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USER CONFERENCE APRIL 13–15 | BOSTON, MA

Advancing Population Health

Chronic Disease Management & Cancer Screening Optimization Using Azara DRVS

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Director of Prevention & Wellness / Population Health

Community Health Center of Buffalo, Inc.

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Today's Presenter

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Buffalo, New York

Learning Objectives

1. Leverage Azara DRVS to optimize chronic disease & screening.
2. Integrate SDOH into population level decision-making.
3. Embed analytics into workflows to sustain measurable improvement.
4. Align quality strategy with value-based payment and equity goals.

The Population Health Challenge for FQHCs

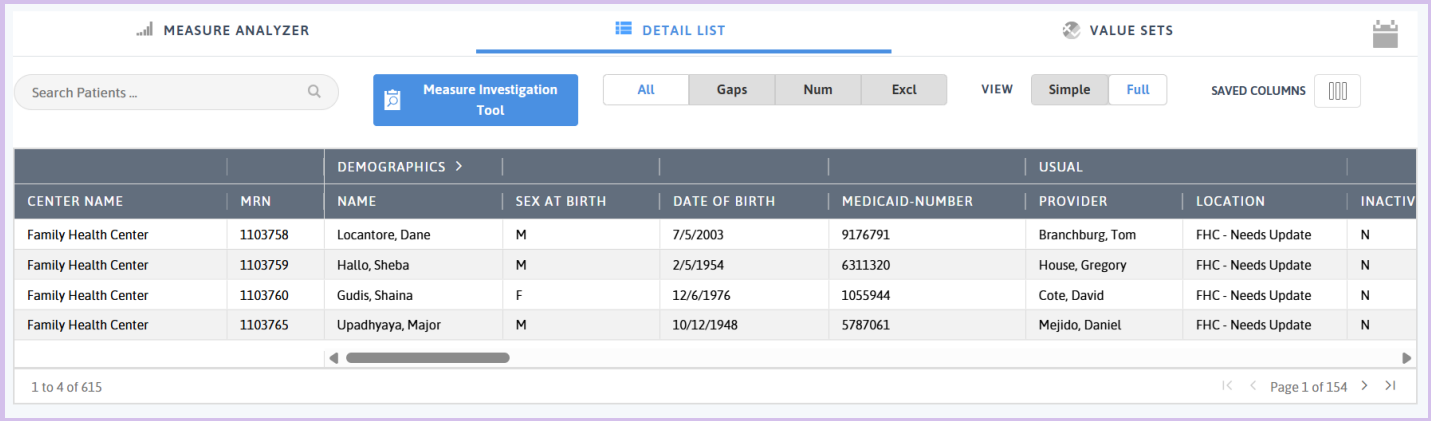
- High prevalence of hypertension & diabetes burden
- Preventable cancer morbidity
- Social & structural barriers (transportation, food insecurity, housing instability)
- Workforce strain & documentation burden
- Multiple reporting demands (UDS, CMS, ACOs)

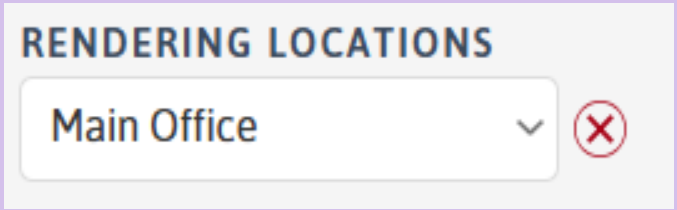
Challenge: No single operational “source of truth”

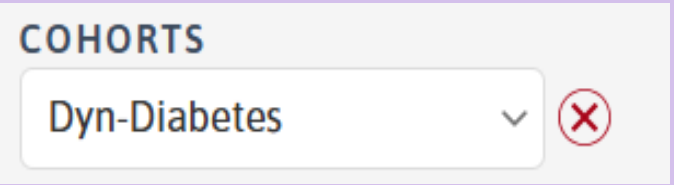
Prior State

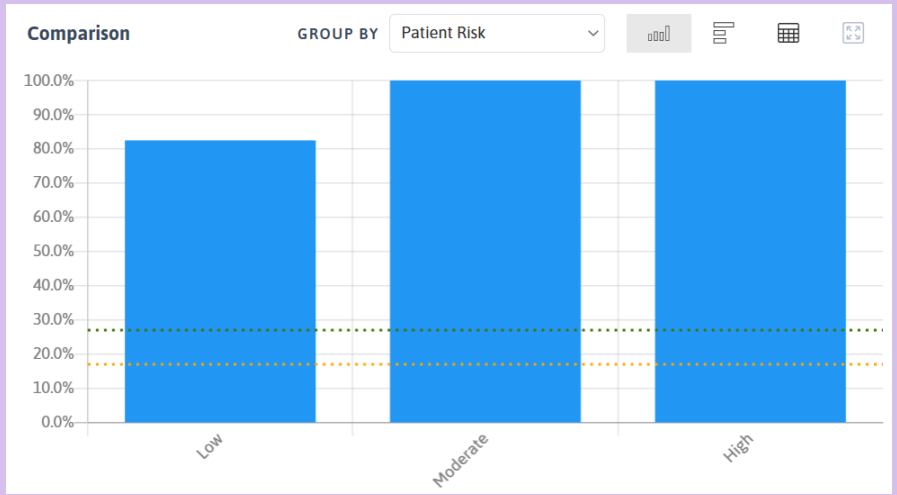
- Data lived in multiple places (e.g., EHR, billing, excel spreadsheets), leading to multiple versions of the truth
- No data infrastructure to be proactive
- Unable to track data continuously or by provider
- Inconsistent naming conventions led to inaccurate data
- No navigation workflow

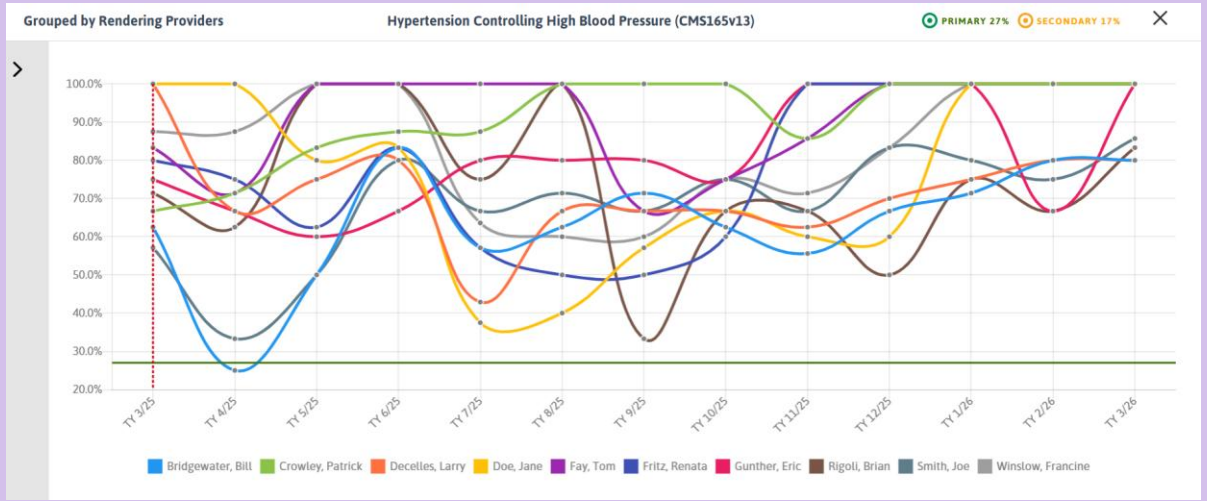
Adopting a Data-Driven Infrastructure











Why This Works

Visit-Based	Population-Based Care
Reactive Care	Proactive Risk Stratification
Static Reporting	Real-Time Performance Management
Volume	Value (CMS, HRSA, ACO Alignment)

Embedding Analytics into Workflows

- Pod communication & huddles
- Outreach lists
- Open order review
- Quality improvement meetings

