PCMH & DRVS

MTPCA User Group

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Agenda

PCMH STANDARDS

AZARA PCMH PREVALIDATION RESOURCES

PCMH CONCEPTS & DRVS TOOLS

2025 ANNUAL REPORTING

WHAT'S NEW IN DRVS & QUESTIONS

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NCQA PCMH Standards

The Patient Centered Medical Home

”

A PCMH puts patients at the center of the health care system, and provides primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

—American Academy of Pediatrics

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Concepts

Concept	NCQA Goal
Team-Based Care and Practice Organization (TC)	• The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care • *Examples: regular team huddles, documented staffing models and empanelment procedures*
Knowing and Managing Your Patients (KM)	• The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services • *Examples: demographics reports, language assessments, connections with local community organizations*
Patient Centered Access and Continuity (AC)	• The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access • *Examples: performance reports on appointment availability, offers same day appointments, timely clinical advice by phone*
Care Management and Support (CM)	• Practice identifies patient needs at the individual and population levels to effectively plan, manage, and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk • *Examples: documented process to identify patients in need of care management (i.e. risk stratification), provides appropriate care plans to patient and family/caregiver*
Care Coordination and Transitions (CC)	• Practice systematically tracks tests, referrals, and care transitions to achieve high quality care coordination, lower costs, improve patient safety, and ensure effective communication with specialists and other providers in the medical neighborhood • *Examples: Running reports to identify open referrals and missing lab results, documented processes around transitions of care such as sharing discharge reports*
Performance Measurement and Quality Improvement (QI)	• Practice establishes a culture of data-driven performance improvement on clinical quality, efficiency, and patient experience, and engages staff and patients/families/caregivers in quality improvement activities • *Performance monitoring against shared goals and benchmarks for at least 5 clinical quality measures, collects survey data on patient experiences*

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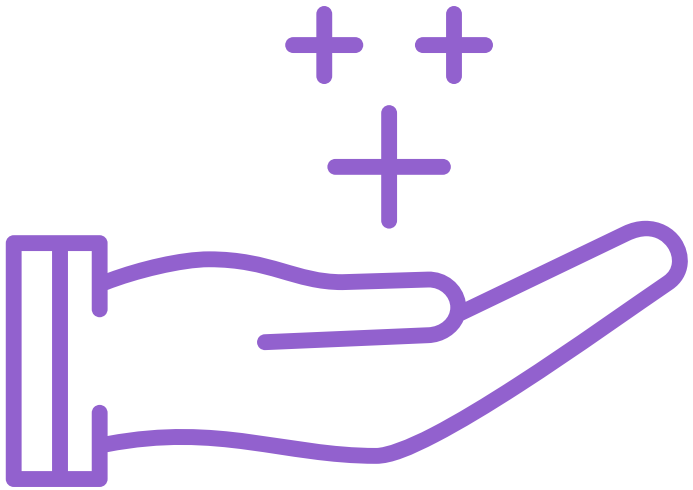
PCMH Value

- Coordinated Care
- Enhanced Access
- Personalized Care
- Prevention & Wellness
- Improved Patient Engagement
- Data Driven Care
- Cost Efficiency



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PCMH & Value Based Care

FOCUS ON
OUTCOMES

QUALITY
METRICS

COST
REDUCTION

ALIGNMENT
WITH PAYERS

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Azara PCMH Prevalidation and Resources

DRVS is Pre-validated for PCMH!

DRVS Module	Full Credit	Partial Credit	Practice Support
Core DRVS			
Core Criteria	5	4	8
Elective Criteria	1	2	13
Risk			
Core Criteria			1 (CM 01)
Elective Criteria			1 (CM 03)
Referrals			
Core Criteria		1 (CC 04)	
Elective Criteria	1 (CC 06)		1 (CC 11)
Transitions of Care			
Core Criteria	1 (CC 14)		1 (CC16)
Elective Criteria			
Payer Integration			
Core Criteria		1 (QI 02)	
Elective Criteria			

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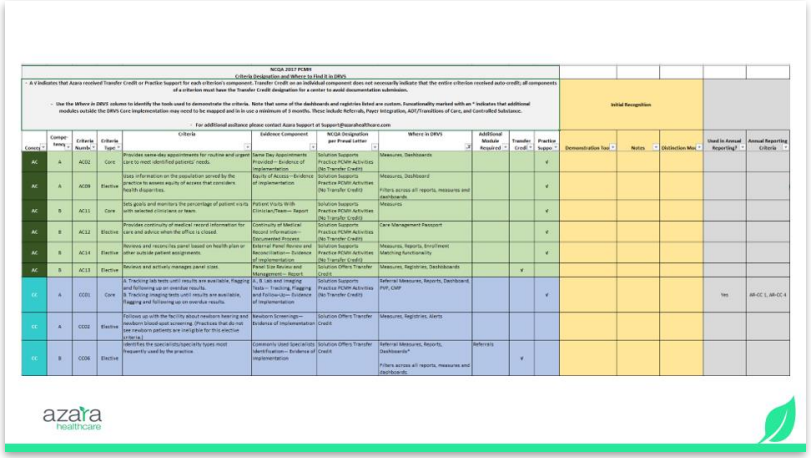
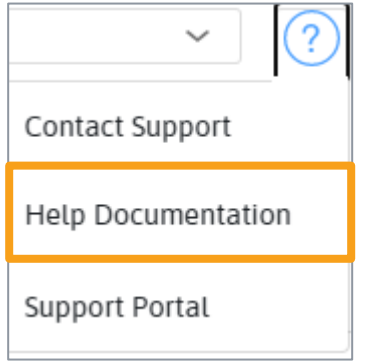
Azara's Resources

Available in the Help section of DRVS

- Azara NCQA PCMH Prevalidation Content Details





- Azara NCQA PCMH Prevalidation Summaries (1 Page Summary)
- Azara NCQA PCMH Prevalidation Resources (1 Page Description of Resources)

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NCQA 2017 PCMH
Criteria Designation and Where to Find it in DRVS

- A √ indicates that Azara received Transfer Credit or Practice Support for each criterion's component. Transfer Credit on an individual component does not necessarily indicate that the entire criterion received auto-credit; all components of a criterion must have the Transfer Credit designation for a center to avoid documentation submission.

- Use the *Where in DRVS* column to identify the tools used to demonstrate the criteria. Note that some of the dashboards and registries listed are custom. Funcationality marked with an * indicates that additional modules outside the DRVS Core implementation may need to be mapped and in in use a minimum of 3 months. These include Referrals, Payer Integration, ADT/Transitions of Care, and Controlled Substance.

- For additional assitance please contact Azara Support at Support@azarahealthcare.com

Concept	Competency	Criteria Number	Criteria Type	Criteria	Evidence Component	NCQA Designation per Preval Letter	Where in DRVS	Additional Module Required	Transfer Credit	Practice Support	Initial Recognition: Demonstration Tool	Initial Recognition: Notes	Initial Recognition: Distinction Module	Used in Annual Reporting?	Annual Reporting Criteria
AC	A	AC02	Core	Provides same-day appointments for routine and urgent care to meet identified patients' needs.	Same Day Appointments Provided— Evidence of Implementation	Solution Supports Practice PCMH Activities (No Transfer Credit)	Measures, Dashboards			√					
AC	A	AC09	Elective	Uses information on the population served by the practice to assess equity of access that considers health disparities.	Equity of Access—Evidence of Implementation	Solution Supports Practice PCMH Activities (No Transfer Credit)	Measures, Dashboard Filters across all reports, measures and dashboards.			√					
AC	B	AC11	Core	Sets goals and monitors the percentage of patient visits with selected clinicians or team.	Patient Visits With Clinician/Team— Report	Solution Supports Practice PCMH Activities (No Transfer Credit)	Measures			√					
AC	B	AC12	Elective	Provides continuity of medical record information for care and advice when the office is closed.	Continuity of Medical Record Information—Documented Process	Solution Supports Practice PCMH Activities (No Transfer Credit)	Care Management Passport			√					
AC	B	AC14	Elective	Reviews and reconciles panel based on health plan or other outside patient assignments.	External Panel Review and Reconciliation— Evidence of Implementation	Solution Supports Practice PCMH Activities (No Transfer Credit)	Measures, Reports, Enrollment Matching functionality			√					
AC	B	AC13	Elective	Reviews and actively manages panel sizes.	Panel Size Review and Management— Report	Solution Offers Transfer Credit	Measures, Registries, Dashbboards		√						
CC	A	CC01	Core	A. Tracking lab tests until results are available, flagging and following up on overdue results. B. Tracking imaging tests until results are available, flagging and following up on overdue results.	A., B. Lab and Imaging Tests— Tracking, Flagging and Follow-Up— Evidence of Implementation	Solution Supports Practice PCMH Activities (No Transfer Credit)	Referral Measures, Reports, Dashboard, PVP, CMP			√				Yes	AR-CC 1, AR-CC 4
CC	A	CC02	Elective	Follows up with the facility about newborn hearing and newborn blood-spot screening. (Practices that do not see newborn patients are ineligible for this elective criteria.)	Newborn Screenings—Evidence of Implementation	Solution Offers Transfer Credit	Measures, Registries, Alerts								
CC	B	CC06	Elective	Identifies the specialists/specialty types most frequently used by the practice.	Commonly Used Specialists Identification— Evidence of Implementation	Solution Offers Transfer Credit	Referral Measures, Reports, Dashboards* Filters across all reports, measures and dashboards.	Referrals	√						

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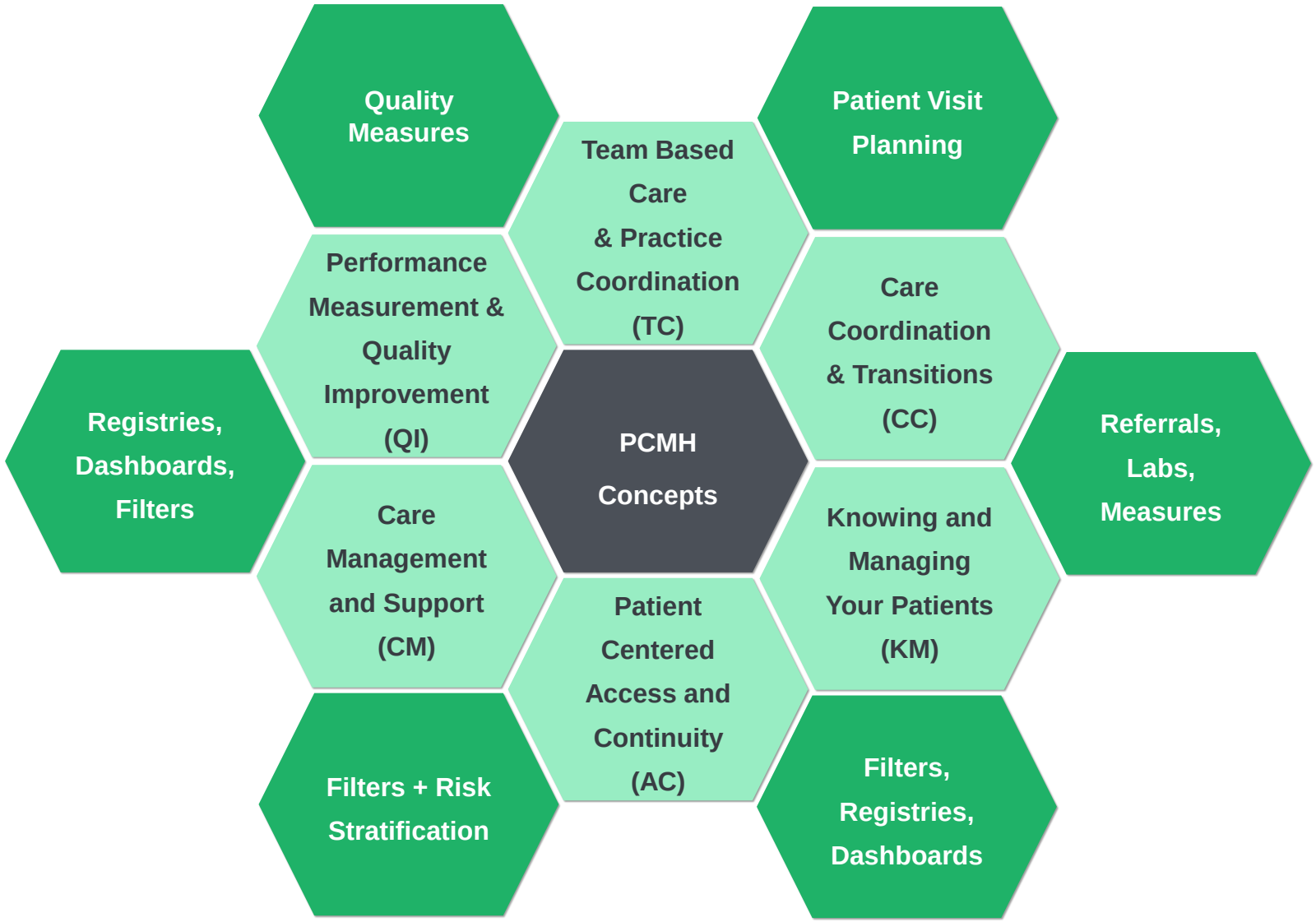
DRVS Alignment with PCMH



