HTN & Home Blood Pressure: How to Raise Your SMBP Program to Lower Blood Pressure

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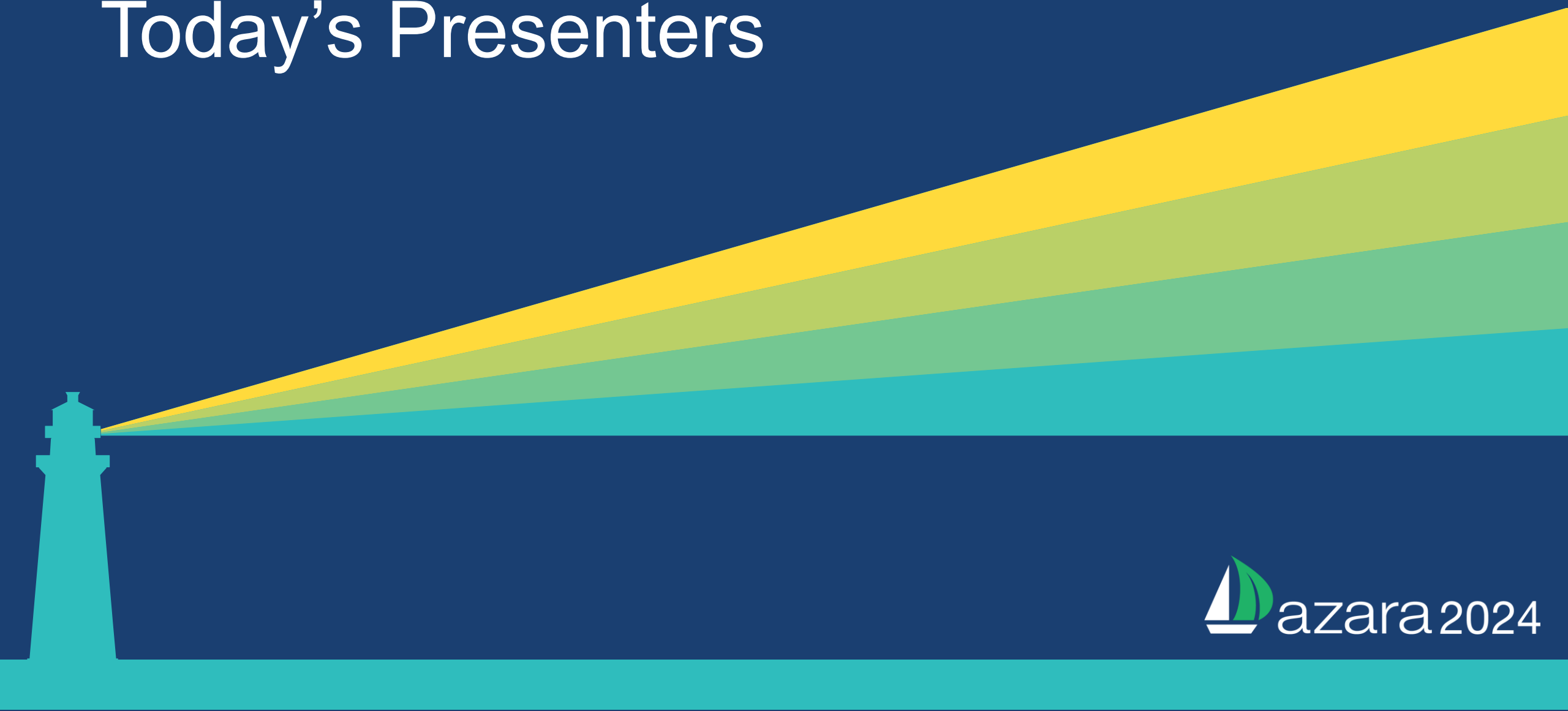
USER CONFERENCE APR 30–MAY 2 | BOSTON, MA

Today’s Presenters



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Azara Healthcare

Agenda

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QUALITY IMPROVEMENT & HTN

SECRETS TO SMBP SUCCESS

DRVS TOOLS & SUPPORTS

QUESTIONS

CareSTL Health

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CareSTL Health

Getting Aboard: Quality Improvement for Hypertension

CareSTL Health | Missouri

5 primary locations in St. Louis, MO

Multiple School-based Sites

Services: Adult Medicine, Women's Health, Pediatrics, Optometry, Behavioral Health, Dental And Chiropractic

Onsite Laboratory, Radiology, and Pharmacy

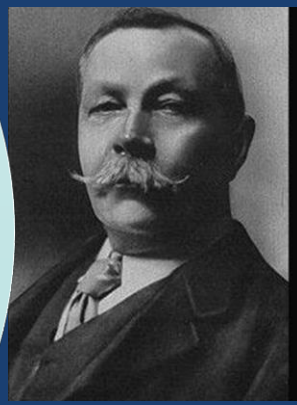
Why Quality Improvement?

High Value Metrics

High Impact Metrics

Improved Outcomes

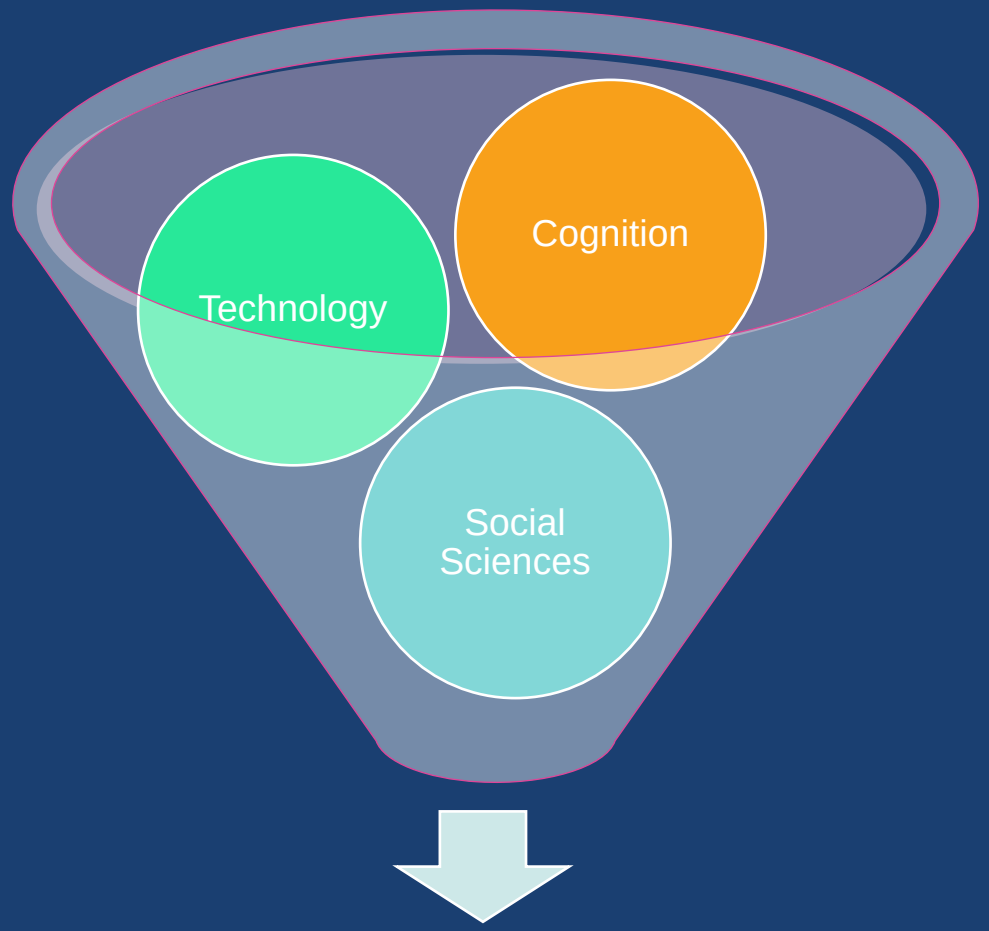
- Proven Methodologies
- Data driven decision making



I never guess. It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts.

(Arthur Conan Doyle)

The Role of Informatics in QI



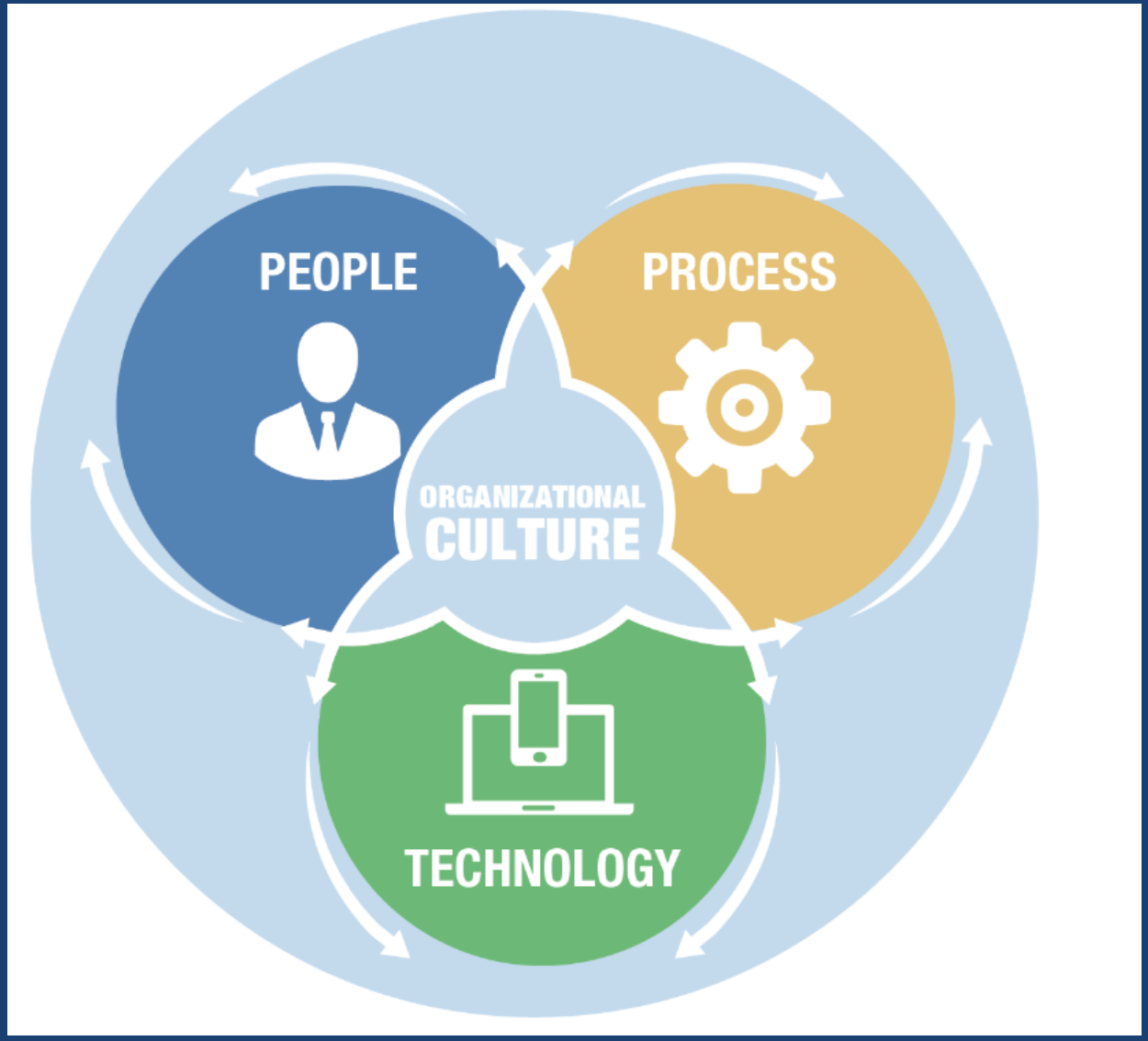
EHR Configuration (input)

Data Integrity (output)

