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

Hook, Line, & Sinker!

How to Promote Provider Engagement Using DRVS

Stacey Curry
Director of Quality Management
Coastal Family Health Center

Dr. Luis Raul Garza, MD
Chief Medical Officer
Project Vida

Today’s Presenters

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Stacey Curry
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Agenda

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COASTAL FAMILY HEALTH CENTER

Learn how sharing unblinded data promoted provider engagement across the organization.

PROJECT VIDA

Review the steps taken to garner provider buy-in for DRVS, and how that buy-in has evolved over time.

Q&A

Answer questions regarding lessons learned & best practices.

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Provider Engagement at Coastal Family Health Center

Biloxi, Mississippi

Stacey Curry

Director of Quality Management

Coastal Family Health Center

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36,000+ patients served annually with over 110,000 visits

12 stand-alone clinics, **1** mobile unit, **4** pharmacies, & **23** schools

PCMH Certified & Joint Commission Accredited for **Ambulatory & Behavioral Health**

Ryan White & **Healthcare for the Homeless**

Pre-Azara Limitations

Coastal Family Health Center has relied on population analytics to drive decisions over the past several years. However, our previous analytics systems posed significant limitations:

Inconsistent use of huddle functionality.

Clinic & provider measure outcomes were difficult to generate and trend over time.

Required extensive manipulation, making data inaccessible to departments outside of quality.

Providers and staff were frustrated with the overall system.

The History | DRVS & Coastal Family

Implemented Azara in 2019 as our new population analytics platform. Were one of four centers within our HCCN to implement the system as a first cohort.

Azara provided easy to access functionality was attractive to providers and nurses & program initiatives led by our Chronic Care CHW/Navigators

Clinics became interested in viewing quarterly reports, and multiple administrative and Practice Managers were trained to utilize the system.

Nursing staff began viewing and printing the PVP reports.

COVID-19 Challenges

While 2019 was a model year for quality, **several quality measures decreased** in 2020 due to COVID-19.

1. PVP report usage dropped significantly.
2. CFHC priorities were structured around Covid-19 mandates and patients/staff safety.
3. Quality measure outcomes dropped significantly when we reported our 2020 UDS clinical outcomes

Regaining Quality Mojo Using DRVS

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Developed provider, clinic, & organizational level **scorecards** based on UDS clinical measures and well visits.

Each provider receives a monthly scorecard **specific to their outcomes**, as well as the organizational scorecards sent via email subscription.

Clinics display **unblinded hard copies** of the clinic level scorecards to staff & patients to see.

Provider Scorecard | Example

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MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	GAP	TO TARGET
Cervical Cancer Screening (CMS 124v11)	52.0%	45.0%	229	440	120	211	0
Breast Cancer Screening Ages 50-74 (CMS 125v11)	78.9%	50.0%	400	507	6	107	0
Colorectal Cancer Screening (CMS 130v11)	57.8%	30.0%	525	909	9	384	0
Tobacco Use: Screening and Cessation (CMS 138v11)	93.3%	87.0%	1,082	1,160	0	78	0
Screening for Depression and Follow-Up Plan (CMS 2v12)	99.0%	93.0%	832	840	420	8	0
Depression Remission at Twelve Months (CMS 159v11)	52.9%	20.0%	9	17	4	8	0
HIV Screening (CMS 349v4)	77.5%	50.0%	747	964	0	217	0
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS 347v2)	85.4%	85.0%	368	431	21	63	0
IVD Aspirin Use (CMS 164v7)	93.7%	90.0%	74	79	9	5	0
Hypertension Controlling High Blood Pressure (CMS165v11)	86.1%	65.0%	630	732	7	102	0
Diabetes A1c > 9 or Untested (CMS 122v11)	22.5%	27.0%	86	382	1	86	0
Medicare Annual Well Visit	68.7%	80.0%	290	422	0	132	48
BMI Screening and Follow-Up 18+ Years (CMS 69v11)	98.3%	77.0%	1,237	1,258	1	21	0

Provider Quality Awards

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Providers participate in a **quality award** quarterly & annually

Quarterly awards are based on **top quality achievers** demonstrated by **cross-tabbed scorecards** & shared at quarterly provider meetings.

Annual awards are presented to providers with the **highest quality achievements** over the previous reporting year & shared at All-Staff meeting.

Providers became competitive… **everyone wanted an award**!

Provider Engagement

Since the distribution of scorecards, providers & nurses have become significantly more engaged in quality improvement strategies:

Providers have asked to be added to the Azara DRVS users so that they can also generate their scorecards.

Providers utilize scorecard details to validate their own data and notify Quality team of discrepancies.

Providers consistently reach out to the Quality team to better understand quality measures, ensure they're documenting correctly, and propose PDSAs to improve performance.

Provider Engagement | Culture of Data Validation

- Providers & nurses are **aware of the frequency of data refreshes**, including PVPs, gap closures, etc.
- Providers & nurses **request 1:1 meetings** to learn more about accurate documentation for reporting gap closures.
- Providers & nurses are able to **identify inconsistencies** with the data and **submit their own support tickets** so that they can work directly with Azara.

Provider-Proposed PDSAs

1. Two providers are using Azara's cohort functionality to perform a PDSA looking into whether allowing patients to mail in their FIT FOBT cards could improve the rate of resulted colorectal cancer screenings.

