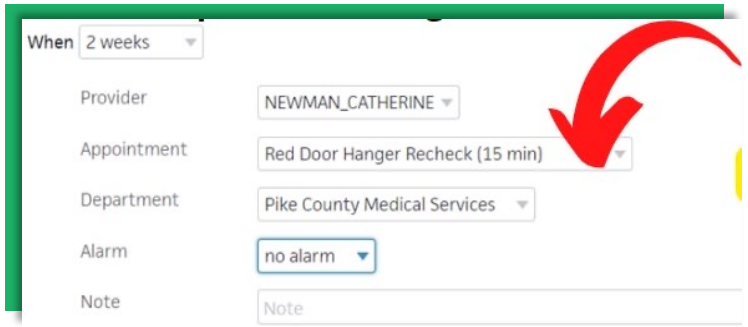
Instructional Posters

Red Exam Room Flags

Introduced a No-Show Process

New Appointment Type





Custom Registry

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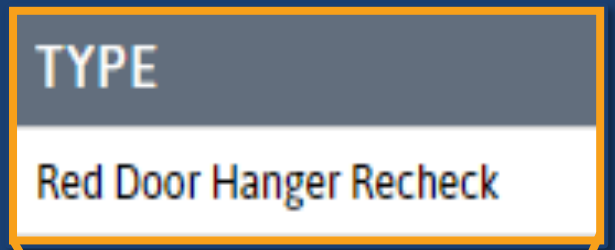
Red Door Hanger Patients
REGISTRY

BP VALUES 1ST			BP VALUES 2ND			NEXT APPOINTMENT			
DATE	SYSTOLIC	DIASTOLIC	DATE	SYSTOLIC	DIASTOLIC	DATE	PROVIDER	TYPE	REASON
2/21/2024	153	80	2/21/2024	167	82	3/11/2024	NEWMAN, CATHERINE	Red Door Hanger Recheck	RED DOOR HANGER



Filter the **"Appointment Type"** column to identify patients coming in for Red Door Hanger Rechecks

Hypertension Control Improvement

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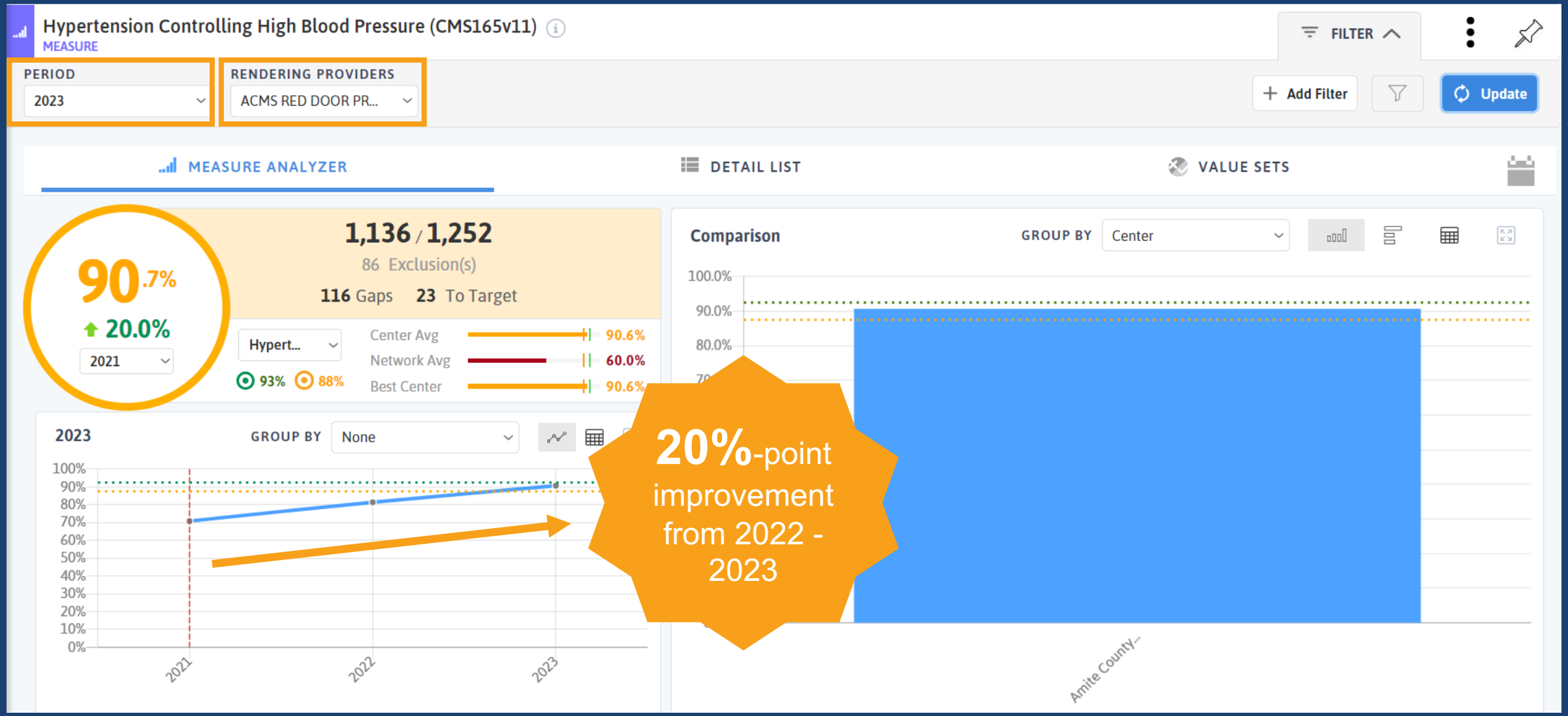

Questions?

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Azara Healthcare

@AzaraDRVS

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We Want to Hear From You!

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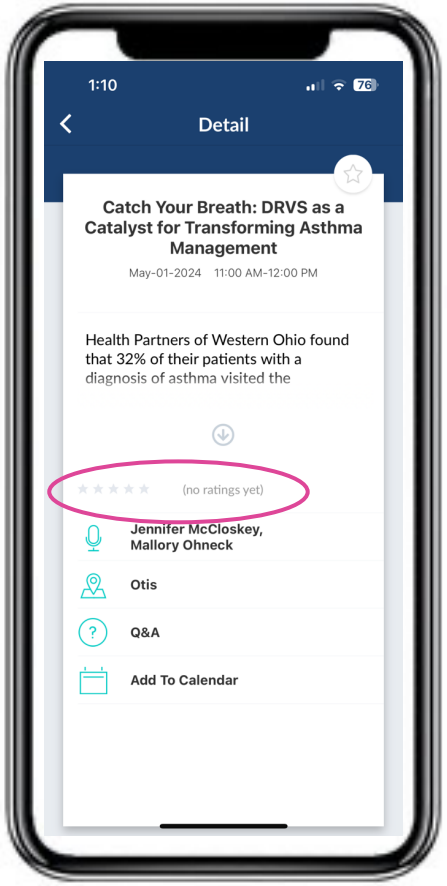
Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy

Provide brief feedback or ideas

Rate the session and the speaker(s)

Help us continue to improve

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Thanks for attending!