COMMUNITY HEALTH CARE ASSOCIATION of New York State

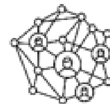
CHCANYS NYS-HCCN presents

Elevating Transitions of Care: Health IT & Health Center Spotlight

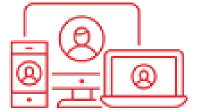
Session 3: Azara Healthcare &
Harmony Healthcare Long Island

May 21, 2026

For more information, please email Anita Li at ali@CHCANYS.org

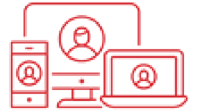


This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award to CHCANYS' New York State Health Center Controlled Network (NYS-HCCN) totaling $4,622,451.00 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov. 09.2024



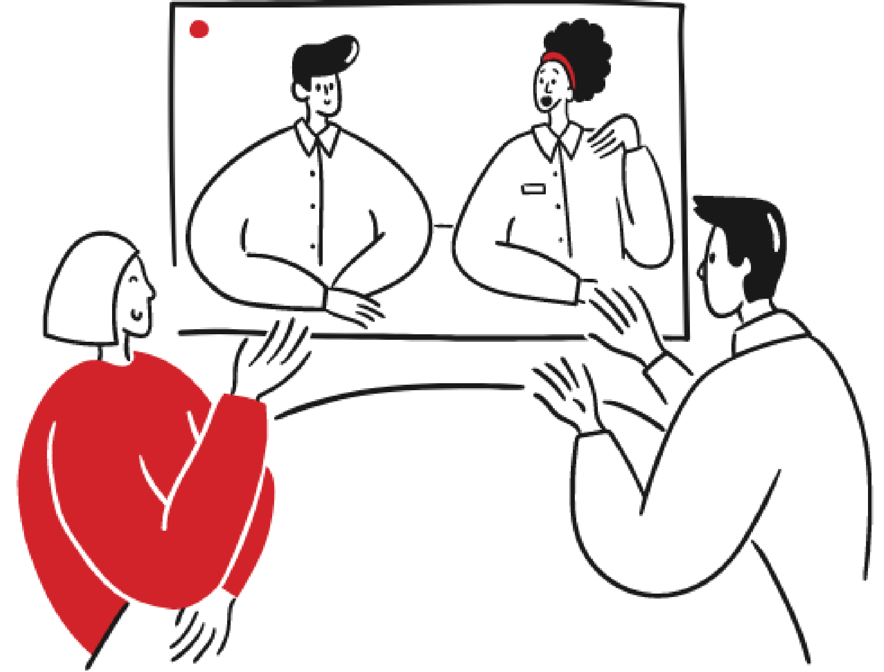
Agenda

1. Welcome & Introductions
2. Azara DRVS Transitions of Care (TOC) Module Overview
3. Using AZARA for Transitions of Care
4. Q&A
5. Closing and Evaluations

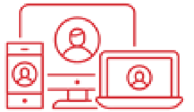


Housekeeping

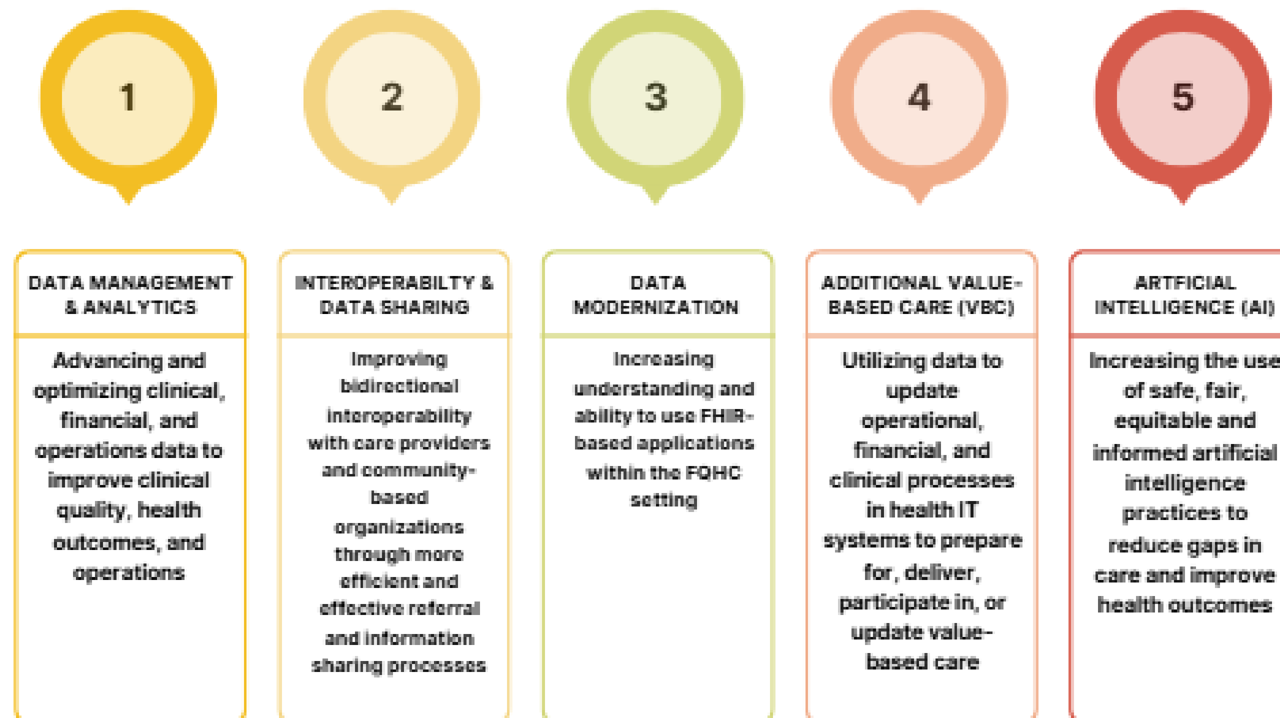
- You have been muted upon entry. Please respect our presenters and stay on mute if you are not speaking.
- Please share your questions in the chat. CHCANYS staff will raise your questions to our speakers and follow up as needed if there are unanswered questions.
- The webinar is being recorded and will be shared after the session along with the slide deck.
- A webinar evaluation will be shared with participants



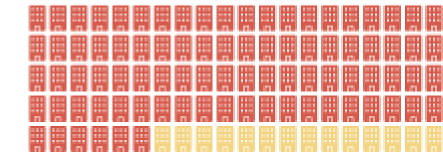
About the New York State HCCN



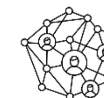
Established in 2012, the NYS-HCCN is one of 52 HRSA funded networks that leverages health IT and data to enhance how centers deliver affordable, accessible, and high-quality care with a specific emphasis on data management and analytics, interoperability of systems, and data modernization



86% OF ALL FQHCS PARTICIPATE IN AN HCCN NATIONALLY



52 HEALTH CENTERS PARTICIPATE IN THE CHCANYS NYS-HCCN



This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award to CHCANYS' New York State Health Center Controlled Network (NYS-HCCN) totaling $1,705,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov. 12.2025

Schedule of Events

Session 1 (5/7)

- HealtheConnections

Session 2 (5/14)

- eClinicalWorks & HealthTexas Medical Group

Session 3 (5/21)

- **Azara Healthcare & Harmony Healthcare Long Island**

Session 4 (5/28)

- HIXNY & APICHA Community Health Center

Meet the Presenters

Leah Dafoulas, MPH
Senior Director, Clinical Transformation

Azara Healthcare

azara healthcare

TOC & Tech

Azara DRVS Transitions of Care (TOC) Module Overview

DATE: 5/21/26

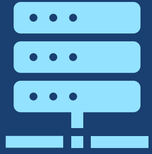
Leah Dafoulas, MPH
Sr. Director, Clinical Transformation

CONFIDENTIAL

This file contains information that is confidential to Azara Healthcare, LLC
Do not view, copy, distribute, or disclose without prior consent.

Today’s Topics

An Overview of Transitions of Care (TOC) Module



Current TOC Practices & Goals

Real World Experience from Harmony Healthcare

Questions

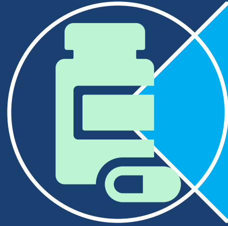
Managing Care Transitions is Important

Benefits of care management include:

1. Improve disease control and self management
2. Reduce distress
3. Improve the coordination of care
4. Prevent admissions or readmissions
5. Reduced cost/burden on individuals and healthcare system

Majewski, P., Lobick, D. Appropriate ED Utilization Leading to Better Care Coordination. AJMC.
Improvingprimarycare.org

The Four Pillars of Care Transition



Medication self-management

The Personal Health Record

Timely primary care/specialty care follow-up

Knowledge of red flags that indicate a worsening in their condition and how to respond

An Overview of TOC Module

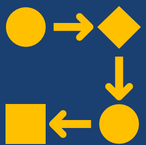
HIE Data in DRVS

Azara uses admit/discharge/transfer (ADT) alerts to populate reports, alerts, and measures

Lists of discharged patients who need follow-up

Identify high utilizers for care management

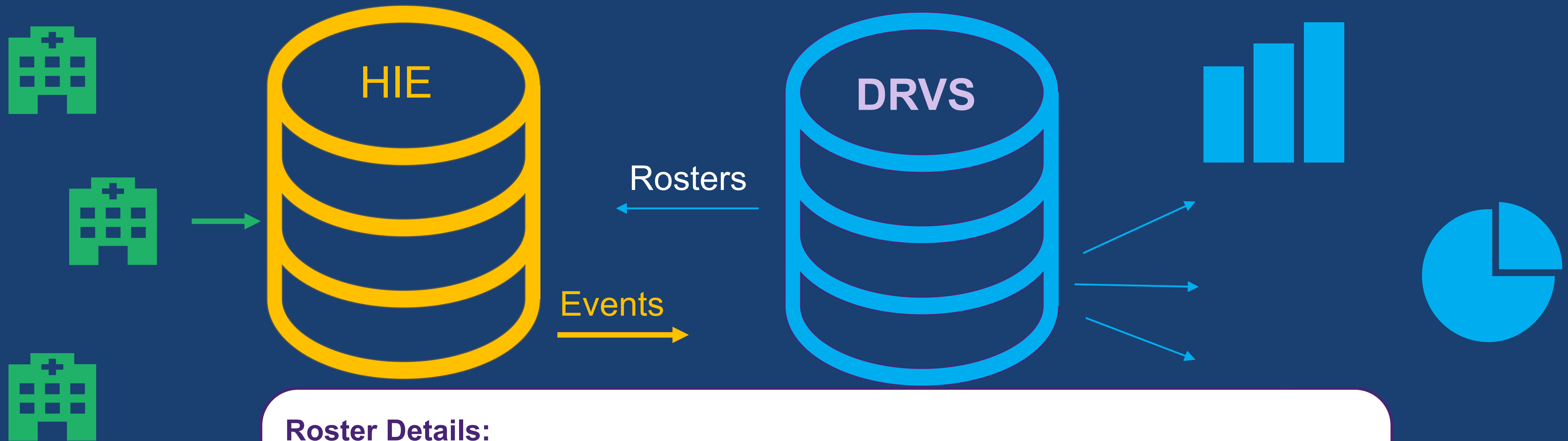
Track readmission rates for cost management



Understand the impact of interventions and process changes

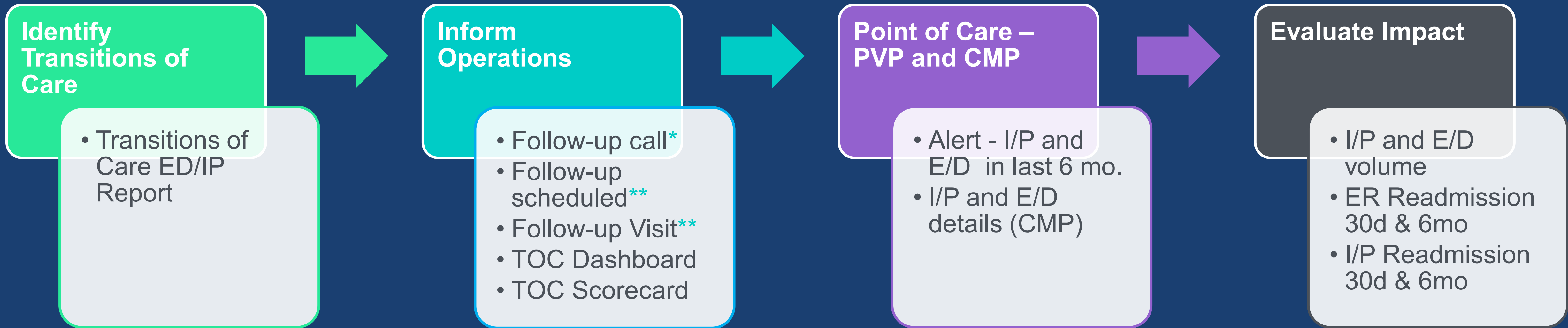
How ADT Data Gets into DRVS (KY KHIE)

Azara integrates Admit, Discharge, Transfer (ADT) Messages from Hospitals and HIEs and combines it with EHR data.