2. One provider recently worked with the CHW to leverage Azara detail lists as recall registries to improve diabetes and hypertension performance. Patients were provided CHW visits alongside their provider visits.

3. Two pediatric providers utilized Azara to improve their HIV screening rates as part of well visits.

Continued Engagement

To date in 2024, staff & providers have run **1,172 reports**. Roughly **600 of those reports are PVPs**.

Utilizing cancer screening scorecards & dashboards to **support initiatives such as the ISCCCE project** with Harvard T. Chan School of Public Health.

Leveraging registries to **advance diabetes and hypertension collaboratives**, as well as **provider PDSAs for cancer screenings and immunizations**.

Providers are using the PVP to **facilitate morning huddles** & **identify / close care gaps** at the point of care.

ISCCCE Project Dashboard

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Data Check In Report - Breast Cancer

Run on 2/23/2024 10:47:48 AM

Breast Cancer Screening and Abnormal Follow-Up

February 2024

MEASURE	RESULT	NUM	DENOM	EXCL	GAP
Breast CA Screening Ages 50-74 (CMS125v11)	50.8%	338	666	9	328
Abnormal Breast Cancer Screening Follow-up	25.0%	2	8	0	6

Abnormal Breast Cancer Screening Follow-Up by Ethnicity

TY February 2024

ETHNICITIES	RESULT	NUMERATOR	DENOMINATOR	GAP
Another Hispanic, Latino/a, or Spanish Origin	25%	2	8	6
Not Hispanic, Latino/a, or Spanish Origin	22%	7	32	25
Unreported/Choose Not to Disclose Ethnicity	67%	2	3	1

Breast Cancer Screening by Ethnicity

February 2024

ETHNICITIES	RESULT	NUMERATOR	DENOMINATOR	GAP
Another Hispanic, Latino/a, or Spanish Origin	57.1%	16	28	12
Not Hispanic, Latino/a, or Spanish Origin	52.0%	316	608	292
Unmapped	0.0%	0	1	1
Unreported/Choose Not to Disclose Ethnicity	20.7%	6	29	23

Abnormal Breast Cancer Screening Follow-Up by Race (Not Hispanic/Latino)

February 2024

RACES AND ETHNICITIES	RESULT	NUMERATOR	DENOMINATOR	GAP
Black/African American/Not Hispanic, Latino/a, or Spanish Origin	0%	0	3	3
Other Asian/Not Hispanic, Latino/a, or Spanish Origin	100%	1	1	0

Breast Cancer Screening by Race (Not Hispanic/Latino)

February 2024

RACES AND ETHNICITIES	RESULT	NUMERATOR	DENOMINATOR	GAP
American Indian/Alaska Native/Not Hispanic, Latino/a, or Spanish Origin	0.0%	0	2	2
Black/African American/Not Hispanic, Latino/a, or Spanish Origin	56.9%	123	216	93
Chinese/Not Hispanic, Latino/a, or Spanish Origin	0.0%	0	1	1
More than One Race/Not Hispanic, Latino/a, or Spanish Origin	66.7%	4	6	2
Other Asian/Not Hispanic, Latino/a, or Spanish Origin	80.0%	8	10	2
Other Pacific Islander/Not Hispanic, Latino/a, or Spanish Origin	0.0%	0	1	1
Unreported/Choose Not to Disclose Race/Not Hispanic, Latino/a, or Spanish Origin	0.0%	0	4	4
Vietnamese/Not Hispanic, Latino/a, or Spanish Origin	25.0%	1	4	3
White/Not Hispanic, Latino/a, or Spanish Origin	49.5%	180	364	184

Abnormal Breast Cancer Screening Follow-Up by Financial Class

February 2024

UDS FINANCIAL CLASSES	RESULT	NUMERATOR	DENOMINATOR	GAP
Dual Eligible Medicare and Medicaid	100%	1	1	0
Medicaid	0%	0	1	1
Medicare	33%	1	3	2
Private Insurance	33%	1	3	2
Uninsured	0%	0	1	1

Breast Cancer Screening by Financial Class

February 2024

UDS FINANCIAL CLASSES	RESULT	NUMERATOR	DENOMINATOR	GAP
Dual Eligible Medicare and Medicaid	60.3%	76	126	50
Medicaid	48.9%	23	47	24
Medicare	59.7%	151	253	102
Private Insurance	47.6%	120	252	132
Uninsured	38.6%	44	114	70

Abnormal Breast Cancer Screening Follow-Up by Language

February 2024

LANGUAGES	RESULT	NUMERATOR	DENOMINATOR	GAP
English	25%	2	8	6

Impact of Provider Engagement on Quality Improvement

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MEASURE	Percent Improvement Between 2022 & 2023 UDS Reporting Year
Trimester of Early Entry (Prenatal)	1.32%
Cervical Cancer Screening	18.05%
Weight Assessment and Counseling for Children and Adolescents	35.19%
Adult Weight Screening and Follow up	36.84%
Tobacco Use Screening and Cessation Intervention	6.04%
Statin Therapy for the Prevention and Treatment of CVD	4.62%
IVD: Aspirin or another Antiplatelet	13.23%
Colorectal Cancer Screening	33.43%
Patients Screened for Depression and Follow up	0.53%
HIV Screening	22.73%
Breast Cancer Screening	16.50%
Deliveries and Birth Weight (Less Than 2500 Grams)	-11.76%
Controlled Hypertension	2.77%
Uncontrolled Diabetes	-1.41%

POC Alert Closure Rates | February 2024

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46% of Adult Weight Screening	86% BMI Percentile	49% Blood Pressure	43% Flu Immunization
69% Nutritional Counseling	63% Physical Activity	49% Tobacco Screening	35% Tobacco Cessation

Looking Ahead | DRVS Expansion

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Collaborating with HCCN and other health centers in MS to identify ways to monitor Joint Commission requirements such as **anticoagulation protocols** and **antimicrobial stewardship programs**.