Improved Usability

Accurate & Reliable Data

2023: Laying The Foundation



Combining Quality AND Informatics

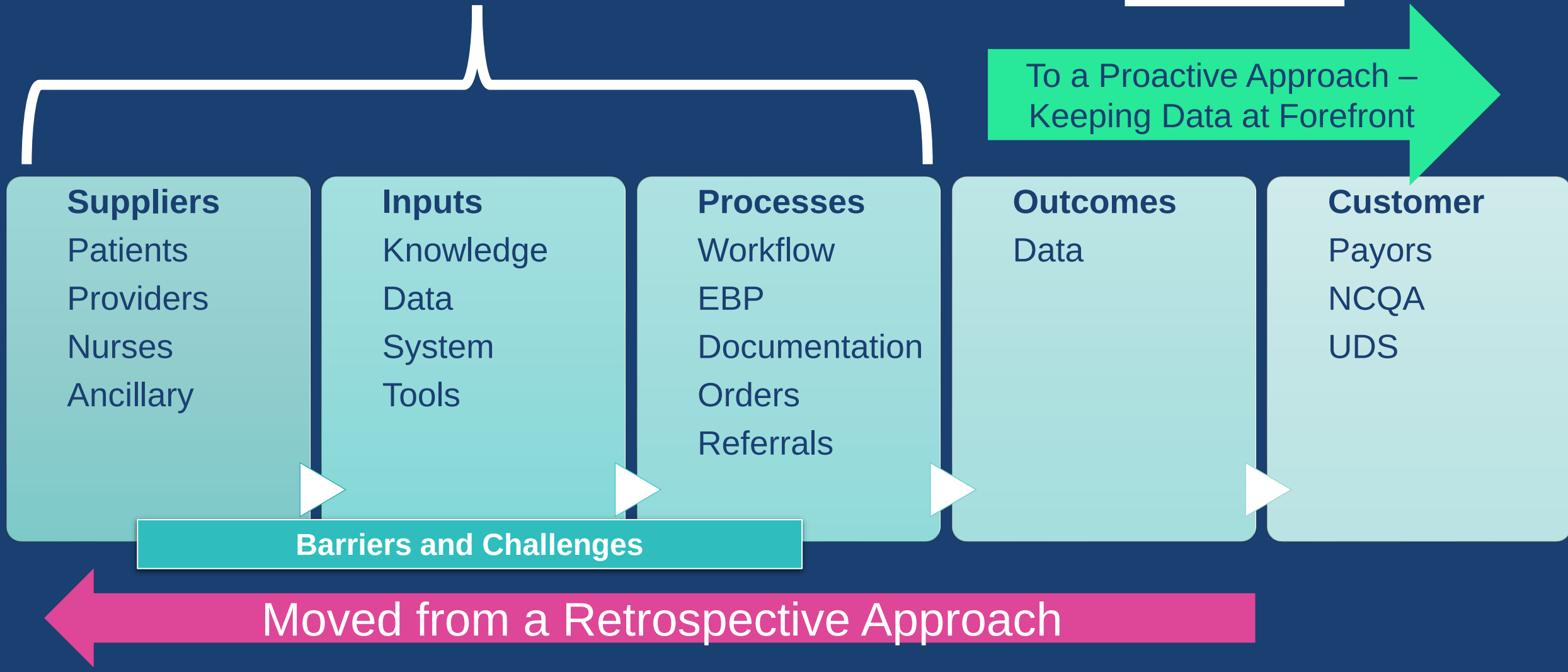
Quality Improvement

- Proven Methodologies
  - Lean Six Sigma
- Data-Driven Decision Making
  - Outcome & Process Metrics

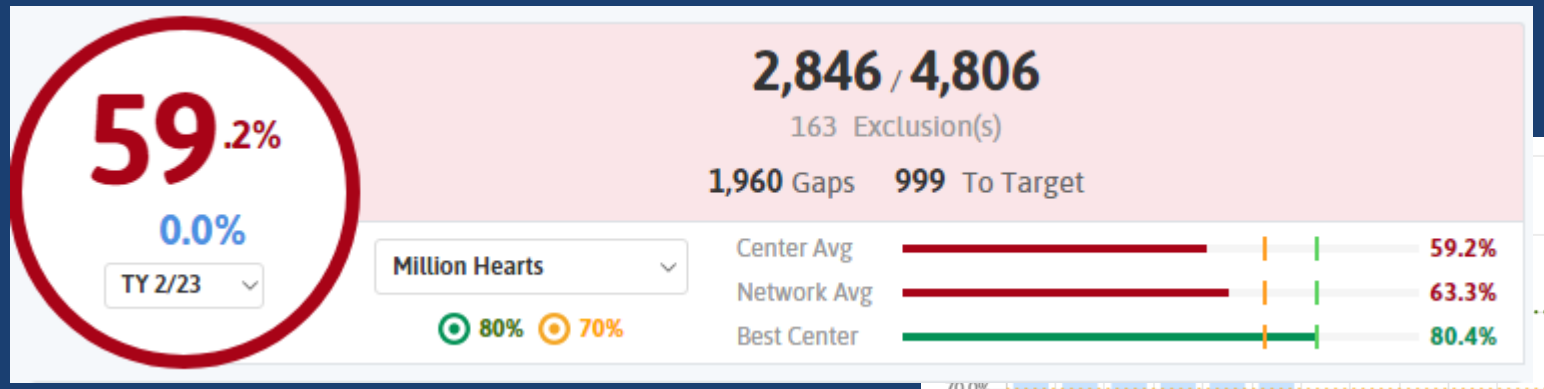
Health Informatics

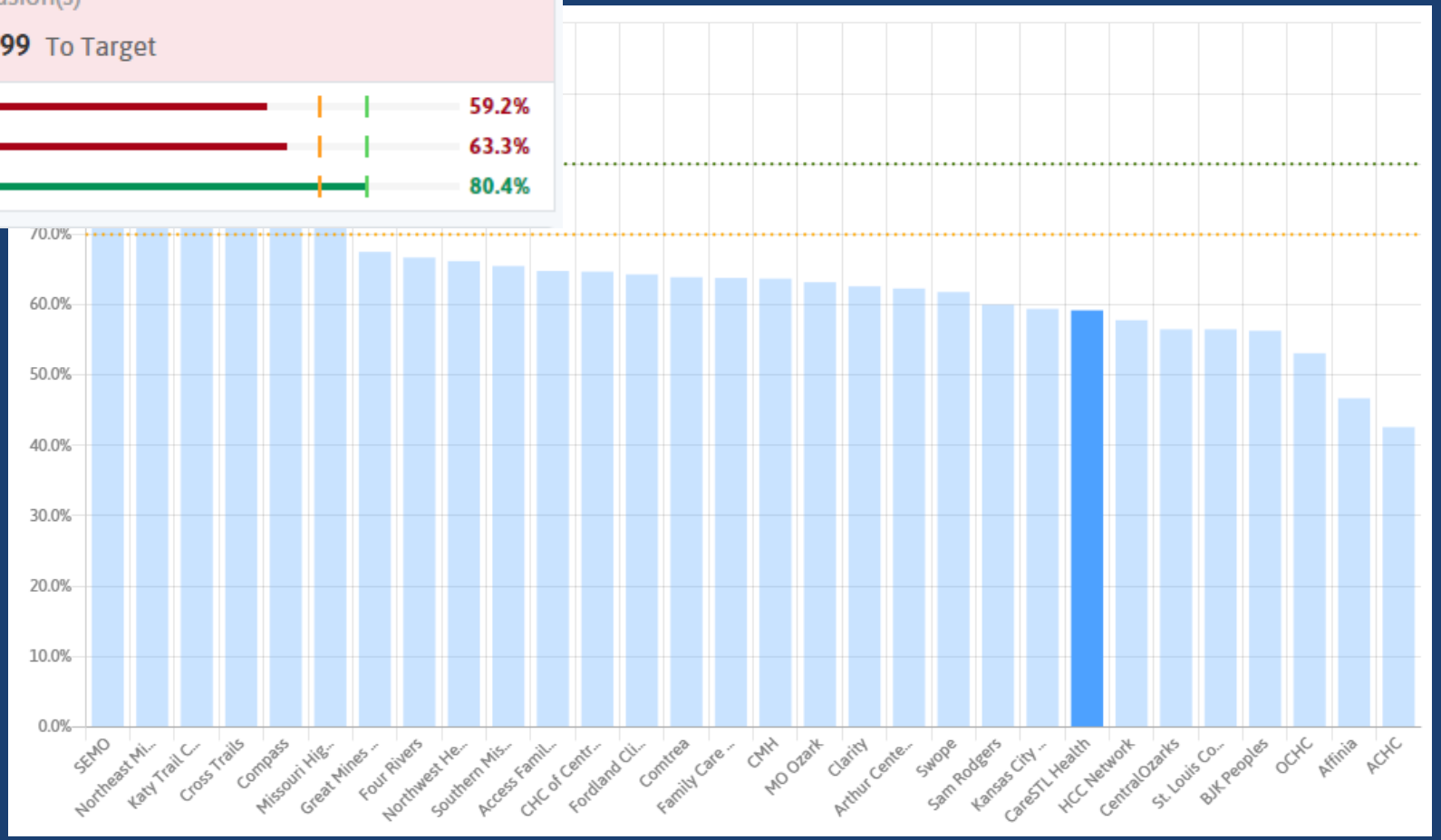
- EHR Configuration (input)
  - Improve Usability
- Data Integrity (output)
  - Accurate & Reliable

Leveraging Quality + Informatics



Baseline
HTN Controlling High Blood Pressure





Department / Provider Scorecards

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MEASURE	RESULT	TARGET	DENOMINATOR	TO TARGET
Diabetes A1c > 9 or Untested (CMS 122v10)	24.5%	25.0%	485	0
Diabetes A1c Tested in the past year (CMS 122v11 Modified)	90.3%	90.0%	485	0
Hypertension Controlling High Blood Pressure (CMS165v11)	70.4%	80.0%	1,010	97
Hypertension Controlling High Blood Pressure - No Blood Pressure Taken (CMS 165v11 Modified)	0.0%	0.0%	1,010	0
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v6)	87.1%	84.0%	597	0
Breast Cancer Screening Ages 50-74 (CMS 125v11)	60.6%	60.0%	523	0
Colorectal Cancer Screening (CMS 130v11)	36.6%	25.0%	1,080	0
Cervical Cancer Screening (CMS 124v11)	57.2%	54.0%	481	0
Screening for Depression and Follow-Up Plan (CMS 2v12)	93.0%	50.0%	1,237	0
Tobacco Use: Screening and Cessation (CMS 138v11)	92.3%	75.0%	1,377	0
HIV Screening (CMS 349v5)	46.5%	57.0%	1,147	121
Documentation of Current Medications in the Medical Record (CMS 68v8)	97.7%	80.0%	1,326	0
I/P Readmission (30 days)	19.0%	*Not Set*	21	

PVP To Support Daily Huddles

2:45 PM Thursday, February 22, 2024 — **Visit Reason:** F/U

PCP: ALDRIDGE, AMBER
Payer: UHC Community
Medicaid HMO
CM: Hammonds, Carla

DIAGNOSES (3)

Anxiety	DM	HTN-E

RISK FACTORS (1)

ASCVD High (22.98)

SDOH (2)

INSURANCE	RACE

RAF GAPS DIAGNOSIS CATEGORIES (2)

Vascular Disease	Gastro

ALERT	MESSAGE	DATE	RESULT
Colon CA 45+	Missing		
A1c	Overdue	10/27/2022	4.9
LDL	Overdue	10/27/2022	115
Fall Risk Scr	Missing		
BMI & FU	Missing Follow-up	5/16/2023	Highest BMI: 28.03 (05/16/2023); Lowest BMI: 25.37 (02/22/2024)
BP	Out of Range	2/22/2024	157/85
PCV Older Adult	Due 1		Due: PCV20 or PCV15 | Date: 3/30/2024
Eye	Missing		
Foot	Missing		

Education & Training Resources | Blood Pressure

Measure blood pressure accurately, every time.

Accurate measurement and recording of BP is essential to categorize level of BP, ascertain BP-related CVD risk, and guide management of high BP.

Measure Accurately

ACT rapidly to address high blood pressure readings.

Take rapid action and follow treatment protocols to bring BP under control.

Act Rapidly

PARTNER with patients, families, and communities to promote self-management and monitor progress.

Improve adherence to treatment and lifestyle changes through collaborative communication and follow-up visits.

Partner With Patients

For more information click here

AMA MAP™ Hypertension

2024 Quality Improvement Approach

Process Mapping > Identify Barriers/Challenges > Strategies for Improvement

Suppliers
- Patients
- Providers
- Nurses
- Pharmacy
- Education
- Outreach
- Health Home
- Behavioral Health
- CHW's
- Payors

Inputs
- High BP readings
- Medication Adherence
- Treatment Plan
- SDOH
- SMBP
- Staffing
- Clinical Rule Engine
- Pre-Visit Planning

Process
- Huddles
- Repeat BP*
- Call pts regarding refill scripts
- SMBP
- Patient Education
- Referrals
- Follow up Appointment
- Medication Intensification
- CPT Coding

Outputs
- Hypertension Controlling High Blood Pressure (CMS 165v11)

Customer
- ACO
- MCO
- Other Payors
- NCQA
- UDS

Lean Six Sigma | Process Improvement

Dashboard | Monitor Outcome & Process

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Hypertension Controlling High Blood Pressure

70.4%

% HTN Pts with BP <140/90

PRIMARY 80% SECONDARY 70%

+6.4% ▲

Oct 23

Hypertension (by Facility)

RENDERING LOCATIONS	RESULT	DENOMINATOR	TO TRGT
CareSTL Health W Florissant	100.0%	3	0
CareSTL Health Pope	79.8%	178	1
CareSTL Health Riverview	74.4%	117	7
CareSTL Health	71.9%	562	46
CareSTL Health Whittier	60.3%	219	44

Repeat BP (by Facility)

RENDERING LOCATIONS	RESULT	DENOMINATOR	TO TRGT
CareSTL Health Whittier	98%	101	0
CareSTL Health	95%	237	0
CareSTL Health Pope	95%	65	0
CareSTL Health Riverview	94%	50	0

Hypertension (by Provider)

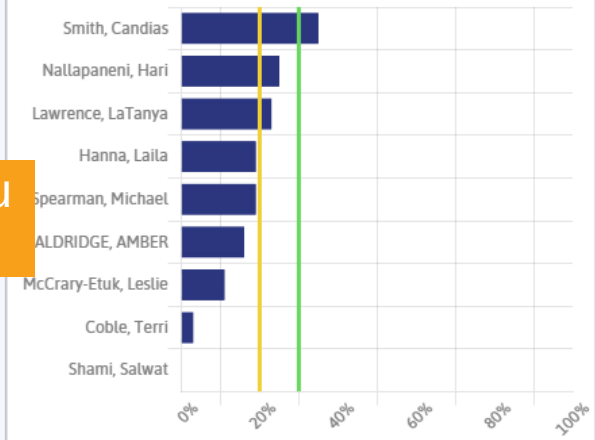
RENDERING PROVIDERS	RESULT	DENOMINATOR	TO TRGT
Hanna, Laila	81.9%	144	0
Coble, Terri	80.7%	171	0
Smith, Candias	76.0%	75	3
Shami, Salwat	70.7%	41	4
Spearman, Michael	69.6%	112	12
Lawrence, LaTanya	66.9%	136	18
Nallapaneni, Hari	65.2%	23	4
ALDRIDGE, AMBER	60.7%	107	21
McCrary-Etuk, Leslie	59.6%	208	43