Roster Details:
HealthELink: Roster sent weekly, UDS Eligible Encounter in 6 years
Healthix: Roster sent weekly, UDS Eligible Encounter in 2 years
RRHIO: Roster sent monthly, UDS Eligible Encounter in 5 years
HealtheConnections: Roster sent monthly, UDS Eligible Encounter in 5 years

TOC Tools



***Filter available to break down timeframe:** <=24 hrs, 2 days, 3 days, 4-5 days, 6-7 days, 8-10 days, 11+ days / No Call

****Filter available to break down timeframe:** <=24 hrs, 2 days, 3 days, 4-5 days, 6-7 days, 8-10 days, 11-14 days,15-20 days, 21-30, 31+/No Follow Up Scheduled

azara healthcare

Accessing TOC DRVS Tools

Reports

Transition of Care

- Transitions of Care (TOC) - ED/IP

Measures

Transition of Care

- ED Follow Up Call
- ED Follow Up Scheduled
- ED Follow Up Visit
- I/P Follow Up Call
- I/P Follow Up Scheduled
- I/P Follow Up Visit

Dashboard

Dashboards | Measures | Registries | Admin

- Predominant Conditions
- Referral Management
- Social Needs All Patients
- Social Needs Assessed
- Substance Use Screening
- Telehealth Expansion and Mapping
- Transitions of Care (ED)
- Transitions of Care (I/P)
- Visit Trends

Mapping | Follow Up Phone Call

Required for follow up phone call measures to work.

Structured Data

- 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.

To get Follow up Phone Call mapped, send a screenshot of where recorded and patient example to Azara support.

See Sample Documentation

Putting Transitions Of Care into Practice

Use Cases and Workflows

Use Cases for TOC

Identify patients with IP or ED visit that need outreach

Evaluate operational performance

Alert care teams of patient’s hospital utilization

Evaluate impact/outcomes

Track populations

Transitions of Care (TOC) – IP Admissions

Run the ED/IP Report by 'TOC Type – IP Only'

Transitions of Care (TOC) - ED/IP
REPORT

FILTER

DATE RANGE	CENTERS	DISCHARGE STATUS	LAST VISIT	TOC TYPE	TOC STATUS
05/09/2024-05/09/2024	All Centers	All Discharge Status	No Required Visit	IP Only	Discharge

Add Filter | Update

Search ...

NEXT APPT: All | No Appt | Upcoming Appt

Reset Columns | SAVED

			ADMISSION EVENT					
MRN	DATE OF BIRTH	PATIENT (Y/N)	TYPE	ADMISSION	DISCHARGE	FACILITY	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS
		Y	Inpatient Stay	2/2/23 6:06 am			1	1
		Y	Inpatient Stay	9/6/22 10:45 am			0	1
		Y	Inpatient Stay	1/19/23 4:04 pm			0	1
		Y	Inpatient Stay	8/30/22 11:47 am			1	2
		Y	Inpatient Stay	10/4/22 3:50 pm			0	1
		Y	Inpatient Stay	10/10/22 11:43 pm			1	2
		Y	Inpatient Stay	3/2/22 8:24 am			0	0
		Y	Inpatient Stay	1/19/23 5:32 am				2

Use these columns to identify "frequent fliers" and patients who may need prioritization

azara healthcare

* Member data may be available for certain organizations.

Prioritize Patients with Most Utilization

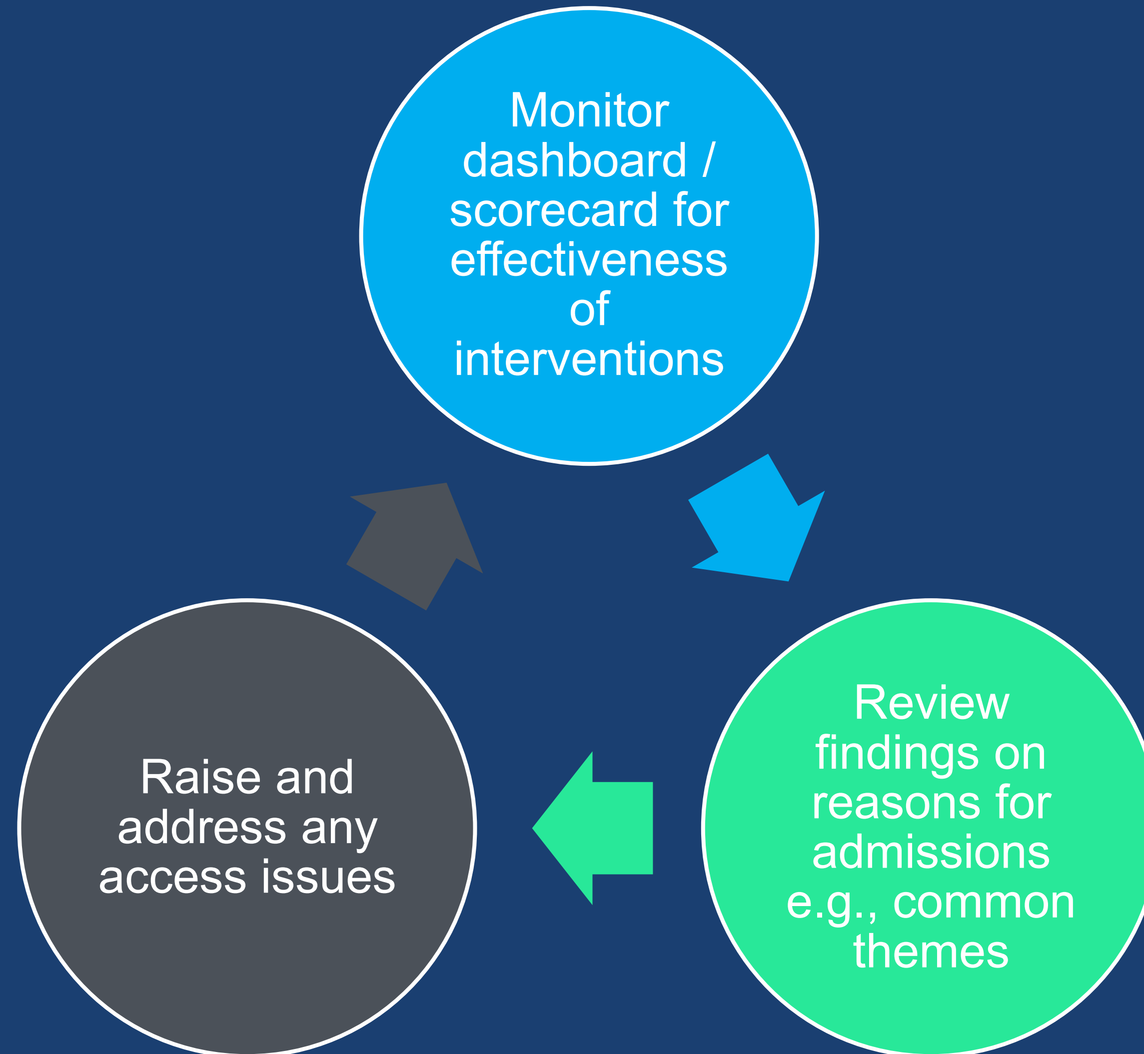
ADMISSION EVENT				
TYPE	ADMISSION	DISCHARGE	FACILITY	ED VISITS LAST 6 MONTHS ↑
ER Visit	6/3/23 7:29 am	6/3/23 10:34 am	AFC	15
ER Visit	6/7/23 11:10 pm	6/8/23 1:14 am	AFC	15
ER Visit	6/9/23 11:14 pm	6/9/23 11:16 pm	TJH	15
ER Visit	6/9/23 11:29 pm	6/10/23 7:29 am	TJH	15
ER Visit	6/16/23 1:06 am	6/16/23 2:46 am	AFC	15
ER Visit	6/18/23 2:23 am	6/18/23 3:59 pm	Temple University Hospital	15
ER Visit	6/20/23 8:21 am	6/20/23 9:24 am	AFC	15
ER Visit	6/23/23 1:59 am	6/23/23 2:29 am	AFC	15
ER Visit	6/30/23 12:35 am	6/30/23 5:14 am	AFC	15
ER Visit	6/5/23 9:13 am	6/5/23 11:40 am	AFC	7
ER Visit	6/5/23 6:46 pm	6/6/23 4:51 am	AEMC	7
ER Visit	6/30/23 1:56 pm	6/30/23 2:01 pm	Temple University Hospital	6
ER Visit	6/2/23 9:41 pm	6/3/23 1:46 am	Nazareth Hospital	6
ER Visit	6/10/23 11:20 am	6/10/23 1:27 pm	Nazareth Hospital	6

Transitions of Care (TOC) – ED/IP Report

The readmission column is looking for a prior admission up to 30 days from the current admission that is between the date range filter applied to the report.

	DIAGNOSIS			NEXT APPOINTMENT
DISCHARGE STATUS CODE	CODE	DESCRIPTION	READMISSIO...	NEXT APPOINTMENT
101			N	
101	F41.1	Generalized anxiety disorder	N	4/14/2022
101	K57.92	Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding	N	
101	M00.9	Pyogenic arthritis, unspecified	N	
103	J96.01	Acute respiratory failure with hypoxia	N	
101	K52.9	Noninfective gastroenteritis and colitis, unspecified	N	3/23/2022