Comparing data between ACO platform & DRVS to support **ACO compliance** activities such as care gaps, well visits, diagnoses resolution, etc.

Looking to engage Azara in our new **Title X** program requirements / reporting.

Project Vida

El Paso, Texas

Dr. Luis Raul Garza, MD
Chief Medical Officer

Project Vida | Practice Overview

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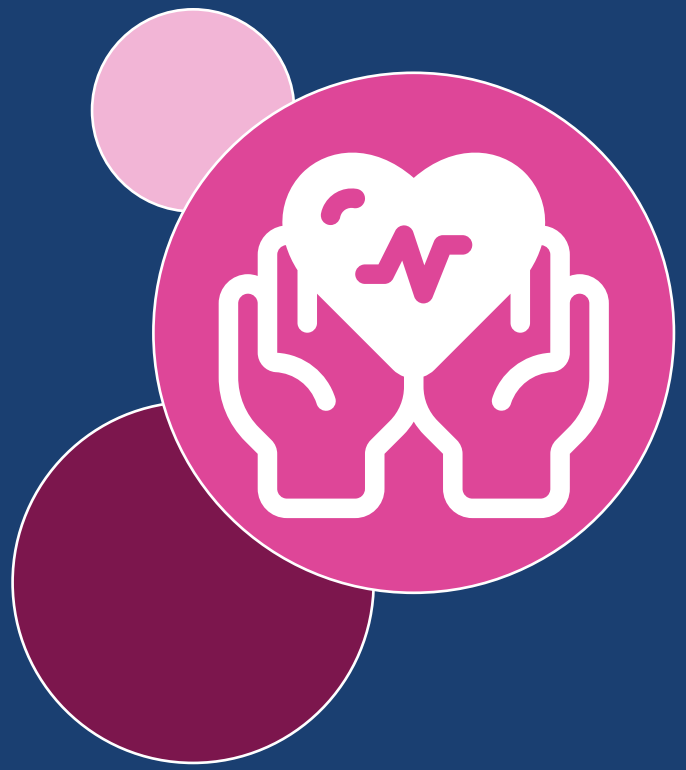

25 providers (including Behavioral Health)

15,000 patients served annually

Community makeup:

- **85%** Hispanic
- **50%** prefer language other than English
- **50%** uninsured
- **5-10%** Medicaid
- **80%** under 100% FPL

Pre-DRVS Reality

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Limited mappings in EHR led to weakened performance

Manually created provider scorecards – 5–6-hour investment each month

Inconsistent huddling processes

The Draw of DRVS

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- Ease running reports
- Functionality to facilitate improvement in CQM performance
- Desire for data-driven solutions

Barriers | Securing Buy-In

Quick uptake from quality team and buy-in secured among leadership, however…

Faced resistance from Providers, MAs, Front Desk, & Clinic Managers

Onboarded to UniteUs & Upstream at the same time

Had to prove that DRVS would create ease by integrating multiple data sources into one location

Going Beyond Quality | What it Took

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1. Upfront investment in **configuring alerts** & establishing a **data hygiene infrastructure**

2. **Aligning the PVP** to Project Vida's care team structures, workflows, goals, and population

