Preparing for Fall

DRVS Tools To Support Well Visits + Immunizations

Emily Holzman
Director, Clinical Transformation
Azara Healthcare

July 24, 2024

Agenda

IMPORTANCE OF WELL VISITS

From Well Childs to Immunization to AWVs

INCREASING WELL VISITS

Tips and Tricks for Well Visit Success

SUCCESS WITH WELL VISITS

Workflows for identification and tracking

WHAT'S NEW IN DRVS

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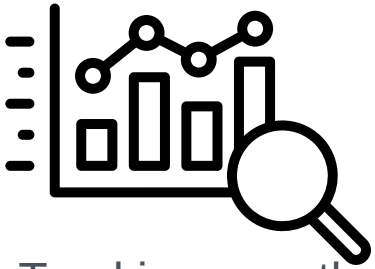
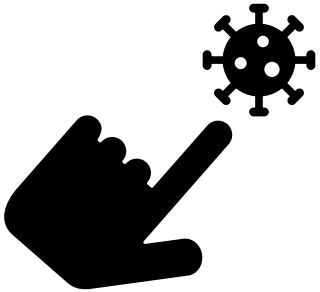
Well Visits

Importance of Well-Child Visits



Tracking growth & developmental milestones



Identifying health concerns

Maintaining immunization schedule

Improved risk accuracy

Reduced system costs

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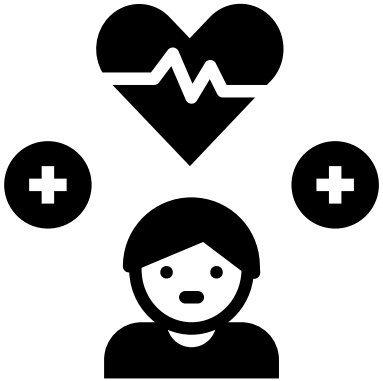
https://pubmed.ncbi.nlm.nih.gov/21886072/

Importance of Medicare Annual Wellness Visits



Disease prevention and health promotion

Increase in preventive services

Improved risk accuracy

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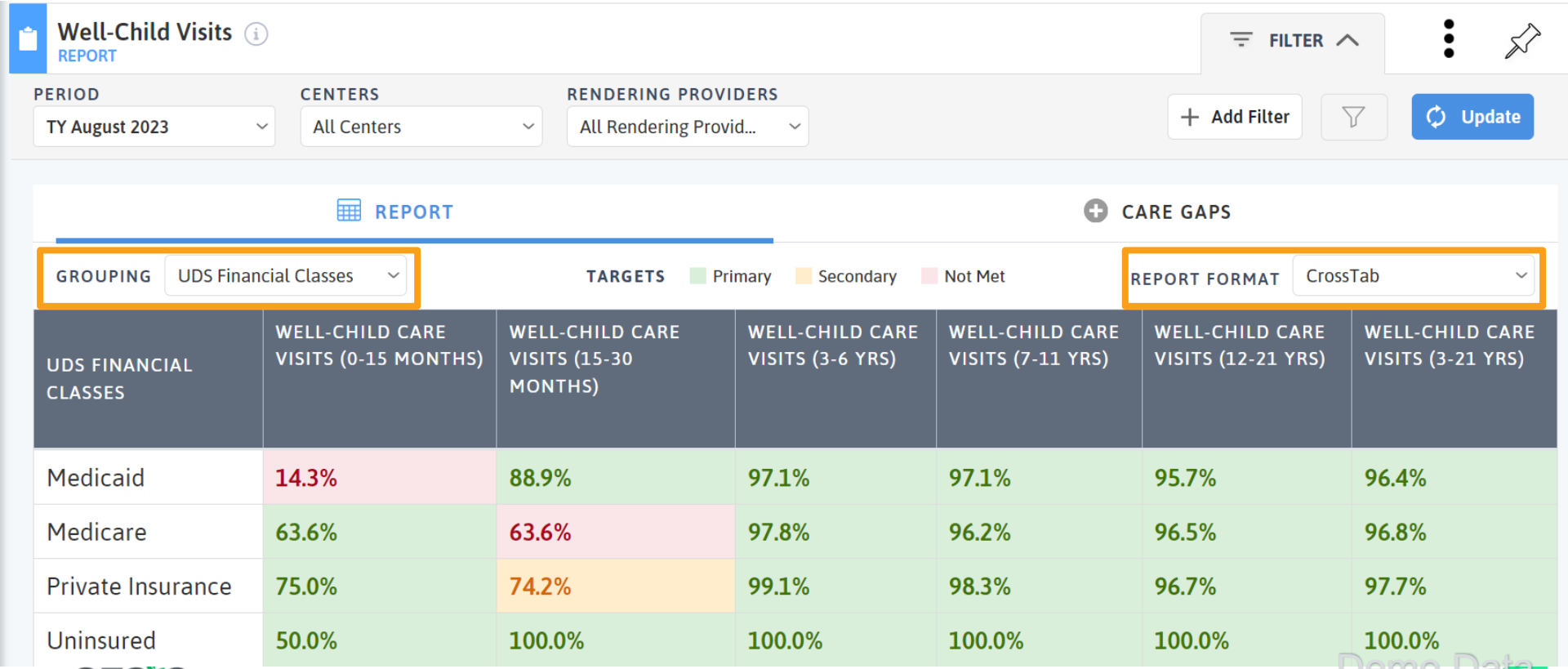
Well-Child Visits



UDS FINANCIAL CLASSES	WELL-CHILD CARE VISITS (0-15 MONTHS)	WELL-CHILD CARE VISITS (15-30 MONTHS)	WELL-CHILD CARE VISITS (3-6 YRS)	WELL-CHILD CARE VISITS (7-11 YRS)	WELL-CHILD CARE VISITS (12-21 YRS)	WELL-CHILD CARE VISITS (3-21 YRS)
Medicaid	14.3%	88.9%	97.1%	97.1%	95.7%	96.4%
Medicare	63.6%	63.6%	97.8%	96.2%	96.5%	96.8%
Private Insurance	75.0%	74.2%	99.1%	98.3%	96.7%	97.7%
Uninsured	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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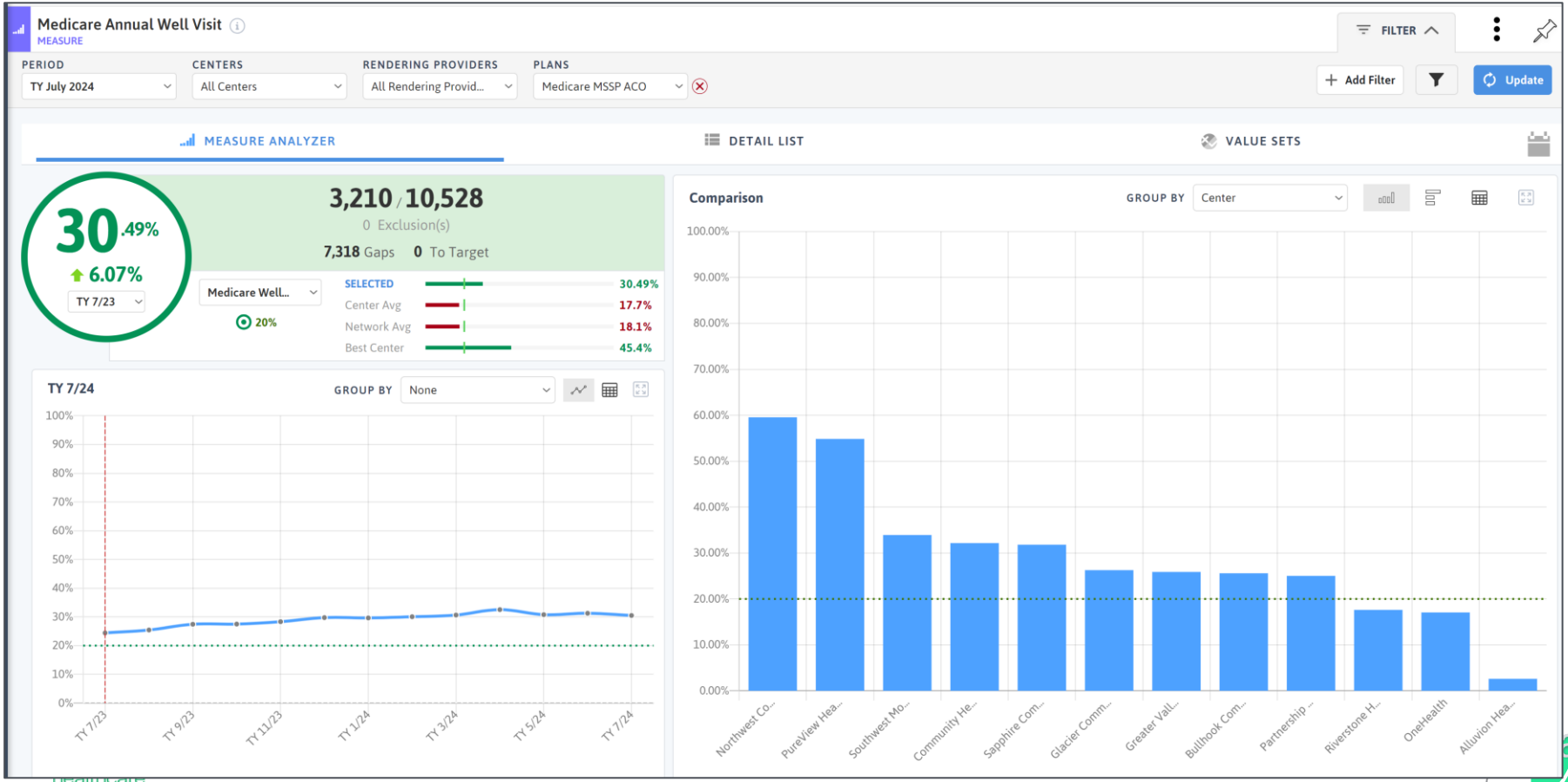
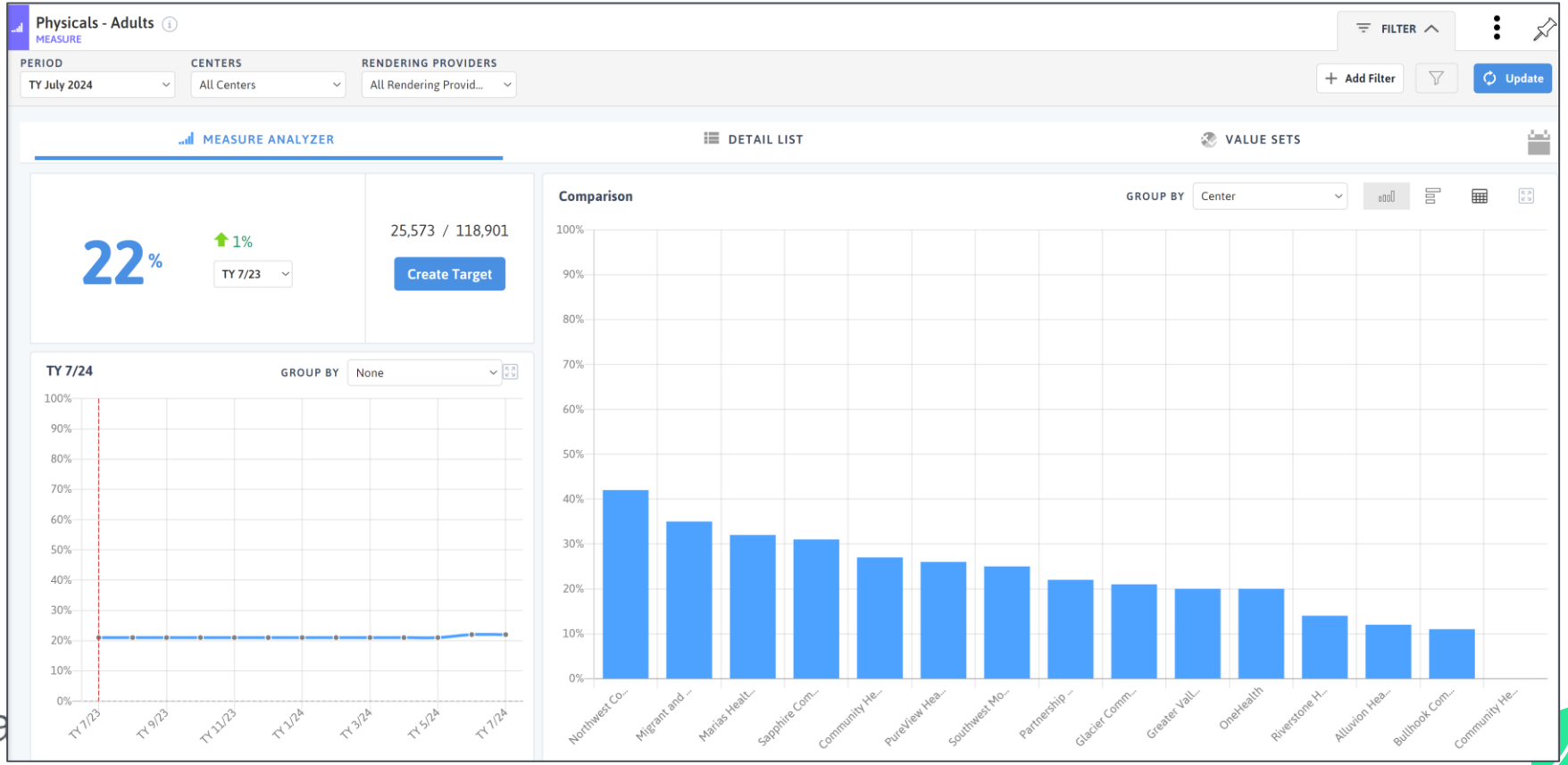
Demo Data