Weekly Workflow



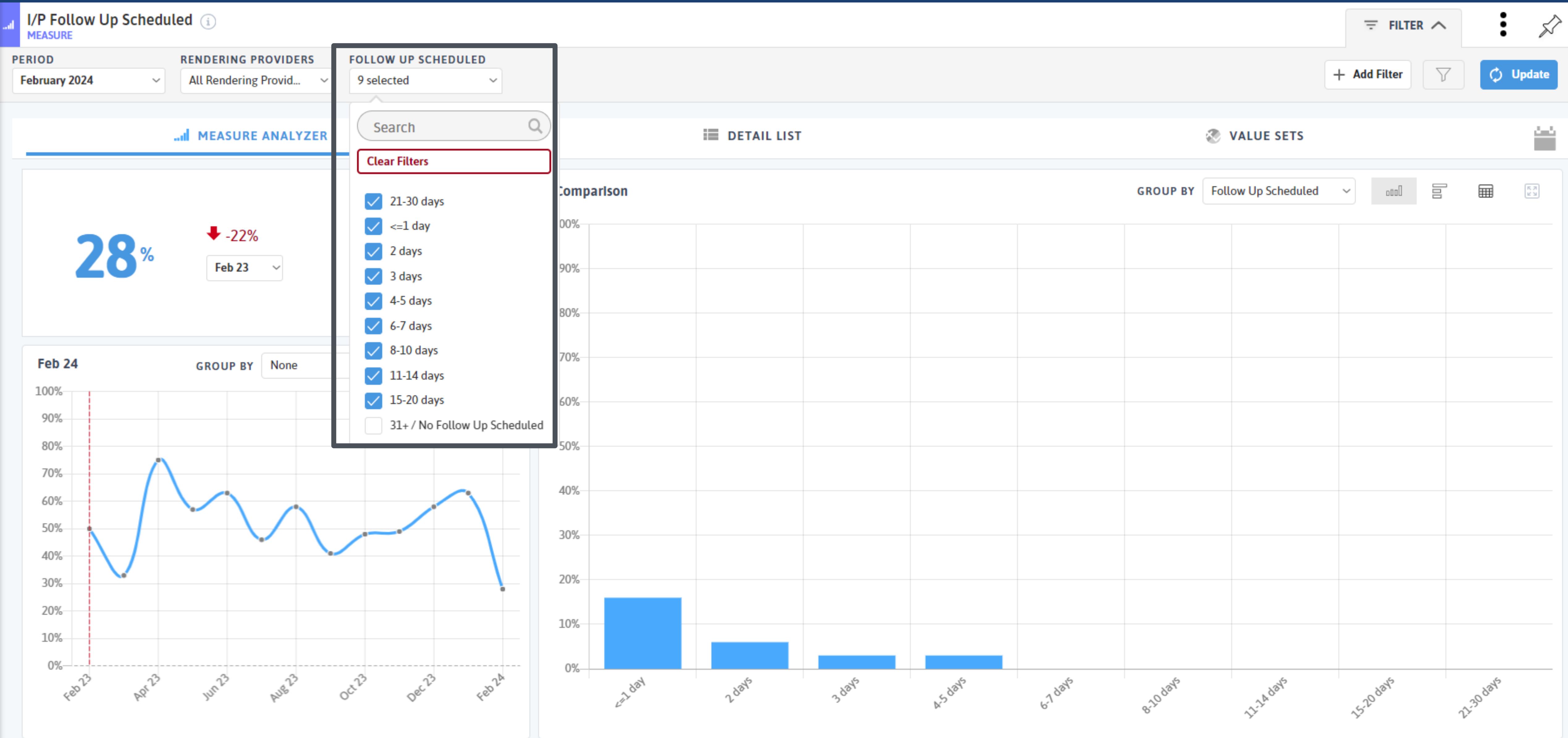
Evaluate Operational Performance

TOC Operational Measures

I/P Measure	ED Measure	Filter Option	
I/P Follow Up Call	ED Follow Up Call	<=24 hrs 2 days 3 days 4-5 days	6-7 days 8-10 days 11+ days/No Call
I/P Follow Up Scheduled	ED Follow Up Scheduled	<=1 day 2 days 3 days 4-5 days 6-7 days	8-10 days 11-14 days 15-20 days 21-30 days 31+/No Follow Up Scheduled
I/P Follow Up Visit	ED Follow Up Visit	<=1 day 2 days 3 days 4-5 days 6-7 days	8-10 days 11-14 days 15-20 days 21-30 days 31+/No Follow Up Scheduled

6 Measures

Drilling into the Measures



Identifying Trends

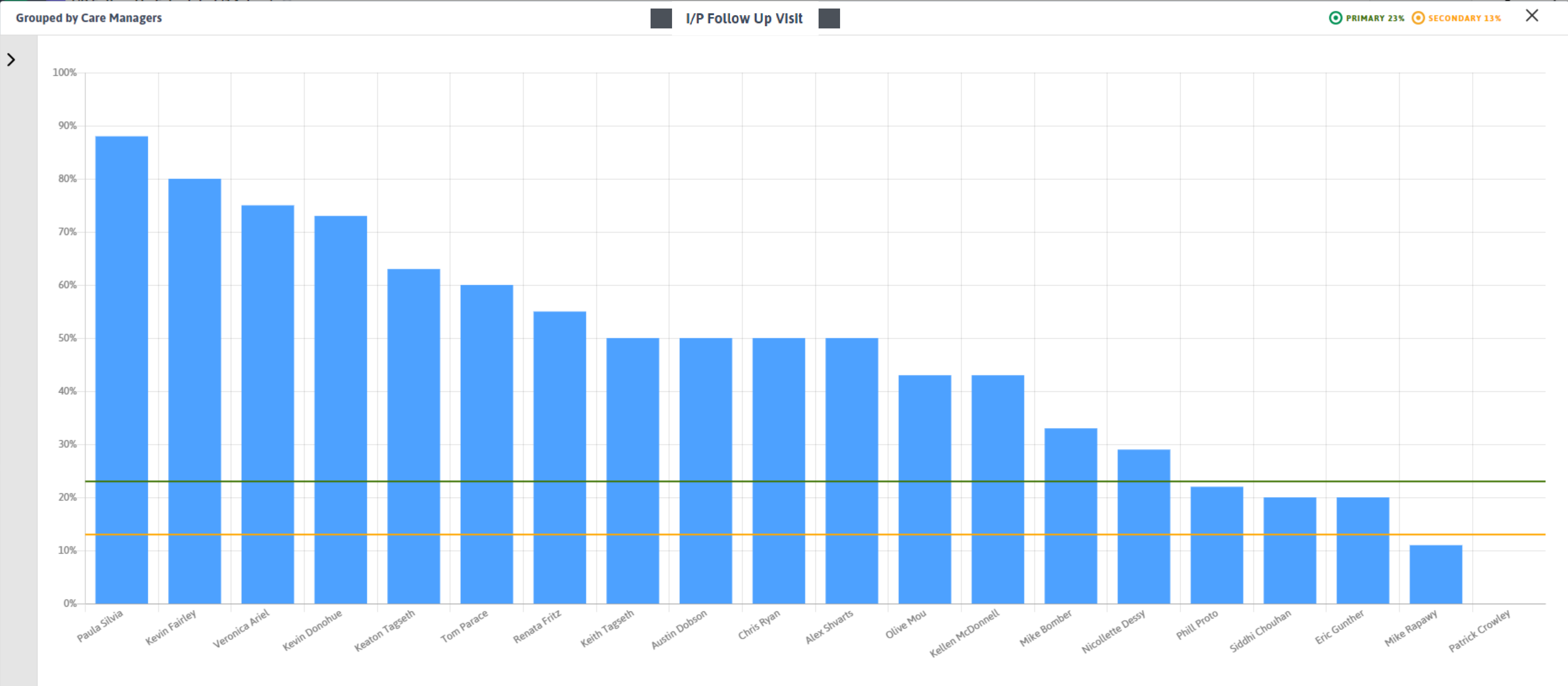
Grouped by Provider - Usual

I/P Follow Up Visit

60%
50%
40%
30%
20%
10%
0%

TY 2/23
TY 3/23
TY 4/23
TY 5/23
TY 6/23
TY 7/23
TY 8/23
TY 9/23
TY 10/23
TY 11/23
TY 12/23
TY 1/24
TY 2/24

Evaluating Adherence to Workflows



azara healthcare

Point of Care: Alerting Care Teams

Point of Care Tool: PVP Alerts

1:55 PM Friday, July 21, 2023

Visit Reason: **Telehealth Hosp F/U clm**

MRN:
DOB:

Sex at Birth: M
GI: Identifies as Male
SO: straight or heterosexual

Phone:
Lang: English

Portal Access: Y

PCP:
Payer: Keystone First CHC
CM: Unassigned

DIAGNOSES (2)

Asthma	CNMP

RISK FACTORS (2)

Chronic Opioid Tx	TOB

SDOH (2)

HISP/LAT	INSURANCE

RAF GAPS DIAGNOSIS CATEGORIES (0)

ALERT	MESSAGE	DATE	RESULT	OWNER
SBIRT	Missing			MA/Tablet
SDOH Screening Due	Overdue	2/17/2021		
BMI & F/U Plan	Missing			MA & Clin
VCC: COVID Dose #1	Missing			
VCC: PCV High-Risk (19-64yo)	Missing			
VCC: Tetanus	Missing			
Inpatient Encounter	Occurred	7/5/2023		

azara healthcare

Enable Alerts in Alert Admin

CATEGORY	NAME	PVP NAME	DESCRIPTION
Other	E/D Encounter	E/D Encounter	Alert will trigger if E/D Episode has occurred in the last 60 days.
Other	I/P Encounter	I/P Encounter	Alert will trigger if I/P Episode has occurred in the last 60 days. This alert is not configurable

Edit

GENERAL | DATE CRITERIA | RESULT CRITERIA | POPULATION DEFINITION

CATEGORY
Other

STATUS Enabled Disabled

ALERT NAME
I/P Encounter
Alert Name must be unique and cannot be changed.

PVP DISPLAY NAME
Inpatient Encounter

ALERT TYPE
Logic not editable

OWNER
Care Coord
Max 10 chars. This will appear on the PVP and CMP

INCLUDE IN POC ALERT CLOSURE MEASURE Yes No

Cancel | Confirm

Turn on the alerts.

Add alert owner

Filter the PVP to Identify Patients

Filter the PVP by Alert

- Filter to the I/P or E/D Encounter Alerts to look for patients who have had a discharge within a given time period.

Filter the PVP by Alert Owner

- Add an owner to the I/P and E/D Encounter Alerts and filter to that owner to see if any patients have appointments that had a discharge within a given time period.

Care Management Passport

Allergies (0)

No active allergies

Medications (Last 10 of 28)

ACTIVE AS OF	NAME
3/3/21	amlodipine 5 MG Oral Tablet
2/19/21	isopropyl alcohol 70 % Topical Swab
2/19/21	ACCU-CHEK GUIDE (GLUCOSE) TEST STRIP
2/18/21	Naproxen 500 MG Oral Tablet
2/18/21	Omeprazole 40 MG Delayed Release Oral Capsule
2/10/21	Zyrtec 10 MG Oral Tablet
2/10/21	Advair Diskus 250/50 Dry Powder Inhaler, 60 ACTUAT
2/10/21	gabapentin 600 MG Oral Tablet
1/8/21	Diclofenac Sodium 75 MG Delayed Release Oral Tablet
1/4/21	Chantix Starting Month PAK

The **Care Management Passport** will help the Care Coordinators, RN Care Managers, and other care team members prepare prior to their communication with the patient.

Alerts (5)

ALERT	MESSAGE	MOST RECENT DATE	MOST RECENT RESULT
LDL	Missing		
Depr Follow-Up	Missing Follow-up		
BP	Out of Range	3/3/21	130/90
Foot	Missing		
E/D Encounter	Occurred	3/2/21	IU Health

Open Referrals w/o Result (4)

TYPE	SPECIALIST/LOCATION	ORDER DATE	APPT DATE
Z12.11 - GASTROENTEROLOGY REFERRAL	IU HEALTH PHYSICIANS GASTROENTEROLOGY / IU HEALTH PHYSICIANS GASTROENTEROLOGY	1/25/21	
M79.605 - PODIATRY REFERRAL	TOD S REED DPM / TOD S REED DPM	8/11/20	
M79.605 - PHYSICAL THERAPY REFERRAL	IU HEALTH BALL MEMORIAL REHABILITATION CENTER / IU HEALTH BALL MEMORIAL REHABILITATION CENTER	8/11/20	
R55 - NEUROLOGY REFERRAL	IU HEALTH BALL MEMORIAL PHYSICIANS NEUROLOGY- ALAN SCHMITT / IU HEALTH BALL MEMORIAL PHYSICIANS NEUROLOGY- ALAN SCHMITT	6/9/20	

Follow up on open referrals to improve coordination of care efforts.

I/P & E/D Utilizations (Last 10 of 35)

SOURCE	TYPE	ADMIT DATE	DISCHARGE DATE	LOCATION	DIAGNOSIS	DESCRIPTION
IHIE	ER Visit	3/2/21	3/2/21	IU Health		
IHIE	ER Visit	3/1/21	3/1/21	IU Health		
IHIE	ER Visit	2/25/21	2/26/21	IU Health		
EHR	Hospital Discharge	2/11/21	2/11/21			
IHIE	ER Visit	2/9/21	2/9/21	IU Health		
IHIE	ER Visit	1/17/21	1/17/21	IU Health		
EHR	Hospital Discharge	1/12/21	1/12/21			
IHIE	ER Visit	1/10/21	1/10/21	IU Health		
IHIE	ER Visit	1/8/21	1/8/21	IU Health		
IHIE	ER Visit	1/7/21		Reid Hospital		

Identify each ER Visit and Hospital Discharge based on the HIE data.