3. Sharing alert closure, usage, and measure performance **unblinded**

Strategies | The Pre-Work

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Configured **Alerts**

Category	Name	PVP Name	Description	Owner
Vitals	Adult Weight Screening	BMI & FU	Alert will trigger if patient has not had a BMI in th	PCP
Screening	Alcohol Screen	Alcohol Screening	Alert will trigger for patients ages >= 14 who have	MA
Well Visit	Annual Well Child 3-6	Well Visit 3-6	Alert will trigger if Physical Exam has not occurred	PCP
Well Visit	Annual Well Child 7-18	Well Visit 7-18	Alert will trigger if Physical Exam has not occurred	PCP
Medication	Aspirin	Aspirin	Alert will trigger if Aspirin or another Anti-Platelet	PCP
Medication	Asthma Control Therapy	Asthma Rx	Alert will trigger if patient age 5-64 has been ident	PCP
Vitals	BMI Percentile	BMI %	Alert will trigger if BMI Percentile 2 has not occurr	MA
Screening	Bone Density	Bone Density - Female	Alert will trigger if DEXA Bone Density Scan has no	PCP
Vitals	BP	BP	Alert will trigger if Most Recent Blood Pressure ha	MA
Immunizations	CDC Immunization Flu	Flu	Alert will appear as Due Soon for patients >= 6 mc	MA
Immunizations	CDC Immunization HPV	HPV	Alert will appear as Due Soon for patients >= 9 an	MA
Cancer Screening	Cervical Cancer Screening	Pap HPV	Alert will trigger 1) if patient age >= 21 and <= 64 c	PCP
Lab	Chlamydia Screening	Chlamydia	Alert will trigger if Chlamydia Lab Tests has not oc	PCP
Cancer Screening	Colorectal Cancer Screening	Colon CA 45+	Alert will trigger if patient has not had a colonosc	PCP
Oral Health	Dental Sealant	Dental Sealant	Alert will trigger if UDS Child Dental Sealant has n	PCP
Screening	Depression Remission	Depression Remission	Alert will trigger if a patient has a diagnosis of dep	PCP
Screening	Depression Screening	Depression Screen	Alert will trigger if Depression Screen Result has n	MA
Screening	Depression Screening Follow	Depression Follow-Up	Alert will trigger if patient had positive depression	PCP
Lab	Diabetes A1c	A1c	Alert will trigger if A1c has not occurred in the last	PCP
Chronic Disease	Diabetes Eye Exam	Eye	Alert will trigger if a patient had Diabetic Retinopa	PCP
Chronic Disease	Diabetes Foot Exam	Foot	Alert will trigger if Foot Exam has not occurred in	PCP
Lab	Diabetes Nephropathy Scree	Nephropathy	Alert will trigger if Nephropathy Screening has not	PCP
Lab	Diabetes/HTN LDL	LDL	Alert will trigger if LDL has not occurred in the last	PCP
Screening	Drug Screen	Drug Screening	Alert will trigger for patients ages >= 14 who have	MA
Vitals	Elevated BP	BP High No Dx	Alert will trigger if a patient has had 2 BP readings	PCP
Possible Chronic Dx	Elevated Glucose	Diabetes Risk	Alert will trigger if patient had an A1c >= 5.7 OR a	PCP
Immunizations	General Childhood Immuniz	Childhood Imms	Alert will trigger for any patients >=15 months anc	MA
Lab	Hep C Screening	Hep C	Alert will trigger if Hep C Screen has not occurred	PCP

Created a **Data Hygiene Calendar**

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

Strategies | Creating Alignment

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Revisited and **aligned workflows with alerts** by building out standing actions & assigning alert owners.

Front desk runs the PVP to identify screening needs

MA runs and prints the PVP for their provider

MA utilizes the PVP during triage to address care gaps

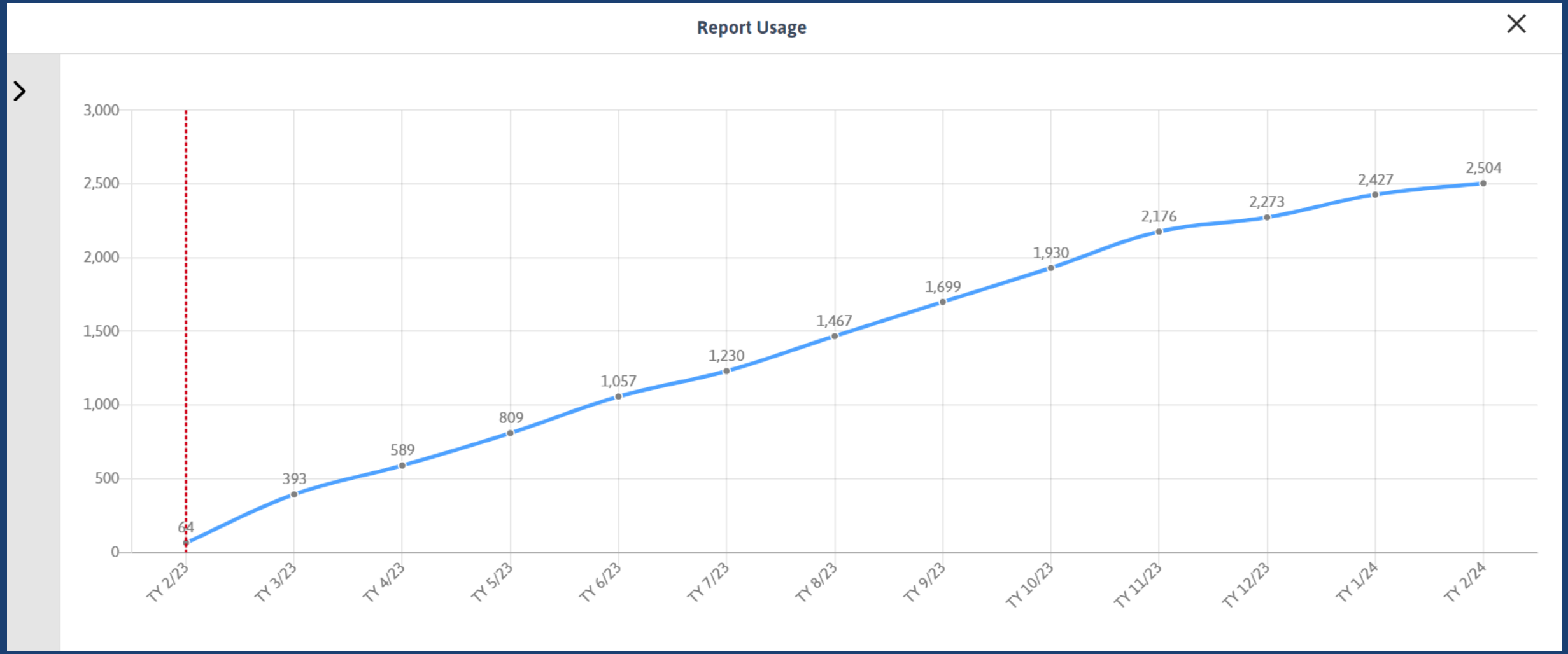
Strategies | Sharing Data

Established monthly meetings with integrated team to openly review:

- PVP Usage
- Alert Closure Rates
- CQM Performance

Set up unblinded email subscriptions to share provider performance across whole organization.