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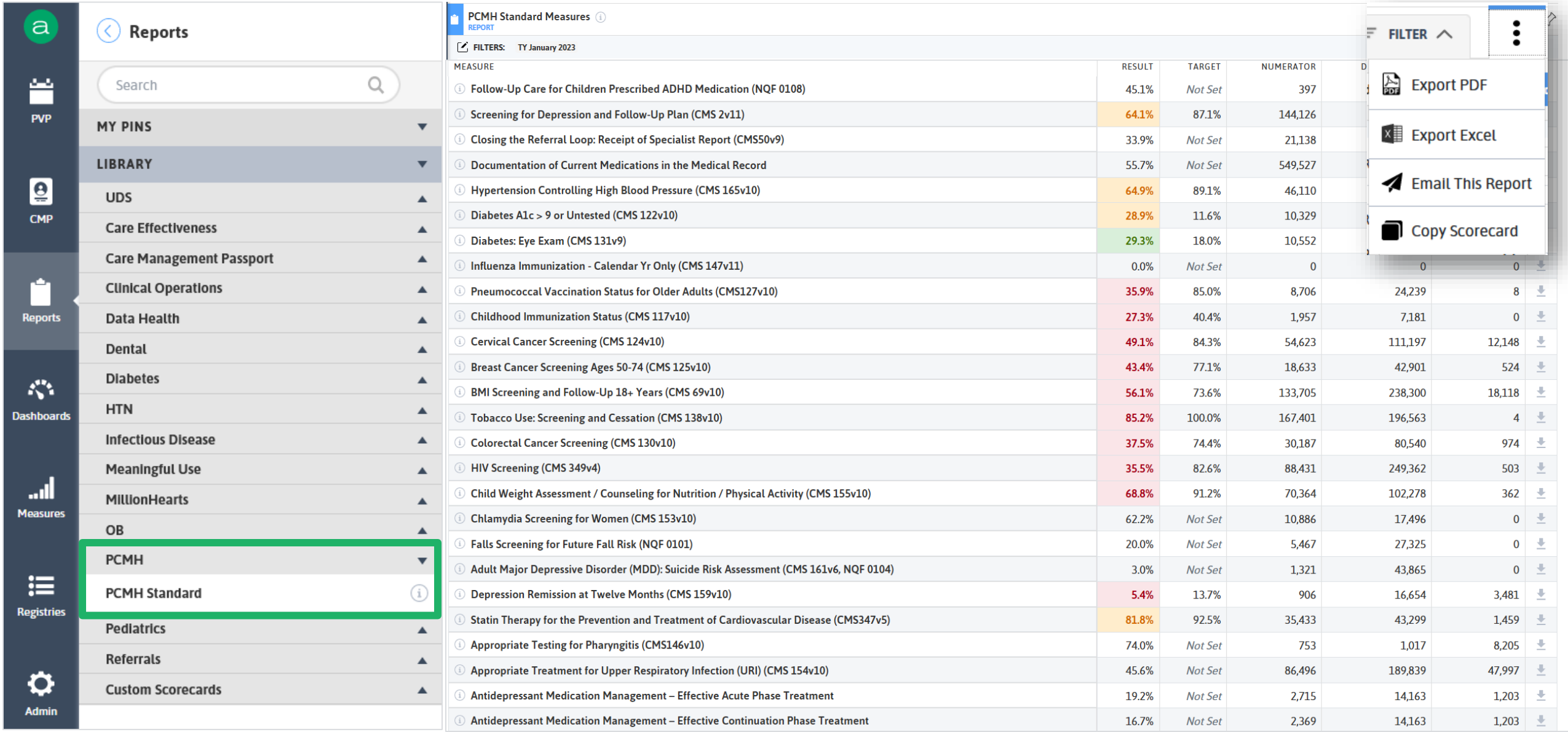
PCMH Scorecard



MEASURE	RESULT	TARGET	NUMERATOR	D	
Follow-Up Care for Children Prescribed ADHD Medication (NQF 0108)	45.1%	Not Set	397		
Screening for Depression and Follow-Up Plan (CMS 2v11)	64.1%	87.1%	144,126		
Closing the Referral Loop: Receipt of Specialist Report (CMS50v9)	33.9%	Not Set	21,138		
Documentation of Current Medications in the Medical Record	55.7%	Not Set	549,527		
Hypertension Controlling High Blood Pressure (CMS 165v10)	64.9%	89.1%	46,110		
Diabetes A1c > 9 or Untested (CMS 122v10)	28.9%	11.6%	10,329		
Diabetes: Eye Exam (CMS 131v9)	29.3%	18.0%	10,552		
Influenza Immunization - Calendar Yr Only (CMS 147v11)	0.0%	Not Set	0	0	0
Pneumococcal Vaccination Status for Older Adults (CMS127v10)	35.9%	85.0%	8,706	24,239	8
Childhood Immunization Status (CMS 117v10)	27.3%	40.4%	1,957	7,181	0
Cervical Cancer Screening (CMS 124v10)	49.1%	84.3%	54,623	111,197	12,148
Breast Cancer Screening Ages 50-74 (CMS 125v10)	43.4%	77.1%	18,633	42,901	524
BMI Screening and Follow-Up 18+ Years (CMS 69v10)	56.1%	73.6%	133,705	238,300	18,118
Tobacco Use: Screening and Cessation (CMS 138v10)	85.2%	100.0%	167,401	196,563	4
Colorectal Cancer Screening (CMS 130v10)	37.5%	74.4%	30,187	80,540	974
HIV Screening (CMS 349v4)	35.5%	82.6%	88,431	249,362	503
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v10)	68.8%	91.2%	70,364	102,278	362
Chlamydia Screening for Women (CMS 153v10)	62.2%	Not Set	10,886	17,496	0
Falls Screening for Future Fall Risk (NQF 0101)	20.0%	Not Set	5,467	27,325	0
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (CMS 161v6, NQF 0104)	3.0%	Not Set	1,321	43,865	0
Depression Remission at Twelve Months (CMS 159v10)	5.4%	13.7%	906	16,654	3,481
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v5)	81.8%	92.5%	35,433	43,299	1,459
Appropriate Testing for Pharyngitis (CMS146v10)	74.0%	Not Set	753	1,017	8,205
Appropriate Treatment for Upper Respiratory Infection (URI) (CMS 154v10)	45.6%	Not Set	86,496	189,839	47,997
Antidepressant Medication Management – Effective Acute Phase Treatment	19.2%	Not Set	2,715	14,163	1,203
Antidepressant Medication Management – Effective Continuation Phase Treatment	16.7%	Not Set	2,369	14,163	1,203

PCMH Concepts & DRVS Tools

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Team-Based Care & Practice Organization

NCQA Concept

"The practice provides continuity of care; communicates its roles and responsibilities to patients/ families/caregivers; and organizes and trains staff to work to the top of their license to provide patient-centered care as part of the medical home."

Competency A: The practice commits to transforming the practice into a sustainable patient-centered practice. Care team members have the knowledge and training necessary to perform their roles, which are defined by the practice's organizational structure

Competency B: Communication among staff is organized to ensure that patient care is coordinated, safe and effective.

Competency C: The practice defines and communicates its role and the patient's role in the medical home model of care.

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Team-Based Care & Practice Organization

The Goal: Designate Staff Responsibilities

RACI Chart – PCMH	Provider	MA	Support	Care Manager	Quality
Scheduling Patients	I	I	R		A
Taking A1c of DM Patients	A	R		I	C
Prescribing Statin	R	I		I	
Outreach to close gaps	I	C	R		A

Responsible
Accountable
Consulted
Informed

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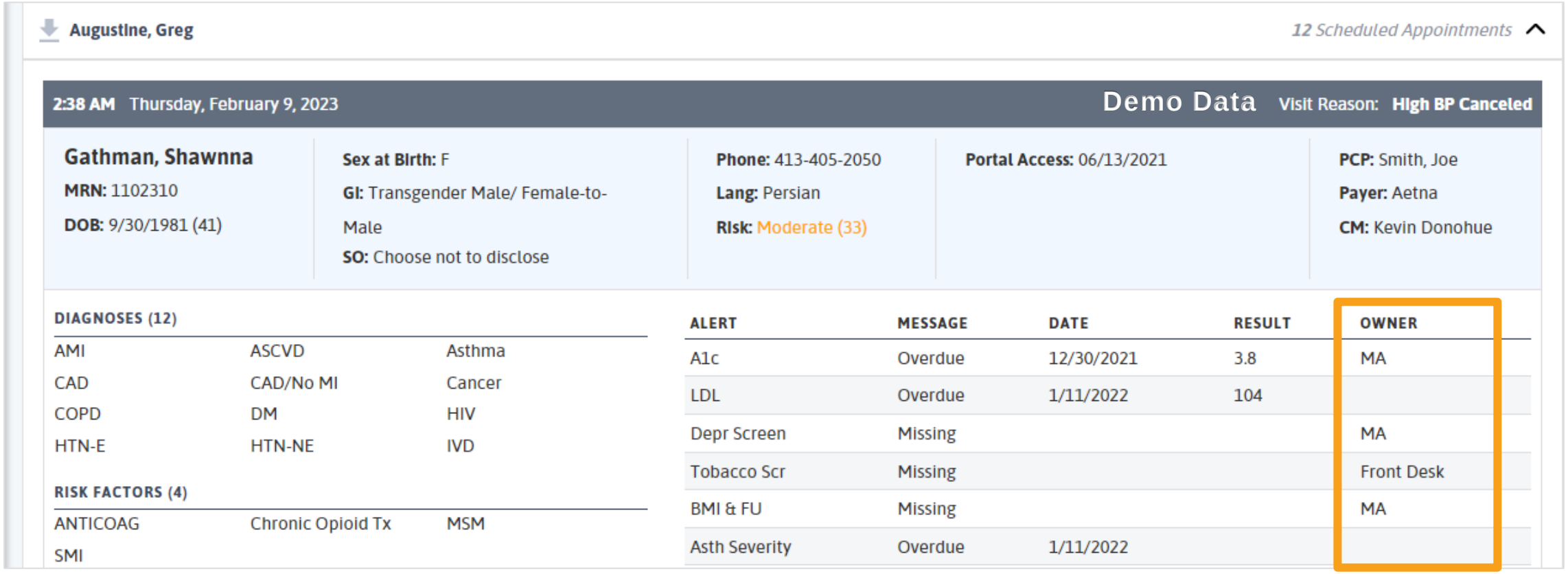
Team-Based Care & Practice Organization

DRVS Support



Augustine, Greg — *12 Scheduled Appointments*

2:38 AM Thursday, February 9, 2023 — Demo Data — Visit Reason: **High BP Canceled**

Gathman, Shawnna
MRN: 1102310
DOB: 9/30/1981 (41)

Sex at Birth: F
GI: Transgender Male/ Female-to-Male
SO: Choose not to disclose

Phone: 413-405-2050
Lang: Persian
Risk: Moderate (33)

Portal Access: 06/13/2021

PCP: Smith, Joe
Payer: Aetna
CM: Kevin Donohue

DIAGNOSES (12)

AMI	ASCVD	Asthma
CAD	CAD/No MI	Cancer
COPD	DM	HIV
HTN-E	HTN-NE	IVD

RISK FACTORS (4)

ANTICOAG	Chronic Opioid Tx	MSM
SMI		

ALERT	MESSAGE	DATE	RESULT	OWNER
A1c	Overdue	12/30/2021	3.8	MA
LDL	Overdue	1/11/2022	104	
Depr Screen	Missing			MA
Tobacco Scr	Missing			Front Desk
BMI & FU	Missing			MA
Asth Severity	Overdue	1/11/2022		

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Knowing & Managing Your Patients

NCQA Concept

"The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services."