Cohorts to Track Populations

Dynamic Cohorts

Cohort Display Name	Description
Hypertension	Patients who have a diagnosis for Hypertension in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.
Hypertension BP > 140/90	Patients who have a diagnosis of hypertension in the last 12 months and whose most recent blood pressure vitals result is > 140/90. If the patient's systolic blood pressure is > 140 mmHg OR their diastolic blood pressure is > 90 mmHg they will be in the cohort. Patients who are deceased or inactive at the center are excluded from the cohort.
Substance Use Disorder (SUD)	Patients who have a diagnosis for Opioid Abuse Disorder in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.
Medication Assistant Treatment (MAT)	Patients who have an opioid use disorder (OUD) medication-assisted therapy (MAT) prescription in the last 90 days. Patients who are deceased or inactive at the center are excluded from the cohort.
Care Management	Patients who are assigned a care manager in DRVS (aka can be from EHR or manually added in ACM). Patients who are deceased or inactive at the center are excluded from the cohort.
CCM	Patients in Chronic Care Management (CCM) through Medicare in the last year. Patients who are deceased or inactive at the center are excluded from the cohort.
ER Visit	Patients who had an emergency room (ER) visit in the last 14 days with the discharge status of home, and who have not had a follow-up call, and do not have an upcoming primary care appointment scheduled. Patients who are deceased or inactive at the center are excluded from the cohort.
IP Visit	Patients who had an inpatient (I/P) visit in the last 14 days with a discharge status of home, and do not have an upcoming primary care appointment scheduled. Patients who are deceased or inactive at the center are excluded from the cohort.
High Risk Patients	Patients who have a risk level of High. Patients who are deceased or inactive at the center are excluded from the cohort.
Low Risk to Moderate Risk	Patients who have a risk score that increased from Low to Moderate. Patients who are deceased or inactive at the center are excluded from the cohort.
SDOH > 11	Patients who have greater than 11 Social Determinants of Health (SDOH). Patients who are deceased or inactive at the center are excluded from the cohort.
Pediatric Preventive Patients	Pediatric patients who are 0 to 1,186 days old, and had at least two well-child visits. Patients who are deceased or inactive at the center are excluded.

Create Cohort of High Utilizers

Transitions of Care (TOC) - ED/IP
REPORT

FILTER

DATE RANGE	CENTERS	DISCHARGE STATUS	LAST VISIT	TOC TYPE	TOC STATUS
05/09/2024-05/09/2024	All Centers	All Discharge Status	No Required Visit	All TOC Type	Discharge

+ Add Filter

Update

Export Excel

Create Cohort

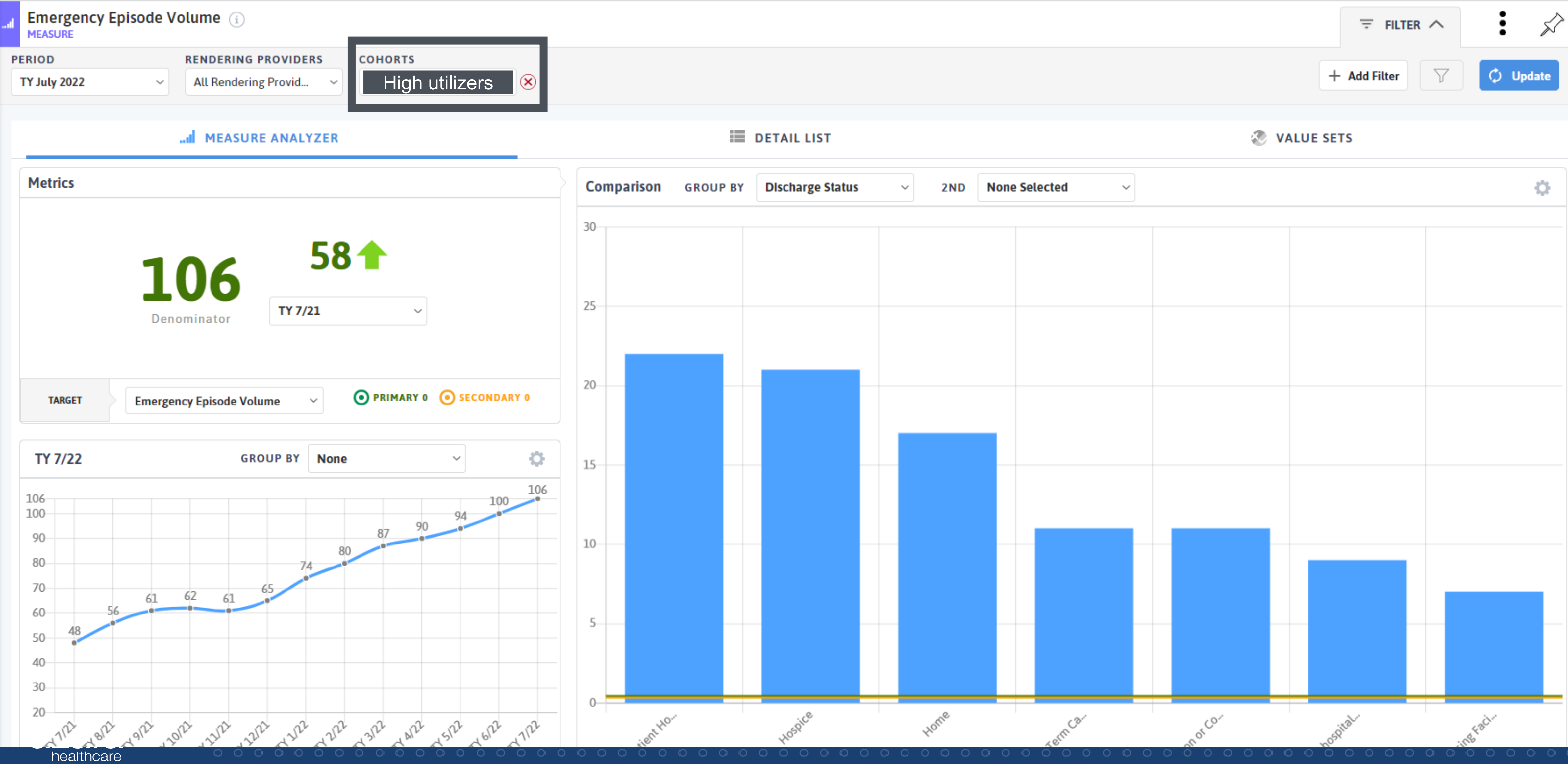
Search ...

NEXT APPT: All | No Appt | Upcoming Appt

Reset

	ED					DIAGNOSIS		NEXT APPOINTMENT	LAST APPOINTMENT	
PLAN	ADMISSION	DISCHARGE	LOCATION	VISITS LAST 6 MONTHS	DISCHARGE STATUS CODE	CODE	DESCRIPTI...	NEXT APPOINTMENT	LAST APPOINTMENT	PRIMAR ENCOU
	8/26/22 6:33 pm	8/27/22 8:59 pm	St. John	5					3/9/2022	3/9/202
	8/28/22 12:15 am	8/28/22 4:39 am	McAlester Regional Health Center	5					4/13/2022	
	8/29/22 6:18 pm	8/29/22 7:34 pm	NORTHEASTERN HEALTH SYSTEM - Tahlequah	6					4/21/2022	4/21/20
	8/29/22 2:15 am	8/29/22 4:15 am	Mercy Health Network	21					11/30/2021	11/30/20
		8/29/22 3:33 pm	Saint Francis Health System	9					8/31/2022	7/19/20
	8/30/22 10:29 pm	8/30/22 11:01 pm	Ardent	18						
	8/27/22 10:19 pm	8/27/22 10:19 pm	Ardent	5					3/21/2022	
	8/28/22 12:56 am	8/28/22 3:21 am	Wagoner Community Hospital	7					8/12/2021	8/12/20
	8/30/22 11:33 pm	8/31/22 4:05 am	NORTHEASTERN HEALTH SYSTEM - Tahlequah	9				9/6/2022	8/29/2022	8/29/20
	8/30/22 5:00 am	8/30/22 5:00 am	Saint Francis Health System	5				9/21/2022	8/19/2022	8/19/20
	8/30/22 6:24 pm	8/30/22 7:11 pm	Saint Francis Health System	5					9/9/2021	9/9/202
	8/30/22 5:09 pm	8/30/22 8:27 pm	NORTHEASTERN HEALTH SYSTEM - Tahlequah	6					4/21/2022	4/21/20

Track ED Visits for High Utilizers



healthcare

Dynamic Cohorts for I/P and ED Patients

I/P Dynamic Cohort: IP Visit

DESCRIPTION

Patients who had an inpatient (I/P) visit in the last 14 days with a discharge status of home, and do not have an upcoming primary care appointment scheduled. Patients who are deceased or inactive at the center are excluded from the cohort.

ED Dynamic Cohort: ED Visit

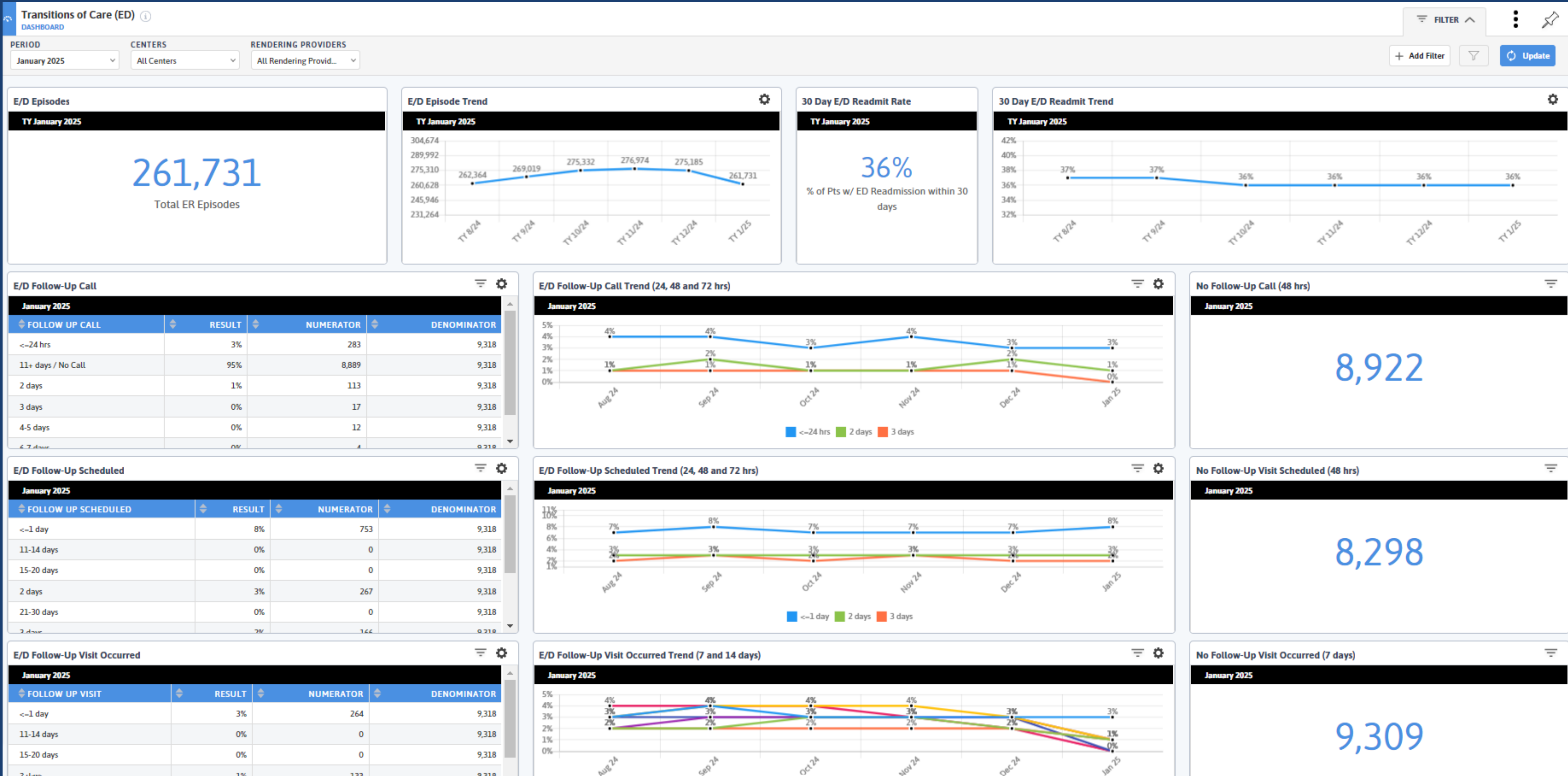
DESCRIPTION

Patients who had an emergency room (ER) visit in the last 14 days with the discharge status of home, and who have not had a follow-up call, and do not have an upcoming primary care appointment scheduled. Patients who are deceased or inactive at the center are excluded from the cohort.