PVP Impact | PVP Usage



PVP Impact | CQM Performance

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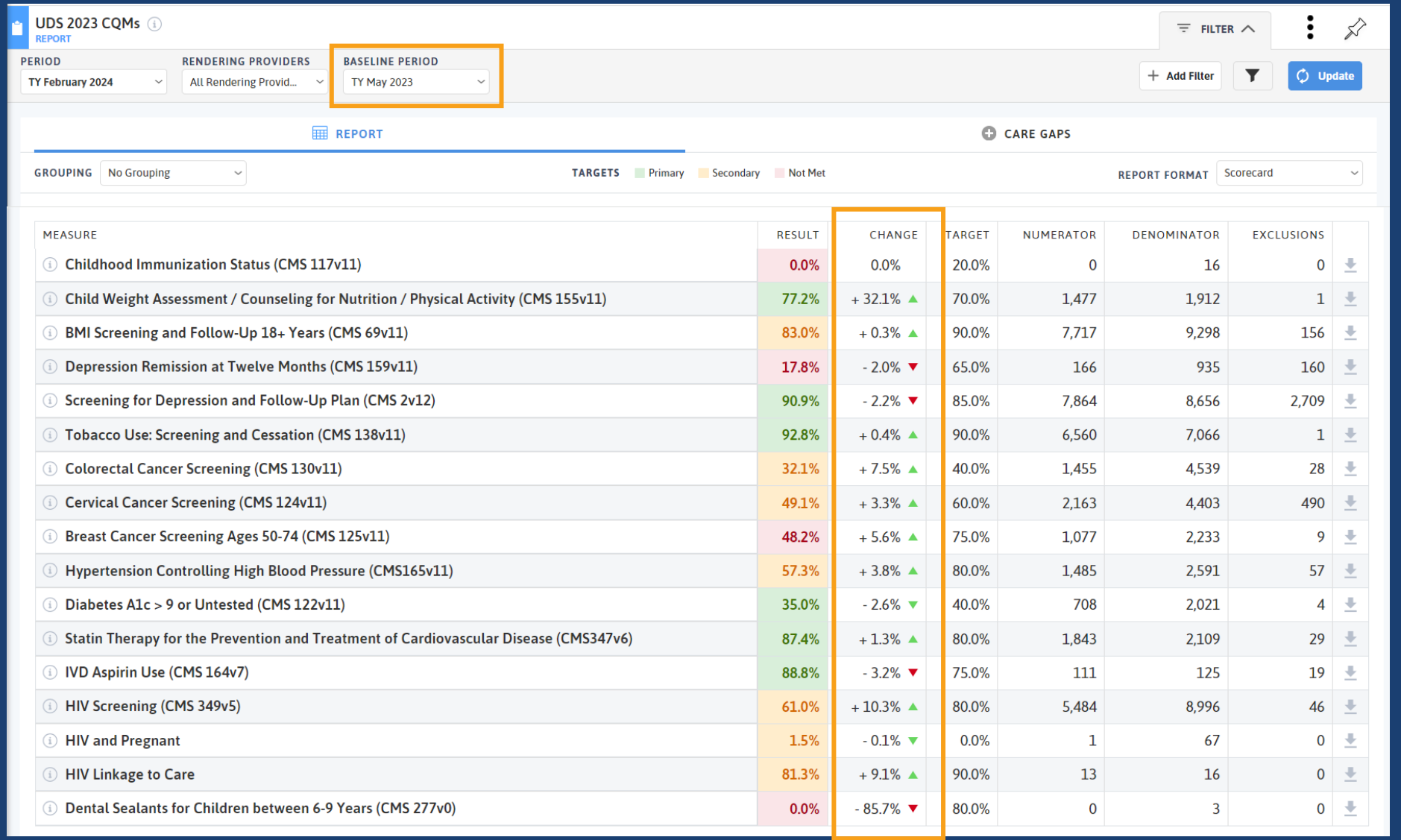


UDS 2023 CQMs
REPORT

FILTER

PERIOD: TY February 2024
RENDERING PROVIDERS: All Rendering Provid...
BASELINE PERIOD: TY May 2023