HTN Follow Up Visit (by Provider)

RENDERING PROVIDERS	RESULT	DENOMINATOR	TO TRGT
ALDRIDGE, AMBER	50%	74	0
Smith, Candias	48%	48	1
Shami, Salwat	44%	25	2
Lawrence, LaTanya			
Nallapaneni, Hari			
Hanna, Laila			
Spearman, Michael	17%	69	23
Coble, Terri	16%	87	30
McCrary-Etuk, Leslie	13%	141	52

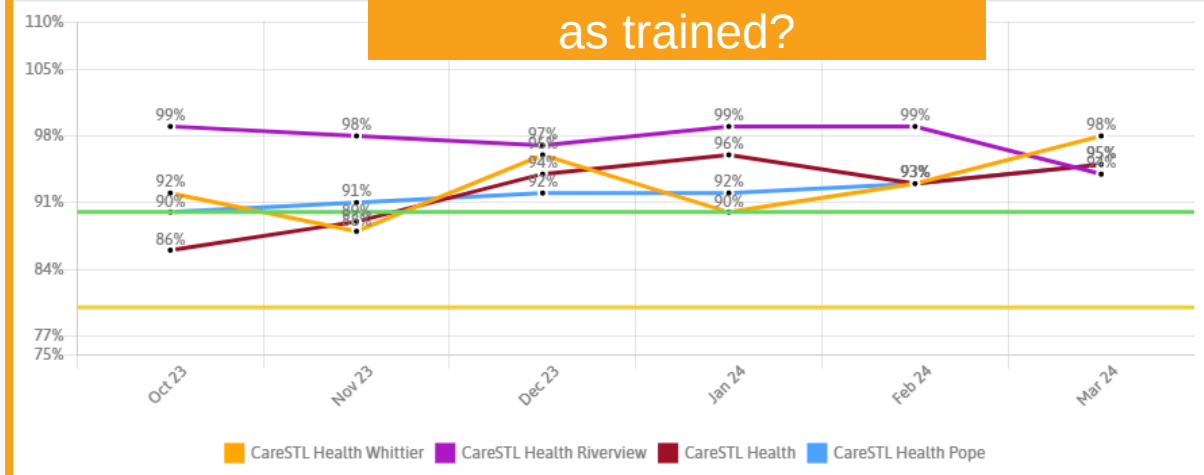
Are pts getting f/u visit?

HTN Medication Intensification (by Provider)



Repeat BP (by Facility) Trending

Are staff taking repeat BPs as trained?



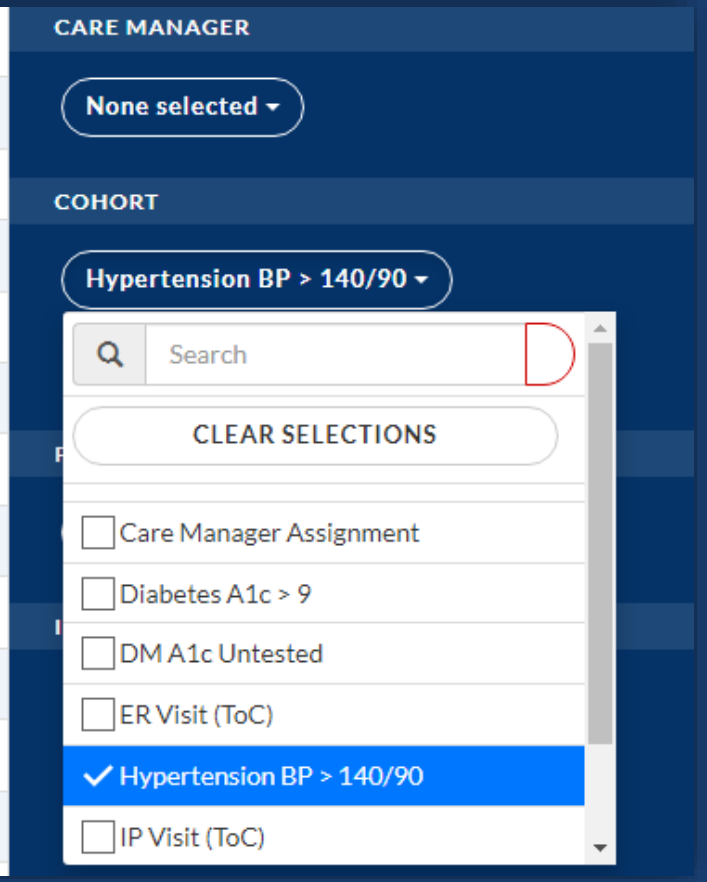
HTN-Improvement in Blood Pressure

RENDERING PROVIDERS	RESULT	DENOMINATOR
Hanna, Laila	57%	40
McCrary-Etuk, Leslie	49%	59
Lawrence, LaTanya	45%	33
Coble, Terri	42%	31
ALDRIDGE, AMBER	32%	19
Smith, Candias	31%	13
Spearman, Michael	31%	32
Shami, Salwat	30%	10
Nallapan		

How are we improving?

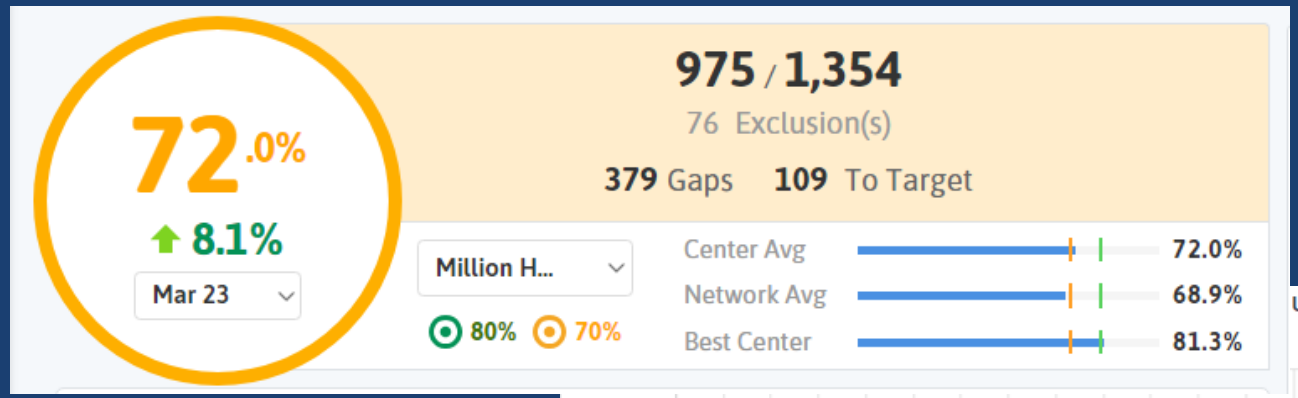
Azara Care Connect

5/15/24 10:00 AM	THOMPSON, BETTY	Care Manager Assignment, Hypertension BP > 140/90, PCHH
4/26/24 11:30 AM	Unassigned	Hypertension BP > 140/90
7/10/24 2:15 PM	Unassigned	Hypertension BP > 140/90
4/1/24 1:00 PM	Unassigned	Hypertension BP > 140/90
3/28/24 12:45 PM	Unassigned	Hypertension BP > 140/90
5/6/24 9:30 AM	Unassigned	DM A1c Untested, Hypertension BP > 140/90
	Unassigned	Hypertension BP > 140/90
4/1/24 3:30 PM	Unassigned	Hypertension BP > 140/90
	Unassigned	DM A1c Untested, Hypertension BP > 140/90
4/8/24 3:30 PM	Unassigned	Hypertension BP > 140/90
	Unassigned	Hypertension BP > 140/90
4/1/24 9:15 AM	JOHNSON, ALICE	Care Manager Assignment, Hypertension BP > 140/90, PCHH

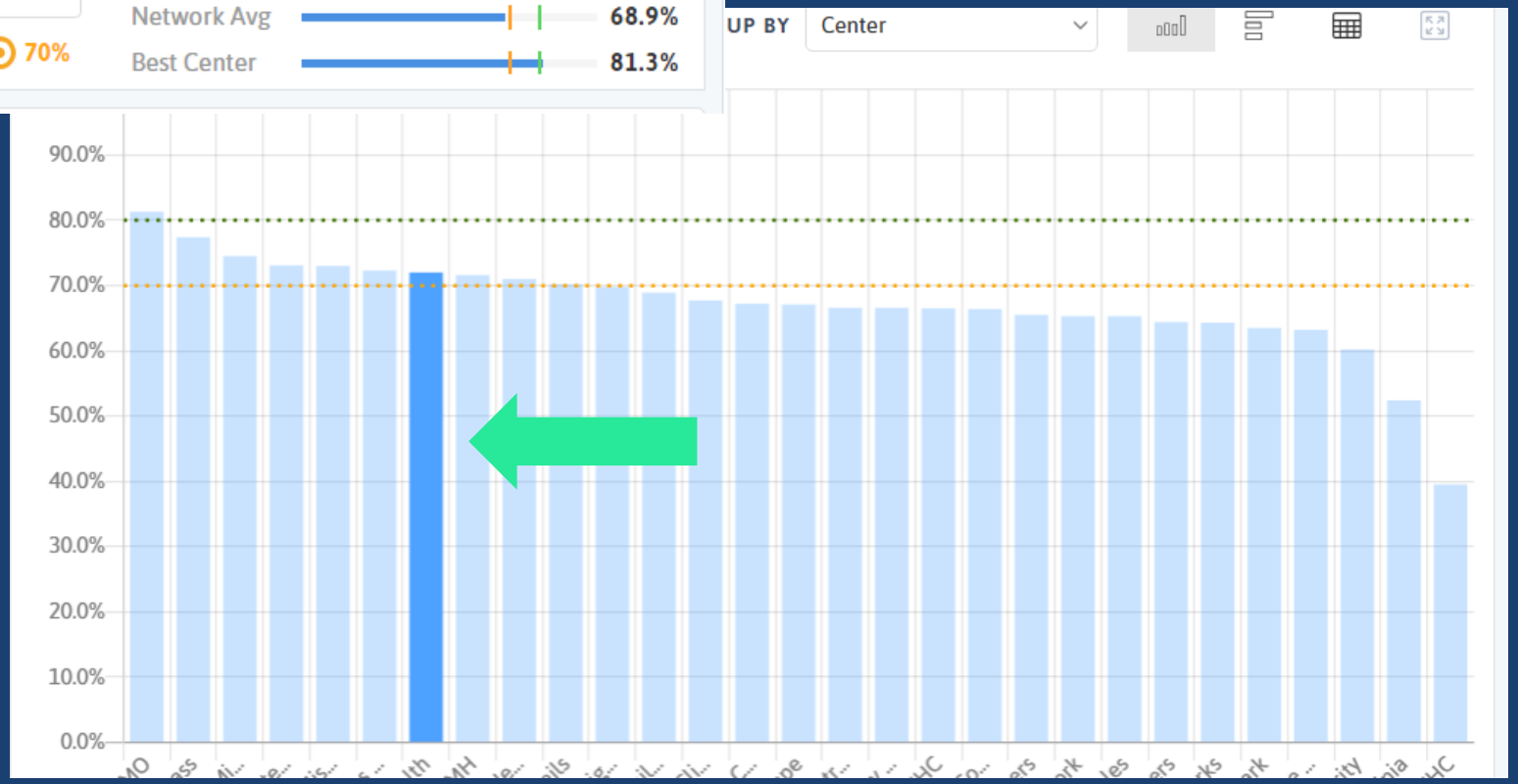


Improvement Results

Hypertension Controlling High Blood Pressure (CMS165v11)
MEASURE



21.6% Increase!



Current State | Monitoring Metrics

- Repeat Blood Pressure INCREASE by 26%
- 1 Facility meeting Million Hearts goal
- 3 Facilities meeting Target BP goal
- **975** patients met goal vs. 750 same period 2023
- Implementing PCC in focus clinic

Getting There!