Competency A: Collecting Patient Info

Competency B: Practice Diversity

Competency C: Addressing Patient Needs

Competency D: Medication Management

Competency E: Evidenced-Based Care

Competency F: Connecting with Community Resources

Competency G: Additional Patient Collaboration

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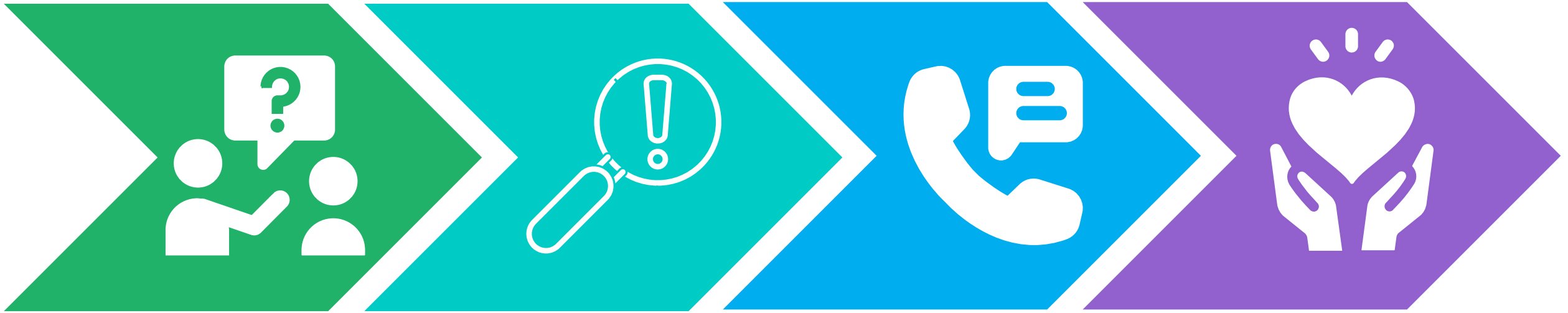
Knowing & Managing Your Patients

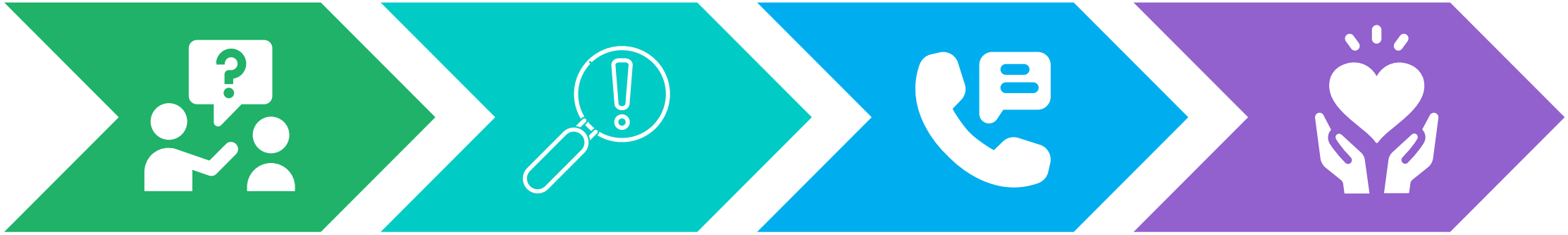
The Goal: Identification & Follow up



Screen **Identify** **Outreach** **Care**

Knowing & Managing Your Patients

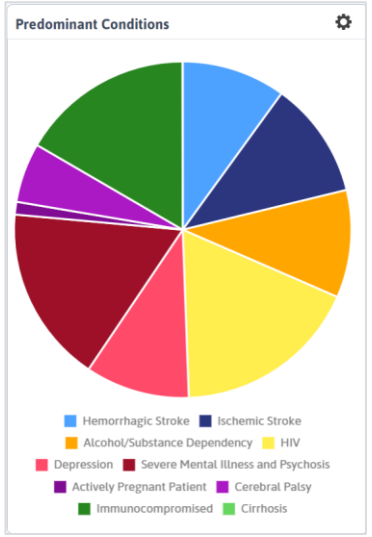
DRVS Tools



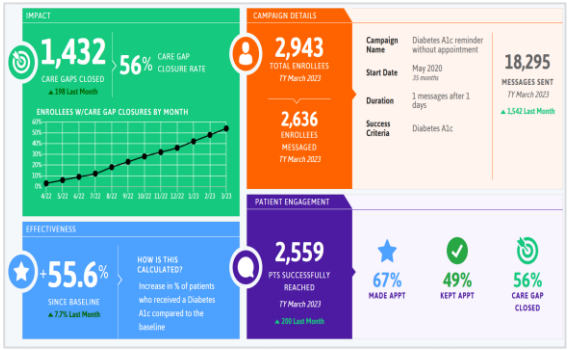
Screen

ALERT	MESSAGE	OWNER
Pap HPV	Missing	Provider
Chlamydia	Missing	
LDL	Missing	
Depr Screen	Missing	MA
Tobacco Scr	Overdue	Front Desk
BMI & FU	Missing	MA
BP	Overdue	MA

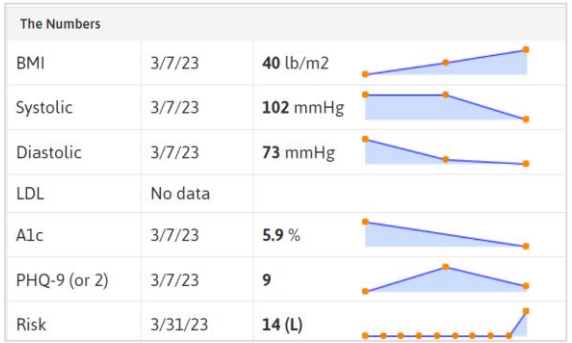
Identify



Outreach



Care



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Patient-Centered Access & Continuity

NCQA Concept

“The PCMH model expects continuity of care. Patients/families/caregivers have **24/7 access to clinical advice** and appropriate care facilitated by their **designated clinician/care team** and supported by access to their medical record. The practice **considers the needs and preferences** of the patient population when establishing and updating standards for access.”

Competency A: Patient Access to Practice. The practice enhances patient access by providing appointments and clinical advice based on patients’ needs.

Competency B: Empanelment and Access to the Medical Record. Practices support continuity through empanelment and systematic access to the patient’s medical record.

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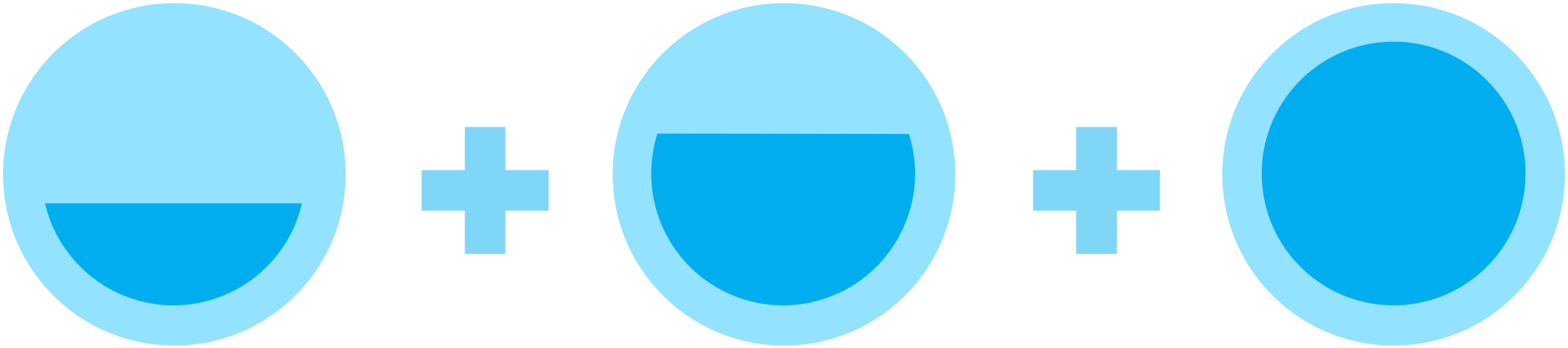
Patient-Centered Access & Continuity

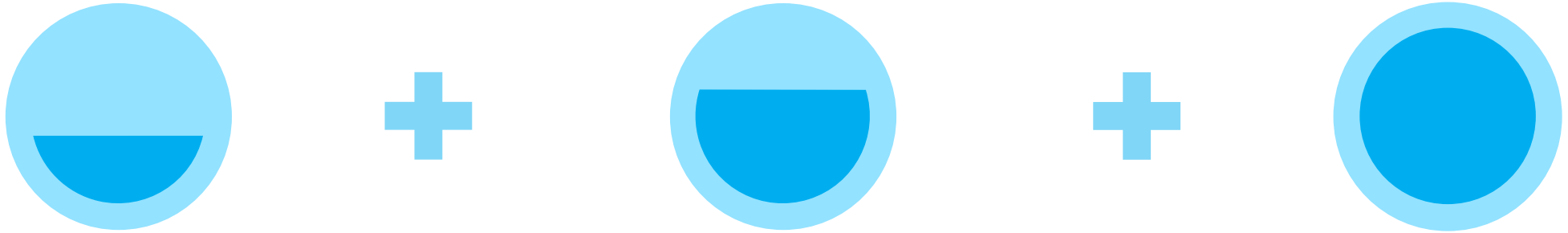
The Goal: Accessible Services



When + How + Who

Patient-Centered Access & Continuity

DRVS Tools



When

- Same Day & Walk In Appointments
- Appointments/Day Appointment times outside of standard business hours

How

- Telehealth appointments
- In person visits

Who

- Panel Assignment & Size
- Provider Continuity

Stratified by factors like age, race, ethnicity, language, or SDOH

Care Management & Support

NCQA CONCEPT

"The practice **identifies patient needs** at the individual and population levels to effectively **plan, manage and coordinate patient care** in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at **highest risk**."

Competency A: The practice systematically identifies patients who may benefit from care management.

Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart.

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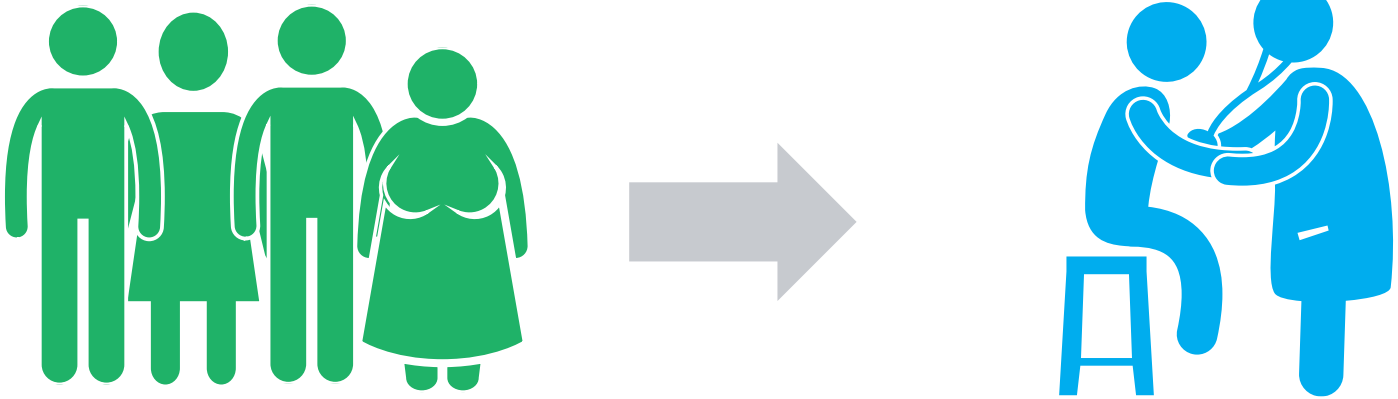
Care Management & Support