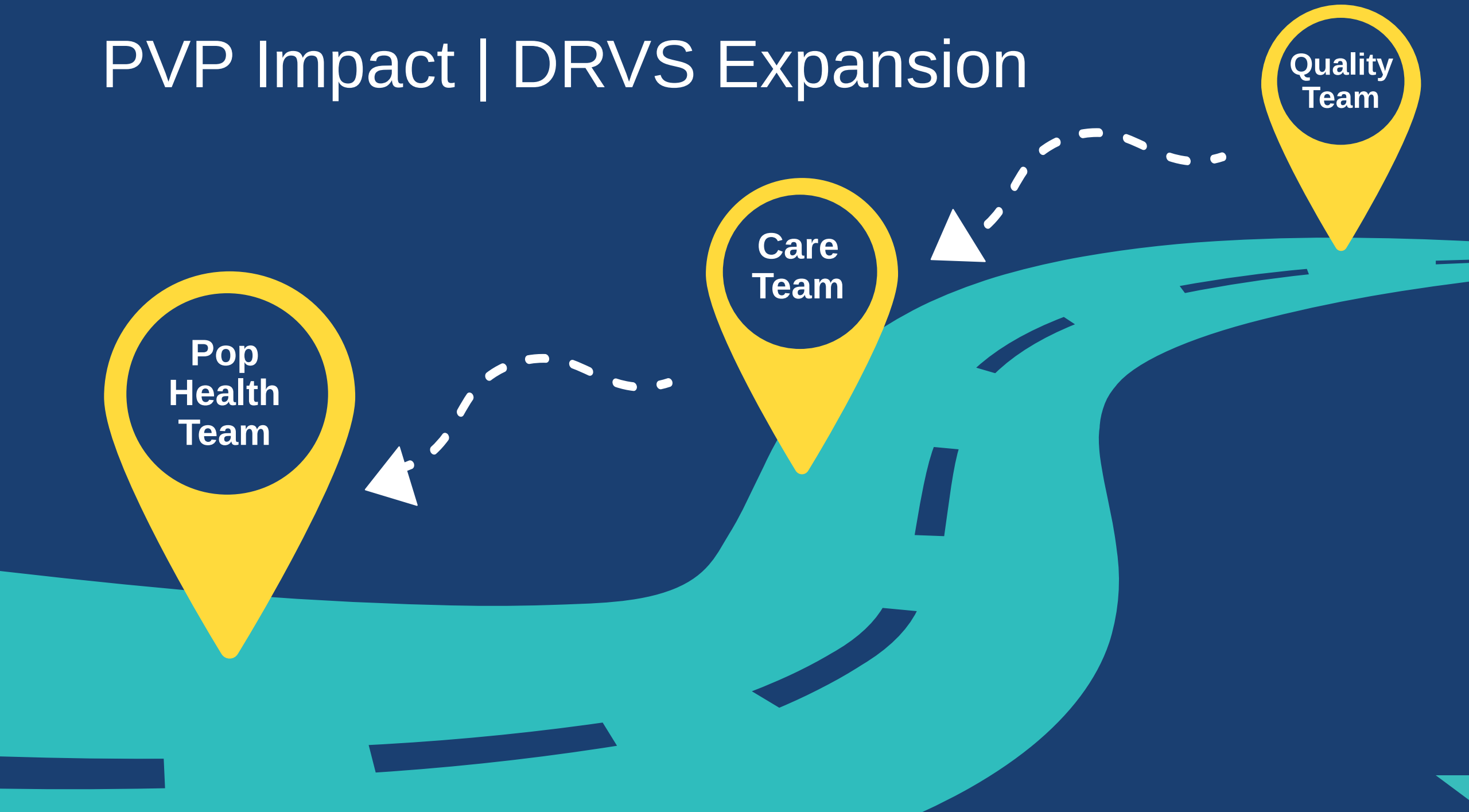
Add Filter | Update

REPORT | CARE GAPS

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

MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Childhood Immunization Status (CMS 117v11)	0.0%	0.0%	20.0%	0	16	0
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v11)	77.2%	+ 32.1% ▲	70.0%	1,477	1,912	1
BMI Screening and Follow-Up 18+ Years (CMS 69v11)	83.0%	+ 0.3% ▲	90.0%	7,717	9,298	156
Depression Remission at Twelve Months (CMS 159v11)	17.8%	- 2.0% ▼	65.0%	166	935	160
Screening for Depression and Follow-Up Plan (CMS 2v12)	90.9%	- 2.2% ▼	85.0%	7,864	8,656	2,709
Tobacco Use: Screening and Cessation (CMS 138v11)	92.8%	+ 0.4% ▲	90.0%	6,560	7,066	1
Colorectal Cancer Screening (CMS 130v11)	32.1%	+ 7.5% ▲	40.0%	1,455	4,539	28
Cervical Cancer Screening (CMS 124v11)	49.1%	+ 3.3% ▲	60.0%	2,163	4,403	490
Breast Cancer Screening Ages 50-74 (CMS 125v11)	48.2%	+ 5.6% ▲	75.0%	1,077	2,233	9
Hypertension Controlling High Blood Pressure (CMS165v11)	57.3%	+ 3.8% ▲	80.0%	1,485	2,591	57
Diabetes A1c > 9 or Untested (CMS 122v11)	35.0%	- 2.6% ▼	40.0%	708	2,021	4
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v6)	87.4%	+ 1.3% ▲	80.0%	1,843	2,109	29
IVD Aspirin Use (CMS 164v7)	88.8%	- 3.2% ▼	75.0%	111	125	19
HIV Screening (CMS 349v5)	61.0%	+ 10.3% ▲	80.0%	5,484	8,996	46
HIV and Pregnant	1.5%	- 0.1% ▼	0.0%	1	67	0
HIV Linkage to Care	81.3%	+ 9.1% ▲	90.0%	13	16	0
Dental Sealants for Children between 6-9 Years (CMS 277v0)	0.0%	- 85.7% ▼	80.0%	0	3	0