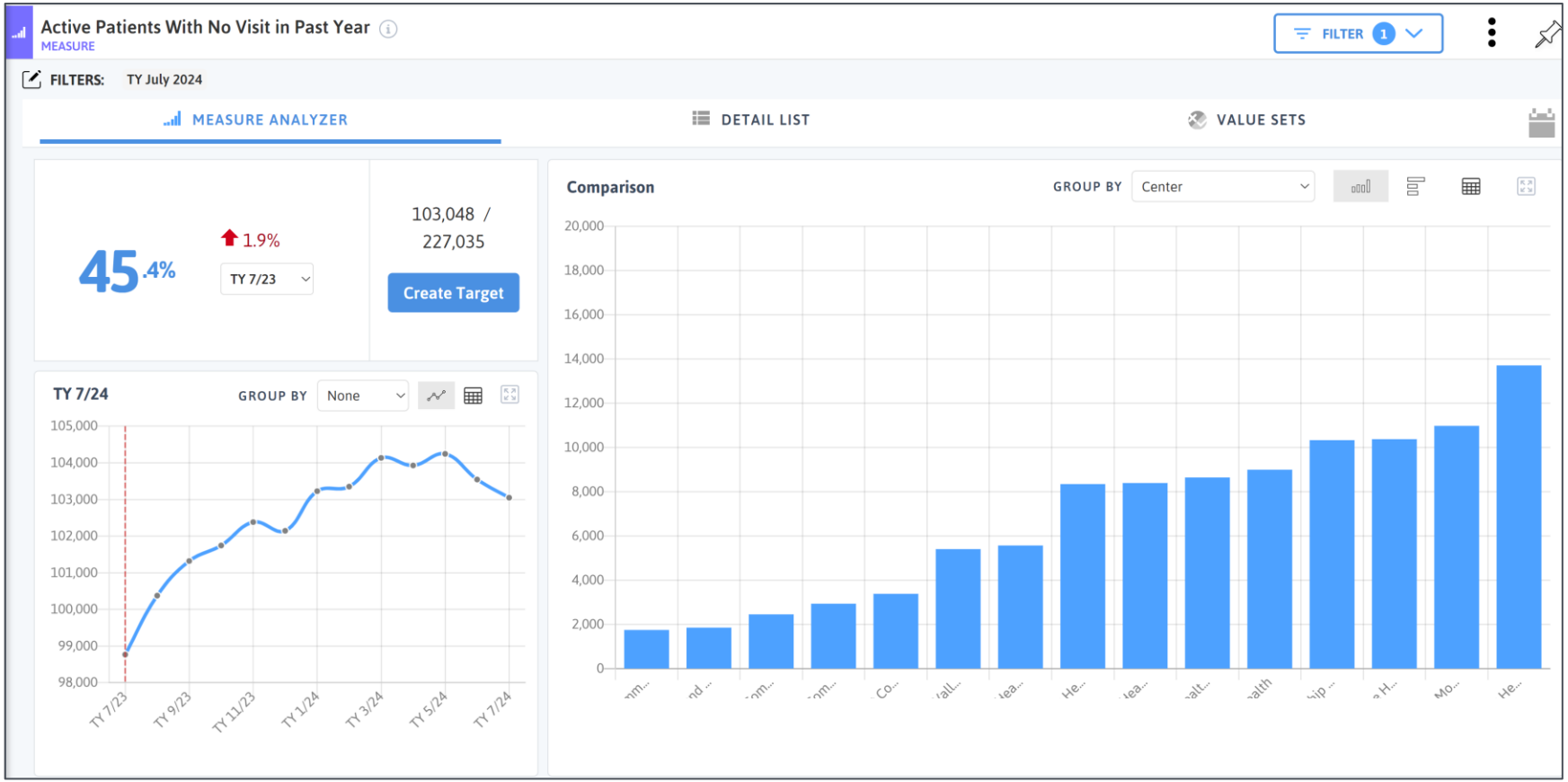
Medicare Annual Well Visits



Annual Visits for All Patients



Annual Engagement w/ All Patients



Increasing Well Visits

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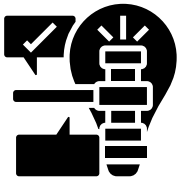
Methods for Increasing Well Visits



Patient/Parent Education

Provider Incentives

Scheduling Patient Follow Up

Structuring the Care Team

Provider & Staff Communication

Health Information Technology

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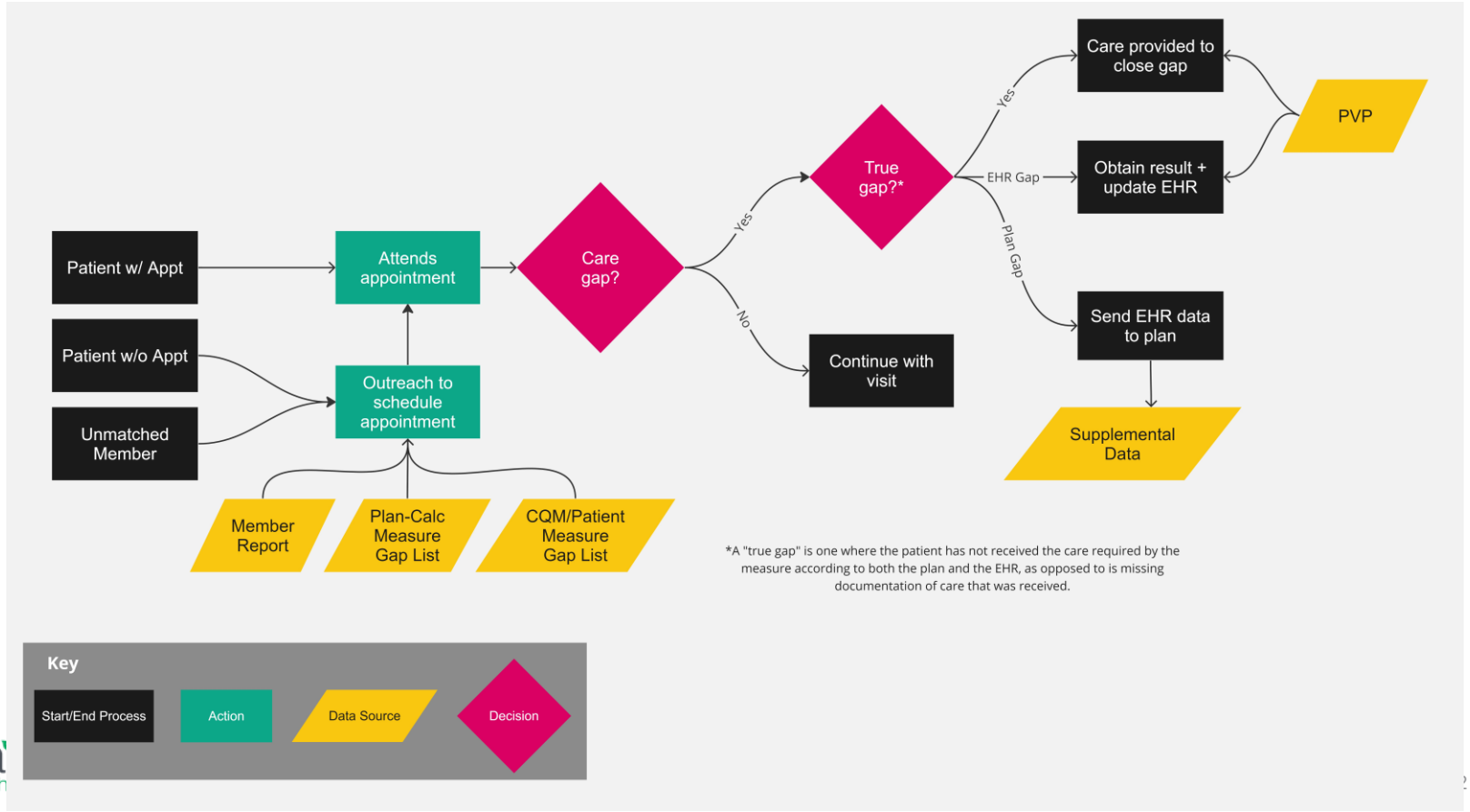
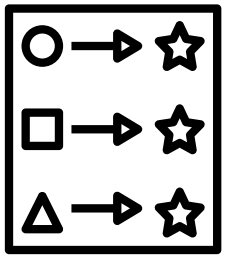
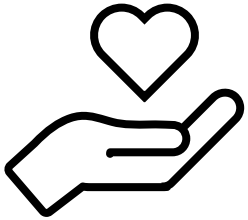
https://www.cms.gov/priorities/innovation/files/x/aco-casestudy-bellin.pdf

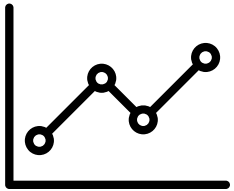
Member + Patient Gap Closure



Well Visit Workflows







Guidelines
When should patients have well visits?

Identify
Who is due for a well visit?

Care
What needs to be done at the point of care.

Track
Who received a well visit.

Infant & Early Childhood Well Visits

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Infancy & Early Childhood | Guidelines

CHILDREN ≤ 30 MONTHS OLD

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

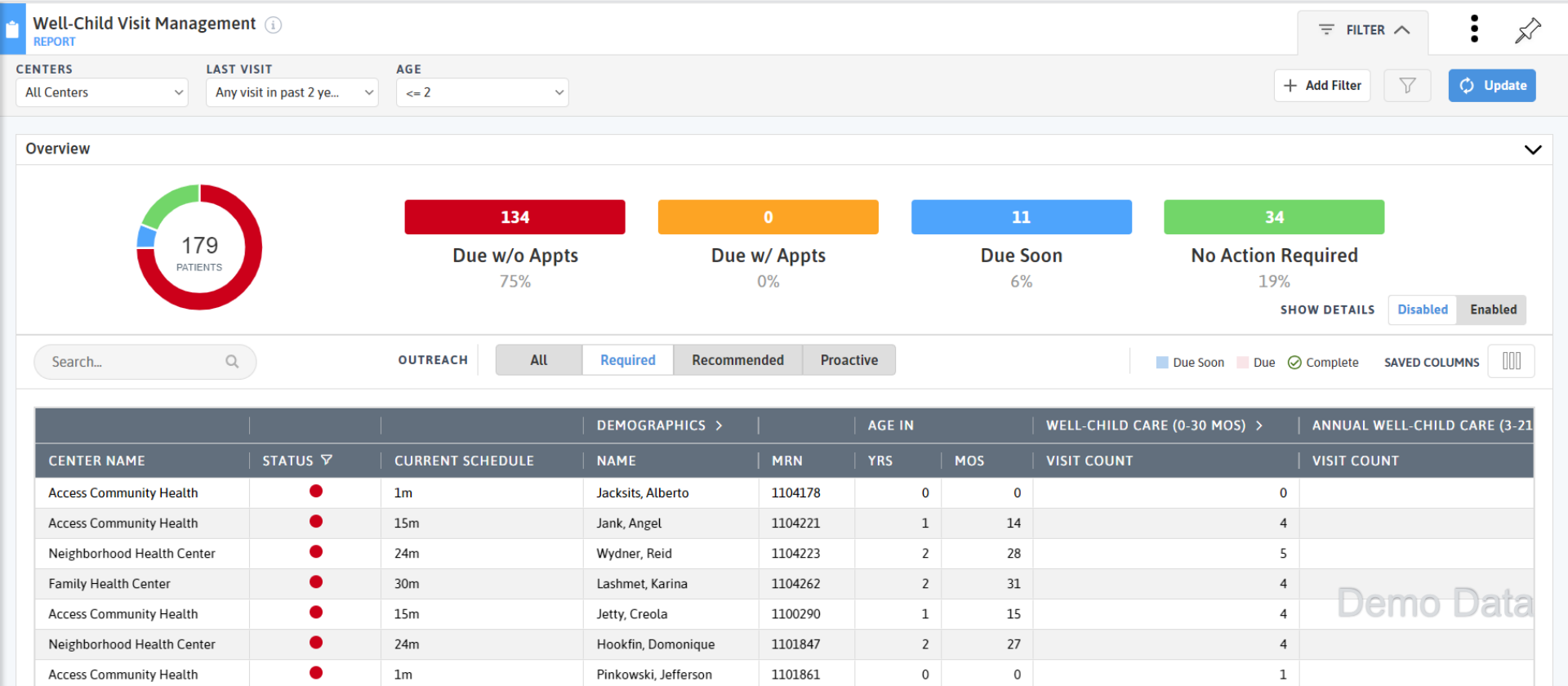
The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★[10]	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9] →		★	★	★		★	★	★	★	★	★	●	●	●	★	●	★	●	★	←	●	→	←	●	→	←	●	→		
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20] →																													
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★																
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	●	→	★	★	★	★	★	←			●	→
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	●	→					
Hepatitis B Virus Infection[31]		★ →																														

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

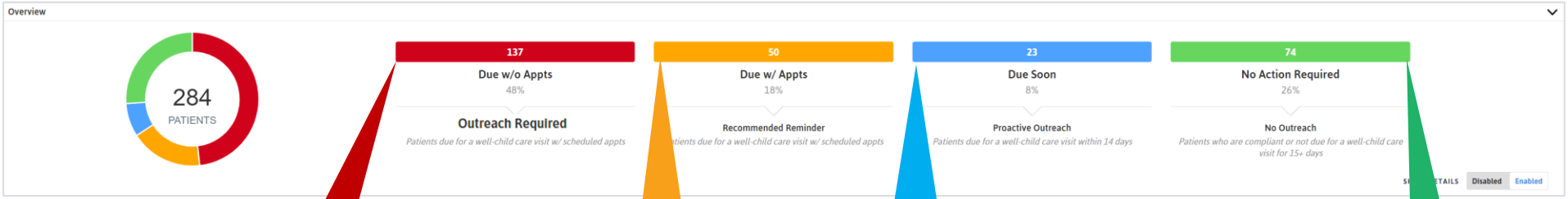
Infancy & Early Childhood | Identify

WELL CHILD VISIT MANAGEMENT REPORT



			DEMOGRAPHICS >		AGE IN		WELL-CHILD CARE (0-30 MOS) >	ANNUAL WELL-CHILD CARE (3-21
CENTER NAME	STATUS	CURRENT SCHEDULE	NAME	MRN	YRS	MOS	VISIT COUNT	VISIT COUNT
Access Community Health		1m	Jacksits, Alberto	1104178	0	0	0	
Access Community Health		15m	Jank, Angel	1104221	1	14	4	
Neighborhood Health Center		24m	Wydner, Reid	1104223	2	28	5	
Family Health Center		30m	Lashmet, Karina	1104262	2	31	4	
Access Community Health		15m	Jetty, Creola	1100290	1	15	4	
Neighborhood Health Center		24m	Hookfin, Domonique	1101847	2	27	4	
Access Community Health		1m	Pinkowski, Jefferson	1101861	0	0	1	