Advancing Population Health Outcomes Using DRVS

Focus Areas for Optimization:

1. Chronic Disease Management Optimization
2. Cancer Screening
3. Age-Friendly Health Systems Integration
4. Social Care Integration

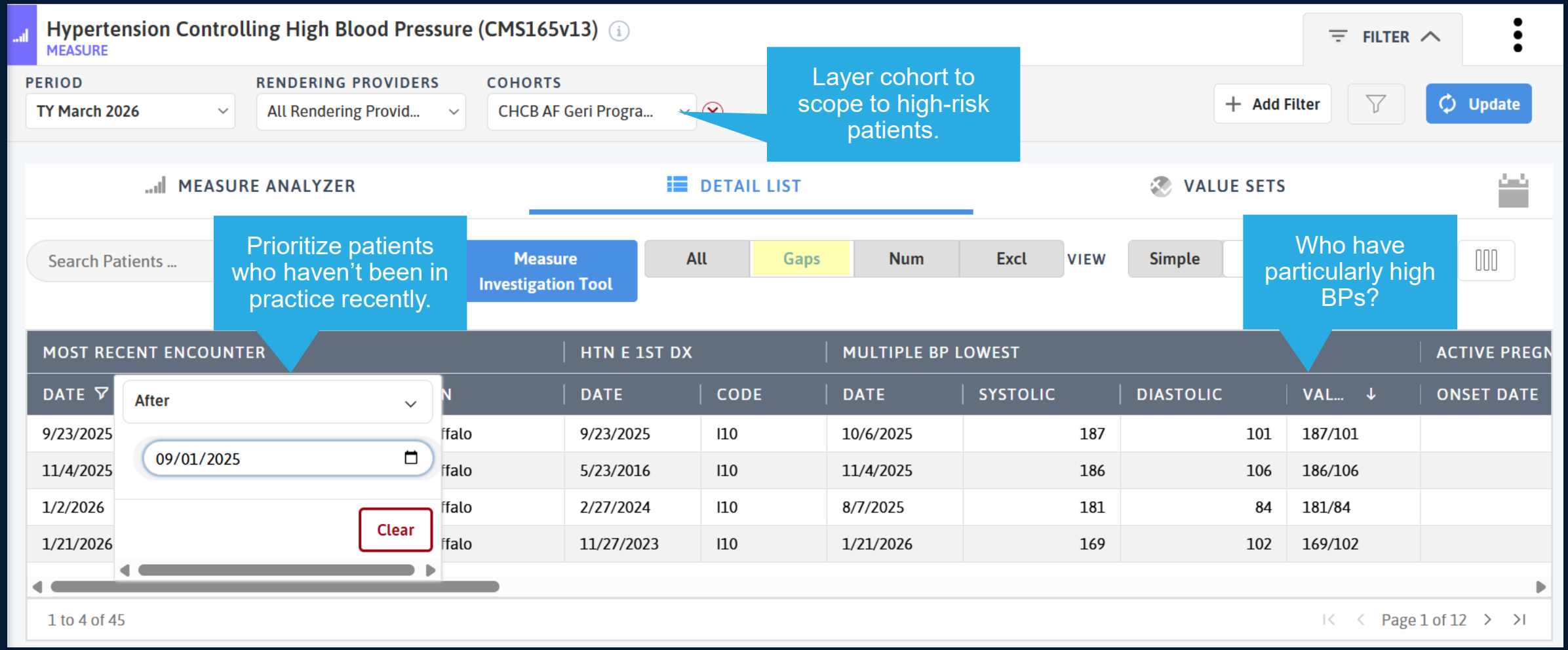
Chronic Disease Management Optimization

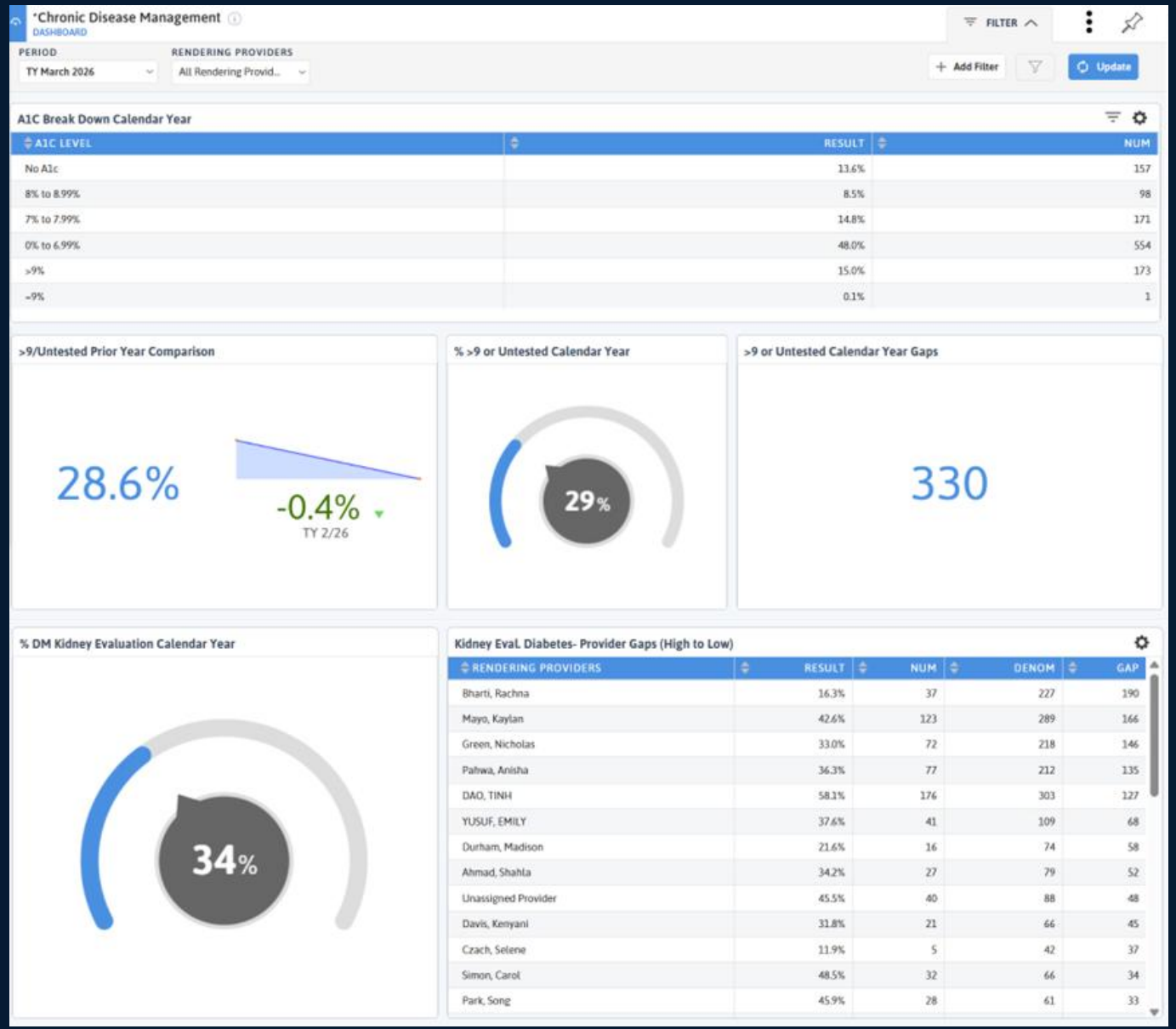
Focus Area: Hypertension & Diabetes Outcomes

Levers for success:

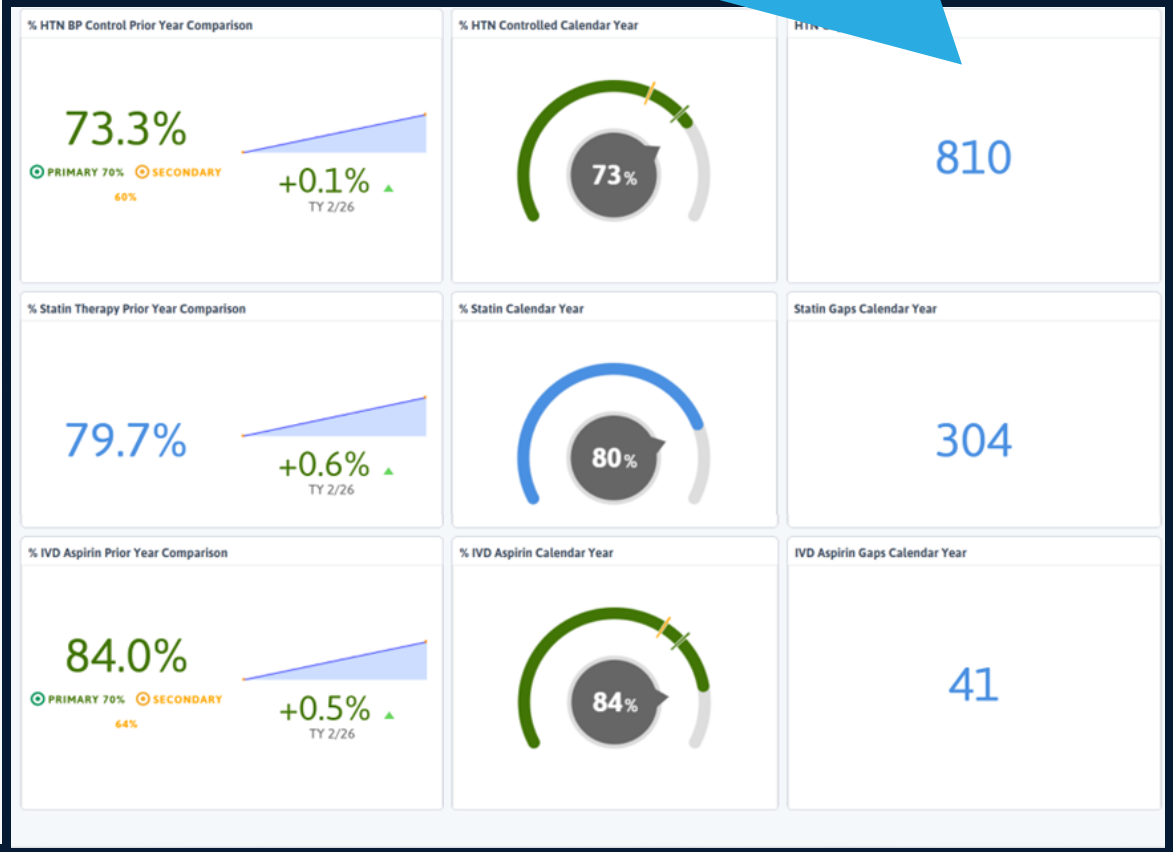
- Risk stratified dynamic cohorts
- Standardized pathways
- Culturally tailored outreach
- Remote Patient Monitoring
- Nurse-led follow-up protocols

Chronic Disease Optimization | Prioritize High-Risk Patients

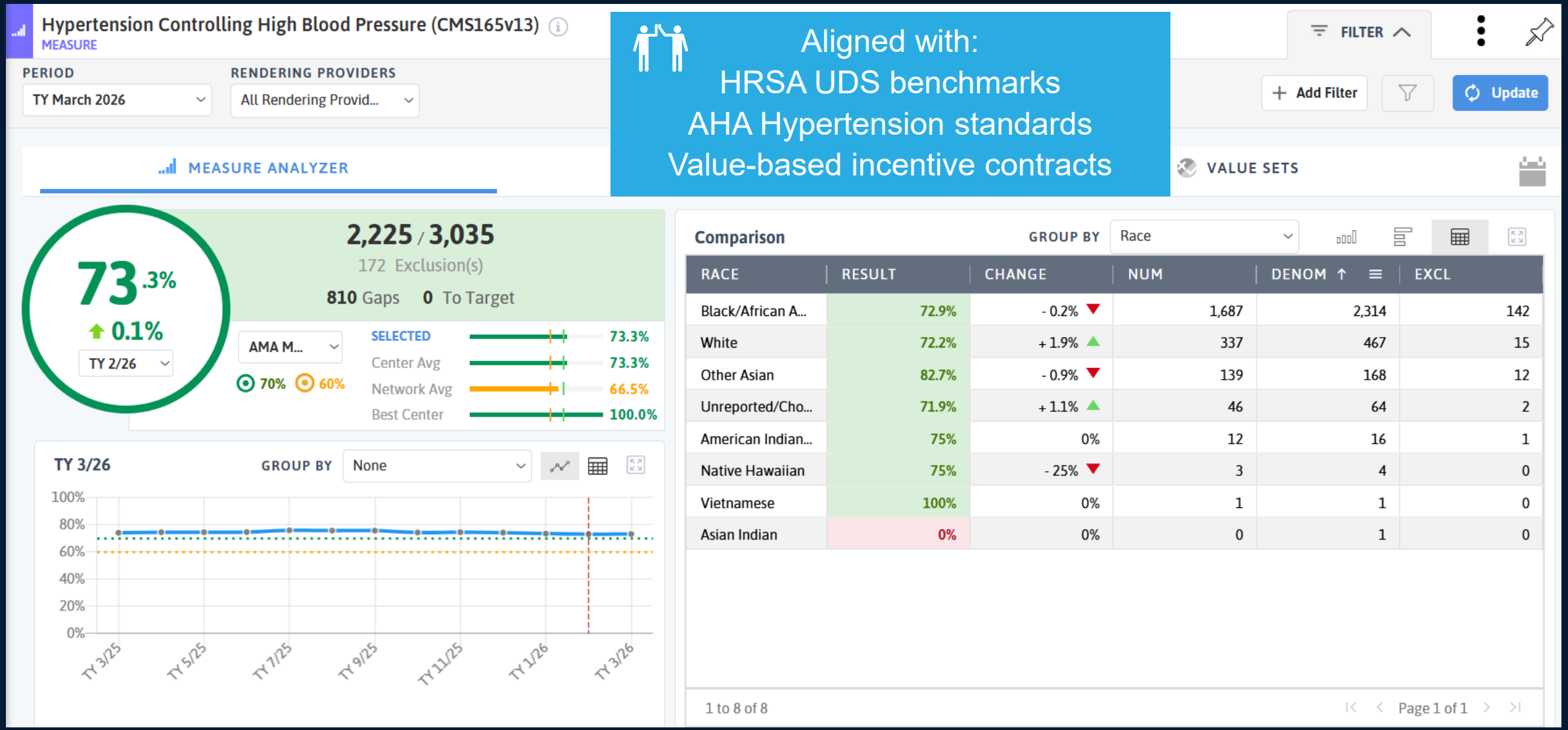




Despite high performance, dashboards allow us to isolate remaining gaps and focus resources on patients who are not yet optimized. DRVS transforms static data into actionable workflows that drive targeted intervention, improve outcomes, and sustain high performance.