PVP Impact | DRVS Expansion



DRVS Expansion | The Pop Health Break-In

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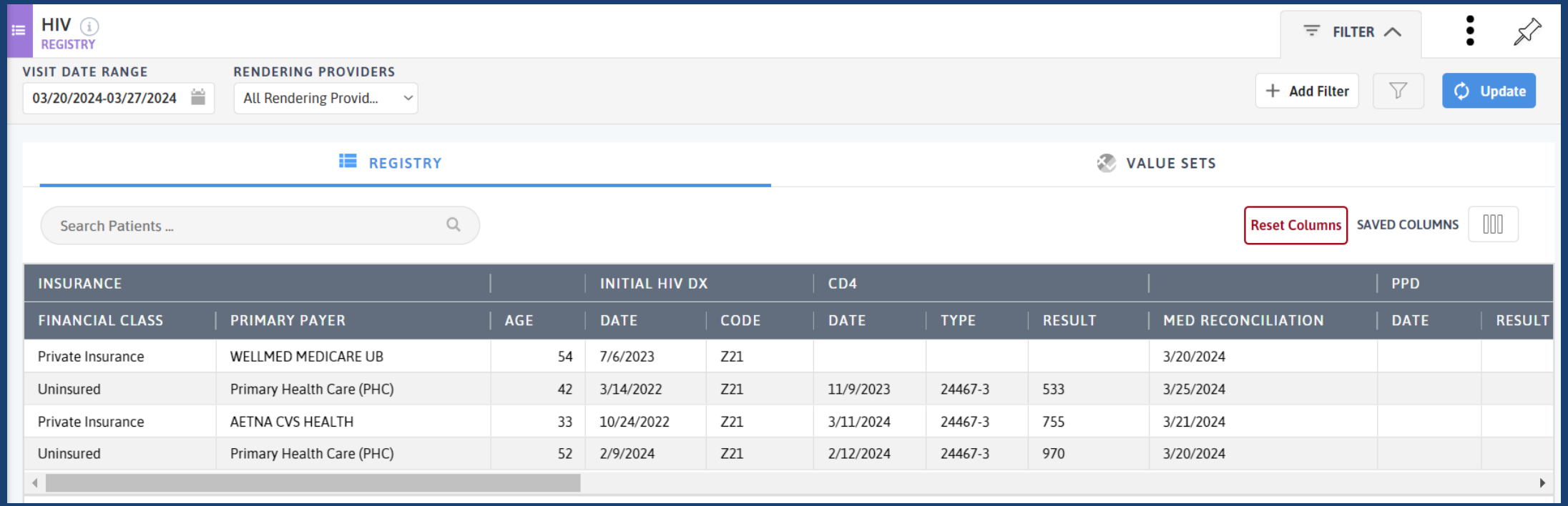
Receiving Ryan White funding prompted engagement among the population health team around leveraging DRVS to simplify reporting. Found success providing one-on-one support.



INSURANCE			INITIAL HIV DX		CD4				PPD	
FINANCIAL CLASS	PRIMARY PAYER	AGE	DATE	CODE	DATE	TYPE	RESULT	MED RECONCILIATION	DATE	RESULT
Private Insurance	WELLMED MEDICARE UB	54	7/6/2023	Z21				3/20/2024		
Uninsured	Primary Health Care (PHC)	42	3/14/2022	Z21	11/9/2023	24467-3	533	3/25/2024		
Private Insurance	AETNA CVS HEALTH	33	10/24/2022	Z21	3/11/2024	24467-3	755	3/21/2024		
Uninsured	Primary Health Care (PHC)	52	2/9/2024	Z21	2/12/2024	24467-3	970	3/20/2024		

DRVS Expansion | Population Health Efforts

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- Gender Affirming Care
- Tobacco Cessation
- Wellness Initiatives
- Outreach & Engagement
- Behavioral Health

Dr. G's Tips for Success

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1. Be involved from beginning to end of the implementation process.
2. Healthy competition prompts the exchange of best practices.
3. Engage the full care team.
4. Stay on top of monthly data hygiene efforts.

Looking Ahead | DRVS Expansion

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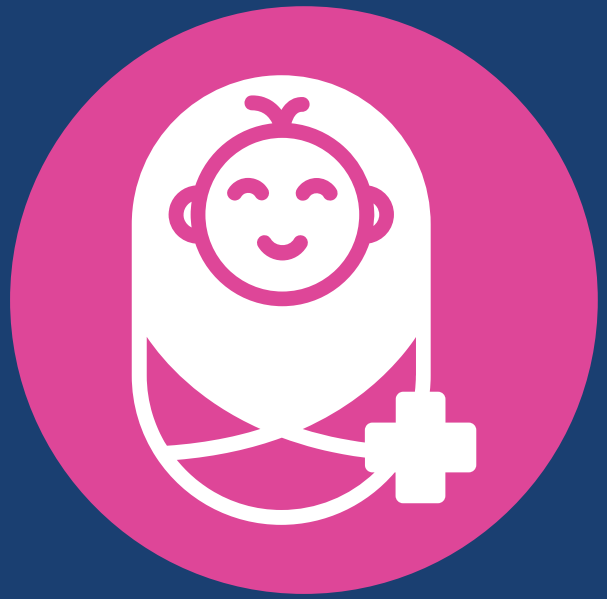
Payer Integration

FPAR 2.0 Reporting



Pediatrics

Questions?