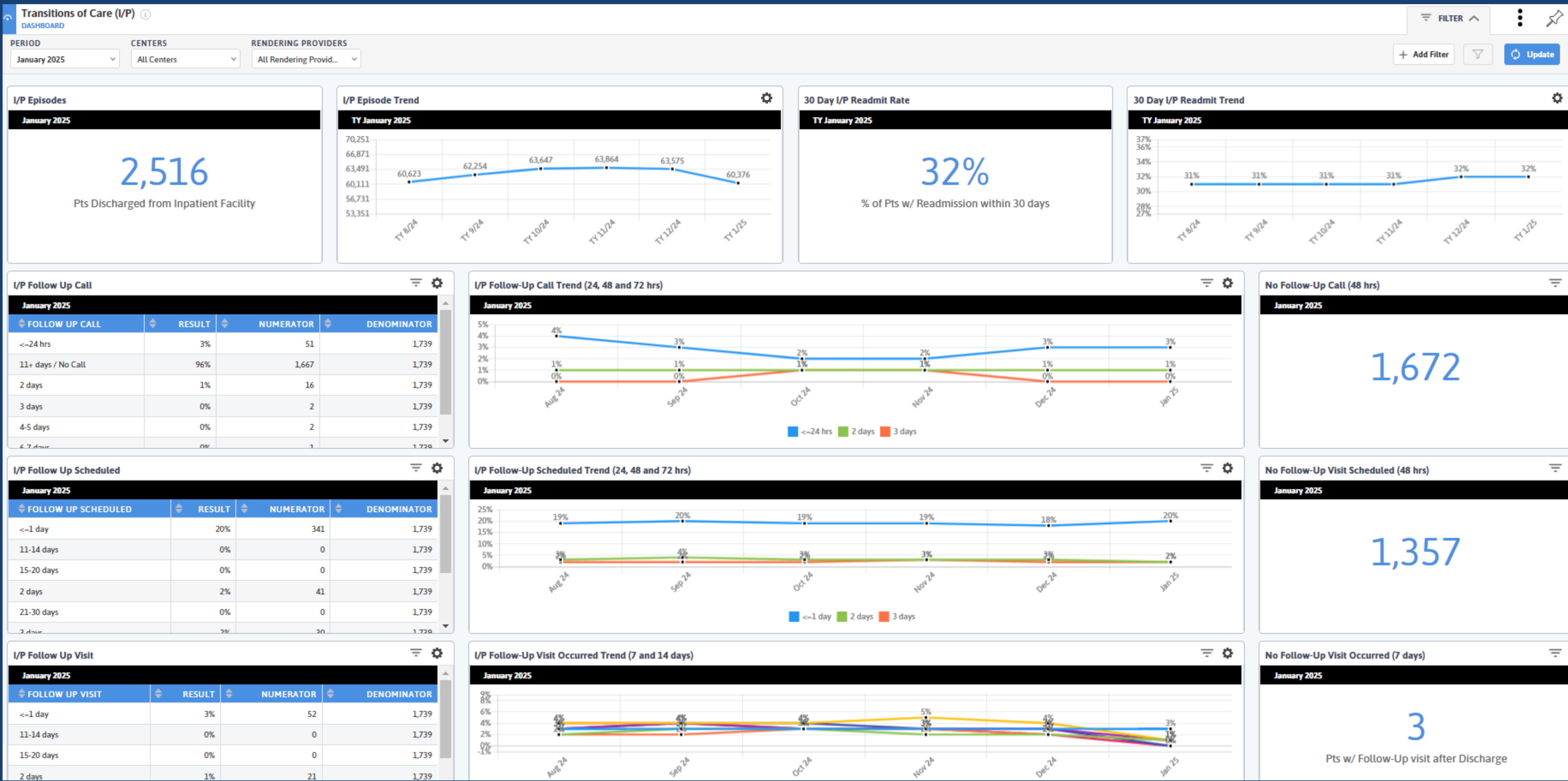
If your center is interested in activating these dynamic cohorts, Admin can contact Azara Support for permissions

Track Outcomes

Stock Dashboard: TOC | ED

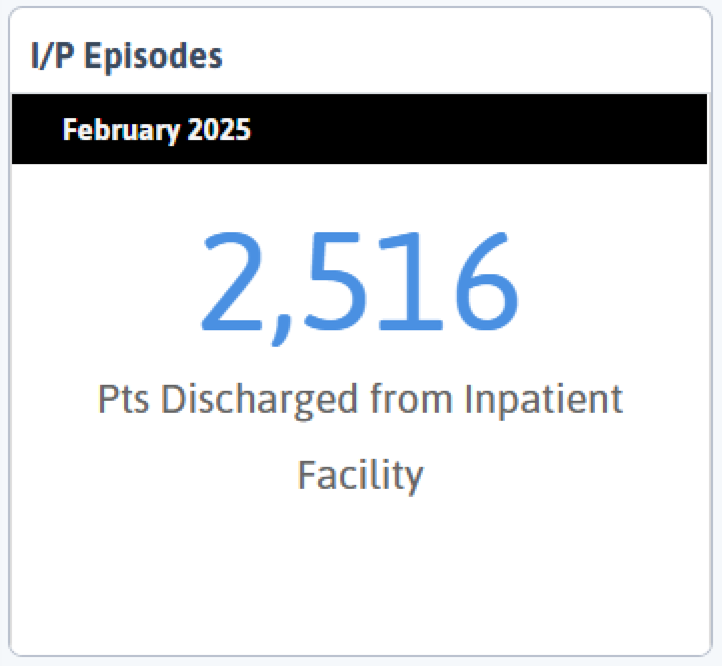


Stock Dashboard: TOC | IP

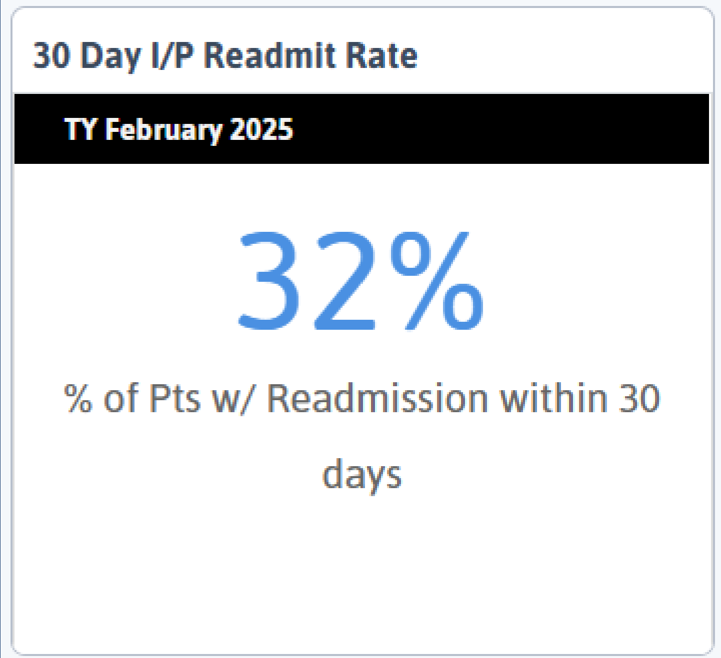


Identify and Understand Admission and Readmission Rates

Inpatient and ER Admissions



Readmission Rates



Track and Schedule Follow Up Appointments

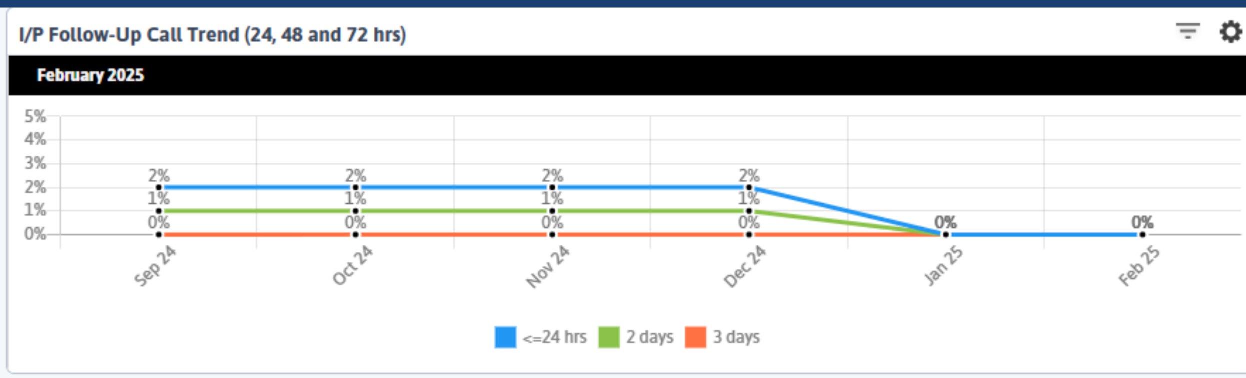
I/P Follow Up Call

February 2025

FOLLOW UP CALL	RESULT	NUMERATOR	DENOMINATOR
<=24 hrs	0%	0	742
11+ days / No Call	100%	742	742
2 days	0%	0	742
3 days	0%	0	742
4-5 days	0%	0	742
6-7 days	0%	0	742

I/P Follow-Up Call Trend (24, 48 and 72 hrs)

February 2025



No Follow-Up Call (48 hrs)

February 2025

742

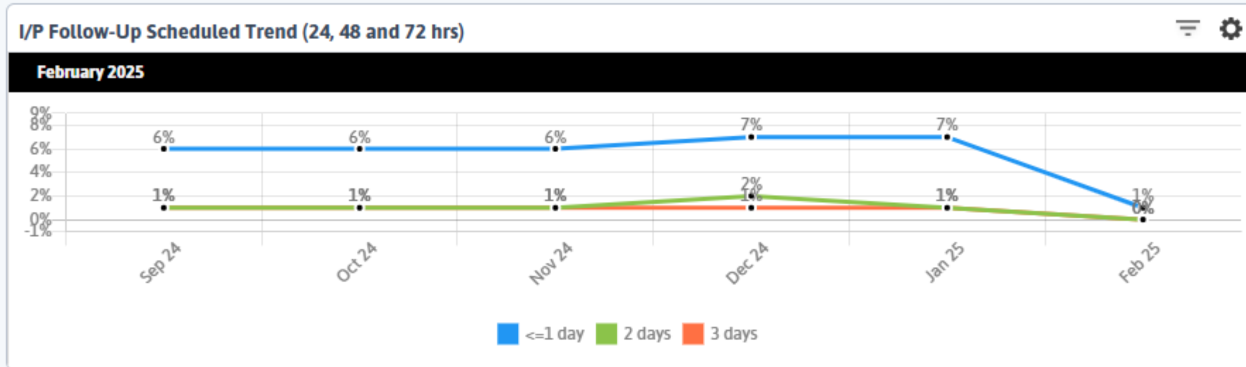
I/P Follow Up Scheduled

February 2025

FOLLOW UP SCHEDULED	RESULT	NUMERATOR	DENOMINATOR
<=1 day	1%	8	742
11-14 days	0%	0	742
15-20 days	0%	0	742
2 days	0%	0	742
21-30 days	0%	0	742

I/P Follow-Up Scheduled Trend (24, 48 and 72 hrs)

February 2025



No Follow-Up Visit Scheduled (48 hrs)