Demo Data



HIGH PRIORITY
Needs to be scheduled for next well child visit

MEDIUM PRIORITY
- Has a future appt
- Need to confirm if appt is adequate length for well child check

LOWER PRIORITY
- Due soon for next well child visit
- May or may not have an appt scheduled

Not due for any well child visit

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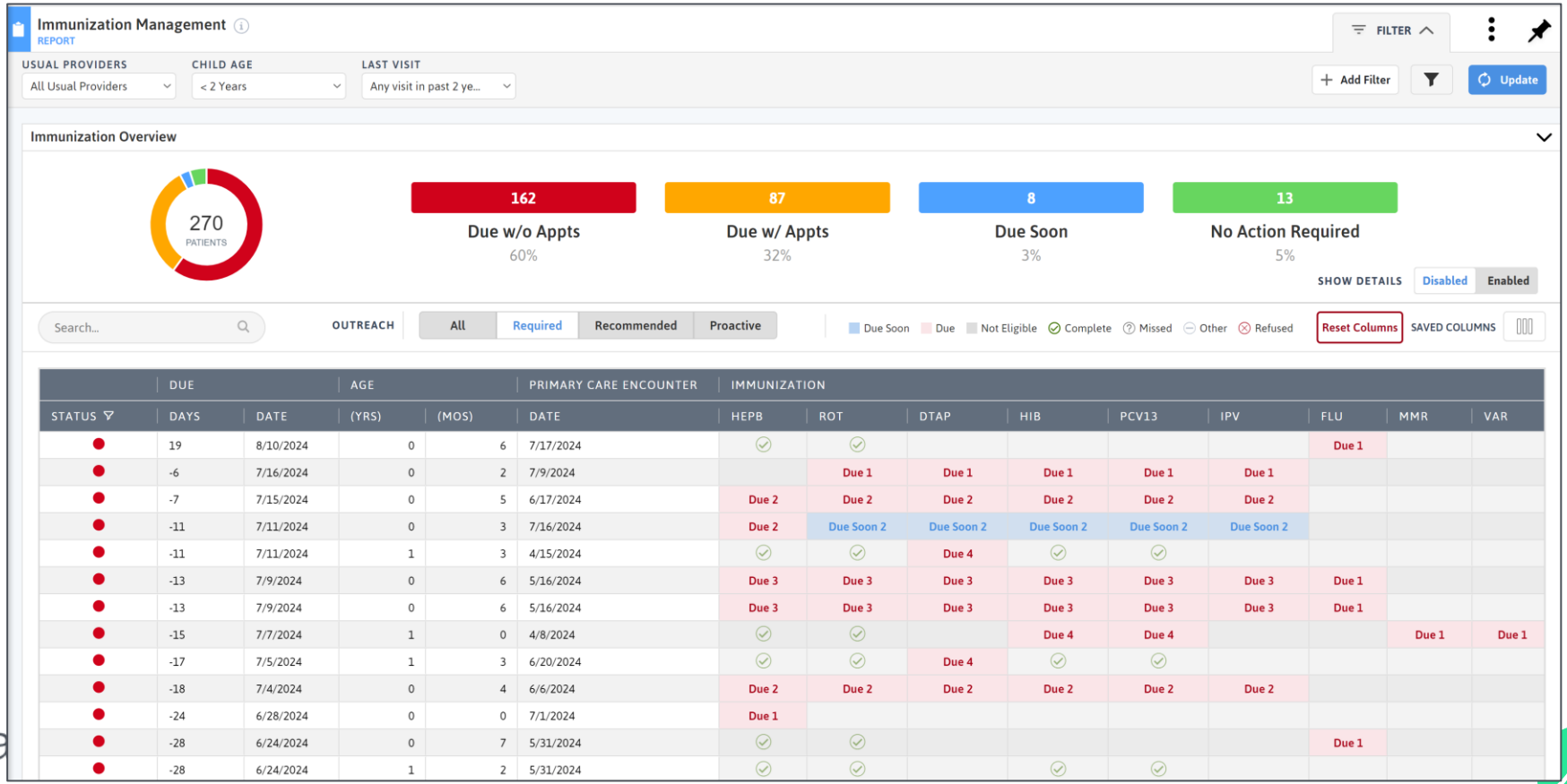
Immunization Management



	DUE		AGE		PRIMARY CARE ENCOUNTER	IMMUNIZATION								
STATUS	DAYS	DATE	(YRS)	(MOS)	DATE	HEPB	ROT	DTAP	HIB	PCV13	IPV	FLU	MMR	VAR
●	19	8/10/2024	0	6	7/17/2024	✓	✓					Due 1		
●	-6	7/16/2024	0	2	7/9/2024		Due 1	Due 1	Due 1	Due 1	Due 1			
●	-7	7/15/2024	0	5	6/17/2024	Due 2	Due 2	Due 2	Due 2	Due 2	Due 2			
●	-11	7/11/2024	0	3	7/16/2024	Due 2	Due Soon 2	Due Soon 2	Due Soon 2	Due Soon 2	Due Soon 2			
●	-11	7/11/2024	1	3	4/15/2024	✓	✓	Due 4	✓	✓				
●	-13	7/9/2024	0	6	5/16/2024	Due 3	Due 3	Due 3	Due 3	Due 3	Due 3	Due 1		
●	-13	7/9/2024	0	6	5/16/2024	Due 3	Due 3	Due 3	Due 3	Due 3	Due 3	Due 1		
●	-15	7/7/2024	1	0	4/8/2024	✓	✓		Due 4	Due 4			Due 1	Due 1
●	-17	7/5/2024	1	3	6/20/2024	✓	✓	Due 4	✓	✓				
●	-18	7/4/2024	0	4	6/6/2024	Due 2	Due 2	Due 2	Due 2	Due 2	Due 2			
●	-24	6/28/2024	0	0	7/1/2024	Due 1								
●	-28	6/24/2024	0	7	5/31/2024	✓	✓					Due 1		
●	-28	6/24/2024	1	2	5/31/2024	✓	✓		✓	✓				

Infancy & Early Childhood | Identify

FILTER CONSIDERATIONS

Filter	Selection	Use Case
Last Visit	PC in last 2 years	Exclude dental-only patients
Age	<= 2	Focus on your infant visit scheduling
Usual Provider	Individual provider's name	If individual care teams are responsible for scheduling their patients
Rendering Location	One specific site	If outreach teams call/schedule patients for each location
Race/Ethnicity/ Language	Specific races/ethnicities/ languages	Have culturally-appropriate outreach staff contact patients
SDOH	Transport-med	Identify potential barriers to accessing care

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Infancy & Early Childhood | Care

PATIENT VISIT PLANNING

- Satisfy immunizations and developmental screenings
- Identify and address RAF Gaps

9:00 AM Thursday, January 4, 2024 — Visit Reason: **Well Child Check WCC Iris**

Mouse, Minnie
MRN: 123456
DOB: 8/23/2023 (4 months)

Sex at Birth: M
GI:
SO:

Phone: (123)-456-7890
Lang: Spanish
Risk: Low (0)

Portal Access: N

PCP: House, Gregory
Payer: Medicaid
CM: Unassigned

DIAGNOSES (0)

RISK FACTORS (0)

SDOH (1)
LANGUAGE

RAF GAPS DIAGNOSIS CATEGORIES (1)
Gastro

ALERT	MESSAGE	DATE	RESULT
DTaP	Due 2	10/23/2023	Due Date: 2023-12-14 | Most Recent: 2023-10-23 - Dose 1
HiB	Due 2	10/23/2023	Due Date: 2023-12-14 | Most Recent: 2023-10-23 - Dose 1
IPV	Due 2	10/23/2023	Due Date: 2023-12-14 | Most Recent: 2023-10-23 - Dose 1
PCV	Due 2	10/23/2023	Due Date: 2023-12-14 | Most Recent: 2023-10-23 - Dose 1
ROT	Due 2	10/23/2023	Due Date: 2023-12-14 | Most Recent: 2023-10-23 - Dose 1
Preventive Care Visit	Most Recent	10/23/2023	
Well Child	Due	1/4/2024	4m

Infancy & Early Childhood | Care

POTENTIAL ALERTS

ACE Pediatric Screening	CDC Immunization Tdap	Lead Screening
CDC Imm - RSV	CDC Immunization VZV	Lead Screening Catch Up
CDC Immunization DTaP	COVID Testing Completed	M-CHAT Screen
CDC Immunization Flu	COVID-19 Immunization 3rd Dose	Newborn Screen
CDC Immunization HepA	COVID-19 Immunization Booster	Pediatric Hearing Screening
CDC Immunization HepB	COVID-19 Immunization First Dose	Pediatric Hemoglobin Screening
CDC Immunization HiB	COVID-19 Immunization Second Dose	Pediatric Vision Screening
CDC Immunization HPV	Fluoride Varnish	Peds Developmental Screening (Less than 36 months)
CDC Immunization IPV	Federal Poverty Level Documented	Preventive Care Visit
CDC Immunization MMR	Lead Screen (under 19 months)	SDOH Needs Assessed
CDC Immunization PCV	Lead Screen (under 28 months)	Well Child Visit 0-30 months
CDC Immunization ROT	Lead Screen (under 3)	

Infancy & Early Childhood | Track

FOCUS MEASURES

Well Child Care Visits (0-15 Months)

Well Child Care Visits (15-30 Months)

Filters/Groupings	Use Case
Rendering/Usual Provider	Understand adherence to well visits by specific providers/care teams
Plan/Primary Payer Group*	Understand adherence to well visits by insurance/payer
Race/Ethnicity/Language/SDOH	Understand adherence to well visits in the context of health equity

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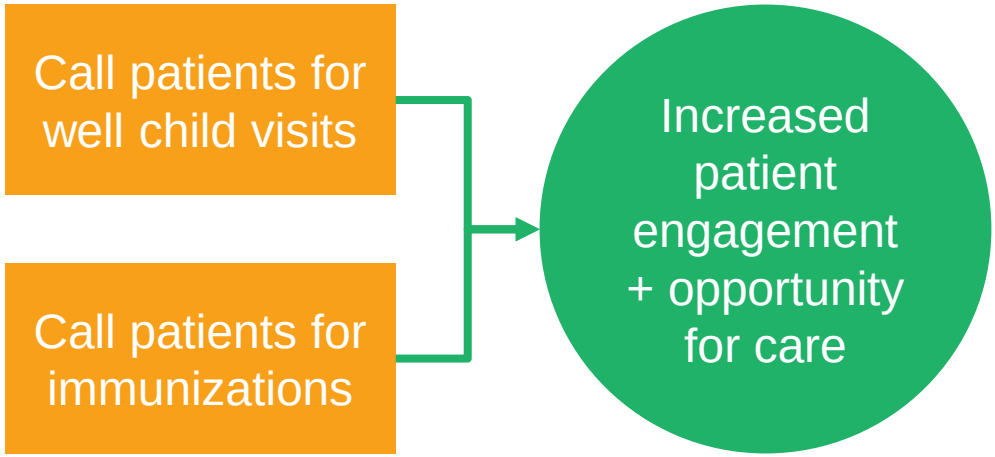
*to set up Primary Payer Groups contact Azara Support

Immunizations + Well Visits



1. Review measure performance for immunizations and well visits to identify areas of opportunity
2. Assess internal workflows with Point of Care Alert Closure report
3. Choose outreach focus: well child visits or immunizations