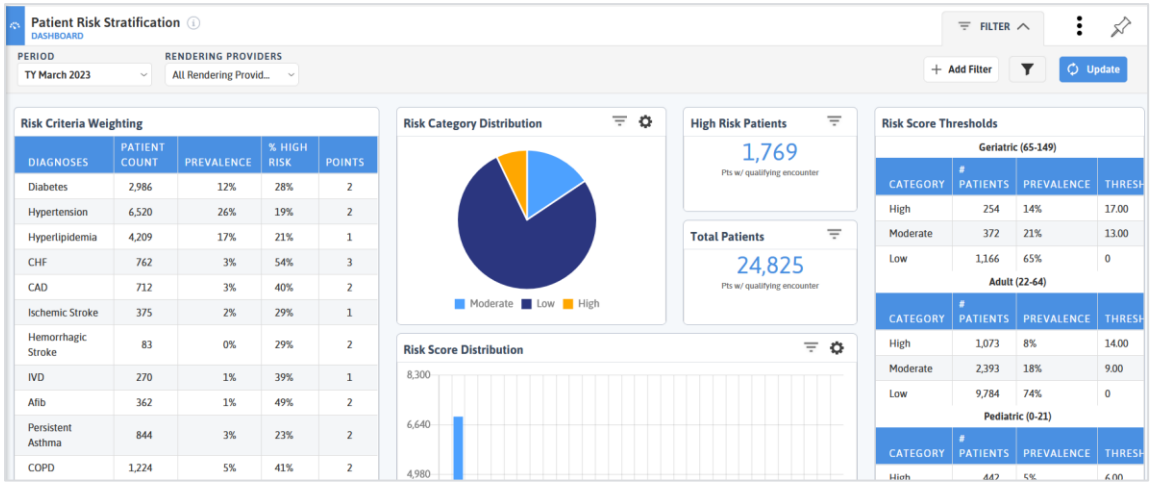
The Goal: Manage Key Populations

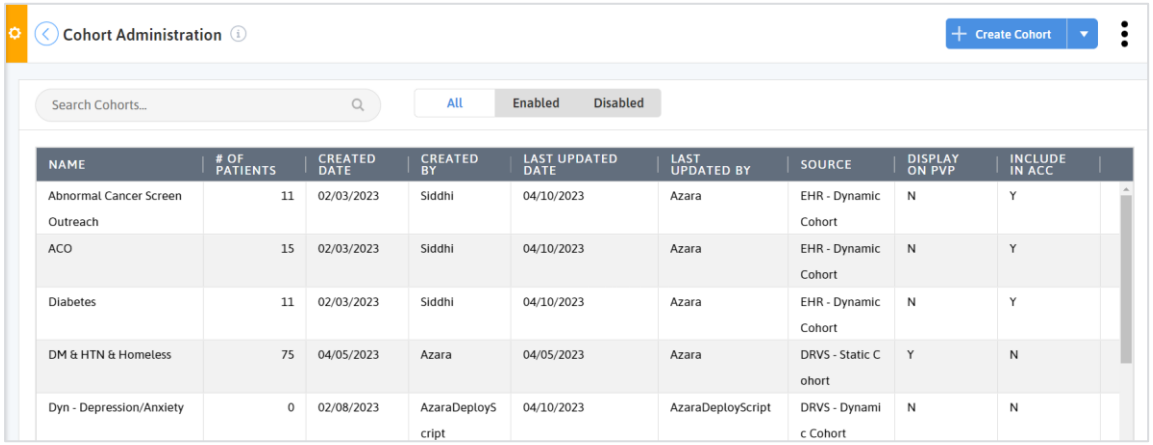


Care Management & Support

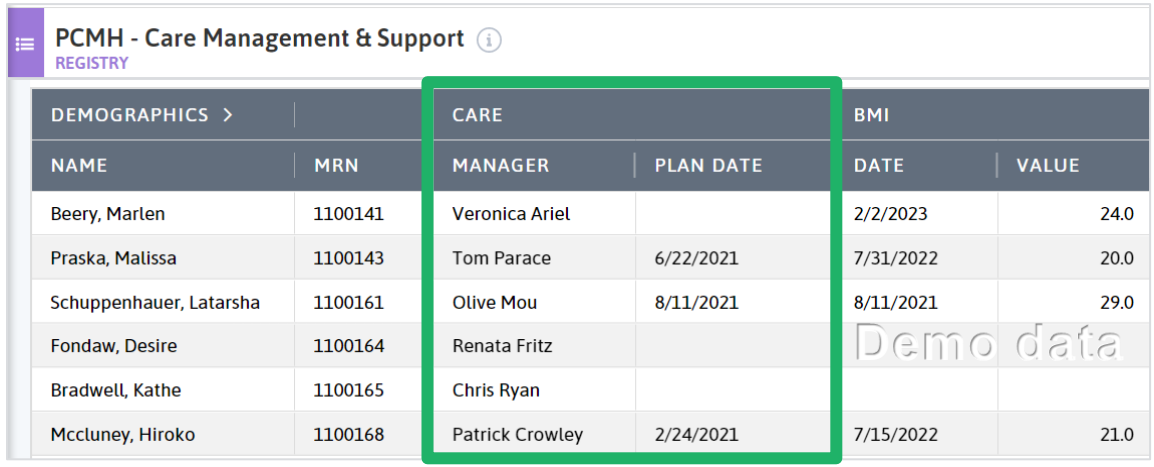
DRVS Tools

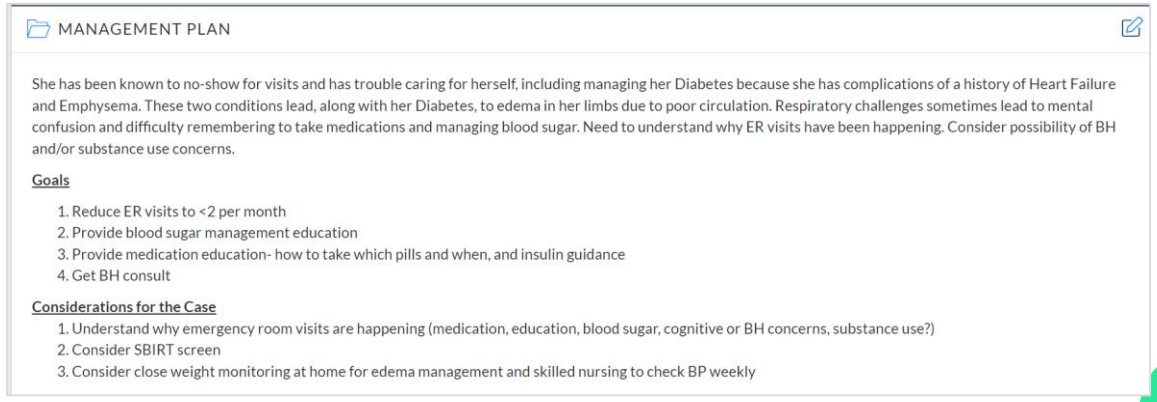
Identification





Management





Care Coordination & Care Transitions

NCQA CONCEPT

"The practice systematically **tracks tests, referrals and care transitions** to achieve high quality **care coordination**, **lower costs**, **improve patient safety and ensure effective communication** with specialists and other providers in the medical neighborhood."

Competency A: The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.

Competency B: The practice provides important information in referrals to specialists and tracks referrals until the report is received.

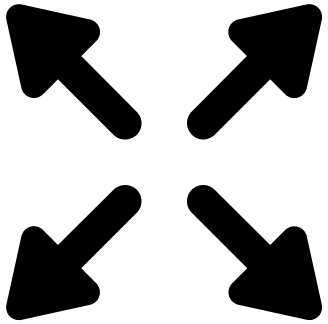
Competency C: The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

Care Coordination & Care Transitions

The Goal: Streamlined Communication

Open Communication

Patient Activation

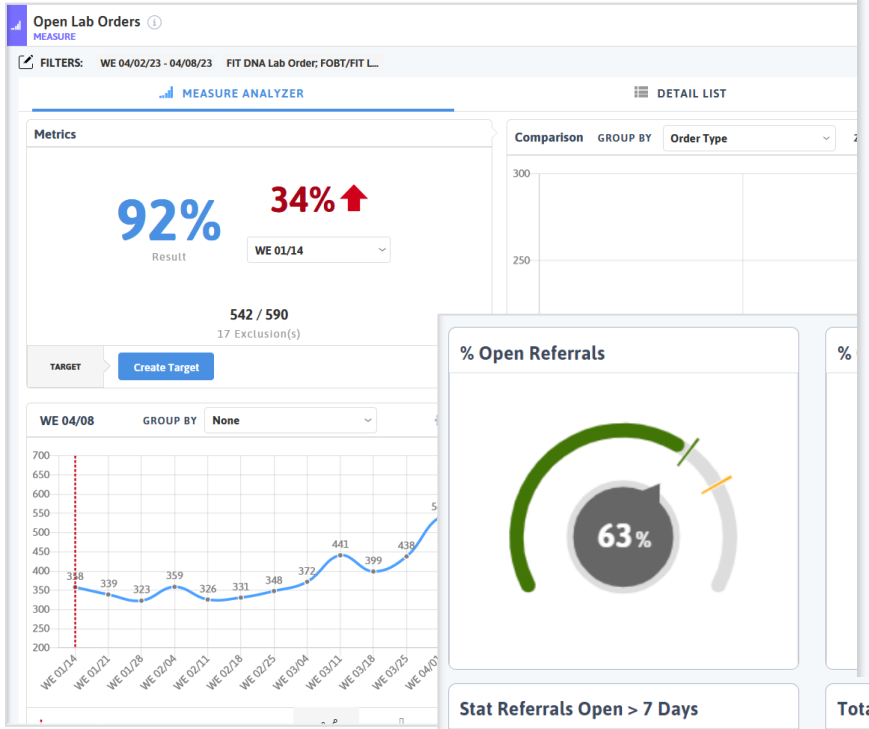


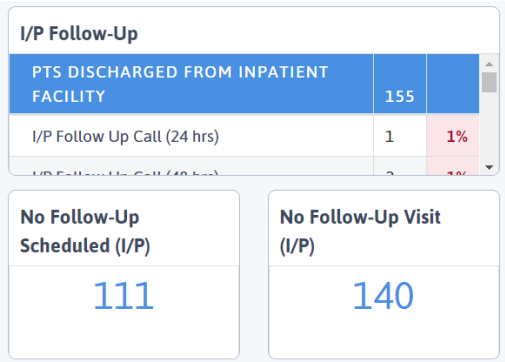
Data Insights

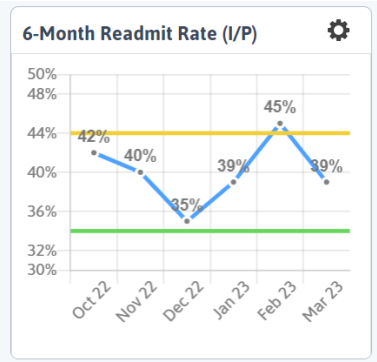
Team-Based Care

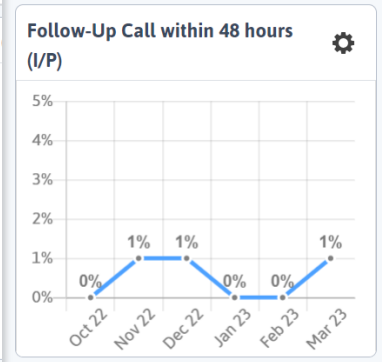
Care Coordination & Care Transitions

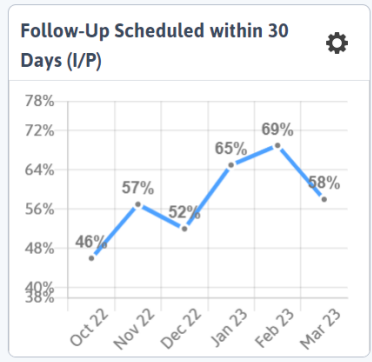
DRVS Tools

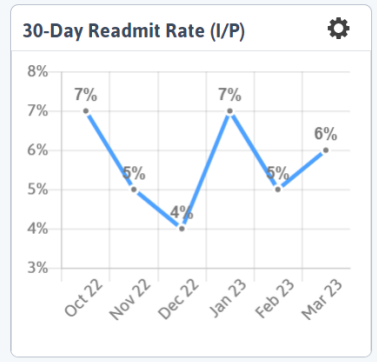


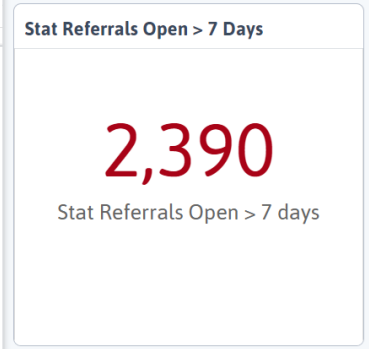


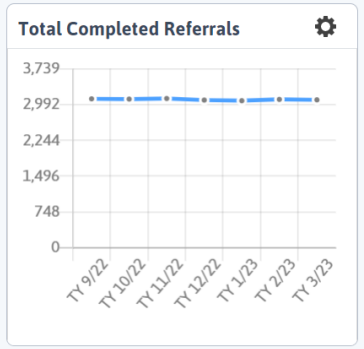


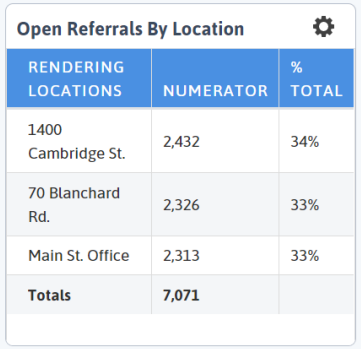


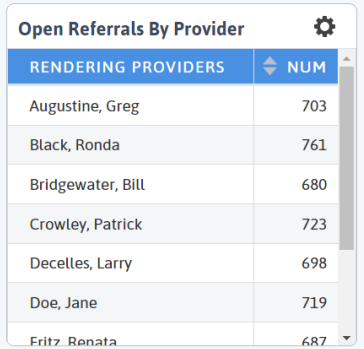












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Impact of PCMHs on High-Cost Patients

A STUDY

Privately insured patients continuously attributed to multipayer PCMHs had a **34% lower** chance of remaining in the high-cost category compared to those in non-PCMH practices

PCMHs effectively **reduce excessive spending** among the costliest patients

The model has the potential to **reshape national health expenditure** patterns as it becomes more widely adopted

Previous research showed significant cost impacts for individuals with specific chronic conditions

This study extends those findings to **patients with complex combinations** of chronic conditions influenced by non-medical factors.

