

## **Azara Care Connect**

**Complete Care Management + Care Coordination Solution** 

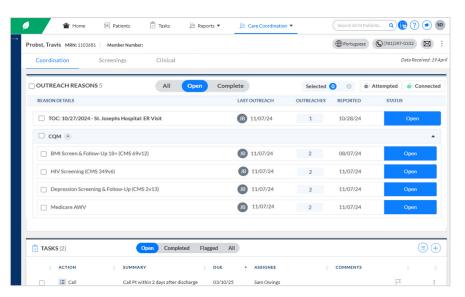
# A fully integrated solution to efficiently manage and coordinate care – leveraging your DRVS data to optimize performance.

Whether you're a Care Manager or Care Coordinator, Azara Care Connect's features and functionality help manage the full spectrum of your organization's patient needs. Care Connect is designed to leverage the full set of clinical, claims, HIE and practice management data in Azara DRVS and makes it available in a simple and intuitive user interface. Care Coordinators are further enabled to improve productivity and efficiency, close care gaps, and track adherence to health plan contract requirements across a large population of patients.

## **Care Coordination**

Simplify care coordination and increase performance by documenting outreach activities, prioritizing patients, and closing care gaps – all in one place.

Care Coordination enables your practice staff to organize patient data from health plans and DRVS to quickly and easily perform and document outreach and outcomes for each patient. These care coordination activities enable organizations to improve



productivity and efficiency, close care gaps, and track adherence to health plan contract requirements—leading to increased performance on value-based care metrics and higher reimbursements.

#### **Features & Benefits:**

- New! Build patient care plans with integrated, evidence-based content from Elsevier.
- Track completion of tasks and interventions provided across your population to close care gaps, lower ED and hospital utilization, and support best practices.
- Drive high-priority patient engagement with flexible filtering and built-in prioritization.
- · Document, view, and complete outreach efforts.

- Set follow-up events in adherence with value-based agreements.
- Automate ingestion of monthly plan gaps with logic to prevent completed or out of date gaps from resurfacing.
- Quickly view medical and demographic information, active gaps, outreach notes, and history for each patient.

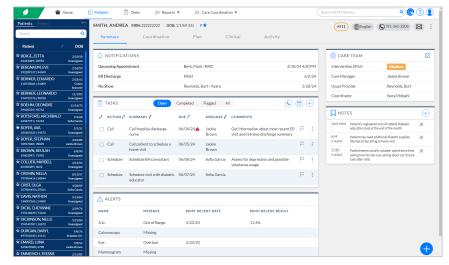




## **Care Management**

Track components of patient care by reviewing and understanding a patient's longitudinal record in a synthesized view of data from multiple sources.

Care Management features enable practices to organize patients into groups of high cost, high risk or other characteristics, such as chronic diseases—allowing care management staff to effectively oversee and monitor a panel of patients by tracking the



day-to-day tasks and follow-up activities related to their care to meet chronic care management and patient centered medical home program requirements.

## Care Management can help solve a variety of patient challenges including:

- Identifying, Tracking and Closing Care Gaps
- Care Plan Creation and Management
- Following up on Transitions of Care
- Chronic Care Management

- Coordination of Hospice or Palliative Care
- Time Tracking and Interaction Documentation for Billing
- Prenatal/Postpartum Patient Programs and Retention

"The data coming out of the Care Connect application saves us tremendous time in the way of reporting performance/activity both internally and to our external Health Plan partners. **I would say the time savings is 70%**, as several of us invested a lot of time each month reviewing, cleaning and normalizing outreach activity data submitted independently by each CHW."

#### **Chris Hicks**

Network Analytics Director | Michigan Community Health Network

### **Interested in learning more about Azara Care Connect?**

Azara Care Connect is a separate application that leverages the data within Azara DRVS. It requires setup, configuration and a separate subscription.