Chronic Disease Management Outcomes



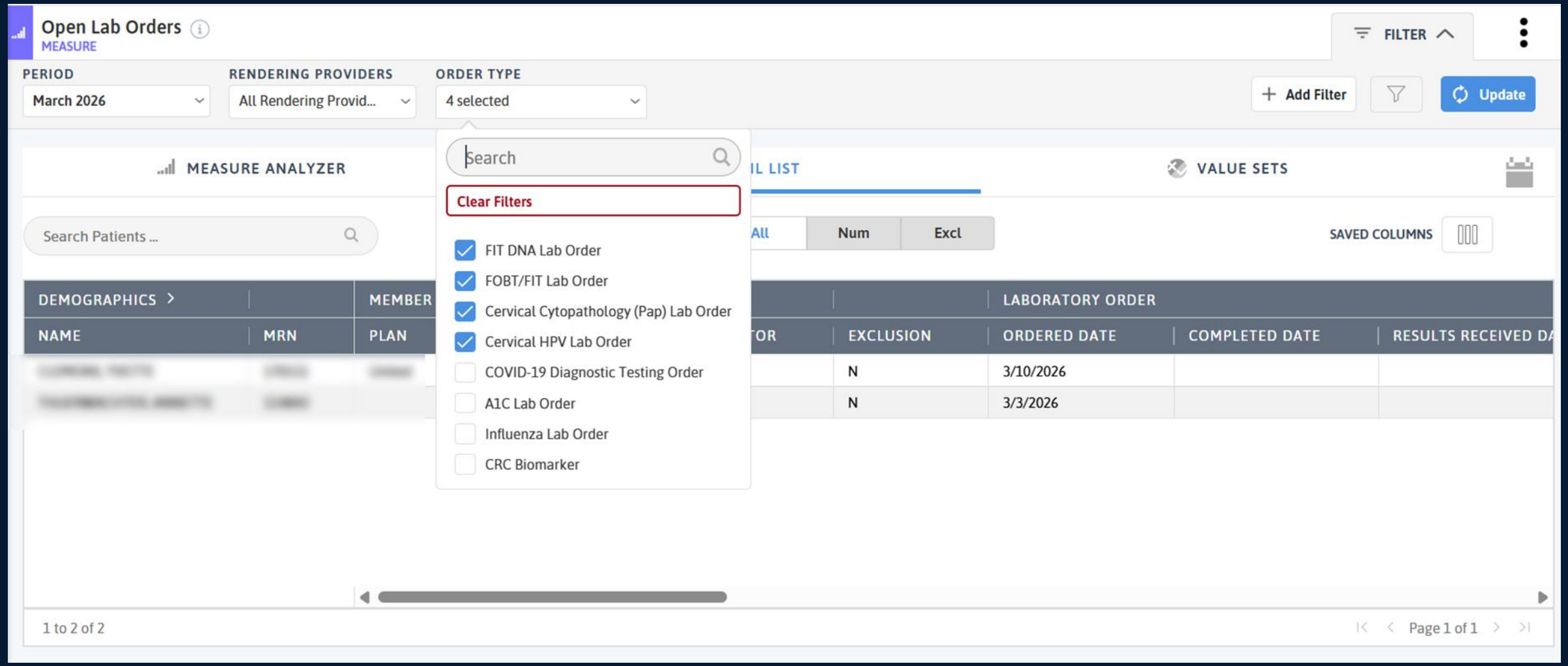
Cancer Screening Optimization

Focus Area: Breast & Colorectal Cancer Screening

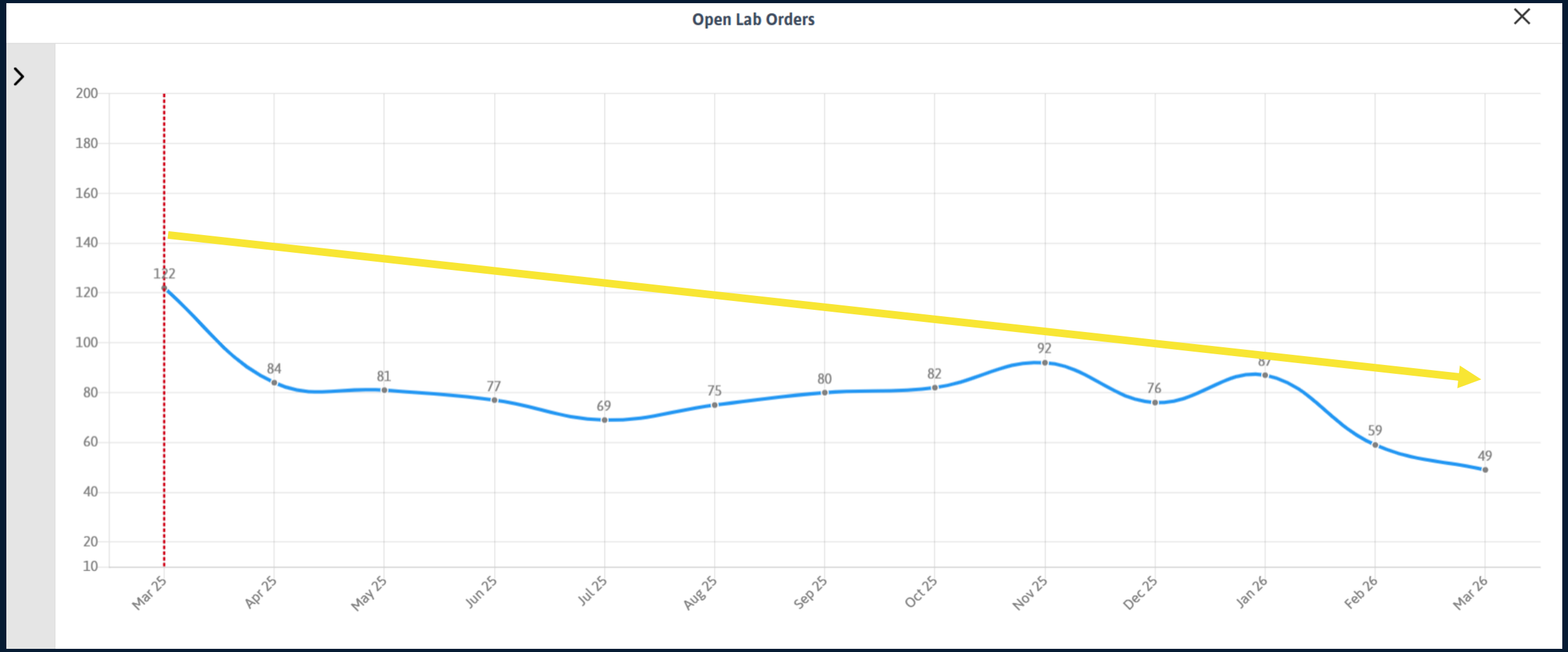
Levers for Success:

- Open order gap lists
- Navigation tracking
- Site-level comparisons
- Standing orders
- Outreach campaigns