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Impact of the Patient-Centered Medical Home on Consistently High-Cost Patients (ajmc.com)

Annual Reporting with DRVS

Initial Recognition vs. Annual Reporting

STEP	EARNING INITIAL RECOGNITION	PCMH ANNUAL REPORTING
Number of requirements	Meet 40 core criteria. Earn 25 credits in elective criteria across 5 of 6 program concepts.	Attest to current PCMH Standards and Guidelines. Reports on 11 requirements.
What NCQA wants to see	Present evidence of implementation through documented processes, data, reports, screenshots, patient records, examples.	Answer questions about how your practice is maintaining PCMH activities associated with each concept. When applicable, provide reports.
The reporting process	Upload evidence (e.g. policies and procedures) in QPASS. Demonstrate meeting other requirements via screen-sharing.	Checklist or data entry in QPASS Minimal documentation upload.
The document review process	Three virtual reviews.	No virtual review (unless selected for audit).

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2025 Reporting

Annual Reporting Requirements		Site-Specific vs. Shared	PCMH Criteria	
Team-Based Care and Practice Organization (AR-TC)				
AR-TC 1: PCMH Transformation Leads	Required	Shared	TC 01	Core
AR-TC 2: Structure and Staff Responsibilities	Required	Shared	TC 02	Core
Knowing and Managing Your Patients (AR-KM)				
AR-KM 1: Comprehensive Health Assessment	Required	Shared	KM 02	Core
AR-KM 2: Diversity	Required	Site-specific	KM 09	Core
AR-KM 3: Community Resource Needs	Required	Shared	KM 21	Core
Patient-Centered Access and Continuity (AR-AC)				
AR-AC 1: Clinical Advice Documentation	Required	Shared	AC 05	Core
Care Management and Support (AR-CM)				
AR-CM 1: Identifying Patients for Care Management	Required	Shared	CM 01	Core
AR-CM 2: Care Plans for Care Managed Patients	Required	Site-specific	CM 04	Core
Care Coordination and Care Transitions (AR-CC)				
AR-CC 1: Referral Management	Required	Shared	CC 04	Core
AR-CC 2: Post-Hospital/ED Visit Follow-Up	Required	Shared	CC 16	Core
Performance Measurement and Quality Improvement (AR-QI)				
AR-QI 1: Clinical Quality Measures	Required	Site-specific	QI 01	Core
AR-QI 2: Resource Stewardship Measures	Required	Site-specific	QI 02	Core
AR-QI 3: Patient Experience Measure	Required	Site-specific	QI 04	Core
AR-QI 4: Goals and Actions to Improve Measures	Required	Site-specific	QI 08 & QI 09	Core

DRVS aligns/supports, but only need to attest

Reporting data found in DRVS

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Prepare for Annual Reporting

Use the Content Details Spreadsheet located in the Help Section of DRVS to document and prepare for Annual Reporting

NCQA 2017 PCMH (based on the latest standards released for Reporting Year 2022)
Criteria Designation and Where to Find it in DRVS

Standards can be found here: http://www.ncqa.org/ar

- A √ indicates that Azara received Transfer Credit or Practice Support for each criterion's component. Transfer Credit on an individual component does not necessarily indicate that the entire criterion received auto-credit; all components of a criterion must have the Transfer Credit designation for a center to avoid documentation submission.
- Use the *Where in DRVS* column to identify the tools used to demonstrate the criteria. Note that some of the dashboards and registries listed are custom. Funcationality marked with an * indicates that additional modules outside the DRVS Core implementation may need to be mapped and in in use a minimum of 3 months. These include Referrals, Payer Integration, ADT/Transitions of Care, and Controlled Substance.
- For additional assitance please contact Azara Support at Support@azarahealthcare.com

Conce	Compe-tenc	Criteria Numl	Criteria Typ	Criteria	Evidence Component	NCQA Designation per Preval Letter	Where in DRVS	Additional Module Require	Transfer Cred	Practice Suppl	2022 Annual Reporting: Used in Annual Reporting?	Annual Reporting Criteria	Repor	Attestatio	Notes
KM	E	KM20	Core	A. Mental health condition.	A. Evidence Based Decision Support—Mental Health Condition— Evidence of	No Transfer Credit or Practice Support Awarded to Solution					Yes	AR-KM 2		√	
KM	E	KM20	Core	E. A condition related to unhealthy behaviors.	E. Evidence Based Decision Support—Unhealthy Behavior—Evidence of	No Transfer Credit or Practice Support Awarded to Solution					Yes	AR-KM 2		√	
KM	E	KM20	Core	G. Overuse/appropriateness issues.	G. Evidence Based Decision Support—Overuse/ Appropriateness—Evidence of	No Transfer Credit or Practice Support Awarded to Solution					Yes	AR-KM 2		√	
KM	E	KM20	Core	F. Well child or adult care.	F. Evidence Based Decision Support- Well Child and Adult Care–Condition & Source	Solution Offers Transfer Credit	Measures, Alerts, PVP, CMP		√		Yes	AR-KM 2		√	
KM	E	KM20	Core	F. Well child or adult care.	F. Evidence Based Decision Support-Well Child and Adult Care—Evidence of	Solution Offers Transfer Credit	Measures, Alerts, PVP, CMP		√		Yes	AR-KM 2		√	
KM	E	KM20	Core	A. Mental health condition.	A. Evidence Based Decision Support—Mental Health Condition— Condition &	No Transfer Credit or Practice Support Awarded to Solution					Yes	AR-KM 2		√	
KM	E	KM20	Core	B. Substance use disorder.	B. Evidence Based Decision Support—Substance Use Disorder— Condition &	No Transfer Credit or Practice Support Awarded to Solution					Yes	AR-KM 2		√	
KM	E	KM20	Core	B. Substance use disorder.	B. Evidence Based Decision Support Substance Use Disorder—Evidence of	No Transfer Credit or Practice Support Awarded to Solution					Yes	AR-KM 2		√	
KM	E	KM20	Core	C. A chronic medical condition.	C. Evidence Based Decision Support—Chronic Conditions—Condition & Source	Solution Supports Practice PCMH Activities (No Transfer Credit)	Measures, Alerts, PVP, CMP			√	Yes	AR-KM 2		√	
				C. A chronic medical condition.	C. Evidence Based Decision Support-Chronic	Solution Supports Practice PCMH Activities	Measures, Alerts, PVP, CMP								

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2025 Annual Reporting

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AR-KM 1 | Comprehensive Health Assessment

PCMH Goal

Includes an examination of the patient's social and behavioral influences in addition to a physical health assessment.

Evidence

Documented Process

AND

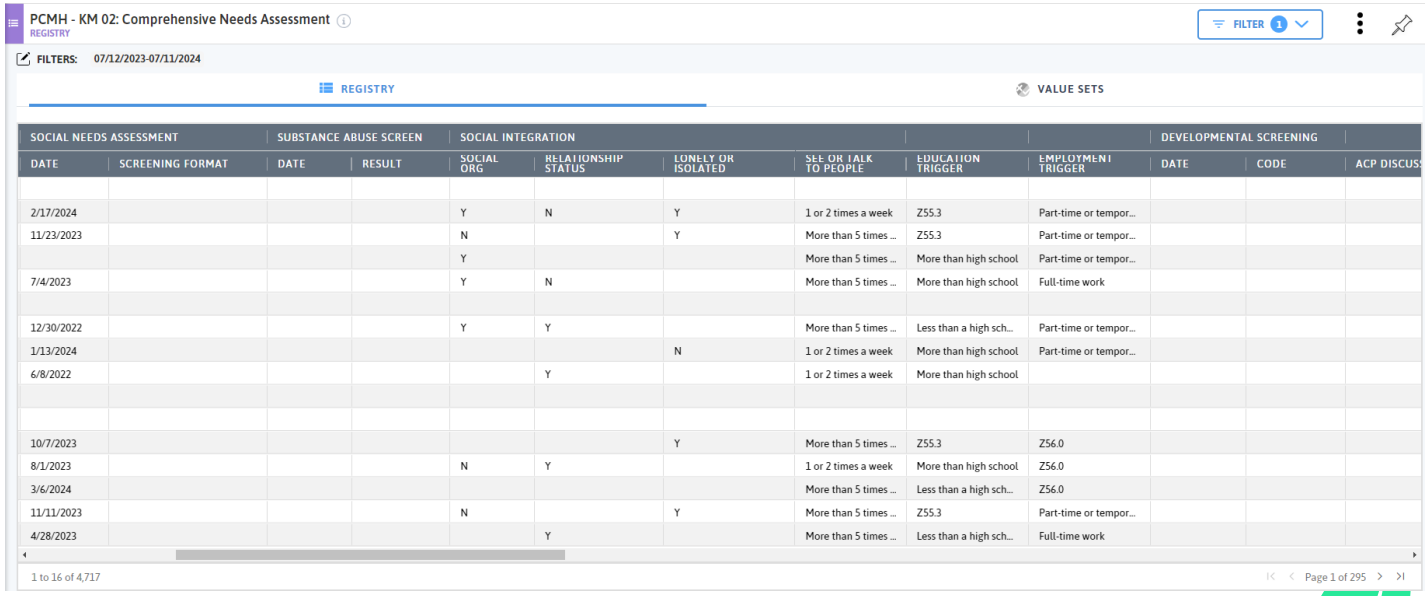
Evidence of Implementation

Considerations

Use alerts to identify *who* needs screening and measures/registries to track population/results.