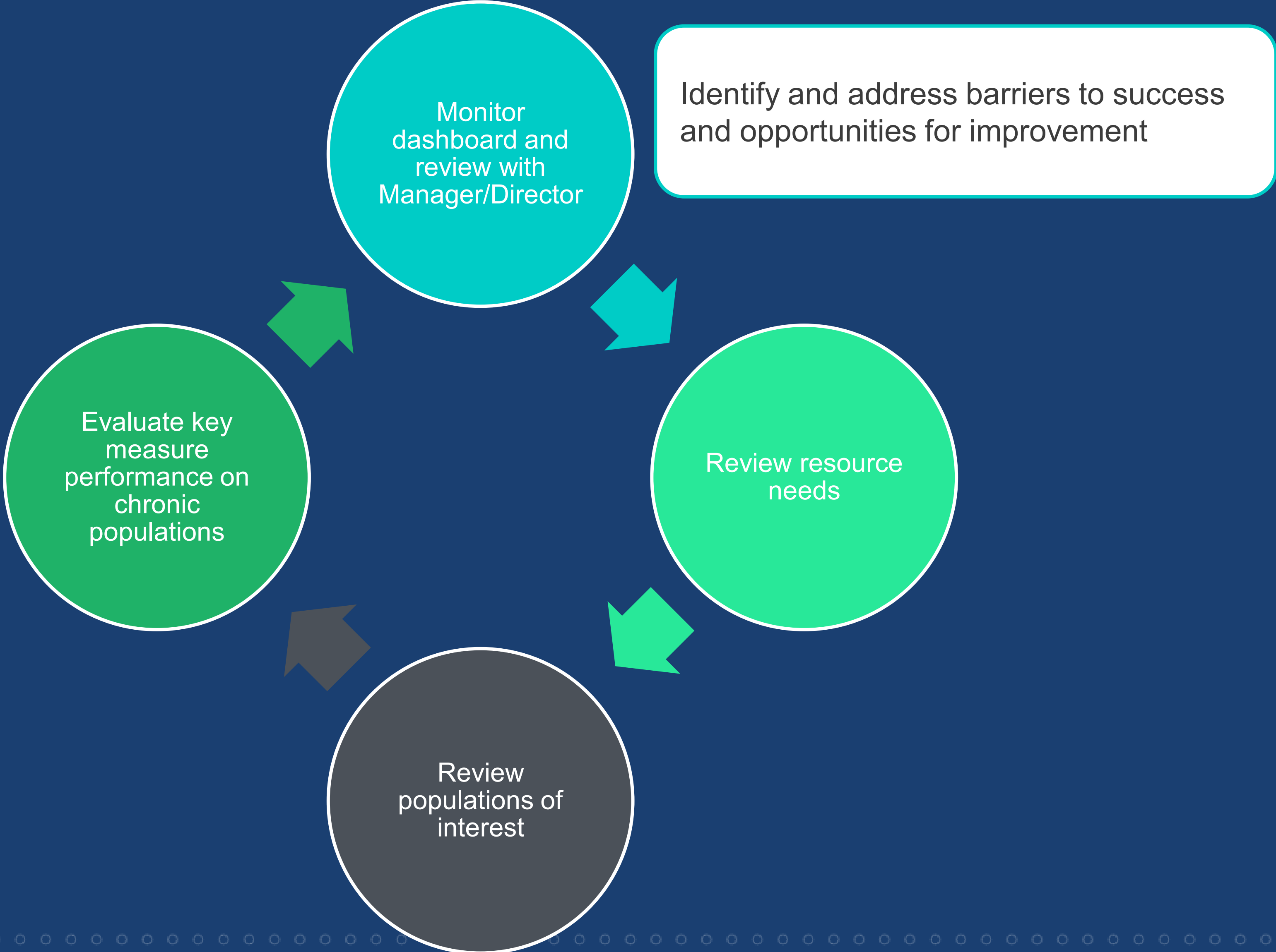
February 2025

734

- Assess follow up scheduled within certain timeframes after inpatient visits
- Understand inpatient follow up trends occurring within certain timeframes.
- Identify missed follow up

azara healthcare

Monthly Workflow

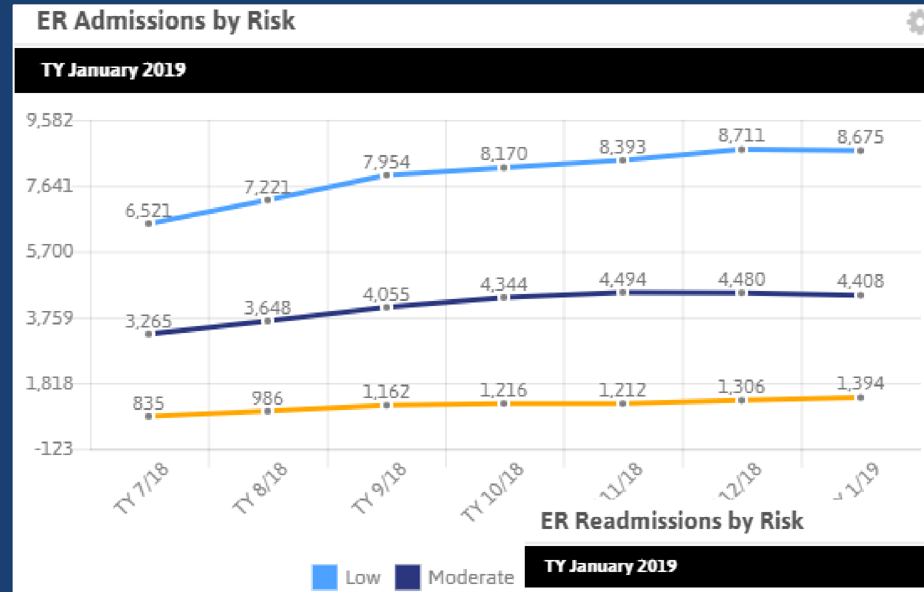


Is it working?

Are follow up appointments adequately addressing the patient's needs?

What are the issues preventing staff from scheduling follow ups?

How can we further specify which patients are highest risk and need the most support?

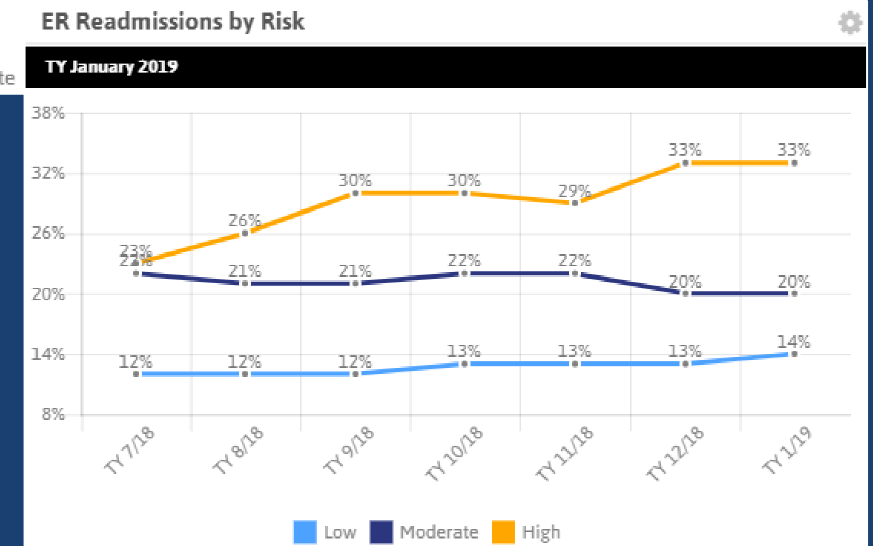


Is Access an Issue?

Higher number of low-risk admissions

More Appropriate Readmission?

High risk patient are more likely to have a readmission



Key Points

Establish performance improvement goals.

Set targets for key measures.

Set up ED/IP report daily.

- Prioritize patient population

Filter by high risk, cohort, diagnosis

Assign task to appropriate staff.

Monitor and share results!

- Set up scheduled email subscriptions for custom dashboards

Explore!

- Expired/deceased patients
- Diagnoses – Ambulatory Sensitive Conditions
- Time of ER admit

Key Players in TOC | The 5 W's

Who	What	When	Where	Why
Care Coordinator	Schedule follow up appointments.	Daily	Report • Transitions of Care (TOC) – ED/IP	Improve coordination of care, disease control, and self management.
MA/LPN	Monitors PVP report to identify patients with a recent IP/ED visit and alerts providing.	Daily	Patient Visit Planning report	Identify patients at the point of care who need IP/ED follow up and care coordination.

RN Care Manager	Assess and create a care plan for patients with frequent ED visits and IP stays.	Daily	• Measures
			  ○ I/P Readmission (apply filters)
			  ○ ED Readmission (apply filters)
				Prevent admissions and readmissions and decrease total cost of care.

Care Management Supervisor	• Track follow up appointments. • Identify and understand readmission rates. • Evaluate condition specific data. • Understand ER visit timing.	Weekly/Monthly	• Condition specific cohorts • Measures > Transitions of Care Report • Transitions of Care (TOC) – ED/IP	Understand program impacts to ensure improved care coordination and disease control, decreased admission and readmissions, and a reduction in the total cost of care. Verify appointment access meets demand.

Prevention Best Practices

Patient Education

Expanded Provider Access

Additional Case Management

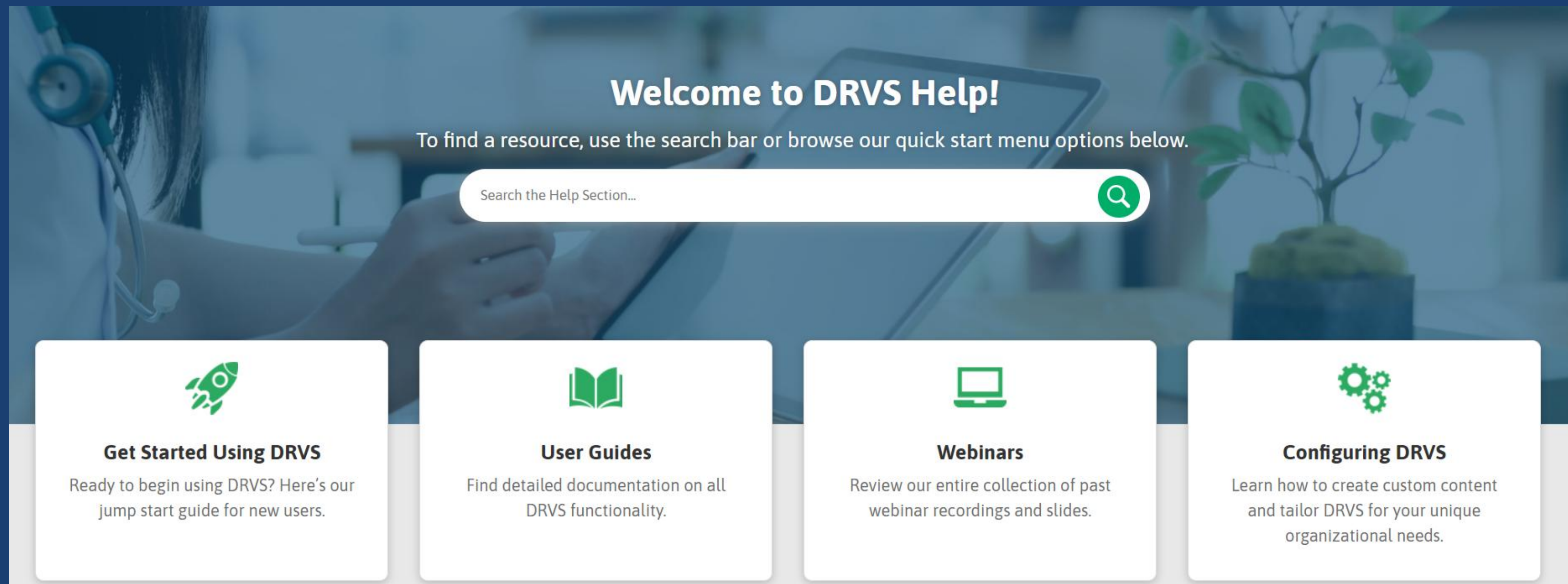
Financial Incentives Alignment Across Care Continuum

Health System Data Sharing

Majewski, P., Lebick, D. Appropriate ED Utilization Leading to Better Care Coordination. AJMC.