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Setting Sail with Self-Monitoring Blood Pressure (SMBP) Success

Self-Monitoring BP Workflow

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1. Identify the patient as eligible and interested

Proper positioning and technique

Use of an app that gathers average BP and curates in a clinical portal

2. Issue a device with an appropriately sized cuff. Teach the patient how to use the device

Assign outreach responsibilities to Care Managers, CHWs, Medical Assistants

3. Provide regular patient contact through remote monitoring and telehealth visits

RN or Clinical Pharmacist perform titration visits

4. Perform treatment intensification based on an algorithm and monitoring

Patient stays engaged until BP<130/80

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Identifying The Why

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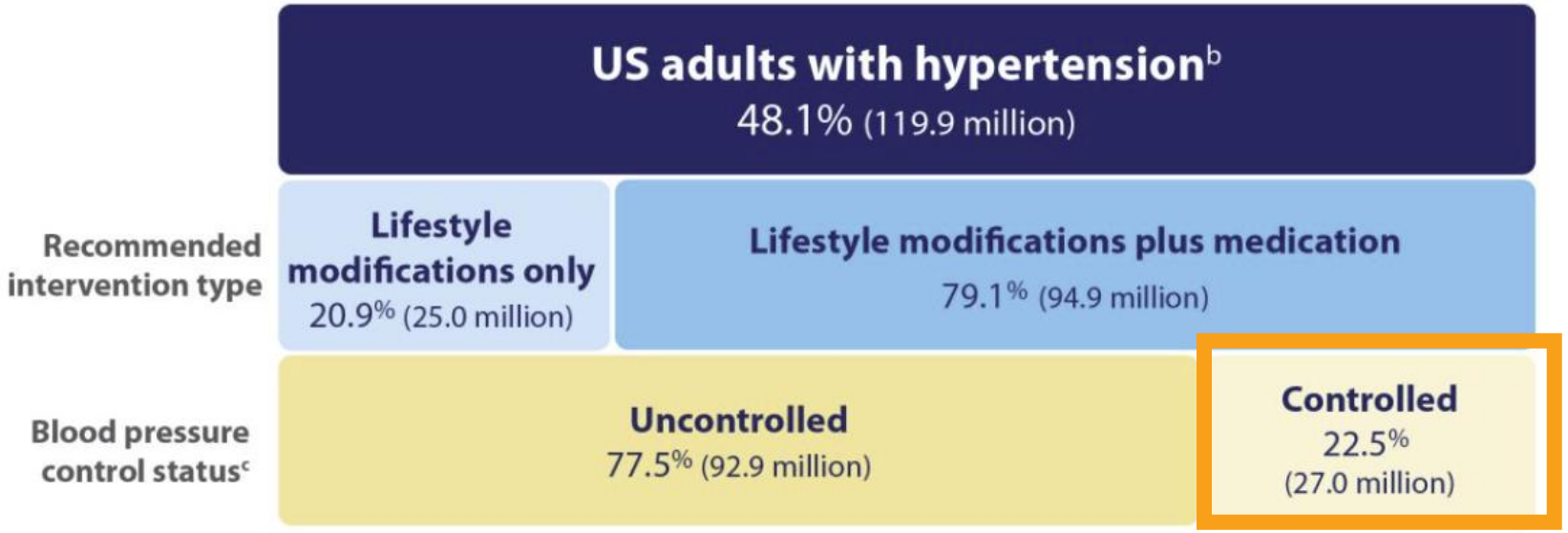
Estimated Hypertension Prevalence, Treatment, and Control (Blood Pressure <130/80 mm Hg) Among US Adults[a]

Applying the criteria from the American College of Cardiology and American Heart Association's (ACC/AHA) 2017 Hypertension Clinical Practice Guideline - NHANES 2017- March 2020



Data source: National Center for Health Statistics, Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES) 2019-March 2020. Definitions: ACC/AHA criteria adapted from Ritchey MD, Gillespie C, Wozniak G, et al. Potential need for expanded pharmacologic treatment and lifestyle modification services under the 2017 ACC/AHA Hypertension Guideline. *J Clin Hypertens*. 2018; 1377-1391. https://doi.org/10.1111/jch.13364

[a] Among adults aged 18 years and older; estimates may not equal 100% due to rounding.
[b] Blood pressure ≥130/80 mm Hg or currently using prescription to lower blood pressure.
[c] Controlled is defined as having a blood pressure <130/80 mm Hg. All adults recommended lifestyle modifications only are considered uncontrolled as their blood pressure is above the threshold.

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Shifting The Culture | BP Management

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Usual Care

- In office Blood Pressure only source of data
- Infrequent contact with patient (in person encounters)
- Therapeutic Inertia
- Start low, go slow

SMBP Plus

- Between visit contact maximizing telehealth
- Improved, accurate, frequent, actionable data
- Team based care
- Encourages SPC and intensification.

Make the default the right thing to do.

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Shifting The Culture | Team Approach

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Usual Care

- Limited access to PCP visits
- SDOH challenges impeding access to care
- Medication side effects may go unaddressed
- Care done to the patient, not with the patient

SMBP plus

- Fewer access challenges
- Empowers and engages the patient in their own care
- Team helps to enhance connection to community resources and behavior change support

Make the default the right thing to do.

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Value Proposition

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Improved provider, staff and patient satisfaction

Care Team performs at the top of their abilities/licensure

Improved HTN control, reduced CVD risk

Models team-based chronic condition management

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Common Challenges For SMBP Programs

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Cost

- Device coverage/ reimbursement
- Device sourcing/ validated devices
- Data storage

Staff

- Resistance to change among providers and other members of the team
- Maintaining staffing

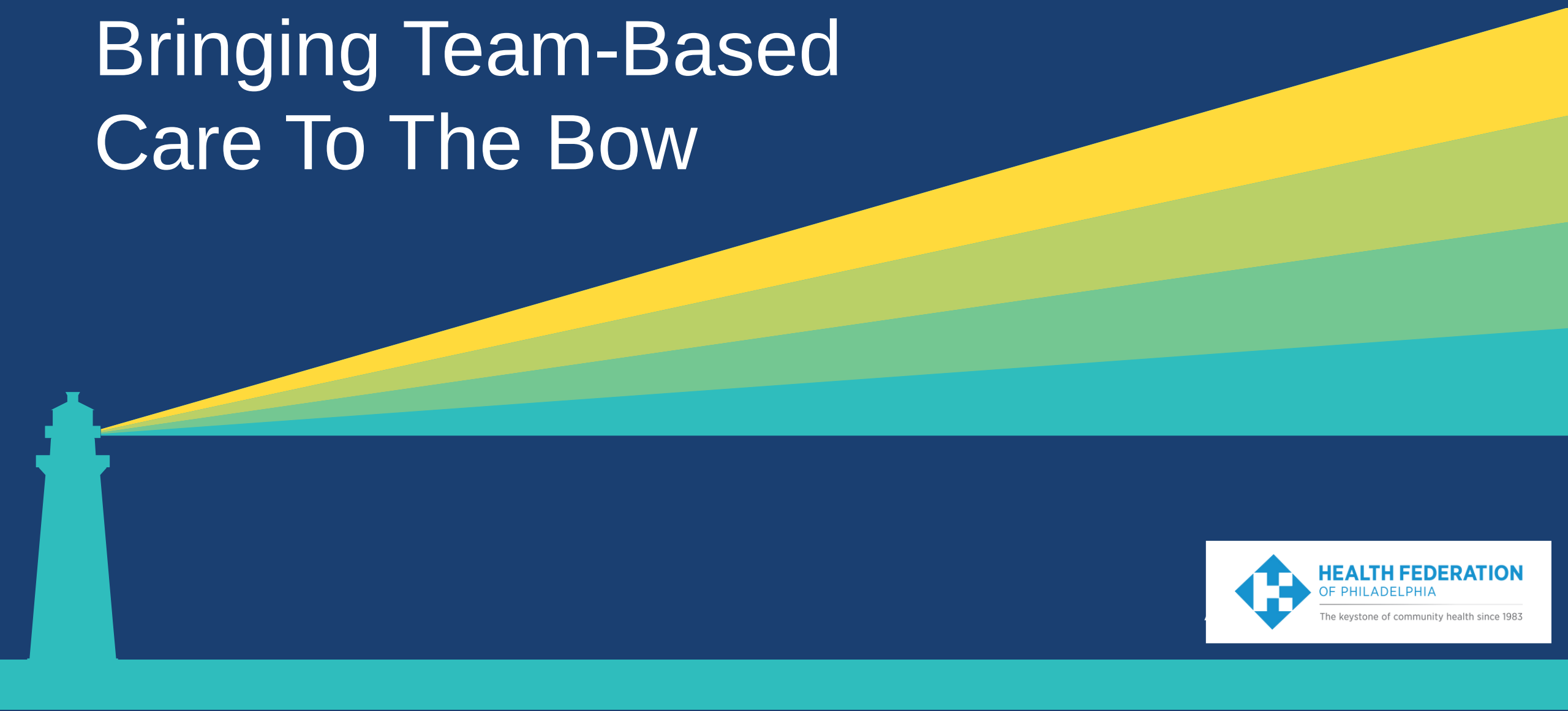
Technology

- EHR limits – Integration
- Broadband access for patients
- Access to SmartPhones for patients

Data

- Misalignment of quality metrics

Bringing Team-Based Care To The Bow



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Interdisciplinary Care Team Model

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Use a team-based, interdisciplinary model with clearly defined roles and responsibilities

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Generic Clinical Workflow | Phases 1 & 2

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Phase 1: Referral & Enrollment

Pt presented with elevated BP

MA executes standing order for SMBP

Pt meets with enrollment team and enrolled in SMBP

Patient-facing app downloaded

Pt Enrolled

Phase 2: Monitoring

Pt submits BPs as directed

NO

YES

Monitoring staff contacts patient

Monitoring staff sends encouraging text messages to pt

Schedules pt for telehealth f/u visit with management staff

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Generic Clinical Workflow | Phase 3 & 4

Phase 3: Treatment Intensification

Phase 4: Stabilization & Goal

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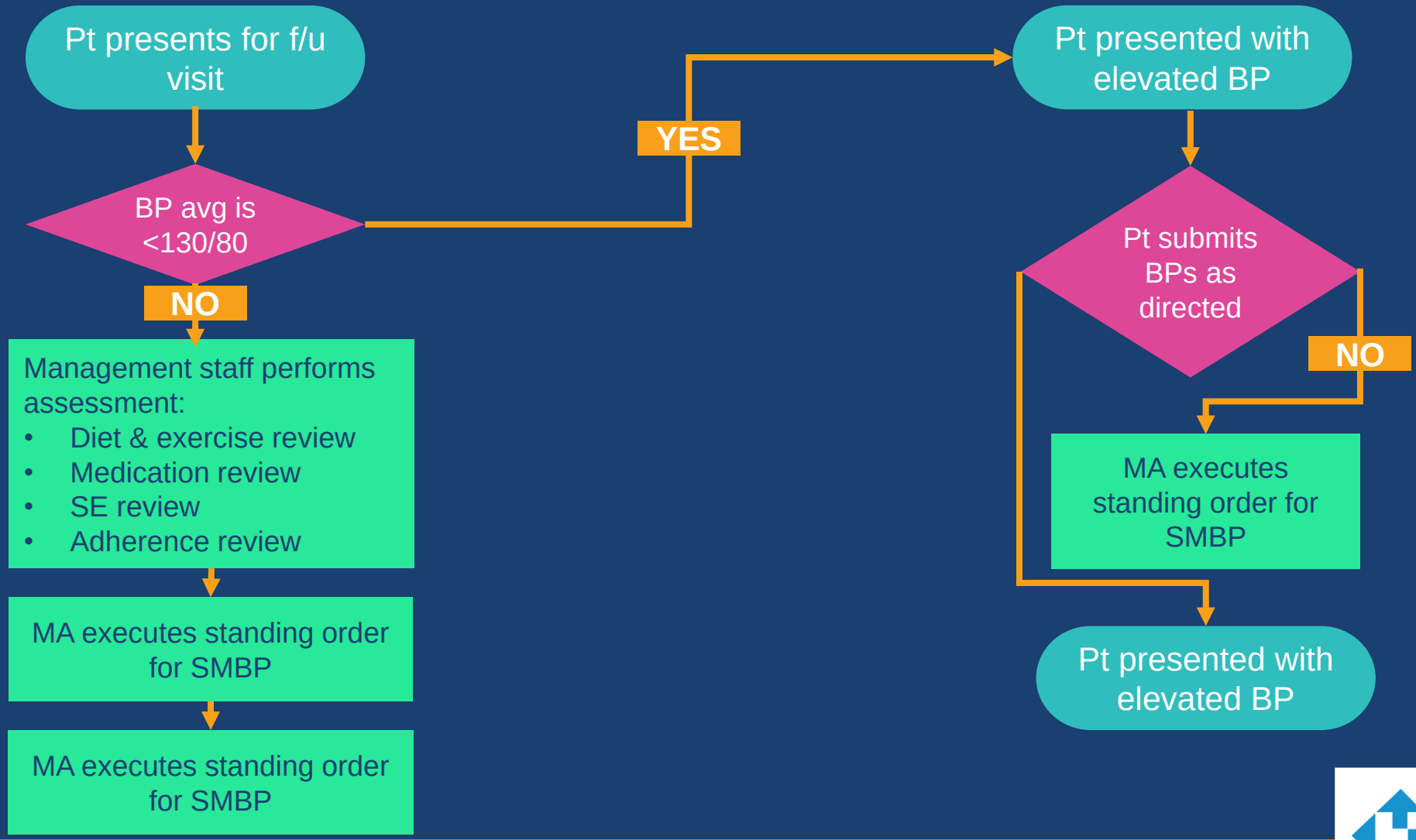

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Medication Algorithm

Consider adopting an evidenced-based algorithm for starting treatment and managing to goal BP

1. Reduces treatment costs
2. Facilitates Team-Based Care, Training and Supportive Supervision
3. Reduces clinical variability and therapeutic inertia

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Treatment Algorithm | Example