DRVS Tools

- PVP & related alerts
- Measures
- Registries (e.g. Primary Care: Adult or custom)



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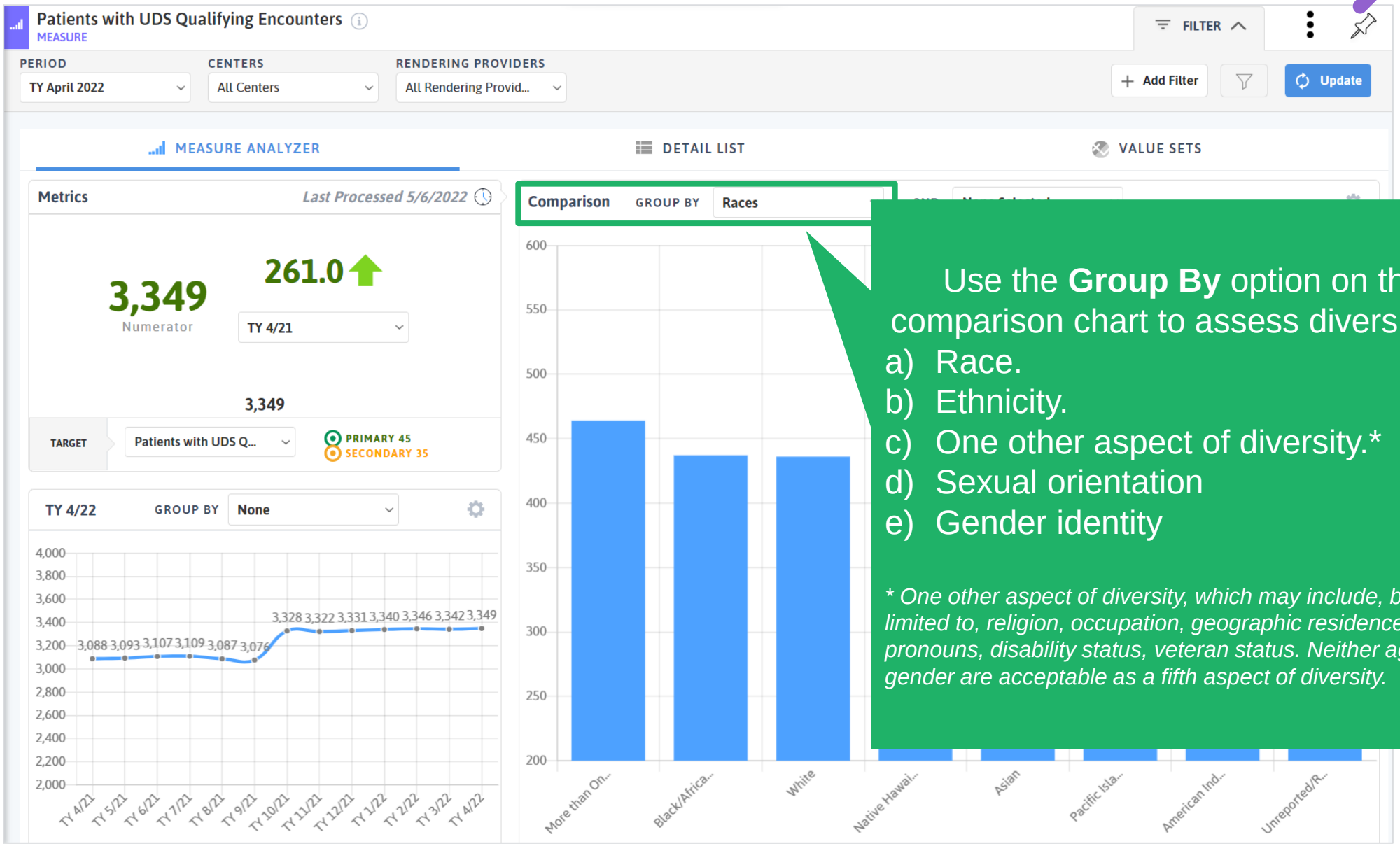
AR-KM 2 – Diversity



Use the **Group By** option on the comparison chart to assess diversity in:

a) Race.
b) Ethnicity.
c) One other aspect of diversity.*
d) Sexual orientation
e) Gender identity

** One other aspect of diversity, which may include, but is not limited to, religion, occupation, geographic residence, pronouns, disability status, veteran status. Neither age nor gender are acceptable as a fifth aspect of diversity.*

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AR-CM 01 | Identifying Patients for Care Management

PCMH Goal

Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management

Evidence

Protocol for identifying patients for care management

OR

CM 03

Considerations

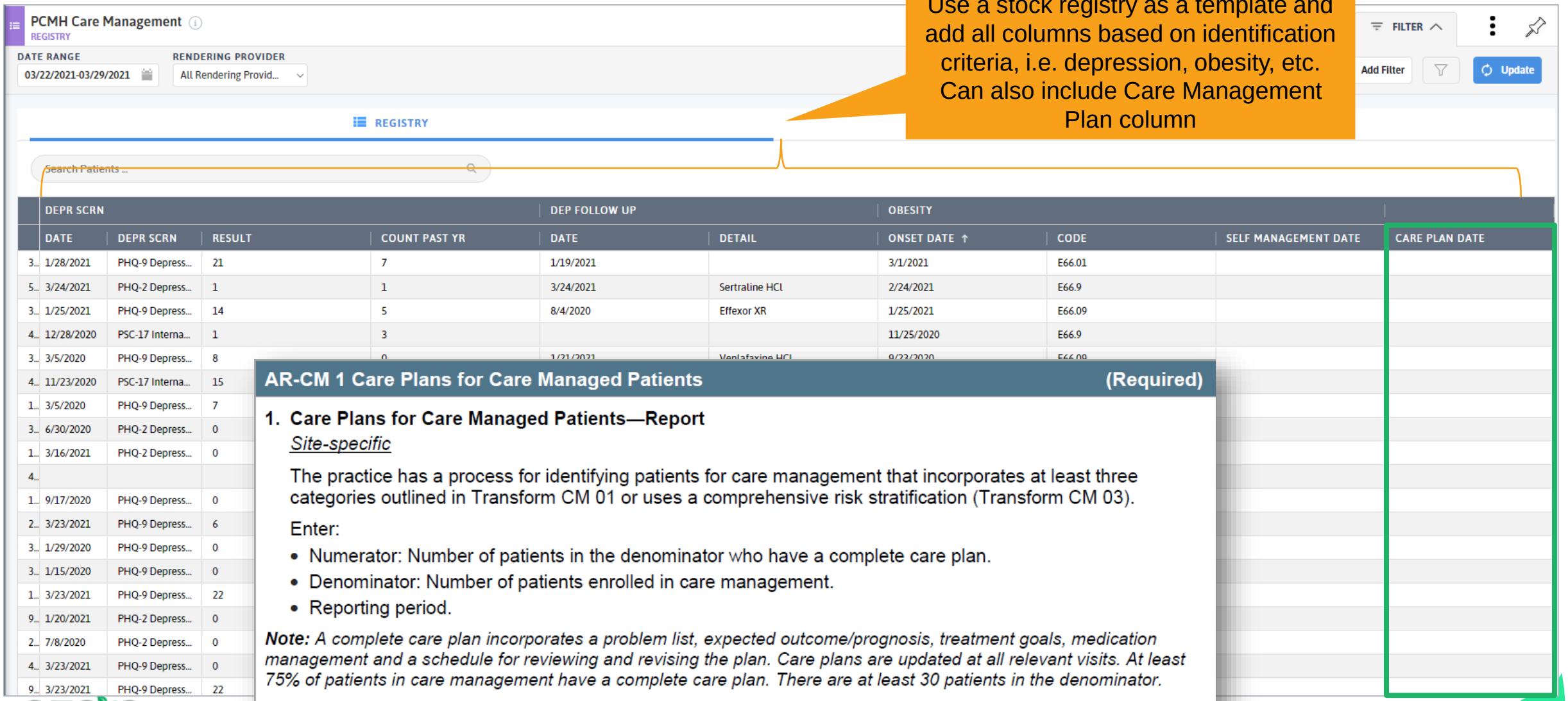
DRVS gets transfer credit for the protocol or practice support for Risk Stratification.

DRVS Tools

- Filters of patients diagnoses, SDOH, custom cohorts
- Azara Risk Stratification

AR-CM 2 – Care Plans for Care Managed Patients | 1

Use a stock registry as a template and add all columns based on identification criteria, i.e. depression, obesity, etc. Can also include Care Management Plan column



	DEPR SCRN				DEP FOLLOW UP		OBESITY			
	DATE	DEPR SCRN	RESULT	COUNT PAST YR	DATE	DETAIL	ONSET DATE ↑	CODE	SELF MANAGEMENT DATE	CARE PLAN DATE
3...	1/28/2021	PHQ-9 Depress...	21	7	1/19/2021		3/1/2021	E66.01		
5...	3/24/2021	PHQ-2 Depress...	1	1	3/24/2021	Sertraline HCl	2/24/2021	E66.9		
3...	1/25/2021	PHQ-9 Depress...	14	5	8/4/2020	Effexor XR	1/25/2021	E66.09		
4...	12/28/2020	PSC-17 Interna...	1	3			11/25/2020	E66.9		
3...	3/5/2020	PHQ-9 Depress...	8	0	1/21/2021	Venlafaxine HCl	9/23/2020	E66.09		
4...	11/23/2020	PSC-17 Interna...	15							
1...	3/5/2020	PHQ-9 Depress...	7							
3...	6/30/2020	PHQ-2 Depress...	0							
1...	3/16/2021	PHQ-2 Depress...	0							
4...										
1...	9/17/2020	PHQ-9 Depress...	0							
2...	3/23/2021	PHQ-9 Depress...	6							
3...	1/29/2020	PHQ-9 Depress...	0							
3...	1/15/2020	PHQ-9 Depress...	0							
1...	3/23/2021	PHQ-9 Depress...	22							
9...	1/20/2021	PHQ-2 Depress...	0							
2...	7/8/2020	PHQ-2 Depress...	0							
4...	3/23/2021	PHQ-9 Depress...	0							
9...	3/23/2021	PHQ-9 Depress...	22							

AR-CM 1 Care Plans for Care Managed Patients **(Required)**

1. **Care Plans for Care Managed Patients—Report**

   Site-specific

   The practice has a process for identifying patients for care management that incorporates at least three categories outlined in Transform CM 01 or uses a comprehensive risk stratification (Transform CM 03).

   Enter:

   - Numerator: Number of patients in the denominator who have a complete care plan.
   - Denominator: Number of patients enrolled in care management.
   - Reporting period.

Note: *A complete care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule for reviewing and revising the plan. Care plans are updated at all relevant visits. At least 75% of patients in care management have a complete care plan. There are at least 30 patients in the denominator.*

Practices that do not have the ability to pull the report from the EHR should refer to the manual chart option in the Record Review Workbook.

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AR-CC 2 | Post-Hospital/ED Visit Follow Up

PCMH Goal

The practice contacts patients/families/caregivers about follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit

Evidence

Upload evidence of implementation

Considerations

For practices with the TOC module, map EHR contact workflows

DRVS Tools

- Care Plan data element
- Custom Registry

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Mapping | Follow Up Phone Call

Must map structured data for follow-up phone call measures to work. To map, send a screenshot of where follow-up calls are recorded, as well as a patient example to Azara support.

Follow Up Call = Follow up phone call for an inpatient or emergency visit episode of care

Examples of data that can be used includes:

- Visit type
- Specific template
- Other structured data to indicate type of call

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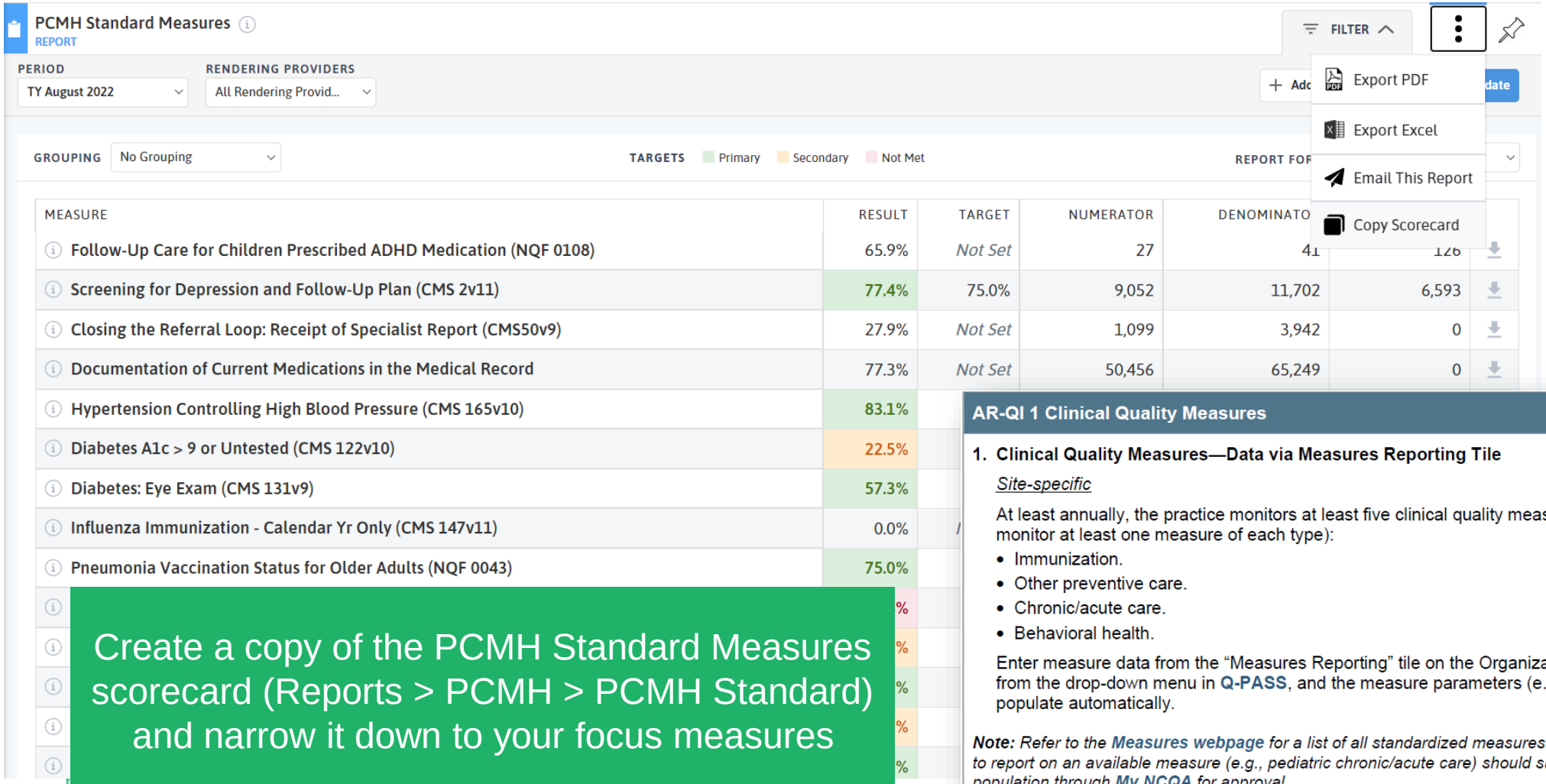
AR-QI 1 & 2 – Clinical Quality & Resource Stewardship Measures