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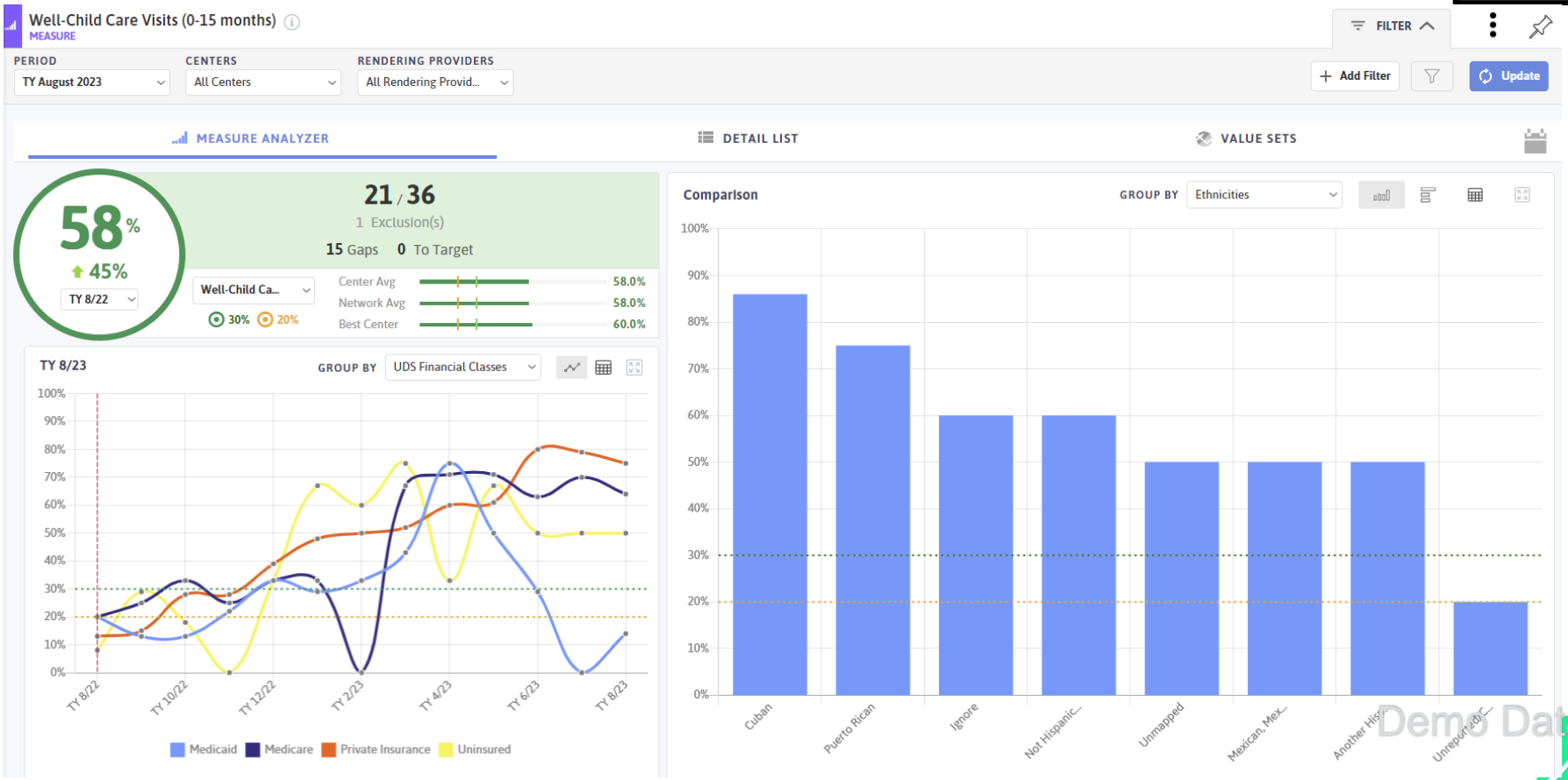
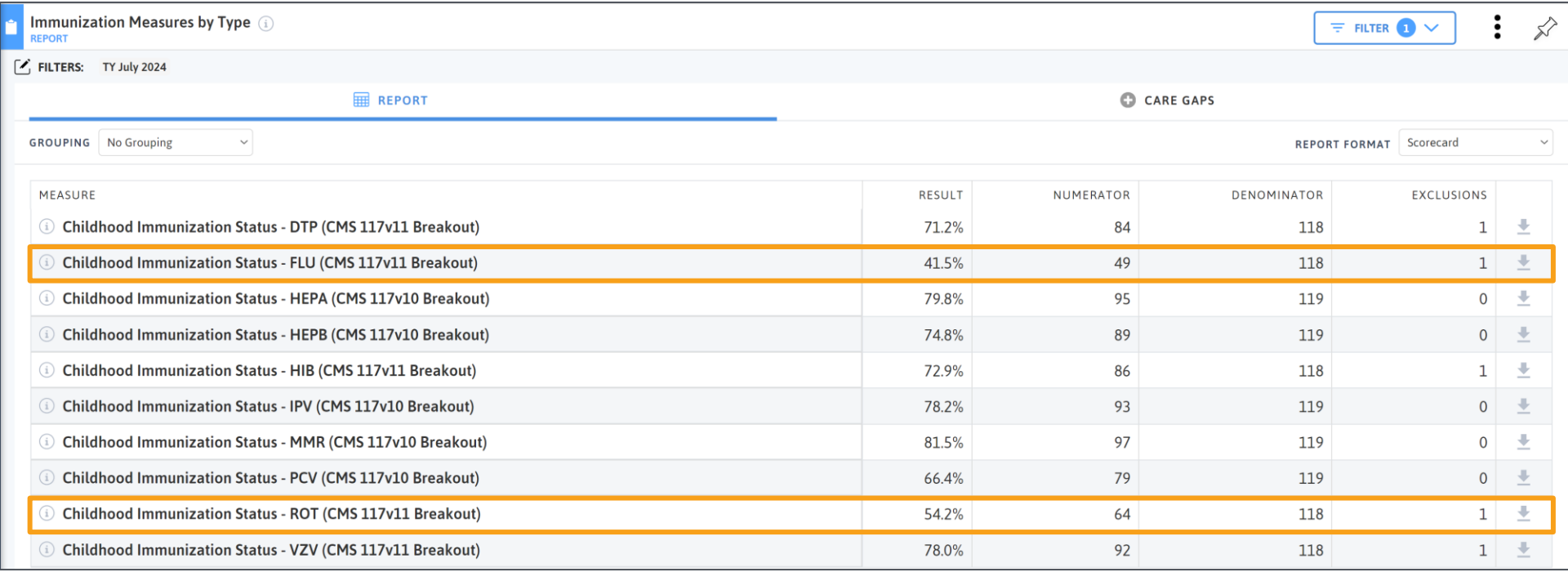
Well Child Visit Measure Performance



Immunizations Measure Performance



Immunization Measures by Type
REPORT

FILTER 1

FILTERS: TY July 2024

REPORT | CARE GAPS

GROUPING: No Grouping

REPORT FORMAT: Scorecard

MEASURE	RESULT	NUMERATOR	DENOMINATOR	EXCLUSIONS
Childhood Immunization Status - DTP (CMS 117v11 Breakout)	71.2%	84	118	1
Childhood Immunization Status - FLU (CMS 117v11 Breakout)	41.5%	49	118	1
Childhood Immunization Status - HEPA (CMS 117v10 Breakout)	79.8%	95	119	0
Childhood Immunization Status - HEPB (CMS 117v10 Breakout)	74.8%	89	119	0
Childhood Immunization Status - HIB (CMS 117v11 Breakout)	72.9%	86	118	1
Childhood Immunization Status - IPV (CMS 117v10 Breakout)	78.2%	93	119	0
Childhood Immunization Status - MMR (CMS 117v10 Breakout)	81.5%	97	119	0
Childhood Immunization Status - PCV (CMS 117v10 Breakout)	66.4%	79	119	0
Childhood Immunization Status - ROT (CMS 117v11 Breakout)	54.2%	64	118	1
Childhood Immunization Status - VZV (CMS 117v11 Breakout)	78.0%	92	118	1

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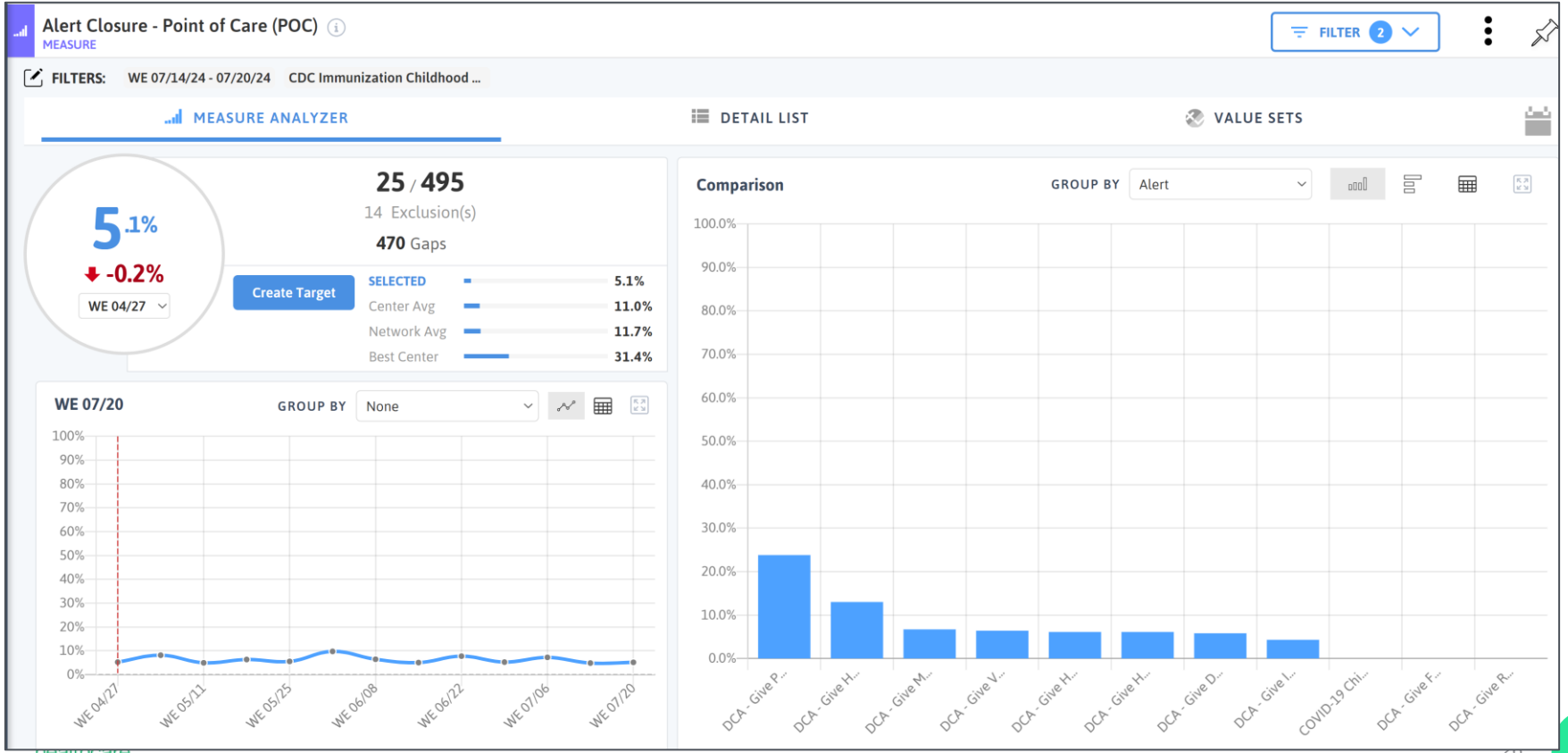
Immunizations at the Point of Care



Middle Childhood & Adolescent Well Visits

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Middle Childhood & Adolescence | Guidelines

CHILDREN 3 – 21 YEARS OLD

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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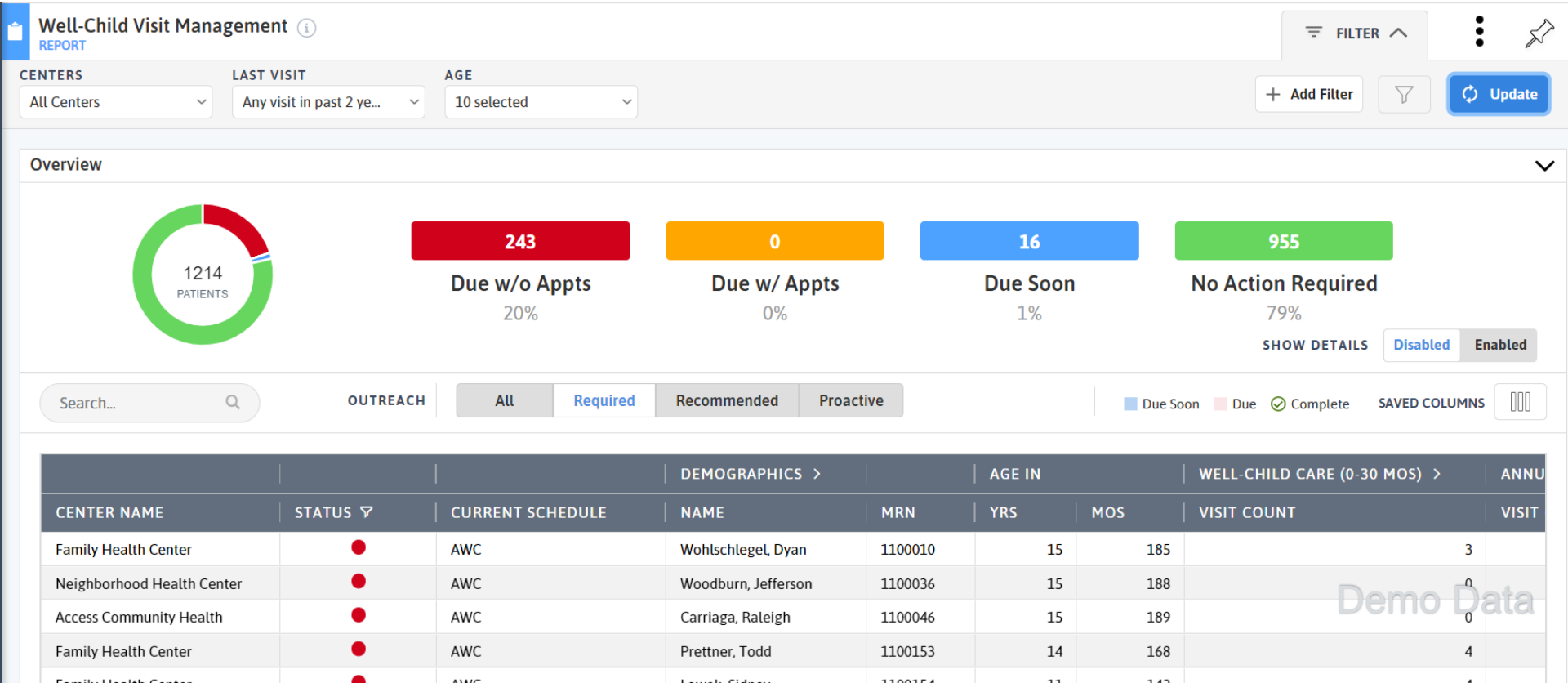
	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	→	★	★	★		★	★	★	★	★	★	●	●	●	★	●	★	●	●	←	●	→	←	●	→	←	●	→		
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★																
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	●	→	★	★	★	★	★	←			●	→
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	●	→					
Hepatitis B Virus Infection[31]		★	→																													

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Middle Childhood & Adolescence | Identify

WELL CHILD VISIT MANAGEMENT REPORT



Middle Childhood & Adolescence | Identify

FILTER CONSIDERATIONS

Filter	Selection	Use Case
Last Visit	PC in last 2 years	Exclude dental-only patients
Age	3-21 years	Focus on your middle childhood visit scheduling
Usual Provider	Individual provider's name	If individual care teams are responsible for scheduling their patients
Rendering Location	One specific site	If outreach teams call/schedule patients for each location
Race/Ethnicity/ Language	Specific races/ethnicities/ languages	Have culturally-appropriate outreach staff contact patients
SDOH	Transport-med	Identify potential barriers to accessing care

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Middle Childhood & Adolescence | Care

PATIENT VISIT PLANNING

- Satisfy immunizations and preventive screenings
- Identify and address RAF Gaps

5:00 PM Monday, January 8, 2024 — **Visit Reason:** Medical Sports P.E.