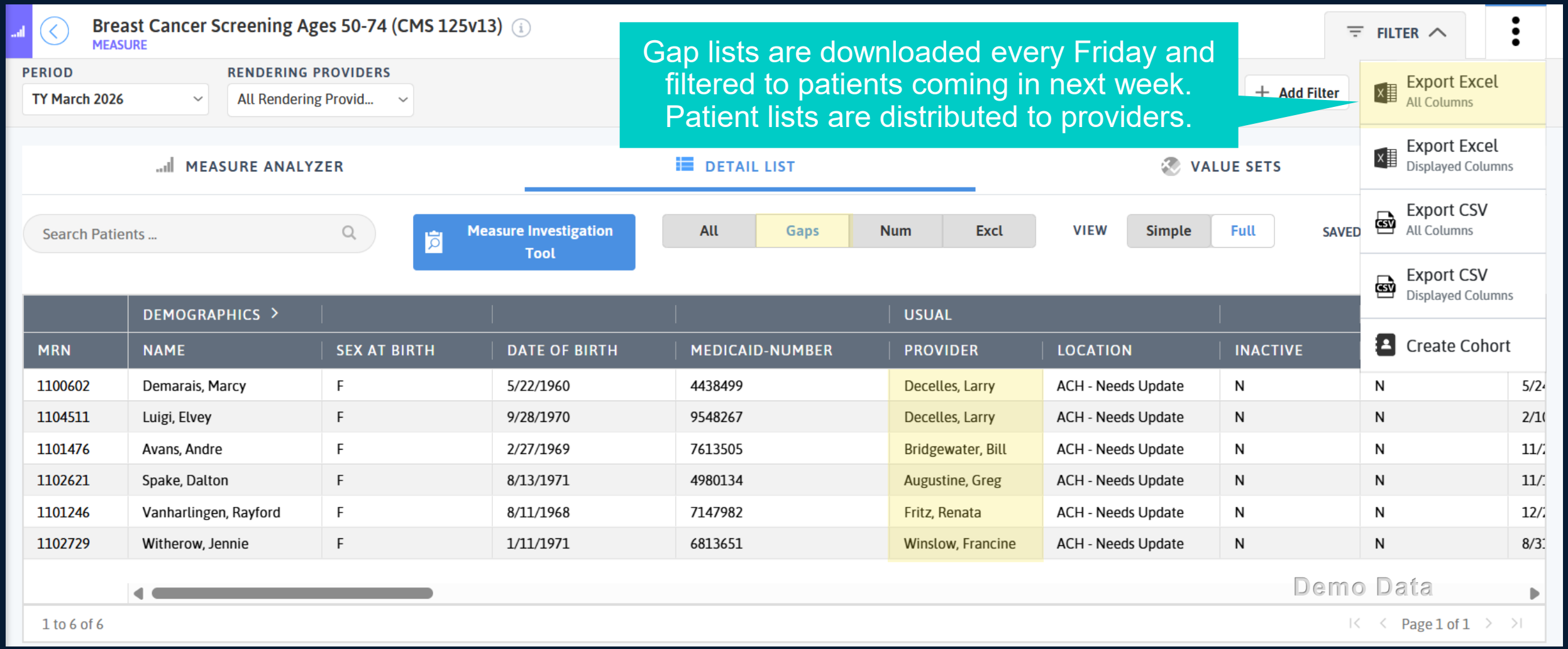
Active Tracking of Open Lab Orders



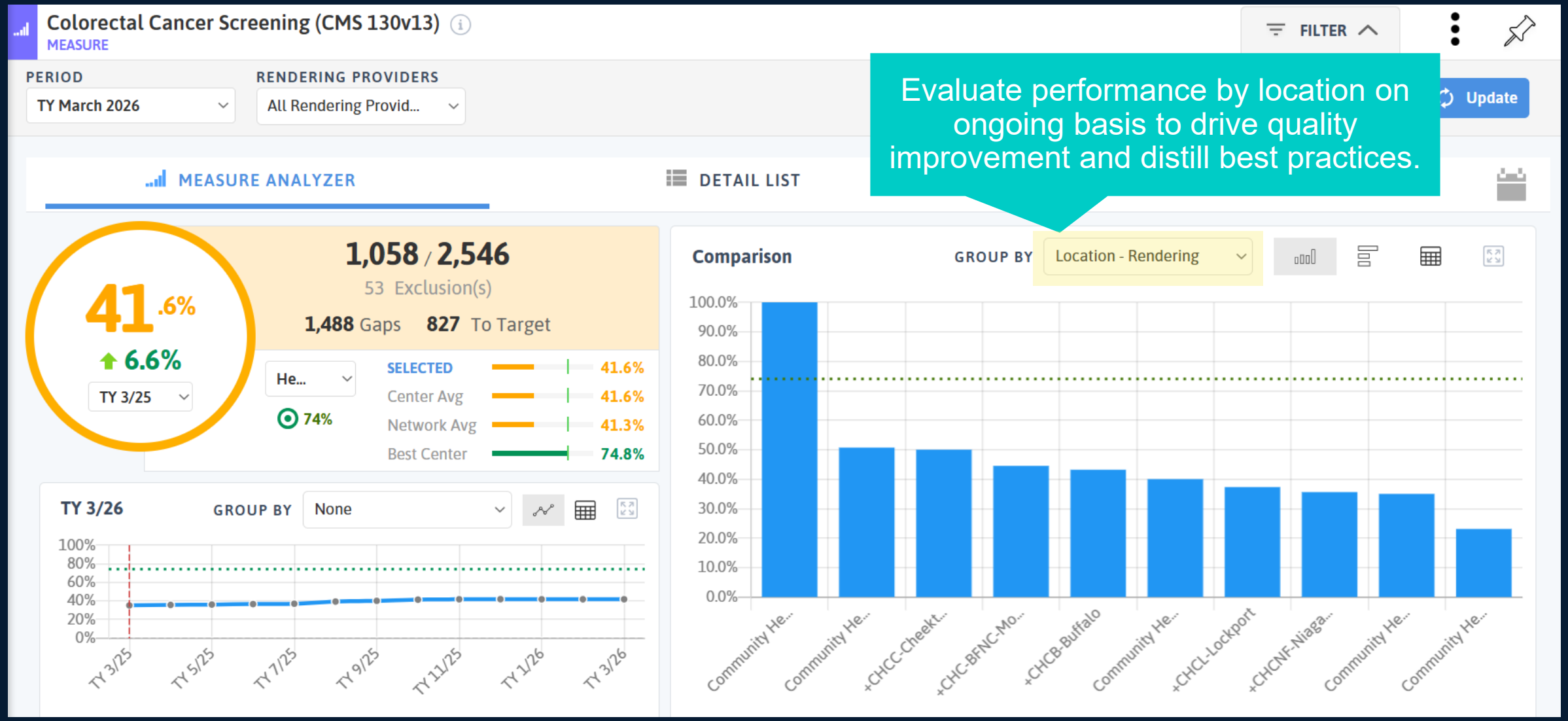
Reduction in Open Lab Volume



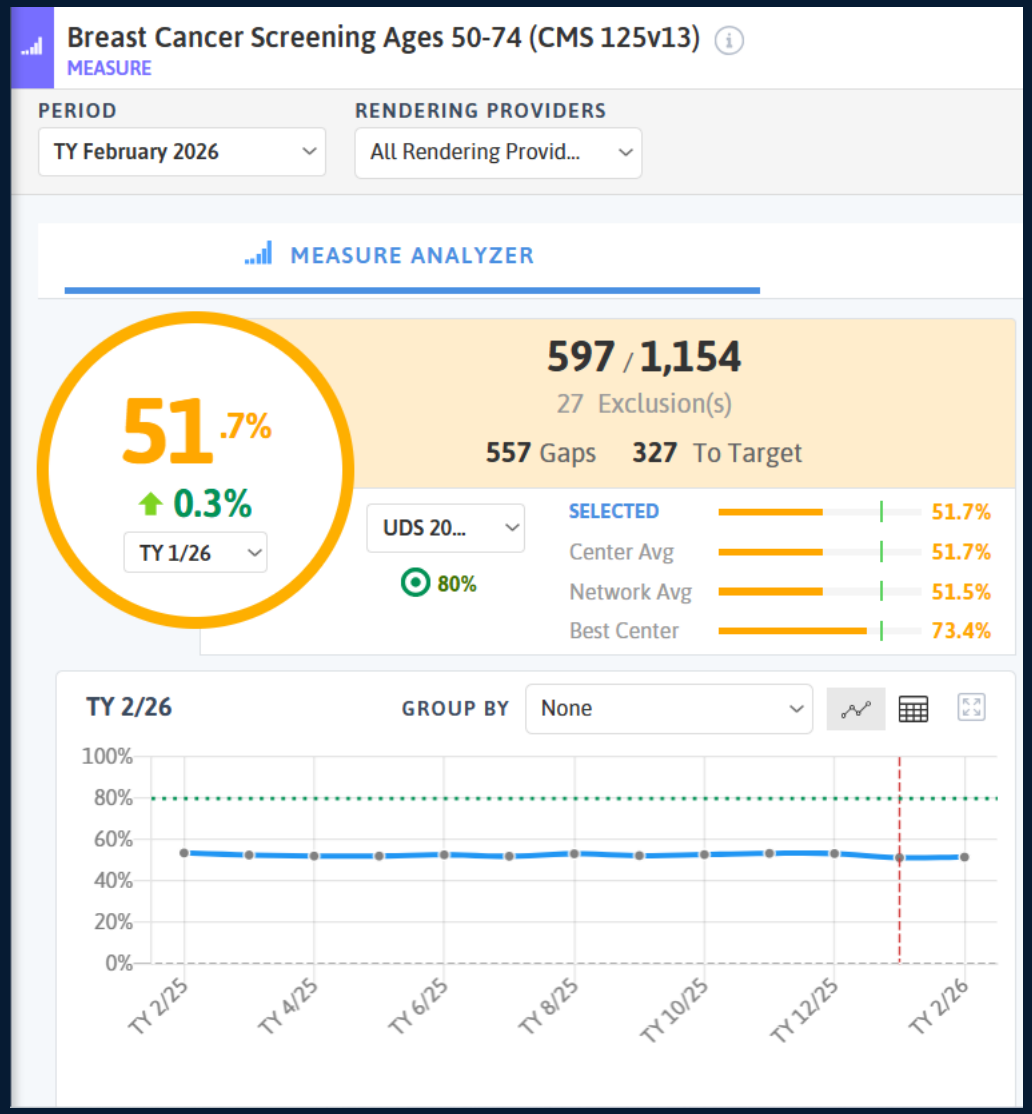
Friday Gap List Distribution

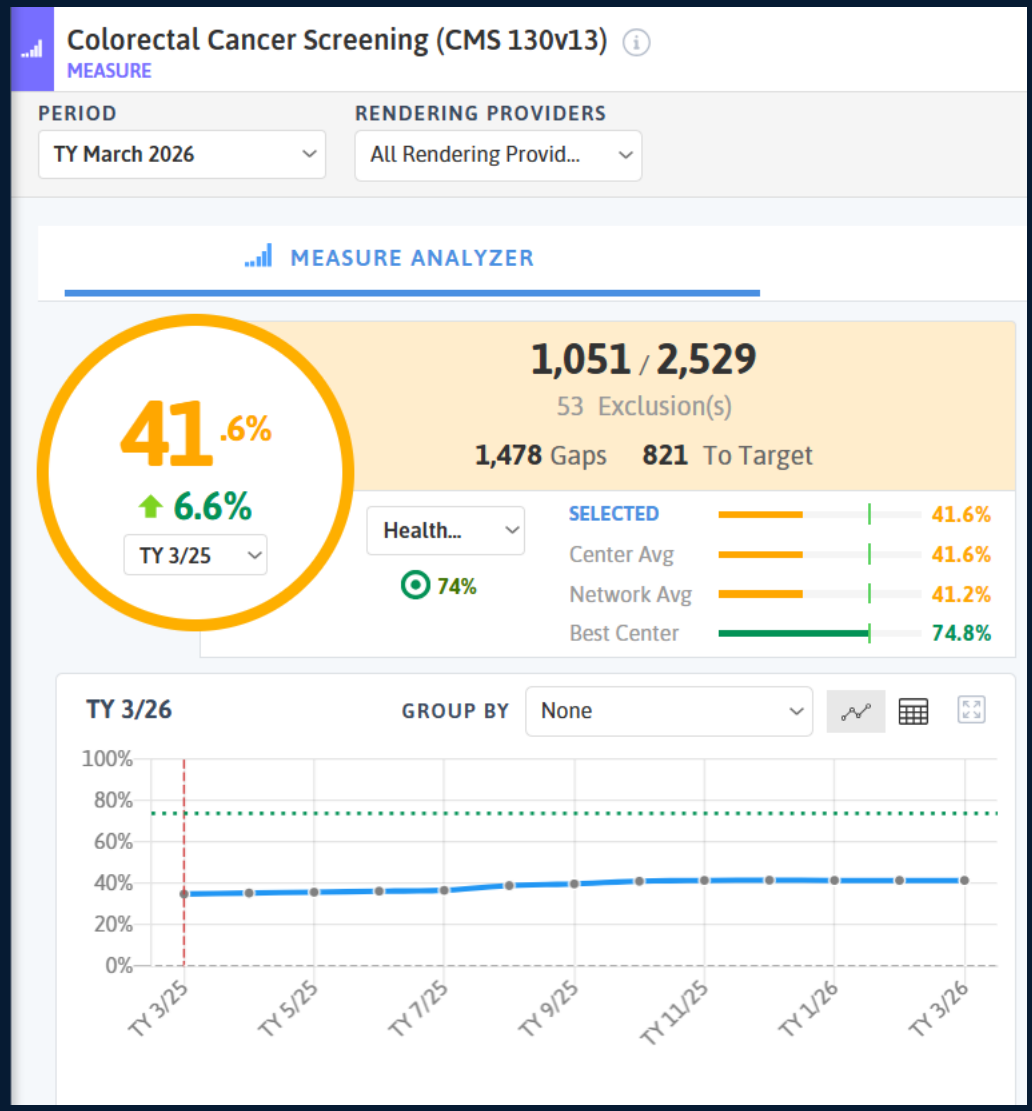


Cancer Screening Optimization



Cancer Screening Optimization Outcomes





Age-Friendly Health Systems Integration

Preventive care aligned with:

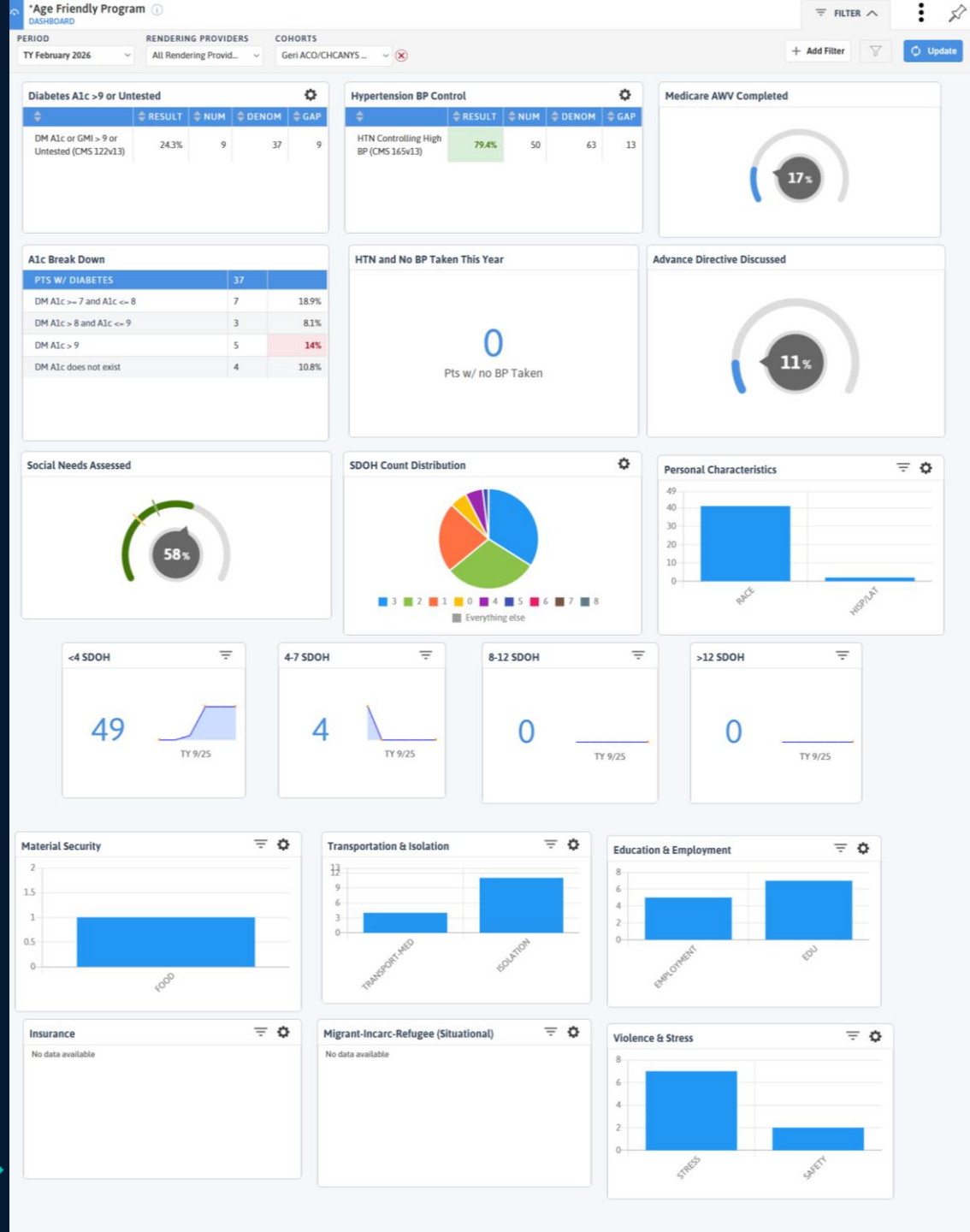
- Medicare Annual Wellness Visits
- Chronic disease alignment
- Geriatric consult workflows

Age-Friendly Quality Tracking

Dashboard demonstrates and facilitates integration between:

- Clinical care (HTN, DM)
- Preventive care (AWV)
- Patient priorities (advance directives)
- Social needs (PRAPARE)

Hidden Gem: Stratify patients based on social risk to prioritize care coordination and resource navigation for those with the highest needs.