Create a copy of the PCMH Standard Measures scorecard (Reports > PCMH > PCMH Standard) and narrow it down to your focus measures

AR-QI 1 Clinical Quality Measures **(Required)**

1. **Clinical Quality Measures—Data via Measures Reporting Tile**

   Site-specific

   At least annually, the practice monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type):

   - Immunization.
   - Other preventive care.
   - Chronic/acute care.
   - Behavioral health.

   Enter measure data from the "Measures Reporting" tile on the Organization Dashboard. Choose the measure from the drop-down menu in **Q-PASS**, and the measure parameters (e.g., numerator description) will populate automatically.

Note: *Refer to the* ***Measures webpage*** *for a list of all standardized measures available in Q-PASS. Practices unable to report on an available measure (e.g., pediatric chronic/acute care) should submit a measure relevant to their patient population through* ***My NCQA*** *for approval.*

Envisioning the Future of PCMHs

- **Integration** with Technology
- Expansion of **Value-Based Care Models**
- Focus on **Social Drivers of Health**
- **Interdisciplinary** Teams
- Patient **Empowerment**
- Data-Driven **Decision Making**
- **Policy Support** and Incentives
- Emphasis on **Mental Health**

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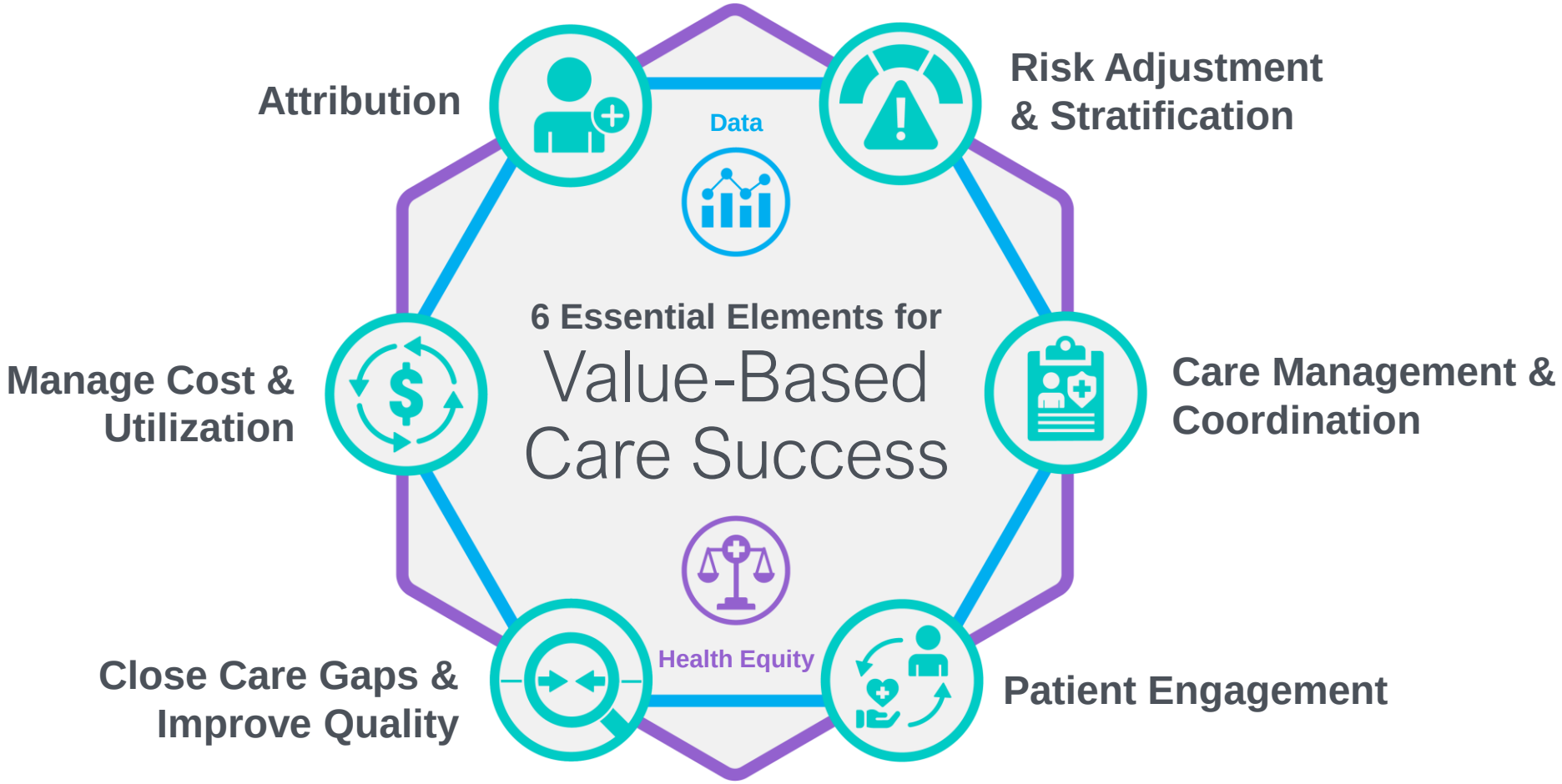
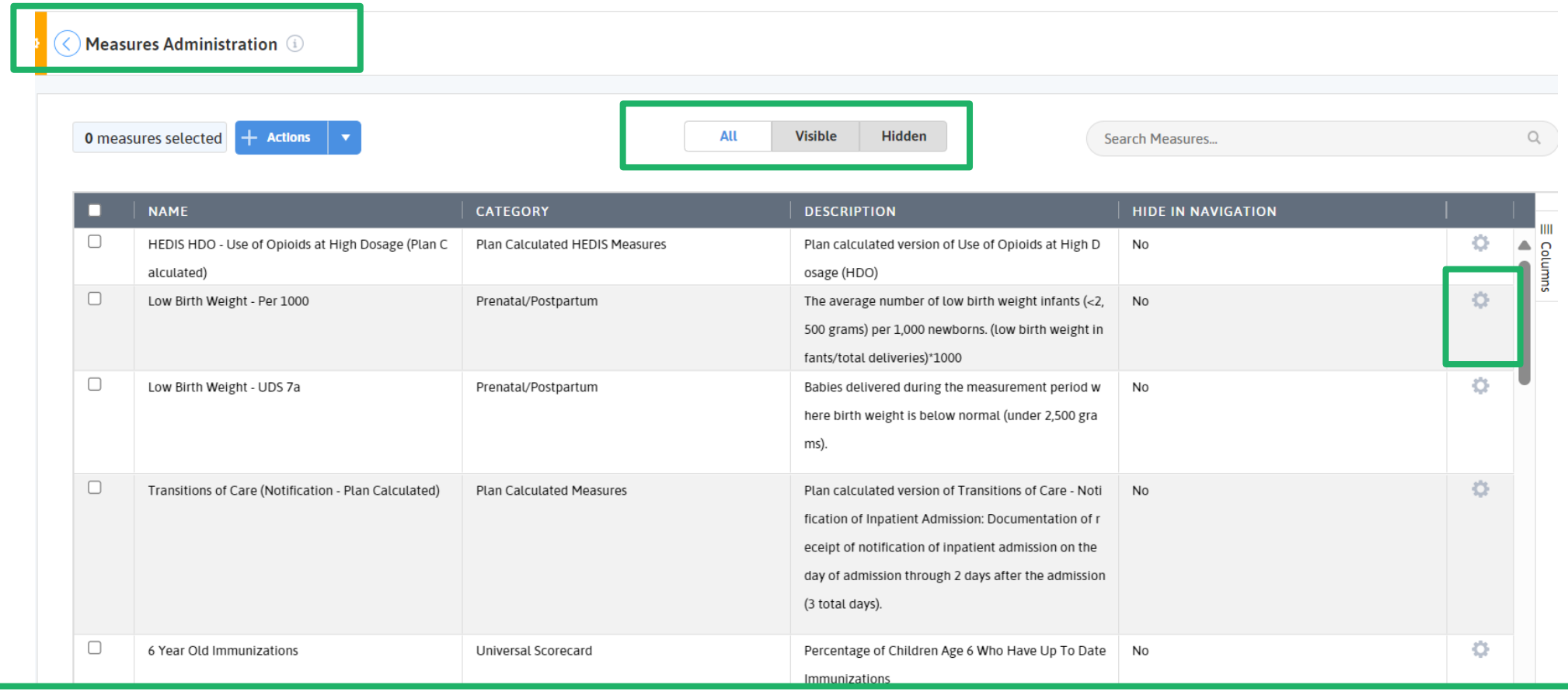
The_Future_of_PCMH-NCQA_White_Paper.pdf (johnahartford.org)

Essential Elements



What's New in DRVS

Measure Administration



- **Hide/Unhide measures** from left-hand navigation & search bar
- Able to streamline view of measures to ensure that users at your practice can find relevant measures
- Admin > Measures

For more information, click **here**

UDS+ Reporting with Azara

COHORT 1 & 2 ARE COMPLETED… WHAT'S NEXT?

Azara submitted CY23 UDS+ data for **129 health centers** in Cohorts 1 and 2

Our focus is now on **providing a seamless UDS+ submission experience** for our users for CY24 reporting

HOW IS AZARA SUPPORTING CY24 UDS+ REPORTING?

- We offer UDS+ submission to our customers **free of charge**
- We currently **meet the HRSA requirements** for CY24 reporting
- Next year, authorized users can create and **kick-off UDS+ submission in DRVS**
- It is our intention to submit the **Controlling High Blood Pressure** (CMS165 v12) measure *(this is the HRSA preferred / recommended measure to submit)*

WHAT CAN YOU DO TO PREPARE FOR NEXT YEAR?