Duck, Donald
MRN: 123456
DOB: 11/06/2011 (12)

Sex at Birth: M
GI:
SO:

Phone: (123)-456-7890
Lang: English
Risk: Low (1)

Portal Access: N

PCP: McCony, Leonard
Payer: Medicaid
CM: Unassigned

DIAGNOSES (0)

RISK FACTORS (0)

SDOH (1)
RACE

RAF GAPS DIAGNOSIS CATEGORIES (1)
Skin

ALERT	MESSAGE	DATE	RESULT	OWNER
Depression Screen	Missing			MA
BMI %	Overdue	11/9/2022	2	MA
HPV	Missing			
Meningo Imm	Overdue			
Tdap Boost	Overdue			
Nutr Counsel	Overdue	11/9/2022		MA
Phys Act	Missing			MA
Well Visit 7-18	Overdue	11/1/2022		

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Demo Data

Middle Childhood & Adolescence | Care

POTENTIAL ALERTS

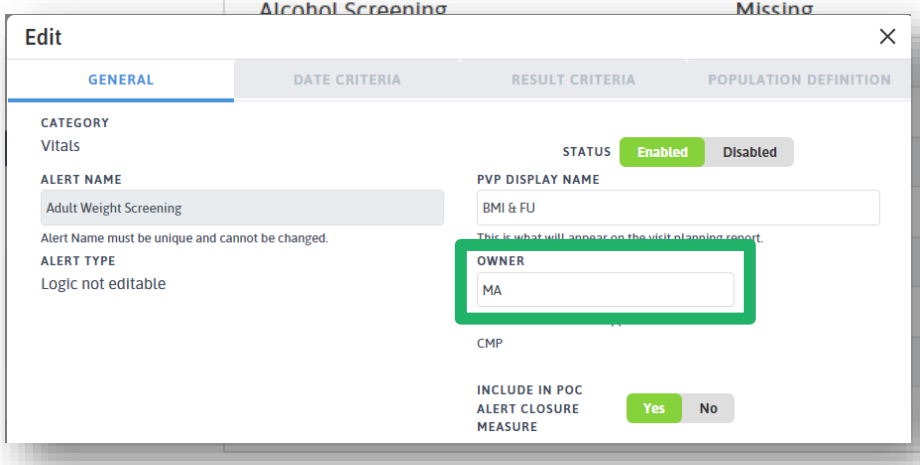
ACE Pediatric Screening	CDC Immunization MenACWY	Depression Remission	Pediatric Hearing Screening
Alcohol Screening	CDC Immunization MenACWY	Depression Screening	Pediatric Hemoglobin Screening
Anxiety Screening	CDC Immunization MenB	Depression Screening Follow Up	Pediatric Symptom Checklist 17
Asthma Control Test	CDC Immunization MMR	Drug Screen	Pediatric Vision Screening
Asthma Control Therapy	CDC Immunization MenB	Federal Poverty Level Documented	Physical Activity Counseling
Asthma Severity	CDC Immunization PCV	Fluoride Varnish	SBIRT Follow Up CRAFFT
BMI % >85%	CDC Immunization Tdap	Hep C Screening	Seasonal Flu
BMI %	CDC Immunization VZV	HIV Screening	Sexual History Screening Complete
CDC Immunization DTaP	Chlamydia Screening	HPV	Tdap Booster
CDC Immunization Flu	COVID Testing Completed	Lead Screening	Tobacco & ENDS Screening Status & Cessation
CDC Immunization HepA	COVID-19 Immunization 3rd Dose	MDD Suicide Risk Assessment	Tobacco Cessation
CDC Immunization HepB	COVID-19 Immunization Booster	Meningococcal Booster	Tobacco Status
CDC Immunization HiB	COVID-19 Immunization First Dose	Meningococcal Vaccine	Preventive Care Visit
CDC Immunization HPV	COVID-19 Immunization Second Dose	Nutritional Counseling	SDOH Needs Assessed
CDC Immunization IPV	Dental Sealant	Pediatric Developmental Screening	Annual Well Child 3-6
			Annual Well Child 7-18

New for UDS 2024
>=12 years

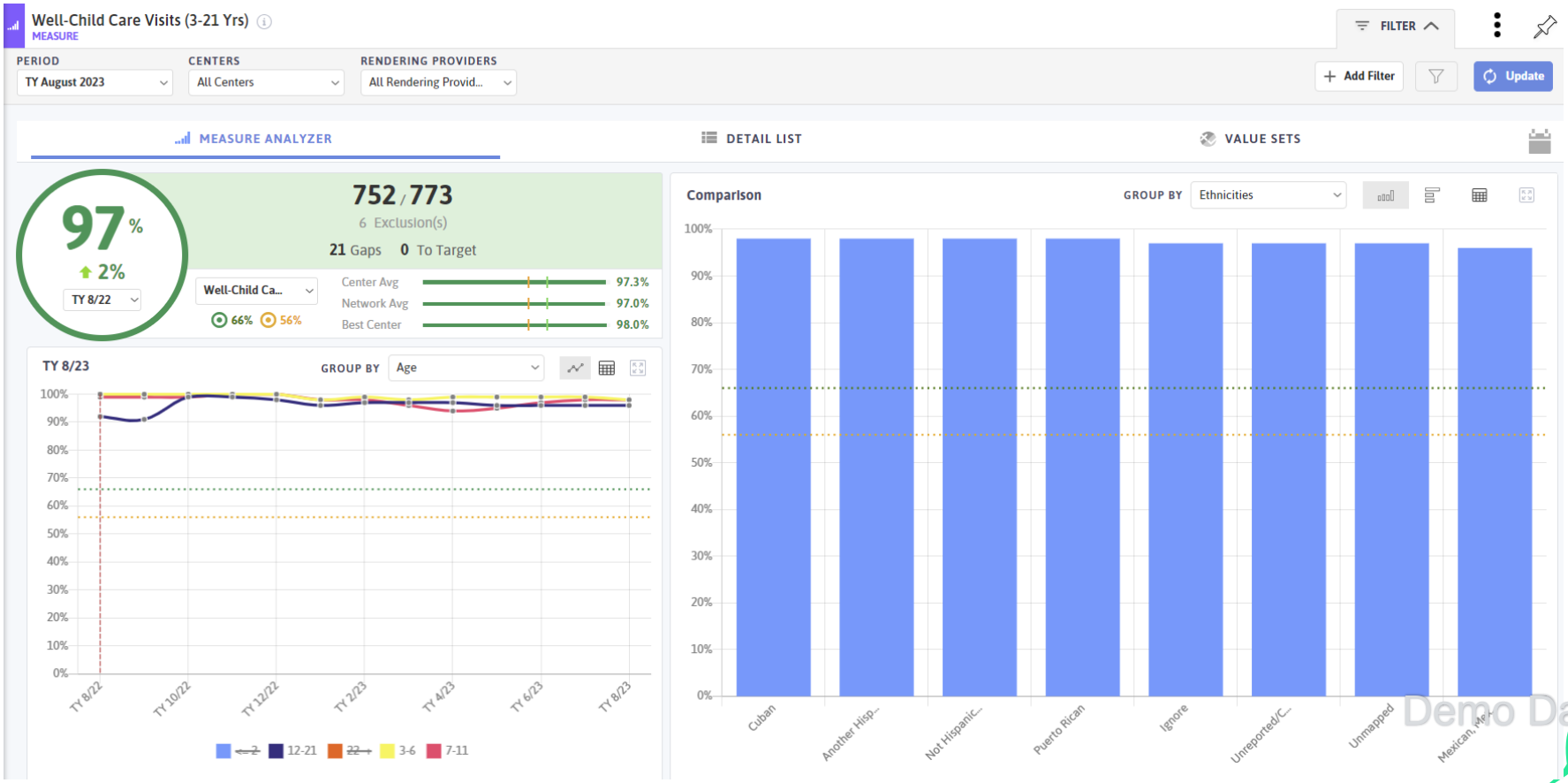
Closing Alerts | Assigning Owner

- Do Care Team members know who is responsible for closing each alert on the PVP?
- Assigning owners clarifies roles, creates accountability, and allows team members to work to the top of their license.

ALERT	MESSAGE	DATE	RESULT	OWNER
Hep C	Missing			
HIV	Missing			
Alcohol Screening	Missing			MA
		9/7/2022	Negative	MA
		9/7/2022	73	MA
		10/26/2020		
		9/7/2022		MA
		9/7/2022		MA
		9/7/2022		



Middle Childhood & Adolescence | Track



Middle Childhood & Adolescence | Track

FOCUS MEASURES

Well Child Care Visits (3-21 Yrs)	Well Child Care Visits (3-6 Yrs)	Well Child Care Visits (7-11 Yrs)	Well Child Care Visits (12-21 Yrs)

Filters/Groupings	Use Case
Rendering/Usual Provider	Understand adherence to well visits by specific providers/care teams
Plan/Primary Payer Group*	Understand adherence to well visits by insurance/payer
Race/Ethnicity/Language/SDOH	Understand adherence to well visits in the context of health equity

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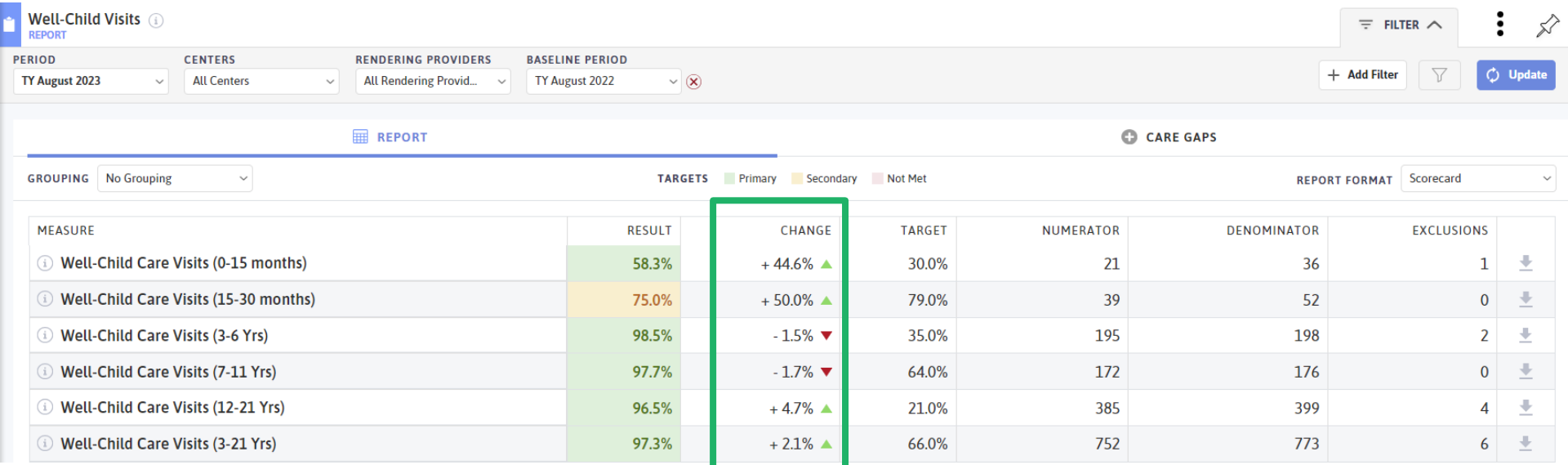
*to set up Primary Payer Groups contact Azara Support

Childhood Well Visits | Track

CUSTOM SCORECARD



MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Well-Child Care Visits (0-15 months)	58.3%	+ 44.6% ▲	30.0%	21	36	1
Well-Child Care Visits (15-30 months)	75.0%	+ 50.0% ▲	79.0%	39	52	0
Well-Child Care Visits (3-6 Yrs)	98.5%	- 1.5% ▼	35.0%	195	198	2
Well-Child Care Visits (7-11 Yrs)	97.7%	- 1.7% ▼	64.0%	172	176	0
Well-Child Care Visits (12-21 Yrs)	96.5%	+ 4.7% ▲	21.0%	385	399	4
Well-Child Care Visits (3-21 Yrs)	97.3%	+ 2.1% ▲	66.0%	752	773	6

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Demo Data

Adult Well Visits

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Adult Well Visits | Guidelines

21 – 63 YEARS OLD

- Focused on preventive screening recommendations based on the patient's age, sex, risk factors, and symptoms
  - USPSTF Guidelines with an A or B grade
- Periodic health evaluations had beneficial association with receipt of cervical cancer screening, cholesterol screening, and FOBTs
  - No association with other preventive screenings