Resources | User Guides

- Utilize the Help section in DRVS for the most current information
- Click the question mark icon and select Help Documentation. Enter your search criteria (i.e., scorecards).
- User Guides are available for many topics covered today (and many more)!



azara healthcare

Questions?

azara healthcare

@AzaraDRVS

Meet the Presenters

HarmonyHealthcare Long Island

Dr. Laurie Ward, MD
Clinical Analyst

Omolara Goyea, DNP, MBA, FNP-BC, PMHNP-BC
Nurse Practitioner

Anne Marie Pitre, MA
Assistant Director, Care Coordination

Nicole Martinez
Transitions of Care Coordinator

Using AZARA for Transitions of Care

Dr. Laurie Ward

Omolara Goyea, DNP

Anne Marie Pitre, MA

Nicole Martinez

Before Optimization

- Hospitalization information payer dependent
  - Inconsistent data by payer email
  - Multiple payer websites if attempting to pull information
  - No ability to view consolidated information at a practice level
- Outreach process not standardized
- Missed opportunities for timely intervention
  - Consistently mediocre performance on Hedis discharge measures (timely follow-up and med req post discharge)

Why Transitions of Care Matters

- High risk period for readmissions and complications
- Medication discrepancies post-discharge
- Gaps in follow-up care
- Increased ED utilization
- Disproportionate impact on high-risk population

Our Approach to Optimization

- Leveraged Azara TOC Module for real-time discharge data
- Built a standardized, role-based workflow
- Defined clear timelines (48-hour outreach, 7-day follow-up)
- Integrated TOC with Care Coordination and Chronic Care Management programs
- Focused on proactive vs reactive care

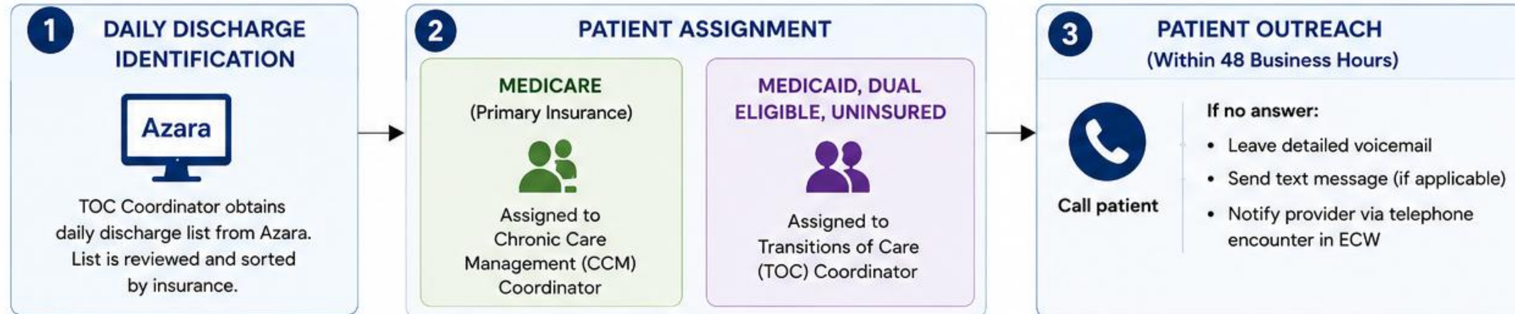
Health IT in Action

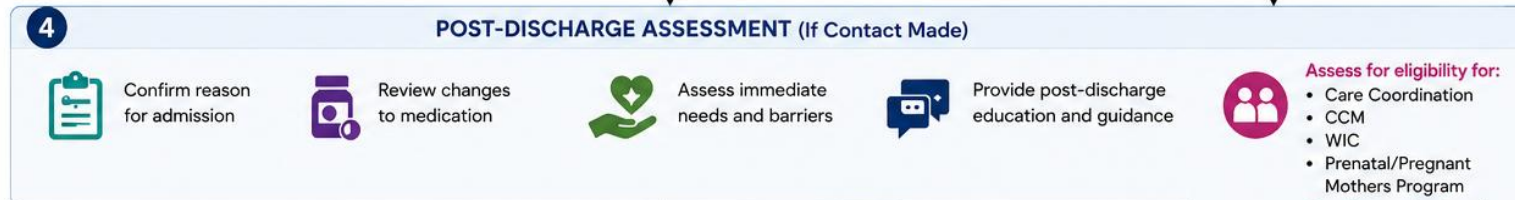
- Daily automated discharge reports
- Patient stratification by risk/insurance
- Centralized tracking of outreach and outcomes
- Improved data visibility across teams
- Supports population health management

Workflow Overview

TRANSITIONS OF CARE WORKFLOW

TIMELINESS STANDARD: All contacts must be made within **48 business hours** of notification.





KEY POINTS

- All contacts must be made within **48** business hours of notification.
- Goal is to ensure safe transitions, reduce readmissions, and improve patient outcomes.
- Team approach with TOC and CCM Coordinators working together.
- Focus on timely follow-up, patient engagement, and care coordination.

Abbreviations

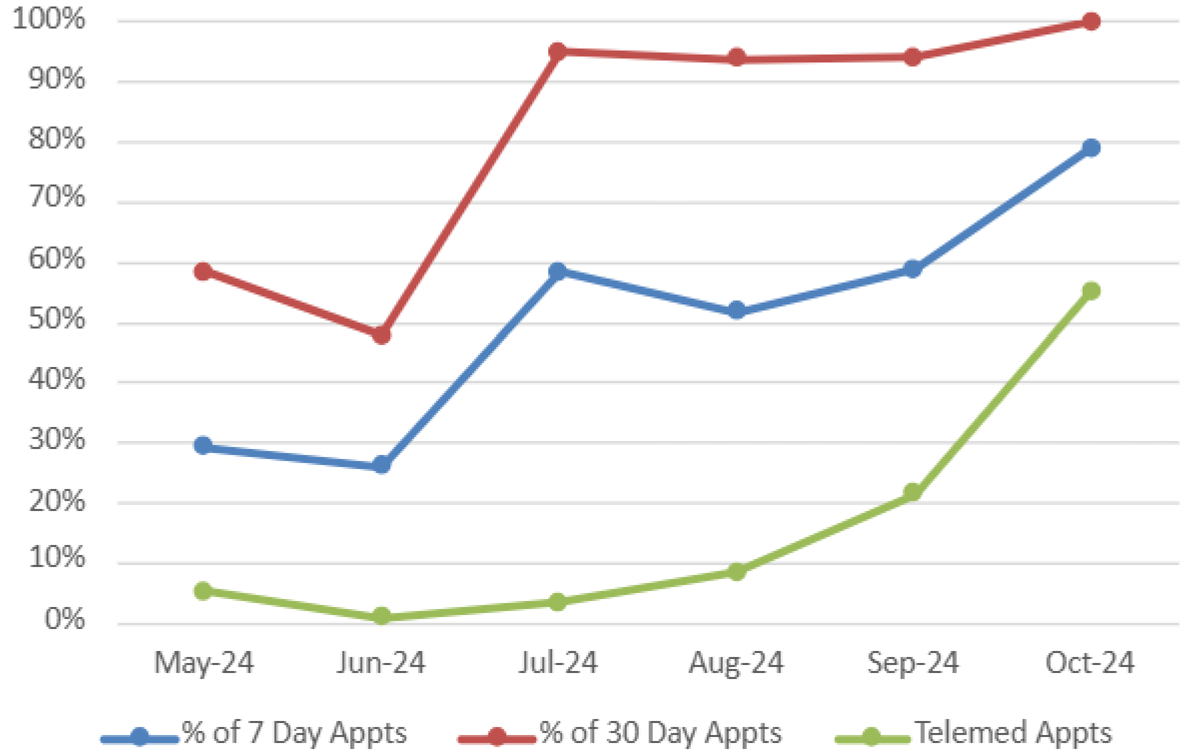
TOC: Transitions of Care
CCM: Chronic Care Management
WIC: Women, Infants and Children
ECW: eClinicalWorks

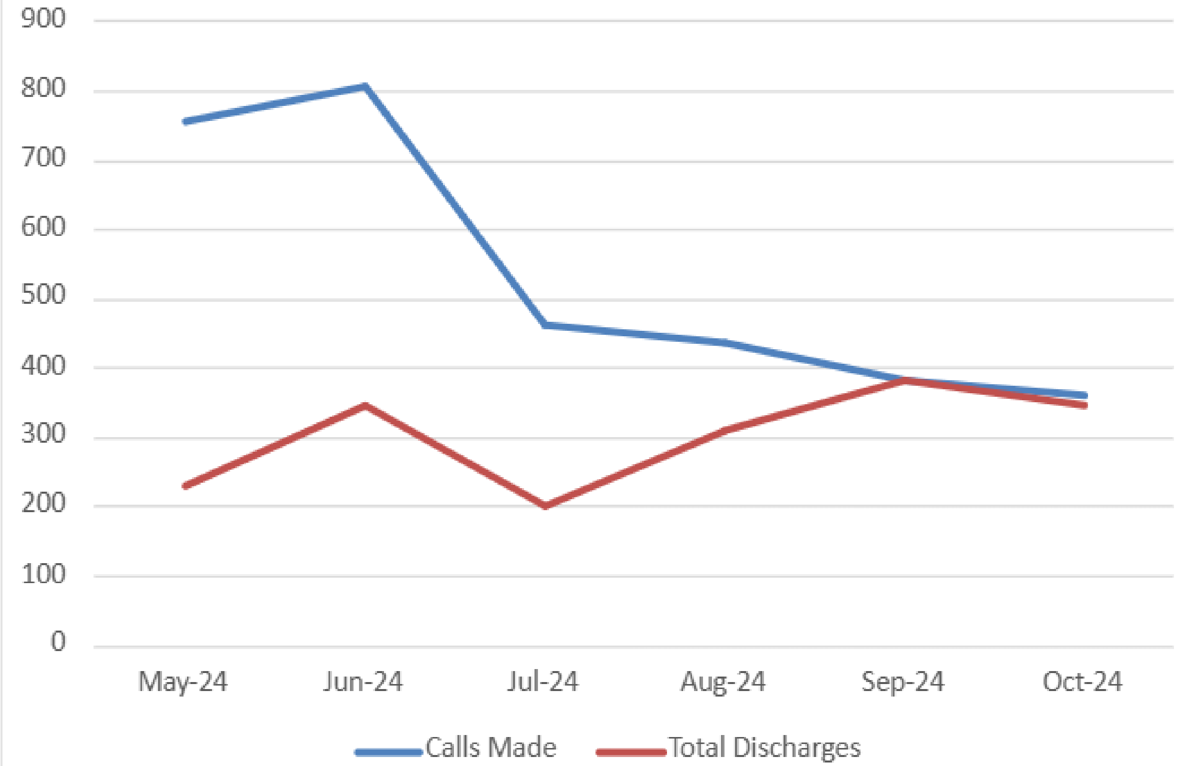
HarmonyHealthcare Long Island

Care Integration & Internal Referrals

- Assess eligibility during TOC outreach for:
  - Care Coordination
  - Chronic Care Management
  - Women, Infant & Children (WIC)
  - Prenatal/Pregnant Mothers Program (Harmony Pregnancy, Birth & Beyond)
- Warm handoffs to internal programs
- Reduce gaps and improves continuity

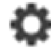
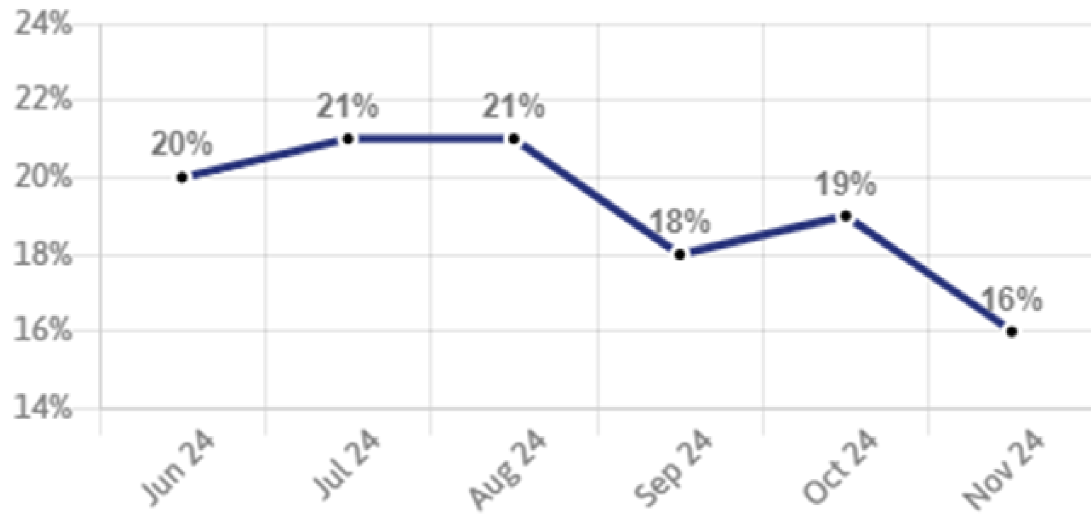
Early Impact