- Join our fall **UDS webinar**
- Consider our **UDS Preparation Sessions**
  - Receive in-depth validation of select UDS measures and surface opportunities for workflow improvements

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Calendar Year 24 (CY24) UDS+ Reporting Requirements

The EHB remains the official report of record for CY24 UDS reporting
UDS+ Submissions are due by April 30th, 2025

Patient Population Requirement

Submit data for your medical (primary care) patients

Demographics Requirement

Submit the demographic table data:
- Patients by Zip Code
- Table 3a: Patients by Age and Sex Assigned at Birth
- Table 3b: Demographic Characteristics
- Table 4: Selected Patient Demographics

Clinical Quality Measure Requirement

Submit 1 eCQM from one of the clinical tables:
- Table 6B: Breast Cancer Screening
- Table 6B: Cervical Cancer Screening
- Table 6B: Colorectal Cancer Screening
- **Table 7: Controlling High Blood Pressure***
- Table 7: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

**HRSA's recommended measure / Azara supported measure for CY24 submission*

Released August 2024

APO Updates:

Choose Campaigns to Send Each Day! | 1

FEATURE

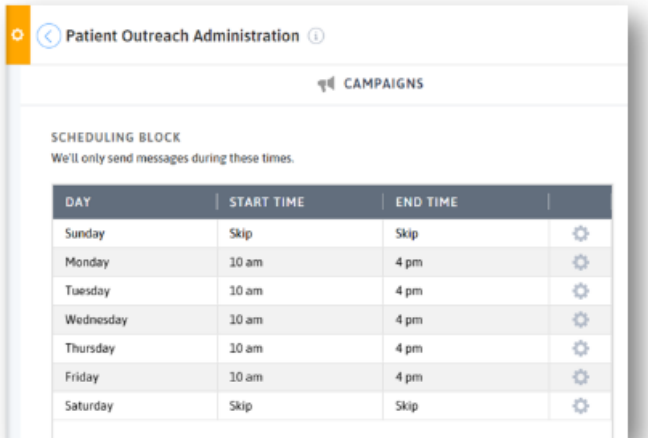
NEW! Choose the Campaigns to send each day

APO Message Scheduling Block

Enhancement overview

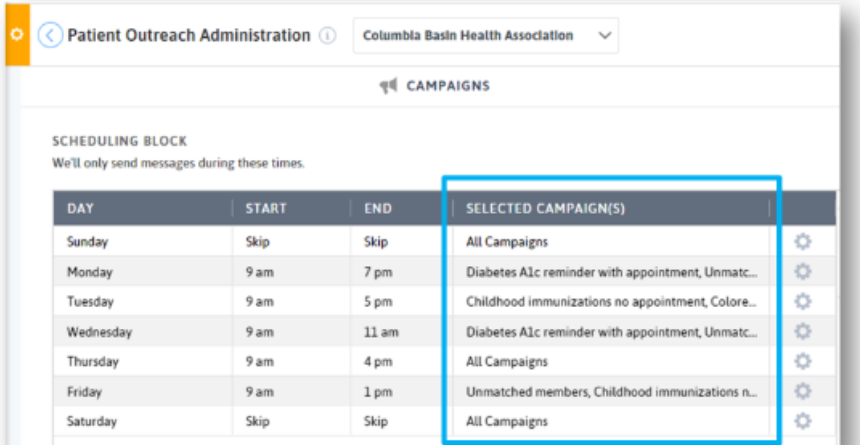
Current Functionality

- Select the days of week for *all enabled campaigns* to run
- Select the time block each day for *all enabled campaigns* to run



New Functionality

- **Select which enabled campaigns to run on each day**
- Choose the days of week for the selected campaign(s) to run
- Choose the time block each day for selected campaigns(s) to run



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Available for practices with the Azara Patient Outreach Module.

Released August 2024

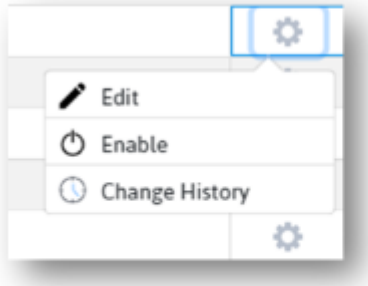
APO Updates:

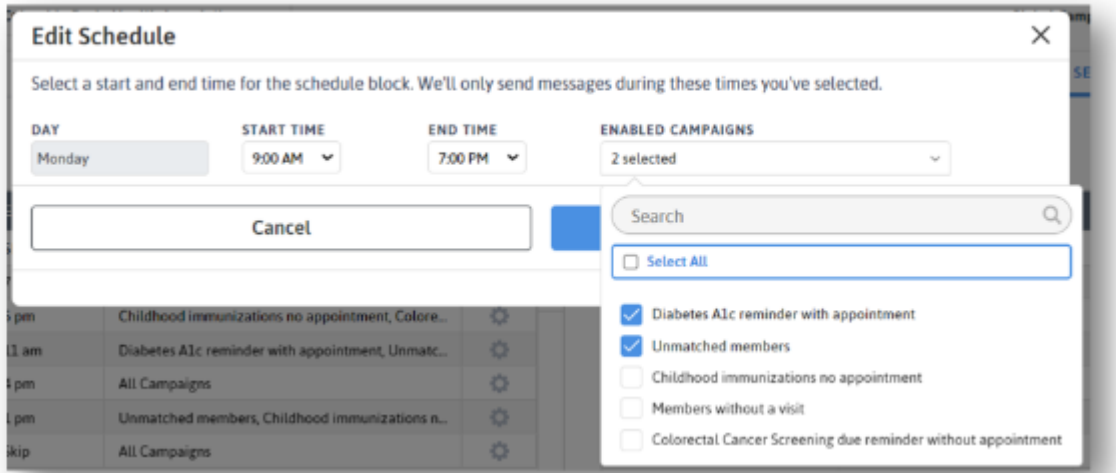
Choose Campaigns to Send Each Day! | 2

FEATURE

Setting the Message Schedule

- Your current Message Schedule settings **will not be affected by this enhancement**
- Choose or Modify the days and times you want campaigns to run by clicking on the gear icon
  - Only the currently enabled Campaigns will appear in the Enabled Campaigns drop-down
- Messages will still be sent according to the Campaign Priority Order and Message Rate Limit





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Available for practices with the Azara Patient Outreach Module.

Released August 2024

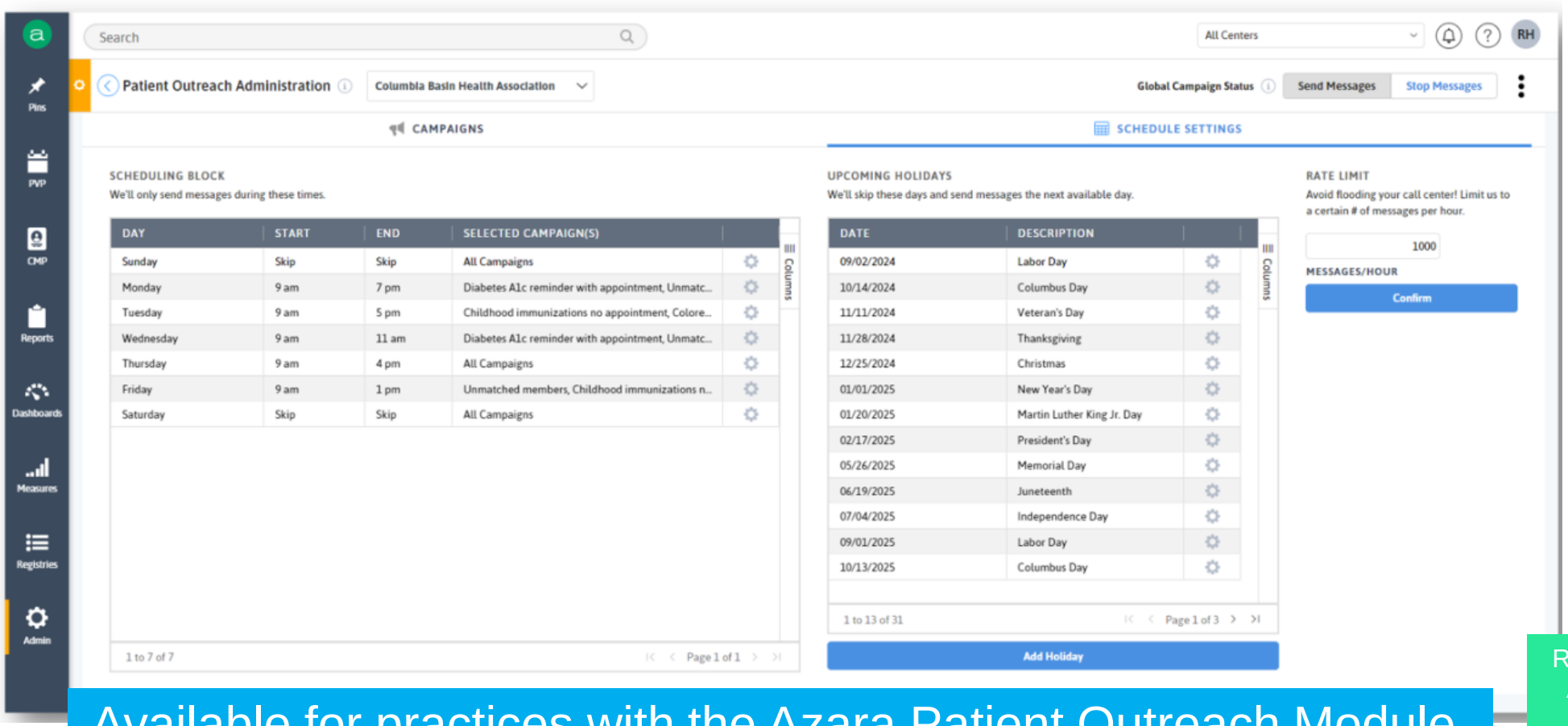
APO Updates:

Choose Campaigns to Send Each Day! | 3

FEATURE

APO Message Scheduling Block

Enhancement overview



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Available for practices with the Azara Patient Outreach Module.

Released August 2024

Family Planning Measures:

Two New Measures Available!

MEASURE

Annual Self-Identified Need for Contraception Screening

Contraceptive Services Encounter

*The Annual SINC Screening measure has also been added to the Family Planning Scorecard.

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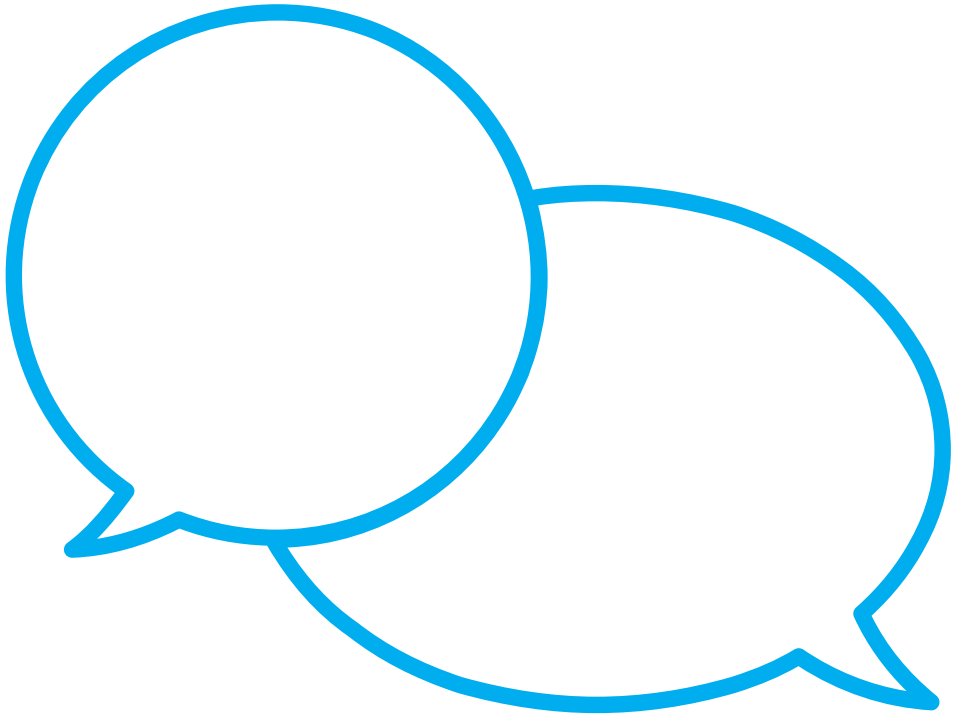
Available for practices with the Family Planning Module.

Released August 2024

Questions?



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@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.

Benefits:

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

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

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Upcoming Webinars

Beyond the Basics: Azara Tools to Support Care Management and Coordination

Thursday, September 26, 2p ET

Register here

Back to Basics: DRVS 101

Tuesday, October 1, 1p ET

Register here

Data-Driven Cancer Care: Using Evidence-Based Insights to Enhance Screening & Follow-Up

Thursday, October 3, 2p ET

Register here

Back to Basics: Data Hygiene

Tuesday, October 8, 1p ET

Register here

Making APO Work for You: Unlocking Creativity for Better Outcomes

Thursday, October 10, 2p ET

Register here

UDS Empowered! – Preparing for 2024 UDS Submissions Using DRVS

Thursday, October 17, 2p ET

Register here

Back to Basics: Dashboards

Tuesday, October 22, 1p ET

Register here

Optimizing Patient Care: Exploring Empanelment Tools in DRVS

Thursday, October 24, 2p ET

Register here

Back to Basics: Population Health Tools

Tuesday, October 29, 1p ET

Register here

Hook, Line, & Sinker: How to Promote Provider Engagement Using DRVS

Thursday, October 31, 2p ET

Register here

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