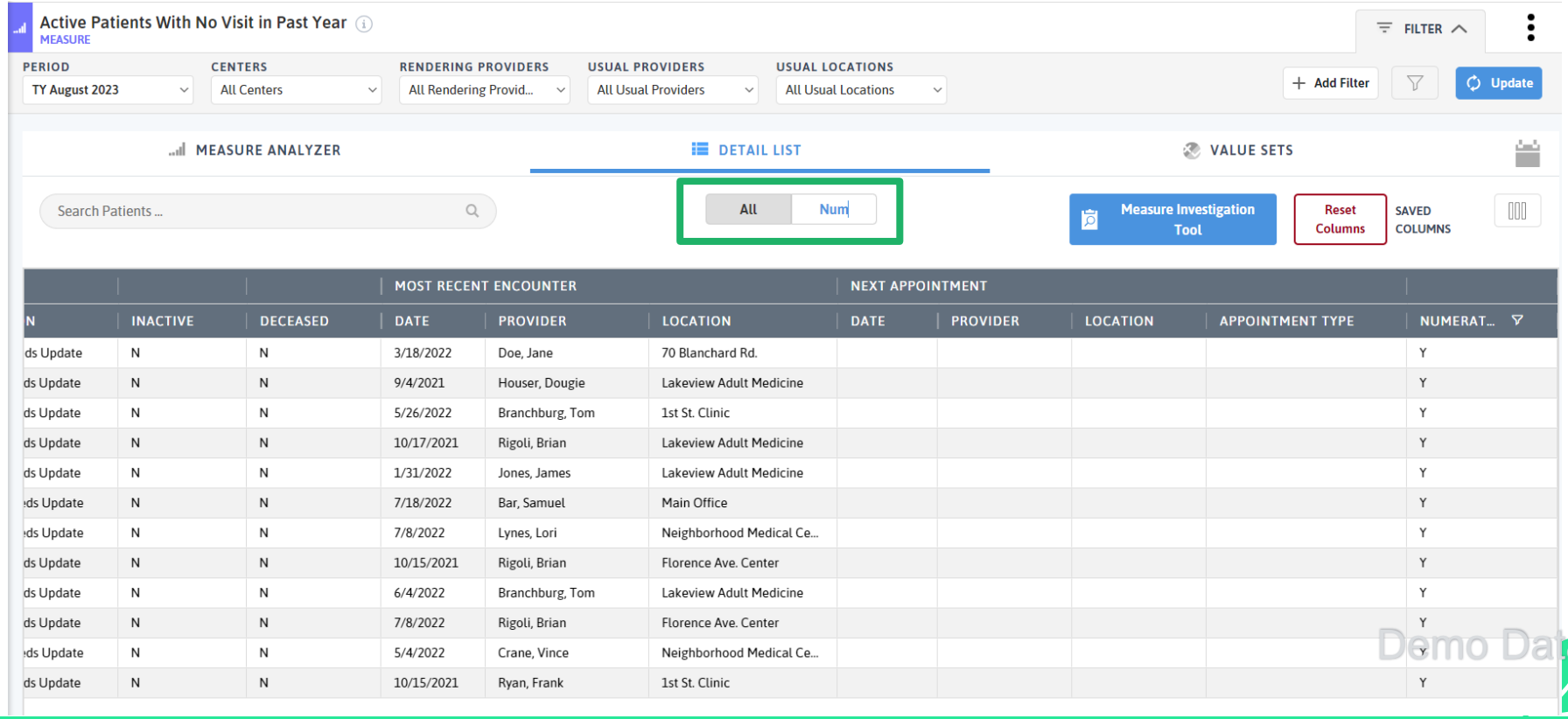
Table 1 United States Preventive Services Task Force (USPSTF) Recommendations for Physical Examination Procedures for Average Risk Asymptomatic Adults

Procedure	To detect…	Grade[#]	Year	Comments
RECOMMENDED				
Blood Pressure (BP)	Hypertension	A	2007	For adults age 18 or older. There is no evidence on which to base a recommendation for optimal interval. The Joint National Committee on Prevention Diagnosis and Treatment of High Blood Pressure recommends every 2 years in persons w/ initial BP < 120/80 and every year in persons with BP 120-139 or diastolic 80-89. VA/DoD guideline (2004) recommends annual
Weight (Body Mass Index)	Obesity[=]	B	2003	Frequency not specified; VA/DoD guideline (2006) recommends annual
PAP smear	Cervical cancer[=]	A	2003	For women with a cervix every 3 years beginning within 3 yrs of onset of sexual activity or age 21 whichever comes first.
Recommend AGAINST				
PAP smear	Cervical Cancer[=]	D	2003	For women without a cervix or women over age 65 if they have had adequate screening in the past and are not at high risk of cervical cancer.
Pelvic examination	Ovarian cancer[=]	D	2004	
Testicular examination	Testicular cancer	D	2011	
Abdominal palpation	Pancreatic cancer	D	2004	
Thyroid examination	Thyroid Cancer[=]	D	1996	"May contain information that is out of date" per USPSTF website accessed 8/31/11

https://www.ncbi.nlm.nih.gov/books/NBK82767/

Adults | Identify

ACTIVE PATIENTS W/ NO VISIT



Adults | Identify

CUSTOM REGISTRY

Well Visit: Adult
REGISTRY

FILTER

VISIT DATE RANGE: 01/08/2023-01/08/2024 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

REGISTRY | VALUE SETS

Search Patients ...

Reset Columns | SAVED COLUMNS

	ANNUAL WELLNESS VISIT		LAST WELL CARE VISIT		NEXT PRIMARY CARE APPOINTMENT					BLOOD PRESSURE
MRN	DATE	CODE	DATE	CODE	DATE	PROVIDER	LOCATION	NEXT PRIMARYCARE APPOINTMENT APPOINTMENT TYPE	AGE	VITALS DATE
1102606	9/18/2023	G0438	9/18/2023	G0438					31	9/18/2023
1104174	2/28/2023	G0438	2/28/2023	99387					33	2/28/2023
1102336	8/5/2023	99383	8/5/2023	99387					32	9/30/2023
1102349	9/23/2021	99383	9/23/2021	99387					48	9/23/2021
1102653	1/16/2023	G0438	1/16/2023	G0438					21	1/16/2023
1104255	12/24/2022	G0438	12/24/2022	G0438					36	12/24/2022
1101845									23	
1102417	8/24/2023	99386	8/24/2023	99383					31	8/24/2023
1100082									27	
1104123	2/20/2023	99383	2/20/2023	99383					32	3/4/2023

Identify:

- Most Recent Well Visit
- Next Primary Care Appointment
- Most Recent Preventive Screens

Demo Data

Adults | Care

PATIENT VISIT PLANNING

- Satisfy preventive screenings
- Identify and address RAF Gaps
- Calculate Risk score

1:53 AM Monday, January 8, 2024 — **Visit Reason:** **Physical Canceled**

Deutschendorf, Polly
MRN: 1102246
DOB: 1/9/1975 (48)

Sex at Birth: M
GI: Transgender Female/ Male-to-Female
SO: Don't know

Phone: 978-534-7729
Lang: Persian
Risk: Low (11)

Portal Access: N
Cohorts: Adults Sys > 110, Clinical Pharmacy, High Risk w/HTN

PCP: Fritz, Renata
Payer: Coventry
CM: Chris Ryan

DIAGNOSES (3)

DM	HIV	HTN-NE

RISK FACTORS (3)

ANTICOAG	Chronic Opioid Tx	MSM

SDOH (4)

HISP/LAT	HOMELESS	RACE
STRESS		

RAF GAPS DIAGNOSIS CATEGORIES (2)

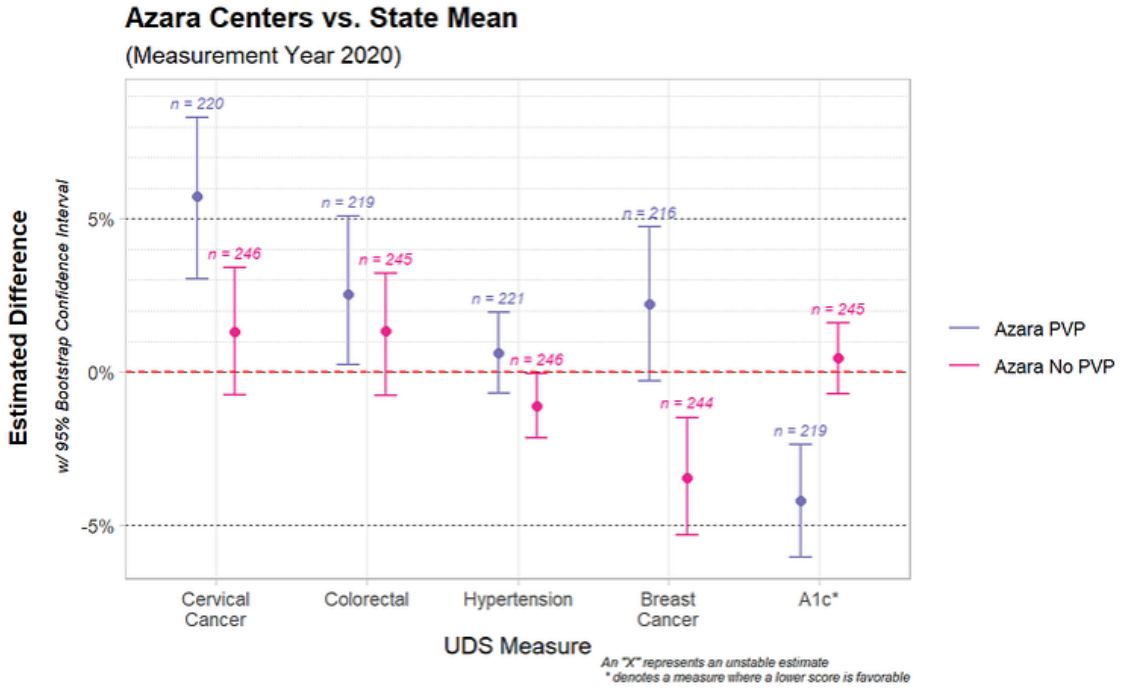
Gastro	Cardio

ALERT	MESSAGE	DATE	RESULT	OWNER
A1c	Missing			
LDL	Overdue	2/21/2022	144	
Depression Screen	Overdue	2/21/2022	Positive	MA
Tobacco Scr	Missing			MA
BMI & FU	Overdue			Provider
BP	Overdue	2/21/2022	130/89	
Foot	Overdue	2/21/2022		
I/P Encounter	Occurred	9/11/2023		

Demo Data

The Azara Effect

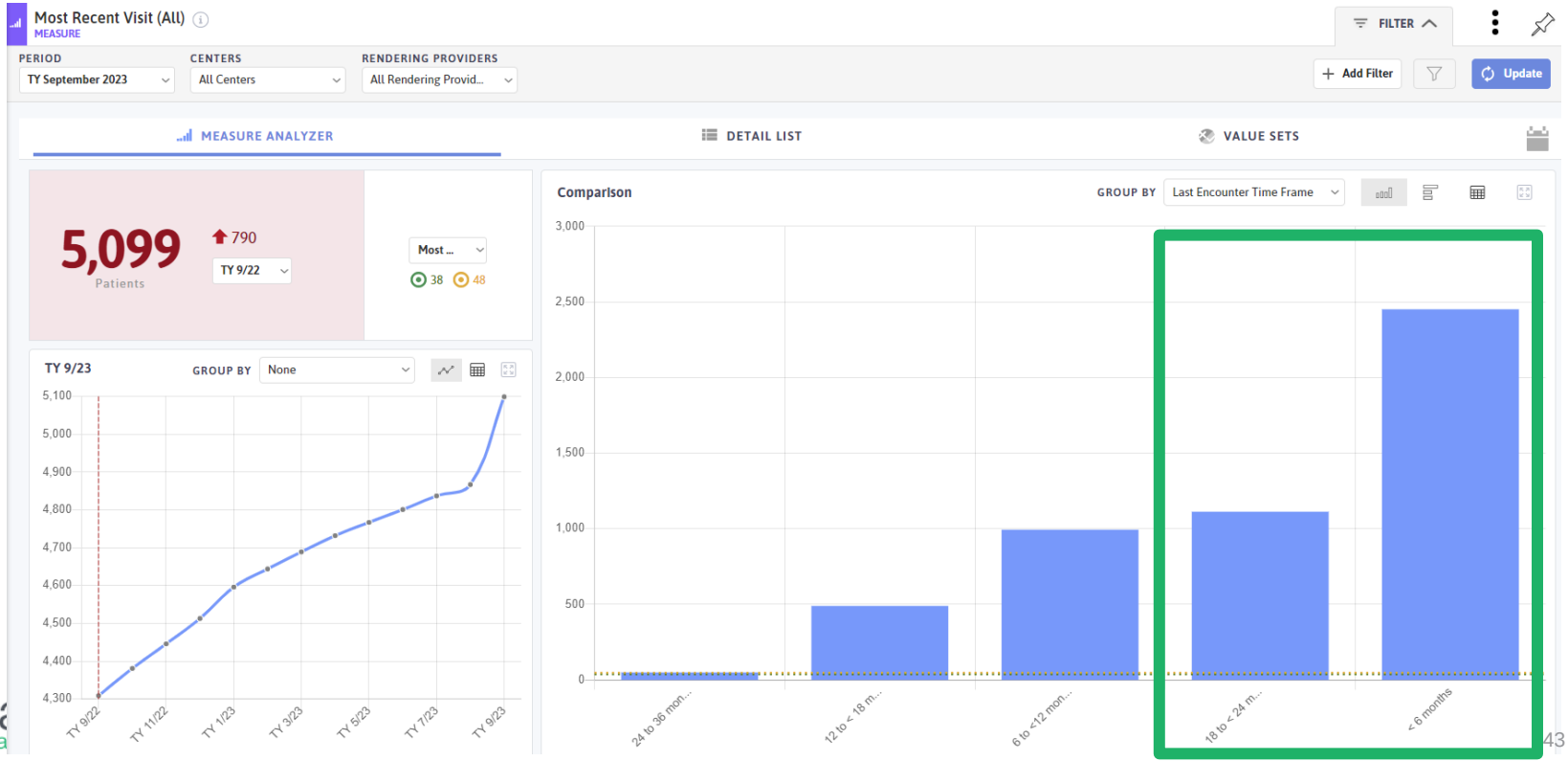
Figure 2: Comparison of Measure Performance when using the PVP



Source: https://www.azarahealthcare.com/blog/the-azara-effect

Adults | Track

MOST RECENT VISIT (ALL)



Medicare Annual Well Visits

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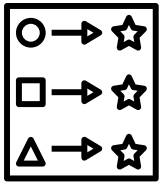
Medicare AWVs | Guidelines



PATIENTS WITH MEDICARE

Medicare Physical Exam Coverage

Initial Preventive Physical Exam (IPPE)

Review of medical and social health history and preventive services education.