Social Care Integration Optimization

Focus Area: Stop asking, “Why aren’t they compliant”. Start asking, “What barriers are preventing engagement?

Explore relationship between upstream barriers to care and:

- Missed mammograms
- Poor BP control
- Medication non-adherence
- No-show rates

Aligning SDOH & Clinical Data

Analytics guide **who** to target, **when** to intervene, and **how** to allocate resources.

Applying insights:

Transportation barriers	→	Mobile mammography scheduling
Food insecurity	→	Diabetes nutrition referral
Medication affordability	→	340B support
Housing instability	→	Care management referral

Prompting SDOH Screening at Point of Care

10:00 AM Tuesday, March 17, 2026 — Visit Reason: TeleHealth Follow up neuropathy, Follow up increase in medication

DIAGNOSES (5)

Asthma	COPD	Depression
HTN-E	SUD No Depend	

RISK FACTORS (3)

ALERT	MESSAGE	DATE	RESULT
HIV	Missing		
Falls Risk Screening	Missing		
PHQ9 Utilization	Overdue	1/3/2025	4
SDOH Needs Assessed	Missing		
Tobacco Scr	Overdue	12/27/2023	Y
BP	Out of Range	2/26/2026	124/83
HepA (Pts >10 mths)	Missing		
Asth Severity	Missing		
Adv Care Discussion	Missing		
Dental	Missing		

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Cardiology	BGH EKG DEPT., .	6/30/2025	

Edit

GENERAL | DATE CRITERIA | RESULT CRITERIA | POPULATION DEFINITION

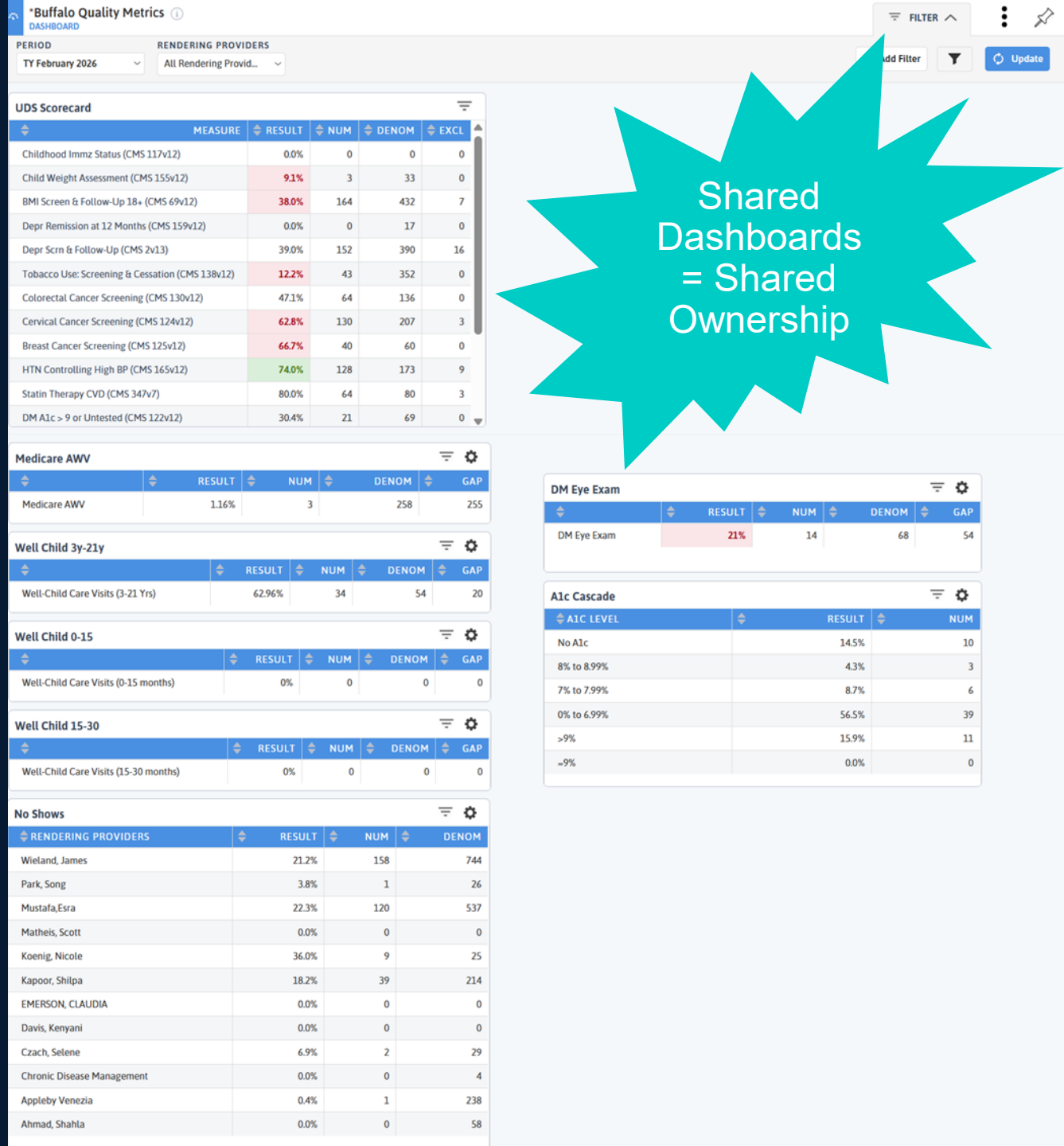
INCLUSION CRITERIA
MIN AGE: 60
MAX AGE: 85
MIN AGE UNITS: Year
MAX AGE UNITS: Year
SEX AT BIRTH: Any

EXCLUSION CRITERIA
EXCLUSION OBSERVATIONS:
REQUIRE ANY OR ALL OBSERVATIONS FOR EXCLUSION: Any

Configured alert to fire specifically for older adults to support healthy aging work

Shared Responsibility | Team-Based Population Health Model

- Providers
- Nurses
- Care managers & Behavioral Health
- Registration & Call Center
- Data & IT teams



Continuous Quality Improvement

Real-time feedback loops replaced delayed quarterly reports. Monthly review structure consists of:

- ✓ Site-level dashboard
- ✓ Provider-level transparency
- ✓ Numerator/denominator transparency
- ✓ Rapid-cycle PDSA

Measurable Impact

Strong Improvements Across:

- Hypertension control
- Breast cancer screening
- Colorectal cancer screening
- Equity-focused outreach
- Documentation

Strong Alignment With:

