# Change Packages toward Value-based Care

| Focus Area | Change Processes | Azara DRVS Tools | Tools for All |
|---|---|---|---|
| Closing Care Gaps at Point of Care | 1. Clinical Decision Support – ID Alerts<br>2. ID PVP standing actions for care team<br>3. ID huddle workflows<br>4. Test and Track Closures | • Azara Alert Administration<br>• PVP Report<br>• Point of care alert closure measure report | • EHR CDS Alerts<br>• NACHC Care Teams Action Guide<br>• AMA STEPS*forward* Pre-Visit Planning<br>• AMA STEPS*forward* Team-Based Care |
| Finding Care Gaps and In-reach for Existing Patients | 1. Identify target care gaps<br>2. Identify gap registry/reports<br>3. Identify outreach workflows<br>4. Test and track appointments and closure | • Azara Care Gap Report<br>• Adult and Child Registries<br>• Disease and prevention registries<br>• Dashboards | • EHR gap registries<br>• EHR quality measure reports |
| Finding Care Gaps and Outreach for Payer-Assigned Panel | 1. Pull down payer care gaps<br>2. Identify outreach scheduling workflows<br>3. Test and tract appointment and closure<br>4. Improve Billing/coding for HEDIS | • Azara Payer Integration Care Gap Reconciliation Report* | • Payer portals<br>• MHS HEDIS Billing Guides |
| Patient Engagement | 1. Identify target patient populations<br>2. Implement Motivational Interviewing<br>3. Implement patient specific education<br>4. Identify care plan follow-up workflows | • Azara Care Gap Report<br>• Disease registries (or measure analyzer) for out of range or untested | • NACHC Patient Engagement Action Guide<br>• EHR dashboards<br>• Elevate |
| Digital Patient Engagement | 1. ID populations for digital engagement<br>2. ID patient barriers to digital engagement<br>3. Identify digital engagement workflows<br>4. Test and track appointments and outcomes | • Azara Care Gap Report<br>• Disease registries<br>• Risk registries | • HITEQ Electronic Patient Engagement |
| Care Coordination and Referral Management | 1. ID Care Coordination staff referral process<br>3. Identify overdue referrals<br>4. Identify referral closure workflow<br>5. Test and Track referral closure | • Azara Referral Module: Referral measures and referral registry* | • EHR dashboards<br>• Elevate<br>• IHIE CareWeb |
| Assess Social Determinants of Health | 1. Identify questions and target populations<br>2. Identify workflows<br>3. Collect SDOH in EHR or Spreadsheet<br>4. Share SDOH with care team | • Azara SDOH mapping in DRVS*<br>• SDOH Dashboard*<br>• SDOH filters* | • NACHC (PRAPARE)<br>• SDOH templates in EHR<br>• AMA STEPS*forward*: SDOH |
| Care Coordination & Navigation with Community-Based Organization | 1. Report and ID common social needs<br>2. Identify community resources and gaps<br>3. Partner with community agencies<br>4. ID community referral staff and workflows | | • Aunt Bertha<br>• Indiana 2-1-1 |

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| Risk Stratification | 1. Identify risk stratification method<br>2. ID priority risk populations<br>3. ID workflow for care management referral | • Azara Risk Registry and filters<br>• Care management passport<br>• Azara care management* | • AAFP Risk Stratification Rubric<br>• NACHC PHM Risk Stratification Action Guide |
| Care Management for High Risk Patients | 1. Identify care management model<br>2. ID care management staff & workflows<br>3. Implement Medicare CCM billing<br>4. Test and Track outcomes | • Azara care management*<br>• Care management passport | • NACHC PHM Models of Care Action Guide<br>• NACHC Care Management Action Guide<br>• IQIN PHM for High Risk/Cost Patients |
| Utilization Tracking | 1. Identify ADT data source(s)<br>2. ID ADT process staff and workflows<br>3. Define and ID high utilizers<br>4. ID workflows for high utilizers | • Azara Transitions of Care with IHIE ADTs*: TOC report, dashboard, measures<br>• PVP report with TOC*<br>• Payer Integration Azara* | • Payer Portal<br>• IHIE CareWeb<br>• IHIE ADTs |
| High ED Utilizers | 1. Identify staff for follow-up<br>2. Identify patient engagement messages<br>3. Identify patient engagement workflow<br>4. Test and Track ED utilization | • Azara Care Management Passport<br>• Care Management*<br>• ED TOC Measure* | • IHIE ADTs |
| Inpatient to Outpatient Transitions of Care (Medicare Transitional Care Management) | 1. Identify transitions of care model<br>2. ID transitions staff & workflows<br>3. Implement Medicare TCM billing<br>4. Test and Track outcomes | • Azara Chronic Care Management Registry<br>• Care Management*<br>• Transitions of Care IP Measure* | • IHIE ADTs<br>• CMS Medicare Transitional Care Management Services |
| Total Cost of Care | 1. Identify cost of care data source<br>2. ID cost of care reporting<br>3. ID high-cost patients for care management<br>4. Identify payer engagement strategy | • Azara Payer Integration: Members and PMPM* | • Payer portals |
| Patient Complexity | 1. Improve ICD-10 complexity coding<br>2. Add SDOH Z-codes to ICD-10 codes<br>3. Add codes for enabling services<br>4. Track social community-based referrals | | • SDOH ICD-10 Z-Codes<br>• PRAPARE ICD-10 Z-codes<br>• Enabling Services Data Collection<br>• HCPLAN APM Framework |

*Azara add-on module or mapping (not standard as part of Azara DRVS Core)