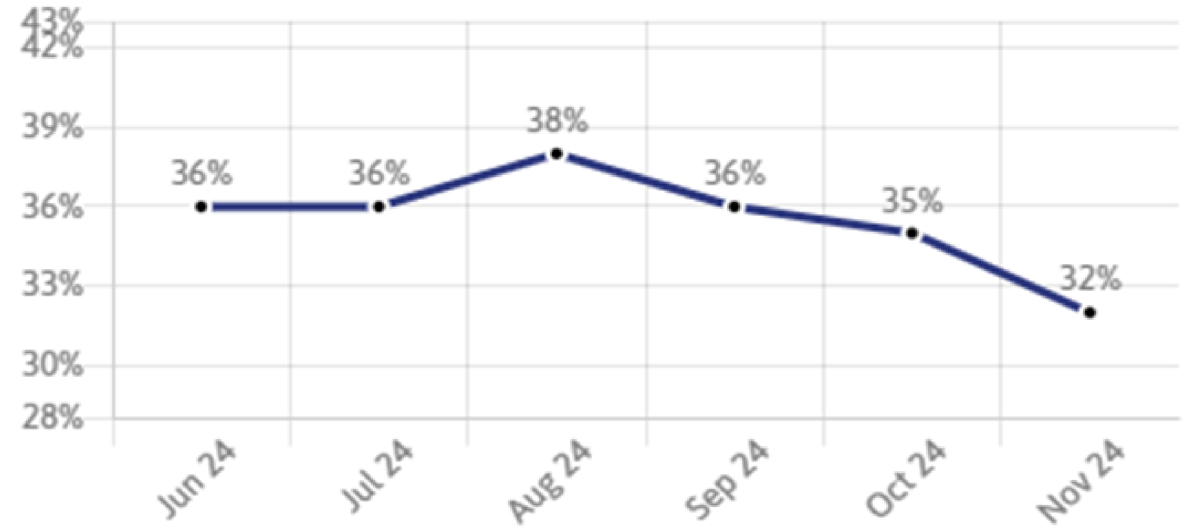




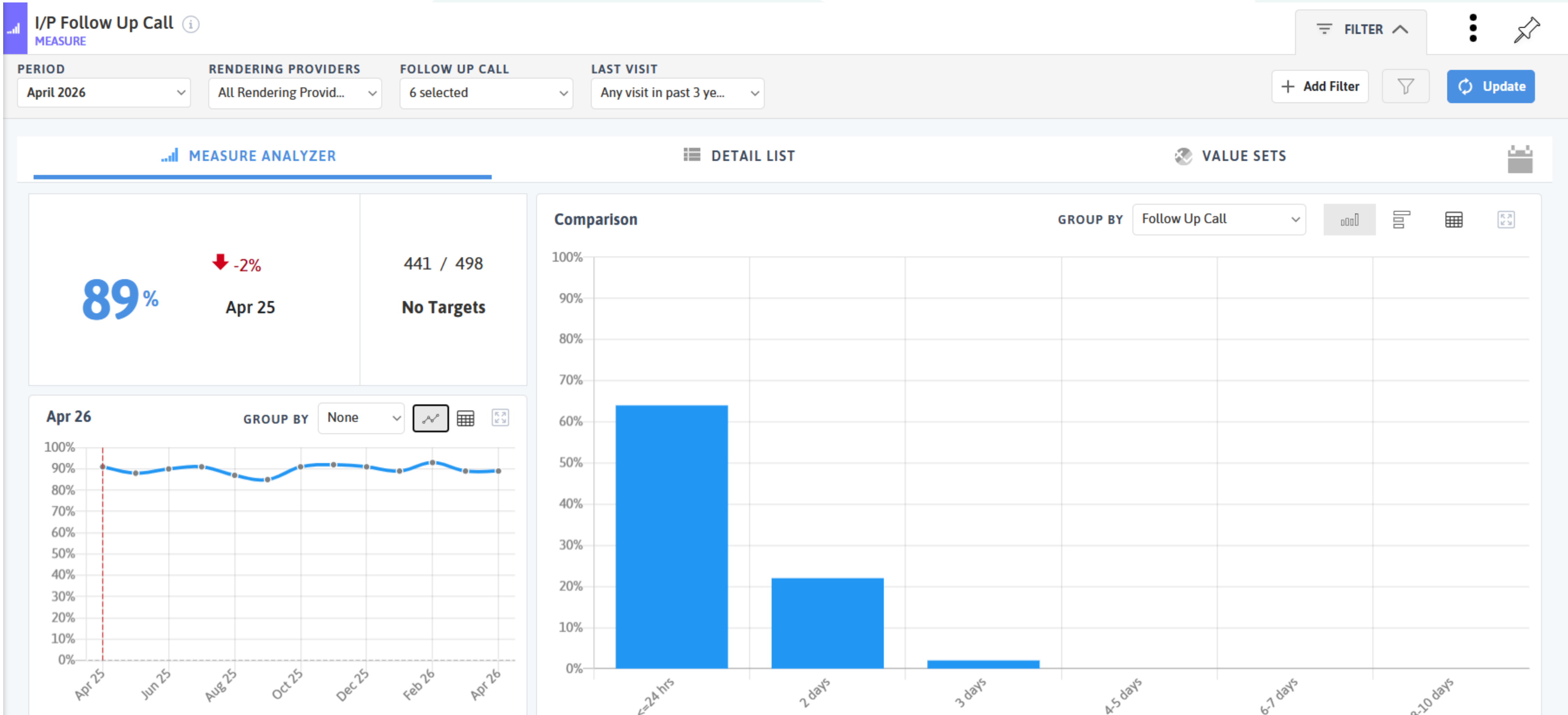
HarmonyHealthcare
Long Island

Early Impact

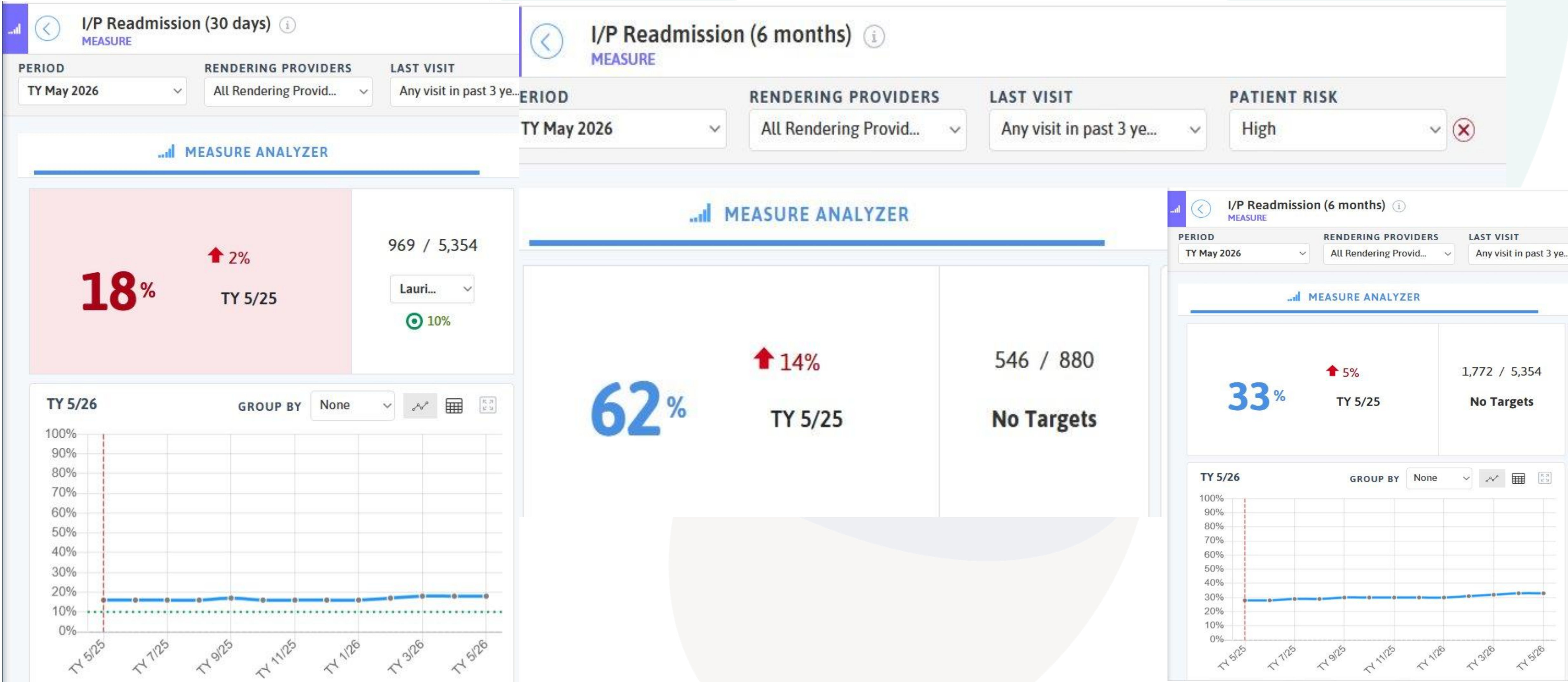





Current State



Current State



Harmony Healthcare Long Island

Challenges and Lessons Learned

- Initial workflow complexity
- Staff role clarity and training needs
- Patient contact barriers (phone, engagement)
- Balancing volume with timeliness
- Importance of leadership support

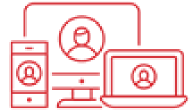
What's Next? Future Initiatives

- Further optimization of Azara reporting
- Expanding telehealth TOC visits
- Enhanced data tracking (readmissions, outcomes)
- Continued quality improvement initiatives
- Scaling model across additional populations

Key Takeaways

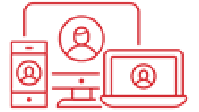
- Standardization drives efficiency
- Health IT enables timely, actionable outreach
- Team-based care is essential
- TOC is a gateway to broader care engagement
- Small workflow changes ⟶ big patient impact

Q & A



Questions?

Save the Date!



Continue the Conversation!

Don't miss the last session of this 4-part series!

Session 4: Thursday, May 28
HIXNY &
APICHA Community Health Center

We hope to see you then!

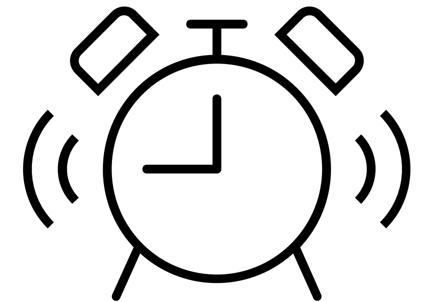
Care Management, Coordination, and Transitions in Practice

May 26, 2026 at 1:00pm

Join the CHCANYS Nursing Subcommittee on May 26, 2027 at 1:00pm for ***Care Management, Coordination, and Transitions in Practice.*** This PCMH-focused session for nurses highlights how to operationalize Patient-Centered Medical Home concepts in everyday clinical settings. It will clarify the roles of care management and care coordination within PCMH, particularly for high-risk patient populations requiring comprehensive chronic care management. Participants will explore common challenges and leave with practical strategies to strengthen care coordination, improve transitions of care, and enhance patient outcomes through team-based, nurse-led approaches, all central to PCMH.

Statewide Common Participation Agreement (SCPA)

- The Statewide Common Participation Agreement (SCPA) is a common legal framework for all health care entities that participate in the SHIN-NY and will **replace** the existing agreements previously governed participation in the SHIN-NY through the RHIO.
- Link to the SCPA
- SCPA FAQs
- Begin the Signage Process HERE
- Reach out to your RHIO or NYeC (scpa@nyehealth.org) if you have additional questions



If your centers haven't already, you must sign the SCPA by June 30, 2026 or risk termination of your access and services with your current RHIO.

Please fill out our survey!

Please share your feedback using the survey link in the chat, the QR code, or the link in the follow up email!

Completing the survey helps us to provide relevant and helpful information. Thank you in advance!