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Generic medication summary

Antihypertensive medication	Sample generic options	Dose once daily (initial)[4]	Dose once daily (intensified)[4]	Estimated Cost (30-day supply)[5]
CCB and ACEI (SPC) (if ACEI not tolerated due to cough, go to next row)	amlodipine/benazepril	(a) 2.5/10 mg (b) 5/10 mg (c) 5/20 mg	(a) 5/10 mg or 5/20 mg (b) 5/20 mg or 10/20 mg (c) 10/20 mg or 10/40 mg	$15–20
CCB and ARB (SPC) (if cost an issue, use CCB monotherapy (amlodipine) and go to next row)	(a) amlodipine/olmesartan (b) amlodipine/telmisartan	(a) 5/20 mg (b) 5/40 mg or 5/80 mg	(a) 5/40 mg or 10/20 mg or 10/40 mg (b) 5/80 mg or 10/80 mg	(a) $29–40 (b) $50–60
Add thiazide-like or thiazide diuretic	(a) indapamide (preferred) (b) chlorthalidone (preferred) (c) hydrochlorothiazide	(a) 1.25 mg (b) 12.5 mg = ½ 25 mg tab (c) 12.5 mg	(a) 2.5 mg (b) 25 mg (c) 25 mg	(a) $4 (b) $8–16 (c) $4
Add spironolactone (optional)	spironolactone	12.5 mg = ½ 25 mg tab	25 mg	$3–$12

*This protocol should not be used in patients with CHF, CAD, pregnancy, CKD stage 3 or albuminuria or ≥ 300 mg/g albumin-to-creatinine ratio or the equivalent in first morning void. Simultaneous use of an ACEI, ARB, and/or renin inhibitor is not recommended.[1e]

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https://www.ama-assn.org/system/files/2020-11/hypertension-medication-treatment-protocol.pdf

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Telling The Story

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Patients In SMBP Cohort

681

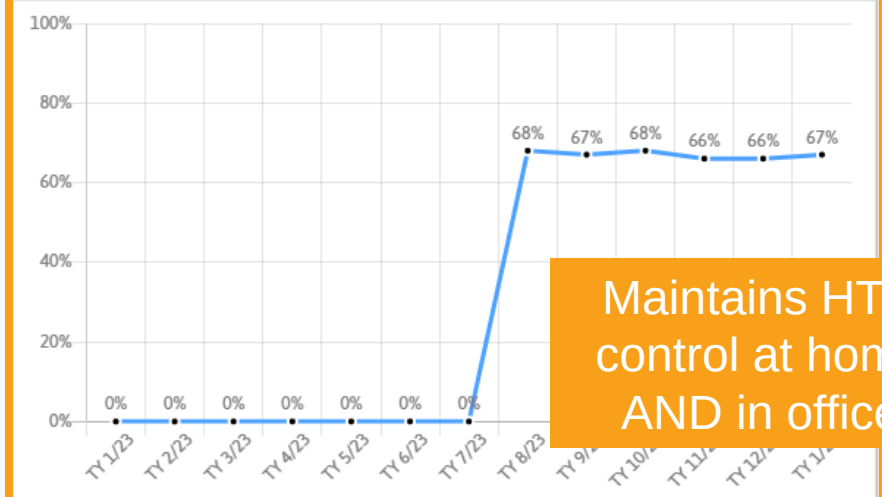
Pts w/ UDS Qualifying Enc

Patients with Self-Reported BP Documented

556

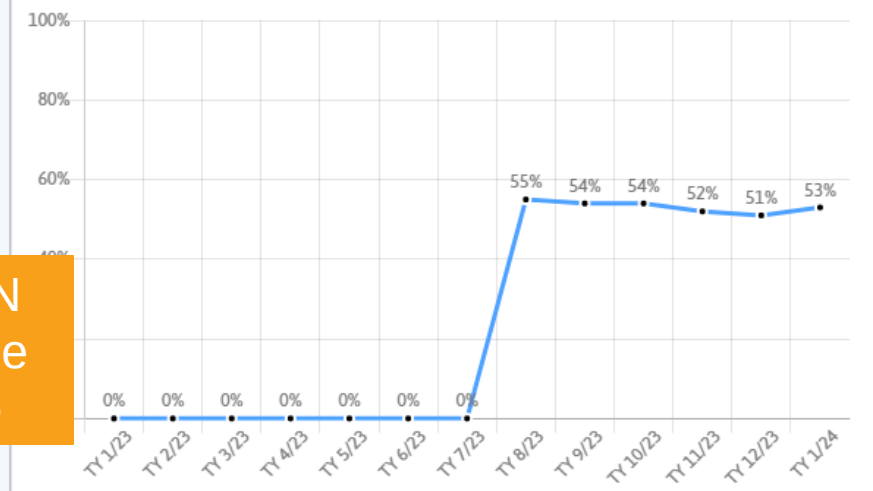
Qualifying Pts

Percent of SMBP Patients with last Self-Reported BP <140/90



Maintains HTN control at home AND in office

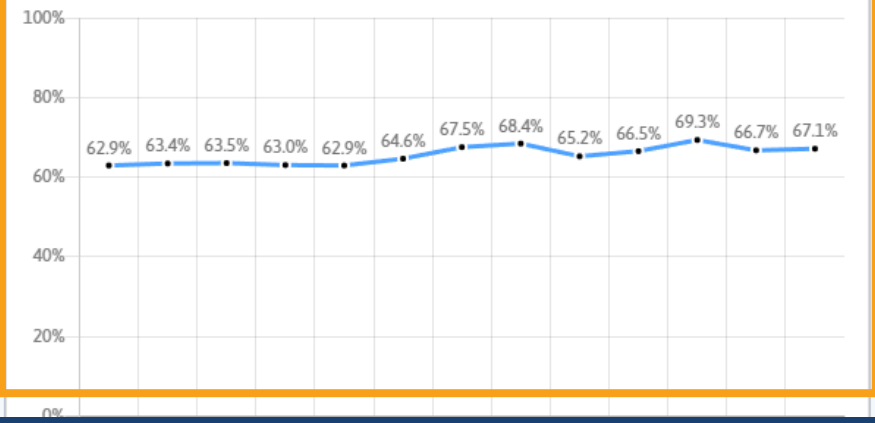
Percent of SMBP Patients with last Self-Reported BP <135/85



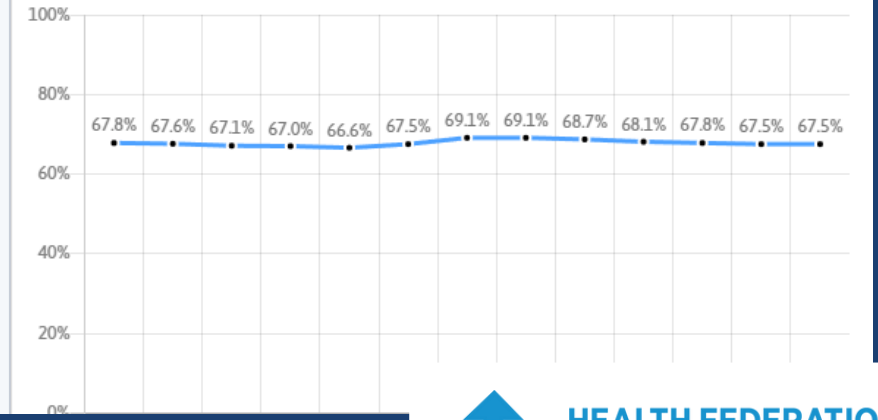
Patients In SMBP Cohort by Race/Ethnicity

RACES AND ETHNICITIES	DENOMINATOR
American Indian/Alaska Native/Another Hispanic, Latino/a, or Spanish Origin	18
American Indian/Alaska Native/Not Hispanic, Latino/a, or Spanish Origin	1
Black/African American/Another Hispanic, Latino/a, or Spanish Origin	131
Black/African American/Not Hispanic, Latino/a, or Spanish Origin	26
Black/African American/Puerto Rican	1
Black/African American/Unreported/Choose Not to Disclose Ethnicity	2

Percent of SMBP Patients with last In-Office BP <140/90



Percent of All HTN Patients with last In-Office BP <140/90



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Resources

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- Payment/Reimbursement Tips for RPM and SMBP
- SMBP Toolkit
- Treatment Algorithm
- SMBP Forum
- Million Hearts Learning Lab
- Collaborative Communication Strategies
- Patient Engagement Playbook

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Articles

Self-Measured Blood Pressure Monitoring During the COVID-19 Pandemic: Perspectives From Community Health Center Clinicians

Blood Pressure Measurements Obtained by Community-Dwelling Adults Are Similar to Nurse-Obtained Measurements: The SMART-BP Validate Study

Self-Measured Blood Pressure Telemonitoring Programs: A Pragmatic How-to Guide

Example of third party for SMBP (email dmcgrath@healthfederation.org for more info)

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The Health Federation of Philadelphia is continually developing new programs in response to both the needs of underserved communities and the availability of data indicating improved approaches to health care and behavioral support.

For more information on our initiatives, please visit:
www.healthfederation.org

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Anchors Away with DRVS Tools

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Supporting the MAP Framework: Hypertension

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Measure Accurately

- **Measures** to identify specific gaps in BP recordings
- **Scorecards** to review adherence to measurement guidelines
- **Dashboard** to understand process and performance

Act Rapidly

- **Alerts** reminding care team to continue taking BPs and providing associated care.
- **Registries** to identify other risk factors/comorbidities
- **Measures** to assess medication adherence and longer-term outcomes.

Partner with Patients

- **Measures** to track population w/ hypertension against operational metrics.
- **Azara Patient Outreach** to connect with patients on their care.
- **Azara Care Connect** to manage work with high-need patients and/or close care gaps.

Population Health | Dashboards

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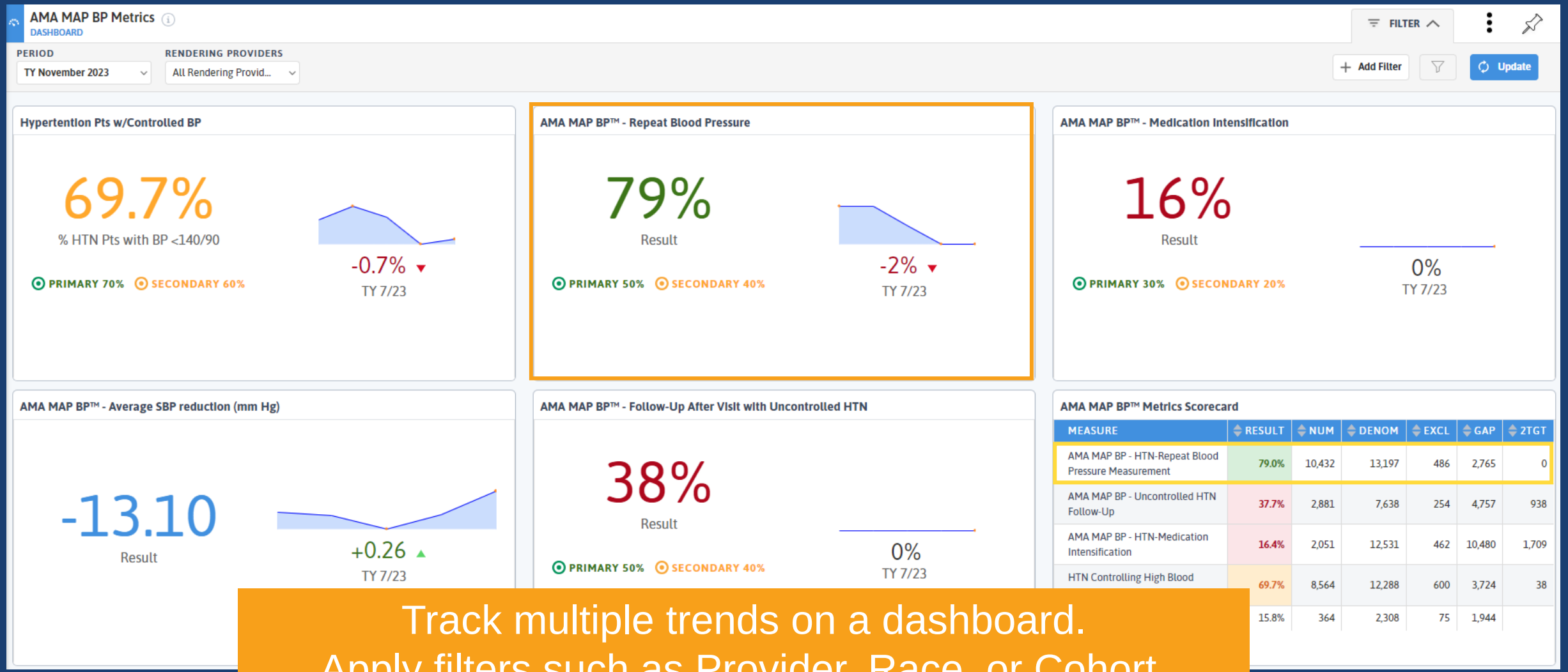
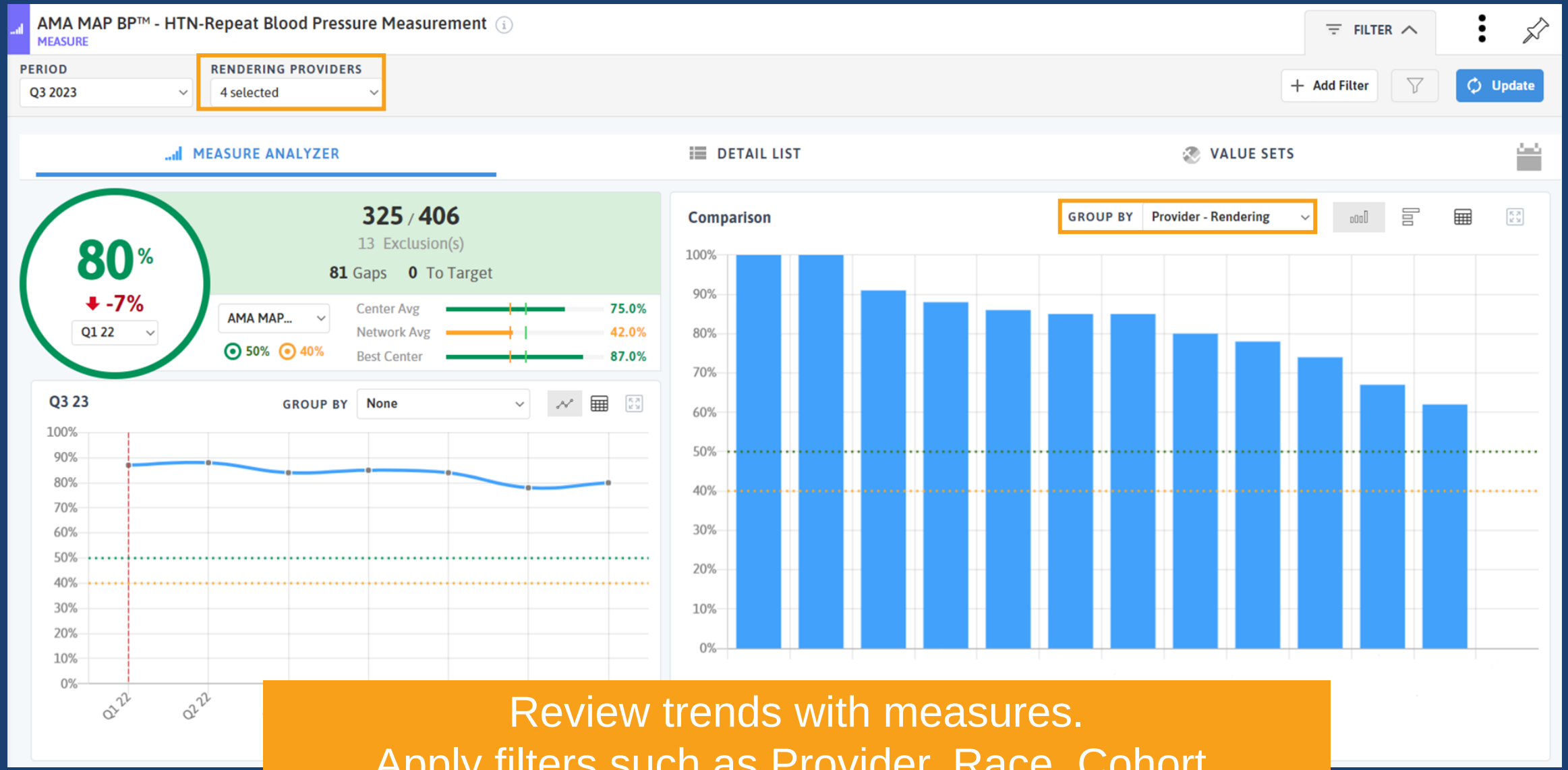