✓ New Medicare patients within 12 months of starting Part B coverage

✓ Patients pay nothing (if provider accepts assignment)

Annual Wellness Visit (AWV)

Visit to develop or update a personalized prevention plan and perform a health risk assessment.

✓ Covered once every 12 months

✓ Patients pay nothing (if provider accepts assignment)

Routine Physical Exam

Exam performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury.

✗ Medicare doesn't cover a routine physical

✗ Patients pay 100% out-of-pocket

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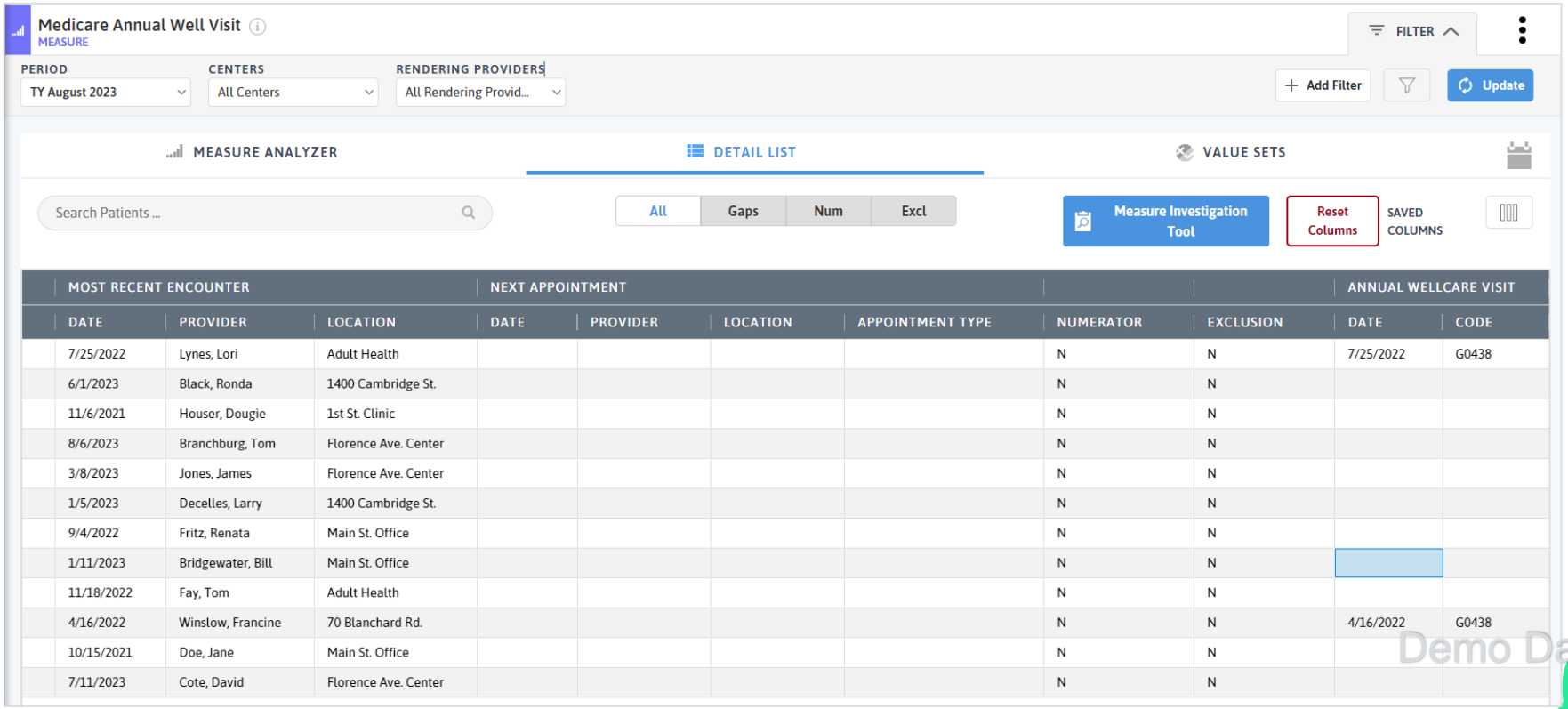
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

Medicare AWVs | Identify

MEDICARE ANNUAL WELL VISIT



Medicare AWVs | Identify

FILTER CONSIDERATIONS

Filter	Selection	Use Case
Usual Provider	Individual provider's name	If individual care teams are responsible for scheduling their patients
Rendering Location	One specific site	If outreach teams call/schedule patients for each location
Race/Ethnicity/ Language	Specific races/ethnicities/ languages	Have culturally-appropriate outreach staff contact patients
SDOH	Transport-med	Identify potential barriers to accessing care
Most Recent AWV (column)	Sort/filter by date	Prioritize patients that have had an AWV in the past, and some type of visit with their provider in the past 12 months.

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Medicare AWVs | Track

FOCUS MEASURES

Medicare Annual Well Visit

AWV – Plan Calculated

Filters/Groupings	Use Case
Rendering/Usual Provider	Understand adherence to well visits by specific providers/care teams
Plan/Primary Payer Group*	Understand adherence to well visits by insurance/payer
Race/Ethnicity/Language/SDOH	Understand adherence to well visits in the context of health equity

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*to set up Primary Payer Groups contact Azara Support

Success with Well Visits

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Success in Well Visits

Identify

- Measures, Scorecards, Registries

Engage

- Azara Patient Outreach
- Patient Visit Planning

Track

- Measures, Scorecards, Dashboards
- Filters and groupings

Succeed!

APO Campaign Performance Report

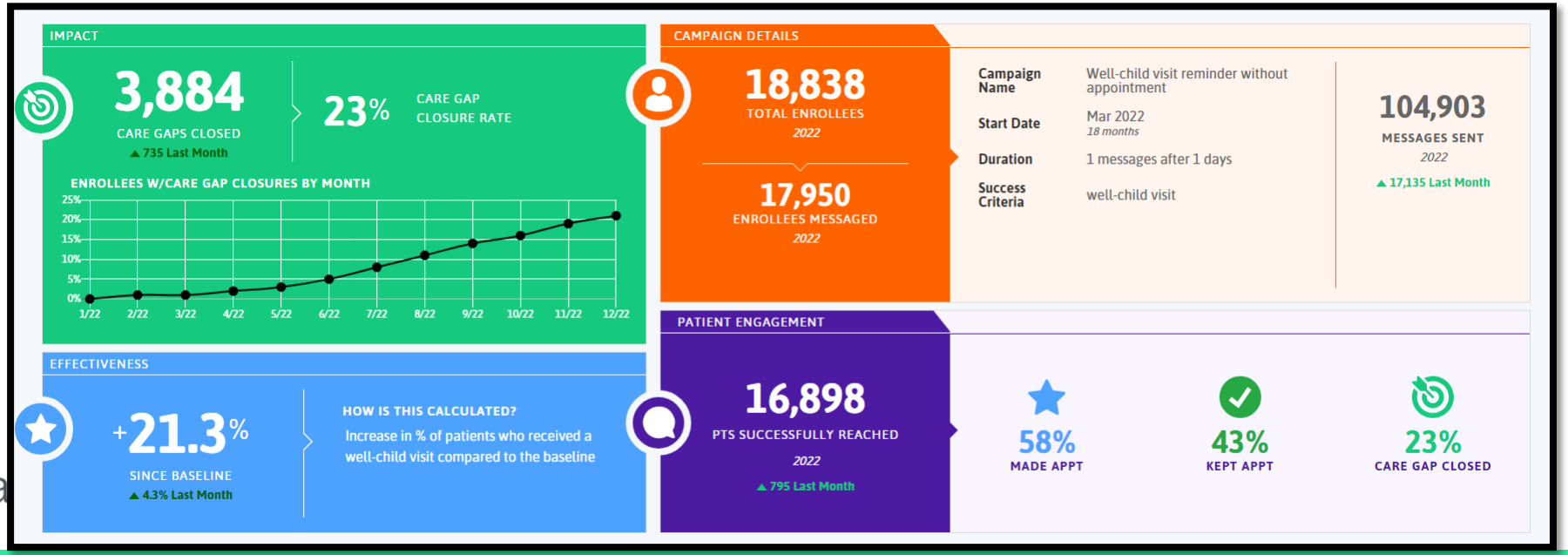
Well Visits Campaign - 2022

Valley Professionals Community Health Center

In 2022, there were 3,884 well visit care gaps closed which resulted in a 23% gap closure rate

The Start Date reflects the date of when this campaign was modified but this campaign was enabled in beginning of 2021

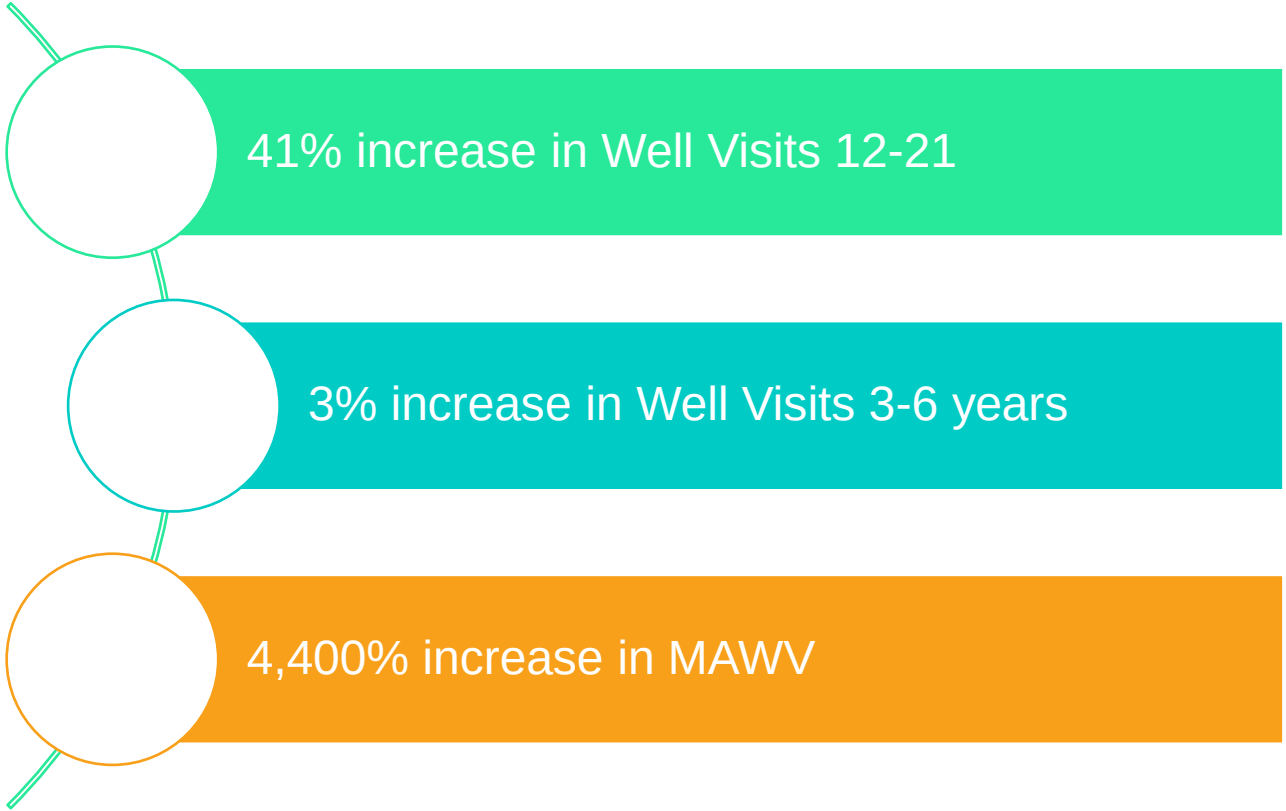
Roughly almost 17,000 patients were successfully reached and resulted in 58% of those patients scheduling an appointment.



Well Visit Measures Increase

Valley Professionals Community Health Center

In two years…



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RN Led AWV

Patients are placed on the RNs schedule in 45-minute appointments.

Receptionists utilize scripting when scheduling, letting patient know that most of their appointment will be spent with the RN.

RN has time to complete a comprehensive overview of their medical problems and medications, as well as any vaccinations and advanced care planning.

At some point during the patient's appointment their provider will stop in to see the patient briefly. These are not scheduled on the providers schedule, so they typically do this between other patients.

The RN completes the components of the AWV and documents these for the providers review and final signature.

If a patient has any concerns that cannot be addressed by the RN at the appointment, a follow-up will be made for them with their provider.