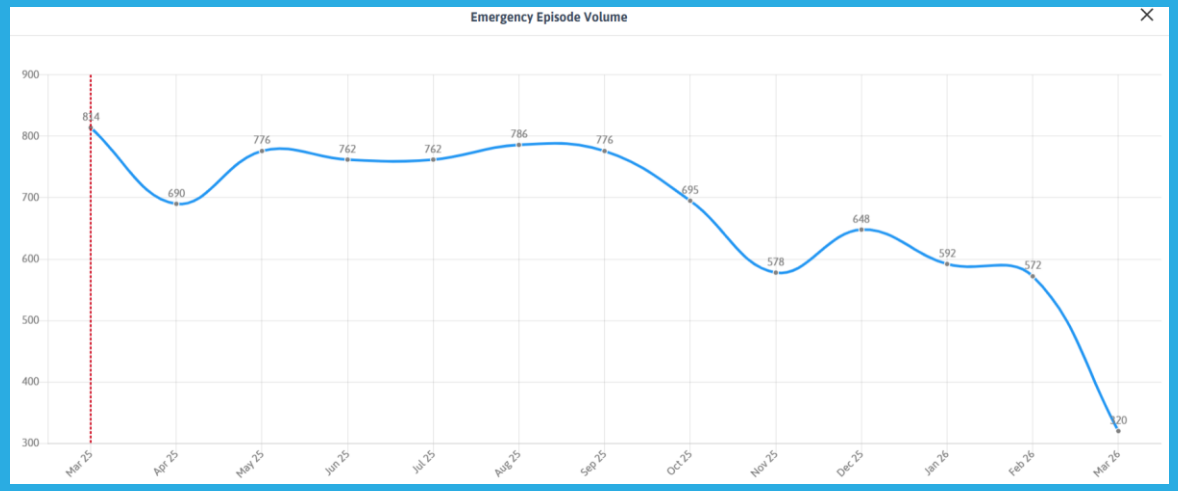
- HRSA UDS
- CMS quality measures
- Value-based contracts
- ACO participation
- AHA certification standards

Value-Based Care / ACO / CMS Financial ROI

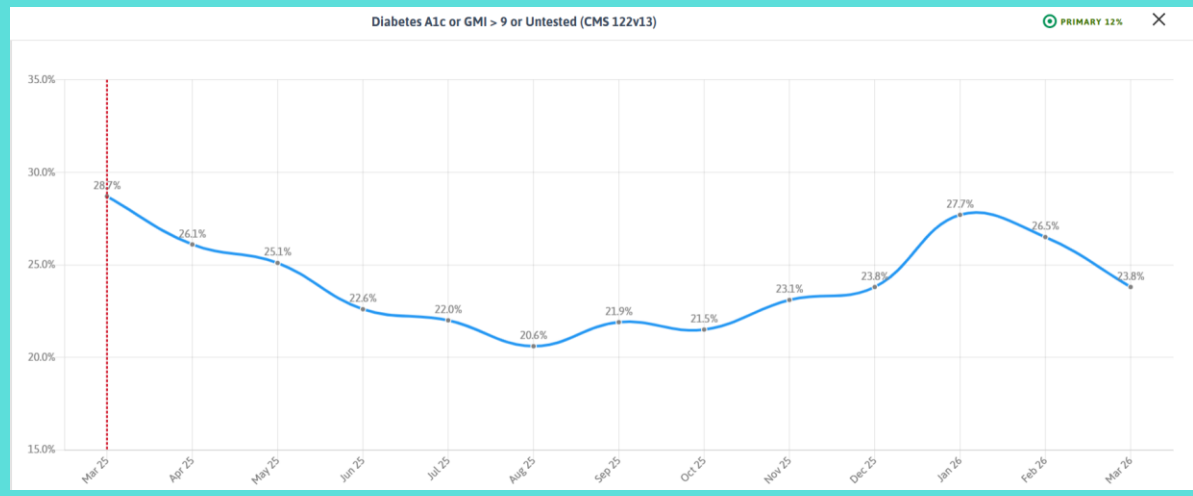
Improved quality scores = higher incentive payments

- Reduced preventable hospitalizations
- Improved HEDIS & UDS performance
- Remote Patient Monitoring (RPM) CPT billing
- Sustainable ROI through proactive care

ED Episode Volume



Diabetes A1C >9 or Untested



Financial Projection | VB Incentives & RPM ROI Modeling

Category	Assumptions	Estimated Annual Impact
Quality Incentives (ACO/CMS)	Improved HTN & screening tied to shared savings	$150,000 – $300,000
Avoided Hospitalizations	Reduced preventable admissions (HTN-related)	$200,000+
RPM 99453 (Setup)	200 pts x $19	$3,800
RPM 99454 (Device Supply)	200 pts x $48 x 12 months	$115,200
RPM 99457 (Monitoring)	200 pts x $50 x 12 months	$120,000
RPM 99458 (Additional Monitoring)	50% eligible x $40 x 12 months	$48,000
Estimated Total ROI	Combined quality + RPM revenue	$636,000 – $786,000+

Practical Implementation Lessons

1. Start with one high-impact cohort
2. Make data visible to frontline teams
3. Standardize documentation before scaling
4. Align outreach with SDOH insights
5. Tie performance to accountability structures

Implementation Roadmap

- **Phase 1** — Foundational Dashboards
- **Phase 2** — Workflow Redesign
- **Phase 3** — SDOH Integration
- **Phase 4** — Equity Stratification
- **Phase 5** — Scale & Sustain through Value-Based Incentives

Key Takeaways | DRVS Analytics Engine

Population health drives performance—but **high-risk care management** drives sustainability.

Real-Time Cohort Identification & Risk Stratification
Workflow-Integrated Gap Closure & Targeted Outreach
Improved Quality Metrics (HTN Control, Cancer Screening, AWV)
ACO Shared Savings & CMS Quality Incentives

Identification of Uncontrolled High-Risk Patients
Remote Patient Monitoring (RPM) Enrollment
Billable CPT Revenue (99453, 99454, 99457, 99458)
Recurring Monthly Revenue Stream

Key Takeaways

Population health success requires:

- Valid, timely data
- Intentional workflow design
- Interdisciplinary discipline

Real-time analytics drive improvement:

- Workflow design ensures sustainability
- Equity integration strengthens outcomes
- Financial alignment secures longevity

Acknowledgment | Strategic Partnership & Support

CHCB gratefully recognizes the AHA and CHCANYS for their continued leadership and investment in equity-driven chronic disease management. Their support has strengthened our ability to operationalize Azara DRVS analytics, advance HTN control, and build sustainable population health infrastructure aligned with VB care. These partnerships have been instrumental in improving outcomes for our most vulnerable communities.

From **Reporting** to **Results**.

From **Data** to **Decisions**.

From **Quality Metrics** to **Health Equity**.

Questions?

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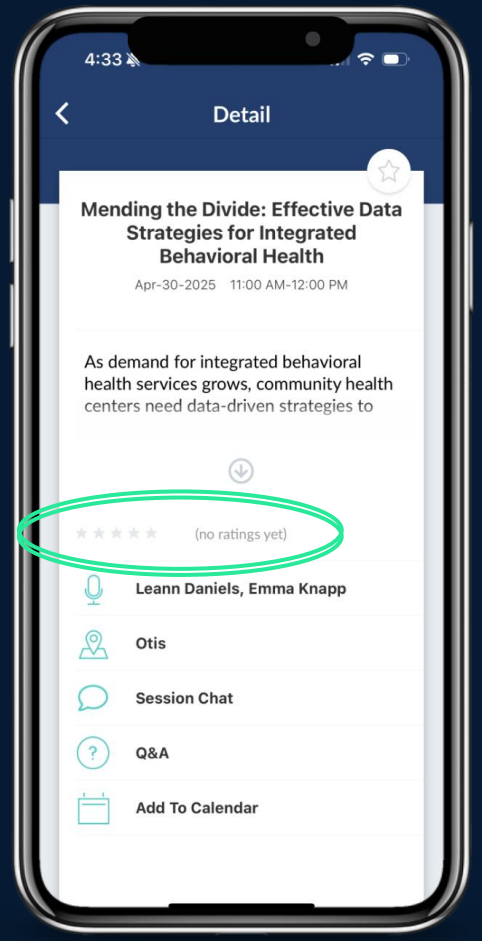

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