Track multiple trends on a dashboard.
Apply filters such as Provider, Race, or Cohort.

Performance | Measure Analyzer

azara 2024



Review trends with measures.
Apply filters such as Provider, Race, Cohort.

Performance | Stock AMA MAP BP™ Scorecards

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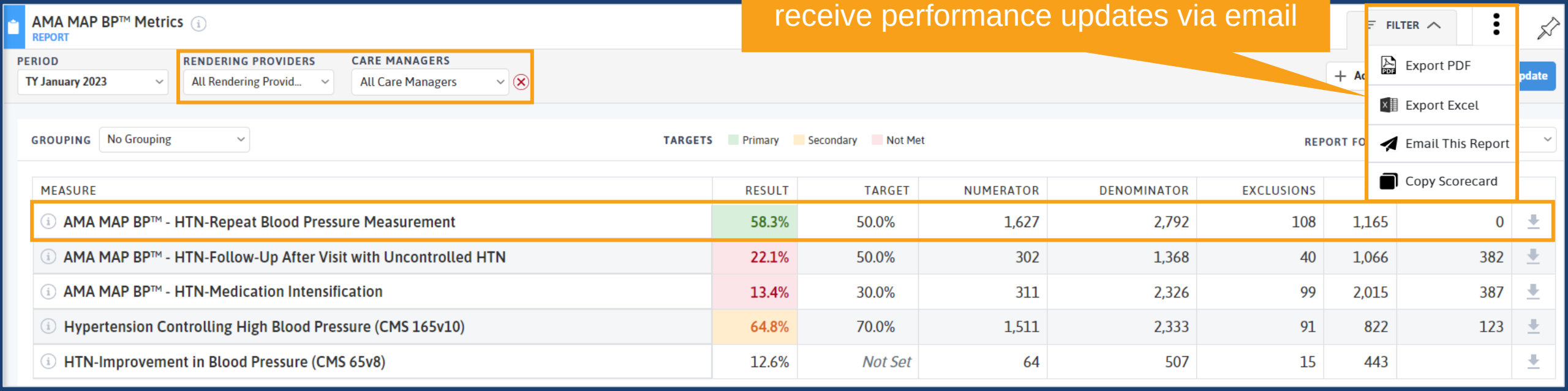
Create a custom scorecard or set up email subscription to automatically receive performance updates via email



Filter by individual providers or provider groups, cohorts, or care managers.

Point Of Care | PVP

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Clinical Pharmacist can use cohorts to identify patients coming in for the day

6:53 AM Tuesday, November 14, 2023 — Visit Reason: **Office visit Departure**

Wilcher, Talitha
MRN: 1103221
DOB: 2/6/1943 (80)

Sex at Birth: M
GI: Transgender Female/ Male-to-Female
SO: Straight (not lesbian or gay)

Phone: 508-443-3742
Lang: Arabic
Risk: Low (30)

Cohorts: Adults Sys > 110, Clinical Pharmacy

PCP: Black, Ronda
Payer: Medicare
CM: Eric Gunther

DIAGNOSES (7)

ASCVD	Cancer	Depression
HCV	HIV	HTN-NE
IVD		

RISK FACTORS (7)

ANTICOAG	Chronic Opioid Tx	IDD
MSM	Pre-DM	SMI
TOB		

SDOH (10)

EMPLOYMENT	HOMELESS	LANGUAGE
MED/CARE	MIGRANT	RACE
STRESS	TRANSPORT-MED	UTILITY
VIOLENCE		

ALERT	MESSAGE	DATE	RESULT
LDL	Out of Range	1/17/2023	154
BP	Out of Range	1/17/2023	158/77

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Allergist	Samantha Frost / Brookline	1/17/2023	1/25/2023
Radiology	Samantha Frost / Burlington	1/17/2023	2/7/2023
Accupuncture	John Smith / Burlington	1/15/2023	2/4/2023

Demo Data

Identify patients with Hypertension and with a BP that's out of range using the PVP.

Point of Care | CMP

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Assessments (Last 10 of 34)

CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	2/9/23	1
N18.3	Chronic kidney disease, stage 3 (moderate)	2/9/23	1
E55.9	Vitamin D deficiency, unspecified	2/9/23	1
Z91.89	Other specified personal risk factors, not elsewhere classified	1/6/22	0
B02.9	Zoster without complications	1/6/22	0
Z28.21	Immunization not carried out because of patient refusal	1/6/22	0
I10	Essential (primary) hypertension	8/20/21	0
Z13.9	Encounter for screening, unspecified	8/20/21	0
Z79.4	Long term (current) use of insulin	8/6/21	0

Medications (8)

ACTIVE AS OF	NAME	SOURCE
2/9/23	amlodipine 5 MG Oral Tablet	
2/9/23	cloNIDine HCl 0.1 MG 12HR Extended-Release Oral Tablet	
2/9/23	atorvastatin 40 MG Oral Tablet	
2/9/23	hydrochlorothiazide 12.5 MG / lisinopril 20 MG Oral Tablet	
2/9/23	empagliflozin 25 MG Oral Tablet [Jardiance]	
2/9/23	pantoprazole 40 MG D	
9/10/20	ergocalciferol 1.25 MC	
1/27/20	hydrochlorothiazide 2	

Active Problems (7)

CODE	DESCRIPTION	MOST RECENT
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	4/22/19
Z79.4	Long term (current) use of insulin	4/22/19
N18.3	Chronic kidney disease, stage 3 (moderate)	1/9/19
E78.2	Mixed hyperlipidemia	1/9/19
M85.88	Other specified disorders of bone density and structure, other site	6/19/18
E55.9	Vitamin D deficiency, unspecified	11/16/15
I10	Essential (primary) hypertension	10/12/15

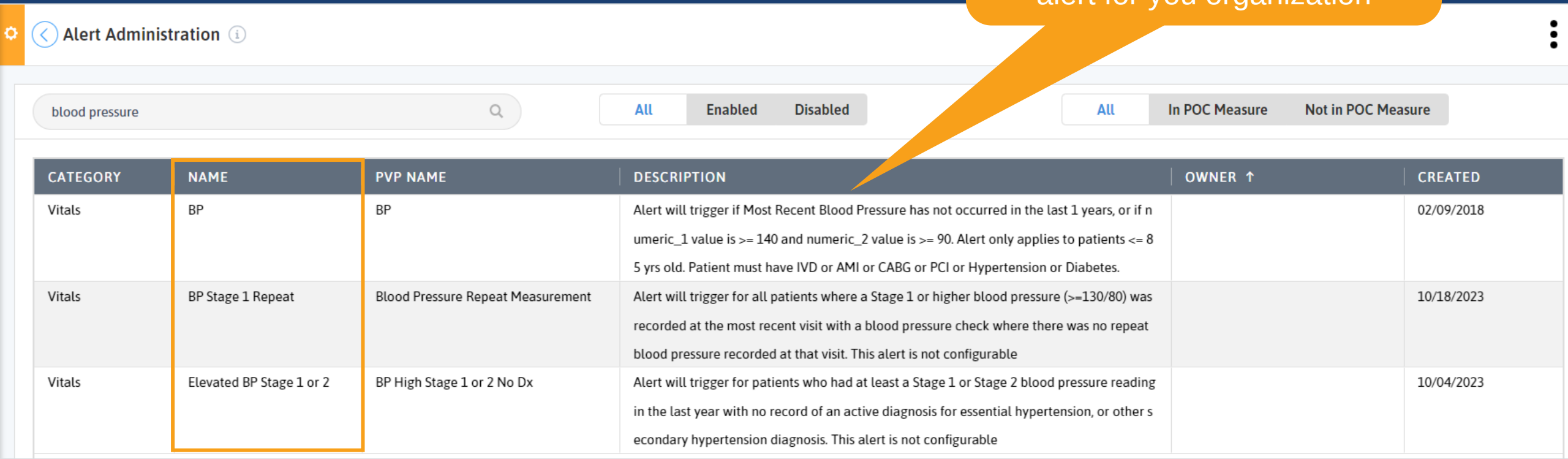
The Numbers

BMI	1/6/22	**26.79** lb/m2
Systolic	8/20/21	**152** mmHg
Diastolic	8/20/21	**55** mmHg
LDL	5/6/21	**99** mg/dL
A1c	8/6/21	**9.8** %
PHQ-9 (or 2)	6/8/21	**0**

Identify patient's trend in Systolic & Diastolic BP and most recent medications.

Point of Care | BP Alerts

Review Alert descriptions and enable the most appropriate alert for you organization



CATEGORY	NAME	PVP NAME	DESCRIPTION	OWNER ↑	CREATED
Vitals	BP	BP	Alert will trigger if Most Recent Blood Pressure has not occurred in the last 1 years, or if n umeric_1 value is >= 140 and numeric_2 value is >= 90. Alert only applies to patients <= 8 5 yrs old. Patient must have IVD or AMI or CABG or PCI or Hypertension or Diabetes.		02/09/2018
Vitals	BP Stage 1 Repeat	Blood Pressure Repeat Measurement	Alert will trigger for all patients where a Stage 1 or higher blood pressure (>=130/80) was recorded at the most recent visit with a blood pressure check where there was no repeat blood pressure recorded at that visit. This alert is not configurable		10/18/2023
Vitals	Elevated BP Stage 1 or 2	BP High Stage 1 or 2 No Dx	Alert will trigger for patients who had at least a Stage 1 or Stage 2 blood pressure reading in the last year with no record of an active diagnosis for essential hypertension, or other s econdary hypertension diagnosis. This alert is not configurable		10/04/2023

Enable appropriate BP Alerts, assign alert owner, and update PVP name if needed.