What’s New in DRVS

Object Visibility:

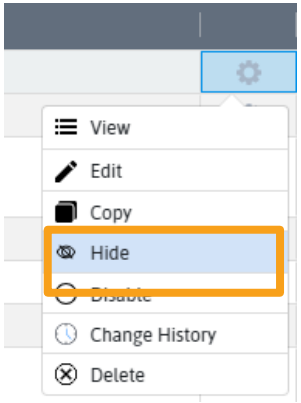
Now Available in Dashboards, Registries & Scorecards

FEATURE

Object visibility for registry, scorecard, and dashboard admin is now available to users

Users can hide registries, scorecards, and dashboards from the left-hand navigation bar and from search results

Users can also see if a dashboard is hidden or unhidden in the new “Hide in Navigation” column



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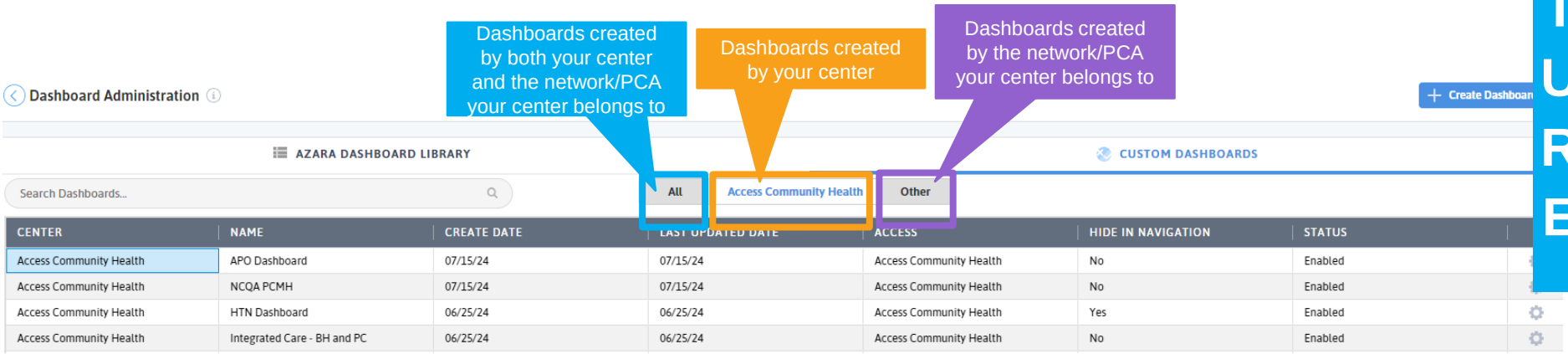
Released July 2024

Object Visibility | Continued

Example: Dashboard Admin



FEATURE

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Released July 2024

New Measure Coming Soon:

Pregnancy Intention Screening

MEASURE

UDS Update

ANNOUNCEMENT

UDS Pregnancy Intention

Azara will be supporting health center efforts to comply, and report results for the new UDS question HRSA is requiring for CY 2024 reporting:

"How many health center patients were screened for family planning needs, including contraceptive methods, using a standardized screener during the calendar year?"

More specifically, we are creating a "Pregnancy Intention Screening" measure that records the number of pregnancy intention screens done (based on screening date). This measure will be released no later than October 31, 2024.

For centers who have the Azara Family Planning module or who are Upstream program participants, the results of the pregnancy intention surveys already mapped will be used for our new measure.

For all other centers who are screening and collecting this information, additional mapping will be required. There will be no additional cost / charge for this mapping. To get this mapped please create an Azara Support ticket and include:

1. A screenshot of the EHR that includes the question being asked, structured results, and date completed (or indicate to use the encounter date for date completed)
2. A patient example where this information has been recorded

Note: that we can only complete this mapping if you are currently screening and documenting pregnancy intention as structured data within your EHR.

Requests submitted to support by September 1, 2024, will be completed by the UDS CY 2024 reporting deadline. Best efforts will be made but completion cannot be guaranteed for requests received after September 1, 2024.

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Automatically available for practices with the Family Planning Module.
Available for all other practices with additional mapping but no extra cost.

Released July 2024

Alerts:

Updated to Align with 2024 CQM Measures

Recent Alert Updates for 2024 CQMs

Alerts updated to UDS 2024 CQMs specifications

Azara has been updating alerts to align with the 2024 CQM measure updates.

To date the following changes have been released:

- CMS124
  - Alert: Cervical Cancer Screening
  - Changes: For centers with payer integration data, a message of "plan has data" will appear if patient is compliant for the measure Cervical Cancer screening according to the current enrolled plan
- CMS125
  - Alert: Mammogram
  - Changes: Add age related exclusion criteria from CQM like advanced illness and frailty
- CMS130
  - Alert:Colorectal Cancer Screening 45+
  - Changes: For centers with payer integration data, a message of "plan has data" will appear if patient is compliant for the measure Colorectal Cancer Screening according to the current enrolled plan
- CMS138
  - Alert:Tobacco Cessation & Tobacco Status
  - Changes:Mimimum inclusion age dropped to 12 years of age and older
- CMS2
  - Alerts:
    - Depression Screening
    - Depression Screening Primary Care
    - Depression Screen with Diagnosis
    - Depression Screening Follow Up (planned release 7/17)
  - Changes:
    - Removed depression diagnosis as exclusion criteria
    - Remove requirement for screening withing 14 days of an encounter to close alert
- CMS347
  - Alert: Statin Therapy
  - Changes: Addition of patients with a 10-year ASCVD risk score >= 20%

Alert development in progress:

- Depression Remission
- General Childhood Immunizations
- Diabetes A1c

Note: There are no changes to the following measures, and thus Azara is not updating the alerts associated with them:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (CMS 155v12)
- HIV Screening (CMS 349v6)
- Hypertension Controlling High Blood Pressure (CMS 165v12)

Please see the Azara UDS Webinar for more information on the 2024 CQM updates. The slides are available here: Preparing for UDS 2024: CQMs, Table Changes, UDS+, Oh My!

Please reach out to Azara Support using the blue link below if you have additional questions.

ALERT

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Released July 2024

2024 HEDIS Measures Certified & Live

MEASURE

HEDIS Measure Year 2024 is Certified and Live!

We are pleased to announce that Azara has certified 55 measure families in compliance with NCQA licensing and certification requirements for Measure Year 2024 (MY2024)

HEDIS MY2024 certified measures have been released to DRVS. The MY2024 versions have replaced older HEDIS certified measures in your scorecards and dashboards. Targets from your MY2023 HEDIS measures were migrated to the MY2024 version of the same measure.

NCQA Measure Certification ensures that our logic has gone through the industry's most rigorous assessment, that our coded measures meet current NCQA standards and produce accurate results.

Please note:
*The MY2023 measure family Hemoglobin A1c Control for Patients With Diabetes (HBD) was revised and renamed to Glycemic Status Assessment for Patients With Diabetes (GSD) in MY2024.
*The measure Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) was retired by NCQA in MY2024.

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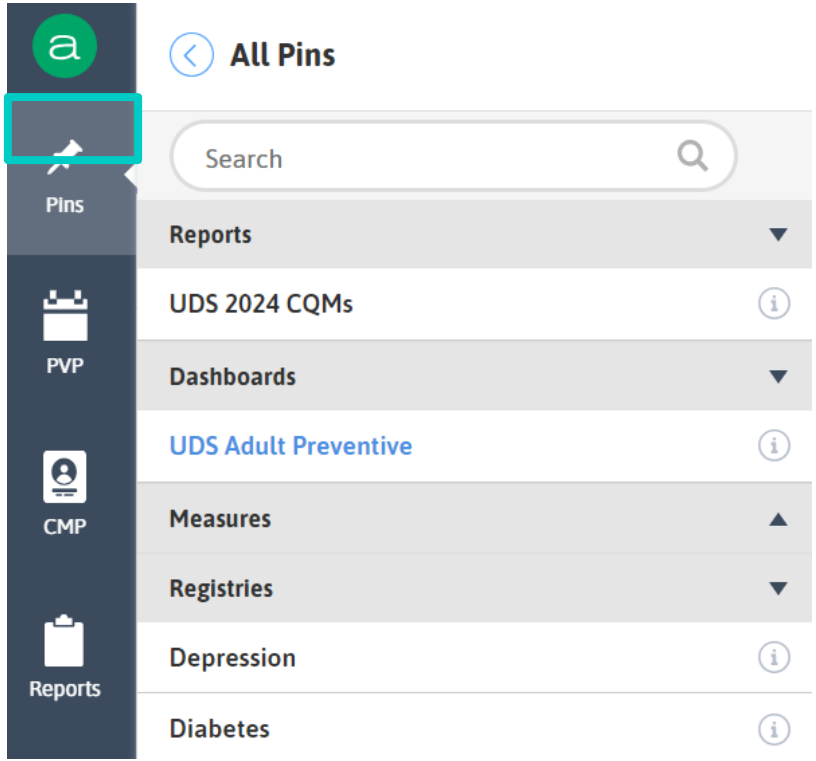
Available for practices with the Payer Integration Module.

Released June 2024

Super Pins:
Now Available!



Users can now access a collection of all of their pinned items in one place

This new feature is located at the top of the left-hand navigation bar, directly above the PVP

FEATURE

Released June 2024

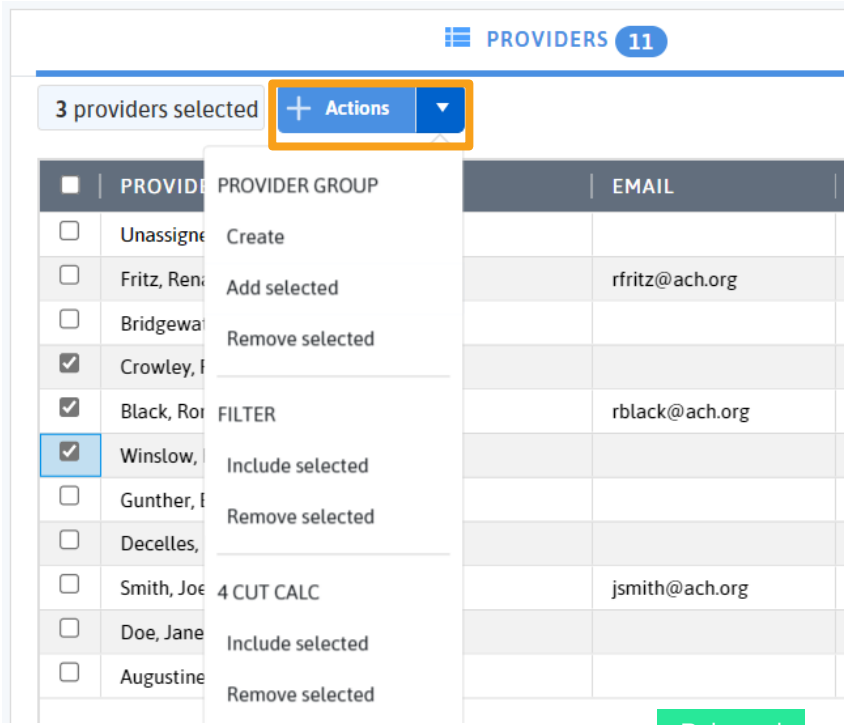
Provider Admin:
Bulk Actions Now Available!

FEATURE

Users can now select multiple providers from Provider Administration

By clicking on the “Actions” button, users can:

- Create a new provider group or update an existing one
- Include or exclude selected providers in filter
- Include or exclude selected providers from 4 cut calculation



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Released June 2024

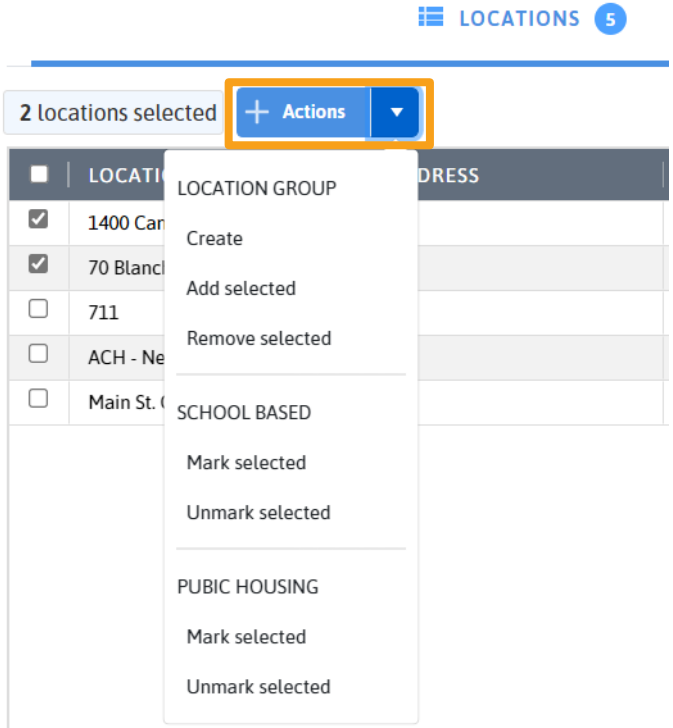
Location Admin:
Bulk Actions Now Available!

FEATURE

Users can now select multiple locations from Location Administration

By clicking the “Actions” button, users can:

- Create a new location group or update an existing one
- Mark or unmark selected locations from School Based Housing or Public Housing



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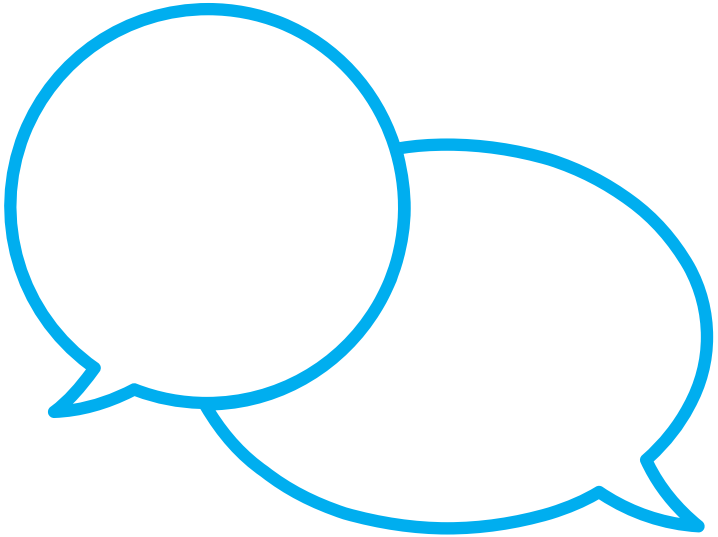
Released June 2024

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.