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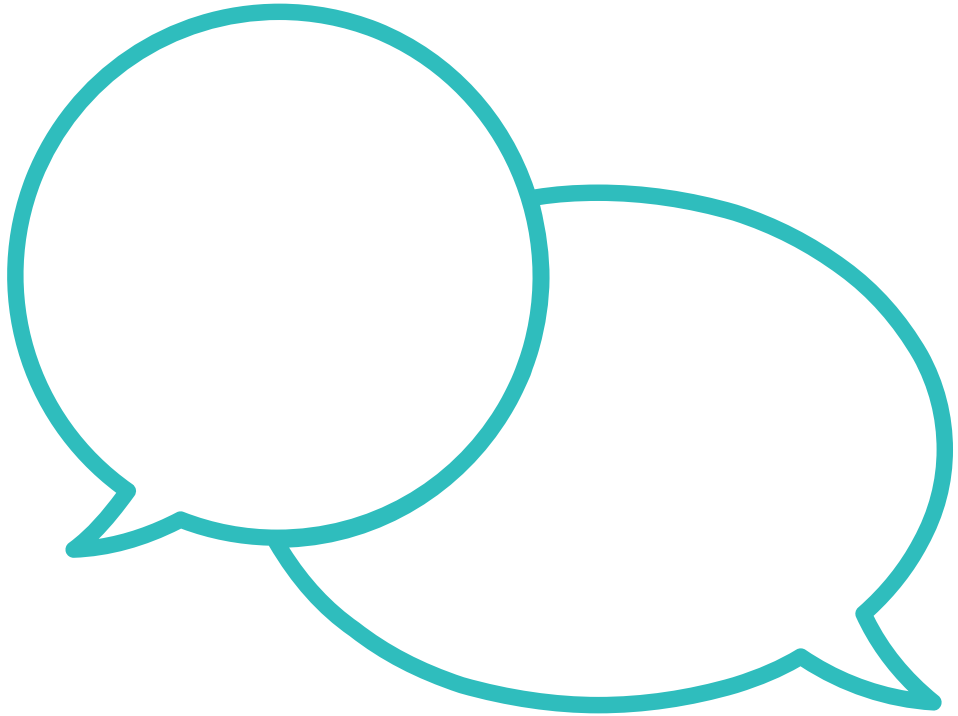

Azara healthcare

@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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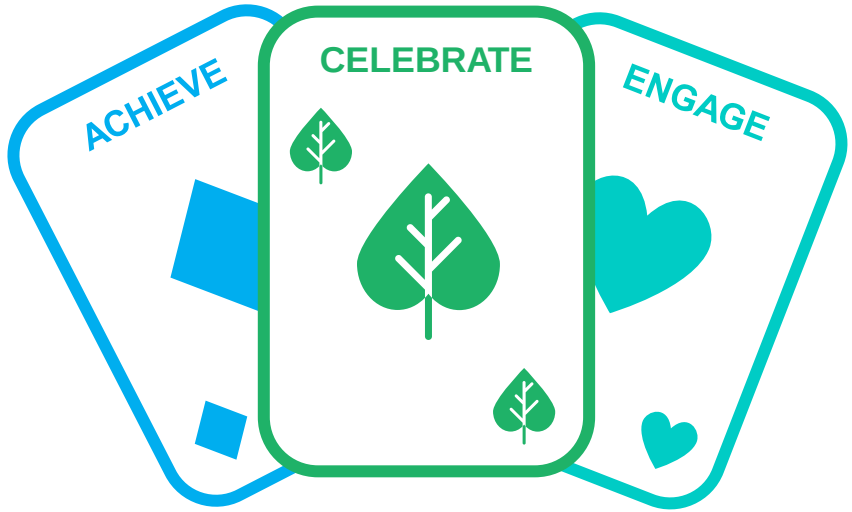
ACE Program



Benefits:

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

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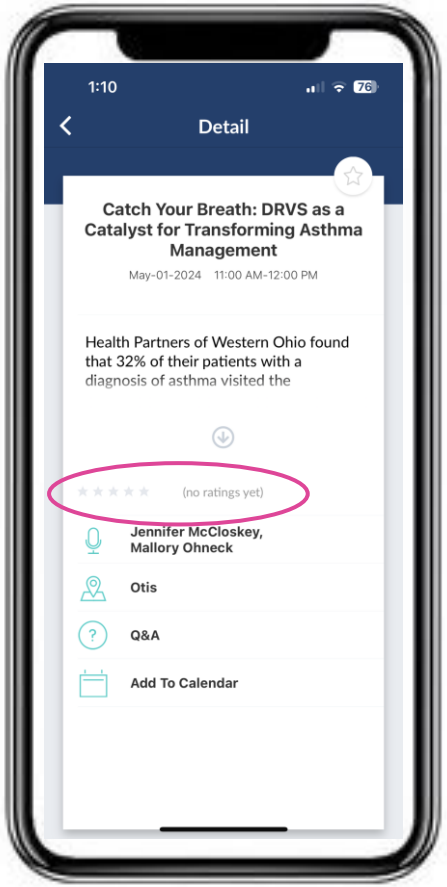

Quick and Easy

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