Population Health | CER Report

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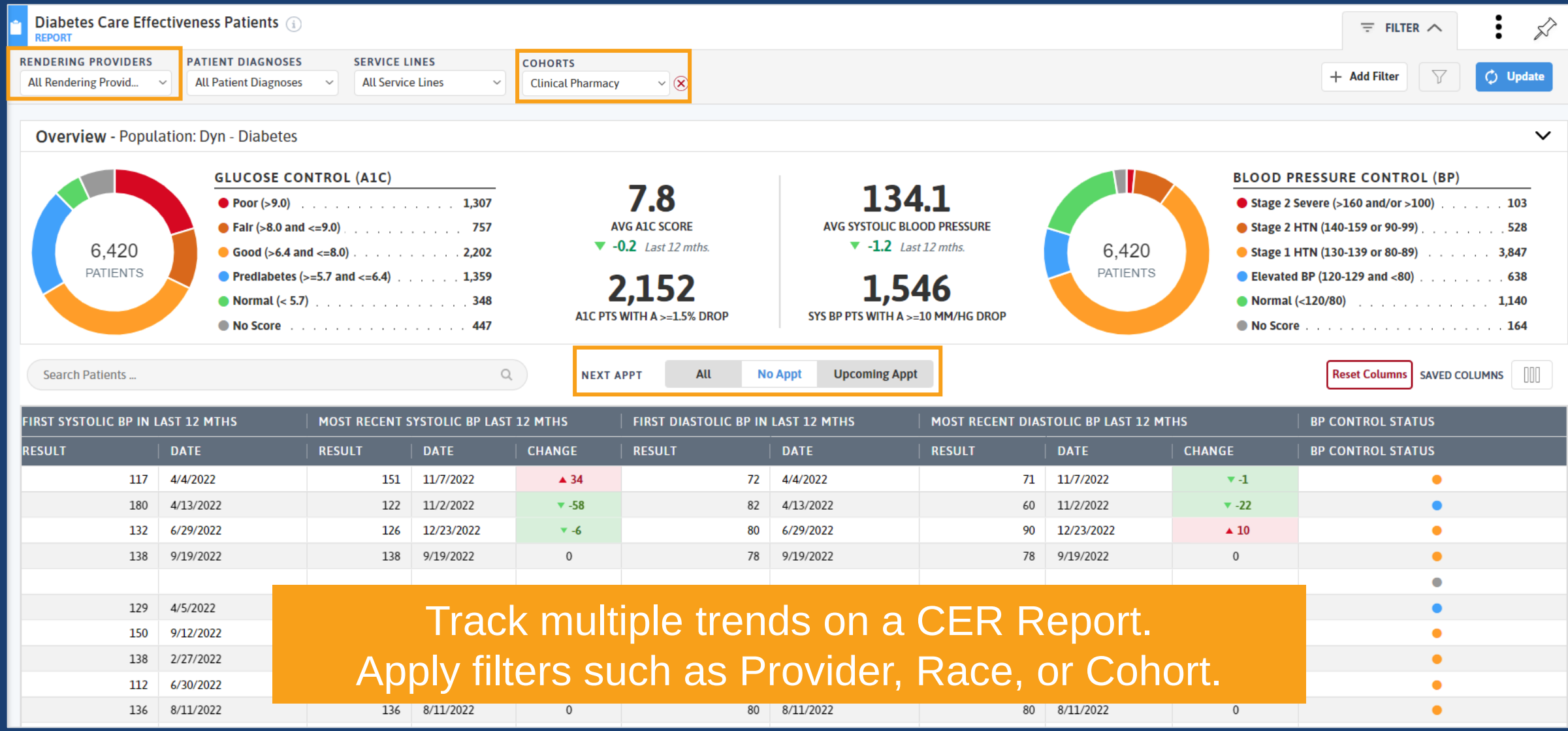

FIRST SYSTOLIC BP IN LAST 12 MTHS		MOST RECENT SYSTOLIC BP LAST 12 MTHS			FIRST DIASTOLIC BP IN LAST 12 MTHS		MOST RECENT DIASTOLIC BP LAST 12 MTHS			BP CONTROL STATUS
RESULT	DATE	RESULT	DATE	CHANGE	RESULT	DATE	RESULT	DATE	CHANGE	BP CONTROL STATUS
117	4/4/2022	151	11/7/2022	▲ 34	72	4/4/2022	71	11/7/2022	▼ -1	
180	4/13/2022	122	11/2/2022	▼ -58	82	4/13/2022	60	11/2/2022	▼ -22	
132	6/29/2022	126	12/23/2022	▼ -6	80	6/29/2022	90	12/23/2022	▲ 10	
138	9/19/2022	138	9/19/2022	0	78	9/19/2022	78	9/19/2022	0	
129	4/5/2022									
150	9/12/2022									
138	2/27/2022									
112	6/30/2022									
136	8/11/2022	136	8/11/2022	0	80	8/11/2022	80	8/11/2022	0	

Track multiple trends on a CER Report.
Apply filters such as Provider, Race, or Cohort.

Population Health | Registries + Cohorts

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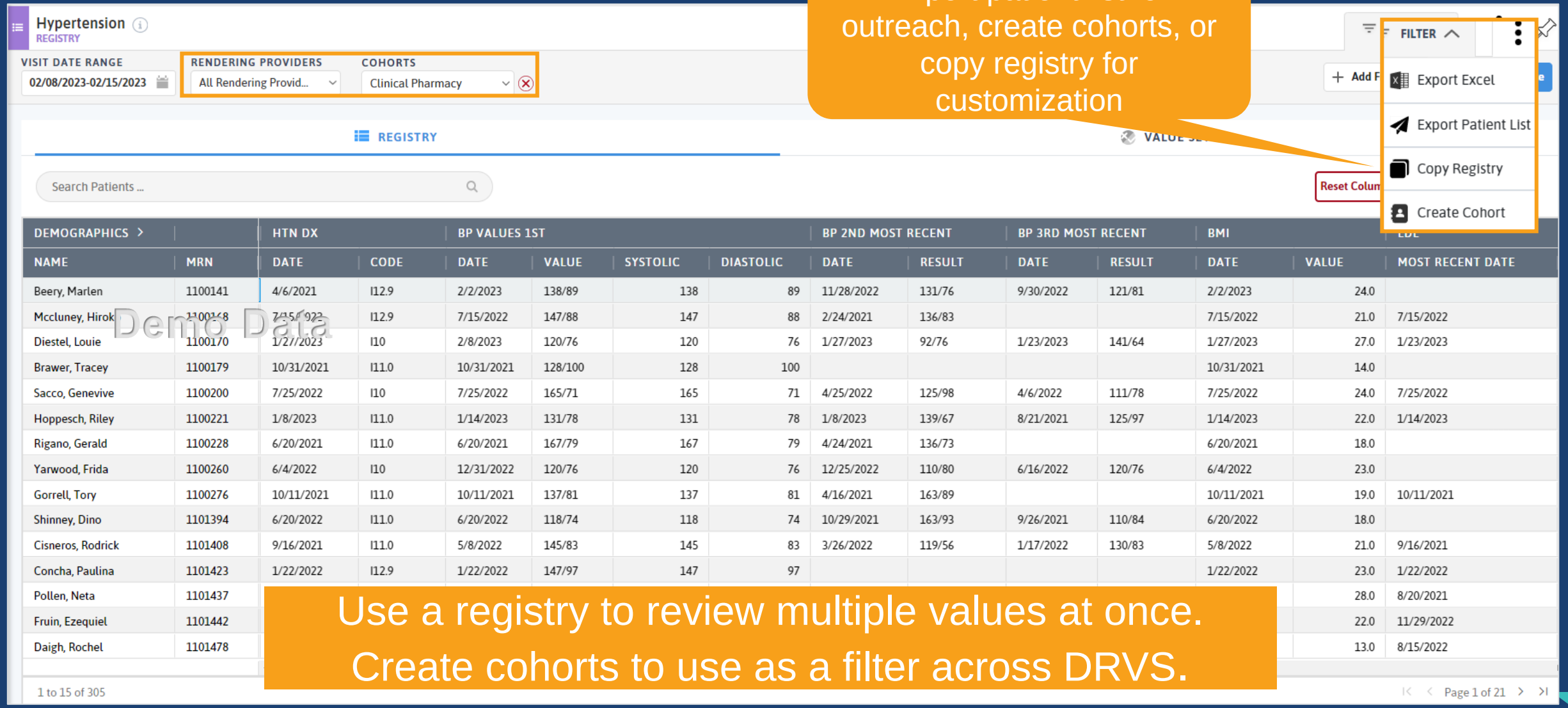
Export patient list for outreach, create cohorts, or copy registry for customization



DEMOGRAPHICS		HTN DX		BP VALUES 1ST				BP 2ND MOST RECENT		BP 3RD MOST RECENT		BMI		LDL
NAME	MRN	DATE	CODE	DATE	VALUE	SYSTOLIC	DIASTOLIC	DATE	RESULT	DATE	RESULT	DATE	VALUE	MOST RECENT DATE
Beery, Marlen	1100141	4/6/2021	I12.9	2/2/2023	138/89	138	89	11/28/2022	131/76	9/30/2022	121/81	2/2/2023	24.0	
Mccluney, Hirok	1100168	7/15/2022	I12.9	7/15/2022	147/88	147	88	2/24/2021	136/83			7/15/2022	21.0	7/15/2022
Diestel, Louie	1100170	1/27/2023	I10	2/8/2023	120/76	120	76	1/27/2023	92/76	1/23/2023	141/64	1/27/2023	27.0	1/23/2023
Brawer, Tracey	1100179	10/31/2021	I11.0	10/31/2021	128/100	128	100					10/31/2021	14.0	
Sacco, Genevive	1100200	7/25/2022	I10	7/25/2022	165/71	165	71	4/25/2022	125/98	4/6/2022	111/78	7/25/2022	24.0	7/25/2022
Hoppesch, Riley	1100221	1/8/2023	I11.0	1/14/2023	131/78	131	78	1/8/2023	139/67	8/21/2021	125/97	1/14/2023	22.0	1/14/2023
Rigano, Gerald	1100228	6/20/2021	I11.0	6/20/2021	167/79	167	79	4/24/2021	136/73			6/20/2021	18.0	
Yarwood, Frida	1100260	6/4/2022	I10	12/31/2022	120/76	120	76	12/25/2022	110/80	6/16/2022	120/76	6/4/2022	23.0	
Gorrell, Tory	1100276	10/11/2021	I11.0	10/11/2021	137/81	137	81	4/16/2021	163/89			10/11/2021	19.0	10/11/2021
Shinney, Dino	1101394	6/20/2022	I11.0	6/20/2022	118/74	118	74	10/29/2021	163/93	9/26/2021	110/84	6/20/2022	18.0	
Cisneros, Rodrick	1101408	9/16/2021	I11.0	5/8/2022	145/83	145	83	3/26/2022	119/56	1/17/2022	130/83	5/8/2022	21.0	9/16/2021
Concha, Paulina	1101423	1/22/2022	I12.9	1/22/2022	147/97	147	97					1/22/2022	23.0	1/22/2022
Pollen, Neta	1101437												28.0	8/20/2021
Fruin, Ezequiel	1101442												22.0	11/29/2022
Daigh, Rochel	1101478												13.0	8/15/2022

1 to 15 of 305

Page 1 of 21

Use a registry to review multiple values at once.
Create cohorts to use as a filter across DRVS.

Population Health | Stock Dynamic Cohorts

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Cohort Display Name	Description
Congestive Heart Failure (CHF)	Patients who have a diagnosis of Congestive Heart Failure in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.
Hypertension	Patients who have a diagnosis for Hypertension in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.
Hypertension BP >140/90	Patients who have a diagnosis of hypertension in the last 12 months and whose most recent blood pressure vitals result is > 140/90. If the patient's systolic blood pressure is > 140 mmHg OR their diastolic blood pressure is > 90 mmHg they will be in the cohort. Patients who are deceased or inactive at the center are excluded from the cohort.
High Risk Patients	Patients who have a risk level of High. Patients who are deceased or inactive at the center are excluded from the cohort.
Diabetes	Patients who have a diagnosis of diabetes. Patients who are deceased or inactive at the center are excluded from the cohort.
DM A1c >9	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.
DM A1c >8	Patients who have a diagnosis of diabetes and whose most recent hemoglobin A1c lab result is > 8.0%. Patients who are deceased are excluded from the cohort.
DM A1c Untested	Patients who have a diagnosis of diabetes and have not had an A1c result in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.

To enabled dynamic cohorts, please open a support ticket.

Performance | Custom Scorecards

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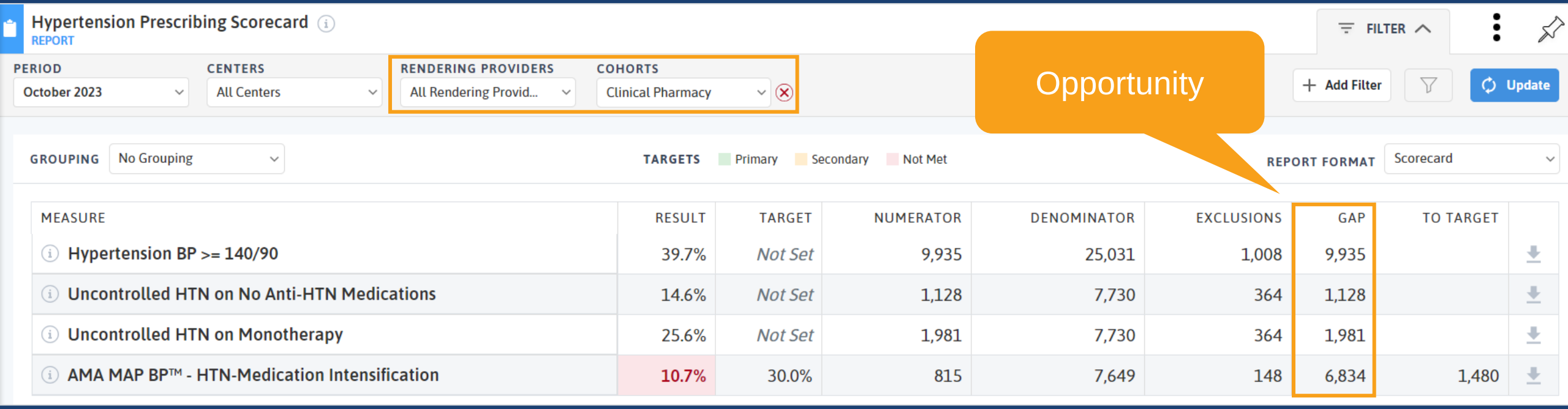

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	GAP	TO TARGET
Hypertension BP >= 140/90	39.7%	*Not Set*	9,935	25,031	1,008	9,935	
Uncontrolled HTN on No Anti-HTN Medications	14.6%	*Not Set*	1,128	7,730	364	1,128	
Uncontrolled HTN on Monotherapy	25.6%	*Not Set*	1,981	7,730	364	1,981	
AMA MAP BP™ - HTN-Medication Intensification	10.7%	30.0%	815	7,649	148	6,834	1,480

Now available under Reports > Custom > AMA Hypertension Prescribing Scorecard

Performance | Measure Analyzer

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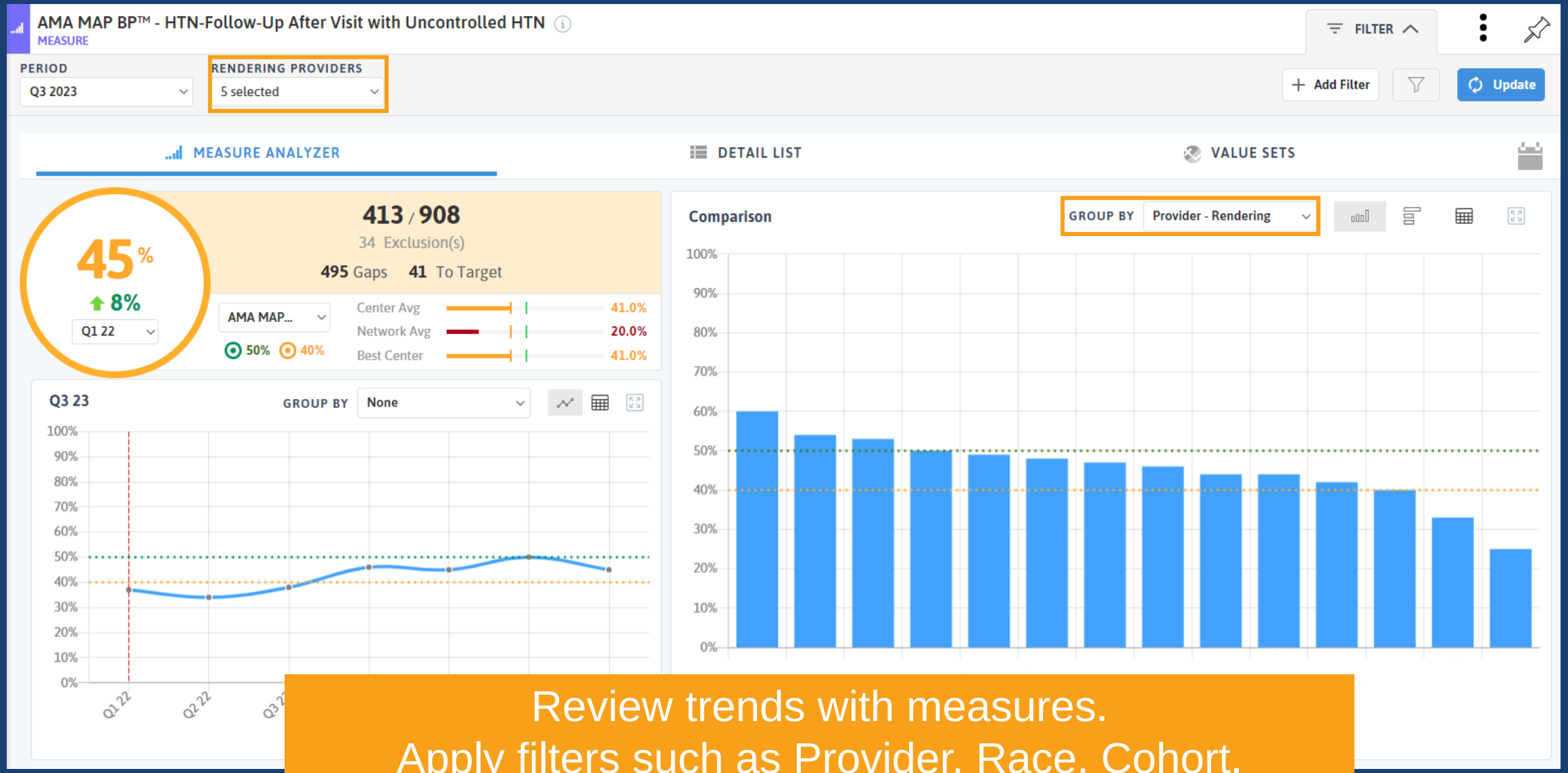

Review trends with measures.
Apply filters such as Provider, Race, Cohort.

Performance | Measure Analyzer

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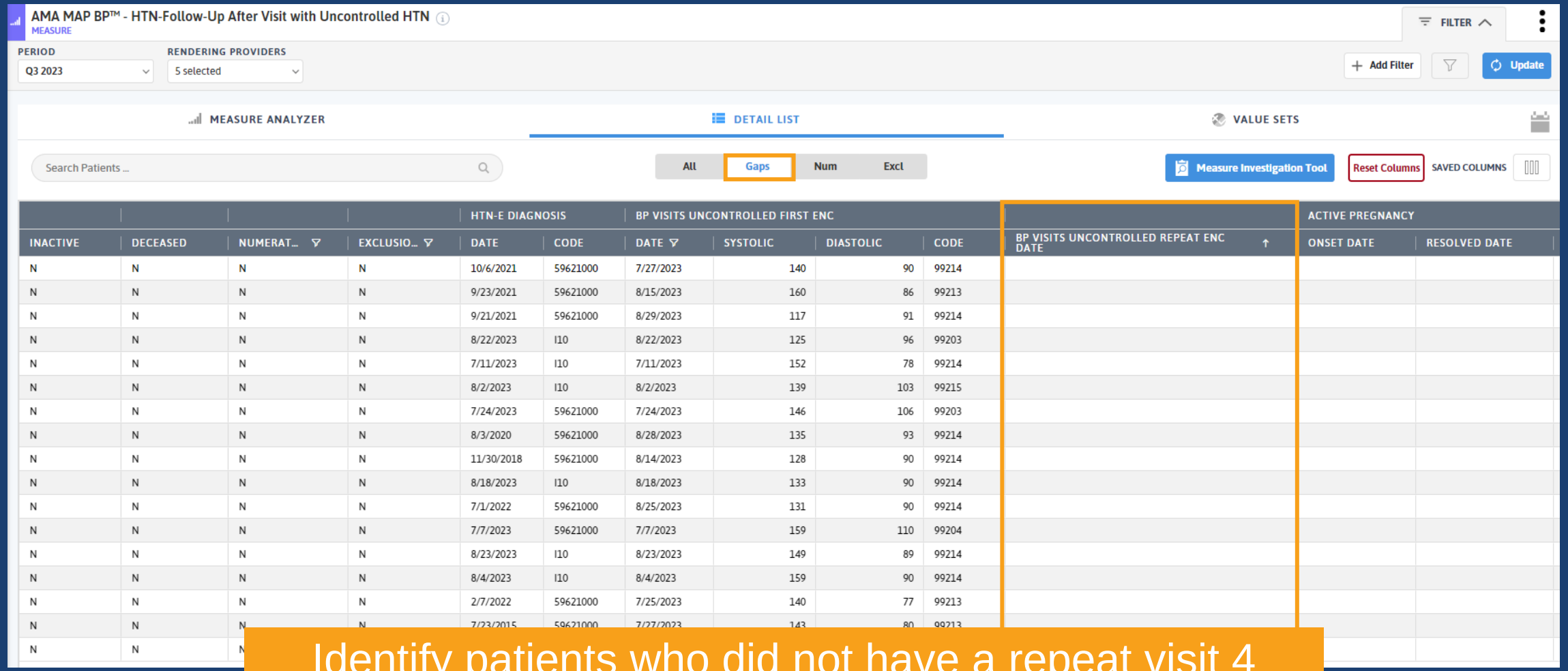

				HTN-E DIAGNOSIS		BP VISITS UNCONTROLLED FIRST ENC					ACTIVE PREGNANCY	
INACTIVE	DECEASED	NUMERAT...	EXCLUSIO...	DATE	CODE	DATE	SYSTOLIC	DIASTOLIC	CODE	BP VISITS UNCONTROLLED REPEAT ENC DATE	ONSET DATE	RESOLVED DATE
N	N	N	N	10/6/2021	59621000	7/27/2023	140	90	99214			
N	N	N	N	9/23/2021	59621000	8/15/2023	160	86	99213			
N	N	N	N	9/21/2021	59621000	8/29/2023	117	91	99214			
N	N	N	N	8/22/2023	I10	8/22/2023	125	96	99203			
N	N	N	N	7/11/2023	I10	7/11/2023	152	78	99214			
N	N	N	N	8/2/2023	I10	8/2/2023	139	103	99215			
N	N	N	N	7/24/2023	59621000	7/24/2023	146	106	99203			
N	N	N	N	8/3/2020	59621000	8/28/2023	135	93	99214			
N	N	N	N	11/30/2018	59621000	8/14/2023	128	90	99214			
N	N	N	N	8/18/2023	I10	8/18/2023	133	90	99214			
N	N	N	N	7/1/2022	59621000	8/25/2023	131	90	99214			
N	N	N	N	7/7/2023	59621000	7/7/2023	159	110	99204			
N	N	N	N	8/23/2023	I10	8/23/2023	149	89	99214			
N	N	N	N	8/4/2023	I10	8/4/2023	159	90	99214			
N	N	N	N	2/7/2022	59621000	7/25/2023	140	77	99213			
N	N	N	N	7/23/2015	59621000	7/27/2023	143	80	99213			
N	N	N										

Identify patients who did not have a repeat visit 4 weeks after a visit with uncontrolled blood pressure.

Tools to Improve BP Control | Add-On Solutions

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- Risk Stratification
- EHR Plug-In
- Transitions of Care (TOC)
- Azara Patient Outreach (APO)
- Azara Care Connect (ACC)
- Azara Cost & Utilization (ACU)

Questions?

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Azara healthcare

@AzaraDRVS

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.

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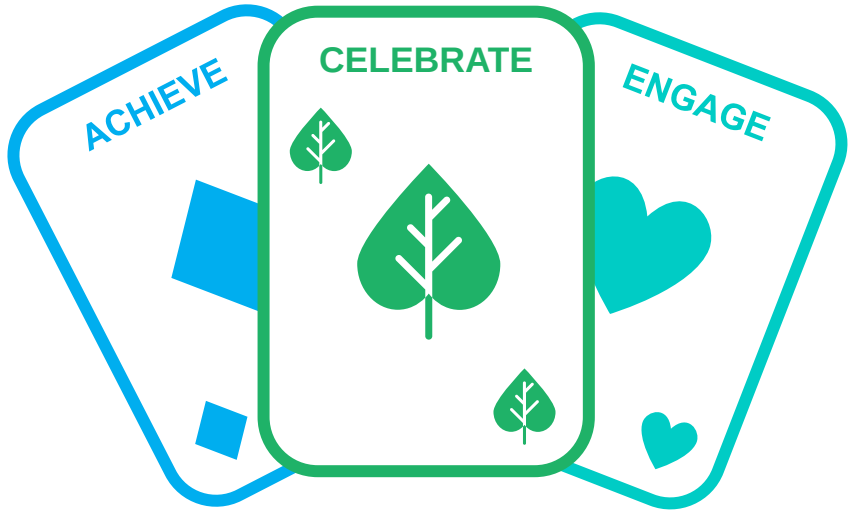
ACE Program



Benefits:

- Azara will help tell your story and provide a client-branded version for your use
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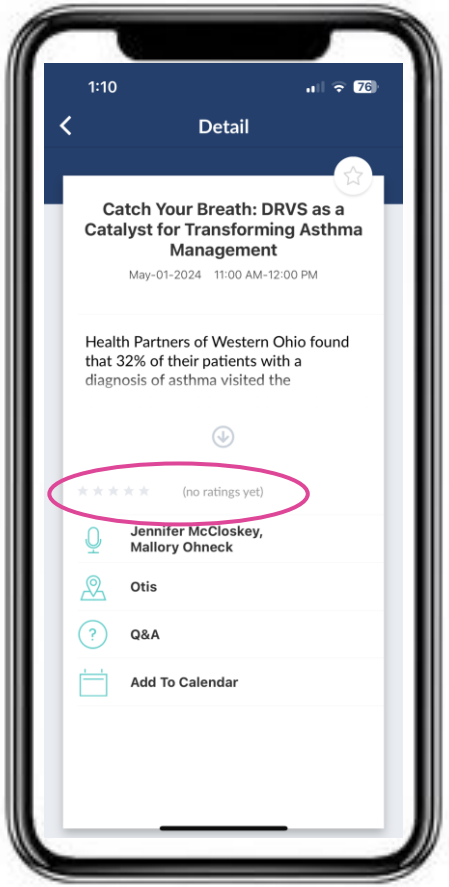

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